



Understanding Morphine and Ativan

As the body begins to shut down, it gradually shifts its focus inward, preserving only the most vital functions. Blood flow slows to the skin and extremities, and breathing and heart rate often change. During this time, symptoms like pain, shortness of breath, and agitation can become overwhelming. Hospice teams carefully monitor these signs—not just vital signs, but also facial expressions, restlessness, and breathing patterns—to

understand whether someone is comfortable or in distress. Medications such as morphine and lorazepam (Ativan) are commonly used—not to hasten death, but to ease discomfort and support a peaceful, dignified transition. Concerns sometimes arise that these medications “cause death,” but research shows otherwise: when used appropriately, **they do not shorten life—they improve the quality of the time remaining.**

MYTH: Morphine stops people from breathing.

FACT: Morphine does not stop breathing—it relieves the sensation of breathlessness, a common and distressing symptom at the end of life. When the body is dying, oxygen needs decrease, but the feeling of air hunger can remain intense. Morphine helps by relaxing the body, calming anxiety, and dilating blood vessels, which improves circulation and allows the lungs to exchange gases more efficiently.

As symptoms ease, the patient’s breathing may slow naturally to match the body’s lower demand for oxygen, just as it does when someone falls asleep. This is not respiratory failure caused by the medication—it is the body slowing down while finally at peace.

A helpful comparison is a runner who finishes a race. During the run, their breathing is fast and shallow to keep up with high oxygen demand. Once the race ends, their body is fully oxygenated, and breathing slows down. In the same way, morphine helps restore balance, so the body can breathe more gently and comfortably—not because it’s sedated, but because it’s no longer struggling.

Patients die with morphine, not because of it.

MYTH: Meds make patients agitated or confused.

FACT: End-of-life agitation, known as **terminal restlessness**, is part of the natural dying process. It may look like a reaction to meds, but it’s actually one of the symptoms we are trying to treat. Lorazepam and morphine can calm this distress and restore peace.

MYTH: Hospice is giving huge doses of medication to sedate or euthanize.

FACT: Sedation typically happens naturally as death nears—even without medications. Hospice medications are given in very small, carefully titrated doses based on symptoms—not to sedate, but to bring comfort. The sublingual form of morphine used in hospice has only 18–20% absorption, making it **far less potent than IV doses**. Hospice starting doses (typically 2.5–5 mg, or 0.25–1 mL) are well within safe, therapeutic ranges, and are **far below lethal levels**. Even a small animal would survive more than what we give to dying patients.

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MYTH: They died right after morphine, so it caused their death.

FACT: Many patients are unable to let go because their symptoms—such as pain, breathlessness, or anxiety—are overwhelming. In some cases, **the body is ready to die, but the suffering is holding on.**

When we use medications like morphine to relieve that distress, the body is finally able to rest. Because morphine works quickly, death may follow shortly after—but **not because of the medication.** The medication simply removes the barrier of suffering that was preventing a peaceful passing.

Our goal in hospice is not to speed up death, but to ensure that it happens **without fear, pain, or struggle.** These medications support a natural dying process—they **do not cause it.** Patients die *with* morphine, not *from* it.

MYTH: Giving both morphine and Ativan is too much—it will just sedate the patient.

FACT: Morphine and lorazepam work in **different but complementary ways** to relieve shortness of breath. Morphine **reduces the sensation of air hunger** by lowering the brain's perception of breathlessness and improving oxygen exchange. Lorazepam **reduces the anxiety and panic** that often come with struggling to breathe, helping patients feel calm and in control.

Used together, they provide **holistic relief** from both the physical and emotional distress of breathlessness. Doses are started low and adjusted based on the patient's response—not given to sedate, but to **restore comfort.**

MYTH: Hospice benefits when patients die faster.

FACT: In reality, **hospice is reimbursed a flat daily rate by Medicare and does not receive more money if a patient dies sooner.**

Hospice care is designed to provide the highest quality of life for as long as the patient lives, whether that's days, weeks, or months. Our focus is on comfort—not cost—and we follow strict Medicare guidelines and ethical standards to ensure care is always patient-centered.

Citations and Evidence

1 Morita T, et al.

Patterns of high-dose morphine use in a home-care hospice service *Cancer*. 2004;100(4):863–870. [Read abstract on PubMed](#)

Patients on high-dose morphine lived longer (median 27–37 days) than those on lower or no doses. High doses did not shorten life expectancy.

2 Beller EM, et al.

Sedative Use in the Last Week of Life and the Implications for End-of-Life Decision Making. *Palliative Medicine*. 2010;24(5):548–556. [Read abstract on PubMed](#)

Use of sedatives in the last week of life did not shorten survival. Those sedated for ≥7 days lived longer than those sedated briefly or not at all.

3 Palliative Care Network of Wisconsin (PCNOW)

Fast Fact #34: Opioid Myths [Read full text](#)

4 Hospice of the Chesapeake *Don't Let These Morphine Myths Get in the Way of a Better Death*. [Read article](#)

5 Palliative Care Network of Wisconsin (PCNOW)

Fast Fact #106: Morphine and Hastened Death [Read full text](#)

6 Palliative Care Network of Wisconsin (PCNOW)

Fast Fact #117: Sublingual Morphine [Read full text](#)