

## 7

## Palliation

*From caring to curing and back again*

*The experience of and response to pain*

*Pain*

*Pain and suffering*

*Responses to pain*

*The moral imperative to relieve pain*

*Physician-assisted suicide*

*Distinguishing forgoing life-sustaining treatment, euthanasia, and assisted suicide*

*Ethical issues*

## FROM CARING TO CURING AND BACK AGAIN

Providing comfort, especially at the end of life, is neither a new concept nor a departure from the traditional responsibilities of the caring professions. Until the middle of the twentieth century, the cure of disease and the prevention of death were largely beyond the capability of those who ministered to the sick by trying to relieve their pain. With the development of biotechnology, the obligation to provide care became the obligation to provide cure, and a focus on comfort was reserved for those times when “nothing more could be done.” Rather than an inevitability, death was perceived as a failure of skill and the very notion of dying made professionals uncomfortable, even guilty. Increasingly sophisticated science and technology inflated both professional and lay expectations about the power of medicine. The resulting belief that cure is always possible led to a perceived requirement to “do everything” and a sense of defeat whenever patients did not recover or improve.

Palliative care as a discipline has successfully reintroduced the notion that relieving pain and suffering is central to the complete and authentic practice of medicine. Its defining philosophy is that cure and comfort are consistent objectives that may assume greater or lesser prominence, depending on the patient’s condition, prognosis, and

values. As discussed in chapter 6, the therapeutic continuum seeks a balance of curative and palliative care that responds to the patient’s changing condition. When the potential exists for significant improvement, the plan of care emphasizes aggressive curative interventions, supplemented by comfort measures. As the likelihood of remission fades and the patient approaches the end of life, the goal of care shifts and aggressive palliation becomes the primary focus.

This transition, which occurs over time rather than at a given moment, depends on attention to the evolving medical status, the clinical effectiveness of specific interventions, and the wishes and values of the patient and family. Helping patients, families, and professionals to adjust their goals and make decisions in ways that have clinical and ethical validity is the contribution of the bioethics committee.

Ill Mrs. Heller has been a resident of a long-term care facility for many years, during which her chronic obstructive pulmonary disease, diabetes, and osteoarthritis have become more severe. She is now confined to a wheelchair because of the intense pain in her back and hips, which she often describes as excruciating. The mild analgesics, including Tylenol, that have been prescribed do not bring relief and she has become increasingly immobilized, withdrawn, and depressed.

When her nephew, Dr. Agin, visited recently, he was alarmed by the deterioration he saw in his aunt. The person he remembered as vibrant and active was now saying, “I have no life. All I have is pain.” When he asked what she would like to be able to do that the pain prevented, he expected her to talk about missing her hiking, gardening, and painting. Instead, she replied, “Sleep. I don’t remember the last time I was able to sleep without being awakened by pain.”

Dr. Agin has requested a meeting to discuss his aunt’s pain management.

## THE EXPERIENCE OF AND RESPONSE TO PAIN

## Pain

Despite its subjective quality, the experience of pain is very real and can be consuming. As one writer describes it,

Pain is dehumanizing. The severer the pain, the more it overshadows the patient’s intelligence. All she or he can think about is pain: there is no past pain-free memory, no pain-free future, only the pain-filled present. Pain destroys autonomy: the patient is afraid to make the slightest movement. All choices are focused on either relieving the present pain or preventing greater future pain, and for this, one will sell one’s soul. Pain is humiliating: it destroys all sense of self-esteem accompanied by feelings of helplessness in the grip of pain, dependency on drugs, and being a burden to others. In its extreme, pain destroys the soul itself and all will to live. (Lisson, 1987, p. 654)

Whatever the clinical setting, medical condition, or technological sophistication, one caregiver mandate remains constant and compelling—the relief of pain. Even when

cure is impossible, the duty of care includes palliation. Moreover, this obligation is central to the therapeutic interaction, unquestioned and universal, transcending time and cultural boundaries. Whether the source of the pain is physiological or psychological, its relief is considered a primary moral goal of medicine because of the unique and intimate connection between those who hurt and those who comfort.

### Pain and Suffering

A related distinction has been made between pain and suffering. Dr. Eric Cassell (1982) has written about pain as a physiological response of the body and suffering as an existential assault on the person. He describes how one can experience pain without suffering when the goal is a noble or joyous one, using as an example the pain of childbirth. Conversely, a person can suffer without physical pain when he feels the disintegration of his personhood and his sense of control. When pain and suffering are closely related, Cassell claims, it is because the patient perceives the pain as overwhelming, uncontrollable, or unending. Emotional isolation may be added by the suggestion that the pain is only imagined. Pain of this kind represents suffering that is a threat, not only to life but to the integrity of the patient's sense of self.

It is impossible to spend any time in a clinical setting without recognizing this distinction. Patients are often asked to endure pain in the pursuit of a cure or remission. In weighing the benefits and burdens of a proposed treatment, the balance of current discomfort for future relief seems ethically appropriate. The calculus is different when the intervention will impose pain or suffering with no benefit. Likewise, suffering without pain is evident in the patient with aphasia that prevents him from communicating with his family, the trained athlete who can no longer care for her most basic physical needs, the father who must accept that his infant will never develop, and the artist trying to create faster than her eyesight is failing.

### Responses to Pain

III Mr. Peters is a 27-year-old African American man with sickle cell anemia, admitted to the ER in sickle cell crisis. He is experiencing severe pain in his thighs, arms, hands, and feet. He is also dehydrated and anemic. An ER resident orders an injection of Demerol for pain and admits him to the hospital.

Following admission, Mr. Peters continues to complain of pain and asks the nurses repeatedly about the medication that has been ordered for him. During morning rounds the next day, the medical team is impressed by how much he knows about his disease and its management. He reports that, most of the time, he is able to manage his pain with an anti-inflammatory drug, such as Motrin. During a sickle cell crisis, however, the only effective pain relief is achieved with intravenous morphine, and he specifies the dosages and schedules that have been successful. He says that, during past hospitalizations, self-administering the morphine with a patient-controlled analgesia (PCA) pump has allowed him

to achieve a constant blood level of medication, with supplementary morphine as needed for breakthrough pain.

The attending tells Mr. Peters that Demerol will be available when he requests it to control his pain. She also asks where and from whom he usually receives care, and Mr. Peters names several hospitals where he has been treated during crises. During postrounds discussion, several residents express concern about the patient's detailed request for a particular narcotic in specific dosages. They suggest that this may be drug-seeking behavior by an addict. One resident recounts a similar case during his internship, concluding, "That patient conned us for two days before we caught on. When we cut off her drugs, she left the hospital."

Nothing should be more self-evident than the clinical and ethical imperative to relieve pain. Yet, pain is a complex phenomenon for both patients and care providers in several important ways. First, pain is solitary, experienced only by the patient. Unlike other indications of illness or injury, information about pain is available to the clinician only through the patient's descriptions of and responses to it. This reliance on patient assessment of symptoms makes the evaluation and treatment of pain significantly different from other patient-physician interactions.

Second, although universally acknowledged, the experience and understanding of pain is influenced as much by personal values and cultural traditions as by physiological injury and disease. If the perception of and response to pain are to be understood in a useful way, they should be examined in the context of culture, gender, power, morality, and myth. These factors are especially important in the health care setting, where pain becomes an interpersonal encounter between the sufferer and the reliever. How pain is experienced and expressed by the patient and how it is understood and responded to by the provider largely determine how it is valued and, ultimately, how it is treated.

Both patient and clinician attitudes are affected by their respective personal and cultural values. For example, physicians' clinical judgments about and responses to pain are influenced by group-based factors, including age, gender, race, ethnicity, and physical appearance. The balance of power between provider and patient is yet another theme in the pain management interaction. So long as therapeutic control is vested in the caregiver, the patient remains the passive victim of pain, a supplicant in the standard p.r.n. (as circumstances require) regimen that requires the patient to ask for medication each time it is needed (Post et al., 1996).

Third, both patients and their doctors are influenced by their understanding—often misunderstanding—of pain and the agents for its relief. Studies have shown that physicians are inhibited by their inadequate professional education about analgesia, misconceptions about opioids and addiction, and fears about regulatory and legal liability. Similar misconceptions are shared by the lay public, and Americans have been shown to reject what they believe to be effective medicinal pain relief because they fear over-

reliance and/or addiction. Reluctance to provide sufficient pain medication has also been related to clinician fears that use of opioids will "kill patients" by depressing respirations and hastening death. These fears, plus concerns about legal liability, are reflected in the stringent laws regulating drug prescription and the suspicions of health care providers who see patient requests for pain relief as drug-seeking behaviors related to addiction. The unsurprising and unacceptable result is the routine undermedication of even terminally ill patients (e.g., Furrow, 2001; Post et al., 1996).

Mr. Peters' case illustrates several of these issues. He comes to the ER requesting morphine, a potent narcotic, and specifying the dosages and intervals that he would prefer. The care team has no prior experience with him and no way of confirming his history of sickle cell or its prior management. Mindful that morphine's effects are euphoric as well as analgesic, and also potentially addictive, the team believes that it must consider the possibility that he is a drug seeker rather than simply a patient in pain. While no explicit mention has been made of his race, it may influence some team members' perception about the likelihood that he abuses drugs. Even if he had not requested a narcotic, by specifying dosages and intervals, Mr. Peters may have seemed "demanding" or "bossy" to some caregivers, who prefer to be in control of the clinical interaction. Individually or in combination, these factors may result in his claims of pain and requests for relief to be discounted.

When dealing with patients in pain, especially pain that is chronic and/or intermittently intense, it is important for caregivers to understand the nature of the discomfort, its effects, and useful ways to respond to it. Assuming that Mr. Peters suffers from periodic sickle cell crises, it is reasonable that he is very familiar with the medications, dosages, and schedules that most effectively treat his pain. Unless and until he demonstrates that his description of symptoms is inaccurate or that he has another motive for his requests, the primary clinical goal should be to relieve his pain as quickly and completely as possible. Collaborating with him in this endeavor has the added benefit of helping him to regain some control over a situation that may well make him feel repeatedly helpless.

III Mr. Charles is a 32-year-old man with end-stage AIDS. He is wasted, noncommunicative, but responsive to painful stimuli. His rapid breathing, sweating, and restlessness indicate that he is experiencing considerable discomfort. His attending, Dr. Fellows, has written a standing order for Tylenol to be given every four hours, with Demerol to be given "if the patient appears especially uncomfortable."

When Mr. Charles' sister, a nurse, arrives from another state, she is appalled by her brother's condition. She discusses his pain management with Dr. Fellows and asks why he is not receiving constant intravenous morphine. Dr. Fellows replies, "Morphine will depress his respirations and may speed up his dying. I will not be responsible for contributing to his death. We can keep him comfortable by increasing his other medication." She responds, "He's dying now and nothing will change that! Why should he have to die this horribly?"

A critical distinction supporting adequate palliation, especially at the end of life, is the doctrine of double effect, which responds to the ethical tension between the obligations to promote patient well-being and to avoid inflicting harm. The doctrine holds that a single act having two foreseen effects, one good and one bad, is not morally or legally prohibited *if the harmful effect is not intended*. The doctrine requires that three conditions be met: the act itself is not wrong; the good effect is the result of the intentional act, not the result of the bad or harmful effect; and the benefits of the good effect outweigh the foreseen but unintended bad effect. All three conditions are essential to prevent the doctrine from being abused or perverted in an effort to justify actions intended to cause harm.

The doctrine of double effect recognizes that, while the administration of sufficient opioids to manage pain at the end of life risks depressing respirations enough to hasten death, the clinical and ethical mandate to relieve suffering is paramount. Mr. Charles may not be verbally asking for analgesia, but he gives every clinical indication that he is in terrible pain. As his sister points out, he is actively and irreversibly dying, so the question is not *whether* he will die, but *how*. His death is not preventable, but dying in pain is. Under these circumstances, the only thing that can be done to benefit him is to relieve his suffering and make his remaining time more bearable. Using the rationale of the doctrine of double effect, the palliative intervention is both justified and protected. Helping physicians appreciate this distinction so that they can comfortably provide adequate palliation at the end of life is often an important part of ethics committee involvement.

#### THE MORAL IMPERATIVE TO RELIEVE PAIN

III Carla is a 9-year-old girl who was diagnosed several months ago with Ewing's sarcoma. She has received radiation and chemotherapy, and was recently hospitalized for amputation of her entire left leg. Following surgery, Carla's pain was being successfully managed with a continuous IV morphine drip supplemented by patient-controlled IV morphine to be used when she felt she needed additional pain control. On the third postoperative day, one of her physical therapists told her that she should not activate the patient-controlled morphine until the pain became unbearable because, if she overused narcotics, she would become addicted. An intern who overheard this statement corrected the physical therapist, explaining that addiction is not associated with use of narcotics in the immediate postoperative period and is rarely the result of even chronic use to control severe pain. The intern also reassured Carla, telling her that she should activate the morphine as often as she needed it and that she would not be risking addiction.

Carla's parents, however, became very concerned about the potential danger of addiction and tried to discourage her from using the patient-controlled morphine. When she continued to use the medication, they insisted that her oncologist, Dr. Brader, stop both the continuous IV drip and the patient-controlled morphine. Dr. Brader replaced the morphine with non-

narcotic analgesia, which was much less effective, and Carla began to experience severe pain. Dr. Brader has recommended restarting the morphine to relieve Carla's pain, but her parents are adamant that she not receive any narcotics.

Do the obligations of care professionals include the relief of pain? Does pain management require the informed consent of a capable patient or an authorized surrogate? Can the conflict between Carla's doctor and her parents be resolved in a way that prevents her from suffering?

More than a professional obligation, the relief of pain has traditionally been considered a moral imperative. It is also an endeavor that reflects the tension between the two fundamental ethical principles of autonomy and beneficence. As discussed in chapter 3, the notion of autonomy is expressed in the health care setting in the doctrine of informed consent. Under this doctrine, capable, knowledgeable, and voluntary consent, either by or for the patient, is required for legally and ethically valid authorization for most diagnostic and therapeutic interventions.

Yet, the requirement of informed consent is conspicuously absent from the relief of pain. The reason goes to the very core of the caring interaction and invokes the mandate to relieve pain and suffering. This imperative is so powerful that it gives rise to the presumption that, unless patients explicitly object, they would want their pain relieved. Thus, respect for autonomy requires that a capable patient's decision to refuse analgesia—either because she finds the experience of pain meaningful or she does not want to chemically compromise her awareness—must be honored.

As discussed in chapters 2 and 3, however, beneficence is elevated over autonomy in protecting and benefiting patients who are vulnerable because they cannot make decisions or advocate for themselves. Thus, an incapacitated patient who is clearly in pain must not be deprived of relief because she is unable to provide informed consent. While honoring the wishes of a capable individual shows respect for the person, withholding relief from one who cannot decide or communicate would be an indefensible abandonment. Rather, principled and compassionate caring embraces both the respect for and the protection of persons. No expressed informed consent is required precisely because relieving pain is central to the very notion of healing, and, for that reason alone, it requires no additional justifications.

Accordingly, adequate relief of Carla's pain may not be impeded by her parents' well-meaning but misguided rejection of morphine. Every effort should be made to help them understand the considerable benefits and minimal risks of opioid use in managing her severe pain, and the distinction between increasing tolerance and addiction. Including the palliative care service in this discussion would be helpful in educating and reassuring her parents about the care plan. The care team should be supportive of their desire to be responsible guardians and the focus should be on the shared goal of promoting Carla's best interest and protecting her from harm. Ultimately, however, her parents must know that, with or without their consent, Carla's pain will be managed according to the standard of care and the ethical requirements of professional practice.

Mrs. Heller, the nursing home resident with multiple medical problems, is experiencing pain severe and persistent enough to interfere with her activities and her sleep. Despite her best efforts, pain has become the focus of her attention and has profoundly impaired her quality of life. Far from rejecting pain medication, she is clearly asking for relief. Her care team has both a clinical and ethical mandate to assess her pain carefully, discuss with her the benefits, burdens, and risks of the analgesic options, and provide her with sufficient medication to relieve her suffering. The team should also identify and address the barriers to adequate pain relief that have prevented her symptoms from being recognized and managed appropriately. Her nephew's request for an ethics consultation can facilitate this process by highlighting Mrs. Heller's needs and goals, and reassuring the care team that the benefits of palliation outweigh the possible risks. Recommending a palliative care consultation should be helpful in achieving these objectives.

#### PHYSICIAN-ASSISTED SUICIDE

III The lab results of Diane's blood tests confirmed Dr. Timothy Quill's worst fears—she did indeed have leukemia. His distress reflected the disappointment common to physicians whose patients contract life-threatening illnesses as well as the special concern he had for someone who had been his patient for many years and with whom he had developed a close and trusting relationship. In addition, he greatly admired the strength and determination with which she had overcome significant physical and emotional difficulties. In the process, she had strengthened her relationships with her husband, son, and friends, and reinvigorated her business and artistic work.

Now they faced this devastating news together, going through the confirmatory tests and discussing with her husband the various options, including chemotherapy, followed by radiation and possible bone marrow transplants. Even with the most aggressive treatment regimen, the chances for long-term survival were 25 percent; the certain outcome of no treatment was death within a few months. After considerable discussion, Diane decided not to undergo chemotherapy because she was convinced that the quality of whatever time she had left was more important than the unlikely benefits of treatment. Despite Dr. Quill's misgivings and her family's attempts to persuade her to change her mind, she remained steadfast in her determination to make the most of her time at home. Ultimately, her family and physician reluctantly supported her decision.

Dr. Quill had known throughout their relationship that, for Diane, regaining and maintaining control of her life was a central value. Now he realized that being in control of her dying was just as important to her as she faced the end of her life. She became preoccupied with deteriorating, lingering, being helpless and in pain. Her anxiety about the prospect of a protracted death became so severe that it threatened to undermine the quality end of life she had as her goal. She asked Dr. Quill to help her avoid the painful, debilitating, and dehumanizing ravages in store by providing drugs that she could take to end her life when she

chose. She was convinced that having the ability to control her death would give her the dignity and peace of mind that she needed.

After extensive discussion and psychiatric consultation, Dr. Quill acceded to Diane's unwavering determination, prescribed the barbiturates, and provided the information necessary for her to take her own life. She was able to spend the next several months focusing on the people, relationships, and activities that were most important to her. She received aggressive palliative treatment but, eventually, she determined that the benefits of life no longer outweighed its burdens. Her death was on her own terms, at the time and in the manner of her choosing. Yet, concerns about potential legal liability prevented her from having her family or physician with her at the end, and she died alone. (Quill, 1991)

#### Distinguishing Forgoing Life-sustaining Treatment, Euthanasia, and Assisted Suicide

Discussions about end-of-life issues inevitably refer to behaviors that promote, permit, or hasten death. Because these concepts are highly charged with medical, legal, ethical, and emotional significance, it is critical that we begin by distinguishing their definitions.

- Assisted suicide is clinician facilitation of a patient's death by providing the means and/or information (prescription, medication, instructions) that enable the patient to perform an act that results in self-inflicted death. The clinician's actions are taken with the knowledge that the patient intends to use the provided drugs and information to end her life, but the agent of death is the *patient*. Assisted suicide is illegal in all states except Oregon, which has adopted a formal, multistep protocol for its limited use.
- Euthanasia is clinician administration of a lethal agent with the intent of relieving the patient's untreatable suffering and/or pain. Whether the act is performed at the request of the patient (*voluntary euthanasia*) or without the patient's request (*nonvoluntary euthanasia*), the agent of death is the *clinician*. Euthanasia of either kind is illegal in all fifty states.
- Forgoing life-sustaining treatment is the withholding or withdrawing of interventions that maintain one or more organ system functions necessary to keep the patient alive. When these interventions are discontinued, the patient's death is considered to be the result of the underlying disease(s). Patients with decisional capacity, health care proxy agents, and, in some states, other surrogates acting on behalf of patients without capacity have the right to refuse unwanted life-sustaining treatments. Even when that refusal leads to or hastens death, the action is not considered suicide, assisted suicide, or euthanasia.
- Aggressive palliation is the provision of therapeutic interventions, including narcotic medications, to relieve pain and manage other symptoms effectively, especially at the end of life. While these interventions may have two possible effects, one positive (e.g., pain relief) and one negative (e.g., depression of

respirations), when the intent is palliation, the action is considered medically, ethically, and legally justified under the doctrine of double effect. Therefore, although aggressive palliation at the end of life may hasten the patient's death, the action is not considered suicide, assisted suicide, or euthanasia.

#### Ethical Issues

It is beyond the scope of this handbook to discuss adequately the multiple and complex aspects of assisted suicide. For our purposes, it is enough to raise some of the ethical issues, including caregiver obligations, individual autonomy, public policy, and the moral imperative to relieve suffering. Some argue that respecting patient autonomy includes respecting the wish of the terminally ill to control when and how death occurs. Consistent with the principle of nonmaleficence, however, the concept of facilitating patient death is counterintuitive to those who devote themselves to promoting and protecting life. Yet, many have come to see assisting the rational suicide of a capable person as the last act in a compassionate continuum of care and forcing the patient to take that final step alone as abandonment. Some suggest that, in vulnerable and disempowered populations, such as the poor and elderly, the right to die may become the obligation to die as a way of relieving family or society of the unwanted burden of their care. Yet others counter that these same marginalized populations, which often lack access to health care and providers, may be deprived of the opportunity to end their suffering under physician care. Ultimately, there is concern that the individual, morally justified act of assisted suicide could become the generalized policy of euthanasia (e.g., Shalowitz and Emanuel, 2004; Bascom and Tolle, 2002; Emanuel et al., 2000; Salem, 1999; Thomasma, 1996).

In June 1997, the U.S. Supreme Court ruled in two cases, *Washington v. Glucksberg* and *Vacco v. Quill*, that sought to turn the right to refuse treatment into a constitutionally protected right to assisted suicide. The cases are discussed in part VI, but it is important to note here that these two rulings are more significant for what they say about palliative care than assisted suicide. Repeatedly, the Court reaffirms the doctrine of double effect, saying that it is both legally and ethically appropriate to give terminally ill patients as much medication as necessary to relieve pain, even if the effect is to hasten death. The Court also strongly reaffirms the distinction between forgoing life-sustaining treatment and assisted suicide. The critical take-away message is that providing sufficient medication to manage pain effectively at the end of life is a clinical and ethical imperative, not to be confused with assisted suicide or euthanasia. The importance of these rulings to compassionate end-of-life care cannot be overstated.

While assisted suicide is not a legal option in forty-nine states, it highlights issues that demand attention in all care settings. Both the public and professionals are troubled by the reality of overtreated disease and undertreated pain, especially at the end of life. Considerable research demonstrates that the medical profession does an inadequate job of pain management and that many people who request assistance in killing

themselves are actually asking for the assurance of pain relief. It is a matter of concern when the debate centers on the questionable constitutional right of terminally ill patients to receive physician assistance in *ending* rather than *easing* their lives.

Among health care's most pressing challenges, then, is the need to improve palliation along the entire therapeutic continuum, especially as death approaches. Encouraging clinicians to collaborate with palliative care specialists can be a valuable contribution of clinical ethics consultation.

## REFERENCES

- American Board of Internal Medicine. 1996. Committee on Evaluation of Clinical Competence. *Caring for the Dying: Identification and Promotion of Physician Competency*. Philadelphia: American Board of Internal Medicine.
- Bascom PB, Tolle SW. 2002. Responding to requests for physician-assisted suicide: "These are uncharted waters for both of us . . ." *Journal of the American Medical Association* 288(1):91-98.
- Blackhall LJ, Frank G, Murphy ST, Michel V, Palmer JM, Azen SP. 1999. Ethnicity and attitudes towards life sustaining technology. *Social Science & Medicine* 48(12):1779-89.
- Brock DW. 1997. Death and dying. In Veatch, RM, ed. *Medical Ethics*. 2nd ed. Sudbury, MA: Jones and Barlett Publishers, pp. 363-94.
- Cassel CK, Vladeck BC. 1996. ICD-9 code for palliative or terminal care. *New England Journal of Medicine* 335(16):1232-34.
- Cassell EJ. 1982. The nature of suffering and the goals of medicine. *New England Journal of Medicine* 306(11):639-45.
- Dworkin R. 2003. Assisted suicide: The philosophers' brief. In Steinbock B, Arras JD, London AJ, eds. *Ethical Issues in Modern Medicine*. 6th ed. Boston: McGraw-Hill, pp. 382-85.
- Dworkin R, Nagel T, Nozick R, Rawls J, Scanlon T, Thomson JJ. 2003. The philosophers' brief. In Steinbock B, Arras JD, London AJ, eds. *Ethical Issues in Modern Medicine*. 6th ed. Boston: McGraw-Hill, pp. 386-94.
- Emanuel EJ, Fairclough DL, Emanuel LL. 2000. Attitudes and desires related to euthanasia and physician-assisted suicide among terminally ill patients and their caregivers. *Journal of the American Medical Association* 284(19):2460-68.
- Emanuel LL. 1998. Facing requests for physician-assisted suicide: Toward a practical and principled clinical skill set. *Journal of the American Medical Association* 280(7):643-47.
- Fischberg D, Meier DE. 2004. Palliative care in hospitals. *Clinics in Geriatric Medicine* 20(4):735-51.
- Furrow BR. 2001. Pain management and provider liability: No more excuses. *Journal of Law, Medicine & Ethics* 29(1):28-51.
- Johnson JA. 2004. Withdrawal of medically administered nutrition and hydration: The role of benefits and burdens, and of parents and ethics committees. *Journal of Clinical Ethics* 15(3):307-11.
- Johnson SH. 1996. Disciplinary actions and pain relief: Analysis of the pain relief act. *Journal of Law, Medicine & Ethics* 24(4):319-27.
- Joranson DE, Gilson AM. 1996. Improving pain management through policy making and education for medical regulators. *Journal of Law, Medicine & Ethics* 24(4):344-47.
- Hyman CS. 1996. Pain management and disciplinary action: How state medical boards can remove barriers to effective treatment. *Journal of Law, Medicine & Ethics* 24(4):338-43.
- Lisson EL. 1987. Ethical issues related to pain control. *Nursing Clinics of North America* 22:649-59.
- Lo B. 2000. *Resolving Ethical Dilemmas: A Guide for Clinicians*. 2nd ed. Philadelphia: Lippincott Williams & Wilkins.
- Lopez SR. 1989. Patient variable biases in clinical judgment: Conceptual overview and methodological considerations. *Psychological Bulletin* 106(2):184-203.
- Morrison, RS, Meier, DE, Cassel, CK. 1996. When too much is too little. *New England Journal of Medicine* 335(23):1755-59.
- Post LF. 2007 (forthcoming). Ethics and the delivery of palliative care. In O'Mahony S, Blank AE, eds. *Choices in Palliative Care*. New York: Kluwer Academic/Plenum Publishers.
- Post LF, Blustein J, Gordon E, Dubler NN. 1996. Pain: Ethics, culture and informed consent to relief. *Journal of Law, Medicine & Ethics* 24(4):348-59.
- Post LF, Dubler NN. 1997. Palliative care: A bioethical definition, principles and clinical guidelines. *Bioethics Forum* 13(3):17-24.
- Quill TE. 1991. Death and dignity: A case of individualized decision making. *New England Journal of Medicine* 324(10):691-94.
- Quill TE, Lo B, Brock DW. 1997. Palliative options of last resort: A comparison of voluntarily stopping eating and drinking, terminal sedation, physician-assisted suicide, and voluntary active euthanasia. *Journal of the American Medical Association* 278(23):2099-2104.
- Quill TE, Meier DE. 2006. The big chill: Inserting the DEA into end-of-life care. *New England Journal of Medicine* 354(1):1-3.
- Salem T. 1999. Physician-assisted suicide: Promoting autonomy—or medicalizing suicide? *Hastings Center Report* 29(3):30-36.
- Shalowitz D, Emanuel E. 2004. Euthanasia and physician-assisted suicide: Implications for physicians. *Journal of Clinical Ethics* 15(3):232-36.
- Steinbock B, Arras JD, London AJ. 2003. Moral reasoning in the medical context. In Steinbock B, Arras JD, London AJ, eds. *Ethical Issues in Modern Medicine*. 6th ed. Boston: McGraw-Hill, pp. 1-41.
- The SUPPORT Principal Investigators. 1995. A controlled trial to improve care for seriously ill hospitalized patients. The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT). *Journal of the American Medical Association* 274(20):1591-98.
- Thomasma DC. 1996. When physicians choose to participate in the death of their patients: Ethics and physician-assisted suicide. *Journal of Law, Medicine & Ethics* 24(3):183-97.
- Vacco v. Quill, 521 U.S. 793 (1997).
- Washington v. Glucksberg, 521 U.S. 702 (1997).
- Weissman DE, Block SD, Blank L, Cain J, Cassem N, Danoff D, Foley K, Meier D, Schyve P, Theige D, Wheeler HB. 1999. Recommendations for incorporating palliative care education into the acute care hospital setting. *Academic Medicine* 74(8):871-77.