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Double Effect and Ethical End-of-Life Care: Assessing the Benefits and Burdens of Lethal Treatment (or Lack Thereof)

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Abstract
Given the wide the range of legally available options for end-of-life care in recent decades: from aggressive, even experimental, treatment to active euthanasia, our ethical analysis struggles to keep pace with technology and law. In this essay I show that the principle of double effect (PDE) remains, and will continue to be, a useful tool for ethical analysis of end-of-life care. According to PDE, an agent may ethically perform an act that s/he foresees will have a significant bad effect (e.g., death) in addition to a good effect (e.g., pain relief) only if s/he does not intend the bad effect, the act is not bad for reasons other than its causing the bad effect, and there is a proportionately serious reason to act.

Following a brief explanation of PDE and preliminary considerations in favor of counting death as a bad effect, I analyze several end-of-life options in terms of the principle. I begin with those that enjoy significant consensus among proponents of PDE: active euthanasia, "passive euthanasia," and palliative care. Then I consider the less-straightforward cases of drug provision, refusing food and water, and terminal sedation, arguing that participation in such actions is justifiable via PDE only under very limited conditions.

Cover Page Footnote
My earlier paper on a similar topic was presented at the 2016 annual conference of University Faculty for Life at Marquette University, Milwaukee, WI, USA and is forthcoming in Life and Learning XXVI (2016). A few short passages from that earlier paper may be recognizable in the current one; I thank Fr. Joseph Koterski (editor) for the relevant permission. I thank the UFL conference participants for helpful feedback on the earlier paper and for helpful discussion of end-of-life care more generally.

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Heidi Giebel

Introduction

Rapid advances in medicine, along with several countries' increasing tolerance of lethal "medical" procedures, have considerably widened the range of legally available options for end-of-life care in recent decades: from aggressive, even experimental, treatment to refusal of food and water—and, in some cases, even active euthanasia. In the current context, then, doing right and living and dying well require that our ethical analysis keep pace with changes in law.

In this essay I show that the classical ethical principle of double effect (PDE) is a useful tool for ethical analysis of end-of-life care—one that will continue to be applicable as new treatment or non-treatment options, with their various benefits and drawbacks, arise. According to PDE, an agent may ethically perform an act that s/he foresees will have a significant bad effect (e.g., death) in addition to a good effect (e.g., an end to suffering) only if:

1. The agent doesn't intend the bad effect as the end (purpose, goal) of the act;
2. The agent doesn't intend the bad effect as a means to the good effect;
3. The act is not bad in itself (independently of its causing the bad effect); and
4. There is a proportionately serious reason to act (i.e., there is at least as strong a reason to perform the act or to seek the good effect as there is to avoid the bad effect).

After briefly explaining the principle and surrounding considerations regarding the value of human life, I show how PDE can be used to distinguish between acceptable and unacceptable options at the end of life. I begin with the more clear-cut cases such as active euthanasia, which PDE rules out on the grounds that death is sought as a means to ending suffering; and refusal (via withdrawal or non-initiation) of treatment judged to be of insufficient benefit to the patient, which PDE allows for a sufficiently serious reason—even if such refusal hastens death. Then I consider some less-clear cases currently under discussion in medical ethics, including terminal sedation and removal of artificial nutrition and hydration. I argue that such actions are justifiable only in very limited circumstances: they frequently involve intention of death or other significant harm or the acceptance of disproportionately serious side effects and thus fail to satisfy the conditions of PDE.

I. Background: The Principle of Double Effect

As its name suggests, PDE is used to evaluate acts having at least two morally significant effects: one good and one bad. Commonly-cited examples include military operations that accomplish legitimate objectives but result in civilian casualties, surgical procedures that save the lives of pregnant women but cause fetuses' deaths, and—more directly relevant to the current topic—end-of-life care that relieves patients' pain but hastens their deaths. Although similar reasoning appears in much earlier texts, Thomas Aquinas's treatment of killing in self-defense in

his *Summa Theologiae* is often taken to be the *locus classicus* of the principle,[1] which was developed and clarified over the next several centuries. A fairly standard formulation, developed in the 19th century, outlines PDE in terms of four conditions, all of which must be met for morally liceity or permissibility:[2]

1. Acceptable-end condition: The bad effect must not be intended as the end or goal of the act.

2. Acceptable-means condition: The bad effect must not be intended as a means to the good effect.

3. Acceptable-act condition: The act must not be bad in itself (independently of its causing the bad effect).

4. Proportionate-reason condition: The agent must have a proportionately serious moral reason for performing the act (i.e., at least as serious a reason to pursue the good act and/or effect as to avoid the bad effect).[3]

To take a fairly well-known real-life example, St. Gianna Beretta Molla, a 20th-century physician, developed a life-threatening fibroma on her uterus while pregnant with her fourth child. She was offered three options: abortion and chemotherapy, hysterectomy, or removal of the fibroma only.[4] Either of the first two options would result in the death of her unborn child but give Molla an excellent chance of recovery; removal of the fibroma would spare the child but likely bring serious medical complications for the mother. Both Molla and PDE clearly ruled out abortion, which aims bring about the child's death as a means to saving the mother's life: in doing so, it fails to meet the acceptable-means condition. Given that the deaths of Gianna and of her child would be bad in similar and ethically significant ways, and that survival of either would be a similarly serious good, PDE would permit either hysterectomy or removal of only the fibroma: neither aims at the bad effect as an end or means, both are otherwise-legitimate medical procedures, and each would pursue a good sufficiently serious to justify allowing the bad side effect. Molla, valuing her child's life above her own, chose removal of the fibroma only and died from complications just a week after the baby's birth.

[1] Thomas Aquinas, *Summa Theologiae* II-II, q. 64, a. 7, http://www.newadvent.org/summa/3064.htm#article7.
[2] PDE was first explicitly formulated in terms of four necessary conditions by J. P. Gury in *Compendium Theologiae Moralis* v. 1 (Ratisbonae: Georgii Josephi Manz, 1874). As Stuchlik explains, it was originally formulated in terms of liceity rather than permissibility; while permissibility addresses the act more abstractly, liceity addresses whether the agent acts well or badly in performing the act—intention is especially relevant to the latter. He proposes the following principle regarding the relationship between liceity and permissibility: "It is permissible for S to do A in C just in case A could licitly be performed in C in light of reasonable beliefs about the circumstances." (Joshua Stuchlik, "A Critique of Scanlon on Double Effect," *Journal of Moral Philosophy* 9 (2012), 178–99, at 194.)
[3] I borrow this statement of PDE's conditions from an earlier paper: H. M. Giebel, "Ends, Means, and Character: Recent Critiques of the Intended-Versus-Foreseen Distinction and the Principle of Double Effect," *American Catholic Philosophical Quarterly* 81.3 (2007): 447–68. There I explain and support each condition in more depth than space allows here. For a thorough defense of PDE, see T. A. Cavanaugh, *Double-Effect Reasoning: Doing Good and Avoiding Evil* (Oxford: Clarendon, 2006).
[4] For a brief biography and description of Molla's options, see "St. Gianna Beretta Molla," Catholic Online, http://www.catholic.org/saints/saint.php?saint_id=6985.

In most end-of-life cases, unlike Molla's, there is only one life at stake: that of the patient. In applying PDE to such cases, the principle's proponents must acknowledge that the proposed treatment—or refusal of treatment—comes with both a good effect (usually an end or reduction of suffering) and a bad effect (typically death). As I'll discuss in more depth in section III, in some circumstances refusal or withdrawal of life-sustaining treatment can meet all four of PDE's conditions and thus be ethically acceptable. Active euthanasia, by contrast, is never acceptable according to PDE: it aims at the patient's death as a means to ending suffering.

To adopt the sort of ethical analysis just outlined, one must acknowledge the badness of human death—an acknowledgement which, though common and intuitively plausible, is not universal.[5] Given this lack of consensus regarding death's badness, it seems wise to make a case (brief though it must be) in its favor. So to that task I now turn.

II. Interlude: Life is Good (and Death is Bad)

Obviously, anyone applying the principle of double effect to a particular case must affirm that at least one foreseen effect of the act in question is an ethically significant bad effect or harm. No bad effect, no "double effect"; no double effect, no need for PDE. Perhaps the badness of human death is obvious to most of us: after all, the paradigmatic example of something a parent or a doctor would describe as "bad for you" is something liable to cause or hasten your death. (In fact, "bad for you" would seem a serious understatement in some such descriptions: e.g., "Don't go skydiving without a parachute—it's bad for you.") We appear to be biologically and psychologically wired to pursue continued life and avoid (or at least postpone) death. Individually and as a society, we tend to praise and reward those who save lives and to condemn and punish those who take them. But perhaps things get a little more complicated with some end-of-life cases, when life doesn't seem so good—and death doesn't seem so bad—to the person whose life or death is at stake. So this section gives a brief analysis of the badness of death. As with the defensibility of PDE, I don't have space for a thorough defense of the claim that death is bad; but I'll give the outlines of both a general commonsense argument and a specifically Thomistic one.

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

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

[5] For example, Judith Jarvis Thomson describes a fictional (though, she thinks, realistic) case in which a physician aims at a patient's death as the end of her action because she thinks his death would be good (in itself?). See Thomson, "Physician-Assisted Suicide: Two Moral Arguments," *Ethics* 109 (1999): 497–518.

to deprive us of their fulfillment, is bad for us. Death, being contrary to life, is just that sort of thing.[6]

To better understand why Aquinas's natural law theory works the way it does, let's take a very quick detour into his metaphysics. Aquinas endorsed a broadly Aristotelian thesis called the convertibility of being and good—a thesis that sounds foreign to modern ears but was quite widely accepted for many centuries and is surprisingly plausible. As in his discussion of natural law ethics, Aquinas begins his discussion of being and goodness by considering the Aristotelian dictum "The good what all desire." What sort of good does every being desire? Its own perfection. What makes something perfect? Actuality: actualizing its potential. And what makes something actual? Most fundamentally, existence: being.[7] So the more something is actualized—the more being it has—the more perfection or goodness it possesses. The more it is deprived of the sorts of goods that actualize or perfect it, the worse it is. Returning to natural law ethics, then, we can see that death is the ultimate privation: it removes—deprives us of—existence, which in turn deprives us of all actuality, perfection, and good.

As straightforward and obvious as the above arguments may sound (and as I think they really are at a general level), real life is complicated. For a significant number of people, particularly those suffering and/or near death, the felt goodness of their lives can be seriously diminished. So even those who accept those basic arguments can raise all sorts of interesting questions like: Maybe in general life is good for us and death is bad, but what about loss of *this unpleasant portion* of life? Or loss of this portion of life in *these unpleasant circumstances*? Couldn't there be parts of one's life, or circumstances surrounding those parts, that render the loss of them not so bad?

Of course, if it turns out that there is no morally significant bad resulting from a particular course of action after all, the principle of double effect does not apply and we'll have to evaluate that action using other ethical tools. However, even in difficult circumstances it is possible to separate (at least for purposes of objective ethical analysis) the value of life itself from the value of the circumstances in which it is carried out. Questions regarding how we construe death and its badness will reemerge in applications of PDE to various end-of-life decisions, to which I turn next.

III. PDE and End-of-Life Care: Some Clearer Cases

As I noted above, some aspects of ethical analysis are simple—including the most basic ethical principle of all: that good is to be sought and evil (bad) avoided. Complications arise, however, when the good effect we seek is packaged together with a bad effect we'd rather avoid; and it is for such cases that the principle of double effect was developed. Fortunately, in many of those complicated situations, the application of PDE is as clear and straightforward as anyone can expect analysis to be in a complex field like ethics—at least given reasonable assumptions about the agent's intentions. In this first application section I'll discuss three such cases; in the next section I'll consider some (at first) less-clear variations. For each, I'll outline the relevant features of the act under consideration, showing how it meets (or fails to meet) PDE's conditions.

[6] Aquinas, *ST* I-II, q. 94, a. 2.
[7] Ibid., I, q. 5, a. 1.

A. Active euthanasia

Although unusual enough in its details to be reported worldwide, the physician-assisted suicide of Belgian identical twins Marc and Eddy Verbessem was in outline paradigmatic of euthanasia cases: the brothers, who were deaf, sought help from physicians to bring about their deaths as a means to avoiding what they considered unbearable suffering at the prospect of also becoming blind. They were eventually successful: after a two-year quest for a hospital willing to administer their euthanasia, the twins died via lethal injection in 2013.[8]

It is not difficult to see why active euthanasia is frequently given as an example of an action forbidden by the principle of double effect. We might summarize the relevant features of the case as follows:

Act: administer lethal injection

End: cessation of suffering (good effect)

Means: death of sufferers (bad effect)

As we notice at this point in the analysis, the bad effect (death) is sought intentionally as a means to the good effect (cessation of suffering). Active euthanasia, which by its nature brings about death intentionally, thus always fails the acceptable-means condition. (One also might reasonably suspect an act labeled "administer lethal injection" of failing to meet the acceptable-act condition, but since the "lethal" in "lethal injection" refers to its causing the bad effect, we needn't commit to the badness of the injection *in itself*—especially given that its failing to meet the acceptable-means condition is sufficient for its failing the PDE test.) We also notice that under PDE there is no need to consider the proportionality of the reasons in favor of pursuing the action despite its bad effect: its failure to meet the acceptable-means condition shows that the act is pursued (in part) *because of* its bad effect—and pursuit of evil is never acceptable.

While the case against active euthanasia via PDE seems clear, some philosophers have argued that active euthanasia is morally equivalent—or even superior—to a course of action many take PDE to approve: "passive euthanasia" via refusal (withdrawal or non-initiation) of medical treatment.[9] I next consider the implications of such refusal through the lens of PDE.

B. "Passive euthanasia"

[8] See "Euthanasia Twins 'Had Nothing to Live For,'" *The Telegraph*, 14 January 2013, http://www.telegraph.co.uk/news/worldnews/europe/belgium/9801251/Euthanasia-twins-had-nothing-to-live-for.html. As is typical in discussions of this and similar cases, physician-assisted suicide is here treated as a type of euthanasia: whether administered by others or by oneself, euthanasia deliberately seeks a "good death" for the one whose life is ended.

[9] For a classic example, see James Rachels' influential article, "Active and Passive Euthanasia," *New England Journal of Medicine*, 292 (1975): 78–80; and Thomas Sullivan's critique of Rachels' reasoning in his "Active and Passive Euthanasia: An Impertinent Distinction?" in *Human Life Review* (Summer 1977), http://www.humanlifereview.com/active-and-passive-euthanasia/.

As the scare quotes in the subtitle just above suggest, the term "passive euthanasia" is misleading: the range of actions subject to such a label includes some that are not passive (e.g., removal of a medical device) as well as many that are not properly called "euthanasia" (i.e., they do not seek a "good death"). A better label might be "refusal": the withdrawal or non-initiation of treatment that might prolong life but that would come with burdens disproportionate to that benefit. Traditionally, such burdensome treatment has been called "extraordinary"—as opposed to "ordinary"—medical care and has not been considered obligatory to provide or pursue.

Examples of refusing extraordinary treatment abound: while they don't often make the headlines, probably most of us need look no further than our own circles of family and friends. My own grandfather's medical treatment (or lack thereof) near the end of his life included both non-initiation and withdrawal. Upon receiving a diagnosis of prostate cancer in his 70s, Grandpa declined chemotherapy, which would have offered an increased chance of living perhaps five additional years but promised significantly unpleasant side effects. As it turned out, despite the non-initiation of chemotherapy (or any other cancer treatment), Grandpa did not die of prostate cancer: a few years later he passed away from previously undetected emphysema. Hospitalized and connected to a respirator soon after being found unresponsive, he was soon declared brain dead; by consensus among his wife and children, the respirator—now considered extraordinary—was removed.

Using PDE, we might analyze the first refusal—the non-initiation of chemotherapy—as follows:

Act: decline chemotherapy

End: avoid side effects of treatment (good effect)

Means: avoid treatment causing the bad side effects

Proportion: Patient was near the end of a typical life span; treatment offered only a chance (nothing like a guarantee) of longer life and was nearly certain to bring the bad side effects.

Here we notice that the act is not bad in itself (chemotherapy is not intrinsically obligatory) and that the bad effect (earlier death) does not appear as the agent's end or means in declining treatment. Thus we must move on to consider the reasons in favor of, and against, accepting the bad side effect along with the intended good effect.

This last part of the application of PDE, like ethical analysis more generally, can be difficult. For present purposes I listed the factors that seem to me to be the most relevant in this particular, not-very-unusual case. But of course we can imagine cases in which the factors I listed obtain but in which the balance of reasons is in favor of the treatment, possibly even as obligatory: for example, suppose the patient is a president whose leadership over the next decade is crucial or a scientist on the verge of discovering a cure for a condition affecting millions. Or perhaps he is a more ordinary fellow who has promised to walk his only daughter down the aisle at her wedding next year. As such variations show, PDE doesn't exempt us from prudence: we need it to sift the more-relevant factors from the less-relevant ones.

C. Palliative care

Another case in which all of PDE's conditions may be met—again, depending upon the relevant features of the situation—is the administration of pain medication that carries a side effect of slowing respiration. Assuming (as in the refusal cases) that the agent's intention is to control pain rather than to bring about death, a PDE-based analysis might look like this:

Act: administer pain medication

End: eliminate or control pain (good effect)

Means: administer pain medication

Here the act just is the means to the end; once again, the bad effect (hastened death from slowing of respiration) does not figure into the agent's end or means. So we continue:

Proportion: Patient's pain is otherwise uncontrollable; her life expectancy is quite short due to the terminal illness causing the pain.

Barring other ethically significant factors impacting proportionality, administration of medication sufficient to control pain appears to meet all four of PDE's conditions and thus be ethically acceptable. As before, however, we can imagine variations upon the theme that would shift the balance of reasons: for example, suppose the patient is in her 20s and is not terminally ill; if she persists through the current ordeal she can anticipate a full recovery. In such a case, death-hastening pain medication clearly is not in order.

It is also important to acknowledge the difficulty that can arise in attributing intentions to other agents. In both the refusal and palliative care cases—unlike the active euthanasia case—it is plausible to suppose that the agent intends the good effect (avoidance of suffering) and not the bad one (death). But of course there could be physicians who intentionally bring about their patients' deaths under the guise of controlling pain or avoiding burdensome treatment. Since PDE doesn't provide a window into others' mental states, we must make reasonable assumptions regarding their intentions. Such assumptions will come into play in the next section as we analyze some initially less-clear relatives of the three clearer cases just discussed.

IV. PDE and End-of-Life Care: Some Less-Clear Cases

The three cases discussed in the previous section—euthanasia, withdrawal/non-initiation of treatment, and death-hastening palliative care—represent end-of-life options that have made frequent appearances in discussions of PDE over the past few decades. They can be quite helpful in showing paradigmatic ways in which the principle is used in ethical analysis, and the distinctions they clarify apply to a wide range of real-life situations. Recent developments in both medicine and law, however, have introduced some related (or seemingly related) options whose ethical status at first appears to be less clear. In this section we will bring PDE to bear on three such cases: drug provision for psychological comfort, refusal of food and water, and terminal sedation.

A. Drug provision

A surprising appeal to PDE as a justification for controversial end-of-life decisions comes from Judith Jarvis Thomson, a PDE opponent. Thomson argues that a doctor who prescribes lethal drugs for her patient—a case externally appearing to be straightforwardly physician-assisted suicide—may do so "intending only to provide the patient with the comfort of knowing that if his condition becomes unbearable, so that he wishes to end his life, he will be able to do so."[10] She suggests that to be consistent, proponents of PDE (who oppose physician-assisted suicide) must advocate laws that allow doctors to prescribe lethal drugs if they do so with such an intention.

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

Act: prescribe lethal medication

End: provide psychological comfort (good effect)

Means: enable patient to take his own life (bad effect)

As with active euthanasia (including physician-assisted suicide), then, the act of prescribing lethal drugs—which provide psychological comfort only *qua* lethal—fails to meet PDE's acceptable-means condition.

As it turns out, however, with one more variation the case Thomson brings up becomes more interesting. A PDE proponent who accepts deception in medical ethics could grant the acceptability of a similar action for a physician with similar intentions who substitutes a placebo for the lethal drug: the patient could thus have the same "comfort of knowing [or at least believing] that if … he wishes to end his life, he will be able to do so" without actually *having* the means to take his life—a scenario that would handily render plausible the claim that the prescribing physician doesn't intend the patient's death or the means thereto. This case seems, at least from the physician's perspective, to be importantly different from active euthanasia, as illustrated by this PDE-based analysis:

Act: prescribe "lethal" placebo

End: provide psychological comfort (good effect)

[10] Thomson, "Physician-Assisted Suicide," 510.

Means: lead the patient to believe he can take his own life

Proportion: to be determined

Lacking space for a full discussion of the ethical implications of such deception (which is understandably controversial), I leave further analysis of proportion to the prudence of my readers. For present purposes I'll simply note two additional complications: First, for the placebo to be effective, it seems the physician still must intend that the patient be *willing* to take her own life under certain conditions;[11] and second, even if deception of this sort is sometimes justifiable, here as in the other cases there will be many other situation-specific factors to be considered before declaring such a course of action acceptable under PDE.

B. Refusing food and water

While drug provision for psychological comfort shows striking similarities to active euthanasia, refusing food and water is sometimes considered to be a variant of refusing extraordinary medical care. In this subsection I'll consider two ways in which such refusal occurs: via removal of artificial nutrition and hydration ("ANH" or simply "feeding tube"), often in unconscious or minimally conscious patients, and through voluntary stopping of eating and drinking ("VSED") by patients capable of eating without mechanical assistance.

As Michael Degnan put it, John Paul II "rocked the world of Catholic biomedical ethics … when he delivered the first explicit papal statement affirming the obligation to provide food and water to patients diagnosed as being in a vegetative state."[12] The papal directive met with a variety of responses among those in the medical, theological, and philosophical communities: some commending the Pope for upholding the dignity of disabled human beings and others arguing that artificial nutrition and hydration represent extraordinary treatment disproportionate to the benefit of continued life—or even that life is not a benefit at all for those in a persistent vegetative state.[13]

Philosophers' and theologians' responses to the papal document show through both their agreements and disagreements that while there certainly is room for nuance regarding the specific circumstances in which feeding tubes are removed, there are also clear lines to be drawn for those of us who consider intentionally killing innocent people to be an ethically out of bounds. Their responses also show, I take it, that in many cases of withdrawing artificial nutrition and hydration PDE clearly applies: that is, there really is a good effect and a bad effect at stake. The bad effect, of course, is loss of life: despite occasional claims that life is not beneficial for the PVS patient, both the arguments I outlined earlier and one by Degnan succeed in showing the good at stake. Here is Degnan's summary of his conclusions: "Providing ANH is a proportionate good for the [vegetative state] patient since it is necessary for the patient to receive the goods of exercise, aesthetically pleasing environment, and human interaction which constitute parts of a humanly

[11] I thank an anonymous reviewer for raising this point.
[12] Michael Degnan, "Are We Morally Obligated to Feed PVS Patients Till Natural Death?" in C. Tollefsen, ed., *Artificial Nutrition and Hydration: The New Catholic Debate* (Dordrecht: Springer, 2008), 39–60, at 39.
[13] See, e.g., Kevin O'Rourke, OP, "Reflections on the Papal Allocution Concerning Care for PVS Patients," in C. Tollefsen, ed., *Artificial Nutrition and Hydration: The New Catholic Debate* (Dordrecht: Springer, 2008), 165–77, at 171–73.

flourishing life."[14] The good effect is elimination of the burdens to the patient and others associated with the mechanically-assisted feeding; sometimes such burdens are sufficiently serious to constitute an ethically significant effect. As Sheehan points out, for example, there are several types of feeding tubes, some more invasive than others, and they occasionally bring medical complications of their own. Further, especially for those in the last stages of dying, the nutrition and hydration provided may not be assimilated by the patient and may increase suffering.[15]

In addition to rocking the world of Catholic biomedical ethics, one might say that John Paul II rocked the world more broadly through his very public last days: via his acceptance of his condition, of medical treatment (including a feeding tube), and of his own imminent death. The end of the pope's life was all the more poignant in comparison and contrast with the similarly public final days of Terri Schiavo, a woman who had been diagnosed as being in a persistent vegetative state and whose feeding tube was removed at the request of her husband (via court order) with the explicit purpose of bringing about her death.

In cases in which a significant good effect as well as a significant bad one would result from removal of a feeding tube, PDE requires both that the bad effect be a mere side effect of the action (not its intended end or an intended means to the good effect) and that there be a sufficiently serious reason for allowing the bad effect. It is difficult to meet both conditions; as was the case with Schiavo, often the point of withdrawing nutrition and hydration is to bring about the death of the patient as a *means* to eliminating the burdens associated with care, as follows:

Act: remove feeding tube

End: elimination of burdens (of continued life) to patient and/or caregivers (good effect)

Means: death of patient (bad effect)

However, where the effects associated with the artificial feeding itself—not the continued life of the patient—are seriously burdensome, its removal (like the removal or non-use of other life-sustaining measures) is permissible according to PDE:

Act: remove feeding tube

End: elimination of burdens (of feeding tube) to patient (good effect)

Means: remove feeding tube

Proportion: Patient's death is imminent and he cannot assimilate food provided, or feeding tube causes or exacerbates a life-threatening condition and thus does not significantly prolong life.

As with all courses of action that *can* be permissible according to PDE, whether they actually *are* permissible in a given situation depends both on the details impacting proportionality of reasons and on reasonable assumptions about the agent's intentions. Unlike paradigmatic cases

[14] Degnan, "Obligated to Feed PVS Patients," 56.
[15] Myles N. Sheehan, SJ, "Feeding Tubes: Sorting Out the Issues," in *Artificial Nutrition and Hydration and the Permanently Unconscious Patient*, ed. Hamel and Walter (Washington, DC: Georgetown University Press, 2007), 15–25.

that PDE is taken to permit, however, removal of a feeding tube represents denial of what is generally ordinary care: provision of food and water. So only in fairly unique circumstances such as the last stages of dying is it in fact reasonable to assume that one removing a feeding tube does *not* intend to bring about the patient's death.

Perhaps even more obviously, voluntary stopping of eating and drinking (VSED) by patients capable of ingesting and assimilating food and water typically is done expressly in order to bring about the patient's death:

Act: refuse food and water

End: elimination of burdens associated with continued life (good effect)

Means: death (bad effect)

From the patient's perspective, then, such a course of action is not permissible under PDE: like the other unacceptable courses of action we've considered, it fails the acceptable-means condition. Analysis becomes more complex, however, when undertaken from the perspective of the physician or nurse, who is often asked to provide medication to control the pain and nausea associated with dehydration and malnutrition. While acknowledging the medical professional's right to refuse any involvement with the patient's suicide, a proponent of PDE might reasonably ask whether there are circumstances in which provision of the requested medication would be permissible. Perhaps so, in a situation like the following:

Act: prescribe or administer medication

End: control pain and nausea (good effect)

Means: prescribe or administer medication

Proportion: Patient is highly determined to go through with VSED; physician or nurse is confident that refusal to provide medication would not dissuade patient but would merely increase his suffering.

While such a scenario is within the realm of possibility, it would seem extremely difficult to reach the level of confidence necessary to ensure that the proportion condition is met. The pain and nausea associated with dehydration and malnutrition can be quite severe—perhaps severe enough to dissuade most seemingly-determined patients.[16] Thus it appears that the more ethically sound course of action on the medical professional's part would be refusal to participate even when the proportion condition might be met: meeting PDE's conditions is sufficient only for permissibility, not for an obligation to undertake the proposed course of action.

[16] As Elizabeth Sutton has pointed out, for example, among typically-requested assistance with VSED is avoidance of offering food or drink to the patient—or, sometimes, even allowing the patient to encounter the scent of food—lest he be tempted to stray from his intended course of action. (Elizabeth Sutton, "Voluntary Stopping of Eating and Drinking at the End of Life: Implications for Nursing Practice," 2016 annual conference of University Faculty for Life (Marquette University, Milwaukee, WI, USA).)

C. Terminal sedation

A final less-clear case in which to apply PDE in today's medical and legal climate is that of terminal sedation—a course of action in some ways similar to the clearer case, discussed in section III, of providing death-hastening palliative care at the end of life. The term is a bit misleading: it sounds as though the sedation itself is the cause of death. And as Johannes van Delden notes, authors' definitions of "terminal sedation" are often ethically loaded in various ways: proponents or opponents may work into their definition the reasons (intentions) for which it is performed, the medical conditions for which it is deemed appropriate, and/or the life expectancy of the patients to whom it is administered. Essentially, though, terminal sedation is simply "sedation until death follows."[17]

Interestingly, Judith Jarvis Thomson, a PDE opponent who discusses terminal sedation, does not comment on whether permanent unconsciousness is an ethically significant bad effect—a determination on this point seems crucial for the application of PDE insofar as the physician who administers terminal sedation intends to render the patient permanently unconscious. In her discussion of terminal sedation, Thomson contrasts it with active euthanasia under the assumption that PDE permits the former but not the latter. She offers an example in which a doctor (Alice) has two drugs, either of which could be injected to relieve her patient's pain (call him "Bob"). Drug D could relieve Bob's pain by causing his death immediately.[18] Drug C could relieve Bob's pain by inducing a coma, which would persist until his eventual death. Thomson objects,

> If PDE is correct, then Alice must choose C. But do the patient's wishes not matter? By hypothesis, if the patient is injected with C he will live longer than if he is injected with D. By hypothesis also, however, that stretch of additional life will be unconscious life, and the patient might prefer not to live it. Does morality, and should law, require him to?[19]

Thomson seems to assume that a PDE-based analysis of injecting C would proceed as follows:

Act: inject coma-inducing drug

End: relieve patient's pain (good effect)

Means: induce coma (*not* bad effect)

Proportion: Since the hypothetical PDE proponent apparently believes that inducing death and inducing coma are the only available options and that death is bad while coma is not, she (according to Thomson) must inject the coma-inducing drug.

[17] Johannes van Delden, "Terminal Sedation: A Restless Ethical Debate," *Journal of Medical Ethics* 33.4 (2007): 187–88.

[18] Some argue that death does not, strictly speaking, relieve the patient's pain but merely ends it: see, e.g., T. A. Cavanaugh, "DER and Policy: The Recommendation of a Topic," *American Catholic Philosophical Quarterly* 89 (2015) 539–56, at n. 26: "Ceasing to exist ends pain but it does not relieve it. (By contrast, as is the case in [terminal sedation], an analgesic relieves pain.)"

[19] Thomson, "Physician-Assisted Suicide," at 513–14.

Because it seems to me that Thomson's analysis is seriously lacking, I'll offer a quick improvement. Although Thomson claims that PDE requires a physician to inject coma-inducing drug C, in the case of doctor Alice and patient Bob, PDE actually "requires" Alice to inject C only if:

(1) Alice would not intend anything significantly bad in injecting C (either because she would not intend to induce coma or because coma is not significantly bad);

(2) Alice would not do anything that is bad in itself (independently of causing coma) in injecting C;

(3) Alice has a sufficiently serious reason for injecting C;

(4) Alice would fail to meet one or more of the above three criteria by injecting D;

(5) No other methods are available to relieve Bob's pain adequately, or Alice would fail to meet one or more of the first three criteria by using the other methods; and

(6) Alice would fail to meet one or more of the first three criteria if she did not relieve Bob's pain.[20]

As I mentioned above, Thomson does not raise the possibility that a proponent of PDE might (like Thomson herself, apparently) believe that permanent unconsciousness is bad in a morally significant way. Notice that if the PDE proponent considers coma until natural death to be a significantly bad effect, then whether or not it is worse than immediate death he will not, *contra* Thomson, claim that Alice must choose to induce a coma as a means to relieving Bob's pain: Alice must *avoid* intending a bad effect as a means to a good one. In that case, a PDE-based analysis would look more like this:

Act: inject coma-inducing drug

End: relieve patient's pain (good effect)

Means: induce coma (bad effect)

Here we see that the bad effect (permanent unconsciousness) is the intended means to the good effect—this course of action, like that of injecting the death-inducing drug—fails the acceptable-means condition.

But is permanent unconsciousness an ethically significant bad effect, as Thomson seems to suppose—and as she seems to assume that PDE proponents deny? It does appear that we could construct similar arguments for the goodness of consciousness (and thus the badness of permanent unconsciousness) parallel to some arguments for the goodness of life and the badness of death: long-term loss of consciousness is generally "bad for you," consciousness is a necessary condition for many other human goods, and it is plausibly described as actualizing our natural potential.

[20] I borrow this analysis from another paper: Heidi Giebel, "The Limits of Double Effect," *Proceedings of the American Catholic Philosophical Association* (2016).

However, PDE proponent Joseph Boyle raises important questions regarding the assumption that consciousness *itself* is a fundamental human good (and, thus, that permanent unconsciousness must be an ethically significant evil). He argues that although consciousness is "evidently a human good" and a "precondition for … distinctively human activities" involving reason and free choice, it is not itself a basic (and thus inviolable) human good but instead is and "empowerment that allows the pursuit of several basic goods … such as friendship, moral integrity, and religion [and also] an element in a temporally significant pattern [of alertness and rest] which is part of the good of biological health."[21]

As Boyle acknowledges, although consciousness isn't an inviolable good (e.g., it's perfectly alright to go to sleep intentionally), *permanent* unconsciousness raises serious ethical considerations because it precludes human activities; some of these—e.g., certain relational or religious activities—may be obligatory. Thus, he argues, it normally may be sought only for patients whose death is imminent, and only "(1) if there is a serious palliative reason for this step, (2) if there is no palliative [alternative] to inducing unconsciousness, and (3) if fulfillment of grave responsibilities is not prevented."[22]

In some cases of terminal sedation, the patient is no longer capable of performing distinctively human activities—of exercising reason and will—and intermittent consciousness no longer contributes to biological health; thus, palliative considerations will be sufficient to justify inducing permanent unconsciousness. In others, there is at least a reasonable possibility that terminal sedation, although palliatively indicated, would bring about a significant bad: It would cause the permanent cessation of all the patient's human activities, including the fulfillment of his or her obligations. In such a scenario, although PDE might be used to justify terminal sedation, it must be used only with caution. That is, although abdication of responsibility is presumably a possible side effect rather than the intended end of the sedation, the more likely it is that the patient in fact would be able to fulfill such responsibilities if not sedated, the more difficult it is to justify inducing unconsciousness:

Act: administer (sufficient dose of) sedative

End: eliminate or control pain

Means: render patient permanently unconscious

Proportion: Patient's pain is otherwise unmanageable; life expectancy is short due to terminal illness; there is (high, moderate, low, or no) likelihood that she would be able to fulfill important moral obligations if not sedated.

Notice that the above considerations of proportion, derived from Boyle's account of the value of distinctively human activities (and the role of consciousness in enabling them), could also be applied to the analysis of proportion in the traditionally less-controversial case of death-hastening palliative care as discussed in section III.C. Since, like permanent unconsciousness,

[21] Joseph Boyle, "The Relevance of Double Effect to Decisions about Sedation at the End of Life," in *Sedation at the End of Life*, ed. Paulina Taboada, Philosophy and Medicine no. 16 (Dordrecht: Springer, 2015), 55–71, at 61.
[22] Ibid., 60.

death precludes the performance of human actions, including those that would fulfill the patient's responsibilities, the importance of such responsibilities and the likelihood that the patient would otherwise be able to fulfill them must be taken into account when considering the ethical implications of accepting death as a side effect of providing effective palliative care.

Conclusion

After briefly discussing the ethical principle of double effect and the frequently-accompanying claim that death is a bad effect, we have considered three fairly typical and paradigmatic applications of PDE to end-of-life options and three variations currently under discussion in medical ethics circles. In discussing the clearer and more typical cases, we have found that while (III.A) PDE rules out active euthanasia, which aims at the death of the patient, (III.B) it often allows "passive euthanasia" or refusal of extraordinary treatment via withdrawal or non-initiation, and (III.C) it may permit provision of medication sufficient to control a patient's pain, even if such medication hastens his death. In the less-paradigmatic variations on these cases, we saw that (IV.A) provision of lethal drugs for psychological comfort suffers from ethical difficulties similar to those associated with physician-assisted suicide, (IV.B) refusal of food and water typically amounts to refusal of ordinary care, presumptively with the intention of causing death, and (IV.C) terminal sedation, which seeks permanent unconsciousness as a means to ending pain, may be justifiable in limited circumstances—when consciousness would neither contribute to biological health nor be likely to allow the fulfillment of the patient's obligations.

Of course, the separation of these cases into "clearer" and "less-clear" ones is somewhat artificial. As I acknowledged above, given the unique features of each situation the assessment of proportionate reasons for action can be difficult, requiring the ethicist to assess the relative importance of various aspects of a particular case. And as I also mentioned, application of PDE requires the employment of reasonable assumptions regarding the agent's intentions; if an agent intends a significantly bad effect, even a course of action generally taken to be permissible according to PDE will not be permissible (or licit) for her to perform. For example, in the case of palliative medication, one administering death-hastening medication bears a burden of proof that a dosage high enough to hasten death is required for pain management—especially if such dosage is atypical or represents a significant increase. Failing to carry that burden of proof casts doubt upon both the agent's intentions and the seriousness of her reason for acting.

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