



# Academy of Aid-in-Dying Medicine

---

## Bitterness/Burning of Aid-in-Dying Medications

### Summary

June 30, 2025

Lonny Shavelson, MD  
Director of Education

This question of burning/bitterness of aid-in-dying medications comes up frequently and repeatedly on the Listserv, so here is, for what it's, my summary.

Thank you to the pharmacist who wrote the following. You nailed it: *"...unfortunately, the sheer amount of pharmaceutical powder contained in the preparation is challenging to overcome with any anti-bitter agent or other measure that attempts to counteract the bitterness."*

Here's a more detailed explanation:

Bitterness and burning are two separate problems: Morphine is extremely bitter even in small doses (as are all opiates except fentanyl, which is synthetic and sweet!). Amitriptyline has local anesthetic properties, but before that kicks in, it burns. A pharmacologic change that might improve bitterness wouldn't necessarily improve burning, and vice versa.

The reason that no remedies are working is based simply on the math:

We use 15,000 milligrams of morphine. Sweeteners come in just a few milligrams. The amount needed to sweeten the bitterness of 15,000 milligrams of morphine would also be in the thousands of milligrams, which would greatly increase the amount of powders used, be difficult for our patients to ingest, have an unknown effect on medication absorption, and still might not work. The math doesn't add up. Unless we switch to fentanyl, the only sweet opiate, we will not remedy the bitterness of the 15,000 milligrams of morphine by adding sweeteners. (And there are dozens of reasons we cannot use fentanyl.)

Before you jump in with "I give my patients honey and it's wonderful," or something similar, please remember that bitterness is a highly variable sensation. We have patients who say they barely notice it, those who find it to be horrible, and everything in between. That is true no matter what sweetener has been tried. Anecdotal experiences of "I've used XX sweetener and it's much better" are looking at personal experiences, not evidence-based medicine.

The same math and anecdotal non-evidence applies to anti-bitterness remedies.

Viscous xylocaine, also often suggested, numbs the pharynx of patients who already have difficulties with swallowing. It is contraindicated for use in medical aid in dying because of the risk of increasing the rate of medication aspiration.

---

Here's something I wrote about this in 2020:

The most significant remedy to bitterness/burning for patients taking aid-in-dying medications is as much psychosocial and behavioral as pharmacological.

- The most important factor in working with this is to advise the patient in advance that there may be burning. If the patient is surprised by the burning, it is much more severe and upsetting. As with any medical procedure, *detailed* information and *calm reassurance* before, during, and after ingestion are essential. And in this case, also advise the patient that any discomfort is quite brief — typically only a few minutes before analgesia and unconsciousness. (If a clinician is not present at the bedside, this information should be conveyed by verbal and written instructions before ingestion.)
- Calmly instruct the patient that stopping the ingestion mid-way only makes it worse by creating a more prolonged mucosal exposure to the amitriptyline. It also delays the administration of soothing sorbet (see below). Encourage the patient to continue swallowing and relief is on the way as soon as full ingestion of the medications is completed.
- *Immediately administer sorbet to cool down the burning.* This has many positive effects: The cold and sweetness are quite pleasant and soothing. And if spooned up to the patient by someone they are close to, it has an added effect of a loving act just before the patient loses consciousness. Patient/family instructions should include having sorbet at the bedside, ready to cool down any burning. (NOTE: Sucking/chewing on a popsicle is also effective.)
- For the rare severe burning, calm reassurance that it is brief is extremely helpful, as are continued spoonfuls of sorbet. (Be careful to limit total volume, since gastric distension can cause vomiting.)

Please note, just providing this information once to the patient is not adequate – it has to be repeated many times to the patient and family, including, when possible, just before ingestion.

I've been at the bedside for more than 200 patients with various aid-in-dying formulations — and by following the practices above, with a reassuring and calming tone, it's been extremely rare for patients to have discomfort to the point of severe distress. And for the few that do, they understand that it's brief and that is very calming. If a clinician (including trained aid-in-dying volunteers or doulas) cannot be at the bedside, please talk the patient and family through this in detail. It's not enough to say it once or provide an information sheet.

Lonny Shavelson, MD

Director of Education  
Academy of Aid-in-Dying Medicine  
[www.AADM.org](http://www.AADM.org)

**I have a small favor to ask.** Our non-profit organization provides essential information about the clinical aspects of aid-in-dying care without charge, but it is not free to produce. If our work improves your work, [please keep us alive with a donation](#).

Clinical Questions? [Here's our Hotline](#)