

Clinical Application of the Rule of Double Effect in Palliative End-of-Life Care

Judith Schwarz, PhD RN

In clinical situations when a proposed intervention has both negative and positive consequences, clinicians are encouraged to apply the principle of double effect as ethical justification for their choice. This procedural principle functions in healthcare settings as a rule that guides clinicians' decisions by helping them weigh the positive outcome that is intended against the negative outcome that is a foreseen but unintended side effect. The moral authority for this principle is derived from a distinction between what one intends as an end or as a means to one's end, and what one foresees will occur as a result of one's action or inaction. The rule of double effect (RDE) is often cited to explain why one end-of-life (EOL) intervention that results in death is morally and legally acceptable while another with the same result is not.¹

To appropriately invoke this rule as justification for an outcome that results in death, the clinician's intentions or motives must be unambiguous—the practitioner must clearly and exclusively intend the positive outcome while recognizing the possibility of the other undesirable and unavoidable outcome.² Commentators who challenge the clinical usefulness of the RDE base much of their criticism on questions about the nature of "intentions" and "intent"—concepts deemed by many to be multilayered, ambiguous, and difficult to understand or isolate in complex clinical cases.³ The RDE is frequently used as justification for occasions when clinicians administer high doses of opiates or sedatives to relieve suffering experienced by terminally ill patients in amounts that may cause or hasten a patient's death as

a secondary result of respiratory depression.¹⁻⁶

The traditional Catholic formulation of the RDE stipulates that four conditions must be met before an action with two possible outcomes, one good and one bad, is morally justified.¹⁻⁶ (1) The act itself must not be intrinsically wrong or in a category of acts that is prohibited, independent of its consequences (e.g., killing an innocent person). (2) The agent must intend only the good and not the bad effect, although the bad "side effect" may be foreseen (e.g., possible respiratory depression following administration of opiates). (3) The bad effect, such as death, may not be the means used to bring about the good effect, such as the relief of suffering. (4) The good result achieved must outweigh the bad effect; the bad effect can be permitted only when there is a proportionally grave reason for permitting the foreseen bad effect.

Caregivers' fears about causing an opiate-related death are well documented.⁷⁻⁹ As a consequence, some clinicians are reluctant to provide adequate doses of opioid analgesia, even when their patients are dying, in part because they fear being held legally or professionally liable for contributing to an earlier death—or for facilitating a patient's wish for a hastened death.^{6,8} Because of the prevalence of such clinician fears, Sulmasy and Pellegrino maintain that "a clear understanding of the proper use of the rule of double effect is essential if healthcare professionals are to maintain their opposition to euthanasia and assisted suicide and yet provide adequate pain relief to dying patients."^{6(p545)}

Support for Clinical Application

Palliative care clinicians who mentor colleagues in the practice of pain management maintain that the RDE is "an essential construct for caregivers to understand if they are going to adequately control complex symptoms at the end-of-life."^{5(p413)} When clinicians appeal to RDE as justification for high doses of opiates, they acknowledge that intentions matter in the moral evaluation of that act—and that intending to cause the death of a patient is always morally wrong.¹⁰⁻¹¹ For clinicians who are morally opposed to hastening death and fearful of committing euthanasia, application of the RDE may enhance their EOL symptom management by supporting the "compassionate use of morphine" as morally permissible even for those who are opposed to euthanasia and assisted suicide.⁶ Sulmasy, a physician ethicist, states that in clinical situations where high doses of opioids are necessary for relief of a dying patient's suffering, although the clinician might *hope* for her patient's death, expect it, or even pray for it, that is not the same as being committed to bringing about the patient's death. "Desire and belief are not intentions. Intention seems to involve something over and above belief and desire. It involves commitment."^{10(p59)}

The nurse's duty to provide effective pain relief to dying patients was made clear in a 1991 position statement that specifically acknowledged the possibility of secondarily hastening death as an ethically justified side effect of proper EOL pain management. "The increasing titra-

continued on page 2

Inside

Identification, Management, and Prevention of Compassion Fatigue...**4**
Staying Soulful...**5**

Religion and End of Life...**6**
Experience All the 2007 AAHPM Annual Assembly Offers...**8**

Paper Sessions...**9**
AAHPM Fellowship Program Grants Help to Grow the Field...**10**

President's Message...**12**
National Palliative Care Research Center...**14**

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Clinical Application of the Rule of Double Effect

continued from page 1

tion of medication to achieve adequate symptom control, even at the expense of life, thus hastening death secondarily, is ethically justified."¹² When experienced hospice or palliative care nurses speak about titrating morphine in order to provide effective symptom management, many readily acknowledge the possibility of secondarily hastening death.¹³

Challenges to Clinical Application

Much of the criticism associated with the clinical application of the RDE centers around the difficulty in distinguishing *intended* from *foreseen* but *unintended* outcomes. Clinicians note that philosophers tend to find a more defined line between relief of symptoms and hastening death than do caregivers at the bedside who may experience a blurring of that line.^{18,11} Hospice and palliative care practitioners who must consider the consequences of increasing the dose of opiates they administer describe this as "a very fine line...it's not black and white—it's a gray, gray area."^{13(p380)}

Philosophers who criticize clinical application of the RDE often question the account of intentions that require clinicians to intend *only* the good and not the bad effects. To avoid the conclusion that an agent intentionally brings about *all* the foreseen consequences of an action, defenders of the RDE "distinguish between acts and effects and then between (1) effects that are desired or wanted and (2) effects that are foreseen but not desired or wanted. The RDE views the latter effects as foreseen, but not intended."^{4(p131)} Another philosopher who challenges the clinical usefulness of the RDE observes that the RDE is often represented as a kind of "mathematical formula for determining the moral permissibility of an action...if one simply plugs in the action, its effects, and the intentions of the agent, the answer will be obvious and consistent for anyone who applies the formula correctly."^{14(p45)} She maintains that in reality, the clinical application of the principle always involves questions that are virtually impossible to answer with any confidence (i.e., those that address the agent's intentions, are based entirely on personal values, or determine whether the good effect outweighs the bad).

In addition to philosophers' challenges, experts in palliative care also question both

the usefulness and the need for appeal to the RDE to justify providing appropriate symptom management. For example, it is often the case that clinicians who care for symptomatic terminally ill patients have more than one intention when providing EOL interventions. In one study of physicians, a third of those who ordered analgesia and sedatives while withholding life-sustaining treatments indicated that they intended both to decrease pain and to hasten death.¹⁵ Similarly, experienced palliative care nurses report difficulty determining whether their EOL interventions were aimed exclusively at relief of suffering. In one study, a home hospice nurse observed about patients whose death was imminent, "as you get close to death, if you're going to die of respiratory arrest, is the respiratory arrest because your lungs finally gave out or is the respiratory arrest because you had a little too much morphine? You know, it almost doesn't matter at that point."^{16(p141)}

Other experts in palliative care challenge the presumed connection between appropriate use of opiate analgesia and a resulting hastened death. One investigator conducted an extensive search of the medical literature and was unable to locate data in support of the presumption that "appropriate use of opioids hastens death in patients dying from cancer and other chronic diseases."¹⁷ There is no debate among clinical specialists in pain management and palliative care that, when used appropriately, clinically significant respiratory depression from opioid use is a rarely occurring side effect.^{5,13,15,17} Other palliative care physicians specifically describe "the myth that opioids, when used for the treatment of pain, are associated with a substantial risk of respiratory depression and death," and add that, "the clinical impression of those treating pain in the terminally ill with opioids is that the patient's death is related to the progression of the disease, not to the use of opioids."^{18(p1390)} These findings lend support to the position that proper use of opioid analgesia for EOL pain management renders the RDE largely irrelevant to the majority of pain management cases, because the actual risk of causing death is remote and clearly unintentional were it to occur as a side effect.

What may also occur is inappropriate “misuse” of the RDE as justification for acts that it was never intended to justify. In a small exploratory study of nurses who were asked by patients for help in dying,^{8,12} one participant described how her hospice colleagues avoid the moral reflection required to appropriately apply the RDE to EOL decision-making. Rather than examining whether their true intent was to end the pain or the patient’s life, they manipulate application of double effect reasoning. “We’re afraid to say that we facilitate death, but we do. We hide behind the principle of double effect. We say we’re medicating for symptoms, but in our hearts we know.”^{12(p380)} She added that occasionally, when caring for a patient whose death was imminent and who wanted the dying process to be over, “I have found myself saying, ‘Oh yes, I’m increasing that dose because of respiratory distress’ or ‘because of the pain.’ But truly, in my heart I know, I really want that suffering over for that patient, because I think their journey has been long and hard—and enough is enough.”^{12(p380)} Another hospice nurse in that study said that if a patient wanted help in dying, she responded by “aggressively titrating opiate drugs” and while she maintained that her “primary intent was to eliminate suffering,” she readily acknowledged that doing so had led to death on a number of occasions.^{8(p230),1}

Conclusion

Does use of the RDE, on balance, hinder or help palliative care clinicians to make ethically supportable EOL decisions? The best answer may be a qualified “it depends.” Appropriate use of the RDE depends upon how well the principle is understood by clinicians and how thoughtfully it is applied to clinical situations involving moral uncertainty. Many clinicians agree that use of the RDE may enhance EOL pain management by reassuring healthcare professionals that prescribing or administering high-dose opiates to terminally ill patients is morally permissible, good palliative care practice, and *not* assisted dying. Others maintain that appealing to the RDE as justification for the presumed risk of an opiate-related death inappropriately supports the myth of the double effect of opiates, which in turn heightens

clinicians’ fears of hastening death and leads to more cases of undertreated pain. Additional research will be needed to further illuminate and resolve this question.

Judith Schwarz is the clinical coordinator of client services in the Northeast for Compassion and Choices, a national end-of-life advocacy and support organization. In 2002, she completed her doctoral research, a qualitative study of the experience of nurses who had been asked by decisionally capable patients for assistance in dying. She can be reached at Judithschwarz@earthlink.net.

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