

# End-of-Life Options and Double Effect: On the Use and Misuse of a Classical Ethical Principle

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ABSTRACT: In this paper I examine several recent appeals to the principle of double effect, a classical ethical principle used to determine the permissibility of actions foreseen to have both good and bad effects. I argue that many applications to end-of-life decision-making are in fact misuses of the principle: for example, there is a fairly heavy burden of proof on the proponent of terminal sedation or of the provision of lethal drugs to show that the bad effect (coma or death) is neither the end of the act nor the intended means to the good effect – a burden that usually is not carried.

**E**VEN AMONG THOSE who agree that active euthanasia is morally unacceptable, there is considerable room for disagreement regarding the acceptable range of options for care – or lack thereof – at the end of life. This paper attempts to sort out just one area of such disagreement: appeals to the ethical principle of double effect. This is a classical ethical principle that is used to assess the performance of actions foreseen to have mixed results. In the cases for which this principle is used, the agent who proposes to perform the action in question foresees that it is likely to have at least two ethically significant effects, one desirable and the other undesirable. This principle helps to determine whether or not such an action is permissible (licit) by, among other things, examining the intention of the agent in performing it: if the agent intends to bring about the bad effect, either as her end or as a means to the good effect, the action is not morally acceptable. So, for example, active euthanasia is ruled out by this principle: the bad effect (death) is clearly intended as a means to the good effect (an end to suffering).

For the purposes of this short paper, I will take it for granted that the principle of double effect is a useful and legitimate tool for ethical analysis. Thus, while my brief explanation of the principle and its role in ethical theory may also provide some support for the claim that it is indeed plausible and

useful, I will not provide anything approaching a thorough defense of it.<sup>1</sup> I have allotted myself the much more manageable task of analyzing a few applications and misapplications of PDE to end-of-life situations. My aim is to show that the principle must be – but often has not been – applied with considerable care to situations that occur at the end of life, especially regarding such cases as terminal sedation and detubation. In these cases it is not always obvious what the agent intends and what effect(s) should be attributed to her action.

### 1. The Principle of Double Effect: Background

As its name suggests, the principle of double effect is used to evaluate acts having at least two significant effects: one good (desirable) and one bad (undesirable). Commonly-cited examples include military operations that accomplish legitimate objectives but result in civilian casualties, surgical procedures that save the lives of pregnant women but cause the death of fetuses, and end-of-life care that relieves patients' pain but hastens their deaths. Although similar reasoning appears in many earlier texts, Thomas Aquinas's treatment of killing in self-defense in his *Summa theologiae* is often taken to be the *locus classicus* of the principle.<sup>2</sup> It has been further developed and clarified over the centuries. A fairly standard formulation, developed in the nineteenth century, outlines the principle in terms of four conditions,<sup>3</sup> all of which must be met for morally liceity or permissibility.

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<sup>1</sup> For such a defense, see T.A. Cavanaugh's excellent book on the topic, *Double-Effect Reasoning: Doing Good and Avoiding Evil* (Oxford UK: Clarendon, 2006).

<sup>2</sup> Thomas Aquinas, *Summa theologiae* II-II, q.64, a.7, <http://www.newadvent.org/summa/3064.htm#article7>.

<sup>3</sup> The principle of double effect was first explicitly formulated in terms of four necessary conditions by J. P. Gury in *Compendium theologiae moralis* v.1 (Ratisbonae: Georgii Josephi Manz, 1874). As Stuchlik explains, it was originally formulated in terms of liceity rather than permissibility. While permissibility addresses the act more abstractly, liceity addresses whether the agent acts well or badly in performing the act. Intention is especially relevant to the latter. He proposes the following principle regarding the relationship between liceity and permissibility: "It is permissible for S to do A in C just in case A could licitly be performed in C in light of reasonable beliefs about the circumstances." Joshua Stuchlik, "A Critique of Scanlon on Double Effect," *Journal of Moral Philosophy* 9 (2012): 178–99 at p. 194.

1. Acceptable-end condition: The bad effect must not be intended as the end or goal of the act.
2. Acceptable-means condition: The bad effect must not be intended as a means to the good effect.
3. Acceptable-act condition: The act must not be bad (morally unacceptable) in itself (independently of its causing the bad effect).
4. Proportionate-reason condition: The agent must have a proportionately serious reason for performing the act (i.e., at least as serious a reason to pursue the good act and/or effect as to avoid the bad effect).<sup>4</sup>

To take a fairly well-known real-life example, St. Gianna Beretta Molla, a twentieth-century physician, developed a life-threatening fibroma on her uterus while pregnant with her fourth child. She was offered three options: abortion, hysterectomy, or removal of the fibroma only.<sup>5</sup> Either of the first two options would have resulted in the death of her unborn child but would have given Molla an excellent chance of recovery. Removal of the fibroma would have spared the child but likely brought serious medical complications for the mother. The principle of doubled effect clearly rules out abortion, and Molla refused to have one. Since abortion would aim at the child's death as a means to saving Molla's life, it would fail to meet the acceptable-means condition. Given that the deaths of Gianna and of her child would be bad and that the survival of either would be a similarly serious good, the principle of double effect would presumably permit either a hysterectomy or a removal of only the fibroma: neither aims at the bad effect as an end or as a means. Both are otherwise legitimate medical procedures, and both would pursue a good sufficiently serious to justify allowing the bad side effect. Molla, valuing her child's life above her own, chose the latter and died from complications just a week after the baby's birth.

## 2. A Crucial Claim for Applying PDE: Death is a Bad Effect

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<sup>4</sup> I borrow this statement of these conditions from an earlier paper: H. M. Giebel, "Ends, Means, and Character: Recent Critiques of the Intended-Versus-Foreseen Distinction and the Principle of Double Effect," *American Catholic Philosophical Quarterly* 81/3 (2007): 447–68.

<sup>5</sup> For a brief biography and description of Molla's options, see "St. Gianna Beretta Molla," *Catholic Online*, [http://www.catholic.org/saints/saint.php?saint\\_id=6985](http://www.catholic.org/saints/saint.php?saint_id=6985).

Obviously, to apply the principle of double effect to a particular real-life case, one must affirm that at least one of the foreseen effects of the act in question is significantly bad or harmful. No bad effect, no “double effect”; no double effect, no need for the principle of double effect. As we saw in Molla’s situation, an effect frequently acknowledged to be bad is the death of an innocent human being. Presumably the badness of human death is obvious to most of us: after all, the paradigmatic example of something that a parent or a doctor would describe as “bad for you” would be something liable to cause or hasten your death. In fact, “bad for you” would seem a serious understatement in some such descriptions: e.g., “Don’t eat that rat poison – it’s bad for you.” We appear to be biologically and psychologically wired to pursue continued life and to avoid (or at least to postpone) death. Individually and as a society, we tend to praise and reward those who save innocent lives and to condemn and punish those who take them. But perhaps things get a little more complicated with some end-of-life cases, such as when life does not seem so good and death does not seem so bad to the person whose life or death is at stake. So, it seems worthwhile to provide a brief analysis of the badness of death. As above, I will not attempt a thorough defense of the claim that death is bad. I will, however, give the outlines of two arguments: a general commonsense argument and then by a specifically Thomistic one.

On a commonsense approach we can see that life is a necessary condition for all other goods. If you prefer, earthly life is a necessary condition for all other earthly goods. That being the case, death – the ceasing of life – removes a necessary condition for the agent’s having any goods at all. That is, death immediately eliminates all of the agent’s current goods and precludes the attainment of any future goods. It makes current and future flourishing impossible. That is bad.

Thomas Aquinas, whose influence on the development of the principle of double effect I mentioned above, gives further reasons to conclude that death is bad for us. In his discussion of natural law ethics, he invites us to consider our nature – what kind of beings we are – as a way to discover our natural ends or goods. Most basically, he argues, we are (living) substances. As is true in other biological creatures, our nature comes with a built-in aim toward continued existence (life). Life is an intrinsic end for us, a natural purpose or goal – a good that we seek. Anything that serves to frustrate our ends, that aims

to deprive us of their fulfillment, is bad for us. Death, being contrary to life, is just that sort of thing.<sup>6</sup>

The better to understand why Aquinas's natural law theory works the way in which it does, let's take a quick look at his metaphysics. Aquinas endorses a broadly Aristotelian thesis called the convertibility of being and good – a thesis that may sound foreign to modern ears but that was quite widely accepted in the medieval period and is surprisingly plausible. As in his discussion of natural law ethics, Aquinas begins by considering the Aristotelian dictum that “the good is what all desire.” What sort of good does every being desire? Its own perfection. What makes something perfect? Actuality: the actualization of its potential. And what makes something actual? Existence: being.<sup>7</sup> So, the more something is actualized – the more being it has – the more perfection or goodness it possesses. The more it is deprived of the sorts of goods that perfect it, the worse it is. Returning to natural law ethics, then, we can see that death is the ultimate privation: it removes – deprives us of – existence, which in turn deprives us of all actuality, perfection, and good.

Presumably this reasoning sounds simple and obvious, but some contemporary philosophers have argued that the way in which we describe something can make a big difference regarding how we evaluate it. So, even those who accept the basic arguments above can raise all sorts of interesting questions about it. Maybe, in general, life is good for you and death is bad, but what about loss of some portion of life? Or loss of this portion of life in certain circumstances? Could there not be parts of one's life, or circumstances surrounding those parts, that render the loss of them not so bad?

If it turns out that there are no bad effects resulting from a given course of action, the principle of double effect simply does not apply and we will have to use other ethical tools. Questions regarding how we construe death and its badness will re-emerge in applications of the principle of double effect to end-of-life decisions in various circumstances.

### 3. End-of-Life Applications of the Principle of Double Effect

Given that death is contrary to human flourishing and thus counts as a bad effect, the proponents of the principle of double effect (and even some of its

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<sup>6</sup> Aquinas, ST I-II, q.94, a.2.

<sup>7</sup> Ibid., I, q.5, a.1.

detractors) tend to agree about its application to a couple of end-of-life choices:

a. *Active euthanasia*. The deliberate ending of a person's life, e.g., by injecting a lethal drug, in order to end the person's suffering or distress.

The principle of double effect clearly rules out active euthanasia as violating at least the acceptable-means condition: it involves intentionally seeking the death of an innocent person as a means to ending suffering. Similarly, physician-assisted suicide, in which the physician provides the means for the patient to take his own life, aims at the patient's (future) death as a means to ending his (future) suffering.

b. *Palliative care*. The provision of painkillers or sedatives at the end of life in a dose sufficient to manage a patient's pain or distress.

The principle of double effect generally permits the use of such painkillers or sedatives when death is imminent, even if a side-effect is the slowing of respiration and thus a hastening of the dying process. Such palliative care would not be permissible according to the principle if the physician's intentions were to assist in the patient's suicide. For example, if her patient is (or claims to be) suffering from pain or distress, a doctor may prescribe the sort of painkillers or sedatives that are appropriate for managing his symptoms. The physician's prescription would become morally blameworthy if done with the intention of enabling her patient to kill himself by taking them in high doses. Such a case will really be one of physician-assisted suicide and thus something forbidden by the principle of double effect. More interestingly and controversially, some have appealed to this principle in attempts to justify other, less straightforward, courses of action, such as terminal sedation, detubation, and drug provision.

c. *Terminal sedation*: The use of painkillers or sedatives to induce coma until (non-drug-induced) death.

d. *Detubation*. Ceasing to administer nutrition and hydration via feeding tube.

e. *Drug provision*. Prescription of lethal drugs for the purpose of giving psychological comfort to patients.

I will discuss each of these three cases below and argue that attempts to justify these courses of action by appeal to PDE generally do not succeed.

#### 4. Terminal Sedation.

As Johannes van Delden notes, the definition of “terminal sedation” is often ethically loaded. Both proponents and opponents can work into their definition the reasons (intentions) for which it is to be performed, the medical conditions for which it is deemed appropriate, and the life expectancy of the patients to whom it is administered. Essentially, though, terminal sedation is simply “sedation until death follows.”<sup>8</sup> Joseph Boyle provides a helpful general discussion of terminal sedation and the principle of double effect by focusing on the question of whether death is intended in terminal sedation. He (correctly in my judgment) determines that it need not be. Like other palliative care at the end of life, it can be performed with the intention of relieving suffering but not of causing death.<sup>9</sup>

Interestingly, neither Boyle nor Judith Jarvis Thomson, who opposes applying the principle of double effect to end-of-life decisions, comments on the practice of terminal sedation by asking whether (permanent) unconsciousness is an ethically significant bad effect. A determination on this point seems crucial for the legitimacy of any application of the principle insofar as the physician who administers terminal sedation intends or even foresees that doing so will render the patient permanently unconscious. In her discussion of terminal sedation, Thomson contrasts it with active euthanasia under the assumption that the principle of double effect permits the former but not the latter. She offers an example in which a doctor (Alice) has two drugs, either of which could be injected to relieve her patient’s pain (call him “Bob”). Drug D could relieve Bob’s pain by causing his death immediately.<sup>10</sup> Drug C could relieve Bob’s pain by inducing a coma, which would persist until his eventual death. Thomson objects: “If PDE is correct, then Alice must choose C. But do the patient’s wishes not matter? By hypothesis, if the patient is injected with

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<sup>8</sup> Johannes van Delden, “Terminal Sedation: A Restless Ethical Debate,” *Journal of Medical Ethics* 33/4 (2007): 187–88.

<sup>9</sup> Joseph Boyle, “Medical Ethics and Double Effect: The Case of Terminal Sedation,” *Theoretical Medicine* 25 (2004): 51–60.

<sup>10</sup> Some argue that death does not, strictly speaking, relieve the patient’s pain but merely ends it: see, e.g., T. A. Cavanaugh, “DER and Policy: The Recommendation of a Topic,” *American Catholic Philosophical Quarterly* 89 (2015): 539–56 at n26: “Ceasing to exist ends pain but it does not relieve it. (By contrast, as is the case in [terminal sedation], an analgesic relieves pain.)”

C, he will live longer than if he is injected with D. By hypothesis also, however, that stretch of additional life will be unconscious life, and the patient might prefer not to live it. Does morality, and should law, require him to?”<sup>11</sup>

Here it seems to me that Thomson’s analysis moves far too quickly from the principle’s ruling out active euthanasia (Drug D) to the inference that it requires terminal sedation (Drug C). Let me offer a quick improvement. Although Thomson claims that the principle of double effect requires a physician to inject coma-inducing drug C, in the case of doctor Alice and patient Bob, it seems to me that the principle justifies Alice’s decision to inject C only if:

- (1) Alice would not be intending anything significantly bad in injecting C (either because she would not be intending to induce coma or because coma is not significantly bad);
- (2) Alice is not doing anything that is bad in itself (independently of causing coma);
- (3) Alice has a sufficiently serious moral reason for injecting C;
- (4) Alice would fail to meet one or more of the above three criteria if she injected D;
- (5) No other methods are available to relieve Bob’s pain adequately (or Alice would fail to meet one or more of the first three criteria by using the other methods); and
- (6) Alice would fail to meet one or more of the first three criteria if she did not relieve Bob’s pain.<sup>12</sup>

As I mentioned above, Thomson does not raise the possibility that a proponent of the principle of double effect might believe that inducing permanent unconsciousness is bad in a morally significant way. If the proponent of the principle considers coma until natural death to be a significantly bad effect (whether or not it is worse than immediate death), he will not, contra Thomson,

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<sup>11</sup> Thomson, “Physician-Assisted Suicide: Two Moral Arguments,” *Ethics* 109 (1999): 497–518, at pp. 513–14.

<sup>12</sup> I borrow this analysis from another paper: Heidi Giebel, “The Limits of Double Effect,” *Proceedings of the American Catholic Philosophical Association* (2016), forthcoming.

claim that Alice must choose to induce a coma as a means to relieving Bob's pain. Alice must avoid intending a bad effect as a means to a good one. Further, notice that we could construct similar (though less-comprehensive) arguments for the goodness of consciousness (and thus the badness of permanent unconsciousness) parallel to those for the goodness of life and the badness of death. Loss of consciousness is generally "bad for you." Consciousness is a necessary condition for many other human goods, and it is plausibly described as a perfection that actualizes our natural potential.

Given the intuitive and philosophical plausibility that permanent unconsciousness is significantly bad, the use of the principle of double effect to justify terminal sedation must be undertaken with due caution. If the induction of unconsciousness is not intended but is itself a side-effect of providing sufficient medication to manage the patient's pain or distress, it passes the test in the same circumstances in which death-hastening palliative care is justified. If not, a heavy burden of proof appears to be on the proponent of the claim that permanent unconsciousness is not a significantly bad effect.

## 5. Detubation

As my colleague Michael Degnan puts it, John Paul II "rocked the world of Catholic biomedical ethics...when he delivered the first explicit papal statement affirming the obligation to provide food and water to patients diagnosed as being in a vegetative state."<sup>13</sup> The papal directive met with a variety of responses in the medical, theological, and philosophical communities. Some commended the pope for upholding the dignity of disabled human beings while others argued that artificial nutrition and hydration represent extraordinary treatment disproportionate to the benefit of continued life, or even that life is not a benefit at all for those in a persistent vegetative state.<sup>14</sup>

The responses by philosophers and theologians to the papal document show through both their agreements and disagreements that there certainly is

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<sup>13</sup> Michael Degnan, "Are We Morally Obligated to Feed PVS Patients Till Natural Death?" in *Artificial Nutrition and Hydration: The New Catholic Debate*, ed. C. Tollefsen (Dordrecht: Springer, 2008), pp. 39–60, at p. 39.

<sup>14</sup> See, e.g., Kevin O'Rourke, O.P., "Reflections on the Papal Allocution Concerning Care for PVS Patients" in *Artificial Nutrition and Hydration: The New Catholic Debate*, ed. C. Tollefsen (Dordrecht: Springer, 2008), pp. 165–77, at pp. 171–73.

room for nuance regarding the specific circumstances in which feeding tubes are removed. Also clear is the need for those of us who oppose intentionally killing innocent people to make clear arguments about when and why tubation is ethically out of bounds. In many cases of withdrawing artificial nutrition and hydration, the principle of double effect does seem to apply, for there are situations in which there really are good effects and bad effects at stake. The bad effect, of course, is loss of life. Despite occasional claims that life is not beneficial for the PVS patient, both the arguments that I outlined earlier and the one by Degnan succeed in showing the good at stake. Here is Degnan's summary of his conclusions: "Providing ANH [artificial nutrition and hydration] is a proportionate good for the PVS [persistent vegetative state] patient since it is necessary for the patient to receive the goods of exercise, aesthetically pleasing environment, and human interaction which constitute parts of a humanly flourishing life."<sup>15</sup> The good effect is the elimination of the burdens to the patient and others associated with the mechanically-assisted feeding. Sometimes such burdens are sufficiently serious to constitute an ethically significant effect. As Myles Sheehan points out, there are several types of feeding tubes, some more invasive than others, and they occasionally bring medical complications of their own. Further, especially for those in the last stages of dying, the nutrition and hydration provided may not be assimilated by the patient and may increase suffering.<sup>16</sup>

In cases in which a significant good effect as well as a significant bad one would result from removal of a feeding tube, the principle of double effect requires both that the bad effect be a mere side effect of the action (not its intended end or an intended means to the good effect) and that there be a sufficiently serious reason for allowing the bad effect. It is difficult to meet both conditions: often the point of withdrawing nutrition and hydration is to bring about the death of the patient as a means to eliminating the burdens associated with care. But where the effects associated with the artificial feeding itself – not the continued life of the patient – are seriously burden-

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<sup>15</sup> Degnan, "Obligated to Feed PVS Patients," p. 56.

<sup>16</sup> Myles N. Sheehan, S.J., "Feeding Tubes: Sorting Out the Issues" in *Artificial Nutrition and Hydration and the Permanently Unconscious Patient*, ed. Hamel and Walter (Washington, D.C.: Georgetown Univ. Press, 2007), pp. 15–25.

some, its removal (like the removal or non-use of other life-sustaining measures) is permissible according to this principle.

#### 6. Drug Provision

Perhaps the most surprising appeal to the principle of double effect as a justification for controversial end-of-life decisions comes from Judith Jarvis Thomson, who has in general been an opponent of its use. Thomson argues that a doctor who prescribes lethal drugs for her patient – a case externally appearing to be straightforwardly physician-assisted suicide – may do so if the physician is “intending only to provide the patient with the comfort of knowing that if his condition becomes unbearable, so that he wishes to end his life, he will be able to do so.”<sup>17</sup> She suggests that, to be consistent, proponents of the principle of double effect must advocate laws that allow doctors to prescribe lethal drugs if they do so with such an intention.

The proponent of this principle, however, will not be convinced by Thomson’s reasoning. After all, the physician who intends to provide psychological comfort clearly intends to do so by giving her patient the means to kill himself. The drugs provided are in fact comforting only insofar as they represent a means to intentionally causing one’s death. That, of course, is the very thing to which proponents of the principle object. The line of intention seems to go from provision of the drug through the patient’s having the means to take his life to the comfort of knowing he can do so (and further, perhaps, to his actually taking his life).

So, once again, it seems that Thomson’s understanding of the operation of this principle is seriously lacking. She seems not to notice the crucial factor of assessing the moral acceptability of the intended means. Why include more of her analysis in this paper, then? As it turns out, with a variation on her theme, the case she brings up becomes more interesting. A proponent of the principle who accepts deception in medical ethics could grant the acceptability of a similar action for a physician with similar intentions who substitutes a placebo for the lethal drug. The patient could thus have the same “comfort of knowing that if...he wishes to end his life, he will be able to do so” without actually having the means to take his life – a scenario that would handily

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<sup>17</sup> Thomson, “Physician-Assisted Suicide,” p. 510.

render plausible the claim that the prescribing physician does not intend the patient's death or the means thereto.

### 7. Conclusion

After reviewing some recent examples of appeals to the principle of double effect as a way to justify controversial courses of action at the end of life, I have argued that most are in fact misuses of the principle: there is a fairly heavy burden of proof on the proponent of terminal sedation, detubation, or drug provision to show that a significantly bad effect (permanent unconsciousness or death) is neither the end of the act nor the means to the good effect -- a burden that usually is not carried (and cannot be carried except in a rather narrow range of circumstances). Even in the less-controversial case of palliative medication, the proponent of death-hastening medication must carry a less-heavy burden of proof that a dosage high enough to hasten death is required for pain management, especially if such dosage is atypical or represents a significant increase. Failing to carry that burden of proof casts doubt upon both the agent's intentions and the seriousness of her reason for acting.

Cases such as these serve to remind us that the principle of double effect -- like other ethical principles -- is not a magic formula that makes all of our difficult medical decisions for us. To apply the principle properly, one must have adequate knowledge not just of ethics but also of both the relevant medical procedures and the unique features of the situation at hand. As with many aspects of human life, decision-making at life's end can be complex; here we see in action the truth of the Aristotelian dictum that acting well requires prudence.