But Can It Travel?

The Doctrine of Double Effect and the

Danger of Interprofessional Motion Disorder

Lisa H. Newton

Lisa H. Newton, *Professor of Philosophy and Director of the Program in Applied Ethics at Fairfield University in Fairfield, Connecticut, is a consultant for several regional heath care providers, corporations, and professional associations. She is author or co-author of several textbooks in the fields of ethics and environmental studies, including* Taking Sides: Controversial Issues in Business Ethics and Society*, and has authored over 70 articles on ethics in politics, law, medicine, and business*
.

Abstract: Since the traumas of the last quarter of the 20th century forced all professions into the light of public scrutiny, we have seen the destruction of the parochial boundaries of the ethical understandings of the past, and the development of a cosmopolitan professional ethics. It is now understood that we have to have an ethics that travels well, whose principles operate with equal force and plausibility in all disciplines. Without good passports, principles become locked into their own disciplines, Ethics as a subject loses its integrity, and every profession has an excellent reason to insist that "their" ethics have nothing to do with the rest of the world. Consideration of professional ethics as a whole shows that the general principles that we use travel very well indeed, and rapidly smokes out those that do not. "The Doctrine of Double Effect" is one of the non-travelers; from that fact we explore the possibility that the Doctrine is radically misconceived even in its home discipline of medicine.

I. Introduction

Until the 1970s, we tended to assume that the various practical disciplines—medicine, nursing, engineering, counseling, law, business, and the like—had their own "ethics," at least their own ethical codes, that operated from some mysterious bond of unity in each discipline, inaccessible to outsiders. The "bond of unity" was more than an accident of common interests; each profession zealously guarded its gates to make sure that the incoming generation would hold the secrets as closely as the outgoing had done.

It had not been that long since the "secrets," the expertise, of each profession had indeed been a traditional lore, passed from father to son and treated as trade secrets.

The "secret lore" understanding of the professions had been quietly disappearing during the 1950s, at the advent of scientific medicine and engineering. But there was nothing quiet about the end of the custom of professional secrecy. The close guard each profession kept upon its own parochial "ethics" was shattered very noisily, beyond repair, in the scandals (the bribery of businessmen, the lawbreaking of the lawyers) and the new and very public ethical dilemmas (withdrawal of life support in medicine, balancing of civil rights and authority in education) of the late 1960s and early 1970s. There is no need to rehearse those formative developments.

The result of the new publicity—emphatically unwanted, in the case of the business and legal brotherhoods, or requested, as with the medical and scientific research communities—was the destruction of the parochial boundaries of the ethical understandings of the past, and the development of a cosmopolitan ethics. When the understandings—not always in the form of "codes"—of each profession lay before the public, certain common elements appeared. The professional was not there just to make money. The professional had a fiduciary obligation to the client—or patient, customer, or student—to serve that client's welfare before his or her own. The professional had an obligation to his art, to advance knowledge and improve practice. And the professional had an obligation to the general public, to protect that public especially from misuse of the art but also from its neglect. The obligations the professions had in common varied in emphasis from art to art. For the physician and the lawyer, the welfare of the individual client stood to the fore; for those engaged in education and research, the autonomy and

choice of the subject or student took precedence; for the judge and legislator, justice and equal treatment was the moral touchstone; for the engineer, the safety of the public was "paramount." But there was a surprising pattern of agreement, one that the Belmont Report (1978; part of the concluding documents of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research) fortuitously summed up. That report, we recall, gave us the Georgetown Mantra, the Ethical Principles of Nonmaleficence, Beneficence, Justice, and Respect for Persons, which proved entirely adequate for sketching out a framework for the ethics of research with human subjects, and has since formed the foundation of interdisciplinary professional ethics.

II. The Implications of a Cosmopolitan Ethics

The first result of the discovered convergence of ethics was joy in the academic teaching and publishing community. If there is one, and only one, discipline of ethics, uniting the conclusions of philosophical ethics and the broad understandings of the professions, then we may offer courses in a wide range of fields of practice. Philosophy departments erupted with courses in medical ethics, business ethics, ethics of counseling, legal ethics, media ethics—only failure of imagination (or available majors) halted the proliferation. A new publishing industry sprang into existence. Did I mention journalism and engineering? The case method, widely adopted already in the professional schools and sanctioned by the National Commission (see Al Jonsen and Stephen Toulmin, *The*

Abuse of Casuistry,[11] for a sum of the lessons learned there) became the accepted teaching method for such ethics courses, and casebooks cascaded into the bookstores beside the new texts.

But beside this small economic miracle for the philosophy departments and publishers, there was a wider implication. If practical ethics is cosmopolitan, equally at home in the large cities all over the professions, then ethics is one, all one. Whatever principles we use ought to operate equally well anywhere.

That, at least, is how we interpreted the results, and the interpretation has served us well. The Principle of Beneficence (Nonmaleficence tucked under its wing) unpacks to entail all of Utilitarianism, a complete moral philosophy of the rational adoption of means to serve good ends, the ends being appropriated from the self-description of the profession (quality patient care for medicine, quality products in the hands of those who want them for business, etc.). So the principles can be adapted to cover "the ethics of" each profession or area of practice, satisfying the requirement that the traditional understandings of each profession be included in any ethic taught in their halls. Respect for Persons (elsewhere, respect for autonomy) unpacks to encompass the entirety of Immanuel Kant's placement of moral agency at the center of ethics; Justice is grounded in John Rawls. The central political values of Liberty, Equality, and the Pursuit of Happiness are neatly captured in the same formulation, although in reverse order.

We have adopted, then, as the substance of the discipline of ethics, a set of logically independent but generally complementary ethical principles. The major rules that govern the ethics of the professions fall easily under the principles, derived from or

grounded in one or more of them. For instance, the ruling principle of Informed Consent in medicine and in clinical research derives directly from Autonomy; Engineering's paramount provision and business's TQM are grounded in Beneficence; all requirements of honesty (from billing practices to representation of professional credentials) are specifications of the imperative of Justice. If ethics is one, we will not find an ethical principle applicable in one profession that violates ethical principles in other professions.

But what if we do? Given the separate origins of the professions, and the historical accidents that have shaped their development, we should not be surprised to find "rules," "doctrines," or general practices that were invented in one profession only for one purpose only, and have never been tested against others. "The Doctrine of Double Effect," known in medicine and tracing its lineage to Thomas Aquinas, may be one such; examining its implications and limitations may give us guidance in handling any others we find.

III. A Case in Point: the Doctrine of Double Effect

The rule of double effect (not really a "doctrine," since the Church never pronounced it) held that if an action permissible in itself and undertaken for a good end has, in addition to its good end, a result that is clearly wrong, it is still permissible to undertake it provided that (1) the goodness of the good result is equal to or greater than the evil of the bad result, (2) there is no way to get the good result without also bringing about the bad result, and above all (3) the action cannot be construed as performing an

evil act, an act not permissible in itself, in order to bring about a good result. The evil

must not be disproportionate to the good; there is no way to avoid the evil; and no using

evil means to achieve a good end.[2] The principle is curious in itself; what purpose could

be served by such an elaborate rule? It all started from Thomas Aquinas' discussion of

tough cases in killing. Granted that we are forbidden to kill, how can we justify killing in

(say) self-defense? Thomas handled that problem by pointing out that we never have a

right *to kill*, but if we are attacked, we certainly have a right, even a duty, to stop the

assailant from attacking us. Unfortunately, often the only way to stop an attacker results

in the attacker's death. Note that you do not kill the attacker *in order to* stop the assault;

that would be using an evil means to a good end. Rather, you do what is necessary to

stop the attack, by non-lethal means if possible, but if those are not available, by any

means you have, and the death of the attacker is a foreseen (but not desired) result. The

same reasoning applied to war, and to all manner of evil things people do to advance the

causes of good institutions—spying, for example.

Gerald Kelly, S.J., one of the first medical ethicists of the contemporary era,

updated the principle in the 1950s to make life easier for Catholic physicians in an

increasingly secular America. For the principle can apply marvelously to abortifacient

procedures, like ending an ectopic pregnancy.[3] By Roman Catholic teaching, recall, an

ectopic pregnancy could not simply be ended (by opening the fallopian tube, removing

the embryo, and sewing up the tube); that would be an abortion, and abortion is

forbidden. Pre-Kelly, a woman with an ectopic pregnancy died or took her problems to a

non-Catholic. Kelly argued that if the fallopian tube had a fetus growing in it, the tube

was clearly diseased, so it was all right (on the Principle of Totality) to remove it to save

the woman's life, just as it is permitted to perform other mutilations (like the removal of a limb) in order to save the life. In the removal of the fallopian tube, the ending of the life of the embryo was foreseen, and regretted, but it was not the goal or the primary characterization of the procedure, so the procedure could be permitted. With the advance of technology to prolong life, the same reasoning migrated to end-of-life issues. It is never permitted to engage in "mercy killing" or euthanasia, but it is morally permitted to give enough morphine to relieve pain even if the morphine will foreseeably shorten the patient's life (by depressing respiration). Note that the crucial distinction is between the use of an evil means to a good end (abortion to save the woman's life, or killing the patient in order to end the pain, both of which are not permitted) and the performance of a good act (removing diseased tissue, relieving pain) which unfortunately includes a regrettable consequence (the death of the fetus, or the shortening of the patient's life). The rule, along with practices like permitting self-starvation and filling requests for prescriptions of lethal drugs, dances along the edge that separates permissible medical procedure from homicide.[4]

It was a rotten principle to begin with. Never mind it stands in complete opposition to our Anglo-American legal traditions of torts and negligence, it stands in opposition to the plain duty to avert foreseeable harm laid out in *Exodus*. At least in the Bible, you will be held accountable for all the consequences of your action that a prudent person could be expected to foresee—or, to quote Erich Loewy (in a discussion of the principle in *The Archives of Internal Medicine*), "one is responsible not only for what one has clearly intended but also for what one could reasonably foresee."[5] If you foresee that your ox may gore your neighbor's ox, and you turn it into the same field intending only

to give it some better feed, you're liable for the price of your neighbor's ox when it (foreseeably but regrettably) gets gored.[6] We have always known that you are not off the hook for any probable consequence of your actions, and have been willing, yea eager, to hold you responsible for the full cost of the avoidable consequences.

The rule then has little purchase in general ethics. Passport denied. It doesn't travel. But is it possible that we can use the travel requirement not only as a test of the general applicability of a rule, but also as a test of its validity? Let us consider the possibility that the famed Doctrine of Double Effect is as useless in medicine as it is anywhere else. Maybe we can simply get rid of it altogether.

IV. Backtracking, Replacing, and Re-Cohering

The key is in the "avoidability" criterion. It is not the case, as Erich Loewy claims, that "In terminal sedation, not only is the patient's death clearly foreseen, it is in fact the *end point* of what is being done. . . . Because the goal of relieving pain and suffering adequately can be attained only by obtunding the patient until death ensues, the patient's death becomes the *end point* and, therefore, one of the *intended goals*."[7] That's simply invalid. "End point" or *telos* has two meanings, "the place where the process stops" and "the achievement of the desired goal." The goal here is relief of pain. If the pain is relieved, the goal is achieved. When death (foreseeably) occurs, you stop the pain relief, not because the "goal" (of death) has been achieved, but because there is no more pain and therefore no more need of the drug. The death of the patient was inevitable,

from the disease itself; the only choice was whether we should sedate the patient to die without pain, or withhold sedation in order to prolong the patient's life, with the (regrettable but foreseeable) consequence that the patient dies, choking and screaming, after days of unspeakable agony. We need no doctrine (or whatever) of double effect to justify pain relief, whether or not the death of the patient is in prospect, and if the death is inevitable, the law is silent: only *avoidable* consequences are of interest to the courts, from *Exodus* to the present.

Then what does "terminal sedation" mean? Just what it says. The patient is terminal, no further medical interventions would be of any benefit, and they are therefore prohibited by the Hippocratic Oath. The only viable medical objective left is relief of suffering, so we relieve it. When the patient dies, we stop. There is nothing "disingenuous" (as Loewy claims) about it. It is precisely the treatment that you or I would choose in those circumstances, and the medical benefit foreseen is the required benefit of relief of pain. The use of terminal sedation, then, for the dying patient experiencing pain, can be derived directly from the principle of Beneficence, with no dubious intermediate rules interposed.

The original purpose for which the Doctrine was invoked in medicine—to explain why it was all right to remove the fallopian tube of a woman with ectopic pregnancy, thereby saving her life, while it would not have been all right to shell the embryo out of the tube, sew up the tube, and restore the woman to normal fertility—seems to have disappeared. Should a Catholic physician insist on the removal of the tube as the only option, the system would refer the woman to a non-Catholic physician. There are injuries

to which we no longer subject women, and the Roman church didn't even try to retain jurisdiction over ectopic pregnancy.

Let us attempt some re-cohering. In the Doctrine of Double Effect, we find a vestige of an earlier day—a day when each profession made up its own rules, promulgated them, and tried to ensure that others followed them. It was a useless rule at the time, but it apparently papered over some very nasty problems for the profession. So it stayed. Maybe it's time to let it go. If we do, we will reintegrate the cases that seem to follow from that principle under other principles—as we just united the discussions of worker, customer, and public welfare under the heading of Beneficence—and the doctrine will be needed no more.

---

[1] Jonsen, Albert R. and Toulmin, Stephen E. *The Abuse of Casuistry: A History of Moral Reasoning,* University of California Press, 1988.

[2] Garcia JLA, Double Effect, *Encyclopedia of Bioethics* revised, 1995, vol. II, 636-641, citing Aquinas T (St.), *Summa Theologiae* part II-II, p. 64 art. 7.

[3] Kelly GA, *Medico-moral Problems*, St. Louis: Catholic Health Association, 1958.

[4] Quill TE, Lo B, Brock DW, Palliative options of last resort: a comparison of voluntarily stopping eating and drinking, terminal sedation, physician-assisted suicide, and voluntary active euthanasia, *JAMA* 1997; 278(23):2099-2104

[5] Loewy EH, Terminal Sedation, Self-Starvation, and Orchestrating the End of Life, Arch Intern Med 2001; 161:329-332

[6] Moses, *Exodus,* Chapter 21.
[7] Loewy, op.cit.