

Palliative Care and the lack of *Double Effect*

A Systematic Review on the Doctrine of Double Effect within Palliative Care

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Background

The Doctrine of Double Effect (DDE) suggests pursuing a morally good action, despite foreseeable bad side-effects (including death) is still ethical, providing that bad side-effects weren't intended if (i) the action was not wrong in itself (ii) only the good effect was intended (iii) harm was not desired rather it was minimised, harm was not the means of the good effect and (iv) there was overall proportionality.

DDE is a 13th century ethical principle, that remains a staple of medical ethics teaching and is recognised in UK law. DDE has primarily been seen as a means of freeing doctors to prescribe morphine for pain at the end-of-life without any legal fears.

However, increasingly the role for DDE in Palliative Care is being questioned because:

1. The paradox: The lack of applicability of DDE in end-of-life care, when knowing that opioids as symptom control do not shorten life, yet the persistent application of DDE only to end-of-life care!
2. DDE's impact: in the wake of media on healthcare professionals fears following apparent/actual poor practices with opioids/sedatives at the end of life: 1950's case law appears out-of-step with current knowledge (reflecting historical opioid use and/or misperceptions around the inevitable fatality of opioids, that follow if we forget that "association is not causation" i.e. patients die on, not because of medicines).

Hence, to provide an updated position, the current arguments both for and against a role for DDE in Palliative Care were collated following a systematic literature review of peer-reviewed publications, from the last 5 years (2013-2018).



The Road to Hell is Paved with *Good* Intentions

Legally, we need DDE whenever there's any harm to our patients!

Clinically, DDE means we can safely err on over-prescribing in end-of-life care patients, to ensure symptom control!

Morally, we need good intentions!

I accidentally 'flattened' a patient with far too much morphine because I didn't know what I was doing... but that's okay, my intentions were good!

I killed a patient on request with a fatal overdose of morphine, but DDE meant I could state comfort as my only intention and walk free from court!

DDE literature / legal cases confirm that opioids do kill end-of-life patients... so you'd better avoid morphine, or else you're mine!

Results

Persuasive support both for, but mainly against a role for DDE in Palliative Care was identified.

Positives

- Legal prerequisite (as inevitably there's morbidity/mortality from drugs, surgery, radiotherapy)
- Important moral 'tool' (doctors require 'good intentions' in their moral reasoning)
- Expert-clinician support (championing DDE; we'd be "paralysed" without DDE).

Negatives

- Unnecessary (no legal/clinical need)
- Not applicable (distancing by palliative care)
- Misinforms, fuels misplaced opioid fears e.g. "predictable opiate deaths" (acting as a barrier to appropriate relief or falsely reassuring 'never too much')
- Paternalistic (focuses on staff, not patient-centred)
- Unusable (too complex, thus misunderstood and misapplied)
- Naïve (as intent/motive are untestable)
- Risks diversion from tailored dosing (can hide poor practice, even if well-meaning, DDE allows an opt out from evidence-based medicine)
- Flawed ethically (only needed if over-prescribe/miss-prescribe)
- Not a blanket 'doctrine' (or becomes an 'untouchable' defense in UK Law if kill patients with opioid overdoses; see R v Adams in 1957; R v Cox in 1992; R v Moor in 1999; and... potentially Gosport...?)
- DDE is increasingly used to justify deep ongoing sedation until death / euthanasia.

Discussion

Though the literature remains divided, support for DDE has sufficiently waned, with stronger and clearer arguments that undermine a current role for DDE within Palliative Care .

DDE has inherent philosophical value with historical impact and a theoretical legal need, that generates some persisting support. However this appears inadequate justification in Palliative Care; ironically 'symptom control' is the one area where DDE doesn't apply (because appropriate symptom control wouldn't cause death). Moreover, DDE is not needed as a defense in other specialties (e.g. DDE is not needed to 'protect' prescribers in chemotherapy-related neutropenic sepsis deaths or the other >1,000 deaths annually attributed to 'complications of medical and surgical care' [ONS, 2018]) and DDE's place in UK Law can allow potential harms (by unintentionally providing a medical defense if deliberately administer a fatal opioid overdose.)

Adherence to 'best practice' appears a better tenet for doctors, superseding DDE, because:

1. DDE is not needed ethically (e.g. 4 Principles or 4 Quadrants Approach offer more), clinically (covered by evidence-based practice) or legally (Bolam & Bolitho tests are more appropriate) and worse;
2. DDE can inadvertently mislead (to foster poor practice, prompting too much / too little opioid) and most worryingly;
3. DDE can be easily misused (to allow unsafe practices; covert overdosing to hasten death and deep ongoing sedation / euthanasia).

