

## Accusations of Murder and Euthanasia in End-of-Life Care

LEWIS COHEN, M.D.,<sup>1</sup> LINDA GANZINI, M.D., M.P.H.,<sup>2</sup>  
CHRISTINE MITCHELL, R.N., M.S., M.T.S.,<sup>3</sup> STEPHEN ARONS, J.D.,<sup>4</sup>  
ELIZABETH GOY, PH.D.,<sup>2</sup> and JAMES CLEARY, M.D.<sup>5</sup>

**P**ROVIDED THEIR ACTIONS are consistent with patient or proxy preferences, physicians have been taught that the provision of aggressive symptom control—even to the point of causing unconsciousness—as well as the withholding or withdrawal of life-sustaining treatments are not criminal acts. Ethicists and medical-legal experts, pointing to a series of court decisions and ethical opinions, assert that a consensus about such issues in end-of-life care was reached many years ago. With the integration of palliative medicine into mainstream health care such practices have become routine.

However, the national media frenzy around the case of Terry Schiavo suggests that many elected officials, government regulators, members of the health care profession, and a significant portion of the public do not seem to know of this consensus about which the ethicists and lawyers speak. Or, more worrisome, they think it is wrong.

Although the majority of medical practitioners who routinely provide end-of-life care are not questioned about their behavior, it would appear that a few become the object of allegations, and a smaller number face criminal investigation and prosecution. Alpers<sup>1</sup> has reviewed two national databases (court opinions and journalistic accounts) in order to identify physicians and nurses who were investigated or prosecuted for manslaughter or homicide in connection with the care of dying patients. Between 1990 and 1997, she

identified 7 doctors who had been charged with killing terminally ill patients, whereas there were only 10 indictments in the previous 55 years. While this may reflect increased use of life-prolonging technology rather than an increase in litigation, *per se*, the finding would again imply that a national “consensus” does not, in fact, exist.<sup>2-4</sup>

Accusations of murder and euthanasia likely have enduring effects on the individuals involved, and they also have the potential to disproportionately influence the specialty of palliative medicine. Awareness of a theoretical framework to understand these unfortunate events can hopefully highlight risk management issues and perhaps reduce litigation. The following vignettes have been selected from cases occurring since Alpers’ survey. Without changing the basic circumstances, demographic details have been altered to disguise the identities of the physicians and nurses.

### VIGNETTES

- Two renal nurses at a tertiary care center were accused by a nursing assistant of murder after the nurses participated in the discontinuation of dialysis of a patient who lacked decision-making capacity. The nurses were well-respected, long-term members of the hospital staff. During the patient’s final hospitalization, they had followed all of the physician’s orders to treat the individual’s symptoms, including

<sup>1</sup>Renal Palliative Care Initiative, Baystate Medical Center, Springfield, Massachusetts.

<sup>2</sup>Oregon Health and Science University, Portland, Oregon.

<sup>3</sup>Division of Medical Ethics, Harvard Medical School, Boston, Massachusetts.

<sup>4</sup>Department of Legal Studies, University of Massachusetts, Massachusetts.

<sup>5</sup>University of Wisconsin Medical Center, Madison, Wisconsin.

modest use of morphine (2 mg. intravenously every 2 hours as needed) for pain control. The family, who were the legal decision makers, actively participated and agreed with the plan to withdraw dialysis; they were entirely pleased with the palliative care provided to the patient.

During a 3-month period, the nurses were placed on administrative leave while the Assistant U.S. Attorney conducted a formal investigation and subpoenaed hospital records for a grand jury. The nursing board of registration requested that the primary nurse have her license suspended—which the hospital opposed. Both an internal hospital review and the investigation by the U.S. Attorney's office ultimately concluded that no crime had been committed, and the matter was finally dropped.

In subsequent interviews, it was apparent that the nurses were surprised by the nursing assistant's accusation, traumatized by the investigatory process, and terrified by the potential consequences of a guilty decision. The experience caused them to distrust their choice of nursing as a career, and to question the philosophy that had always guided their treatment of the terminally ill.

- A hospice medical director in a federal facility followed accepted guidelines when providing palliative sedation to a few of his terminally ill patients. This resulted in a formal investigation by the Office of the Inspector General. Over a period of 1 year, the physician faced criminal charges and the loss of his job. Although cleared from having performed either unethical or criminal acts, he was sufficiently upset by the experience that he left his position and moved to another state.
- The training director of a palliative care teaching program, reported, "When I first performed 'terminal' sedation on the ward, nurses really had a problem. Just last week, I had a resident accuse me of euthanasia, because I ordered a low-dose morphine drip. It's part of the day-to-day way of life in hospital palliative care."
- A nurse followed the orders of an attending physician, and administered several doses of intravenous morphine to a male patient with end-stage chronic lung disease who had persistently requested that his respirator be removed. The patient was evaluated psychiatrically and determined to have capacity to make decisions for himself; he understood his con-

dition, as well as the benefits, risks, and alternatives of the medical treatments and the near certainty of death without respiratory support. After extubation, the patient appeared panic-stricken, physically uncomfortable, and his respiratory rate increased. The attending surgeon, following standard approaches to dose escalation of opioids for severe dyspnea, ordered 10 mg to be slowly pushed intravenously, which had little effect. Five minutes later the dose was doubled without significant relief. Additional intravenous morphine was provided at the patient's request. He appeared to become much more peaceful, and died several minutes later. Another nurse on the unit accused her fellow staff members of having killed the patient, and the matter was criminally investigated. Depositions and expert testimony from ethicists representing both the prosecution and defense were presented to a grand jury. The grand jury chose not to indict either the physician or the nurse.

- A psychiatrist, who was the associate medical director of a geropsychiatric unit, provided palliative care to several elderly patients with the foreknowledge and assent of family members. Accused of multiple counts of murder by a nurse, the physician was later indicted by a grand jury and convicted of manslaughter. This occurred despite an initial review by a state appointed palliative medicine consultant, who found no evidence of improper medical care and recommended that the case not be pursued. After the criminal proceedings ensued, the previously supportive family members then initiated civil law suits. Before the criminal sentence was overturned, the physician served 6 months in prison. After being exonerated, legal costs forced her to declare bankruptcy and she lost possession of her home. Now several years later, she continues to struggle to resume the practice of medicine in another state.

In these vignettes, doctors and nurses who delivered palliative care were accused of euthanasia and murder, underwent administrative or criminal investigations, and faced the possibility of loss of income, career, reputation, and liberty. The examples illustrate the need for all professionals working in the field not to assume that everyone with whom they work shares the same ethical "consensus." Furthermore, they provide a

caution against trying to truncate, or eliminate the team-based decision-making and education that accompanies medical decision-making when death is imminent or foreseen. In the following sections the medical behaviors that shorten life will be summarized and the ethical complexities highlighted. Although the accusations and investigations reflect some bioethical ambiguity, they more importantly reveal that not all health care professionals or patient family members uniformly share the same knowledge base or values. These examples also suggest that the process of coming to a final treatment decision may be as important as the ethical and legal basis on which such decisions are made.

## DISCUSSION

Substantial numbers of Americans agree that, although we have the means to extend and prolong physical life through the application of medical technology, it neither makes sense in all circumstances nor is it always morally correct to do so. In the United States, 1 in 4 deaths now take place with hospice care.<sup>5</sup> In 2002, there were 885,000 individuals or their families who decided to refrain from further attempts at curative treatment in order to focus instead on comfort and palliation.<sup>5</sup> It is estimated that more than 90% of the 500,000 deaths in critical care units are now preceded by withdrawal or withholding of life-support treatments.<sup>6,7</sup> Over 15,000 Americans die after discontinuation of dialysis, and in New England, 1 in 3 end-stage renal disease deaths are preceded by a decision to stop renal replacement therapy.<sup>8,9</sup>

In 1998, the American Medical Association clarified in its Code of Ethics that, "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."<sup>10</sup> The interpretive statements of the Code for Nurses from the American Nurses Association similarly address nurses' responsibility to provide comfort and alleviate pain and suffering.<sup>11,12</sup>

Most American health care professionals are confident that it is ethically and legally well-established for competent patients to forgo or terminate life-sustaining treatments (including food and hydration), in accordance with autonomy and individual liberty, as well as to receive pain

and sedative medications under the principle of beneficence.<sup>13,14</sup> Family and other legally recognized surrogates may participate in these decisions on behalf of patients who lack decision-making capacity, or physicians may rely on advance directives to delineate health care preferences. The use of pain medications, sedatives, and anxiolytics to relieve suffering may have respiratory-depressant side effects that hasten death in some patients, or they may contribute to other patients ceasing to eat or drink. Such actions are not considered euthanasia or murder if the primary intent of the clinician is to relieve suffering (not hasten death), and the medical treatment is proportional and guided by standard medical practice (only administer as much sedative or opioid as needed to treat symptoms).<sup>7,15,16</sup> In the 1997 U.S. Supreme Court decision that found no constitutional bar to a state's criminalizing assisted suicide, several justices expressed the belief that most states should *not* use criminal prosecutions of physicians to prevent dying patients from obtaining adequate pain relief—even if the pain medication also hastens death.<sup>17,18</sup> Definitions of the different practices are provided in Table 1.

### *Intentions*

For many medical ethicists, intentions are an essential element in evaluating ethically acceptable clinical actions. Much weight is placed on the principle or Rule of Double Effect (RDE).<sup>19–21</sup> Developed by Roman Catholic moral theologians, the principle is discussed by the President's Commission in their treatise on *Deciding to Forego Life-Sustaining Treatment*, and has been accepted by most major religious traditions.<sup>22</sup>

The RDE was first articulated by St. Thomas Aquinas (1225–1274), who wrote in a chapter titled, "Whether it is lawful to kill a man in self-defense?" the following, "Nothing hinders one act from having two effects, only one of which is intended, while the other is beside the intention. Now moral acts take their species according to what is intended, and not according to what is beside the intention. Accordingly, the act of self-defense may have two effects, one is the saving of one's life, the other is the slaying of the aggressor. Therefore this act, since one's intention is to save one's own life, is not unlawful."<sup>23</sup>

In order to handle the moral ambiguity in circumstances where doing good may also cause harm, the RDE specifies four conditions that

TABLE 1. DEFINITIONS

- 
- *Withholding and withdrawal of life-sustaining medical treatments* include: cardiopulmonary resuscitation, mechanical ventilation, hemodialysis, vasopressors, blood transfusions, antibiotics, as well as parenteral nutrition and hydration. The right of a patient to refuse or withdraw medical treatment—including, life-sustaining treatment—has been recognized in law for many years as a consequence of the tort law requirement of informed consent. It is understood by most legal observers over the last fifteen years to be an aspect of an individual's constitutional right to liberty as defined by the U.S. Supreme Court. The existence, enforcement, and physician-protection provided by advance directives are all based on recognizing patients' rights to refuse life-sustaining treatment.
  - *Palliative or terminal sedation* relies on high doses of sedatives and narcotics to induce sleep in terminally ill patients who have unremitting pain and suffering that cannot be relieved with other palliative care measures while conscious. Hydration is often withheld, and death may accordingly be hastened.
  - *Physician-assisted suicide* involves the provision by a physician of a pharmacologic means to cause death to a decisional patient suffering from a terminal, incurable, or painful disease. The patient chooses the circumstances and whether or not to take the drug, which is usually a high-dose barbiturate. Physician-assisted suicide is proscribed in the AMA Code of Ethics, and a number of states have made it illegal. The Supreme Court has declined to impose a single constitutional requirement on the entire nation in this matter, and has ruled that individual states are constitutionally free to make their own decisions about the legality of physician-assisted suicide. A highly regulated form for terminally ill patients is legal in Oregon.
  - *Euthanasia* is derived from the Greek words for a good, painless death.
  - *Voluntary euthanasia* is the act of intentionally ending another person's life at the person's competent request. Because of its intentional nature, this form of euthanasia may be subsumed under a state's murder or assisted-suicide laws unless specifically permitted by statute.
  - *Nonvoluntary euthanasia* is the intentional killing of patients who lack the cognitive capacity to make their own decisions about dying, because of severe dementia, delirium, coma, or other conditions. It may also occur surreptitiously when a clinician decides for a patient that further medical treatment is futile and the patient's life is no longer worth living. Lethal doses of medication might be given without the patients' knowledge and consent or that of the family, proxy, or guardian. Nonvoluntary euthanasia is considered to be a form of murder in American jurisdictions.
  - *Murder* is the unlawful killing of a human being with malice aforethought. Malice may be expressed or implied. There are several "degrees" of murder and attempted murder, and definitions vary from state to state.
  - *Manslaughter* is the unlawful killing of a person without malice. Again, there are several types of manslaughter charges, and they also vary in their elements from one state to another.
- 

must be met for such an act to be ethically justified. First, the act, prior and apart from the potential harm, must be good or at least neutral, such as the relief of the suffering associated with dialysis sessions. The second condition assumes a morally significant difference between intending evil and permitting evil, such that the moral agent intends the good effect and merely tolerates or permits the foreseeable evil effect. The third condition prohibits using evil means even to achieve good effects; thus, the clinician may not justifiably kill a patient in order to end suffering. And, last, there has to be a proportionately important good to be achieved in order to justify the possibility of permitting an evil effect as well.<sup>24</sup> Thus, acts with harmful effects that would be morally wrong if caused intentionally, are permissible when they are unintended, even though they may be foreseen.<sup>25</sup> By invoking the RDE, clinicians have a basis to alleviate suffering with therapies that may also predictably shorten life. Another basic bioethical principle—autonomy—allows patients or their proxies to refuse food, hydration and other life-sustaining

treatments that may similarly contribute to accelerating death.<sup>26</sup>

A valid criticism of the RDE is that intentions can be ambiguous, multilayered, subjective, difficult to independently assess, and frequently contradictory.<sup>20,25</sup> This has been highlighted by several research investigations. A study of American intensive care units demonstrated that staff members may have mixed intentions when withdrawing and withholding life-support treatments.<sup>27</sup> Critical care physicians and nurses acknowledged that in 39% of the cases where medications were simultaneously provided, this was done with an intention of hastening death. In another study from The Netherlands, terminal sedation and withholding of nutrition and hydration were relied upon to relieve intractable distress in the imminently dying, and in 47% of the cases physicians admitted that a secondary intention was hastening death, while in 17% of cases this was the primary and explicit intention.<sup>28</sup>

Palliative sedation for dying patients is both legal and ethical depending on the reasons for its

use and the clinician's intention.<sup>29,30</sup> This was evident in a Supreme Court ruling that raised the possibility of a constitutional right to palliative care.<sup>18</sup> When other methods are not sufficient to relieve suffering from pain, dyspnea, and agitated delirium, patients are rendered unconscious with either opioids or benzodiazepines. Fainsinger and associates<sup>31</sup> reported that at three Canadian inpatient hospices terminal sedation was required by 4% of the patients, as well as 10% of the patients treated at a tertiary palliative care unit. Data from Israeli, Spanish, and South African palliative care inpatient programs found rates of controlled sedation for intractable symptoms varying from 15% to 36%, with delirium being the most common problem requiring this approach.<sup>32</sup>

### Conflicts

While the potential weakness of the RDE is that clinicians may have multiple intentions, doctors and nurses seem to be most at risk for prosecution by others due to misperception of their intentions and/or their understanding of what is legally and ethically permissible. In other words, a clinician may act to relieve suffering, but be perceived by others as intending to kill. As such, it may be useful to conceptualize allegations of euthanasia or murder by health care professionals, as a way for observers to express an extreme type of conflict in medical practice.

There is a substantial literature on conflict and dispute resolution involving end-of-life decision-making in the setting of intensive care units.<sup>33-35</sup> Tulskey and associates<sup>35</sup> studied cases where withdrawal or withholding of life-support was a consideration and found almost one half (46%) of responding family members acknowledged that conflicts had occurred during intensive care unit admissions, and one third of the disagreements took place around decisions to either not initiate or to terminate treatment. In another study, the same investigators qualitatively analyzed interviews with two primary physicians and two primary nurses for each of 102 patients (92% of whom had life-support withheld or withdrawn).<sup>36</sup> Conflicts were identified by at least one health care provider in 78% of the cases, and the researchers concluded that family and staff disagreements may reflect deep-seated differences in values.

Brennan and associates have emphasized that disputes are not confined to staff and patients or their families, but may also occur among clini-

cians ("intrateam") and within families ("intrafamily").<sup>33,37</sup> In a pediatric intensive care study, the majority of disagreements were between clinicians and family members, while more than one-third took place among clinicians.<sup>33</sup> Only 1 of the 16 intrateam conflicts in this study was acknowledged by both nurses and physicians—the balance were reported by nurses or physicians alone. Nurses showed a greater propensity to identify conflicts, and this likely reflects their closer proximity and sensitivity to the concerns of patients and families.<sup>38</sup>

Dissension may be compounded by educational, racial, economic, and cultural differences; patients involved in conflicts are significantly more likely to be nonwhite and have Medicaid insurance coverage.<sup>39</sup> Differences exist not only between staff and patients/families, but within a health care team that includes doctors, nurses, nurses' aides, and other staff members. Research suggests breakdowns in communication are at or near the top of the list of key factors that result in both team-family and intrateam conflict.<sup>33,39</sup>

Conflicts and decisions involving severely ill patients are further complicated by the finding that clinician attitudes and practices are sometimes more influential than patient preferences in shaping treatment plans.<sup>40-42</sup> Fifteen years ago, Asch and colleagues<sup>43</sup> surveyed members of the Critical Care Section of the American Thoracic Society and reported that physicians often continue life-sustaining treatment despite patient or surrogate wishes that it be discontinued, and many doctors unilaterally withhold or withdraw life-sustaining treatment that they judge to be futile. Some decisions were made without the knowledge or consent of patients or surrogates, and some were made over their objections. While one would assume that this situation has improved, critical care units remain especially conducive to conflict, because patients are often unable to meaningfully participate in decisions, the stakes are life or death, determinations occur frequently and with rapidity, and there are rarely preexisting staff-patient-family relationships.<sup>44,45</sup>

By contrast, most palliative medicine professionals pride themselves on having good communication skills to facilitate the eliciting of patient preferences and the cooperation of families. However, the intentions of these clinicians are carefully scrutinized because of the role they play in shifting from curative to palliative care; this is multiplied by the sheer volume of dying patients whom they manage.

Conflicts may be especially likely in recent years as palliative care clinicians have moved into hospital settings where they encounter a predominant ethos of sustaining life.<sup>46</sup> In the hospice, a relatively small group of health care professionals with similar values are accustomed to working together over time and learning the same set of principles and practices. In contrast, literally thousands of professionals may be employed in large medical centers, preventing this kind of unanimity of education, skill, and values.

Palliative care clinicians recognize the necessity to communicate intentions and goals to other members of the treatment team, and to document these in the medical record. Yet, it may be impossible to include all possible clinicians (every nurse on every shift, every therapist, every housekeeper). Consequently, intent is not always crystal clear to all observers and communication may be incomplete. When a patient is dying and appears to be suffering, death may be seen as a relief and a release for many of their health care professionals and families, but not for all. At the same time, observers may point out that it is far from an ideal moment to make life-and-death decisions—families are exhausted by extensive caregiving and financial burdens, and they are desperate to intellectually and emotionally comprehend what is occurring.<sup>47</sup> Under these circumstances, frustration or misperception fueled by powerlessness on the part of even a single family member or ancillary health care provider can readily lead to allegations of euthanasia or murder. It is logical to assume that despite strong communication skills, palliative care personnel face heightened risks of conflict.

There are other factors that may contribute to the genesis of these extreme conflicts. Although cessation of life-support treatment and administration of medications to ameliorate pain and other symptoms are both bioethically condoned, our diverse and multicultural society may neither uniformly grasp nor fully accept these practices. Subtle differences are not self-evident to the average layman, and they are likely to be just as unclear to staff members from the district attorney's office or the state medical/nursing board. Different religions hold dissimilar opinions concerning such matters, and medical staff attitudes about end-of-life decisions vary greatly.<sup>48</sup> Emotionally charged words such as "euthanasia" engender strong emotional reactions; and it is worth noting that withholding and withdrawal of life-support treatments have been labeled by some as

"passive euthanasia," and terminal sedation as being "slow euthanasia."<sup>15,16,49</sup>

For several years, physician-assisted suicide and end-of-life issues have been the focus of extensive publicity and debate in Oregon. Despite this a significant proportion of patients receiving treatment in Oregon clinics appear to misunderstand options in terminal care. In a study of general medical outpatients ( $n = 728$ ), only 69% of respondents understood the meaning of treatment refusal, 46% withdrawal of treatment, 23% assisted suicide, 32% active euthanasia, and 41% the RDE.<sup>50</sup> In this sample, more accurate knowledge was significantly associated with being white and having at least a college degree.

There may be a clash between ethics and laws that are affirmed nationally or in different states, and what individuals maintain and actually believe in their local communities. Investigations or criminal prosecution by law enforcement, medical institutions, and state boards are only partially influenced by a national, ethical, or judicial consensus. Instead, what may be of greater practical importance are individual and regional mores, local politics, religious beliefs, and state statutes and case law.

This was evident in Meisel and associates'<sup>3</sup> survey of the National District Attorneys Association ( $n = 761$ ), in which 12% of the respondents were involved in at least one end-of-life care case. Although interpretation was limited by a low response rate (27%), the prosecutors' views on the morality of clinicians' actions and whether they might want such treatment for themselves were both associated with whether they would proceed with legal prosecution. Only 3% of the district attorneys appeared to ascribe to a vitalist position, believing that in all circumstances life should be maintained for as long as possible by whatever means possible. Of greater concern was the finding that 14% of the sample did not believe that giving morphine at the request of a terminally ill and competent patient with cancer to alleviate pain—if the dose was thought to have contributed to hastening his/her death—was morally correct, and 19% expressed willingness to take formal action against the physician.

#### *Other contributing factors*

Several additional factors may likewise be influential. Palliative care specialists are often referred cases where there is a conflict brewing, the

patient is already in crisis, or within days of death. Despite communication expertise, the clinical reality may preclude adequate opportunities to develop trusting relationships with the patient or with other medical personnel. Also, despite the clinician's best efforts at facilitating good communication, the practical realities of the palliative care team may limit the time that a specialist spends with patients and families. In addition, as palliative care is incorporated into the practices of other medical specialties, fellow staff members may not completely understand or be able to explain the subtleties of the ethical principles or the differences between euthanasia and other end-of-life care.

Palliative medicine clinicians bring an ethos that values quality of life and the alleviation of suffering on par with quantity of life. They also accept the inevitability of death. These values are not uniformly shared by all Americans, and some recent events both illustrate this and have the potential to fuel a backlash against the current ethical basis of palliative care. They include the papal allocution regarding food and hydration for patients in a persistent vegetative state, as well as the stand taken by Florida's state legislature, and the federal legislative and executive branches around the Terri Schiavo case. These suggest that a substantial and politically powerful portion of the American population may not entirely agree with cardinal beliefs held by palliative care practitioners and much of organized medicine. Mistrust of palliative medicine clinicians may be fueled by the acrimonious debates in several states to legalize physician-assisted suicide, or the continuing revelation that euthanasia is occurring even while illegal. Matters are not helped by the publicity surrounding cases where clinicians actually are mass murderers. To illustrate this last point, New Jersey's leading mass murderer is a nurse, Charles Cullen, and Great Britain's most prolific serial killer appears to have been a well-liked family physician, Dr. Harold Shipman.

Furthermore, America's War on Drugs now appears to be focusing on the medical administration of opioids.<sup>51-53</sup> Organizations such as the Pain Relief Network and the American Pain Institute fear that recent convictions of physicians, e.g., Dr. William Hurwitz, will have a profoundly chilling effect on the management of both chronic and acute pain. While there have been nascent efforts to influence medical regulators (e.g., state medical boards and the Drug Enforcement

Agency [DEA]) there is a growing concern that more of these prosecutions are coming.<sup>54-56</sup> In fact, the federal government presently asserts that the Attorney General has the power under the Controlled Substances Act to judge the intentions of doctors prescribing schedule 2 drugs for terminally ill patients. The case considering the issue, *Oregon v. Gonzales* was heard in U.S. Supreme Court earlier this year.

Before concluding, it is worth inquiring whether increased allegations and investigations actually reflect a genuinely lowered threshold on the part of clinicians to accelerate dying, and whether the accusations of euthanasia or murder may be grounded in reality. On one hand, mortality statistics from critical care units, dialysis units, and hospices all imply that more Americans are taking advantage of the legal and ethical opportunities to decline life-sustaining interventions. Physicians are participating and in many cases playing a leading role in these situations. This does not, however, necessarily mean that they are at fault or should assume blame for the deaths. The Harvard Medical Practice Study of malpractice litigation makes the emphatic point that there is a disconnection between claims, injuries, and clinical mistakes.<sup>57</sup> Studdert and associates<sup>57</sup> have emphasized that not only do few clear-cut instances of negligent injury give rise to claims, but the majority of claims that are initiated do not appear to be grounded in identifiable instances of negligence. Consequently, it is doubtful that any increase in investigations or criminal prosecutions necessarily reflects a trend toward more euthanasia or improper acts by clinicians.

In summary, death and dying are regular occurrences in the practice of palliative medicine, as are clinical practices that directly or indirectly result in the shortening of survival. There are reasons to question the solidity of the ethical and legal consensus that has hitherto formed the rationale underlying clinicians' treatment of pain and suffering in the context of terminal illness. In our divided, complicated, and litigious society, it is not surprising that medical professionals are being accused of improperly hastening patient deaths. Doctors and nurses are especially vulnerable in their care of the dying during conflicts that arise when any of the participants fail to understand or reach agreement with the treatment plan.

The authors are interested in studying this phenomenon, and welcome contact from medical and nursing staff who have been targeted and ex-



onerated. We believe the prevalence of such allegations needs to be determined, a more complete understanding of the medical, social, and legal circumstances surrounding accusations should be reached, and the bioethical issues underlying end-of-life care warrant further examination. We hope to discover whether there are specific risk management strategies, public policies, or legal initiatives that can be used to meet this challenge.

### ACKNOWLEDGMENTS

The authors would like to thank The Greenwall Foundation for its support.

### REFERENCES

- Alpers A: Criminal act or palliative care: Prosecutions involving the care of the dying. *J Law Med Ethics* 1998;26:308-326.
- Pestaner JP: End-of-life care: Forensic medicine v. palliative medicine. *J Law Med Ethics* 2003;31:365-376.
- Meisel A, Jernigan JC, Youngner SJ: Prosecutors and end-of-life decision making. *Arch Intern Med* 1999;159:1089-1095.
- Oakes GA: A prosecutor's view of treatment decisions. In: Doudera AE, Peters JD (eds): *Legal and Ethical Aspects of Treating Critically Ill Patients*. Ann Arbor: AUPHA Press, 1982, pp. 194-200.
- Volunteers for Hospice: Hospice Facts and Figures; February, 2004. ([www.vfhaz.org/mc/page.do?sitePageId=2374](http://www.vfhaz.org/mc/page.do?sitePageId=2374)) (Last accessed September 26, 2005.)
- Prendergast TJ, Luce JM: Increasing incidence of withdrawal and withholding of life support from the critically ill. *Am J Respir Crit Care Med* 1997;155:15-20.
- Cohen LM: Pulling the plug. *Palliat Support Care* 2003;1:279-283.
- Cohen LM, Germain MJ, Poppel DM: Practical considerations in dialysis withdrawal: "To have that option is a blessing." *JAMA* 2003;289:2113-2119.
- Cohen LM, Germain MJ: Palliative and supportive care. In: Brady HR, Wilcox CS (eds): *Therapy of Nephrology and Hypertension: A Companion to Brenner's The Kidney*, 2nd ed. Philadelphia: Elsevier Science, 2003, pp. 753-756.
- American Medical Association Council on Ethical and Judicial Affairs, Code of Medical Ethics, 1998, Sec. 2.20, 46.
- American Nurses Association, Code for Nurses with Interpretative Statements. Silver Spring, MD: American Nurses Publishing, 2001.
- ANA Center for Ethics and Human Rights Advisory Board, adopted by ANA Board of Directors, December 5, 2003. ([www.nursingworld.org/readroom/position/ethics/etpain.htm](http://www.nursingworld.org/readroom/position/ethics/etpain.htm)) (Last accessed September 26, 2005.)
- Daly BJ, Newlon B, Montenegro HD, Langdon T: Withdrawal of mechanical ventilation: Ethical principles and guidelines for terminal weaning. *Am J Crit Care* 1993;2:217-223.
- Emanuel EJ: Care for dying patients. *Lancet* 1997;349:1714.
- Derse AR: Limitation of treatment at the end-of-life: Withholding and withdrawal. *Clin Geriatr Med* 2005;21:223-238.
- Rosenfeld B: Assisted Suicide and the Right to Die: The Interface of Social Science, Public Policy, and Medical Ethics. Washington, D.C.: American Psychological Association, 2004.
- Vacco v. Quill*, 521 U.S. 793, (1997); *Washington v. Glucksberg*, 521 U.S. 702 (1997).
- Burt RA: The Supreme Court Speaks: Not assisted suicide but a constitutional right to palliative care. *N Engl J Med* 1997;337:1234-1236.
- Repenshek M, Slosar JP: Medically assisted nutrition and hydration: A contribution to the dialogue. *Hastings Cent Rep* 2004;34:13-16.
- Congregation for the Doctrine of the Faith, "Declaration on Euthanasia." Section 4. ([www.vatican.va/roman\\_curia/congregations/cfaith/documents/rc\\_con\\_cfaith\\_doc\\_19800505\\_euthanasia\\_en.html](http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html)) (Last accessed September 26, 2005.)
- American College of Healthcare Executives: Decisions Near the End of Life. Policy Statement, November 2004. ([www.ache.org/policy/endoflif.cfm](http://www.ache.org/policy/endoflif.cfm)) (Last accessed September 26, 2005.)
- President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment. Washington, D.C.: US Gov Printing Office, 1983, pp. 77-82.
- Aquinas T: The Summa Theologica of St. Thomas Aquinas. Translated by Fathers of the English Dominican Province. London: R.T. Washbourne, 1918, p. 209.
- Quill TE: *Caring for Patients at the End of Life: Facing an Uncertain Future Together*. New York: Oxford University Press, 2001.
- Quill TE: The ambiguity of clinical intentions. *N Engl J Med* 1993;329:1039-1040.
- Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990).
- Wilson WC, Smedira NG, Fink C, McDowell JA, Luce JM: Ordering and administration of sedatives and analgesics during the withholding and withdrawal of life support from critically ill patients. *JAMA* 1992;267:949-953.
- Rietjens JA, van der Heide, A, Vrakking AM, Onwuteaka-Philipsen BD, van der Maas PJ, van der Wal G: Physician reports of terminal sedation without hydration or nutrition for patients nearing death in the Netherlands. *Ann Intern Med* 2004;141:178-185.
- Emanuel EJ, Daniels ER, Fairclough DL, Clarridge BR: The practice of euthanasia and physician-assisted suicide in the United States: Adherence to proposed safeguards and effects on physicians. *JAMA* 1998;280:507-513.



30. Orentlicher D: The Supreme Court and Terminal Sedation: rejecting assisted suicide, embracing euthanasia. *Hastings Constit Law Q* 1997;24:947-968.
31. Fainsinger RL, De Moissac D, Mancini I, Oneschuk D: Sedation for delirium and other symptoms in terminally ill patients in Edmonton. *J Palliat Care* 2000;16:5-10.
32. Fainsinger RL, Waller A, Bercovici M, Bengtson K, Landman W, Hosking M, Nunez-Olarte JM, deMoissac D: A multicentre international study of sedation for uncontrolled symptoms in terminally ill patients. *Palliat Med* 2000;14:257-265.
33. Studdert DM, Burns JP, Mello MM, Puopolo AL, Truog RD, Brennan T: Nature of conflict in the care of pediatric intensive care patients with prolonged stay. *Pediatrics* 2003;112:553-558.
34. Abbott KH, Sago JG, Breen CM, Abernathy AP, Tulsy JA: Families looking back: One year after discussion of withdrawal or withholding of life-sustaining support. *Crit Care Med* 2001;29:197-201.
35. Marcus LJ, Dorn BC: *Renegotiating Health Care: Resolving Conflict to Build Collaboration*. San Francisco: Jossey-Bass, 1995.
36. Breen CM, Abernathy AP, Abbott KH, Tulsy JA: Conflict associated with decisions to limit life-sustaining treatment in intensive care units. *J Gen Intern Med* 2001;16:283-289.
37. Burns JP, Mellow MM, Studdert DM, Puopolo AL, Truog RD, Brennan TA: Results of a clinical trial on care improvement for the critically ill. *Crit Care Med* 2003;31:2107-2117.
38. Studdert DM, Mello MM, Burns JP, Puopolo AL, Galper BZ, Truog RD, Brennan TA: Conflict in the care of patients with prolonged stay in the ICU: Types, sources, and predictors. *Intensive Care Med* 2003;29:1489-1497.
39. King P, Leslie Wolf L: Empowering and Protecting Patients: Lessons for assisted suicide from the African-American experience. *Minnesota Law Review* 1998;82:1015-1043.
40. Christakis NA, Asch DA: Biases in how physicians choose to withdraw life support. *Lancet* 1993;342:646.
41. Cook DJ, Guyatt GH, Jaeschke R, Reeve J, Spanier A, King D, Molloy DW, Willan A, Streiner DL: Determinants in Canadian health care workers of the decision to withdraw life support from the critically ill: Canadian Critical Care Trials Group. *JAMA* 1995;273:703-708.
42. Teno JM, Hakim RB, Knaus WA, Wenger NS, Phillips RS, Wu AW, Layde P, Connors AF Jr, Dawson NV, Lynn J: Preferences for cardiopulmonary resuscitation: Physician-patient agreement and hospital resource use. The SUPPORT Investigators. *J Gen Intern Med* 1995;10:179-186.
43. Asch DA, Hansen-Flaschen J, Lanken PN: Decisions to limit or continue life-sustaining treatment by critical care physicians in the United States: Conflicts between physicians' practices and patients' wishes. *Am J Respir Crit Care Med* 1995;151:288-292.
44. Burns JP, Mitchell C, Outwater KM, Geller M, Griffith JL, Todres ID, Truog RD: End-of-life care in the pediatric intensive care unit after the forgoing of life-sustaining treatment. *Crit Care Med* 2000;28:3060-3066.
45. Fins JJ, Solomon MZ: Communication in intensive care settings: The challenge of futility disputes. *Crit Care Med* 2001;29(suppl):N10-N15.
46. Cohen LM: A revolution in death-hastening decisions. *Palliat Support Care* 2003;1:377-379.
47. Covinsky KE, Goldman L, Cook EF, Oye R, Desbiens N, Reding D, Fulkerson W, Connors AF Jr, Lynn J, Phillips RS: The impact of serious illness on patients' families. *JAMA* 1994;272:1839-1844.
48. Fried TR, Stein MD, O'Sullivan PS, Brock DW, Novack DH: Limits of patient autonomy: Physician attitudes and practices regarding life-sustaining treatments and euthanasia. *Arch Intern Med* 1993;153:722-728.
49. Billings JA, Block SD: Slow euthanasia. *J Palliat Care* 1996;12:21-30.
50. Silveria MJ, Dipiero A, Gerrity MS, Feudtner C: Patients' knowledge of options at the end of life: Ignorance in the face of death. *JAMA*. 2000;284:2483-2488.
51. Gilson AM, Joranson DE: Controlled substances and pain management changes in knowledge and attitudes of state medical regulators. *J Pain Symptom Manage* 2001;21:227-237.
52. Portenoy RK: Opioid therapy for chronic non-malignant pain: Clinicians' perspective. *J Law Med Ethics* 1996;83:761-786.
53. Johnson SH: Disciplinary actions and pain relief: Analysis of the Pain Relief Act. *J Law Med Ethics* 1996;24:319-327.
54. Joranson DE, Gilson AM: Controlled substances and pain management: A new focus for state medical boards. *Fed Bull* 1998;85:78-83.
55. American Academy of Pain Medicine and American Pain Society: The use of opioids for the treatment of chronic pain: A consensus statement. American Academy of Pain Medicine and American Pain Society, 1997.
56. Martino AM: In search of a new ethic for treating patients with chronic pain: What can medical boards do? *J Law Med Ethics* 1998;26:332-334.
57. Studdert DM, Brennan TA, Thomas EJ: What have we learned since the Harvard Medical Practice Study? In: Rosenthal MM, Sutcliffe KM (eds): *Medical Error: What Do We Know? What do we do?* San Francisco: Jossey-Bass, 2002, pp. 3-33.

Address reprint requests to:  
 Lewis Cohen, M.D.  
 Baystate Medical Center  
 Department of Psychiatry  
 Chestnut Street S2669  
 Springfield, MA 01199

E-mail: lewis.cohen@bhs.org