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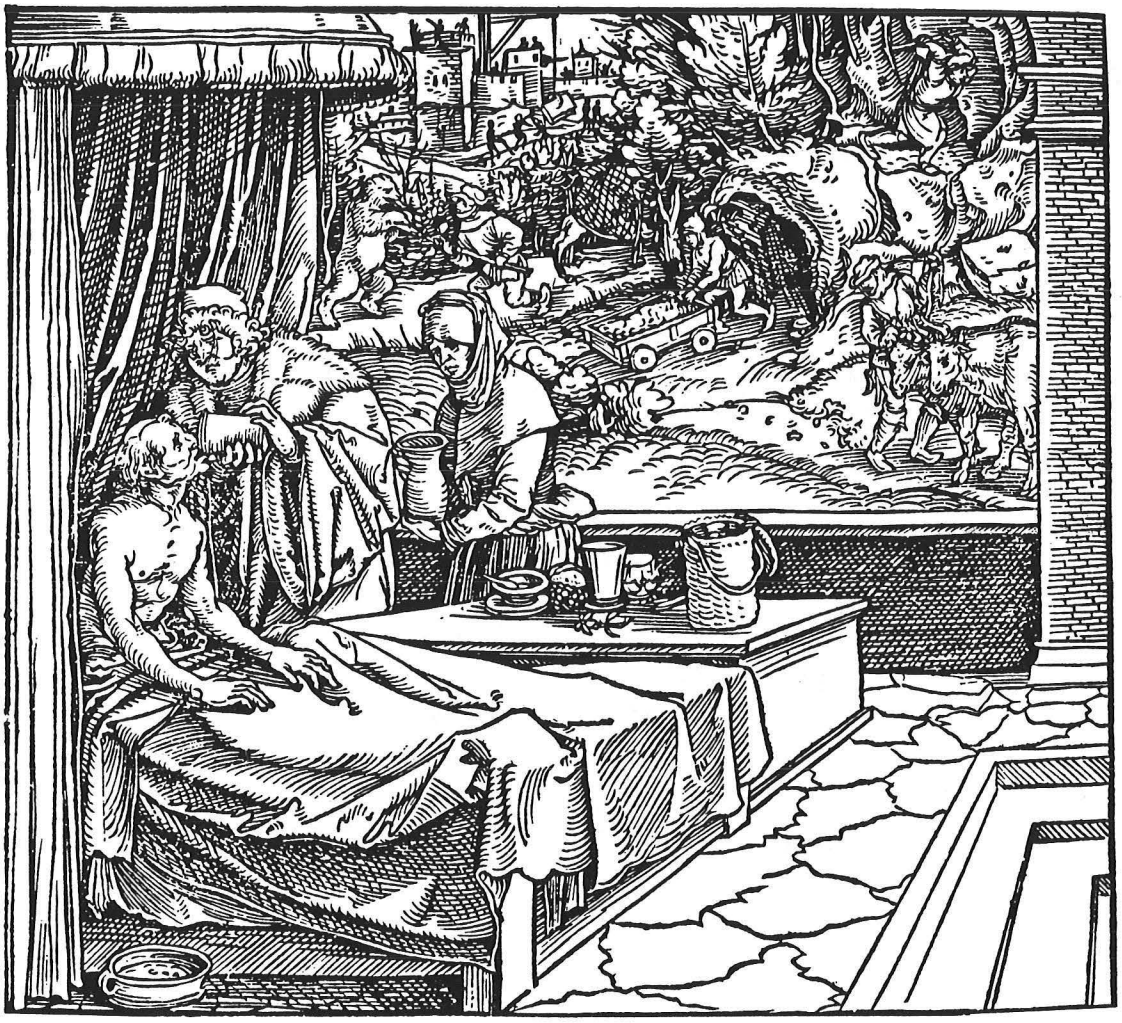

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"Human action has no value other than the intention which directs it."
Pierre Teilhard de Chardin[1]

All philosophical discourse begins in a reflection upon commonsense experience. Such reflection gave rise to the principle of double effect (PDE).[2] It has its roots in intuitive morality.[3] It stems from the perception that certain actions ought always to be considered wrong regardless of the circumstances combined with a commonsense realization that we live in a world where a single action has more than one effect. This commonsense realization led to the development of PDE. The principle arises from intuitive notions about action, intention, proportionality, and what may legitimately be done in the pursuit of a good. At the heart of PDE lies a question: If a single action has a desired effect and an undesired effect, can we justify the action?

In the history of human endeavor, some thinkers held that certain actions are so heinous and contrary to human nature that they should be prohibited. However, these same thinkers also realized that sometimes human beings must act such that their actions have two effects, one good effect and one prohibited effect. A synthesis in these two ideas resulted in PDE. The institution of medicine has traditionally used it to justify the use of high doses of medications such as morphine to control pain—a desired effect—which might also hasten the death of the patient—traditionally, an undesired effect. Drugs like morphine, benzodiazepines, and barbiturates are used to relieve pain or sedate a terminally ill person with a foreseen side effect of decreasing respiratory drive. Its proponents hold that in appealing to PDE, one could claim moral innocence for the hastened death of the patient.

Other scholars have argued that appealing to PDE simply alleviates the consciences of health care providers.[4] When applying PDE to end-of-life care, these scholars argue that PDE serves as a euphemism for euthanasia. They contend, therefore, that the institution of medicine should be more open to passive and active participation in suicide by physicians rather than relying on euphemisms. They maintain that in reality the drugs are used as the means to kill the patient and thus end their suffering. Recently Timothy Quill et al have argued that PDE is no longer of value.[5] Others have argued that it hinges on ancient notions of morality and action that are no longer useful to medicine and end-of-life care. Quill and others have stated that PDE does not contribute and may actually be detrimental to end-of-life care. They contend that those who employ the language of PDE really do intend the deaths of their patients.[6] They argue that the use of morphine at the end of life is really equivalent to euthanasia and that, if it is euthanasia, then other forms of euthanasia should be allowed.[7] Both Quill and Jack Kevorkian have received press coverage for their active or passive participation in euthanasia. They act out of a sense of compassion for their fellow human beings to take the life of the terminally, or in Kevorkian's case, not so terminally ill. These actions have as their impetus a certain notion of autonomy and a sense of compassion.[8]

In this paper, I will attempt to explain what our philosophical predecessors believed with regard to intention, activity, and proportionality in order to clarify PDE for our own time. This examination will not be limited to the ancients. A close analysis of

recent criticisms of PDE will also reveal the misconceptions about PDE that seem to pervade our contemporary understanding. I will trace the historical roots of PDE, describe the arguments criticizing PDE, discuss the philosophical basis of PDE, and examine its relevance for today. Finally, I will argue from the commonsense perspective that PDE plays an important role in all of medicine and particularly end of life care.

Various Versions of PDE

Several versions of PDE exist. While there are subtle differences in the various versions that might lead to diametrically opposed actions, for the most part, they are similar.[9] Given the wide acceptability of Beauchamp and Childress's general introduction to biomedical ethics, I will present the four criteria of double effect as delineated by them.

> Each [criteria] is a necessary condition, and together they form sufficient conditions of morally permissible action:
> 1. *The nature of the act*. The act must be good, or at least morally neutral (independent of the consequences).
> 2. *The agent's intention*. The agent intends only the good effect. The bad effect can be foreseen, tolerated, and permitted, but it must not be intended.
> 3. *The distinction between means and effects*. The bad effect must not be a means to the good effect. If the good effect were the direct causal result of the bad effect, the agent would intend the bad effect in pursuit of the good effect.
> 4. *Proportionality between the good effect and the bad effect*. The good effect must outweigh the bad effect. The bad effect is permissible only if a proportionate reason is present that compensates for permitting the foreseen bad effect.[10]

These four criteria are sufficient and all are necessary in order to consider an action as morally acceptable. While these criteria contain complex philosophical ideas, they all stem from a commonsense morality. They are based in the fact that few actions achieve their goal without also achieving some undesired effects. Throughout the complexity that follows, I shall attempt to return to the commonsense perspective.

Recent Criticisms and Questions

A brief reading of the four necessary and sufficient criteria of PDE reveals the first of several problems. The criteria are very cumbersome and difficult to utilize in the every day practice of medicine. Certain difficult questions come to mind: What is a good or neutral act? How should we define good or neutral? What constitutes an act? These questions cause people to become skeptical of philosophers who sit around and think of such rules that are not, to use a modern colloquialism, 'user friendly.'

Also questions surround intention and cause. What is meant by intention? Can we really understand our intentions?[11] Can we really distinguish between death caused by the disease and death caused by withdrawal of care? Numerous scholars have argued that the use of the word intention adds a certain level of complexity leaving those in moral dilemmas without a clue as to how to proceed. Edmund Pellegrino has argued that in the withdrawal of care, the disease causes the death.[12] Howard Brody takes issue

with such distinctions and argues that it becomes very difficult to talk of intention and cause in clinical circumstances. Brody presents the following case:

> Case 1: A patient who is ventilator dependent and suffering from a degenerative and terminal disease has voluntarily requested cessation of artificial life support. The patient also has a deadly enemy who knows that the patient needs the respirator to survive, but is unaware of the patient's long-term prognosis and he requests to be disconnected. The physician intends to turn off the respirator, but first administers a sedative so that the patient will not suffer from gasping or air hunger in his last moments. The physician is called away briefly. At that moment, the enemy enters the patient's room, seizes this opportunity to unplug the respirator, and then flees.[13]

How is the intention of the doctor different from that of the enemy? Do they both not intend the death of the patient? Did the enemy cause the death? Or, did the disease cause the death? Brody concludes:

> ... [I]f the physician performs an action and thereby does not cause the death, while the enemy causes the patient's death when he does the same thing, then the concept of 'cause' here is not doing the sort of moral work that Pellegrino seems to require of it. It gives us no *independent* reason to praise what the physician does or condemn what the enemy does.[14]

Brody's point is well taken. I shall formulate a response later.

More questions surround the possibility of means. Are there actions which, regardless of the circumstances or potential good consequences, should never be done? What about the rules on which society functions? Can these be violated in order that a higher good is achieved? Thou shalt not kill, unless a higher good is achieved. Is this not the justification of war? Do we not fight and kill people in order to achieve a higher state of world peace? Thou shalt not steal, unless one is in real need and a life depends on it. Think of Jean Valjean in Victor Hugo's classic novel, *Les Miserables*. Was Valjean justified in stealing the loaf of bread?

The final clause of PDE, proportionality, makes the most sense to us as moderns. We look for the balance in what we do. Yet we have difficulty defining proportionality. We tend to look for the proportionality to be formulaic in application. Yet, PDE does not lend itself to easy quantification: Proportional to what? Can we truly make a calculation to come up with the proportional action? With all of the above questions and criticisms, there does not seem to be much hope for PDE, which I have said comes out of commonsense morality. Where is the common sense in a principle plagued by philosophical language and in need of so much interpretation?[15]

History

One could argue that PDE has its earliest roots in Augustine of Hippo followed by Abelard. They both discuss intention in moral action.[16] According to Anthony Kenny, Augustine argued that there are some actions that can not be justified regardless of

circumstances or consequences. Yet Augustine does not dwell on the negative inhibitions of law. Love serves as a motivating factor. The intention to love would affect every action. If you loved your neighbor, naturally you would not need the injunctions not to kill, steal, or bear false witness. Abelard, on the other hand, tends to think that intentions were the central factor in deciding moral culpability. Certainly one could not be held responsible for an action, if one did not know the action to be illegal or wrong, or if one was ignorant of the circumstances which made the action wrong. A bad intention may ruin a good act. These two thinkers came to a semblance of PDE without the benefit of the developed theory as outlined above. Rather, the notion arose from lived experience.

However, PDE as it exists today owes most to Thomas Aquinas.[17] Some scholars argue that it stems from Thomas's distinction between indirect voluntary actions and direct voluntary actions.[18] Others have argued that PDE stems from Thomas's discussion of self-defense.[19] Thomas did not explicitly define the criteria of PDE in the systematic way that it now exists. Certainly he and his subsequent followers did not think of its use in medical situations. Regardless of the exact Thomistic source, subsequent moral philosophers and theologians utilized his thought in order to delineate the four criteria of PDE. Thomas seems to have come to the possibility through a commonsense application of his thought. In the second part of the second part of the *Summa Theologiae*, question 64, Thomas comes closest to defining double effect when he discusses whether it is legitimate for a person to take the life of another in self defense. Thomas concludes that it is, if the intention of the person who uses force is to protect oneself. The intention must be to save his own life and the intention cannot be to the take the life of the aggressor. Though scholars may argue over whether this discussion is the source of PDE, it nicely illustrates PDE from a commonsense perspective.

> A single act may have two effects, of which one alone is intended, whilst the other is incidental to that intention. But the way a moral act is to be classified depends on what is intended, not on what goes beyond such an intention, since this is merely incidental there to... In the light of this distinction we can see that an act of self-defense may have two effects: the saving of one's own life, and the killing of the attacker. Now such an act is not illegitimate just because the agent intends to save his own life, because it is natural for anything to preserve itself in being as far as it can. An act that is properly motivated may, nevertheless, become vitiated if it is not proportionate to the end intended... It remains... that it is not legitimate for a man actually to intend to kill another in self-defense.[20]

Here within this single article of question 64, Thomas has contained all of the criteria that now are listed within the PDE. We find intention, action, proportionality, and a good end does not justify a bad means. From this rather short discourse, taken in conjunction with the rest of Thomistic thought, comes PDE.

Thomas's notion of the moral quality of actions also contributed to the development of PDE. First, the moral quality of an action comes from the ontological status of the actor. As Thomas puts it: "...as a thing is, so does it act."[21] Here Thomas speaks of the virtues in action. The virtues are a habitual state that comes about by habitually practicing virtuous actions. If you are in the virtuous state, you will produce

virtuous actions. Likewise, if one practiced a vice, the vice would come to characterize the habits of the agent. For Thomas Aquinas, human action consists of two parts. The first part is the intention, the part that exists voluntarily in the will. The second part of an action is the material part or the physical means by which an action occurs. While the parts can be distinguished for the purposes of discussion, they cannot be separated ontologically in an action.[22] In other words, the willful intention vivifies the physical means to bring about the action. Intention, then, is the state of affairs that we will to bring about.

For the next 200 years after Thomas Aquinas, nothing was added to the notion of double effect. The principle was not really mentioned again until the early sixteenth century with Thomas de Vio Cajetan.[23] He uses the principle to further explicate the possibility of self-defense. The principle becomes more explicitly applied in the early seventeenth century and its use can be found among several moralists who develop it within certain practical situations.[24] During this time the principle is used to justify cases of war where innocents might be killed indirectly, causing others to do wrong by ones own actions, participating in the evil of another, and exposing oneself to mortal danger for a good cause. PDE is implied in all of these areas. However, it was not until the middle of the seventeenth century that we find PDE fully developed in a form recognizable to us. Domingo de Santa Teresa and his Salmanticense followers in *Cursus Theologicus* state the principle in theoretical terms.[25]

Recent Developments

In the last 50 years, Catholic moralists, as well as others with deontological tendencies, have used PDE. It has been employed to defend the use of death hastening drugs and certain cases of abortion in order to save the life of the mother. To briefly describe the various applications of PDE, I will use several famous theoretical cases. While these cases are highly speculative, they serve to delineate several distinctions for the purposes of discussion.

> Case 2: A woman's life is endangered by uterine cancer. She will die unless a hysterectomy is performed. The woman is pregnant, hence—on the assumption that the fetus is a person—the surgical removal of the woman's uterus will result in the death of an innocent person, the fetus.

All Catholic moralists would allow that such an abortion is allowed on the basis of PDE. First, the act of removal of the uterus is not considered to be evil. Secondly, the intention of the surgeon is not the death of the fetus, for certainly if she could save the fetus she would. Thirdly, the death of the fetus is not the means of the good effect, saving the woman's life. Lastly, the action of hysterectomy is certainly proportionate to the possibility of the removal of the uterus and the foreseen, but not intended death of the fetus. Thus each of the four criteria are met within this case.

However, a similar case remains controversial for some Catholic moralists. Others who hold to different versions of deontology have found the following case to be the same as Case 2 described above.

> Case 3: A woman will die in childbirth unless the skull of the fetus [stuck within the birth canal] is crushed. The fetus will die if its skull is crushed hence the performance of the craniotomy upon the fetus will result in the death of an innocent person, the fetus.[26]

This case presents several problems of interpretation. Strict Catholic interpretations would not allow the craniotomy because the surgeon intends the death of the fetus.[27] Those who criticize PDE as rigid rule following are certainly justified in doing so in this case. However, a strict interpretation of the principle results in the death of both the fetus and the woman. As I will point out later, to intend not to act certainly leaves one culpable for an act of omission in the case of the woman. Other moralists have understood that the action of craniotomy is not the action of killing, but of the removal of the fetus from the birth canal.[28] Alan Donagan proposes that a good test of intention is "to suppose that, by some fluke or miracle, the action does not have the effect you foresee, and to ask whether you then consider your plan carried out and your purpose accomplished."[29] Using Donagan's test, the physician does not intend the death of the fetus directly. Certainly if by some miracle the fetus survived, the physician would not think she had failed her goal. Rather the intended effect is the removal of the fetus from the birth canal, but the foreseen, yet permitted effect is the death of the fetus. Given the complexity of the above discussion, one would be justified in asking of what value PDE really is. Does it do the work that we ask of it? Of what value is a principle that needs constant interpretation?[30] I shall attempt to answer such questions after discussing the nature of action and a brief analysis of the various clauses of double effect.

Nature of Action

Briefly I would like to explicate the various parts of an action as a moral event as described by Edmund Pellegrino. He finds action divided into four parts: the physical action, the circumstance under which it is taken, the consequences of the act, and its intention.[31] As Pellegrino astutely discerns, various schools of thought seem to focus on a particular portion of the moral event. For the consequentialists, the consequences determine the moral character of the event; for the situationists, the situation or circumstances determines the moral character of the event; for the deontologists, the intention or the intrinsic rightness or wrongness of the event determines the moral character of the event. Pellegrino, betraying his own bias, states that the virtue-ethicist takes the entirety of the moral event in all its parts to determine the moral character of the event.[32]

An evaluation of the moral event is somewhat more complex than that developed by Pellegrino. Certainly intentions enter into the moral calculus, not only of deontologists, but also into that of the consequentialists[33] and situationists. Intention remains very important to all three aspects of an action. Situation ethics remains a form of casuistry. Where a casuist relies on similar cases to evaluate the moral implications of the particular case at hand, the situation ethicist seeks to understand the particulars of a case and how they bare on interpretation of the right or wrong action.[34] Since the particulars of every case are different, the situation ethicist finds the right course of action to be dictated by the particular circumstances of the case. Moreover, situation ethicists state that their intention is to express love or justice in each particular situation.[35]

For the consequentialist, the intended consequences become the means to evaluate the moral character of a particular event. If the consequences are good, then any means to achieve that good are allowed as long as the good achieved is proportionate to the means. For the most part, the means does not matter as long as the good achieved outweighs the bad means. They realize that some actions may not be so easily justified, and therefore the proportionality clause becomes important.[36] This stipulation often is interpreted to violate the final clause of PDE. However, several schools have argued that all evil is pre-moral and the intention is what makes something moral or immoral. These rely heavily on the commensurality of an action to the perceived situation or the whole endeavor.[37]

Deontologists get their name from the Greek word, *deon*, which means *ought*. Deontologists believe there are certain positive *oughts* or duties to which all are compelled. However, the deontologists are best known for the negative *oughts*. A person ought not lie, steal, etc. A deontologist would stipulate that a physician ought not to kill his patients. While an upper limit of duties often is difficult to delineate, the deontologist holds that the lower limit is plain and accessible to all. However, in most deontological theories, intentions enter into the duties. If a person does the right thing for the wrong reason, they have not truly done a good deed. If a person decides not to kill another person because it might land him in jail, the person has acted correctly, but receives no moral brownie points. The same is true for the person who sends his money to orphanages in order to receive praise from his peers. The truly moral person will do the right thing for the right reason, with the right intentions. Intention then enters into every aspect of moral evaluation; it enters consequences as intended, the situation as discerned, and the duties as followed. I will now further delineate the various clauses of PDE, beginning with intention.

Intention

As stated above, Thomas Aquinas believed that human action consists of two parts. The first part, the intention, vivifies the second, physical part. The two, taken together, combine to make an action. Intention is the first cause of any action. Intention is what makes actions alive and real within the world. To assess the moral character of action, I should define what scholastic philosophers and theologians mean by moral evil and by ontic evil. Ontic evil is that evil that exists, but not necessarily as intended. For example, a storm that destroys property or life would be ontic, physical, or pre-moral evil.[38] No one intended the harms to come upon the sufferers, and therefore no one is morally culpable. This evil is not moral evil. On the other hand, if I were to somehow cause the storm, my action would be considered a moral evil, because my action is vivified by my intention.

In order to determine moral responsibility, one must know the intentions of the individual who acts.[39] By looking at the consequences of an action one can tell whether the consequences of an action are ontically good or bad. However, one cannot determine whether the person responsible for the actions is morally responsible because one must know the intention of the action. If we stand atop the empire state building and observe one person killing another below, we do not know if the action is morally evil until the intentions are known. A pre-moral evil occurred regardless of the intentions of the killer.

If the person was threatened with personal harm or was protecting his children, then we would not consider him guilty of a moral evil. However, if he intended to collect the insurance policy of the victim after the death, we would understand this as a moral evil.

Let me give an example of a patient with a gram-negative infection that can only be treated with Gentamicin. It is possible to will or intend that a person be treated for their infection with Gentamicin understanding that I do not intend for the patient to sustain renal failure. My intention, treating the infection, brings about the use of Gentamicin as a means to achieve the intended end, without intending, but knowing fully that I could also cause renal failure. If the renal failure occurred, I would not be considered morally culpable for the renal failure (assuming all precautions and monitoring were carried out). On the other hand, as Quill et al point out, the law, especially tort law usually does not take intentions into consideration.[40] If renal failure results from my action, then I might be legally culpable.

This description of moral intention leads to a few problems. Quill and others argue that with PDE, we are simply attempting to alleviate a guilty conscience.[41] Here I think that Quill misjudges clinicians who appeal to PDE. Quill has mistaken psychological intention with moral intention. I may psychologically and intellectually know that a person who is suffering is better off dead. I may even psychologically desire the death of the patient out of empathy. Desire becomes intention when it leads to action or inaction. Intentions take on a moral quality once they have begun to bring about the state of affairs necessary to achieve the intended end. They are morally acceptable if the intended actions are justified. To psychologically know that a person will die, and even to desire that the person die, is one thing; to vivify my actions with my intention to cause the death seems to be another.

Pellegrino argues as well that one can differentiate between desire, motivation, and intention.[42] To desire something is to find it as attractive and valuable; to intend something is to take steps to bring a state of affairs into existence. It is true that, as Quill points out, intentions are such complex things that it is difficult for physicians to understand their reasons for acting.[43] There are many psychological and sociological dimensions that make it virtually impossible to know the real intention of an agent. I do not, however, believe that PDE was ever used, or even claimed to be able, to help a third party figure out the moral culpability of an agent after an action. Rather, the intention of the person results from the moral deliberation of the agent, and the subject in the case of medicine, prior to the action.

In medicine, only the physician and patient can deliberate over the action. The intention of the agent is the sum total of all deliberation prior to the moment of action. On the part of the patient, deliberation must include sociological and cultural factors, religious beliefs, notions of mind-body, value structures, psychological factors, desires, and motivations. Patient deliberation also revolves around the perceived experience of the symptoms, the meaning attached to those perceptions, the subjective interpretation of the perceptions, and the quality of life before, during, and after a medical intervention. On the part of the physician, deliberation revolves around the medical interpretation of the patient's symptoms, and physiological and pharmacological concerns. Also entering

into the physician's deliberation are the sociological, religious, and psychological factors of the patient, as well as the physicians own socio-cultural, philosophical and religious views. Likewise the physician's desires, motivations, and various other psychological presuppositions enter into the deliberation. Intention, then, is none of these things. Intention results from deliberation as it moves into action. It seeks to bring into existence the moral event to achieve the one thing it hopes to bring about—in the case of Gentamicin, one intends treatment of infection; one does not intend the renal failure. No one has ever claimed our intentions to be anything other than complex. Intention requires that a person voluntarily will and initiate the action, not just desire the death of the person out of empathy. In end-of-life care, the question is not whether I know that death is the only way to end suffering. Indeed, I may know it and even desire death for a patient. However, to intend to act on it seems to be different.

Commission-Omission, Active-Passive, and Direct-Indirect

Central to traditional versions of PDE is the distinction between direct and indirect causes. Much confusion surrounds this distinction and it often is confused with active and passive means. I will first discuss the active-passive distinction. Is there a difference between allowing a patient to die and actively taking the life of a patient? It is commonly accepted in the philosophical tradition that actively killing an innocent person is the same as choosing not to intervene. Drowning a child in a tub of water in order to collect the insurance is not different from standing beside the tub and allowing the child to drown in order to collect the insurance. The person is equally morally culpable for either decision; in the first case, one acts to kill and in the other, one does not act in order that the child die. The former is considered to be an act of commission, the latter is an act of omission. Acts of commission are not morally different from acts of omission.

Some might argue that there is a moral difference in strangling a dying patient, pushing a bolus of potassium chloride, and prescribing enough barbiturate, narcotic, and/or benzodiazepine to end life. However, I do not believe there is a real moral difference. Common sense holds that a person driving the get away car is as guilty of robbery as the colleague who does the robbery is. The person who gave the order to gas the inmates at Auschwitz is as guilty as those who followed the orders, if not more so. In addition, we would consider the person who blocks the exit of a burning gymnasium to be as culpable as the arsonist who sets the fire. I will give a medical example. A patient comes to a physician. The patient is on benzodiazepines for anxiety. The patient requests more medication and leads the doctor to believe that he will use it to drug his boss. If the physician still gave the medication, then common sense would consider the physician to be culpable for the action. Though the physician does not actively participate in the death of the patient's boss, he did so passively. I would argue that the difference between strangling, pushing a bolus of potassium chloride, and prescribing enough medication for the patient to kill herself is really an aesthetic one and not a moral one. Under the described notion of intention, there is no moral difference.

However, the distinction between direct and indirect causes does not contribute to the differences between omission and commission. The direct-indirect distinction is commonly confused with the active-passive or commission-omission distinction. Quill et al[44] and Howard Brody[45] do not seem to see the difference. The distinction hinges on the

difference between action and intention. If I act to drown the child or if I do not act to save the child, I am morally culpable because my intentions are to kill an innocent person or to let an innocent die when I could intervene to save the life. I have directly participated in either action. However, it seems to me that knowing that a procedure or medical intervention has the risk of causing a harm like death and doing a medical procedure in order to cause harm or death is different. The difference lies in my intentions. I directly cause the death if my intention is the death of the person upon whom I act or from whom I withhold action. If my intention is to do good and the action results in harm or death I have indirectly and therefore innocently, caused the death of the person. For instance, a surgeon who performs a surgery on a critically ill patient who is as likely to die of the operation as of the disease is not morally culpable if the patient dies of the procedure. Neither is the surgeon morally culpable, if the procedure is not done. The resultant action remains within acceptability because the surgeon's intention is to help the patient. If he acts and the patient dies of the action, then he indirectly causes the harm. Likewise, if the surgeon does not act, knowing death will ensue, then he indirectly permits the harm. The difference between direct and indirect is the difference in intending to commit (or intending to omit)[46] and intending to permit something that results in a harm to the patient.[47]

The use of direct-indirect is an unfortunate misnomer relative to our contemporary terminology. While the scholastic terminology of Thomas Aquinas and his subsequent pupils revolves around the direct voluntary action of the will, today we understand direct-indirect in causal terms. Thomas's terminology no longer makes sense to our contemporary ears. To further clarify the point, active or passive participation and acts of commission or omission are both forms of direct causes if they are intended. Permitting or allowing a negative as a side effect, such as the death of the patient who in all likelihood will die anyway, is an indirect cause because the harm is not intended. The surgeon is not morally culpable because his intention was to help the patient at the risk of death. This death is indirect. To return to care at the end-of-life, certainly our giving morphine may contribute to the death of the patient. Yet, because our intention lies in the relief of pain, the death is indirectly allowed to happen. Therefore, there is no moral culpability. There is no moral difference between acts of commission and omission, between active and passive means to achieve our goals, but there is a difference between the directly caused and the indirectly foreseen and allowed.[48]

The Role of Intention in Distinguishing Between Allowing and Causing Death

I must now address the distinction between allowing and causing death. Prior to the Supreme Court's decision that patients do not have a constitutional right to physician-assisted suicide, Ann Alpers and Bernard Lo wrote to critique two lower court decisions.[49] These lower court decisions revolved around plaintiffs with terminal diseases who maintained that they should have equal protection under the law. They argued that they have a right to physician-assisted suicide because other patients with similar diseases who were farther along in the disease process could refuse life-sustaining interventions and die as a result. The plaintiffs argued that if one person with advanced lung cancer can hasten death as the result of refusing therapy, then another, who is not as advanced and has nothing to refuse, has the right to hasten death with the aid of a physician. These lower courts were essentially attempting to equalize the likelihood of death of those with

end-stage terminal disease and those who were not as near the end. Alpers and Lo argued that the lower court refused to take into account the fact that clinical circumstances dictate what is medically indicated.

Alpers and Lo contend that the court rulings are based on faulty clinical assumptions. They center their arguments on the subtleties that exist in clinical medicine. While similarities in cases may exist, no two cases are close enough alike to allow the courts to draw such conclusions. They give two cases to illustrate their point.

> Case 4: Ms. Adams... has lung cancer metastatic to her liver and bone 2 years after a lobectomy. She suffers from weakness, weight loss, and bone pain that requires regular doses of narcotics.
>
> Case 5: Mr. Bass... also has lung cancer metastatic to his liver and bone. Mr. Bass develops fever, cough, purulent sputum, and shortness of breath and is presumed to have pneumonia.[50]

The courts seemed to misunderstand the role of clinical variables.[51] The patient who has pneumonia has the opportunity to refuse treatment and to be allowed to die. They argue that Mr. Bass's clinical circumstances allow a chest x-ray, admission to the hospital, and antibiotics. Ms. Adams's clinical circumstances do not indicate any of these. Just because Mr. Bass can refuse any or all of these in hopes of ending his life does not necessarily mean that the Ms. Adams is entitled to help from physicians in ending her life. The clinical realities dictate what is indicated for a patient, not a patient's demand. Moreover, allowing a patient to die as a result of a disease process does not seem to be clinically the same as terminating the life. In the former, a patient is refusing a clinical intervention; in the latter, the patient requests a medical intervention that does not have a clear-cut medical indication.

The courts also seemed to miss the point that a refusal of medical intervention does not necessarily mean that a person desires to die as much as it means they do not desire the means of staying alive.

> Case 6: Mr. Cone... has end-stage chronic obstructive lung disease. Over the past year he has had four hospitalizations for exacerbation of his disease and once he required intubation for two weeks. He is admitted for increased sputum, cough, shortness of breath, and ventilatory failure. His chest x-ray is clear. Because of CO_2 retention, intubation is indicated. He and his wife agree to intubation and mechanical ventilation. Mr. Cone is treated with inhaled bronchodilators, prednisone, and antibiotics. Five days later, he is weaned of the ventilator. That afternoon he begins to tire. He again agrees to intubation and mechanical ventilation if needed. However, he says that he is uncomfortable on the breathing machine and frustrated at his difficulties communicating with people when intubated. He does not want to stay on the machine. Later that day, he does require intubation and mechanical ventilation. Four days later, his physicians believe that his condition has been optimized and that extubation can be attempted. Mr. Cone writes that if he fails extubation, he does not want to be

> reintubated. He also indicates that he understands that he will die without intubation if he cannot breathe on his own. If he cannot live without a ventilator, he will accept death rather than an unwanted intervention, but it is not clear that he is seeking death.[52]

Did Mr. Cone intend his death? It is questionable whether he wanted to die. Rather, he did not want to be kept alive on the ventilator. It seems to me that Mr. Cone did not necessarily intend his death. To the contrary, if he could have lived off the machine he would have. Rather, he did not wish to continue the means necessary to stay alive. It is therefore possible to distinguish between intending to die and foreseeing death. This case brings us to the question of allowing to die versus causing death.

Brody proposes several cases in true casuistic form where one might find a continuum from removal of care to passive or active participation in euthanasia.[53] I will briefly go through some of his cases to point to a few misconceptions that Brody perpetuates.

> Case 7: An 83-year-old patient with widely metastatic lung cancer is readmitted to the hospital in a confused state. He is discovered to have bacterial pneumonia. His prognosis is believed to be death within several weeks, even if all available treatment is given. In accordance with a living will written a year ago when the patient was competent and knew his diagnosis, no antibiotic is administered, and the patient dies peacefully in 36 hours.
>
> Case 8: A 66-year-old man with late-stage chronic obstructive lung disease has had three hospitalizations for severe respiratory infection with respiratory failure, each requiring three weeks of ventilator support before the patient could recuperate. At home, despite oxygen therapy, the patient is very limited in his activities and is quite frustrated with his level of function. While his pulmonologist explains that his next several bouts of infection could probably be treated successfully in the same manner as before, the patient, who is competent, refuses consent for any further intubation and instead requests sedation and other comfort measures. He argues that the three-week ventilator course is sheer hell for him, and that it is not worth going through that hell to return to a life of inadequate function from his point of view. With his next bout of infection, the pulmonologist does as directed, and the patient dies.
>
> Case 9: A 50-year-old man becomes quadriplegic from a cervical fracture, in the same automobile accident in which his beloved wife is killed. The patient has always been an active and vigorous individual, chafing at any limits in his ability to function. He is ventilator dependent in the first several months following the accident; during this time he communicates his considered wish that the ventilator be discontinued, based on the dismal quality of life (as he sees it) that faces him in the future as a quadriplegic widower. The staff object that it is their policy never to allow a patient's desire to withdraw treatment to be carried out in the first year following a spinal-cord injury, since so many patients are initially depressed and later come to accept their new life prospects. The patient replies that he has

> considered the matter very carefully and feels confident he would not change his mind; moreover, after a year of therapy, he would no longer be ventilator dependent (in all probability) and could not then effect a wish to die through the withdrawal of life-sustaining treatment. A psychiatric evaluation shows no depression or mental instability. The staff make an exception to their general policy in the face of the persistence and reasonableness of the patient's plea, and he dies.

This series of cases serves to blur the lines between causing death or allowing death. The final case as described by Brody seems to be the most regrettable. Most ethicists and clinicians would be comfortable with allowing the patient's in cases 7 and 8 to die. Some might argue that the patient in case 9 does not meet the criteria necessary for withholding care and may indeed be depressed. However, the quality of the life before, during, or after a medical intervention, in this case a prolonged intubation, has always been part of the equation to evaluate the possibility that care is extraordinary. As Kevin Wildes points out, the long moral tradition has argued that withholding care for quality of life reasons is acceptable as extraordinary means.[54] As sad as this case may be, I find nothing wrong with extubating the patient.

Brody argues further that "both the physician and the disease made a causal contribution, of sorts, to the patient's death" in all of the last three cases.[55] However, he never really describes the sort of causation to which he refers. The sort of causation does not appear to be the sort of cause-effect causation of which we commonly think. He goes on to state that each physician also intends the death of the patient. First of all, this does not seem to necessarily be the case. Each physician could probably make the statement, that, if the patient survived, they would not see her purpose as totally failed. If the patient with pneumonia in case 7 survived without antibiotics, however unlikely this might be, the physician would not consider her mission as failed. The same would be true for the patient with COPD in case 8. If the patient survived without intubation, the physician would not consider it as a failure. The same still seems to be true for case 9. Would the physician have considered it to be a failure if the quadriplegic man began to breathe on his own? While the patient may have considered his plans thwarted, I think the physician would reevaluate the circumstances and rethink the prognosis, rather than seeing the case as a failure to her and the patient's purposes.

The next two cases proposed by Brody look at the notion of physician-assisted suicide, though the cases may not typically be interpreted in that way.

> Case 10: A 38-year-old quadriplegic man has been dependent upon a ventilator for several years, and he could go on living in this state at least for another decade. Despite many efforts to assist in his range of activities and to provide emotional support, he declares that his life is miserable and meaningless for him, and he requests that the ventilator be turned off. Two psychiatrists declare him mentally competent. A judge refuses to issue a ruling in the case, stating that the law is completely clear on the patient's right to refuse, and no one is opposing his request. The physician administers a sedative and then disconnects the respirator, and the patient dies in a few minutes.

> Case 11: A 45-year-old woman is admitted to the hospital with a bacterial pneumonia. She has suffered from severe chronic diarrhea for 11 years; this has made her life miserable and has made her totally dependent upon her parents, with whom she lives. She has had numerous bowel evaluations at various major referral centers, but no one has been able to treat the diarrhea effectively. She has just begun an evaluation by a new gastroenterologist, and the physician learns that the patient consumes huge quantities of a diarrhea-causing antacid. It is not clear whether this item of the patient's medical history was known to previous diagnosticians. There has, as yet, been no chance to try discontinuing the antacids to see whether the diarrhea would improve.
>
> The patient deteriorates in the hospital and begins to develop a full-blown adult respiratory distress syndrome. The physicians feel this is potentially reversible with several days to a week of ventilator support and that the prognosis for full lung recovery is very good. The patient, at this point, refuses intubation and ventilation, citing the miserable quality of her life due to the chronic diarrhea. She has no hope whatever that this will ever get any better (and sees no reason to think this new gastroenterologist will succeed where numerous predecessors have failed), and she does not wish to be maintained on a ventilator simply to return to that unacceptable existence. Her parents back her wishes fully. There is inadequate time for psychiatric evaluation before a decision on intubation must be made.

Brody presents cases 10 and 11 as those where the patient could go on living many years. When looked at in this light, these cases, he claims are really no different from suicide. Certainly the patient in case 10 knows that he will die without the ventilator, so to refuse might be construed as suicide. However, as discussed above, quality of life issues enter into the final assessment of the patient as to whether a procedure, medication, or continuous intervention qualifies as extraordinary or burdensome. What might be ordinary for one person may be extraordinary for another.[56] It is not life itself that is cumbersome for the patient; it is the means to stay alive that is cumbersome. Therefore to extubate does not seem to be suicide. On the other hand, case 11 presents the possibility of psychological pathology. It seems that the patient is operating at a deficiency on two levels: first, she has not been given the information about the diarrhea-inducing agents, second, she may be limited by her psychopathology. It seems to me that this case is tantamount to suicide in a person with clouded reason. For the woman in case 11, it is life itself that has become cumbersome, not the means to stay alive.

Now let me return to case 1 offered by Brody. The following case really tests the notion of intention as I have presented it in this paper.

> Case 1(repeated): A patient who is ventilator dependent and suffering from a degenerative and terminal disease has voluntarily requested cessation of artificial life support. The patient also has a deadly enemy who knows that the patient needs the respirator to survive, but is unaware of the patient's long-term prognosis and he requests to be disconnected. The physician intends to turn off the respirator, but first administers a sedative so that the patient will not suffer from

> gasping or air hunger in his last moments. The physician is called away briefly. At that moment, the enemy enters the patient's room, seizes this opportunity to unplug the respirator, and then flees.[57]

This case provides an excellent question: What is the moral difference between the enemy pulling the "plug" and the physician pulling the "plug"? At first glance it seems that there is really no difference. Brody claims that both the physician and enemy intend the death of the patient. However, there still remains a semblance of a difference. If an observer did not know the roles of the physician or the enemy it would be difficult to judge the actions. The observer might conclude that both are equally culpable. However, if the physician and the enemy each provide a truthful explanation of their actions, the observer would conclude that the former is not morally responsible and the latter is. The physician intends to carry out the patient's wishes to end the medically cumbersome care. The physician really does not intend the death, for if she did, she would act independent of the patient's wishes. What if, by some miracle, the patient began to breathe on his own? Would the physician go on to strangle the patient, or give a bolus of potassium chloride, or an extremely large dose of barbiturate? It seems doubtful. On the other hand, if the enemy had these possibilities at his fingertips, it seems certain that he would carry out his real intention. Rather, the physician acts at the patient's behest because the patient has deemed the care as extraordinary, or as medically cumbersome. The intention clause relies on a distinction between intended and foreseen consequences.

Means

After an extensive examination of intention and causing death, I should now examine the means of an intended end. This discussion will revolve around the distinction between act and consequences. I would argue that part of the problem with understanding the above cases relies on an understanding of means. Are there actions so heinous, or so evil, that no amount of good that comes from them justifies the means? Intuitively, I think I could conceive of actions that fit the bill. I think most people would agree that it would be very difficult to find a purpose good enough to justify something like rape or pedophilia. Therefore it seems that there might be actions so heinous that no amount of good could justify them. Killing of the innocent would have fallen into this category in times past. Some would argue that killing at all, even during war, might fall into that category.

The role of means in moral action has occupied moral philosophers and theologians for years. Thomas Aquinas certainly believed that the end had to be commensurate to the means.[58] He believed that intent plus circumstances dictated the rightness or wrongness of an action. William E. May finds that intent plus content go to dictate the moral character of an action.[59] Other scholars have argued that no means are truly wrong and that most places where moralists have allowed an ontic or pre-moral evil, the intention and consequences have already been included in the calculation. In other words, the prohibition against killing is suspended in war because the intent and consequences have already been included in the assessment of the moral character of the event.[60]

However, it seems that certain suspect actions cannot be described differently

because of the goodness of the consequences.[61] For example, we might describe the D-Day invasion in terms of saving the world from Hitler. This seems reasonable because the consequences of not invading Germany could have been the end of Europe, as it was known; not to mention the numbers of further Jews who would have died. However, an event like the Mylai massacre cannot be construed in any way as saving the world from communistic dictatorships. If those dictatorships actually existed and the killing of the innocent villagers would have toppled the entire communistic dictatorship, could one really construe the incident as the saving of the world from communism? What distinguishes these two wartime cases, are the circumstances of each. In the first, combatants are killed to achieve the goal, in the latter, non-combatants. In the former, the means to achieve the end of greater world peace seems acceptable, and in the latter, the means does not. It seems that a good end does not justify a bad means. As pointed out by Philip Devine, certain actions are of such moral significance that no amount of logic allows us to describe the means in terms of the end. He places the taking of human life into this category.[62]

This brings us to an evaluation of the moral character of our therapeutic actions. In evaluating the moral character of medical therapies, I return to the notion of common sense. As Devine points out, there are certain actions that can be described in terms of the consequences. For example, the action of giving intravenous Gentamicin can be described as treating a gram-negative infection. Intentions enter into the descriptive process as well. It seems odd to describe the giving of intravenous Gentamicin as causing renal failure for the intention is never to cause renal failure.

While certain actions can be described in terms of their consequences, Devine points out that it is difficult to elide certain other actions into their consequences. Certainly, it would be ludicrous to remove someone's head in order to treat a migraine. You cannot describe the action of decapitation as treating the pain of migraine. It is decapitation, pure and simple. Describing euthanasia or physician-assisted suicide seems to fall into that category. It seems odd to list euthanasia as a mode of therapy for pain or any other disease for which we have no cure. Can an intravenous bolus of potassium chloride be construed as a therapy for pain? Can it be construed as therapy for end-stage congestive heart failure, or any other end-stage disease for which therapeutic interventions are limited or medically cumbersome? I think not. While one could describe the amputation of a leg as the saving of a patient's life, it seems odd to depict intravenous potassium chloride as treatment of pain, or as a means to achieve some sort of dignity. Use of barbiturate or morphine in order to treat pain seems to be a therapeutic action. One could easily describe the action as treating pain. As for physician-assisted suicide, use of these medications in order to treat pain by terminating life seems to be another kind of action. It seems odd to treat pain by prescribing death or to treat indignity by giving a high dose of sedative.

Proportionality/Commensurality

The commonsense descriptions of the above can be boiled down to the final clause of PDE. Proportionality is often understood as a balance between the good effect and the bad effect. If I choose to treat a gram-negative sepsis with Gentamicin, I know that there exists a one-percent risk of renal failure. I also may know that if the sepsis is

not treated quickly and accurately death could arise. The risk of renal failure is certainly proportional to the risk of death. Also, every minute sooner that a patient gets an antibiotic there is less chance that other end organ damage occurs. I might be able to balance the statistical possibilities of renal failure from Gentamicin with the statistical possibilities of renal failure from sepsis. If the possibility of multi-organ failure exists in sepsis, then certainly the risk is proportional. Like balancing renal failure with death, this too would be a proportional judgment of risks. Proportionality seems easy on the surface.

There are however, two significant problems with such formulaic thinking. First, we are dealing with statistical risks, risks that can be measured against one another. However, there is very little possibility of accurately predicting which particular patients will suffer renal failure if given Gentamicin, and which will suffer renal failure from the sepsis. Second, we are dealing with risks to a particular organ. How can we really assess the value of risking lung failure from gram-negative infection induced adult respiratory distress syndrome with end-stage renal disease? We are comparing apples and oranges. Throw in the relative value of life with a tracheostomy versus life with hemodialysis, can a judgment of proportionality really be made?

To contemporary understanding, proportionality has been understood in an almost formulaic manner, attempting to tally the pluses and minuses. However, there is no formula to which one can appeal to determine if the pluses out-weigh the minuses. It is not enough to say that the evil accepted must be out-weighed by the good achieved. As Peter Knauer points out, we are no closer to an explanation of proportionality, for "such a quantitative comparison is not possible, as it is a matter of qualitatively different values which cannot be compared with one another."[63] In other words, no formula exists to compare apples and oranges.

Rather, the judgment of proportionality is a commonsense judgment. It is a judgment of the wise, of those who are in the habit of making such judgments. They are subjective. They are as subjective as sitting in the moment, interpreting the physical signs as they present themselves, and falling back on one's acquired habits of determining how sick a patient is. It relies on the qualitative assessment of those sitting in the circumstances. However, the judgment should not just be one of proportionally comparing the bad effect to the good effect. Rather, I agree with Knauer's assessment: one should judge whether the action is commensurate to the whole of the endeavor. Knauer offers the following example and explanation:

> A student may desire to learn the most possible. He can be successful in this pursuit only if he interrupts his work from time to time. If he is so bent on his objective of learning that he injures his own health, perhaps for a short time he may achieve something above average but the result on the whole will be less. In an extreme case he becomes sick from overwork and cannot accomplish anything. Then in the last analysis he contradicts his own purpose. Something similar happens in any immoral act. An objective is sought which has an appropriate price (*tantum—quantum*), but it is sought at any price. In unmeasured desire there is sacrificed what alone would assure the greatest possible achievement of the end.[64]

While pain control and maintaining the dignity of a patient are definite goods that have a price, the question remains: What price? Should they be sought at any price? With Knauer's explanation, we find a method that not only considers the effects and the immediate situation, but rather the whole of the endeavor. Knauer asks that we keep a perspective.

When applied to medicine and PDE as it relates to end-of-life care, it seems that morphine or benzodiazepines are proportional to our goal to treat the patient's pain, even if it results in a shorter life. To treat the patient's pain by giving a bolus of potassium chloride in order to terminate life does not seem proportional, because life is a necessary presumption for pain or any other disease. We should keep in perspective the end or the goods that our profession holds. At the very highest-level sits life itself, for it is the necessary presumption of any goal that we can hope to achieve, including alleviating pain. To have a good end, relief of pain, achieved by the means of terminating life, seems incongruous. This incongruity not only exists in regard to the particular patient, but also with the entire endeavor of medicine, which has life as a necessary presumption. The action of terminating life is incommensurate with the whole of the endeavor of caring for patients because it denies the necessary presupposition of life in caring for patients.

Conclusions

In moving through the complexity that surrounds the care of the dying, I have attempted to see the practical, commonsense boundaries of actions that have moral dimensions. The whole of the event must be evaluated. The beginning of all action of value is intention. We must intend to act before a moral valuation can be applied to any action, including those surrounding the care of the dying. Antecedent to intention, one finds deliberation—taking into account all known variables with a healthy dose of honesty about unrecognized presumptions. As one philosopher puts it, common sense considers the particulars of each case and discerns the appropriate action.[65] I have attempted to show that intention plays a central role to all action and that it is the primary determinate of causation. This relation between intention and causation is true not only in regard to end of life care, but every medical encounter.

It is certainly true that providing care to the dying sometimes induces a desire for death in the patient, the family, and the providers. As pointed out above, the proponents of euthanasia and physician-assisted suicide support such measures out of a sense of compassion for a fellow human being. However, certain actions exist that cannot be re-described in terms of their consequences. It seems odd to construe terminating life as treating pain, cancer, or congestive heart failure. As Devine states, some actions are of such moral significance that they cannot be characterized in terms of their consequences.

The proportionality clause is usually defined as the desired effect proportional to the undesired effect. I think we should begin to understand the qualitative importance of this clause to the entire endeavor of care for the dying. Often we intervene in cases where intervention only leads to prolonging the inevitable. Perhaps if we let more people die of concomitant illnesses like infection, we would not have to look to euthanasia as an option. I have attempted to show how allowing a patient to die where medical

intervention is cumbersome, fruitless, or undesired, is morally different from actively or passively taking the life. Perhaps the presentation of the statistical data could be balanced by the addition of quality of life predictions. This will undoubtedly lead to objections that we are not being objective or that we are coloring our patient's decisions by discussing quality of life as understood by the doctor or the medical community. But I ask you to look at the alternative.

The alternative relates to what Martha Minow refers to as a lie.[66] She refers to a lie which,

> ...depends on the very idea that some line would remain between abuse and nonabuse in a regime permitting assisted suicide. The lie is the denial that such a regime reaches beyond vulnerable patients to all patients, dying or not; to all family members, self-serving or not; and to all physicians, those who endorse suicide assistance and those who do not. The option of medical assistance in dying would alter the menu for all involved. It would turn the continuations of living into a question, open for debate, doubt, and persuasion.[67]

In other words, a right to have a physician assist you in suicide makes staying alive a daily choice.[68] If we change the law, we are changing the face of medicine. A similar thing has already happened in the case of Do Not Resuscitate (DNR) orders. Patients with terminal illnesses are given the option of resuscitation in the event that a cardiopulmonary arrest ensues. Should the patient request resuscitation, there is a subtle, implicit pressure for her to justify why she refuses to be DNR. The option to assist in suicide will result in subtle changes and understanding in the doctor-patient relationship.

While the principle of double effect stems from ancient notions about intention, action, proportionality, and what can be done legitimately in the pursuit of good, it remains important for us today. We should not dismiss it as purely theological or philosophically cumbersome because it has roots in commonsense morality. The principle, as it stands today, is an attempt to encapsulate the lived experience of real people. It calls for prudence in intention, judgement in weighing qualitative differences and honesty in describing the means to an end. The principle is not a euphemism for euthanasia, because it reveals truths about all action, whether taken at the end of life or in any medical situation. Every action in medicine has both desired and undesired effects. This is a commonsense observation. Are we morally culpable for the unintended side effects? Certainly we do not intend renal failure in treating a fungus that is only susceptible to Amphotericin B. If the patient's life is at stake, we might push the limit of giving Amphotericin B and not intend the subsequent renal failure if all the precautions were taken. While we might be legally culpable for the renal failure, at least we are not morally culpable.

Finally, what is the distinction between moral culpability and legal culpability? As stated above, PDE arose from ancient notions. The ancients believed that while one might escape the long arm of the law, one would not escape the hand of God. This argument relies heavily on thirteenth-century notions of God, and does not satisfy modern questions. One might ask: "Once the legal restriction is removed, who cares about moral

culpability?" I believe it does have an effect on the clinical encounter that escapes the theological trappings of thirteenth-century thought. When participating in questionable actions, something changes within the actor. Drawing on the ancient notion of actions having an ontological effect on the actor, one could argue that choosing to participate in euthanasia or physician-assisted suicide changes who one is and how one sees oneself. It changes who we are as physicians. At first our self-perception may not change. However, over time we will begin to change how we see and understand our roles as physicians. Our understanding of the clinical encounter will begin to change, and ultimately, our perception of the patient will change. As Minow points out, once euthanasia, active or passive, is an option, everything will be different.[69] We might be able to change the law, but in participating in euthanasia, we will change our roles as physicians and it will change the perceptions of those for whom we care. The principle of double effect allows us to care for our patients, to alleviate their pain and suffering, without requiring us to fall down the slippery slope into a condition where patients might feel pressured, whether explicit, implicit, or unreal, into something that they really do not wish to do. It allows us, as physicians to provide care without changing our understanding of ourselves as healers into understanding ourselves as assistants of death. Such a change may have irrevocable damage on our relationships to our patients.

Endnotes

[1] Pierre Teilhard de Chardin, *The Divine Milieu*, (New York: Harper and Row, 1960): 53. Originally published as *Le Milieu Divin*, Paris: Editions de Seuil, 1957. De Chardin declares intention as incomplete to the human endeavor. Intention makes action alive, but it is as action that the realness exists.

[2] Philip E. Devine, "The Principle of Double Effect," in the *American Journal of Jurisprudence* 19 (1974): 44.

[3] Thomas Nagel, *The View from Nowhere* (Oxford: Oxford University Press, 1986): 175-180.

[4] See Daniel Callahan's critique of PDE. He criticizes various older interpretations of PDE in *Abortion: Law, Choice and Morality* (London: Collier-Macmillan, 1970): 422-426.

[5] Timothy E. Quill, Rebecca Dresser, and Dan W. Brock, "The Rule of Double Effect—A Critique of Its Role in End-of-Life Decision Making," in the *New England Journal of Medicine* 337: 1768-1771, 1997. See also Timothy E. Quill, Bernard Lo, Dan W. Brock, "Palliative Options of Last Resort: A Comparison of Voluntary Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia," in the *Journal of the American Medical Association* 278: 2099-2104, 1997. See also Callahan, 428-429.

[6] Quill, Lo, and Brock, "Palliative Options," 2101.

[7] Quill, Dresser, and Brock, "Rule of Double Effect," 1770-1771.

[8] Francis Dominic Degnin, "Levinas and the Hippocratic Oath: A Discussion of Physician-Assisted Suicide," in *Journal of Medicine and Philosophy*, 22: 99-123, 1997. Here Degnin argues that both sides of the euthanasia and physician suicide debate have at their heart a certain compassion. No one can therefore argue that his or her opponent is at his or her core somehow evil for holding a different view.

[9] Donald B. Marquis, "Four Versions of Double Effect," in the *Journal of Medicine and Philosophy* 16:515-544, 1991.

[10] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, Fourth Edition, (New York: Oxford UP, 1994): 207. Various versions of PDE are in existence. See also Marquis, 515-544. Thomas J. Bole, III, "The Theoretical Tenability of the Doctrine of Double Effect," in the *Journal of Medicine and Philosophy* 16: 467-473, 1991, has reduced PDE to two criteria: "1. The harms are not intended but brought about as side effects and 2. There are sufficiently serious moral reasons for doing what brings about such harms," 476.

[11] Timothy Quill, "The Ambiguity of Clinical Intentions," in the *New England Journal of Medicine* 329: 1039-1040, 1993. See also Quill, Dresser, and Brock, "Rule of Double Effect," 1770.

[12] Edmund Pellegrino, "Doctors Must not Kill," in the *Journal of Clinical Ethics* 3: 95-102, 1992.

[13] Brody, 113.

[14] Brody, 113.

[15] Nancy Davis, "The Doctrine of Double Effect: Problems of Interpretation," in *Pacific Philosophical Quarterly* 65 (1984): all pages.

[16] Anthony Kenny, "The History of Intention in Ethics," in *The Anatomy of the Soul* (Oxford: Blackwell, 1973): Appendix 129-147. Augustine was a fifth-century thinker who lived in North Africa. Abelard was an twelfth century thinker in France.

[17] Thomas Aquinas, *Summa Theologiae*, IIa-IIae, q. 64. This question deals with the legitimate reasons one may take the life of another. For the purposes of this paper, I will use the Black Friars edition. This volume edited and translated by Marcus LeFebure, Volume 38 (New York: McGraw-Hill, 1975): 19-47.

[18] J. Ghoos, "L'acte a double effect: Etude de theologie positive," in *Ephemerides Theologicae Lovaniensis* 27: 30-52, 1951.

[19] Joseph T. Mangan, "An Historical Analysis of the Principle of Double Effect," in *Theological Studies* 10: 41-61, 1949.

[20] Mangan, 41-43.

[21] Thomas Aquinas, *Summa Theologiae*, Ia-IIae, question 55, article 1, translated and edited by W. D. Hughes, Black Frairs edition (New York: McGraw-Hill, 1975): 9.

[22] Janssens, 40-93.

[23] Mangan, 52.

[24] Mangan, 54.

[25] Mangan, 56-57.

[26] Though both of these cases exist in various forms in other places, I have used Nancy Davis's version, 109.

[27] See Callahan, 422-426.

[28] See Peter Knauer, "The Hermeneutical Function of the Principle of Double Effect," in *Moral Theology: Moral Norms and Catholic Tradition*, Volume 1, edited by Charles Curran and Richard McCormick (New York: Paulist Press, 1979): 20. See also Joseph Boyle, "Who is Entitled to Double Effect?" in the *Journal of Medicine and Philosophy*16 (1991): 480. See also Alan Donagan, "Moral Absolutism and the Double Effect Exception: Reflections on Joseph Boyle's 'Who is entitled to Double Effect?'" in the *Journal of Medicine and Philosophy* 16 (1991): 497.

[29] Donagan, 496.

[30] See Davis, 107-123.

[31] Edmund D. Pellegrino, "The Place of Intention in the Moral Assessment of Assisted Suicide and Active Euthanasia," in *Intending Death: The Ethics of Assisted Suicide and Euthanasia*, edited by Tom L. Beauchamp, (New Jersey: Prentice Hall, 1995): 163.

[32] Pellegrino, "Place of Intention": 163.

[33] William E. May, "Becoming Human in and through Our Deeds," in *Becoming Human: An Invitation to Christian Ethics* (Dayton: Pflaum Publishing, 1975): chapter four, 79-112. Here May argues that

consequentialist ethicists rely to heavily on the goodness of the consequences of enacted intentions. He holds that intentions resulting in good results do not justify a bad means. Intent plus content results in morally acceptable results.

[34] Joseph Fletcher, *Situation Ethics: The New Morality,* (Philadelphia: Westminster Press, 1966): 26-28.

[35] Fletcher, 26-28.

[36] See the article by Knauer, 1-39. See also Louis Janssens, "Ontic Evil and Moral Evil," in *Readings in Moral Theology: Moral Norms in the Catholic Tradition*, Volume 1, edited by Charles Curran and Richard A. McCormick, (New York: Paulist Press, 1979): 40-93. Knauer argues for a notion of commensurality that takes the whole of the endeavor into consideration. Janssens argues that one must distinguish between ontic and moral evil. What is strictly prohibited is moral evil, while an ontic evil can be permitted if a higher good is permitted.

[37] Knauer, 1-39.

[38] Janssens, 40-93.

[39] Thomas J. Bole, III, "The Theoretical Tenability of the Doctrine of Double Effect," in the *Journal of Medicine and Philosophy* 1991 16: 469.

[40] Quill, Dresser, and Brock, "Rule of Double Effect," 1768-1771.

[41] Quill, Lo, and Brock, "Palliative Options," 2099-2104. See also Callahan, 428-429.

[42] Pellegrino, "Place of Intention": 164-165.

[43] Quill, "Ambiguity," 1039-1040. See also Quill, Dresser, and Brock, "Rule of Double Effect," 1770.

[44] Quill et al, "Palliative Options", 2102. However, Bernard Lo, who co-authored this paper, seems to recognize the differences in these distinctions. See Ann Alpers and Bernard Lo, "Does It Make Clinical Sense to Equate Terminally Ill Patients Who Require Life-Sustaining Interventions with Those Who Do Not?" in the *Journal of the American Medical Association*, 277: 1705-1708, 1997.

[45] Howard Brody, "Causing, Intending, and Assisting Death," in the *Journal of Clinical Ethics*, 4:112-117, 1993.

[46] Thomas Aquinas, *Summa Theologiae*, Ia-IIae, q. 6 a. 3, Volume 17, edited and translated by Thomas Gilby (New York: Black Friars/McGraw-Hill, 1970): 15-17.

[47] Albert Di Ianni, "The Direct/Indirect Distinction in Morals," in *Moral Theology: Moral Norms and Catholic Tradition*, Volume 1, edited by Charles Curran and Richard McCormick (New York: Paulist Press, 1979): 215. Here Di Ianni points out that Thomas, in the above citation, argues that permitting a harm in an act of omission is indirect. The author also points out that Medina Vaqueez is the first to argue the same is possible in acts of commission. Regardless, the point remains that if one intends harm either by an act of omission and an act of commission one has directly caused the harm. If one sees a potential harm but does not intend the harm then one has indirectly caused the harm. This does not result in moral culpability.

[48] I am indebted to Mark Lowery for pointing out this difference to me. He is Associate Professor of Theology at the University of Dallas.

[49] *Compassion in Dying v Washington*, 79 F3d 790 (9th Cir), *cert granted sub nom, Washington v. Glucksberg,* 135 Led2d 1128 (1996). *Vacco v. Quill*, 80 F3d 716 (2nd Cir), *cert granted*, 135 Led2d 1127 (1996).

[50] Alpers and Lo, 1706.

[51] Alpers and Lo, 1705-1708.

[52] Alpers and Lo, 1707.

[53] Brody, 112-117.

[54] Kevin Wildes, "Ordinary and Extraordinary Means and the Quality of Life," in *Theological Studies* 57: 500-512, 1996. Here Wildes argues that, while means are objectively discernable, the decision of whether or not to proceed with an intervention is subjectively made within the context of the life story of the person.

[55] Brody, 114.

[56] Wildes, 506-507.

[57] Brody, 113.

[58] See the quotation cited in number 17. See also Thomas Aquinas, *Summa Theologiae*, Ia-IIae, 20, 2.

[59] May, 102-103.

[60] Knauer, 1-39 and Janssens, 40-93. See also Richard McCormick in "Notes," *Theological Studies* 37: 73-74, 1976 and 39: 93, 1978.

[61] Devine, 48-49.

[62] Devine, 48-49.

[63] Knauer, 11.

[64] Knauer, 12.

[65] Bernard J. F. Lonergan, *Insight: A Study of Human Understanding* (New York: Harper & Rowe, 1978). See chapters 6 and 7, which are devoted to common sense.

[66] Martha Minow, "Which Question? Which Lie? Reflections on the Physician-Assisted Suicide Cases," in *The 1997 Supreme Court Review* (Chicago: University of Chicago Press, 1997): 21-23.

[67] Minow, 22.

[68] Minow, 22-23.

[69] Minow, 22-23.

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