

The Linacre Quarterly

Volume 60 | Number 2

Article 12

May 1993

The Principle of Double Effect and Safe Sex in Marriage: Reflections on a Suggestion

Mark A. Johnson

Follow this and additional works at: <http://epublications.marquette.edu/lnq>

Recommended Citation

Johnson, Mark A. (1993) "The Principle of Double Effect and Safe Sex in Marriage: Reflections on a Suggestion," *The Linacre Quarterly*: Vol. 60: No. 2, Article 12.

Available at: <http://epublications.marquette.edu/lnq/vol60/iss2/12>

The Principle of Double Effect and Safe Sex in Marriage: Reflections on a Suggestion

by

Mark A. Johnson, Ph.D.

The author is Assistant Professor, Department of Philosophy and Religion, Saint Joseph's College, Rensselaer, IN. His principle interest in moral theology is the thought of St. Thomas Aquinas. He received his Ph.D. in Medieval Studies at the University of Toronto in 1990.

The calls for "safe sex" education have increased recently in the wake of the tragic revelation that the basketball mega-star, Earvin "Magic" Johnson, has contracted the HIV virus, which leads to the Acquired Immune Deficiency Syndrome, or AIDS. Johnson acquired the virus during his sexual liaisons with hundreds of women on road-trips, and while no mention is made of the fate of the many women who may have contracted the virus from him, his celebrity and personal charisma have served as a rallying-point for advocates of "safe sex" as a way to stop the spread of the HIV virus. Johnson himself is now understandably a belated advocate of "safe sex."

Advocates of safe sex agree that sexual abstinence is the only foolproof way to avoid contracting the HIV virus through sexual relations, but insist that it is unrealistic to expect that people will simply desist from sexual activity for fear of contracting HIV. Given this, they have turned their attention to "safe sex," the use of a latex condom during sexual intercourse, as the most effective way both to engage in sexual relations and reduce, though not eliminate, the chances of contracting HIV. In heterosexual relations, the male partner's wearing of the condom is beneficial to both himself and the female partner. If he is infected, it prevents his virus-carrying semen from ever entering the vagina, such that any lesions in the vagina or cervix of the woman will not become sites for the virus's entry. If the female is infected, the coverage that the condom affords the male will mean that any virus-carrying traces of blood or vaginal mucosa will not come into contact with the penis, thus preserving the male from infection, since the penis could itself have lesions that would be sites of the virus's entry.

Admittedly the principal target for campaigns of safe sex are those who engage in extra-marital sexual relations, whether heterosexual or homosexual. Since the

Catholic Church's restriction of sexual activity to marriage endures, its own obvious and simple response — critics say "simplistic" — to calls for safe sex is itself a call to sexual abstinence until marriage for heterosexuals, or to perpetual celibacy for confirmed homosexuals.¹ Traditional Catholic teaching thus provides direction, albeit unpopular direction for many, to most cases that would otherwise be subject to the practice of safe sex.

"Safe" Sex Not a Reality

I personally very much support this stance, especially because the "politically correct" presentation of safe sex seems to me to be quite misguided. With reports of condom breakage of four to five percent, coupled with a general method failure rate of twelve to fifteen percent — thus potentially yielding a combined failure rate of up to twenty percent! — it is statistically quite possible that one in five "safe sex" sexual unions is anything but safe. Even should someone insist upon the value of condom usage in order to have "safe sex," or "safer sex," as it is now more correctly called, even then the sexually active person must use a condom in *every* single sex act. Not very likely. A young, libidinous population that has been fed the message of "have sex with anyone you please, just wear a condom" will be habitually quite unprepared, it seems to me, to deal with the occasion for sexual activity when, alas, a condom is nowhere to be found. They are quite likely to think that, just this once, they will do without. How many people have gotten HIV because, just once, they did without? The safe sex campaign is quite unrealistic, and it continues to refuse to hear the salutary message that sexual abstinence is the only real way to safeguard the health of those who could engage in sexual activity. But then, abstinence requires self-control, something quite foreign to modern culture. Again and again, Catholic teaching on the nature and purpose of human sexuality, with its resultant teaching on homosexuality, pre-marital and extra-marital sex, should make more sense to a population desperately in need of the wisdom it provides.

But what about the occasional, deplorable case of a *marriage* in which one of the spouses has become infected with HIV? That spouse will obviously not want to infect the other spouse. Forgetting for a moment the foolhardiness of the broader "safe sex" campaign, is there perhaps room in Catholic thought for the practice of safe sex within a recognized marriage? David F. Kelly, the noted moral theologian, thinks that there is room, and in a recent book makes his case using the principle of double-effect. In this note I will present Kelly's suggestion, and raise some doubts about the solidity of his argument. I shall then close with some broader comments of my own.

David Kelly's Suggestion

The book for which Kelly is best known in Catholic moral theology is his *The Emergency of Roman Catholic Medical Ethics in North America*, a historical presentation of medical ethics in America as a discipline undertaken by Catholics.² As a medical ethicist himself, Kelly was an interested observer in the

history and methodologies he reported, and he considered most of pre-Vatican II Catholic medical ethics to have suffered from what he calls "physicalism," an approach to moral evaluation that places emphasis — critics will say "undue" emphasis — upon the physical character of an act.³ An argument against the use of a condom for contraceptive ends, based upon the intrinsic teleology of the human reproductive organs, would be considered "physicalist." Kelly is not alone, of course, in his dissatisfaction with physicalism,⁴ and he has come to favor a system of moral evaluation he calls "personalism," which as near as I can tell is another name for the system otherwise called "proportionalism."⁵ Proportionalism as a moral method insists that the morality of an act be assessed on all the factors of the act, including the agent's intention and present circumstances. Assessing an act on the basis of its physical character alone, proportionalism maintains, is only a very partial view of the whole act. Such an assessment, in fact, is "pre-moral," and physical disvalues produced by an act may well be justifiable if there is proportionate reason.

Kelly's latest book, *Critical Care Ethics: Treatment Decisions in American Hospitals*, manifests his continued dissatisfaction with physicalism, and his support of personalism.⁶ The book itself is a collection of papers concerning issues in critical care medicine, particularly issues of the withdrawal of treatment in medically hopeless cases — parenthetically, I find Kelly's humane arguments on this generally persuasive, materially speaking.⁷ It contains four appendices that provide concrete suggestions to hospitals about various issues. Appendix D (pp. 204-208), my concern henceforth, concerns AIDS, and the possibility of distributing condoms in Catholic hospitals.

It would be very difficult to deal justly with the entirety of this appendix, since in it Kelly is compelled to deal with a host of complicated, allied issues: the "safety" of condoms in avoiding HIV transmission, the reasons for teenage sexual activity, contraceptive mentality, material and formal cooperation, the politics of the United States Catholic Conference, on and on. He is convinced that Catholic hospitals may provide not only condom education to individuals but also the condoms themselves (p. 205). And he thinks that even those who are leery of such involvement can justify it according to the notion of material, that is, remote, cooperation (p. 206).

My interest in Kelly's comments does not have so much to do with the policy-decisions he is urging Catholic hospitals to make as it does with how he thinks about, and describes, the sexual act in which a condom is used to avoid HIV transmission. More than once Kelly says that the use of a condom during sexual relations in order to avoid HIV transmission is "not contraceptive" (pp. 206, 208). When he justifies his point by noting that "contraception is only *one* of the purposes of condom use; it is not the only purpose" (p. 206), one might think that he has in mind the case, say, of a man who suffers from slight bladder leakage, who wears a condom throughout the day in order to avoid spotting his pants. But this is not what Kelly has in mind. He rather means to say that the use of a condom during sexual relations in order to avoid HIV transmission is not contraceptive because the couple who uses this method is intending to avoid HIV transmission, not the conception of a child. "In most cases it is not at all a question

of preventing pregnancy. Where contraception is intended — to prevent AIDS in the baby — the purpose surely is not 'selfish contraception' or a 'contraceptive mentality' This is an indirect contraception, and the prevention of AIDS transmission is sufficiently important to give it moral warrant" (p. 206). In short, for Kelly, the intention of the couple employing safe sex in marriage and that of those who are trying to avoid a child are different, a difference that is morally significant.⁸ And it is at this point that my reflection upon his suggestion leads to some questions.

There is a very real sense, of course, in which the claim that "the intention of the couple employing safe sex in marriage and that of those who are trying to avoid a child are different" is true. The goal of each couple, what each is "after," is different. In the former case the couple is "trying not to spread HIV," and in the latter case the couple is "trying not to have a child." And if one takes the term "contraception" in strict accordance with its etymology, "against contraception," then Kelly's claim that safe sex in marriage is not contraceptive would seem to ring true, if only because the couple practicing safe sex in marriage is in all likelihood not even *thinking* about having a child. All the same, I wonder whether it is not as easy as all this. I shall elaborate my misgivings shortly, but first I need to mention briefly the notion of double-effect that is operating in the background here.

This well-known principle is traditionally invoked to help assess the morality of an act in which both good and bad results are foreseen. Though its remote origin is thought to be Thomas Aquinas's treatment of killing in self-defense, or his treatment of scandal,⁹ its more modern, codified treatment is generally attributed to the French Jesuit, Johannes Gury (1801-1866).¹⁰ A reliable, modern statement of the principle is as follows:¹¹

When an act is foreseen to have both beneficial and harmful results, the following conditions must be met in order for it to be morally correct:

1. The directly intended object of the act must not be intrinsically contradictory to one's own fundamental commitment to God and neighbor (including oneself).
2. The intention of the agent must be to achieve the beneficial effects and to avoid the harmful effects as much as is possible (the harm must be only "indirectly" intended).
3. The foreseen beneficial effects must be equal to, or greater than, the foreseen harmful effects.
4. The beneficial effects must follow from the action at least as immediately as the harmful effects do.

The principle of double effect depends heavily upon the notion of the agent's real intention in an action and the role of the means in attaining the end. The doctor confronted with the classic case of a pregnant woman's having uterine cancer is able to justify the morality of the death of the unborn child because his action of removing the entire uterus conforms to each of the conditions given in the principle of double effect.

- Condition 1:** His immediate deed or action, the removal of a uterus diseased with cancer, is not contradictory to his relationship to God or neighbor, but is an application of the principle of totality, according to which a lower function provided by a part of the body may be sacrificed when diseased in order that the total function of the whole body may continue.
- Condition 2:** The doctor undertakes the removal of the cancerous uterus to prevent the cancer from metastasizing to other members of the woman's body, thus saving her life. According to his judgment, the entire uterus must be removed, the presence of the unborn child in the uterus notwithstanding, though he would be delighted if the woman had not been pregnant.
- Condition 3:** The ultimate goal of the medical treatment, the saving of the woman's life, stands in equal proportion, as life, to the lost life of the child in the womb.
- Condition 4:** The medical goal of saving the mother's life is as immediately accomplished by the removal of the uterus as is the death of the child, since the one act of removing the uterus prevents both the cancer's metastasis to other bodily members, and the access of the unborn child to the continued nutrition and protection necessary for its life.

Turning to the case at hand, it might seem that the principle of double effect as traditionally described could be used to justify safe sex within marriage, since what a couple intends in such sexual relations is the non-transmission of HIV, and not the non-conception of a child. Again, Kelly maintains that such sexual unions are "not contraceptive," because their goal is saving lives, not preventing new lives. The goals are different, then. And, Kelly claims, the prevention of pregnancy is not the means to the saving of life (p. 208).

Yet for all that, I think there is another sense in which it is true to say that the couple contracepting and the couple practicing safe sex are actually intending *the very same thing* if we really examine the actions performed in their concrete reality. What has been missing thus far is the distinction between the proximate and remote intentions in these acts, and this distinction must be borne in mind in any attempt to use the principle of double effect.

It can be said that the "intention" of the contracepting couple and that of the couple practicing safe sex is different, but only when we look to what the *remote intention* of either couple is. True enough, each couple engages in certain behavior in order to attain a certain goal, and the goals are different: preventing pregnancy on the one hand, avoiding HIV transmission on the other. Yet when we examine the behavior each couple performs in order to attain their remote goal, we see that that behavior is exactly the same: the use of a condom in order that the ejaculation that is the immediate goal of the sex act from the man's perspective not enter the vagina, the ejaculate's proper receptacle. This is the

proximate intention of each couple, and it is identical. And this identical proximate intention is the means by which each couple attains to its remote goal. The contracepting couple's goal is attained because the fact that the ejaculate does not even enter the vagina means that the spermatozoa contained in it cannot make their way through the cervix up into the fallopian tubes to penetrate the ovum. And the goal of the couple practicing safe sex is attained because the fact that the ejaculate does not enter the vagina means that HIV-carrying semen cannot come into contact with the vaginal walls or the cervix, and hence any lesions that may be there, thus preserving the woman from infection.

The question in assessing the moral appropriateness of the use of condoms in safe sex in marriage thus becomes whether the direct object of the act, its proximate intention, is compatible with human intelligence and recognized human needs. Here I am compelled to suggest that it is not. I do not see how we can intelligently have as our proximate goal in the voluntary sex act the non-disposition of the semen in its proper receptacle when in fact the whole purpose of the sex act, as a sex act, is precisely its proper disposition. Our employment of condoms in the case of safe sex, and condoms, diaphragms, spermicidal foams and jellies in the case of contraception, is implicitly a recognition of this very fact. It might be objected that such a consideration of human sexual morality is "physicalist," because it would seem to reduce the morality of an action to the teleology of the sexual organs, thus approaching a Stoic notion of natural law. This sort of objection, which Kelly himself intimates (p. 94), is made often nowadays in reaction to Catholic teaching on the integrity of the sex act. In fact, the objection is often made precisely on behalf of human intelligence, in order that it be given its proper due as the distinguishing feature of human beings, and not be held captive to the teleologies inherent in the body.

Yet if we assert an epistemology of moderate realism, according to which as embodied spirits we know first and best material things, and our voluntary actions are concerned with physical things, and proceed from and through physical organs — the brain, our eyes, hands, the sexual organs — then it becomes anachronistic to say that the moral assessment of human sexuality is "physicalist" because it treats very seriously the inherent directedness of human sexual architecture. For the moderate realist it is the body, our experiences with it, and through it, that teaches us what we really are, and what we need in order to be complete, to be happy.

On the other hand, according to a phenomenological epistemology — proportionalism is very dependent upon Schelerian and Heideggerian epistemology and metaphysics — the mind is cognitively prior to the body and is the ultimate source of meaning and importance for human moral conduct (even conduct that concerns bodily activity that otherwise has its own directedness), a cognitive priority that results in intuitions of "pure moral values," not garnered from sensible experience, but from the mind's apprehension of itself and its thought-forms. The difficulty this view presents for moral methodology, however, is that once we deny the body a direct voice in establishing what needs our decisions must bear in mind in the moral life, it becomes difficult to discern criteria for including the body and its structures in our decisions at all.¹²

Author's Suggestion

I would rather suggest that our human intelligence, our intellect, whose chief function is to discern and dwell upon order, tells us that our personal bodily architecture is essential to what we are — it is true that we are not just bodies, but we are *at least* bodies — and manifests to us our needs as embodied spirits created by a God whose design of nature manifests in varying ways his splendor. In this view, for us to use our sexual powers in a way contrary to their design is for us thus to embrace an untruth about our relationship to ourselves as sexual beings and to God Who desires that in understanding ourselves and other things in nature we move towards having some understanding of Him, our final goal.¹³

In the end then, my contention is that the suggestion that safe sex within marriage could work within the context of the principle of double effect is incorrect, since the proximate intention of the act of safe sex is the very same as that of the contracepted act. Given that, I am compelled to suggest that safe sex fails the first of the four conditions found in the principle of double effect, namely that the directly intended action not be intrinsically contrary to one's commitment to God and neighbor, since to perform the act we must embrace as intellectually compatible the performance of the sex act, whose immediate goal is the ejaculation of the semen in its proper site, while performing it in such a way that that not really happen. And to do this, our mind, which sees the order of things, must embrace disorder. And embracing intellectual disorder is the antithesis of human fulfillment.

Notes

*Thanks are due to Fr Benedict Ashley, O.P., who read this article in its entirety, and who made some very important suggestions. He is not, of course, responsible for what I say.

1. The latter claim is made in the Congregation for the Doctrine of the Faith's *Letter to the Bishops of the Catholic Church on the Pastoral Care of Homosexual Persons* (October 1, 1986), which drew much critical attention. For a volume of critical studies on the letter see *The Vatican and Homosexuality: Reactions to the "Letter for the Bishops of the Catholic Church on the Pastoral Care of Homosexual Persons."* Of the twenty-five articles in the volume, only two, by Bishop John Quinn and Benedict Ashley, explicitly support the letter. See Ashley's measured study, "Compassion and Sexual Orientation," on pp. 106-111. Ashley notes that there is not necessarily a clear distinction between heterosexuals and homosexuals, since some heterosexuals may have some homosexual leanings, and vice versa.

2. David F. Kelly, *The Emergence of Roman Catholic Medical Ethics in North America: An Historical, Methodological, Bibliographical Study* (Toronto: Edwin Mellen Press, 1979).

3. *Ibid.*, pp. 244-274, 416-429.

4. See, for instance, Charles E. Curran, *Transition and Tradition in Moral Theology* (Notre Dame: University of Notre Dame Press, 1979), pp. 3-43; *id.*, *Tensions in Moral Theology* (Notre Dame: University of Notre Dame Press, 1980), p. 76; *id.*, *Moral Theology: A Continuing Journey* (Notre Dame: University of Notre Dame Press, 1982), p. 144.

5. For a general overview of proportionalism and its intellectual origins, together with a bibliography of the seminal articles and other sources, see Bernard Hoose, *Proportionalism: The American Debate and its European Roots*, (Washington: Georgetown University Press, 1987). One could add to this John A. Gallagher's *Time Past, Time Future: An Historical Study of Catholic Moral Theology*, (New Jersey: Paulist Press, 1990), although his stated intention is not to present and explain proportionalism, to which he is an adherent.

6. David F. Kelly, *Critical Care Ethics: Treatment Decisions in American Hospitals* (Kansas City: Sheed and Ward, 1991). I shall refer to this work henceforth by page number, in the body of the text.

7. I do have concerns about the more methodological or formal character of Kelly's thinking, as will be pointed out below. To anticipate, I am concerned that the strains of phenomenological epistemology that "drive" the proportionalist system of moral evaluation render Kelly's account of intention vague, leaving it bearing insufficient relation to the concrete causality of the actions we actually perform.

8. Although Kelly himself is by no means one who necessarily opposes the use of contraception, as is clear from pp. 93-94, and from a discussion I have had with him in November, 1991.

9. See *Summa theologiae*, II-II, q. 64, a. 7 for self-defense, and *ibid.*, q. 43, *passim*, for scandal. The generally vague notion of "double-effect" seems in fact to have been a more or less common instrument in dealing with particular cases in Thomas's time, and in fact in my studies of quodlibetal questions dating from during Thomas's writing career I have encountered unpublished questions in manuscripts that ask the very question "Should a doctor give medicine to a pregnant woman knowing that it will kill the child, but without which medicine both will die?"

10. Johannes P. Gury, S.J., *Compendium theologiae moralis* (Lyon, 1850), vol. 1, pp. 4-5: "Licet ponere causam ad bonum effectum, quamvis ex ea sequatur effectus malus, si adsint sequentes condiciones, scilicet: 1) Si finis agentis sit honestus; 2) Si causa sit in se bona, vel indifferens; 3) Si bonus effectus aequae immediate ac malus ex causa sequatur; 4) Si bonus effectus malum saltem compenset." The literature on the principle of the double-effect is massive, but some more recent articles are: Daniel F. Montaldi, "A defense of St. Thomas and the Principle of Double Effect," *Journal of Religious Ethics* 14/2 (1986) 296-332; Joseph M. Boyle, "Praeter Intentionem in Aquinas," *The Thomist* 42 (1978) 649-665. The study to which all modern Catholic scholarship refers is that of Joseph Mangan, S.J., "An Historical Analysis of the Principle of Double Effect," *Theological Studies* 10 (1949) 41-61.

11. I am paraphrasing here the account of the principle found in B. A. Ashley's and K. D. O'Rourke's *HealthCare Ethics: A Theological Analysis*, 3rd ed. (St. Louis: Catholic Health Association, 1989), p. 185. See *ibid.*, pp. 184-188 for a fuller treatment.

12. See Kelly, p. 94, where, in the context of claiming that the body's design and teleology should not dictate the morality of an act, he nonetheless claims that "biological and physical aspects are humanly significant." But how, and why, are they significant? Do they have a significance prior to, and independent of, our investing them with other significance? Or do they have significance because we grant it to them, i.e., because we "say so"? Kelly does not say, here or elsewhere in the book.

The criticism I give here is basically a moral theologian's application to moral method of the philosopher Etienne Gilson's criticism of Cartesian and post-Cartesian epistemology, found in his marvelous book, *The Unity of Philosophical Experience*, 2nd ed. (New York: Scribner, 1965), pp. 196-197. Gilson's complaint is basically this: when one decides to begin philosophy or knowledge as a pure mind, from within the mind, and not as an embodied spirit, whose source of knowledge is material things, one has great difficulty ever really getting out of the mind to the world of material things we think we know!

13. This is the sort of approach one finds in Benedict M. Ashley's *Theologies of the Body: Humanist and Christian* (Braintree, Mass.: The Pope John Center, 1985), pp. 360-372.