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# Double Effect and Death-Hastening or Death-Causing Palliative Analgesic Administration

Thomas A. Cavanaugh
*University of San Francisco*, cavanaught@usfca.edu

T. A. Cavanaugh, Philosophy, University of San Francisco

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# THE ETHICS OF DEATH-HASTENING OR DEATH-CAUSING PALLIATIVE ANALGESIC ADMINISTRATION TO THE TERMINALLY ILL

## ABSTRACT

Double-effect reasoning is a nonconsequentialist analysis of a hard ethical case. In a hard ethical case, one can achieve some good end only if one also causes harm. Sometimes palliative analgesic administration to a terminally ill patient is a hard ethical case, for by it one relieves pain or distress while unavoidably hastening or causing the patient's death. Is it ethically in the clear to administer an analgesic to relieve pain or distress knowing that one will hasten or cause the patient's death? Using double-effect reasoning, I argue that death-hastening or death-causing palliative analgesic administration to a terminally ill patient is sometimes ethically in the clear and, at times, even obligatory.



**KEY WORDS**

Double effect, death-hastening, death-causing, pain and distress relief, ethics

This paper considers the nature and use of double-effect reasoning in clinical practice. Specifically, the paper discusses double effect's role in analyzing death-hastening and death-causing palliative analgesic administration to a terminally ill patient. Sometimes, the administration to a terminally ill patient of an opioid analgesic hastens or causes the patient's death insofar as it depresses or suppresses respiration.[i,ii,iii] Is such an action ethically in the clear? Employing double-effect reasoning, I will argue that the administration of an opioid analgesic to a terminally ill patient which will hasten or cause the patient's death can be ethically in the clear, and, at times, even obligatory. In making this argument, double-effect reasoning and its central presuppositions will be clarified.

The administration of an opioid analgesic to a terminally ill patient which hastens or causes death is a hard ethical case which may trouble the consciences of medical professionals and laypeople.[iv,v,vi] In the discussion of such a case, one needs to recognize those particular features of it which trouble such consciences and in virtue of which the case deserves to be called a hard ethical case. Since double-effect reasoning applies to hard cases, in order to understand double effect, one must first describe what an ethically hard case is.

## WHAT IS AN ETHICALLY HARD CASE IN MEDICAL PRACTICE?

In medicine, as in other practices and human activity in general, particular goods are to be sought and evils (harms to goods) to be avoided. Teachers try to educate their students and to avoid causing confusion; investment advisors try to realize financial gains for their clients while avoiding losses; parents try to discipline a child without breaking his or her spirit. Similarly,

medical professionals try to benefit their patients while not harming them. Sometimes, however, one cannot benefit a patient without causing some harm to the patient. Such a case is an ethically hard case.

A hard case has a number of features. First, in a hard case the action by which one can realize some good will **inextricably** cause harm. Insofar as good is to be done and harm is to be avoided, it is not clear what one ought to do in such a case, for what is to be done and what is to be avoided attend one and the same action. One does not face a hard ethical case -- in the present sense --if, for example, one could relieve the pain or distress of the patient just as easily without causing or hastening the patient's death. Thus, a hard case is one in which the good which one seeks is able to be realized only if the harm which one avoids is also brought about: in such a case, good and harm are not able to be disentangled.

For example, medical professionals ought to relieve severe pain or distress. Yet, health care professionals ought not to kill a patient or hasten the patient's death as these are harms to be avoided in medical practice. Palliative analgesic administration to a terminally ill patient sometimes meets this first condition of being a hard case. For in palliative analgesic administration to a terminally ill patient, sometimes one cannot relieve pain or distress without hastening or causing death.

Second, one faces a hard case if the action one considers is the least harmful of those actions by which one can realize the good in question. If one could relieve pain without hastening death, one would not -- as the phrase is defined for present purposes -- face a hard case. Thus, a hard case is one in which, first, harm is inextricably bound up with what one does, and second, the action considered is the least harmful of those actions by which the good can be achieved.

In accordance with these two conditions, one can characterize a hard case as an action which is good **but for** its causing harm. That is, one is reasonably confident that if the harm were not to attend the action, the action would not be ethically troublesome and, indeed, would be a

good action without qualification. For example, a physician would not be troubled about administering an analgesic to relieve pain or distress if he were confident that no harm would be caused by administering the analgesic. Thus, in determining what to do when one faces a hard case, one needs to determine whether the causing of the harm renders the action ethically out of bounds. The causing of harm is the ethical issue in a hard case, the action having been characterized as good, **but for** its causing harm.

In accordance with the above characteristics, palliative analgesic administration to a terminally ill patient is sometimes a hard ethical case. For sometimes one cannot relieve pain or distress without hastening or causing death. Moreover, this is sometimes the least harmful of those actions by which one can achieve the good of pain relief. Indeed, palliative analgesic administration may be the **only** action by which one can relieve pain or distress.

I will argue that palliative analgesic administration which will hasten or cause the patient's death can be ethically in the clear if certain conditions, associated with what is often referred to as the rule, principle or doctrine of double effect, are met. I will present those conditions and argue that palliative analgesic administration can meet them.

## DOUBLE-EFFECT REASONING

Double-effect reasoning consists in two conditions used in nonconsequentialist thought to analyze the ethical status of acting in hard cases. It belongs within nonconsequentialist accounts of ethics -- broadly construed -- insofar as such accounts do not identify actions as good or bad solely in virtue of their consequences. In order to situate double-effect reasoning in its broader nonconsequentialist context, I will briefly distinguish between consequentialist and nonconsequentialist ethical accounts.

### Double-Effect Reasoning in a Nonconsequentialist Ethical Account

In analyzing the goodness or badness of actions, nonconsequentialist accounts partially focus, in

contrast to consequentialist accounts, on an agent's intentions as ethically significant in themselves. In T.S. Eliot's play **Murder in the Cathedral**, Thomas à Becket expresses a nonconsequentialist ethic when he says, "This is the worst treason, to do the right deed, for the wrong reason." In a nonconsequentialist ethic, when one wants to ask whether an action is ethically in the clear, one generally looks at what is being done (the deed) and why it is being done (the agent's reason or intention.)

For example, if what is being done (the deed) is good, say, relieving the hunger of the homeless, and why it is being done is good (the reason), say, for the sake of the homeless, then, on such an account, the action would be good. If the deed were good, yet it were being done to garner praise for oneself and not to relieve the hunger of the homeless person, then the goodness of the action would be vitiated. For although the deed is good, the agent's reason is not good, and an action's goodness is comprised of a good deed done for a good reason.

On a consequentialist account, the two acts, insofar as they are consequentially similar in relieving the hunger of the homeless, are essentially the same. A nonconsequentialist ethic, however, makes what it takes to be ethically relevant distinctions between actions which are the same in terms of their consequences, for it looks at what is being done (deed) and why it is being done (reason/intention) to determine whether this act (deed and reason) has integral goodness. This is one of the most prominent differences between consequentialist and nonconsequentialist accounts of ethics.

As noted, double-effect reasoning plays a role in a nonconsequentialist ethic which acknowledges hard cases. Accordingly, double-effect may prove useful to agents who think that actions are good or bad not solely in virtue of their consequences, but also, if not chiefly, in virtue of why (reason/intention) what is being done (deed) is being done, that is, in virtue of the agent's intentions.

As observed earlier, a nonconsequentialist uses double-effect reasoning to analyze a hard

case. Thus, one relies on double-effect reasoning to determine whether or not the action which is good **but for** its causing a foreseen harm is ethically in the clear **all things considered**. Is the good action which causes harm ethically in the clear given that it causes harm? To answer this question, one employs double-effect reasoning.

**The Conditions of Double-Effect Reasoning**

In double-effect reasoning, two conditions determine whether the proposed action in a hard case is ethically in the clear. First, if the harm is foreseen, even foreseen as an inevitable consequence of the action, but not intended as an end in itself or as a means to achieving one's intended end, it **may** be ethically in the clear to act. The supposition underlying the first condition is that, if the harm were intended, the act would be malicious and, therefore, ethically out of bounds. Thus, since the harm is not intended, it is not malicious to cause the harm, and, if the second condition is met, the action may be ethically in the clear.

The second condition concerns one's obligations. If one's obligation to realize the intended good at issue is as great as one's obligation to avoid causing the foreseen harm, then the action will be ethically in the clear. The action, already characterized as good **but for** its causing harm -- if it meets double effect's two conditions -- will be ethically in the clear **all things considered**.

Of course, meeting the first condition does not absolve one of responsibility for causing the foreseen harm. If one foreseeably causes harm, one bears responsibility for doing so. Indeed, the second condition of double effect would be superfluous if one did not bear responsibility for what one causes with foresight. Thus, the two conditions work in conjunction with one another.

The first condition of double-effect relies on the intended/foreseen distinction. The intended/foreseen distinction operates in common morality (and in common law, for example, in the concept of **mens rea** and associated distinctions) insofar as one distinguishes between what one intends and what one foresees as an inevitable concomitant of one's action, but does not intend. In accordance with such a distinction, one becomes angry at one's neighbor who, **in order to**

**bother you** (intentionally), rattles garbage cans in the early morning while one does not become angry (or as angry) at the garbageman who unavoidably rattles the garbage cans, knowing that this bothers you (with foresight), but not in order to bother you (not intentionally).

Similarly, according to the intended/foreseen distinction, the doctor who prescribes chemotherapy as a therapy for cancer is not thought to be malicious, although he foresees his patient's nausea, hair loss, and sickness which inevitably follow from the chemotherapy. Of course, if the doctor were to intend to cause the patient's sickness and not intend to cure the patient of cancer by the chemotherapy, we would regard his action very differently, even if the chemotherapy were to cure the patient. Such judgements are based on the intended/foreseen distinction. How does one draw the line between what one intends and what one foresees? I will now address this question.

**Making the Intended/Foreseen Distinction**

I wish, first, to consider two ways in which one **does not** make the intended/foreseen distinction. First, one does not draw it insofar as the harmful effect is less likely than the good end; for the distinction applies when the harm is foreseen as inevitable. Of course, if it applies in such cases, it will apply in cases where the harm is not foreseen as inevitable. Nonetheless, it is not based on the intended good end being more probable than the foreseen, but not intended harmful effect. Thus, the intended/foreseen distinction does not distinguish between what we do and what we risk doing. This is not to say that a distinction between doing and risking is not ethically relevant, only that the intended/foreseen distinction is different from such a doing/risking distinction.

Second, the distinction between intention and foresight is not drawn, and I say this only because some writers present it as if it were so drawn, as a line distinguishing between what one does and what one allows to happen.[vii,viii,ix,x,xi,xii] To do so is to confuse the intended/foreseen distinction with the distinction (or distinctions) between what one does and what one allows,

accepts, or permits to happen. To see this, one can consider the usual connotations of "permits," "accepts," and "allows" and the traditional application of double- effect reasoning to death-hastening or death-causing palliative opioid administration.

To say that an agent "permits," "accepts," or "allows" some effect implies: first, that something else independently causes the effect, and, second, that the agent could but does not prevent the effect from coming about by intervening in the causal process, as, for example, when a leaf within my reach flows downstream. A cause other than me, the current, carries it downstream; and I could but do not prevent it from going downstream. Thus, generally, one permits, accepts, or allows what one could but does not prevent from happening by intervening in an independent causal process.

In administering an opioid in the palliative setting to a terminally ill patient, the doctor and nurse do not accept, permit, or allow the foreseen death. In this case, the need for double- effect reasoning arises from the ethically troublesome aspect of the agents causing harm **by their interventions**. Thus, it is potentially misleading for one who engages in double-effect reasoning to use terms such as "allows," "permits," or "accepts" to describe the agents' causing of the bad effect in this case which is traditionally thought to illustrate double effect.

This is not to say that the distinction between doing and allowing and the distinction between intending and foreseeing mutually exclude one another. Indeed, one can intentionally allow something or foreseeably cause something without intending it. The point is that in the cases to which double-effect reasoning applies the agent does not allow harm by his non-intervention in some causal process so much as he causes harm by his intervention. Thus, although one need not intend what he foreseeably causes as an inevitable concomitant of what he does intend, it does not thereby follow that one allows or permits this effect. The above considerations illustrate two misleading ways of drawing the intended/foreseen distinction. How does one distinguish the intended from the foreseen?

Double-effect reasoning originates with Thomas Aquinas.[xiii] He offers resources for drawing the line between what one intends and what one foresees as an inevitable effect of one's act, but does not intend. As Aquinas notes, to intend is to **tend towards**.[xiv] Tending towards something involves a space through which the tending occurs. In intention, the analog to the space intervening between the one intending and the object tended towards is the means, that through or by which one achieves one's end. Thus, we will health, we choose medicine for the sake of health, and we intend health through medicine. In more general terms, we will the end, we choose the means, and we intend the end through the means. Returning to the metaphor of distance, we tend to the end by first going through the means, the middle between us and our achievement of the end.

How do agents discover means? By deliberation. The intention of an end poses a problem for the agent. By deliberating, the agent attempts to solve the problem posed by his intention. The problem faced in deliberation is: how do I realize this end which I will? Characteristically, the willing of an end leads an agent to deliberate about means effective of the end. The intention of an end poses a problem for an agent which problem the agent attempts to solve in deliberation. In deliberation the agent searches for means effective of the intended end. Thus, the intention of an end issues in deliberation. This is one way of drawing the distinction between the intention of an end and foresight: foresight does not issue in deliberation while the intention of an end does; for foresight does not concern the **problem of how to cause** some intended end.

Moreover, the intention of an end leads to the intention of means effective of the end. This is a second way of distinguishing between intention and foresight: foresight does not issue in the intention of means, for foresight does not have as its object an end to be realized. One can draw the intended/foreseen distinction by noting these two prominent features of intention which foresight does not share.

**The Hard Case of Death-Causing/Death-Hastening Palliative Analgesic Administration**

The administration of death-causing or death-hastening opioids to terminally ill patients in

the palliative setting requires a clinically and ethically complex decision. For example, one might administer the opioid to relieve pain, to relieve distress, or to relieve pain and distress. Certainly, one will need to take into consideration the severity of the pain or distress when considering the use of the death-hastening or death-causing opioid. Similarly, one will consider the temporal proximity of the patient's death, the family and staff's perceptions of such an action, and, of course, as much as is possible, the patient's own wishes and perceptions concerning pain and distress relief as balanced against the hastening or causing of his death. After taking such considerations into account, one faces the question as to whether it is ethically in the clear to administer a death-causing or death-hastening opioid. To answer this question, one appropriately employs double-effect reasoning.

As noted in the discussion of the intended/foreseen distinction, when one applies double effect to particular cases, one seeks to determine the intentions of the agents. In palliative analgesic administration to a terminally ill patient which will hasten or cause death, the doctor who prescribes, for example, an escalating dose of an opioid analgesic, and the nurse who administers it deliberate about how to relieve their patient's pain or distress. They do not, however, deliberate about how to kill their patient. Thus, their end is to relieve their patient's pain or distress.

Of course, it is possible for the doctor and the nurse, or either one of them, to intend to kill the patient, and choose this dose of opioid as a means of killing the patient. The point is not that this is not possible, but that it is not necessary: it is possible for them to foresee that the patient will die without intending to kill the patient. They need not intend their patient's death as an end in itself. The doctor and nurse can have pain or distress relief as their end which causes them to deliberate about how to achieve this end.

In order to achieve pain or distress relief, they deliberate about which analgesic, dosage, and route to use. In their deliberation, they arrive at an opioid analgesic, in such a dose, over such a period, delivered in some specific way. They do not choose to kill their patient as a means to

relieving their patient's pain or distress. Thus, they do not intend the death of their patient as a means. Accordingly, they meet the first requirement of double-effect reasoning: the foreseen harm is not intended either as an end, or as a means.

Of course, as earlier noted, if they administer the opioid knowing that this will hasten or cause the death of the patient, they will be responsible for hastening or causing the patient's death. Thus, they need to have a good reason for bringing about this foreseen harm, and this brings us to the second condition of double-effect reasoning, the obligations of the doctor and nurse in such a case. At issue are two competing obligations, namely, the obligation not to harm one's patient and the obligation to relieve a terminally ill patient's severe pain or distress. If one has as great an obligation to relieve pain or distress as one has not to hasten or cause the patient's death, then it will be ethically in the clear to administer the opioid, all things considered.

It seems that one has as great an obligation to relieve the terminally ill patient's pain or distress as one has not to hasten or cause his death. For one of the goods which one can realize at the end of a patient's life is pain and distress relief. Indeed, one cannot prevent the death of a terminally ill patient. It is a matter of time when the patient will die. That the patient will die and will die soon is out of the hands of the caregivers. It is not, however, out of their hands whether or not the patient's death will be preceded by severe pain or distress. Thus, since one can give one's patient relief from pain and distress, other things being equal (such as respecting the patient's wishes; for example, the patient may prefer to forego some pain relief in order to remain alert and visit with family members), one's obligation to relieve pain and distress is as great as one's obligation not to hasten or cause the death of one's patient who is dying in any case. Basically, one faces a situation in which the patient will die free of pain or distress some time before he would have died in pain and distress. It is reasonable to think that one has an obligation to relieve the pain or distress of the patient which is as great as one's obligation not to hasten or cause the patient's death.

Indeed, if one's obligation to relieve pain or distress were **greater** than one's obligation not to hasten the patient's death, then the death-hastening or death-causing palliative analgesic administration would be obligatory. The greater the pain or distress of one's patient and the more imminent his death is, the greater the obligation one has to relieve his pain or distress. In certain cases, one's obligation to relieve pain or distress will be greater than one's obligation to avoid hastening or causing death. In such cases, it would be obligatory to administer the opioid.

Applying double-effect reasoning to the case of death-hastening or death-causing palliative analgesic administration to a terminally ill patient, one realizes that it is ethically in the clear, and at times even obligatory, to administer the analgesic which one foresees as hastening or causing death, but which one does not intend to hasten or cause death. Such a nonconsequentialist analysis, which employs double-effect reasoning to hard cases can be found within contemporary legal reasoning.[xv] Moreover, although historically associated with Catholic moral theology, it has a firm basis in common morality and contemporary secular philosophical thinking and fits well into ethically pluralistic clinical settings.[xvi,xvii,xviii] In the management of pain and distress in the terminally ill, there are sound ethical arguments based on double-effect reasoning for taking aggressive palliative measures even when these actions hasten or cause death.

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