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Pain Relief for the Dying: The Unwelcome Intervention of the Criminal Law

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Pain Relief for the Dying: The Unwelcome Intervention of the Criminal Law

Abstract
This Article addresses physician-assisted suicide and the medical treatment of pain and suffering. Part II discusses various medical misconceptions about the treatment of pain and how modern medicine fails to fulfill this aspect of its palliative care role. Part III reviews how the law currently circumscribes the patient and doctor's ability to make medical decisions when the patient is terminally ill. As will be shown, the law is clearer and more respectful of good medical practice than most medical practitioners currently believe. Moreover, this section will also establish that, while several competing philosophical positions surrounding physician-assisted suicide exist, these same philosophies harmoniously approve of aggressive pain treatment. Part IV examines the role of the criminal law in medical treatment decisions, particularly those made at the end of life, regarding palliative care to relieve pain and suffering. It will in no way exhaust the subject of end-of-life medical treatment, nor will it discuss every possible place at which the practice of medicine and the criminal law might cross paths. Rather, Part IV considers some of the most important points of intersection between the two, and attempts to clarify the most significant principles of law and ethics that apply when the criminal law seeks to scrutinize medical decisions about palliative care to dying persons. It then should be apparent that the rush to legalize assisted suicide is misdirected and diversionary.

Keywords
Criminal law, assisted suicide, pain treatment, pain medication, medical negligence, morphine, euthanasia

Disciplines
Criminal Law | Medical Jurisprudence
PAIN RELIEF FOR THE DYING: THE UNWELCOME INTERVENTION OF THE CRIMINAL LAW

Phebe Saunders Haugen

If the changes we fear be thus irresistible, what remains but to acquiesce with silence, as in the other insurmountable distresses of humanity? It remains that we retard what we cannot repel, that we palliate what we cannot cure.

— Samuel Johnson

I. INTRODUCTION ...................................................................... 326

II. MEDICAL MISCONCEPTIONS AND THE FAILURE OF MODERN MEDICINE TO TREAT PAIN .......................................................... 331
A. Inadequate Access to Palliative Care and Lack of Proper Physician Training ............................................ 332
B. Medical Misconceptions Regarding the Use of Drugs to Treat the Terminally Ill .............................................. 335

III. THE LAW AND ETHICS OF TREATING THE TERMINALLY ILL ........................................................................................ ;.337
A. Explicating Terminology to Define the Scope of the Problem ........................................................................ 337
B. The Minnesota Morphine Investigations ............................................. 341
C. The Law of Treatment Withdrawal ............................................................. 343
  1. The Courts’ Response to Treatment Withdrawal ............. 343
  2. Withdrawal of Ventilators: Why Courts Treat It Differently ............................................................. 346

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The subject of physician-assisted suicide has inundated America’s culture over the course of the last decade. For the last seven years, Dr. Jack Kevorkian, the notorious pathologist from Michigan, has defied the American legal system to find him guilty of a crime. With his assistance, at least forty-five people have ended their lives. Nonetheless, three juries have acquitted him of statutory and common-law versions of the crime of assisting suicide. While Michigan authorities have apparently surrendered in their attempt to circumscribe his death-inducing activities, Dr. Kevorkian continues to make regular public appearances in which he describes exactly what he has done and why he believes his acts are justifiable. Moreover, he continues to declare adamantly that he will continue helping virtual strangers end their lives.

While Dr. Kevorkian persists in his practices, the public clamor for the legalization of physician-assisted suicide has intensified. Surveys reveal that up to two-thirds of Americans support some form of medical assistance to hasten the death of the terminally ill.
In addition, some studies reveal that more than half of the nation's doctors support physician-assisted suicide, despite the fact that numerous professional organizations do not condone the practice. The appearance of electoral proposals further evidences the strength of current public opinion. While previous measures in two states narrowly failed, in 1994, Oregon voters passed the


However, a recent poll produced more complicated results. Forty percent of the respondents did not know that it was legal to give patients pain medication that might hasten death, and 35% were unfamiliar with the terms "hospice" and "palliative care." After these terms were explained, 73% said they would choose hospice care, palliative care, or natural death if terminally ill, 14% were undecided, and only 13% said they would still choose physician-assisted suicide. See AMA Poll: The More Patients Know, the Less They Want Suicide Aid, AM. MED. NEWS, Jan. 13, 1997, at 3.

9. See Melinda A. Lee et al., Legalizing Assisted Suicide – Views of Physicians in Oregon, 334 NEW ENG. J. MED. 310, 310 (1996) (noting that studies show that between 31% and 54% of United States physicians do not oppose legalizing physician-assisted suicide or euthanasia).

10. See, e.g., Council on Ethical and Judicial Affairs, American Medical Association, Decisions Near the End of Life, 267 JAMA 2229, 2233 (1992) (concluding that physicians should not assist patients with suicide until the issue has been more thoroughly examined); Nessa Coyle, The Euthanasia and Physician-Assisted Suicide Debate: Issues for Nursing, 19 ONCOLOGY NURSING F. 41, 44 (1992) (stating that the American Nurses Association takes the position that it is against the ethical tradition of nursing to help patients end their lives).

The Council on Ethical and Judicial Affairs states that although "in highly sympathetic cases physician-assisted suicide may seem to constitute beneficent care, due to the potential for grave harm the medical profession cannot condone physician-assisted suicide at this time." Council on Ethical and Judicial Affairs, supra, at 2233. Instead, the Council directs the medical profession to strive to identify the concerns behind patients' requests for assisted suicide and to find ways other than assisted suicide to address these concerns, such as providing more aggressive comfort care. See id.

The American Medical Association reaffirmed its position when it formed a coalition to ask the U.S. Supreme Court not to legalize the practice when ruling upon the physician-assisted suicide cases argued recently before it. See AMA Poll: The More Patients Know, supra note 8, at 3.

11. See Death with Dignity Act, 1992 Cal. Legis. Serv. Prop. 161 (West) (rejected by the voters Nov. 3, 1992); Death with Dignity Act, 1991 Wash. Legis. Serv. Init. Meas. 119 (West) (rejected by the people Nov. 5, 1991); see also Bachman et al., supra note 8, at 303 (noting the defects of the Washington and California initiatives and discussing the Oregon initiative); William Carlsen, When Patients Choose to Die, S.F. CHRON., June 3, 1996, at A1 (noting that the California proposi-
Death with Dignity Act,\textsuperscript{12} the nation's first statute permitting doctors to prescribe lethal medications to allow terminally ill patients to kill themselves.\textsuperscript{13} Other states have considered legislation legalizing physician-assisted suicide, but, as yet, no statutes have been passed.\textsuperscript{14}

More recently, the push for the legalization of physician-assisted suicide entered the courthouse. In January 1997, the United States Supreme Court heard arguments regarding the constitutionality of statutes from New York\textsuperscript{15} and Washington\textsuperscript{16} that prohibit anyone from assisting another in committing suicide.\textsuperscript{17} The Second Circuit Court of Appeals ruled that New York's bar against physician-assisted suicide is an unconstitutional infringement of the Equal Protection Clause.\textsuperscript{18} The Ninth Circuit took a

\begin{enumerate}
  \item See OR. REV. STAT. §§ 127.800-.897 (1996) (passed by voters in a general election on Nov. 8, 1994). Oregon voters approved the measure by the narrowest of margins, 51\% to 49\%. \textit{See} Clark, supra note 11, at 58 n.40.
  
  At the time of this writing, several bills are before the Oregon legislature to amend or repeal the statute. One bill proposes the addition of provisions that provide physicians with immunity from civil and criminal liability and professional discipline for good-faith compliance with Oregon's Death with Dignity Act. \textit{See} H.B. 3362, 69th Leg., 1997 Reg. Sess. (Or.). Another bill expands the scope of the required counseling for patients who request physician-assisted suicide. \textit{See} H.B. 2965, 69th Leg., 1997 Reg. Sess. (Or.). A third repeals the Death with Dignity Act. \textit{See} H.B. 2700, 69th Leg., 1997 Reg. Sess. (Or.).
  
  
  
  15. See N.Y. PENAL LAW §§ 120.30, 125.15(3) (McKinney 1987) (declaring a person guilty of a felony for promoting a suicide attempt; declaring a person guilty of manslaughter in the second degree for intentionally causing or aiding another person to commit suicide).
  
  16. See WASH. REV. CODE ANN. § 9A.36.060 (West 1988) (designating it a felony to promote a suicide attempt by knowingly causing or aiding another person to attempt suicide).
  
  
different route to reach the same result. It concluded that the Due Process Clause of the Fourteenth Amendment renders Washington's statute unconstitutional, because it impermissibly prohibits doctors from prescribing potentially lethal medications to competent, terminally ill patients who wish to end their lives. A decision from the high court is expected during the summer of 1997.

Underlying much of the discussion about physician-assisted suicide is the public’s fear of undergoing a prolonged and painful demise. Advocates of physician-assisted death have focused on this fear, rather than dealing with the most critical component of this issue: the ability of medicine to treat pain. The current debate has incorrectly centered on the perception of a painful death rather than how medical practitioners carry out their role of alleviating pain. Yet it is clear that fears about inadequate pain control, which drive the physician-assisted suicide debate, are at the heart of the issue. Patients whose pain is adequately controlled rarely want assisted suicide. In a recent study, seventy-three percent of persons, when they understood what “palliative care” and “hospice” meant, said they would choose those options over physician-assisted suicide. By refocusing attention on how medicine addresses the problem, rather than the problem itself, the public's motivation for favoring physician-assisted suicide seemingly dissipates.

Shifting attention to how medicine addresses pain, though, reveals an entirely separate set of difficulties. As many have observed, no physician in the United States has ever been convicted of murder or assisted suicide for providing a patient with high doses of medication for pain relief. Despite this, a recent study revealed

20. See id. at 838.
24. See, e.g., Buchan & Tolle, supra note 22, at 57 (“To our knowledge, no physician in the United States has ever been convicted of murder or assisted suicide for providing a patient with appropriate high-dose pain medication.”); Leon-
that physicians consistently fail to treat pain adequately.25 The study, involving 687 physicians and 759 nurses in five hospitals, asked the health care providers to assess the care that dying patients received at the end of their lives.26 Overall, eighty-one percent of the participants reported that “the most common form of ‘narcotic abuse’ in the care of the dying is undertreatment of pain.”27 Just over one-third of the physicians and forty-four percent of the nurses expressed the view that under-medication is most often due to the “fear of hastening a patient’s death” or, in other words, of providing a last, lethal dose.28 Thus, the fact that modern medicine fails adequately to address patient pain certainly lends credence to the public’s fear of a horrible end.

Minnesota’s experiences further detail this disturbing trend. Two investigations of several physicians and their palliative care of two dying patients occurred in Hennepin County, Minnesota, in 1989.29 While these cases never proceeded beyond the investigation stage,30 they caused considerable distress in the local medical community.31 More importantly, they reveal the fears physicians face when they attempt to provide appropriate pain relief to dying patients.32

This Article addresses some of the issues that these cases raise. Part II discusses various medical misconceptions about the treat-
ment of pain and how modern medicine fails to fulfill this aspect of its palliative care role. Part III reviews how the law currently circumscribes the patient and doctor's ability to make medical decisions when the patient is terminally ill. As will be shown, the law is clearer and more respectful of good medical practice than most medical practitioners currently believe. Moreover, this section will also establish that, while several competing philosophical positions surrounding physician-assisted suicide exist, these same philosophies harmoniously approve of aggressive pain treatment.

Part IV examines the role of the criminal law in medical treatment decisions, particularly those made at the end of life, regarding palliative care to relieve pain and suffering. It will in no way exhaust the subject of end-of-life medical treatment, nor will it discuss every possible place at which the practice of medicine and the criminal law might cross paths. Rather, Part IV considers some of the most important points of intersection between the two, and attempts to clarify the most significant principles of law and ethics that apply when the criminal law seeks to scrutinize medical decisions about palliative care to dying persons. It then should be apparent that the rush to legalize assisted suicide is misdirected and diversionary.

II. MEDICAL MISCONCEPTIONS AND THE FAILURE OF MODERN MEDICINE TO TREAT PAIN

For many, the prospect of legal access to a physician's help in bringing about a swift end to a long and painful dying process is a welcome blessing. The thought of dependence, indignity and, worst of all, unremitting suffering at the end of life is an unimaginable horror. For some doctors, the most difficult aspect of caring for such patients is the knowledge that at some point they may have to say no to a patient's plea for a swift and easy death, or risk professional sanctions and perhaps criminal prosecution for acceding

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33. See George C. Garbesi, The Law of Assisted Suicide, 3 ISSUES L. & MED. 93, 104 (1989) (noting that the pain and suffering associated with terminal illness leaves some “unable to derive even minimal pleasure from their existence”).
34. See Wanzer, Physician's Responsibility, supra note 24, at 956 (noting that a “physician's schooling, residency training, and professional oath emphasize positive actions to sustain and prolong life”); Julia Pugliese, Note, Don't Ask — Don't Tell: The Secret Practice of Physician-Assisted Suicide, 44 HASTINGS L.J. 1291, 1300, 1306 (1993) (stating that doctors face a difficult quandary: assisting suicide is illegal, yet refusing to assist is contrary to medical ethics).
to the desperate request. Many physicians, in addition to wanting to avoid this issue, find the public’s growing demand for physician aid in dying as posing the gravest of risks to the integrity of the medical profession and to the relationship between the doctor and the dying patient.

A. Inadequate Access to Palliative Care and Lack of Proper Physician Training

Palliative care refers to the care of terminally ill patients near the end of their lives. The primary goal of this type of care is to alleviate pain, rather than to prolong life. During the latter part of this century, palliative medicine finally has been endorsed as a critical part of any rational health care policy. An outgrowth of this evolution in medicine has been the advent of hospice care, which has flourished in the United States. Hospice care has steadily become a favored way of treating the terminally ill since such facilities specialize in all aspects of palliative care, with the goal of

35. See Buchan & Tolle, supra note 22, at 53-54; Pugliese, supra note 34, at 1291-92 (narrating the story of one doctor who assisted a terminally ill patient in ending his life and later lied about and covered up his actions to avoid possible negative repercussions).
36. See Pugliese, supra note 34, at 1315-16 (stating that some doctors fear their role will be seen, at least in the eyes of some potential patients, as that of a killer rather than a healer).
38. See id. “Palliative therapy is treatment undertaken with the objective of relieving symptoms, particularly when these are painful, or in some other way distressing, but in the knowledge that it will not affect the outcome of the disease.” THE OXFORD MEDICAL COMPANION 722 (John Walton et al. eds., 1994).
40. See id.; Wanzer, A Second Look, supra note 22, at 845; Walter Parker, Medicine, Law Clash over Morphine, ST. PAUL PIONEER PRESS DISPATCH, Oct. 2, 1989, at 1A.
41. Webster’s defines hospice as “a home like facility to provide supportive care for terminally ill patients.” WEBSTER’S UNABRIDGED DICTIONARY 879 (2d ed. 1983). Hospice care in this country follows the principles of its English originator, Dame Cicely Saunders, founder of London’s St. Christopher’s Hospice. See Ronald Melzack, The Tragedy of Needleless Pain, SCI. AM., Feb. 1990, at 27, 28. The richness of hospice care, as Dr. Saunders envisioned and practiced it, cannot be adequately described here. The control of physical pain, our concern here, is but one part of this extraordinary form of treatment. For a detailed description of how the hospice program works and how patients have become part of the movement to help others, see generally SANDOL STODDARD, THE HOSPICE MOVEMENT: A BETTER WAY OF CARING FOR THE DYING (1978).
preserving and enhancing the quality of life for those who are near its end.\textsuperscript{42} Excellent pain relief is its hallmark.\textsuperscript{43} Still, hospices in the United States presently serve only a disappointing seventeen percent of all dying patients.\textsuperscript{44} The primary reason for this is that home care is an integral, often required, component of most hospice plans.\textsuperscript{45} As a result, hospice care usually is inaccessible to those patients without family members who can provide twenty-four-hour support.\textsuperscript{46} Since nearly eighty percent of Americans die in either hospitals or nursing homes,\textsuperscript{47} the vast majority of dying patients are subject to the most uneven quality in palliative care.\textsuperscript{48}

Palliative care has struggled to take root in the United States for reasons other than lack of access to hospice care. The failure of medical schools properly to train students how to manage pain effectively exacerbates the problem. Most medical students are offered only a short elective course in palliative care in their last year of school, and few choose it.\textsuperscript{49} Residents in a majority of hospitals receive little training and experience in how to care for the terminally ill.\textsuperscript{50} Moreover, studies reveal that health care professionals’

\begin{itemize}
\item \textsuperscript{42} See Melzack, \textit{supra} note 41, at 28.
\item \textsuperscript{43} See id.
\item \textsuperscript{44} See Cassel & Vladeck, \textit{supra} note 39, at 1232.
\item \textsuperscript{45} See id.
\item \textsuperscript{46} See id.
\item \textsuperscript{47} See id. (noting that 17\% of Americans die in nursing homes and 61\% die in hospitals).
\item \textsuperscript{48} See id. at 1232-33. The care of dying patients in America varies greatly among hospitals. According to one study, half the physicians did not respect or know about patients’ advance directives, the majority of do-not-resuscitate orders were not instituted until 24 hours before the patients’ death, and most soberingly, 40\% of patients had severe and potentially treatable pain for more than several days before they died.
\item \textsuperscript{49} See id. at 1232. The American Medical Association’s report on medical education states that only five of 126 medical schools in the country require a separate course in care of the dying. See T. Patrick Hill, \textit{Treating the Dying Patient: The Challenge for Medical Education}, 155 \textsc{Archives Internal Med.} 1265, 1265 (1995).
\item \textsuperscript{50} See Hill, \textit{supra} note 49, at 1265. Of 7048 residency programs, only 26\% offer a course on the medical and legal aspects of care at the end of life as a regular part of the curriculum. See id; see also Kathleen M. Foley, M.D., \textit{Competent Care for the Dying Instead of Physician-Assisted Suicide}, 336 \textsc{New Eng. J. Med.} 54, 55-56 (1997) [hereinafter Foley, \textit{Competent Care}] (“According to a survey of 1068 accredited residency programs in family medicine, internal medicine, and pediatrics and fellowship programs in geriatrics, each resident or fellow coordinates the care of 10 or fewer dying patients annually.”).
\end{itemize}
knowledge of the science of pharmacology and the management of pain control is sorely deficient in the United States.\textsuperscript{51} This remains true despite the fact that in recent years, proponents of palliative medicine have developed helpful guidelines for the aggressive management of intractable symptoms in dying patients.\textsuperscript{52} Not only do these guidelines recommend dosages of opioids and other drugs to manage pain, they also approve sedation for patients whose pain cannot be controlled effectively.\textsuperscript{53}

Many explanations have been offered for our fixation on physician-assisted suicide as the only solution to the problem of suffering at the end of life. All of them, however, seem to involve a recognition that humane, compassionate, and effective care for the dying, especially good pain relief, is provided only irregularly in this country.\textsuperscript{54} This remains true despite the fact that numerous professional organizations have stressed the critical importance of

\begin{itemize}
\item[53.] See Cherny, \textit{Guidelines in the Care of the Dying Patient}, \textit{supra} note 52, at 265 (stating that adequate relief of physical and psychological pain in terminally ill patients can be accomplished through comprehensive care); Cherny & Portenoy, \textit{supra} note 52, at 35 (recommending alternatives to opioids to sedate patients with refractory pain); Truog, \textit{supra} note 52, at 1681.
\end{itemize}
good pain control for dying patients, even when the drugs given may incidentally shorten life.  

B. Medical Misconceptions Regarding the Use of Drugs to Treat the Terminally Ill  

In addition to the inadequate access to hospice care and training of medical practitioners, other hurdles prevent patients from receiving aggressive pain treatment. A common obstacle to zealous pain relief for dying patients has been the collective misunderstanding by patients and physicians of the process by which patients may develop tolerance to morphine and other opioids. Physicians and patients alike often have unfounded concerns about addiction, and they erroneously equate the normal development of tolerance to opioids with addiction. As research shows, these fears are unsubstantiated.  

Numerous studies have shown addiction to be extremely rare in patients who had not previously shown such tendencies. Clinical observation of patterns of opioid use instead have revealed that many patients maintain stable doses of opioids for long periods of time without requiring a dose escalation or reduction. While the majority of patients may be managed within a fairly standard range of dosage, some patients require and tolerate increasingly high  

55. See, e.g., AMERICAN NURSING ASSOCIATION, POSITION STATEMENT ON PROMOTION OF COMFORT AND RELIEF OF PAIN IN DYING PATIENTS 1 (1995) (promoting the belief of the American Nurses Association that nurses are obligated to use aggressive efforts to relieve pain and other symptoms of dying patients); American College of Physicians, AMERICAN COLLEGE OF PHYSICIANS ETHICS MANUAL THIRD EDITION, 117 ANNALS OF INTERNAL MED. 947, 955 (1992) (stressing that physicians should make the relief of pain in dying patients their number one objective, “even if a side effect is to shorten life”).  

56. See C. Brian Tuttle, Drug Management of Pain in Cancer Patients, 132 CAN. MED. ASSOC. J. 121, 132 (1985). Morphine is a central nervous system depressant derived from opium poppies. See PDR GENERICS 1974-75 (1st ed. 1995). It is frequently prescribed for “the relief of severe acute and severe chronic pain.” Id. at 1976. When used incorrectly, morphine can lead to serious side effects, such as respiratory depression, systemic failure of the nervous system, coma, and death. See id. at 1980.  

57. See Tuttle, supra note 56, at 132.  


59. See Tuttle, supra note 56, at 132.  

60. See id.
doses of morphine and other opioids, but they still can obtain
good pain relief without undesirable side effects. It is critical to
understand that tolerance has no upper limit. In patients who
develop tolerance to these drugs, the medication must be with­
drawn slowly, as the need for pain relief diminishes, to prevent
withdrawal symptoms. This physiological tolerance, however, is
not “addiction.” True addiction is the psychological condition
“characterized by constant craving and compulsive drug-seeking
behavior,” and it rarely occurs in these situations.

Respiratory depression appears to be another greatly over­
stated risk of morphine use in dying patients. Considerable evi­
dence indicates that pain and other discomfort serves to counteract
any depressive effects of the drug. Risk obviously is involved in
suddenly and sharply elevating any patient's morphine dosage, just
as it is risky to give large doses to an “opiate naive” patient. Hospice care has demonstrated, however, that if administration of the
drug is begun earlier in the course of the patient's disease, in doses
just large enough to control pain, the patient's quality of life may
be greatly improved, even as the patient's morphine requirements
increase with the progression of disease.

Authorities on palliative care for the terminally ill have identi­

died additional explanations for why physicians fail competently to

61. See id.
62. See id. See generally Shirley L. Lo & Robert R. Coleman, Exceptionally High
Narcotic Analgesic Requirements in a Terminally Ill Cancer Patient, 5 CLINICAL
PHARMACY 828 (1986) (describing a terminally ill patient who required high doses
of narcotics to control pain and overcome tolerance).
63. See Kathleen M. Foley, M.D., Misconceptions and Controversies Regarding the
Use of Opioids in Cancer Pain, 6 ANTI-CANCER DRUGS 308, 314 (1995) [hereinafter
Foley, Misconceptions and Controversies].
64. See Tuttle, supra note 56, at 132.
65. See Foley, Treatment of Cancer Pain, supra note 54, at 88; Tuttle, supra note
56, at 132.
66. Foley, Controlling Pain, supra note 58, at 165.
67. See Tuttle, supra note 56, at 132.
68. See Steton Grond, M.D., et al., Validation of World Health Organization
Guidelines for Cancer Pain Relief During the Last Days and Hours of Life, 6 J. PAIN &
69. See, e.g., Foley, Treatment of Cancer Pain, supra note 54, at 84 (discussing
how to treat the severe pain associated with incurable cancer); Lo & Coleman,
supra note 62, at 828 (tracking the progress of a terminally ill cancer patient who
was given exceptionally high doses of narcotic analgesics to control chronic, se­
vere pain and to overcome tolerance).
70. See Tuttle, supra note 56, at 132.
71. See id.
utilize morphine and other analgesic drugs to relieve pain. Kathleen M. Foley, M.D., chief of the pain service in the department of neurology at Memorial Sloan-Kettering Cancer Center in New York City, has written several articles about the need to dispel the myths and to deal with the lack of knowledge that result in the undertreatment of pain in the dying patient. She attributes this undertreatment to a number of factors. She relies on numerous studies that "demonstrate a significant lack of knowledge in both the theoretical and practical understanding of analgesic drug therapy in both acute pain and cancer pain management." She cites poor communication between doctors and patients about pain assessment as another significant barrier to adequate treatment. She also notes that the increase worldwide in the availability of morphine and other opioids has raised unsubstantiated fears that the drugs will be diverted to the illicit market. In many instances, however, it is not just the lack of experience and knowledge that impedes the provision of good palliative care at the end of life, but also physicians' fears of legal liability and professional sanctions for causing or hastening death.

III. THE LAW AND ETHICS OF TREATING THE TERMINALLY ILL

A. Explicating Terminology to Define the Scope of the Problem

Initially, some language must be clarified. Much diverting and inflammatory discussion of this subject already has resulted from the interjection of terminology that is used improperly or defined.
poorly.\textsuperscript{78} "Euthanasia," as the term is used correctly, is the intentional killing of a suffering person for reasons of compassion\textsuperscript{79} – commonly referred to as "mercy killing."\textsuperscript{80} Sometimes, this intentional killing also is called "active euthanasia,"\textsuperscript{81} to distinguish it from an act of withholding or withdrawing medical treatment.\textsuperscript{82} The withholding or withdrawal of medical treatment is referred to as "passive euthanasia,"\textsuperscript{83} an utterly inappropriate and inflammatory term for activities well recognized as legally and ethically justifiable.\textsuperscript{84} Although commentators long have used this active/passive terminology to describe the critical distinction between active, intentional killing and the withdrawal or withholding of medical treatment,\textsuperscript{85} it should be abandoned.

Euthanasia also must be distinguished from assisted suicide. In assisted suicide, the one who is aiding does not do the ultimate life-ending act, but instead provides or helps to provide the means used by another person to end his or her own life.\textsuperscript{86} It may refer to a family member who helps arrange some means of suicide,\textsuperscript{87} such as giving a suffering relative a loaded gun. Other times, as in the latest circuit court cases,\textsuperscript{88} assisted suicide may apply to a physician who provides a suffering patient with sufficient medication and instructions for a life-ending dose.\textsuperscript{89} The ultimate act, however, is done by the person wishing to end his or her own life, not by the one supplying the means.\textsuperscript{90} For many, a critical moral and ethical distinction exists between euthanasia and assisted suicide, irrespec-

\textsuperscript{78} See Ezekiel J. Emanuel, Euthanasia: Historical, Ethical, and Empiric Perspectives, 154 ARCHIVES INTERNAL MED. 1890, 1890 (1994).
\textsuperscript{79} See Robert I. Misbin, Euthanasia: The Good of the Patient, the Good of Society 10 (1992).
\textsuperscript{80} See id. at 11-12.
\textsuperscript{81} See Emanuel, supra note 78, at 1891.
\textsuperscript{82} See id. at 1890-91.
\textsuperscript{83} Id. at 1891.
\textsuperscript{84} See id. (noting that the withholding or withdrawal of life-sustaining treatment is supported by an ever-widening consensus of ethical literature and is permitted by decisions in most states and by the Supreme Court).
\textsuperscript{85} See Misbin, supra note 79, at 11-14.
\textsuperscript{86} See Introduction to Euthanasia: Opposing Viewpoints 12 (David Bender et al. eds., 1995).
\textsuperscript{87} See id.
\textsuperscript{88} See Quill v. Vacco, 80 F.3d 716, 719 (2d Cir.), cert. granted, 117 S. Ct. 36 (1996); Compassion in Dying v. Washington, 79 F.3d 790, 794-95 (9th Cir.), cert. granted, 117 S. Ct. 37 (1996).
\textsuperscript{89} See Introduction to Euthanasia: Opposing Viewpoints, supra note 86, at 12.
\textsuperscript{90} See Pugliese, supra note 34, at 1291-92.
tive of the law's treatment of each. 91

In Minnesota, both euthanasia and assisted suicide are illegal. Although euthanasia is not defined anywhere in its statutes, such an act of intentional, albeit compassionately motivated, killing would constitute first-degree murder. 92 As in most other states, 93 as-

91. See Garbesi, supra note 33, at 109-10.
92. See Minn. Stat. § 609.185 (1996) ("Whoever does any of the following is guilty of murder in the first degree .... (1) causes the death of a human being with premeditation and with intent to effect the death of the person .... ")

Five states criminalize assisted suicide through the common law. See Crook v. State, 160 So. 2d 884, 895 (Ala. Ct. App. 1961) ("Suicide is murder at [c]ommon [l]aw .... An agreement compassing it is a criminal conspiracy. If one of the conspirators dies, ... the survivor - if he contributed to the suicide whether present or not - can legitimately be found guilty of murder."); State v. Marti, 290 N.W.2d 570, 583 (Iowa 1980) ("We believe that preparing and providing a weapon for one who is unable to do so and is known to be intoxicated and probably suicidal are acts 'likely to cause death or serious injury,' within the definition of involuntary manslaughter found in section 707.5(2) [of the Iowa Code]."); State v. Willis, 121 S.E.2d 854, 856-57 (N.C. 1961) ("Since suicide is a crime, one who aids and abets another in, or is accessory before the fact to, self[-]murder is amendable to the law."); Wackwitz v. Roy, 418 S.E.2d 861, 864 (Va. 1992) ("[A]lthough the General Assembly has rescinded the punishment for suicide, it has not decriminalized the act. Suicide, therefore, remains a common law crime in Virginia .... "); Md. Op. Att'y Gen. No. 93-036 (Sept. 8, 1993) (concluding that assisted suicide is probably a common-law crime in Maryland and recommending that the General Assembly promptly pass a statute prohibiting physician-assisted suicide).

Nine states address the subject in living will or death with dignity statutes. These acts expressly state that the government neither condones nor legalizes as-
sisted suicide also is prohibited by statute in Minnesota. Nevertheless, the statute now makes an exception for health care providers who attempt to relieve patients' pain.

The 1989 Minnesota investigations involved two deaths following the use of morphine. The medical examiner ruled the deaths homicides. This ruling required a determination that the morphine was, in each case, the cause of death and that its administration in the quantities given was wrongful. A successful criminal prosecution of these cases would have required proof that the doctors either (1) directly intended to kill the patients, so as to be guilty of first-degree murder, or (2) were so culpably negligent in their use of the drug in such quantities as to be guilty of manslaughter in the second degree.


94. See MINN. STAT. § 609.215, subd. 1 (1996) ("Whoever intentionally advises, encourages, or assists another in taking the other's own life may be sentenced to imprisonment for not more than 15 years or to payment of a fine of not more than $30,000 or both.").
95. See id. subd. (3)(a) (providing immunity for health care workers in certain circumstances); see also infra notes 302-03 and accompanying text.
96. See Mark Brunswick, Homicide Rulings Raise Questions About Drug Treatment of Terminally Ill, STAR TRIB. (Minneapolis), Aug. 30, 1989, at 1A.
97. See id.
98. See id.
99. See David Shaffer, Hennepin County Report Urges Painkiller Guidelines, ST. PAUL PIONEER PRESS DISPATCH, Apr. 24, 1990, at 1B.
100. See MINN. STAT. § 609.185 (1996) (providing that a person is guilty of first-degree murder if he or she "causes the death of a human being with premeditation and with intent to effect the death of the person or of another").
101. See id. § 609.205 ("A person who causes the death of another by any of the following means is guilty of manslaughter in the second degree . . . : (1) by the person's culpable negligence whereby the person creates an unreasonable risk, and consciously takes chances of causing death or great bodily harm to another.").
B. The Minnesota Morphine Investigations

In the spring of 1989, two patients in separate hospitals in Hennepin County, Minnesota, died following the withdrawal of their mechanical respirators and the administration of relatively large doses of morphine to ease the attendant suffering. Both patients were imminently dying and required the assistance of a mechanical ventilator to breathe. In each case, the ventilator was withdrawn pursuant to the patient’s direction. One patient had executed a living will. The other had expressed his wishes in a family conference shortly before his death. Following expressions of concern by some attending health care workers about the amounts of morphine given, the Hennepin County Medical Examiner reviewed both cases. The examiner ruled both deaths homicide by morphine poisoning, a finding sharply criticized by the Minnesota Medical Association and disputed by legal experts. After extensive, thoughtful investigation, the Hennepin County Attorney declined to present the cases to a grand jury for criminal prosecution.

The cases sparked intense debate and concern in the medical community and active comment in the press. Inflammatory
rhetoric abounded. The self-proclaimed "pro-life" movement immediately labeled the cases instances of active euthanasia. Much of the medical community, already feeling beleaguered by malpractice claims, now believed it also had to fear criminal liability for some very common end-of-life medical treatment decisions. Physicians caring for dying patients saw their judgments being subjected to review not only by civil lawyers examining negligence claims, but by prosecuting authorities looking for crime as well. In the ensuing years, considerable anecdotal evidence from local hospitals has shown that some terminally ill cancer patients have been medicated inadequately for pain, because their doctors have feared being subjected either to a criminal investigation or to an inquiry from the state’s medical licensing board. As one hospice nurse-administrator remarked, the investigations “set palliative care back five years.”

The investigations, though not unprecedented, were highly unusual. They raised questions whose resolution lay at the intersection of law, medicine, and ethics. It became clear rather quickly that little guidance on the precise issue exists. Considerable literature is available on the ethical issues involved in decisions to forego life-sustaining treatment of terminally ill patients. In addition, a well-developed body of case law supporting such decisions exists. Precious little has been written, however, to help physicians implement decisions to withdraw or withhold specific interventions, while at the same time providing their dying patients

113. See Terminally Ill: Don't Let Painkiller Rules Chill Final Care, St. Paul Pioneer Press Dispatch, Apr. 30, 1990, at 10A.
114. See Cook & Parker, supra note 31, at 1A.
115. See, e.g., Feldman, supra note 108, at 20; Walter Parker, Medicine, Law Clash over Morphine, St. Paul Pioneer Press Dispatch, Oct. 2, 1989, at 1A.
116. Interview with Kate Cummings, R.N., Metropolitan Medical Center (Spring 1989).
117. See Garbesi, supra note 33, at 109-10.
118. See, e.g., H. Tristram Engelhardt, Jr., The Foundations of Bioethics (1986); Ethics and Law in Health Care and Research (Peter Byrne ed., 1990); Euthanasia: Opposing Viewpoints (David Bender et al. eds., 1995).
119. See, e.g., Cruzan v. Director, Mo. Dep’t of Health, 497 U.S. 261, 278-79 (1990) (recognizing that a “competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment”); In re Quinlan, 355 A.2d 647, 663 (N.J.) (concluding that the unwritten constitutional right of privacy includes an individual’s right to refuse unwanted medical interventions), cert. denied, 429 U.S. 922 (1976); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 424 (Mass. 1977) (recognizing that ethical medical practice does not require that all life-prolonging interventions be attempted in all cases).
with good palliative care. This guidance void has created considerable misunderstanding in the medical community. Consequently, this misunderstanding has led members of the medical community to fear the potential legal repercussions if practitioners exceed what they perceive as murky boundaries. The investigations in the morphine cases fueled those fears.

C. The Law of Treatment Withdrawal

1. The Courts’ Response to Treatment Withdrawal

Each of the Minnesota investigations involved the withdrawal of a mechanical ventilator from a dying patient, whose previously expressed wishes were being honored. In this respect, the cases were perhaps the least controversial of any at the intersection of biomedical ethics and the law. It is well-settled that a competent adult patient has the right to forego any life-prolonging intervention. This right of autonomous decision-making has been upheld repeatedly and has been grounded in both the constitutional right to privacy and the common-law right to bodily self-
determination. In 1990, the United States Supreme Court, in *Cruzan v. Director, Missouri Department of Health*, acknowledged that a competent patient has a constitutionally protected liberty interest in refusing unwanted medical treatment as well. The right to refuse treatment has been upheld even in the case of an incompetent patient whose family or court-appointed guardian requests the withdrawal of treatment on the patient's behalf, either because it is what the patient would have wanted, or because it is in the patient's best interests.

refuse "unwanted infringements of bodily integrity in appropriate circumstances"); *Quinlan*, 355 A.2d at 663 (stating that the constitutional right to privacy is broad enough to include a patient's decision to refuse medical treatment in certain circumstances).

126. See, e.g., Natanson v. Kline, 350 P.2d 1093, 1099 (Kan.) (recognizing that because Anglo-American law is premised on self-determination, a patient may refuse lifesaving surgery or other medical treatment), clarified, 354 P.2d 670 (Kan. 1960); *In re Gardner*, 534 A.2d 947, 950 (Me. 1987) (reiterating the long-standing common-law right of every individual to control his or her own person without interference from others); *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his [or her] own body.").


128. *Id.* at 278 ("The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.").

129. See, e.g., *Gray v. Romeo*, 697 F. Supp. 580, 587-88 (D.R.I. 1988) (concluding that in balancing the patient's constitutional right to refuse life support against the competing governmental interest, one must consider evidence that if the patient were competent, she would decline life support); *In re Estate of Longeway*, 549 N.E.2d 292, 300 (Ill. 1989) (holding that the key element in determining whether to allow withdrawal of artificial sustenance is proof, by clear and convincing evidence, of the patient's intent); *Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626, 633 (Mass. 1986) (taking into account the patient's views pertaining to life support when ascertaining whether to honor the substituted judgment of an incompetent person in a persistent vegetative state to refuse the continuance of life support); Superintendent of Belchertown State Sch. v. *Saikewicz*, 370 N.E.2d 417, 431 (Mass. 1977) (holding that courts should attempt to determine the incompetent person's preferences regarding medical treatment); *Quinlan*, 355 A.2d at 664 (holding that the only practical way for an incompetent patient to assert the privacy right to terminate treatment is for a guardian to determine whether the patient would have wanted to exercise that right); *In re Westchester County Med. Ctr.*, 531 N.E.2d 607, 613 (N.Y. 1988) (holding that the decision to withhold or withdraw treatment must always be based on the patient's expressed intentions).

130. See, e.g., *In re Conservatorship of Drabick*, 245 Cal. Rptr. 840, 857 (Ct. App. 1988) (holding that California law allows a conservator of an incompetent person in a vegetative state to withdraw artificial life support if the withdrawal is in the patient's best interests); *In re Conservatorship of Torres*, 357 N.W.2d 332, 337 (Minn. 1984) (stating that a court may allow a conservator to order the removal of life support if it is in the patient's best interests); *In re Conroy*, 486 A.2d 1209,
The Cruzan case involved the withdrawal of medical interventions from an incompetent patient.\textsuperscript{131} Nancy Cruzan had been in a persistent vegetative state for almost eight years\textsuperscript{132} when her parents, as her legal guardians, sought court permission to end her artificial feeding.\textsuperscript{133} The Missouri Supreme Court required the Cruzans to prove by clear and convincing evidence that their daughter would have wanted her feeding tube disconnected under the circumstances.\textsuperscript{134} This proof of Nancy's wishes was to be gleaned from her prior expressions.\textsuperscript{135} On appeal, the United States Supreme Court recognized in dictum a constitutionally protected right in the \textit{competent} patient to refuse unwanted medical treatment and indicated that a competent person might have a liberty interest in refusing artificially-delivered fluids and nutrition.\textsuperscript{136} Nevertheless, it upheld Missouri's very stringent evidentiary requirement that when a guardian seeks to have a feeding tube withdrawn from a permanently unconscious patient, there must be clear and convincing proof that the patient would want to have the feeding tube withdrawn.\textsuperscript{137}

The Cruzan case must be carefully distinguished from the vast majority of treatment termination cases which have come before the courts and from the two Minnesota cases discussed previously. Cruzan involved the withdrawal of a feeding tube from a patient who was permanently unconscious, but not dying, and whose wishes on the subject, it was argued, could not be reliably deter-

\textsuperscript{1232} (N.J. 1985) (ruling that in the absence of evidence indicating the patient’s intent to decline medical treatment, life-sustaining treatment may be withheld or withdrawn from a formerly competent person if the burden of treatment outweighs its benefit).

\textsuperscript{131} Cruzan, 497 U.S. at 265.
\textsuperscript{132} Id. at 266.
\textsuperscript{133} Id. at 265.
\textsuperscript{134} Id.
\textsuperscript{135} Id. at 268.
\textsuperscript{136} Id. at 278-79.
\textsuperscript{137} Cruzan, 497 U.S. at 284 (concluding that a state “may apply a clear and convincing evidence standard in proceedings where a guardian seeks to continue nutrition and hydration of a person diagnosed to be in a persistent vegetative state”). After the Supreme Court issued its decision, another hearing was held before a county probate judge to determine whether, under the newly articulated “clear and convincing” standard, sufficient evidence of Nancy’s wishes existed to justify removing the feeding tube. The judge ruled that there was sufficient evidence, and the state did not appeal. The tube was removed, and Nancy Cruzan died on December 26, 1990, 11 days later. See 1 Alan Meisel, \textit{The Right to Die} § 2.3, at 44-45 (2d ed. 1995).
Further, the *Cruzan* decision merely affirmed the Missouri Supreme Court opinion. It does not affect the law in any other state. It is also significant to note that the *Cruzan* case involved artificial feeding, an intervention about which there is not full societal consensus. Tube feeding involves important emotional factors, largely the result of the symbolism we attach to providing sustenance to the vulnerable, that are not present in cases involving mechanical ventilators.

2. Withdrawal of Ventilators: Why Courts Treat It Differently

Perhaps the most famous case involving the removal of a respirator from a patient is that of Karen Ann Quinlan. On April 15, 1975, Karen was taken to the hospital after she "ceased breathing for at least two fifteen minute periods." Thereafter, her condition worsened and it was determined that she was in a chronic, persistent vegetative state, needing twenty-four hour intensive nursing care and the assistance of a respirator, a catheter, and a feeding tube. Joseph Quinlan, Karen's father, wished to be appointed guardian of his daughter and to be allowed to authorize the discontinuance of her ventilator support. In a landmark decision, the New Jersey Supreme Court allowed her parents to order her

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139. *See id.* at 287.
140. *See* JAMES M. HOEFLER & BRIAN E. KAMOIE, DEATHRIGHT: CULTURE, MEDICINE, POLITICS, AND THE RIGHT TO DIE 182-83 (1994); Alan Meisel, A Retrospective on *Cruzan*, 20 LAW, MED. & HEALTH CARE 340, 343, 345 (1992) (observing that the Court, in rendering its decision, focused solely on the validity of the Missouri Supreme Court's holding, but failed to promulgate a national policy).
142. *See* GEORGE M. BURNELL, M.D., FINAL CHOICES: TO LIVE OR TO DIE IN AN AGE OF MEDICAL TECHNOLOGY 106-11 (1993) (discussing the competing viewpoints as to whether providing food and water is a necessary and ordinary treatment).
143. *See* Bryan Jennett, Letting Vegetative Patients Die, in EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 169, 181-82 (John Keown ed., 1995); *see also* Barber v. Superior Court, 195 Cal. Rptr. 484, 490 (Cl. App. 1983) (recognizing that the distinction between cases involving mechanical breathing devices and those involving mechanical feeding devices is based more on emotional symbolism than on rational differences).
144. *See In re Quinlan*, 355 A.2d 647 (N.J.), cert. denied, 429 U.S. 922 (1976). The Quinlan court determined that under appropriate circumstances, a comatose patient's family may order the removal of the patient's ventilator. *Id.* at 651.
145. *Id.* at 653-54. The reason why Karen stopped breathing is still unclear. *Id.*
146. *Id.* at 654.
147. *Id.* at 651.
respirator disconnected. The court determined that the state's interest in the preservation and the sanctity of human life was outweighed by Karen's individual right to decline medical treatment under such circumstances, a right which her family could exercise on her behalf. Since In re Quinlan, decisions to forego ventilator use have been readily upheld.

The use of ventilators to keep patients alive has always been considered highly unnatural, intrusive and, in the language of the Catholic Church, "extraordinary." Traditionally, Catholic moral theology drew a distinction between "ordinary" and "extraordinary" means of preserving life. The term "ordinary means" refers to "all medicines, treatments and operations, which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain or other inconvenience." "Extraordinary means" are "all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a

148. Id. at 671.
149. Id. at 663-64. This individual right arises when the attending physician and the facility ethics committee agree that: 1) there is no reasonable possibility of the patient ever emerging from the comatose condition to a cognitive state; and 2) the life-support apparatus should be discontinued. Id. at 671-72. The court further noted that the decision ultimately rested with Karen. But since she was grossly incompetent and thus unable to assert her rights, her guardian or family members could render their best judgment as to whether Karen would exercise her right to discontinue treatment in these circumstances. Id. at 664.
150. See, e.g., McKay v. Bergstedt, 801 P.2d 617, 625 (Nev. 1990) (holding that the patient's liberty interest in refusing the use of a respirator to sustain his life outweighed the state's interest in preserving his life); In re Eichner, 420 N.E.2d 64, 72 (N.Y. 1981) (approving the withdrawal of a patient's respirator where the patient had expressed his views prior to becoming incompetent); In re Grant, 747 P.2d 445, 454 (Wash. 1987) (stating that the right to refuse lifesustaining treatment extends to all artificial procedures intended to prolong the life of a terminally ill patient, including a ventilator), modified, 757 P.2d 534 (Wash. 1988).
151. See GERALD KELLY, MEDICO-MORAL PROBLEMS 129 (1958). The Roman Catholic Church is by far the largest single religious body in the United States. See Reverend Richard E. Coleson, Contemporary Religious Viewpoints on Suicide, Physician-Assisted Suicide, and Voluntary Active Euthanasia, 35 DUQ. L. REV. 43, 45 (1996). Its views are significant for several reasons, including "the church's (1) long history of moral scholarship; (2) extensive and articulate contemporary pronouncements on moral issues; (3) large and influential worldwide presence; and (4) strongly hierarchical structure, which permits a central authority to speak authoritatively for the church." Id. at 45 n.11.
152. See KELLY, supra note 151, at 129.
153. Id.
reasonable hope of benefit." This distinction between ordinary and extraordinary means remains important, and the Catholic Church continues to be an articulate, well-respected authority on issues relating to termination of treatment in the dying patient. The "extraordinary/ordinary" language, however, has been abandoned in virtually all medical ethics writings and in most court decisions, in favor of a discussion that evaluates the treatment intervention by weighing the burdens it imposes against the benefits it may afford to the patient.

Ethically, the obligation to sustain life, while an important one for the medical profession, is not absolute. Not only does the doctrine of proportionality temper this duty, it also is necessary to evaluate the responsibility to sustain life in light of the duty to promote patient well-being. In other words, the duty to promote patient well-being requires an assessment of whether a lifesustaining intervention will prove more beneficial than burdensome to the patient. This assessment, and decisions about the withdrawal or refusal of the intervention, reside primarily with the patient or his legal surrogate, rather than with the physician. 

The patient in Barber suffered severe brain damage, leaving him in a likely permanent vegetative state. The patient's family,

154. Id.
155. Other religions have different views. For example, Judaism does not permit euthanasia because of its strong belief in the preservation of life. Many Rabbinic interpretations, however, conclude that Judaism does permit suicide and the withdrawal of life support if the patient is near death and in great pain. Islam also endorses the principle that life should be preserved. Therefore, it does not permit suicide, euthanasia, or the withdrawal of life support. See Matthew P. Previn, Note, Assisted Suicide and Religion: Conflicting Conceptions of the Sanctity of Human Life, 84 GEO. L.J. 589, 596-97 (1996).
156. See, e.g., 1 MEISEL, supra note 137, § 8.14, at 502 (stating that when deciding whether to forego life-sustaining treatment, the balancing approach is the most frequently used); Wanzer, A Second Look, supra note 22, at 846; see also Barber v. Superior Court, 195 Cal. Rptr. 484, 491 (Ct. App. 1983) (weighing the benefits of the proposed treatment against the burdens it would impose on the patient).
157. See Wanzer, A Second Look, supra note 22, at 846. "Somewhere between the unacceptable extremes of failure to treat the dying patient and intolerable use of aggressive life-sustaining measures, the physician must seek a level of care that optimizes comfort and dignity." Id.
158. See id.
159. See Wanzer, Physician's Responsibility, supra note 24, at 955.
161. Id. at 486. The patient suffered a cardio-respiratory arrest and was revived, but remained in a comatose state. After examining him, the physicians determined that the patient also had suffered brain damage and that his vegetative
upon learning of the dim prognosis for recovery, requested in writing that the hospital discontinue the use of all life support machines.\textsuperscript{162} Responding to the family's wishes, two doctors removed the ventilator and other life-sustaining equipment.\textsuperscript{163} After the patient died, the doctors were charged with murder and conspiracy to commit murder.\textsuperscript{164}

In determining whether the two doctors should be held to answer the charges, the court considered whether the doctors had a duty to continue to provide life-sustaining treatment.\textsuperscript{165} The court held that no duty to continue the use of life-sustaining machines exists once their use has become "futile in the opinion of qualified medical personnel."\textsuperscript{166} Continued life support becomes futile or "disproportionate," the court said, when the benefits to be gained from the proposed treatment are outweighed by the burdens to which it would subject the patient.\textsuperscript{167} "[P]roportionate treatment is that which, in the view of the patient, has at least a reasonable chance of providing benefits to the patient, which benefits outweigh the burdens attendant to the treatment."\textsuperscript{168} The court acknowledged that the determination as to whether the burdens of treatment are worth enduring for any individual patient depends on the unique circumstances of each case.\textsuperscript{169}

Thus, the Barber court recognized that a ventilator may be discontinued when the burdens of the intervention are greater than the benefits.\textsuperscript{170} The patient should be the ultimate decision-maker regarding the burden issue, unless the patient is incapable of making this decision due to his or her medical condition or for other reasons.\textsuperscript{171} It is important to keep in mind, then, that ventilator-dependent patients are legally and ethically entitled to decide to have their ventilator support withdrawn and to die.\textsuperscript{172} The critical

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\item state was likely to be permanent. \textit{Id.}
\item \textit{Id.}
\item \textit{Id.}
\item \textit{Id. at 490.}
\item \textit{Barber}, 195 Cal. Rptr. at 491.
\item \textit{Id.}
\item \textit{Id.} (emphasis added).
\item \textit{Id. at 492.}
\item \textit{Id.}
\item \textit{Id.}
\item The court admitted difficulty in determining who should have the power to make the decision when the patient is incapacitated; however, it implied that the decision should reside with the patient's family. \textit{Id.}
\item \textit{See} cases cited \textit{supra} note 150; \textit{see also} Wanzer, \textit{Physician's Responsibility}, \textit{supra} note 24, at 955 (addressing the importance of the patient's role in decision-
question is what procedures physicians should follow when withdrawing such ventilator support.

The answer to this question is of crucial importance for ventilator-dependent patients who are dying. The "air-hunger" or suffocation that characterizes the dying of a ventilator-dependent patient from whom breathing support has been withdrawn is a peculiar and acute suffering. Morphine is well-accepted as the most effective palliative drug to alleviate this distress. Often, however, dying patients needlessly suffer because of the inadequate administration of morphine and other opioid pain-relieving medications. A variety of reasons have been offered for physicians' reluctance to medicate adequately in this situation. It is clear, however, that misconceptions about both the use of morphine and the application of the criminal law to such situations have contributed to the problem.

It would, of course, be unjustifiable homicide for doctors deliberately to give patients an overdose of narcotics or sedatives for the purpose of ending life quickly. Yet, after the ventilator is withdrawn, it becomes the physician's ethical responsibility to provide whatever amount of medication is necessary to relieve any apparent symptoms of pain and suffering, so as to make the dying process comfortable and peaceful. Indeed, the ethics literature emphasizes that once curative efforts have been discontinued, the physician's primary goal in caring for dying patients is to relieve their pain and suffering. If, in so doing, a physician administers

making).

174. See Foley, Misconceptions and Controversies, supra note 63, at 6 (noting that morphine is the preferred drug according to the World Health Organization's Cancer Pain Guidelines).
175. See supra notes 56-71 and accompanying text.
176. See supra notes 72-77 and accompanying text.
177. See supra note 77 and accompanying text.
178. See, e.g., MINN. STAT. § 609.02, subd. 9(3) (1996). If the physician's purpose is to end the patient's life, rather than relieve pain, then the "intentional" element of homicide is satisfied. See id. But cf. MEISEL, supra note 137, § 18.18, at 479 ("The taking of the life of another person by some affirmative act . . . , regardless of the fact that the motive may be the relief of suffering, is culpable homicide.").
179. See Buchan & Tolle, supra note 22, at 54-55; Wanzer, A Second Look, supra note 22, at 847 ("The proper dose of pain medication is the dose that is sufficient to relieve pain and suffering, even to the point of unconsciousness.").
morphine in such amounts that he or she hastens death by depressing the patient's respiration, no liability arises.\textsuperscript{181} Ethically and legally, a physician's actions are protected if the intent was to relieve suffering, even though as a necessary incident, the patient's life is shortened.\textsuperscript{182}

D. The Principle of Double Effect

The problem of administering pain medication to dying patients is an old one in medical ethics. The principles which govern it have a long and respected tradition beginning, it is believed, with St. Thomas Aquinas' notion of \textit{praeter intentionem}.\textsuperscript{183} As it has come to be known, the principle of double effect is used to analyze the morality of actions that involve more than one effect, specifically one good and one evil consequence.\textsuperscript{184} The principle of double effect states that an action that has an evil consequence as well as a good one can be justified if it satisfies four conditions:

\begin{enumerate}
\item \textbf{Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment: Ethical, Medical and Legal Issues in Treatment Decisions (1983) [hereinafter President's Commission]} (reporting on the ethical, medical, and legal issues in treatment decisions).
\item See Wanzer, A Second Look, supra note 22, at 847.
\item Some physicians have recognized in themselves what Dr. Timothy Quill has called the "ambiguity of clinical intention." Timothy E. Quill, M.D., \textit{The Ambiguity of Clinical Intentions}, 329 NEW ENG. J. MED. 1039, 1039 (1993). That is, when they give heavy narcotics to relieve their patients' severe suffering, these physicians are aware that in addition to a desire to relieve the patients' pain, they sometimes harbor feelings that death would not be unwelcome. Indeed, they may often hope that death will come sooner, rather than later, to these desperately ill patients. See \textit{id.} Still, for purposes of the criminal law, \textit{intent} requires more than the knowledge that there is an increased risk of hastening death and an ancillary hope that the patient's suffering will not continue too long. "Intentionally" means that the actor either has a purpose to do the thing or cause the result specified [i.e., the death of the patient] or believes that the act . . . , if successful, will cause that result." MINN. STAT. § 609.02, subd. 9(3) (1996) (emphasis added). Knowing that an increased risk of death from large doses of some medications exists - even when the belief that the patient's death would be a good thing accompanies that knowledge - does not constitute the required mental state in these cases.
\item See The Westminster Dictionary of Christian Ethics 162 (James F. Childress & John Macquarrie eds., 1986) (defining \textit{praeter intentionem} to mean a resulting wrong or evil consequence of an action which is "not directly sought" or "an unintended by-product of the action"); Kevin J. Flannery, \textit{Natural Law Mens Rea Versus the Benthamite Tradition}, 40 AM. J. JURIS. 377, 394 n.52 (1995) (stating that \textit{praeter intentionem} means a wrongful consequence of an action which is "outside the intention" of that action).
\item See Flannery, supra note 183, at 394-95 nn.52 \\& 54.
\end{enumerate}
(1) The action from which evil results is good or indifferent in itself; it is not morally evil. (2) The intention of the agent is upright – i.e., the evil effect is sincerely not intended. (3) The evil effect must be equally immediate causally with the good effect, for otherwise it would be a means to the good effect and would be intended. (4) There must be a proportionately grave reason for allowing the evil to occur.¹⁸⁵

The use of morphine in the dying patient is a classic illustration of the principle in action. The good effect of the morphine is the relief of suffering; the bad effect is the possible hastening of death. The first element of the principle of double effect is met because when the physician administers morphine to the patient, the physician does not bring about the relief of suffering by means of weakening the patient's condition. Thus, the evil effect is not the means to the desired effect and the action is not morally evil. The second condition also is satisfied. The intent of the doctor is to relieve the patient's suffering, not to kill the patient. The adverse effect, possibly hastening the patient's death, comes from dangers inherent in the use of the drug and is not intended; rather; it is a necessary risk. Third, both the good and the evil effects result simultaneously. The risk of speeding the patient's death occurs at the same time as the benefit of relieving the patient's pain. Finally, the relief of suffering in the dying patient is critically important. The physician's primary duty is to relieve the patient's pain and suffering once curative efforts have ceased. This duty provides ample reason for using the morphine in whatever dosage is necessary to accomplish that goal.¹⁸⁶ Therefore, the principle of double ef-

¹⁸⁵. THE WESTMINSTER DICTIONARY OF CHRISTIAN ETHICS, supra note 183, at 162; accord ENGELHARDT, supra note 118, at 307. It is interesting to note that in his second trial for assisted suicide, Dr. Kevorkian asserted – despite his prior public statements to the contrary – that his goal was primarily to relieve suffering, and that the deaths were an unavoidable consequence of that goal. See KEVORKIAN SAYS HE'S LIKE AN EXECUTIONER, FLA. TODAY, Mar. 5, 1996, at 6A; Barbara Dority, "In the Hands of the People": Recent Victories of the Death-with-Dignity Movement, HUMANIST, July 17, 1996, at 6. It is difficult to see how, even under the most generous interpretation of his actions, the principle of double effect would apply to protect Kevorkian. The first requirement of double effect is that the evil effect (the death of the patient) must not be the means to produce the good effect (the relief of suffering). See ENGELHARDT, supra note 118, at 307. No one could seriously contend that potassium chloride (whose only purpose when used this way is to stop a beating heart) and carbon monoxide are pain relief medications which carry a necessary and unavoidable risk of death.

¹⁸⁶. See JOHN ARRAS & NANCY RHODEN, ETHICAL ISSUES IN MODERN MEDICINE
fect fully justifies the use of enough morphine and other analgesic drugs to relieve pain in terminally ill patients, even at the risk of shortening their lives.

IV. EXAGGERATED FEARS OF CRIMINAL LIABILITY

In many cases, medical professionals have a greatly exaggerated fear of legal liability. It is possible to put these fears into perspective, however, by understanding just how infrequently doctors have been charged with criminal conduct in connection with medical treatment decisions of any kind, including those which have involved intentional killings and are clear cases of murder.

Notably, no physician has ever lost a civil case or been criminally convicted based on a decision to withhold or withdraw treatment from a terminally ill patient. Even more remarkable, no doctor has ever been successfully prosecuted for a direct act of euthanasia. Even among the relatively small number of non-medical defendants charged with "mercy killing," convictions are rare. Sentences that amount to anything significant are rarer still, and jury nullification is common.

27 (3d ed. 1989) and THE WESTMINSTER DICTIONARY OF CHRISTIAN ETHICS, supra note 183, at 162, for good discussions of this principle. The Roman Catholic Church has approved the specific applicability of the principle of double effect to the use of narcotics to relieve suffering in the dying. See THE WESTMINSTER DICTIONARY OF CHRISTIAN ETHICS, supra note 183, at 163.

187. See Buchan & Tolle, supra note 22, at 57 ("To our knowledge, no physician in the United States has ever been convicted of murder or assisted suicide for providing a patient with appropriate high-dose pain medication."); Wanzer, Physician's Responsibility, supra note 24, at 956 (noting that criminal charges against physicians who withdraw life support are rare).

188. See Glantz, supra note 24, at 231, for an excellent discussion of this issue and a review of some of the cases.

189. See id. at 235-36.

190. See id. at 232, 240; Wanzer, Physician's Responsibility, supra note 24, at 956.

191. See Glantz, supra note 24, at 235.

192. See id. at 232-34.

193. See id. (listing cases involving "mercy killings" by non-medical defendants).

194. See id. at 234. For example, the author cites a case involving a father who killed his bedridden son using chloroform. The jury convicted the defendant of second-degree manslaughter, but the defendant was given a suspended sentence and released. See id. at 232.

195. See id. at 232-33 (noting several cases in which the grand jury refused to indict or acquit based on temporary insanity).
A. Cases Involving Intentional Killing by Physicians

Few physicians and other health care providers have ever been charged criminally with intentionally killing a patient. One of the few cases involved Dr. Herman Sander, who, in 1950, injected air into the veins of a terminally ill cancer patient. Dr. Sander noted in the patient's chart: "Patient was given 10 c.c. of air intravenously repeated four times. Expired within ten minutes after this was started." Despite the clear evidence and the obvious homicidal (albeit benignly motivated) intent of the defendant, he was acquitted.

Other cases have had similar results. In 1973, a jury acquitted Dr. Vincent Montemarano of killing a cancer patient with an injection of potassium chloride. In 1981, Anne Capute, a nurse, was charged with murdering a suffering, terminally ill patient by administering large doses of morphine. Like Dr. Sander, Ms. Capute carefully had documented her acts with respect to the patient, noting that she gave the patient 195 milligrams of morphine within seven hours of death. The prosecution presented four medical experts who testified that the morphine caused the patient's death. Still, the jury acquitted the nurse. In 1986, Dr. Peter Rosier administered a morphine overdose to his terminally ill wife but was unsuccessful in causing her death. He was acquitted, however, for his role in attempting to assist in her suicide.

Other recent cases have had different results, but still no jury verdicts of guilty and no prison sentences. In 1986, Dr. Joseph Hassman was charged with manslaughter after injecting his termi-

196. See id. at 233.
197. Glantz, supra note 24, at 233.
198. See id. (noting that 90% of the townspeople signed a petition supporting the doctor).
199. See id.
200. See id. at 234.
201. See id.
202. See id. To rebut the prosecution's evidence, the defense called three medical experts who testified that cancer and heart and lung disease caused the patient's death. See id.
203. See Glantz, supra note 24, at 234.
205. See id. Because Dr. Rosier's efforts failed to kill his wife, her stepfather finished the task by suffocating her with a pillow. See id. at 112 n.152.
nally ill mother-in-law with an overdose of Demerol.\textsuperscript{207} He pled guilty and was given two years probation.\textsuperscript{208} In 1988, Dr. Donald Caraccio was charged with murder after injecting a patient with potassium chloride.\textsuperscript{209} Dr. Caraccio pled guilty and was sentenced to five years probation.\textsuperscript{210} In England, the story has been much the same.\textsuperscript{211} In 1981, Dr. Leonard Arthur acceded to the request of parents of a Down's Syndrome infant that the baby be allowed to die.\textsuperscript{212} The infant died after sixty-nine hours without being fed and after being given dihydrocodeine, an opiate drug, to alleviate his distress.\textsuperscript{213} After being charged with murder, Dr. Arthur contended that the death was due to Down's Syndrome-induced broncho-pneumonia.\textsuperscript{214} The prosecution asserted, however, that lung stasis resulting from the drug's toxicity was the cause of death.\textsuperscript{215} In one of the few English prosecutions of a physician to go to a jury, Dr. Arthur was acquitted.\textsuperscript{216} More recently, in 1986, a jury acquitted another physician of attempted murder after he administered barbiturates to a patient suffering from inoperable lung cancer.\textsuperscript{217}

In the earliest and most infamous English case, Dr. John Bodkin Adams was prosecuted for causing a patient's death by administering excessive doses of heroin and morphine.\textsuperscript{218} The court instructed the jury that the law does not recognize a special defense for acting to prevent severe pain.\textsuperscript{219} It continued, however, by stating that a doctor need not calculate in any precise manner the effect of medicines upon a patient's life and may do all that is necessary at the end of life to relieve suffering, even employing measures that may "incidentally shorten human life."\textsuperscript{220} "If a person is being treated for an illness and that treatment has the incidental effect of

\begin{itemize}
\item \textsuperscript{207} See Persels, \textit{supra} note 204, at 112.
\item \textsuperscript{208} See id.
\item \textsuperscript{209} See id.
\item \textsuperscript{210} See id.
\item \textsuperscript{211} See DAVID W. MEYERS, \textsc{The Human Body and the Law} 282-83 (2d ed. 1990) (detailing cases of English physicians who brought about the deaths of patients through prescription drugs).
\item \textsuperscript{212} See \textit{id.} at 282.
\item \textsuperscript{213} See \textit{id.}
\item \textsuperscript{214} See \textit{id.}
\item \textsuperscript{215} See \textit{id.}
\item \textsuperscript{216} See \textit{id.} at 283.
\item \textsuperscript{217} See MEYERS, \textit{supra} note 211, at 282.
\item \textsuperscript{218} See \textit{id.} at 283.
\item \textsuperscript{219} See \textit{id.}
\item \textsuperscript{220} Id.
\end{itemize}
determining the exact moment of death, it could not be said that
the doctor caused the patient's death.\footnote{221} The jury returned a
verdict of not guilty.\footnote{222} Other countries have been similarly reluctant
to prosecute physicians for helping terminally ill patients end their
lives.\footnote{223}

In many of the cases in which physicians have been charged
with intentional killings, the defendants were acquitted following
defenses asserting that the prosecution was unable to prove causa­
tion.\footnote{224} It is unclear whether these were actually cases in which the
prosecution had difficulty proving causation beyond a reasonable
doubt – a very real possibility given the extreme circumstances of
the patients\footnote{225} – or were simply cases of jury nullification corre­
sponding with feelings of compassion. In any event, the inability of
the state to procure convictions in these cases of direct medical kill­
ing suggests that, absent very aggravated facts, the prosecution al­
ways has an uphill battle.

\footnote{221} Id. at 284.
\footnote{222} See id. at 283.
\footnote{223} While assisted suicide is illegal in the Netherlands, its physicians openly
practice it. If doctors follow the Royal Dutch Medical Association's strict proce­
dures, the government will not prosecute them. However, assisted suicide is con­
sidered as a treatment choice only when all other options for terminally ill pa­
tients have been exhausted. See Alison C. Hall, \textit{Note, To Die with Dignity:}
Comparing Physician-Assisted Suicide in the United States, Japan, and the Netherlands, 74

In 1995, Australia's Northern Territory passed the Northern Territory Rights
of the Terminally Ill Act. The Act allows physicians to prescribe and administer
lethal substances to terminally ill patients who formally request assistance in end­
ing their lives. See Christopher James Ryan & Miranda Kaye, \textit{Euthanasia in Austra­}
\textit{lia – The Northern Territory Rights of the Terminally Ill Act, 334 NEW EN­}
\textit{G. J. MED.} 326, 326 (1996). In all other Australian states, voluntary euthanasia and assisted sui­
cide remain illegal, “although some have recently enacted laws recognizing a right
to have life-sustaining treatment withdrawn and protecting members of medical
staffs against liability if they stop treatment at a patient's request.” \textit{Id.}

The Supreme Court of Canada recently struggled with the constitutionality
of a statute criminalizing assisted suicide. A competent patient suffering from
Lou Gehrig's disease asked for a judicial declaration that the statute was void as
applied to her and her physician. The Court dismissed her petition, concluding
that human life must be respected and that no societal consensus existed in favor
of legalizing physician-assisted suicide. See \textit{Meisel, supra} note 137, § 18.22, at 505­
06.

\footnote{224} See Glantz, \textit{supra} note 24, at 235.
\footnote{225} See id. (“[P]roofing beyond a reasonable doubt [that terminally ill elderly
patients] died as victims of homicide, rather than from natural causes, will
often be difficult.”).
B. The Criminal Law and Extreme Medical Negligence

The involvement of the criminal law in cases where some extreme form of professional negligence has caused death also appears to be highly unusual.\textsuperscript{226} Doctors rarely have been charged criminally with conduct that must be evaluated by scrutinizing the standard of care used in treating patients.\textsuperscript{227} Only one decision to withdraw treatment from a terminally ill patient, the \textit{Barber} case,\textsuperscript{228} has resulted in the criminal prosecution of the treating physicians.\textsuperscript{229} That prosecution ended, however, when the California Court of Appeals granted a writ of prohibition.\textsuperscript{230}

More often, a prosecutor’s decision to pursue a conviction has been based on conduct that does not involve evaluating the standard of care.\textsuperscript{231} Typically, the alleged wrongful actions fall into one of two categories: 1) conduct that would be criminal whether done by a doctor or anyone else – for example, sexually molesting patients,\textsuperscript{232} committing Medicaid fraud,\textsuperscript{233} or prescribing drugs for nontherapeutic purposes;\textsuperscript{234} or 2) conduct that is so aggravated that expert testimony is scarcely needed to demonstrate the conduct's

\begin{itemize}
\item \textsuperscript{226} See \textit{id.} at 231 (discussing judicial reluctance to interfere with physicians’ practice of medicine).
\item \textsuperscript{227} See \textit{id.} at 236.
\item \textsuperscript{228} See \textit{supra} notes 160-71 and accompanying text.
\item \textsuperscript{229} See \textit{Barber} v. Superior Court, 195 Cal. Rptr. 484, 486 (Ct. App. 1983). In this case, two California physicians were charged with murder after assenting to the requests of a patient’s family to withdraw all life support systems. \textit{See id.; see also} Glantz, \textit{supra} note 24, at 236.
\item \textsuperscript{230} See \textit{Barber}, 195 Cal. Rptr. at 486.
\item \textsuperscript{231} See Glantz, \textit{supra} note 24, at 231.
\item \textsuperscript{232} See, \textit{e.g.}, Commonwealth v. Helfant, 496 N.E.2d 433, 436 (Mass. 1986) (finding a physician guilty of rape after he drugged a patient in order to have sexual intercourse with her); Minnesota v. Poole, 489 N.W.2d 537, 545 (Minn. Ct. App. 1992) (stating that a physician is guilty of criminal sexual conduct if the “actor accomplishes the sexual [contact] by means of a false representation that the contact is for a bona fide medical purpose by a health care professional”).
\item \textsuperscript{233} See, \textit{e.g.}, United States v. Khan, 53 F.3d 507, 513-15 (2d Cir. 1995) (finding several physicians and the clinic organizer guilty of participating in a racketeering enterprise designed to defraud the New York State Medicaid system); United States v. Laughlin, 26 F.3d 1523, 1526-27 (10th Cir. 1994) (finding a physician guilty of Medicaid fraud).
\end{itemize}
gross departure from accepted medical practice. 235

An example of the second type of conduct involved a prosecution for involuntary manslaughter in Pennsylvania. 236 A jury found a doctor criminally liable for the death of a seventeen-year-old patient who died of complications related to an overdose of the barbiturate Tuinal. 237 The doctor had written numerous prescriptions for controlled substances for the patient in the months preceding her death. 238 In the seven weeks before her death, he had given the patient seven separate prescriptions for Tuinal, in double the normal strength. 239 On one occasion, about a month before her death, the patient had arrived at a pharmacy in such a stuporous condition that she had to hold on to the cash register to maintain her balance. 240 When the pharmacist called the physician to express his reluctance to refill the prescription, the doctor told him to “fill the damn thing.” 241 The evidence detailed by the court’s opinion so overwhelmingly demonstrated the defendant physician’s gross irresponsibility in prescribing the medication 242 that one could conclude that expert testimony was unnecessary to support the jury’s finding that the doctor “consciously disregarded a substantial and unjustifiable risk . . . [involving] a gross deviation from the standard of conduct a reasonable person would have observed.” 243

In another case involving conduct that grossly departed from accepted medical standards, Dr. Tony Protopappas, a California dentist, was convicted of second-degree murder for the deaths of three of his patients following anesthesia overdose. 244 Dr. Protopappas caused the deaths of three young women within five months, 245 two of them within four days of each other, by his staggering disregard for the most basic principles of competent ad-

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236. See id.
237. See id. at 1359.
238. See id. at 1360-61.
239. See id.
240. See id. at 1361.
241. Youngkin, 427 A.2d at 1361.
242. See id. The court found relevant the facts that the patient was an outpatient and Tuinal is rarely prescribed to outpatients, the strength of the prescription, and the frequency of the prescription. See id.
243. Id.
244. See People v. Protopappas, 246 Cal. Rptr. 915, 916 (Ct. App. 1988).
245. See id. at 926-27.
ministration of general anesthesia.\textsuperscript{246} The court summarized the doctor's outrageous conduct\textsuperscript{247} and then stated:

No reasonable person, much less a dentist trained in the use of anesthesia, could have failed to appreciate the grave risk of death posed by the procedures he utilized. It was not a question of whether a fatality would occur, only a question of when; and ultimately there were three of them.\textsuperscript{248}

The conduct in each of the aforementioned cases clearly supported the jury's verdict. These actions are inapposite, however, to a physician's attempt to alleviate pain by prescribing high doses of morphine to terminally ill patients.

In another case involving extreme medical negligence, the physician was convicted of willfully violating New York's public health laws.\textsuperscript{249} In 1990, Dr. Gerald Einaugler transferred his seventy-eight-year-old patient from a hospital to a nursing home across the street.\textsuperscript{250} There, Dr. Einaugler mistook the patient's peritoneal-dialysis catheter for a gastrostomy tube and directed the staff to feed her through it.\textsuperscript{251} When the mistake was discovered by a nurse, Dr. Einaugler was advised to "get the patient to a hospital."\textsuperscript{252} He delayed the transfer for more than ten hours, despite his knowledge that peritonitis would likely develop and could become fatal if untreated.\textsuperscript{253} Peritonitis did develop, and the patient died within days.\textsuperscript{254} Dr. Einaugler was convicted of recklessly endangering his

\textsuperscript{246} See id. at 927.
\textsuperscript{247} See id. at 927-28. The court observed:
Protopappas did not supply proper general anesthesia or tailor the dosage to the patient. Without the patient's authorization he substituted surrogate dentists who were neither licensed nor qualified to administer general anesthesia. He instructed them to give improperly preset dosages for extended periods with little or no personal supervision and caused multiple patients to receive ever increasing amounts of general anesthesia at the same time, none of them enjoying his undivided attention. He was also habitually slow in reacting to the resulting overdoses; and in the case of Craven, simply abandoned her.
\textsuperscript{249} See George J. Annas, \textit{Medicine, Death and the Criminal Law}, 333 NEW ENG. J. MED. 527, 528 (1995) (discussing the case of Dr. Gerald Einaugler).
\textsuperscript{251} See id.
\textsuperscript{252} Id.
\textsuperscript{253} See id.
\textsuperscript{254} See id.
patient and of willfully violating New York's health laws. On appeal, the court found that his conduct fully supported the conviction for reckless endangerment and was a "willful act of neglect," in violation of New York's public health laws. It found that the doctor displayed a conscious disregard for the patient's safety by failing to transfer her to a hospital for treatment. It was not Dr. Einaugler's misidentification of his patient's dialysis tube that ran afoul of the criminal law but, rather, his attempt to conceal that error by delaying her transfer to a hospital. He was never charged criminally with the patient's death, however.

In several recent cases, the criminal law again has been used to sanction physicians for the deaths of patients where the physician's conduct has been deemed particularly outrageous. In another New York case, Dr. David Benjamin was convicted of murder for knowingly and intentionally causing the death of a patient after performing a late-term abortion. The court found that Dr. Benjamin knew he did not have the required skills, yet he performed the abortion in deliberate indifference to the health and safety of his patient, who died from excessive bleeding. At the time of the death, the state licensing authority had revoked the doctor's medical license temporarily for exhibiting gross incompetence and negligence while treating five other patients. The state, however, permitted Dr. Benjamin to continue to practice pending final revocation of his license.

In 1995, in Colorado, prosecutors charged Dr. Joseph J. Verbrugge, Jr., an anesthesiologist, with manslaughter after he fell asleep during ear surgery on an eight-year-old boy. When the pa-

255. See id. at 414-15.
256. Einaugler, 618 N.Y.S.2d at 415-16.
257. See id. at 415.
258. See id. at 415-16. "[T]his case does not support the proposition that medical professionals need fear the prospect of unwarranted criminal prosecutions for honest errors of medical judgment." Id. at 416.
259. See Annas, supra note 249, at 528 (hypothesizing that one reason for the district attorney's failure to prosecute was that he may not have believed that he could prove beyond a reasonable doubt that the patient would have survived had she been transferred sooner).
260. For a fuller discussion of these cases, see id. at 527.
262. See id.
263. See id.
264. See id.
265. See Howard Pankratz, Manslaughter Charge Filed in Fatal Ear Surgery,
tient died, the Colorado Board of Medical Examiners found that the doctor's "actions fell 'grossly below accepted standards of medical practice' and 'likely resulted' in the boy's death."²⁶⁶ Besides failing to monitor the boy during surgery and remaining awake, vigilant, and responsive to the developing crisis, Dr. Verbrugge also falsified the boy's medical chart.²⁶⁷ In April of 1995, when he was charged with manslaughter in connection with the boy's death, it was alleged that Dr. Verbrugge had fallen asleep during at least six other operations in the recent past.²⁶⁸

In perhaps the most egregious case, Dr. Milos Klvana, a California obstetrician, was convicted of nine counts of second-degree murder for nine deaths that took place over an eleven-year period.²⁶⁹ The court found that he acted deliberately and with a conscious disregard for life.²⁷⁰ The opinion in this astonishing case revealed the outrageousness of Dr. Klvana's conduct.²⁷¹ He repeatedly engaged in grossly incompetent and unsafe obstetrical practices, lost privileges at several hospitals, lied to patients and to the hospitals at which he sought privileges, disregarded numerous warnings from other doctors about his practice methods and his attitude, and asked his patients to suppress facts about their deliveries and to lie to authorities.²⁷²

These isolated and highly unusual cases involve conduct which can properly be called - at the very least - willful and wanton. In some, it was sufficiently aggravated to be found intentional.²⁷³ In a number of them, it seems the failure of the medical boards to intervene decisively was an important factor in the involvement of the criminal law.²⁷⁴ Certainly, the physicians' acts far exceeded anything that could be regarded as the exercise of good-faith medical


²⁶⁶. Id.
²⁶⁷. See id.
²⁶⁸. See Annas, supra note 249, at 528.
²⁷⁰. See id. at 526.
²⁷¹. See id. at 527.
²⁷². Id.
²⁷³. See Annas, supra note 249, at 529 (stating that criminal charges against physicians almost always involve extreme conduct that recklessly or intentionally deviates from the accepted standard of care).
²⁷⁴. See id. ("In the rare cases of criminal prosecution, charges have usually been brought because a pattern of deaths and reckless disregard for patients' safety has emerged and, for some reason, the physician's license has not been revoked.").
C. Physicians' Good-Faith Treatment of Patients

When physicians engage in good-faith efforts to treat patients, courts are extremely reluctant to try to regulate their conduct by means of the criminal law. Courts have recognized that manslaughter and murder statutes are inappropriate and ineffective as means of such control. In Commonwealth v. Edelin, a 1976 Massachusetts case, a physician was tried for manslaughter after performing an abortion of an allegedly viable fetus. The court reversed a jury conviction, pointing out that even if the doctor's judgment of nonviability had been wrong, "manslaughter could not be supported by proof merely of a mistake of judgment, even if that was the result of negligence or gross negligence." So long as the physician's judgment is made in good faith and is not "grievously unreasonable by medical standards," the law will not interfere. As the majority opinion in Edelin stated: "A larger teaching of this case may be that, whereas a physician is accountable to the criminal law even when performing professional tasks, any assessment of his responsibility should pay due regard to the unavoidable difficulties and dubieties of many professional judgments."

The President's Commission, in its 1983 report entitled Deciding to Forego Life-Sustaining Treatment, cogently articulated the reasons for deferring to medical judgment, and the importance of it, especially in the administration of pain medication to the dying pa-

275. See id. (concluding that physicians' good-faith errors and inadvertent mistakes in the treatment of patients will not result in criminal liability).

276. See, e.g., Barber v. Superior Court, 195 Cal. Rptr. 484, 486 (Ct. App. 1983) ("[I]t appears to us that a murder prosecution is a poor way to design an ethical and moral code for doctors who are faced with decisions concerning the use of costly and extraordinary 'life support' equipment."). The Florida Supreme Court best summarized this reasoning when it stated:

To be relieved of potential civil and criminal liability, guardians, consenting family members, physicians, hospitals, or their administrators need only act in good faith. For them to be held civilly or criminally liable, there must be a showing that their actions were not in good faith but were intended to harm the patient.


278. Edelin, 359 N.E.2d at 5.

279. Id. at 13.

280. Id. (emphasis added).

281. Id. at 18.
The report stated:

[Although medication is commonly used to relieve the suffering of dying patients (even when it causes or risks causing death), physicians are not held to have violated the law. How can this failure to prosecute be explained...?]

The explanation lies in the importance of defining physicians' responsibilities regarding these choices and of developing an accepted and well-regulated social role that allows the choices to be made with due care. The search for medical treatments that will benefit a patient often involves risk, sometimes great risk, for the patient: for example, some surgery still carries a sizable risk of mortality, as does much of cancer therapy. Furthermore, seeking to cure disease and to prolong life is only a part of the physician's traditional role in caring for patients; another important part is to comfort patients and relieve their suffering. Sometimes these goals conflict, and a physician and patient (or patient's surrogate) have the authority to decide which goal has priority.282

For these reasons, the courts properly hesitate before interfering with a physician's medical judgment, except in egregious cases.

D. The Appropriate Role of the Criminal Law in Medical Decisions

Criminal prosecutions of physicians engaged in treating terminally ill patients and making good-faith decisions about medication to control pain and suffering should rarely, if ever, be brought. Patients in these extreme circumstances require and are entitled to the fearless, aggressive efforts of their doctors to control their final pain and suffering. The intensity of these measures often can and should rival earlier efforts to keep the patient alive.283 To allow a patient to experience unbearable pain or suffering is an unethical medical practice, and physicians should not allow exaggerated fears of legal action to deter them from providing dying patients with aggressive, intensive palliative care. Morphine and a few other drugs in the medical arsenal are the heaviest of artillery,

282. President's Commission, supra note 180, at 78-79.
283. See Wanzer, A Second Look, supra note 22, at 847. Dr. Wanzer and his colleagues remarked that "[t]o withhold any necessary measure of pain relief in a hopelessly ill person out of fear of depressing respiration or of possible legal repercussions is unjustifiable. Good medical practice is the best protection against legal liability." Id.
used for the most urgent of reasons. Some risk will always be attendant to their use. The dosage requirements for adequate pain relief and the susceptibility of individuals to dangerous side effects are highly variable factors which may make every administration of morphine hazardous. Nevertheless, morphine appropriately remains the drug most often prescribed for the effective treatment of terminal pain and suffering, whether it be the pain of metastatic cancer, or the frightening, gasping suffocation that often follows withdrawal of a ventilator. Morphine can keep most patients virtually pain-free, anxiety-free, and often alert for long periods. How best, how much, and when to administer morphine are peculiarly medical decisions, with which the criminal law should not interfere, except in the most extraordinary of cases.

In addition, it is important to contemplate the ramifications for other dying patients if physicians are made fearful of criminal liability when they seek to manage terminal pain and suffering aggressively. For many people, the fear of pain and extreme anxiety regarding the ability of the medical profession to deal with it greatly exceed the fear of dying. Medicine knows how to control pain in most cases. Yet, when doctors become fearful of using the tools at their disposal, they become incapable of doing what they are able to do. Patients consequently suffer needlessly. Criminal prosecutions in cases like the Minnesota morphine investigations, even if unsuccessful, have the potential to cause enormous damage, in exchange for little social value. The Minnesota cases were not about euthanasia, and they were not about culpable negligence. Such cases rarely are. The intervention of the criminal law is not likely to deter or remedy either problem.

During the investigation of the two Minnesota cases, it became apparent that there was inadequate documentation substantiating

285. See id. at 88-89 (noting that the potential side effects and complications include addiction, excessive sedation, respiratory depression, nausea and vomiting, constipation, overdose, and seizures).
286. See id.
287. See id. at 89.
288. See Melzack, supra note 41, at 28.
290. See Melzack, supra note 41, at 28-29.
291. See id. at 27 (stating that pain can be worse than death itself and can erode the patient's will to live).
292. See Buchan & Tolle, supra note 22, at 59.
the need for morphine at the levels given in both cases. It was also clear that most health care institutions had no procedures or guidelines to assist physicians in the appropriate use of large dosages of pain-relieving medication. In an effort to give some clarity to the issue and guidance to physicians, the Hennepin County Medical Society prepared a paper entitled "Position Paper on Management of Pain and Suffering in the Dying Patient." A wide consensus of the Minnesota medical community supported the paper.

Subsequently, the Hennepin County Attorney and the Hennepin County Medical Examiner jointly issued a statement calling on medical institutions to formulate guidelines for the administration of pain-relieving drugs. The statement strongly advised health care centers to examine and revise their own policies to reflect the concerns the morphine cases raised (particularly concerns about documentation), and to give better, more specific guidance to doctors who must decide how to best dispense high dosages of narcotics to dying patients.

Although the medical community initially did not react favorably to that joint report, considerable constructive dialogue followed between representatives of the Minnesota Medical Association and the Hennepin County Attorney and Medical Examiner. A number of hospitals began to take steps to adopt procedures to help ensure the delivery of well-documented, effective, and compassionate palliative care for hopelessly ill patients. In

293. See Feldman, supra note 108, at 23-24 (stating that "[i]nadequate documentation appears to be at the heart of the matter in the two Hennepin County cases" and arguing that better documentation is needed in all medical records).

294. See id. at 24.

295. See J. Paul Carlson, Managing Pain and Suffering in the Dying Patient, MINN. MED., June 1990, at 35, 35. This paper has been reproduced in Appendix A of this Article.

296. See id. (stating that the paper represents the "position of organized medicine on this subject").


298. See id. at 23-24.

299. See id. at 24 (noting that the medical community objected to the report's recommendation that hospitals formulate guidelines "as an unwarranted intrusion into medical matters").

300. See id. at 20.

301. See Johnson, supra note 24, at 29. Several hospitals instituted guidelines similar to those proposed by the county attorney and the medical examiner. According to Johnson, physicians at these facilities are less likely to be the subject of a criminal investigation and prosecution. See id. Johnson posits:
time, horror stories of end-stage cancer patients dying in excruciating pain have become less common.

Other encouraging developments have occurred since the morphine investigations. In 1992, Minnesota amended its assisted suicide statute by adding a subdivision that describes acts or omissions not considered aiding suicide.\textsuperscript{302} It states:

A health care provider . . . who administers, prescribes, or dispenses medications or procedures to relieve another person’s pain or discomfort, even if the medication or procedure may hasten or increase the risk of death, does not violate this section unless the medications or procedures are knowingly administered, prescribed, or dispensed to cause death.\textsuperscript{303}

Other states have passed similar provisions, in an effort to assure doctors that criminal charges will not result from their appropriate and compassionate palliative care for dying patients.\textsuperscript{304}

As noted earlier, hospice care is on the rise in the United States.\textsuperscript{305} Medicare now reimburses providers for this type of care.\textsuperscript{306} In 1996, the Health Care Financing Administration approved a new diagnosis code for palliative care, which should lead to the creation of a special diagnosis-related group to allow payment of palliative care expenses for hospitalized patients as they approach death.\textsuperscript{307} In addition to the guidelines for the treatment of cancer pain to which this Article previously referred,\textsuperscript{308} at least forty-seven states have started cancer pain initiatives to increase awareness and knowledge about effective palliative care strategies.\textsuperscript{309}

Still, uncontrolled pain remains an important motivation be-

Compliance with the guidelines will be overwhelming evidence that the physician not only acted in good faith, but also that the administration of the pain-relieving drug was done in a manner consistent with prevailing medical standards. In such circumstances, there can be no criminal liability.

\textit{Id.}

302. \textit{See Minn. Stat. § 609.215, subd. 3(a) (1996).}  
303. \textit{Id.}  
305. \textit{See Cassel & Vladeck, supra note 39, at 1233.}  
306. \textit{See id. at 1232.}  
307. \textit{See id. at 1232 (noting that “only in 1996 are we beginning to acknowledge that some of the care delivered in hospitals is palliative”).}  
308. \textit{See supra} notes 52-53 and accompanying text.  
309. \textit{See Foley, Pain Relief, supra note 72, at 2149.}
hind many patients' desire for suicide. In one survey, sixty-nine percent of cancer patients reported that they would consider committing suicide if their pain were not treated adequately. More than half of all cancer patients experience severe pain, and two-thirds of those with advanced disease report pain. Yet studies indicate that as many as ninety-five percent of these patients can get good pain relief if skilled practitioners administer the right quantities of the right medications.

V. CONCLUSION

The prospect of legal access to physician-assisted suicide raises deep and disturbing questions about our commitment to the compassionate care of the dying. Many articulate and persuasive challenges have been raised against physician-assisted suicide, by individuals and groups on all fronts, conservatives and liberals, believers and agnostics, physicians and philosophers.

311. See Foley, Misconceptions and Controversies, supra note 63, at 311.
313. See The SUPPORT Principal Investigators, A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments, 274 JAMA 1591, 1594 (1995). The study revealed that families of 50% of a sample of patients who died in the hospital believed that the patients “experienced moderate or severe pain at least half the time during their last [three] days of life.” Id.; see also Foley, Treatment of Cancer Pain, supra note 54, at 84 (asserting that pain control should be sufficient to allow the patients with advanced disease to function at a level that they choose and to die relatively free of pain).
315. See Paul Wilkes, The Next Pro-Lifers, N.Y. TIMES, July 21, 1996, § 6 (Magazine), at 22 (listing “agnostics and believers; those who support legalized abortion and those who oppose it, those who bow to God and those who exalt reason; AIDS activists and Orthodox rabbis, the American Medical Association and Pope John Paul II”). See generally Yale Kamisar, Against Assisted Suicide – Even a Very Limited Form, 72 U. DET. MERCY L. REV. 735 (1995) (arguing adamantly against assisted suicide); Daniel Callahan, The Troubled Dream of Life (1993) (proposing plausible ways of bringing the legal and policy issues in the care of the dying and the critically ill back into closer contact with some of the oldest questions of human existence).
Not only have the two decisions from the Second\textsuperscript{316} and the Ninth\textsuperscript{317} Circuits provoked widespread discussion and commentary, they have evoked anew the concerns that physicians and others have expressed for years: that there is no principled way to limit assisted suicide to terminally ill, mentally competent patients who make rational requests for such aid; that assisted suicide will lead to euthanasia, and that both will be “practiced through the prism of social inequality and prejudice that characterizes the delivery of [health care] in all segments of society”,\textsuperscript{318} that although there may be morally acceptable exceptional cases for assisted suicide, such cases cannot justify such a dramatic change in public policy, with its enormous potential for abuse; that the relationship of doctors to their dying patients, already emotionally taxing and complicated, will be disastrously changed, with trust eroded;\textsuperscript{319} that elderly, poor, and disadvantaged patients will be subject to pressures they cannot withstand; that the many terminally ill patients who suffer from treatable depression will remain untreated, and “physician-assisted suicide [will] take the place of psychiatric intervention and care”,\textsuperscript{320} and finally, that we will no longer vigorously pursue means to make dying more comfortable, more peaceful, and more meaningful for the vast majority of dying patients who do not want suicide.

Perhaps we need to be reminded again of the relationship our physicians traditionally have had with us and of the ancient Hippocratic command known to all doctors, that “[t]o please no one will I prescribe a deadly drug, nor give advice which may cause his death.”\textsuperscript{321}

How then, . . . do I respond to patients’ requests for physician-assisted suicide? In the only way I can, by saying that I value their lives and their worth and therefore cannot kill them. I tell them, too, that I will care for them and treat their symptoms, and, if their pain cannot be adequately controlled while they are dying, that I will honor their choice to be sedated. And, last, I assure them

\textsuperscript{316} See Quill v. Vacco, 80 F.3d 716 (2d Cir.), \textit{cert. granted}, 117 S. Ct. 36 (1996).


\textsuperscript{318} Kamisar, \textit{supra} note 315, at 738.


\textsuperscript{320} Foley, \textit{Physician-Assisted Suicide}, \textit{supra} note 310, at 165.

\textsuperscript{321} \textit{OXFORD MEDICAL COMPANION} 371 (John Walton et al. eds., 1994).
that I will never abandon them but will remain to the end a witness to their dying.  

APPENDICES

After the Minnesota morphine investigations, the Hennepin County Medical Society issued a position paper and the Hennepin County Attorney and Medical Examiner jointly issued guidelines on the management of pain in terminally ill patients. Both are reproduced below.

APPENDIX A

HENNEPIN COUNTY MEDICAL SOCIETY POSITION PAPER ON MANAGEMENT OF PAIN AND SUFFERING IN THE DYING PATIENT

Statement of Need

Fear, misunderstanding, and misplaced concern can contribute to the pain and suffering of the dying patient. The patient's fear of pain may accentuate the pain or the suffering of both patient and family. Misunderstanding by health care professionals of ethical and legal principles can contribute to the problem. Physicians and nurses may be concerned that administering large amounts of morphine, or other narcotics, to the dying patient may be viewed by others as euthanasia, an intentional act to cause death for reasons of compassion, rather than as an effort to control pain and suffering. This concern is misplaced. The administration of large quantities of narcotic analgesics is not euthanasia when the purpose is to alleviate pain and suffering, not to shorten the life of the patient. There are sufficient ethical, moral and medical reasons to prescribe morphine, and other pain relieving medications, even at the risk of hastening the patient's death.

Physicians, and other health care providers, have an obligation to provide maximal relief from pain and suffering for dying pa-

tients. To fulfill this obligation, health care providers must understand applicable ethical and legal principles, as well as current practices in pain management. They must also be attentive to the individual patient's response to narcotic and sedative drugs.

**Scope of Statement**

This statement applies only to the use of narcotics, and other analgesia, in the management of pain and suffering in dying patients, based on accepted medical, ethical, and legal principles and practices. Other institutional policies and guidelines address pain control for non-terminal patients, as well as termination of life-sustaining treatment for dying persons, and specific treatment modalities such as cardiopulmonary resuscitation, sustained assisted ventilation, etc. Other policies and guidelines address the decision-making process, including the role of advance directives. Physicians, and other health care professionals, should be knowledgeable about all policies and guidelines that apply to the care of persons with terminal conditions.

A dying patient is an individual with an incurable and irreversible condition that usually leads to death, unless life-sustaining treatment is instituted or continued.

**Principles for the Management of Pain and Suffering for Dying Patients**

Dying patients who possess the capacity for decision-making, or the appropriate surrogates of patients who do not have the capacity to make decisions, have the right to participate in decisions about the course of their own medical treatment, including the degree of pain relief desired. Health care professionals should make every effort to relieve the suffering of the dying patient, even if this requires intermittent or continued administration of significantly larger doses of narcotics and sedation, which in circumstances other than anticipated death would be considered inappropriate. The goal of treatment is to relieve patient suffering to the fullest extent possible. For dying patients there is no "cap" dose; high doses may be required for relief of pain and suffering.

The role of the physician in caring for the dying patient is to provide comfort and maintain dignity. Dying patients should be assured that maximal comfort will be provided even in the face of impending death, and even when the physical effects of narcotics, or other analgesics, such as falling blood pressure, declining rate of
respirations, or altered level of consciousness, are present. On the other hand, it is unacceptable for health care providers to administer such drugs for the purpose of abetting the patient's suicide, or to deliberately cause the patient's death for reasons of compassion. In managing dying patients, health care professionals are not obligated to do that which violates their conscience or professional judgment, but have the duty to arrange for alternative care under such circumstances.


APPENDIX B

JOINT GUIDELINES OF THE HENNEPIN COUNTY ATTORNEY AND HENNEPIN COUNTY MEDICAL EXAMINER FOR THE ADMINISTRATION OF PAIN-RELIEVING DRUGS

I. Governing Principles

A. The administration of large dosages of pain-relieving drugs to terminally ill patients is appropriate only as necessary for the relief of pain, discomfort or distress.

B. Proper decision-making and proper administration include thorough documentation particularly of the need for the drug at the dosage level administered.

C. Hospitals and other institutions should develop and adopt specific guidelines establishing the acceptable standard of medical practice for the treatment of terminally ill patients with large dosages of pain-relieving drugs.

D. Hospitals and other institutions caring for terminally ill pa-
patients should develop and adopt procedures to ensure doctors and other professionals under their authority follow their guidelines.

E. Creation of and adherence to such guidelines should assure patients of compassionate and effective treatment and should create community confidence in the actions of hospitals and health care professionals involved in the care of terminally ill patients.

II. Policies and Procedures

A. The specific policies and procedures adopted may vary from institution to institution. However, such guidelines should address at a minimum:

1. Patient selection criteria;
2. Obtainment of consent and notification of patients and/or their families or legal representatives;
3. Documentation of treatment decisions made, their underlying rationales and goals, the patient’s symptoms and indications for such treatment decisions and the patient’s responses to such treatment;
4. Administration procedures to be followed, including the content of the Physician’s Order authorizing the drug;
5. Responsibilities of and coordination of responsibilities among physicians, nurses, and other health care professionals;
6. A review process for the treatment given pursuant to the guidelines. (By way of analogy, blood transfusion review and surgically removed tissue review are universally familiar facets of hospital quality assurance.)

B. An example of existing guidelines that may serve as a basis for appropriate policies and procedures is the UCLA Medical Center Policy No. 0024 dealing with the “Administration of Narcotics for the Dying Patient” (copy attached), a pioneering effort in creating a systematic and medically sound treatment approach to the dying patient.

III. Effect of Guidelines

The development of specific guidelines consistent with the above and adherence to such guidelines should obviate the need for involvement by the Hennepin County Medical Examiner and Hennepin County Attorney. In the event involvement is necessary,
the existence of such guidelines and adherence to them will be an important consideration in the review process.

UCLA MEDICAL CENTER POLICY NO. 0024.

Subject:
Administration of Narcotics for the Dying Patient.

Purpose:
To relieve maximally the pain and suffering of dying patients.

Reference:
Nursing Service Policy # 048, Medication Administration.

Principles:
1. Dying patients (or an appropriate surrogate) who possess decision-making capacity have the right to participate in decisions about the course of their own medical treatment, including the degree of pain relief desired in the final stage of life.
2. Health care professionals must make every effort to relieve the pain and suffering of the dying patient even if this requires either intermittent or continued administration of significantly larger doses of narcotics which in circumstances other than anticipated death would be considered inappropriate. The goal of treatment is to relieve pain and suffering to the fullest extent possible.
3. Dying patients should be assured the maximal possible comfort even in the face of impending death as heralded by falling blood pressure, declining rate of respirations, or altered level of consciousness.
4. Health care professionals are not obliged to do that which violates their conscience or professional judgment, but have the duty to arrange for alternative care under such circumstances.

Implementation:
1. Establish that patient fits the selection criteria.
2. Establish guidelines for ordering and administering the narcotic, and for documentation.

Patient Selection Criteria
A. Patient must have current Do Not Resuscitate (DNR) order.
B. Patient must be dying and experiencing symptoms causing pain, discomfort, or distress for which narcotics are an accepted treatment.
Protocol for Ordering, Administering and Documenting

A. Physician Responsibility

1. The rationale and goals of narcotic therapy for the dying patient must be documented in the Progress Notes of the patient's medical record. A statement that the patient (or appropriate surrogate) agrees with this therapy must be included as well. This note must be written by the attending physician, or by the house officer with the verbal concurrence of the attending or chief resident. The attending must concur with this note within 24 hours by signing the house officer's Progress Note.

2. The Physician's Order must begin with the statement: "Administration of Narcotic for the Dying Patient." This order must be written by the attending physician, or by the house officer with the verbal concurrence of the attending or chief resident. The attending must concur with this note within 24 hours by signing the house officer's Physician's Order.

3. The Physician's Order must specify:
   a. The amount of drug: the amount of diluent.
   b. The time interval and amount of drug in mgs/hour for incremental dose increase.
   c. That incremental dose increases are to be based on pain or symptom assessment and not vital sign parameters.
   d. A maximum or "cap" dose is not required.
   e. The conditions under which he/she wishes to be notified.

4. The narcotic order must be renewed every 72 hours.

5. Telephone and/or verbal orders are not acceptable when initiating or changing the order.

6. The physician should assess the efficacy of narcotic treatment on a frequent basis.

B. R.N. Responsibility

1. Only staff R.N.'s who have passed the U.C.L.A. Pharmacology exam may administer narcotics.

2. If IV/SQ continuous infusion narcotics are ordered, they must always be administered via an infusion pump. The IV tubing proximal to the infusion device must be clearly identified signifying that this line is infusing a narcotic.

3. Administrative Nurse (A.N.) II, III, IV, or V, or a unit based Clinical Nurse Specialist must co-sign the order.
4. The pharmacy is to be notified at least 30 minutes before the next bag of narcotic infusion is needed to allow for drug preparation.

5. The R.N. administering the narcotic will:
   a. Increase the medication by the amount specified in mgs/hour within the given time increments should the patient continue to experience pain or other distressing symptoms.
   b. Assess the efficacy of treatment on a frequent basis and inform the physician when pain or other distressing symptoms are not relieved.
   c. Alert the physician when the maximum dose of the narcotic has been given.
   d. Not discontinue the narcotic in the event the narcotic order is not renewed in 72 hours according to policy, but rather will notify the physician immediately so that a renewal order may be written at once.
   e. Discontinue the narcotic only upon the physician's order.
   f. Document the initiation or titration of the IV infusion on the Continuous Narcotic Administration Record, on the Nurses Notes, and on the Controlled Substance Audit Sheet.

6. Two nurses must co-sign any wastage of unused narcotic solution in the Controlled Substance Administration Record per Nursing Service Policy #050. Any narcotic being returned to Pharmacy must also be documented on this Record.

7. Vital signs may be obtained to assess the patient's status in the dying process, but should not influence decisions about administering narcotics in the presence of continued pain or other distressing symptoms for which the narcotic is an accepted treatment.

8. The following narcotics administered by continuous infusion may include but are not limited to:
   a. Morphine Sulfate
   b. Hydromorphone (Dilaudid)
   c. Methadone
   d. Fentanyl