

Legal Foundation and Protection for Palliative Care

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Frequent Concerns

- Fear of Accusations of Euthanasia
- Withdrawing or Withholding Life-Sustaining Care

Getting the Terminology Straight

- Physician Assisted Suicide: acquiescence in a patient request for lethal medication specifically to be used for the *purpose* of causing death. Legal only in Oregon.
- Euthanasia: purposefully causing death that the patient has not requested. Not legal anywhere in US/Canada.
- Palliative Sedation (aka, “terminal sedation”) sedation to unconsciousness at the patient or surrogate’s request. Legal everywhere.

AND..

Intent to ease pain and treat symptoms of a terminal illness is neither illegal nor unethical even if the result is the patient's death.

Ethical

“Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death.”

AMA Ethical Standard 2.5

Legal

“The reasons...[for my position in Glucksberg]... also support the distinction between assistance to suicide, which is banned, and practices such as termination of artificial life support and death-hastening pain medication, which are permitted.

(Souter, J. concurring, Glucksberg v. Quill, 1997)

More on Legal: The Controlled Substances Act

There are NO CSA cases involving clinical care of a terminally ill patient.

“I'm here to tell you that we trust your judgment. You know your patients. The DEA does not intend to play the role of doctor. Only a physician has the information and knowledge necessary to decide what is appropriate for the management of pain in a particular situation. We never want to deny deserving patients access to drugs that relieve suffering and improve the quality of life.”

DEA Administrator Asa Hutchinson to the APS, April 2002.

Can Be Viewed As a Double Effect Analysis...or Not

- Aggressive pain management, including palliative sedation, has long be ethically justified as a manifestation the “double effect.”
 - A good effect is desired.
 - A bad effect may be inevitable.
 - The bad effect is not the means to the good effect.
- Double Effect Analysis presumes that high dose opioids almost certainly cause respiratory depression and hasten death.
- More recent clinical studies indicate that respiratory depression is not as inevitable as previously thought when opioids are well titrated.

Analysis therefore may be based on beneficence.

Since 1980 only two prosecutions in the US involving opioids for palliative care.

- **State v. Narramore** (Kansas, 1998)
- **State v. Weitzel** (Utah, 2000)

Protect Yourself

- DOCUMENT your decisions and the basis for them.
- Obtain INFORMED consent. Explain both the benefits and the risks of aggressive pain management.
- Maintain a respectful and compassionate attitude with the patient and family. Make your palliative intent known to them.
- Never, ever speak lightly with staff.
- Talk about and treat pain as the disease progresses—highlighting pain management at “the end” distorts its role in the plan of care.

Be Mindful of Potential Liability for Undertreatment of Pain

- Malpractice
- Intentional or Negligent Infliction of Severe Emotional Distress.
- Abandonment
- Elder Abuse

OR ALL OF THE ABOVE

Negligent Infliction of Severe Emotional Distress-PA Elements

- The defendant had a duty toward the plaintiff, which was violated.
- The violation caused bodily injury.
- The injury was reasonably foreseeable.
- Bodily injury includes mental trauma that is more than “merely transitory” (and in practice needs to be substantial enough to require treatment: nightmares, depression, anxiety, etc.)
- Requires proof by an expert witness that the injury occurred.

Intentional Infliction of Emotional Distress

- (1) Extreme and outrageous conduct intentionally or recklessly causes severe emotional distress. (physical injury not required).
- (2) Liability extends to patient

AND

(a) to a member of such person's immediate family who is present at the time, whether or not such distress results in bodily harm, or

(b) to any other person who is present at the time, if such distress results in bodily harm.

Taylor v. Albert Einstein Medical Center, No. 33 E.D. App. Dkt. 1999 (Pa. 05/17/2000)
(Restatement of Torts Sec. 46)

Abandonment

- “Why didn’t I return your phone calls about pain? I don’t know anything more to do for you.”
- “The doctor is not answering his pages. We can’t do anything without an order.”
- “Nobody’s going to find a bottle of pills in the street with my name on them.”
- “I don’t believe she is really in that much pain.”

ABANDONMENT- ELEMENTS

- A physician-patient relationship.
- Neglected or terminated without notice that is adequate for the for the patient to find a competent successor.
- At a “critical juncture” (only some states).
- Requires proof by expert testimony.
- Supplemented by statute and/or medical board regulations in many states. Usual provision requires at least 30 days written notice.

Withdrawing and Withholding Life-Sustaining Treatment

- The competent patient may refuse any medical care.
- The incompetent patient's advance directives speak for him/her and trump the surrogate's own opinion.
- Where there are no advance directives, the designated health care surrogate makes the decisions. Family members that disagree have no recourse other than to petition the courts to have the surrogate removed.
- The surrogate's standard is always "the patient's wishes, if known and, if not known, the best interests of the patient."

Advance Directives and Health Care Powers of Attorney are Statutory.

- All state statutes follow in most ways the model Health Care Decisions Act.
- You **MUST** know your state's requirements for witnessing and execution of AD and POA's.
- You **MUST** know your state's limitations, if any, on the surrogate's ability to direct the withdrawal of artificial nutrition and hydration.

AD/POA Must Be in Writing But May Be Revoked or Modified Orally

- Most states do not require that the patient be competent at the time of revocation or change.
- If done orally some states require that it be communicated to a health care provider. Other states merely require the change to be documented in the record.
- Potentially difficult if the family cannot agree. Involve the Ethics Committee and document all communications. Make sure the staff is aware of the issues and similarly documents.

Without a POA or AD, State Law Designates the Surrogate.

- In most states, surrogacy moves from the spouse, to children (as a class), to siblings (as a class) and then to more remote relatives (in classes).
- A few states permit a “close friend” who has recent contact with the patient and who knows the patient’s wishes may be substituted to be chosen over a family member with less direct participation in the patient’s life.
- When there are differences between class members, states differ in how they react:
 - Majority rule
 - Passing over the class to the next class.
- The “best interests of the patient” continue to govern the surrogate’s decisions.

What the Law Can't Do

- Demand POA/AD—but the physician has the best hope of getting them. EARLY.
- Resolve difficult intrafamily disputes.
- Prevent subtle bullying by family members of a weak patient.

HOWEVER...

--Frank and considerate conversations along the way will ease the family into decisions and make for less frantic “last minute” dispute.

--If treating pain and relieving the worst aspects of terminal illness is part of a continuum, symptoms of nausea, depression, apnea.

Making good palliative care the
best defense of all...