A perfect storm: fear of litigation for end of life care

Should doctors fear legal sanction for using opioids at the end of life?

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A perfect storm arises from a rare confluence of adverse meteorological factors, and is a metaphor for an especially bad situation caused by a combination of unfavourable circumstances (www.oed.com). Health care at the end of life has been significantly disturbed by two converging fronts. The first is very public conversations relating to opioid overuse. The second is the current tension between standard end-of-life care and voluntary assisted suicide.

The top 20% of opioid prescribers in Australia — including almost 5000 general practitioners — were recently sent letters warning them that their clinical practice was being scrutinised. This warning was an attempt to arrest an increasing number of deaths caused by overuse of prescription opioids.[1] An unintended but predictable consequence[2] appears to have arisen: anecdotal reports of some practitioners choosing to abandon end-of-life care altogether rather than risk professional ruin should they persist in the use of any opioid therapy.[3] While this is still anecdotal information, when added to an overcautious attitude towards prescribing higher dose opioids among some medical practitioners even when it is clinically warranted,[4] the consequences for patient care could be serious.

Treatment of chronic pain with long term opioids and opioid use at the end of life are two different issues. The National Pain Strategy emphasises the importance of a multimodal approach to chronic pain, highlighting the need of learning to live effectively with pain but not withholding opioids should they be necessary.[5] In many patients, long term opioid use is appropriate, allowing a normal and productive life. For others, prolonged high dose opioid is used in isolation from other treatment modalities. In palliative care, opioid use is usually limited to the final months of life and is therefore unlikely to lead to the same problems that can arise in chronic pain practice. Tolerance and dose escalation are of almost no consequence because the intent is time-limited symptom control.

The second storm front is assisted suicide. Victoria has passed assisted suicide legislation, Western Australia plans to follow suit in 2019.[6] There is considerable concern that normal palliative care practice, which might bear passing resemblance to voluntary assisted suicide, might land practitioners into hot water. The doctrine of double effect, where a treatment aimed at alleviating a symptom may cause harm, explains why some palliative treatments may be construed as euthanasia.[7] The difference is intent.

The fear is that the use of medicines to minimise suffering and distress at the very end of life may hasten death and be construed by critics as euthanasia by stealth.[8] The reality is that the person is dying. While treatments such as opioids may theoretically shorten life marginally, it is the disease that causes death, not the treatment. Such practice is more properly viewed as the treating practitioner aiming to minimise the suffering experienced by a person facing inevitable death. Medical practitioners who manage patients at the end of life can feel pressure regardless of their approach to end of life practice. They can be accused of hastening death with treatments that control symptoms. However, if they hesitate to treat people as actively as their symptoms may require, they might be accused of perpetuating avoidable suffering.[8]

In this context, we have published a systematic review of all Australian case law up until 30 June 2017, including the deliberation of coroners and criminal, civil, performance and conduct proceedings to test the extent to which there have been legal sanctions against health practitioners on the basis of overmedication possibly hastening death, in the setting of life-limiting illnesses.[9] We identified 12 cases in total across all jurisdictions in publicly available electronic databases, and of those, only two had adverse findings recorded. One was dealt with by the Queensland Nursing Council and one by the NSW Civil and Administrative Tribunal. Database searches revealed that neither led to criminal proceedings.[9] This indicates that regulatory bodies are not seeking to blame practitioners when death occurs in the presence of opioid administration, and that the intention to alleviate suffering and adhere to good clinical practice is respected.

How then should doctors and other health professionals respond to people with life-limiting illnesses? They should use both treatments and doses that are clinically indicated to alleviate the person's suffering. Opioids should not be avoided, and the minimum dose that achieves pain relief or reduction of chronic breathlessness should be prescribed. In some cases, the dose may appear very large, but as long as titration to that dose occurs steadily, the risk of adverse events such as respiratory depression being induced by the treatment is negligible. Clinical practice that seeks to alleviate suffering will be respected by the law and not punished.

Perfect storms do not last forever. The fronts move on and the convergence dissipates. This is likely to happen in this situation as well. In the meantime, practitioners can be assured that the law does not constitute a hazard to safe practice, but an ally to be valued.

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