Palliative Medicine Doctors Meeting

Double Effect

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CASE PRESENTATION

A 72 years old gentleman diagnosed CA Lung and underwent a left upper lobectomy in March 2000 and histology confirmed adenocarcinoma. He began to have right-sided chest pain in November 2000. X-ray thoracic spine showed collapsed T8 vertebra. Bone scan revealed multiple bone metastases. A course of palliative radiotherapy was given to T4 – T10, and L3 vertebrae and pain controlled with NSAID. In January 2001, he developed cord compression presenting with paraparesis. New collapse of T12 vertebra was found and further palliative radiotherapy was given. He remained chairbound and was put on syrup morphine 5mg tds by his attending physician. Both the patient and his daughter worried about the potential side effects of morphine and did not want to take much of it.
The patient was referred to our Palliative Care Unit in February 2001. With some explanation, the family agreed adjusting morphine to four-hourly doses and later switched to sustain-released morphine tablets. The patient's general condition further deteriorated but he preferred to stay at home. He was finally admitted in March in very poor condition with disseminated lung and brain metastases. He had pain and dyspnoea. Oxygen, dexamethasone and haloperidol were given and after discussion with his daughter, she agreed the priority of making her father comfortable and to step up morphine despite worry. Her father passed away comfortably on the next day.

DISCUSSION

Double effect – Introduction

Sometimes the relief of suffering, an intended good effect, also has a potential bad effect that is foreseen but not the primary intention. This is referred to as "double effect". It is an effect that would be morally wrong if caused intentionally, but permissible if unintended, even if foreseen. As fundamental basic principles of medical ethic include beneficence (consider best interest of the patient) and non-maleficence (strive to do no harm), double effect should meet the following criteria:

Intended effect must be a good one
Harmful effect must be foreseen but not intended
Harmful effect must not be a way of producing the good effect
The good effect must on balance outweigh the harmful effect

The principle has guided physicians for years in giving drugs to patients for the relief of distressing symptoms while, at the same time, running the risk of hastening their deaths. In the Encyclopedia of Bioethics, it was quoted that “A physician seeks to alleviate a patient's pain by administering the painkiller morphine but recognizes that the dosage is likely to shorten the patient's life. The physician regrets this result but can avoid it only by so reducing the dosage that the chemical will not have sufficient painkilling effect.... The physician expects to kill but does not intend to do so ....”[1] Does the physician expect to kill?

Intention & Likelihood

Dr C Y Tse, in his article mentioning double effect[2], has raised the concern of how much weight should we give to the “intention” and how about its likelihood and extent. “Whose intention” is also important. Usually physician’s intention is of premium importance but really there is a much lesser role on the patient’s will. Intention can be complex, multi-layered, and sometimes ambiguous. It may not be as clear-cut and can be very problematic in clinical scenarios. There is also difficulty in evaluating a physician's intention. In general, physicians try to do good overall and treatment offered only after calculation of risk-benefit ratio.

How about patients’ will and informed consent? Would it be equivalent to physician-assisted suicide if the patient has a desire to die? For those emphasizing patient autonomy, is there any limit in satisfying patient’s wish? The right modality of treatment should also be emphasized. Underlying depression may need other treatment rather than simply pain-killers. What about existential angst? What is the most appropriate treatment? The nature and severity of their suffering and the adequacy of palliative care should be taken into overall consideration. The intervention has to be proportionate to the situation with smaller dose for mild pain and higher dose for severe pain. If a person starts talking about wanting to die, we have an obligation to listen to them and try to respond. What the patient needs may be somebody to accompany, to reinforce his value, meaning and dignity.

Morphine hastening death – any evidence?

Double effect of pain medication is a recurring theme in articles discussing end-of-life issues. Bert Keizer, a nursing home physician was quoted: “Doctors all over the world shorten the lives of patients under the cover of pain reduction. And only we are stupid enough to talk about it”[3] and there were other publications with similar opinion. American Nurses Association has its position statement[4] saying: “The increasing titration of medication to achieve adequate symptom control, even at the expense of life, thus hastening death secondarily, is ethically justified”.

However, there is little data to support morphine hastening death in the literature. Patient's death can be related to the progression of the disease rather than morphine. It is possible that treatment by inexperienced physicians may lead to unintentional overdoses of medication, but this is neither inevitable nor unavoidable.

Although respiratory depression (greatest risk in opioid-naive patients after acute opioid administration) and arrest is possible, it usually occurs in combination with mental clouding, alerting physician to adjust the dosage. Proper titration (minimal dose to achieve pain control) seldom leads to excessive opioid dosing. Moreover, patients in pain respond differently to opioids. Pain acts as a natural antagonist to the respiratory depressant effect of opioids. As pain increases, the level of opioid necessary for relief goes up, but so does the tolerance to respiratory side effects. With careful titration, even very large doses may be safely administered. In fact, Dr. Twycross suggested that "The correct use of morphine is more likely to prolong a patient's life ... because he is more rested and pain-free."[5]

Walsh reported seven cancer patients who were pain free on morphine and did not have depressed respiratory rates or elevated PaC02.[5] Citron et al. reported safety of 15 courses of continuous IV morphine in 13 patients.[6] Changes in PaO2 and PaCO2 during the first 24 hours occurred in a minority of patients. Then they tended to remain at or return toward baseline values. Only 1 patient required dose reduction. Similar experience was reported by others.

Possible abuse

If morphine is given to hurry things up and end a patient's life, that would be direct euthanasia, not pain relief. Every health care professional has the obligation to deal with this suspected abuse and act as the patient's advocate.

Undertreatment of pain

Misperceptions about opioids are a major cause of undertreatment of cancer pain. 65% of the respondents (ECOG survey)[7] admitted that concerns about managing S/E limited their use of analgesics. Solomon[8] found that 41% agreed that clinicians give inadequate pain medication most often out of fear of hastening a patient's death. A patient in extreme pain presents a medical emergency. Every physician has the responsibility to provide prompt pain relief.

Confusion with euthanasia

Double effect is frequently mistaken as euthanasia and there are terms such as "double effect euthanasia" and "accidental euthanasia". Even the AMA's Council stated that: "ethical distinction between palliative care that may have fatal side effects and providing euthanasia is subtle".[9]

Double effect - Is it really important?

The practice of medicine always involves weighing the benefits and burdens of treatment. Noting the slight possibility of a complication of treatment is different from expecting the complication to occur. An overdose of medication would be an accidental side effect, not a foreseen and

expected occurrence. This is also supported by Bleich in his article.[10]

Conclusion

Prescribing appropriate pain medication does not seem to hasten death. It is not indirect or any other type of euthanasia. Double effect should not be a significant hindrance in clinical practice.

Reference:

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