

The Doubling Undone? Double Effect in Recent Medical Ethics

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ABSTRACT

This article treats recent bioethical discussions of double effect reasoning (DER) by offering a summary account of DER and construing it as rooted in a sensible view of what is central to someone's identity as a moral agent. It then treats objections raised in recent years by Judith Thomson, Alison McIntyre, and Frances Kamm against familiar ways of applying DER to certain controversies within medical ethics, especially that over physician-assisted suicide. After detailing, interpreting, and attempting to rebut the challenges from these philosophers, who are especially interesting because their criticisms of DER come from allies in DER's struggle against consequentialist reasoning, the essay engages DER's contribution to a recent dispute over treatment of patients in what is called "persistent vegetative state." Near its end, the paper sketches several possible points of entry to DER and sources of justification for it. The essay concludes by indicating a connection between these paths and its opening idea of moral identity.

A piece of verse, remembered from my grammar school, begins this way:

Which is you, old two-in-one?
Which is which, old one of two?
When the doubling is undone
Which one is you?

It concludes inconclusively:

That woman says, old one of two,
In body was the soul begun:

Now two are one and one is you: –
Which one? Which one?¹

One of the dualities the poet plainly has in mind is the human being's nature as both body and mind ("soul"). Even when we act, we relate to the external world in two different ways that do not always closely align. On one hand, our bodies cause changes in things; on the other, our minds fix on certain ways in which the world can be: choosing some, spurning others, adopting some as goals to pursue while regarding others as unfortunate results in spite of our causing which we enact. We act so that we bring about certain consequences in fact and also, in the image embedded in the term's etymology, we metaphorically "stretch toward" some possibilities by intending (*in plus tendere*) their occurrence.² These largely match up, but not everything that we cause (or do) is something that we intend to, nor do we succeed in everything that we intend to cause (or do). Which type of relation matters more for purposes of moral evaluation, the way in which our bodies affect things or the direction in which our minds list and lean? One way to answer this question, to choose among these options and to reflect within ethics this human duality, is double effect reasoning (DER).³

¹ Archibald MacLeish, "What the Serpent said to Adam" from "Songs of Eve" (1954) in Archibald MacLeish, *New & Collected Poems: 1917-1976* (Boston MA: Houghton Mifflin, 1976), p. 449. The woman to whom the poem refers is Eve, humanity's first female.

² Mary Geach, following Anscombe, has pointed out to me that some experts trace the etymology more narrowly to *in tendere arcum*: to stretch the bow towards, that is, to aim at.

³ I borrow this term "double effect reasoning" from Thomas Cavanaugh, who offers it as a corrective to the inaccurate terms "doctrine" and "principle" of double effect, which are more common in the philosophical literature. See his *Double Effect Reasoning* (New York NY: Oxford Univ. Press, 2006). For a general discussion of double effect as a form of reasoning, see J.L.A. Garcia, "Double Effect" in *Encyclopedia of Bioethics* (revised edition), ed. Warren Reich (New York: Macmillan/Simon & Schuster, 1995), vol. 2, pp. 636-41. My talk here of "duality" simply recognizes an obvious difference among the features that characterize a human being and should not be construed so as to commit me to any strong (e.g., Cartesian) metaphysical dualism of substance.

It suggests that among the things that we physically cause and those that happen as a result of our not moving our bodies in certain ways, a crucial moral distinction lies between those we intend and those we do not, even though among the latter are some results that we expect from our actions.⁴ This suggests that, at least with respect to morality, what matter most centrally are certain mental stances (attitudes) rather than physical causal relations. It also takes the second option in a way that specifies which attitudes matter morally, why, and how. Our decisions, choices, and preferences, as captured in our intentions, are the things that (we might say in light of the poet's questions) do most to constitute the moral self. Rejection of DER and its apparatus, to which we turn next, often reflects an unwillingness to make features of an agent's mind morally determinative in this way.

We can construe DER as a mode of ethical analysis and assessment, inspired and perhaps adumbrated in Aquinas's discussion of self-defense, that utilizes two principal claims: first, that otherwise innocent/permissible (non-vicious) actions done with the agent intending certain undesirable states of affairs to ensue are immoral while otherwise similar actions with the same effects may be morally licit if the undesirable *sequelae* are not ones that she intends, even if she expects them to follow; second, to act licitly in the latter case, the agent must have "proportional" (that is, adequate) reason to act as she does, despite the undesirable consequences, in pursuit of some good goal. The mode of reasoning has recently drawn attention from outside the circle of Roman Catholic theologians, where it originated as the middle ages ended. This wider interest owes initially to the sympathetic use made of it in medical ethics by Princeton's Protestant religious ethicist Paul Ramsey and, later, to the Princeton political theorist Michael Walzer's similarly sympathetic attention to DER in his influential discussions of just and unjust warfare.⁵ It was Elizabeth Anscombe who

⁴ In light of what was said above, note that the etymology of "intend" involves a metaphor of mentally leaning, listing, inclining in some directions.

⁵ The most prominent Catholic moral theologians have now so emphasized the second element in DER as to generate a new position, now usually called "proportionalism" because of this focus. Though originally developed and

did most to stimulate the interest of secular moral philosophers in DER. In fact, however, most of these treatments have been sharply critical, with only a few—most notably, brief discussions by Robert Nozick and Thomas Nagel, and longer ones by Warren Quinn, and Jeff McMahan—generally sympathetic to the principle’s use of the distinction between intention and foresight. Even these latter philosophers significantly restrict its application and modify it in the direction of less absolutist employment against consequentialist moral reasoning.⁶

Previously, I have defended DER against some critics most of whom are comparatively sympathetic to utilitarian or other consequentialist accounts of the morality of action—Helga Kuhse, Jonathan Bennett, James Rachels, Robert Holmes, among others.⁷ In the present discussion, in contrast, I look to objections against DER by some who are allies in their

presented as a revision of DER, it is now plain that it marks a repudiation of DER’s distinguishing and most important feature: the moral significance of a (non-moralized) distinction between what effects are intended, as means or as ultimate ends, and what are foreseen but not intended at all. Pope John Paul II devoted his 1993 encyclical letter “Splendor of Truth” to an extended critique of this deformation of his religious tradition’s moral thinking. For more on proportionalist moral theology’s motivation, origins, and inadequacies, see Christopher Kaczor, *Proportionalism and the Natural Law Tradition* (Washington, D.C.: The Catholic Univ. of America Press, 2002).

⁶ See Thomas Nagel, *The View from Nowhere* (Oxford UK: Oxford Univ. Press, 1986), pp. 180-85; Robert Nozick, *Philosophical Explanations* (Cambridge MA: Harvard Univ. Press, 1981), pp. 497-98; Warren Quinn, “Actions, Intentions, and Consequences: The Doctrine of Double Effect,” *Philosophy & Public Affairs* 18 (1989): 334-51; and Jeff McMahan, “Revising the Doctrine of Double Effect,” *Journal of Applied Philosophy* 11 (1994): 201-12.

⁷ See J.L.A. Garcia, “The New Critique of Anti-Consequentialist Moral Theory,” *Philosophical Studies* 71 (1993): 1-32. See also Garcia, “Double Effect” (1995) and J.L.A. Garcia, “Intentions in Medical Ethics” in *Human Lives*, ed. J. Laing and D. Oderberg (London UK: Macmillan Press, 1997), pp. 161-81. Also see Helga Kuhse, *The Sanctity of Life Doctrine in Medicine: A Critique* (Oxford UK: Oxford Univ. Press, 1987), ch. 3; Jonathan Bennett, *The Act Itself* (Oxford UK: Oxford Univ. Press, 1995), ch. 11; James Rachels, *The End of Life* (Oxford UK: Oxford Univ. Press, 1986), pp. 92-105; and Robert Holmes, *On War and Morality* (Princeton NJ: Princeton Univ. Press, 1989), pp. 196-99.

explicit rejection of all forms of consequentialism as acceptable accounts of moral evaluation or deliberation. I will here concentrate on the writings of three women—Alison McIntyre, Frances Kamm, and Judith Thomson—who contest the ways in which DER has been employed in medical ethics, especially its use to show that physician-assisted suicide (hereinafter, PAS) is immoral. At the end, I also treat a new discussion of care for patients in the condition sometimes called persistent vegetative state (hereinafter, PVS), and DER’s relevance to it. I will argue that intentions can matter in medical ethics in ways that DER indicates, and further suggest that this is best explained in connection with role-relative virtues. Here I shall concern myself principally with Thomson’s, McIntyre’s, and Kamm’s arguments against the application of DER in medical ethics, especially its application in regard to physician-assisted suicide, setting aside their more theoretical objections.

JUDITH THOMSON

Thomson’s objections to DER and its applications in medical ethics are unpersuasive.⁸ I will treat only a few parts of her criticism of DER’s application to PAS. Thomson holds that the doctor in a PAS case need not intend the patient’s death but may act “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.”⁹ (Alternatively, it might be maintained that the physician in a PAS case may intend only, say, compliance with her patient’s wishes for a drug, not her death.)

A physician may indeed wish to provide such comfort, but it is not all that she intends. Sometimes she may mean to silence the patient’s pestering by *deceiving* the latter into thinking that she is now equipped to kill herself. In other cases, she may mean to give the drugs with neither a belief nor a concern about what the patient will do with them and whether it will

⁸ I plan to engage and rebut their ethical theoretical objections to DER in a separate article, though I begin to sketch some of that argument in this essay’s final sections.

⁹ Judith J. Thomson, “Physician-Assisted Suicide: Two Moral Arguments,” *Ethics* 109 (1999): 497-518, at p. 510.

succeed. The former course of action may be justified in some extreme cases, though it manifests scant respect for the patient so to trick her. The latter course is plainly irresponsible. Thomson, however, talks of a physician who provides to her patient lethal means in order to secure her “the comfort of *knowing*” that she can kill herself if she so chooses (emphasis added). The comfort in that case must depend on the patient’s confidence that she can kill herself if she wishes, and what justifies this confidence, when it is justified, is the fact that, because of the physician’s action, she now can kill herself. But insofar as the doctor means to facilitate and enable the patient’s self-destruction should the latter later so wish, she acts with a conditional intention that the patient die and will act impermissibly in doing so.¹⁰ She does not provide the drugs or machinery

¹⁰ By a “conditional intention” I mean an intention that something be the case (especially that one does something) contingent on some condition’s being met, i.e., it is an intention whose content/object has the complex form of a hypothetical. The immorality of acting with a conditional intention that a bad result occur is important in, for example, deterrence policies. It is, I think, a topic to which theorists of double effect reasoning need to devote greater attention.

Note also that there is little reason to classify as PAS a situation where a physician is not trying to assist the patient in self-destruction. We should not so classify a case where a doctor inadvertently, or for other reasons, did something that wound up helping a suicide. She is not then a collaborator in the suicide. However, it is different where the doctor means to help by facilitating and, though it is a somewhat different type of case, there is little moral protection in the excuse that the doctor meant only to enable the patient to put herself to death should she so decide.

One commentator offers the following problem. Suppose the patient uses the drugs to kill herself, but survives and then changes her mind. Must the doctor then feel frustrated? Might she not nonetheless be pleased, having provided the lethal dosage reluctantly, or with mixed motives, or hoping they would go unused? And, if so, does this not show that she didn’t, even conditionally, intend the patient’s death? I think all that this shows is that the doctor, like her patient, has changed her mind. She could, of course, have tried to fool her patient by prescribing a placebo or only a non-lethal dose or arranging for nurses to rush in and thwart the attempt. But she did none of those things. By hypothesis, she acted to assist—to help in—her suicide, and that means acting so that the patient’s actions should take her own life. If, like the imagined

for other reasons, merely foreseeing that she may also thereby facilitate suicide. Rather, enabling suicide is precisely the point of the physician's actions. The morality of acting with an intention that someone die, should certain conditions be met, is sometimes a complicated matter, to be sure, and one to which we shall return. Here, however, it is plain that the physician takes the patient's (conditional) plan for death into her own plan of action. It can be helpful to compare the intentions in a PAS case with those of situations where someone complies with a request to supply unusual tools desired with the aim of killing someone (either *tout court* or

patient, then, she is later pleased that they failed, this indicates a change of heart, not one without an earlier homicidal intent.

In correspondence with me (July 2005), Prof. Sulmasy suggests that Catholic moral deliberation about PAS does better by relying on "the principle of cooperation [in evil]" rather than DER. This, however, is problematic. The relevant discussions of one person's (P_1 's) cooperating in another's (P_2 's) immoral project rely on a crucial distinction between "formal cooperation," which is deemed impermissible always and as such, and merely "material cooperation," which can sometimes be licit. What distinguishes formal from material cooperation in the moral tradition is precisely that in the former, but not the latter, P_1 , the facilitating agent, adopts the bad intention of P_2 , the principal agent. (Moreover, P_1 's unintended, "material" cooperation will be permitted only when she has adequate "proportional" reason for her doing what helps P_2 .) So, I cannot see that discussing PAS in terms of principles of cooperation really stands as a genuine alternative to DER, for it depends on the same crucial distinction between what the agent does intend and what she does not. According to consideration of modes of cooperation, as also according to DER, PAS is morally excluded when, because, and insofar as the doctor has an intention that extends, even if only conditionally, to include the patient's death.

Of course, a physician may intend only to enable her patient to commit suicide should the latter so decide, without the physician herself meaning her to. This is not so much assisting suicide in the proper sense as empowering its execution and is, morally speaking, a somewhat different matter. There the issue is more whether the physician has adequate justification for her acts intended to enable. I think we should reject the claims that the patient's preference for death justifies either her or the physicians actions meant to further it. As I indicate, the patient's preferring death doesn't make it a good thing for her, and the physician's purposely facilitating it is still antithetical to her professional calling as a healer.

conditional on things taking this or that turn). Surely, in general, we should say that the provider partially adopts the death-dealing intentions that she intends to facilitate.

Thomson also thinks DER irrelevant to PAS because DER applies only to intending evils, while the patient's death in PAS is not something bad but good for the patient.¹¹ She also maintains that there is no such thing as intrinsic evil, thus blocking DER's defenders from replying that the patient's death is an evil, something intrinsically evil, even though not bad *for* her.¹²

What is relevant, however, is whether death (in the sense, which I take to be Thomson's, of the event of dying) remains an evil, in the sense of an (objectively, impersonally) undesirable occurrence that befalls someone. This seems to be so, since its dying is the destruction of an entity inclined by its nature to continue living, whether or not one thinks that the patient would be comparatively worse off alive (if such comparison makes sense).¹³ Death is an evil for someone, the loss of a significant and defining good for any living creature, irrespectively of whether it is *also* worse for her than some alternatives. The patient's preference for death no more changes that fact about value than her preference for enslavement would mean that her liberty stops being a good thing. Intuitively, in both cases, what fixes the value (positive for freedom, negative for death) are factors about human dignity and status, on which we will touch below. Still less do such preferences transvaluate evils into goods or goods into evils. So, the physician intends an evil, something impersonally undesirable, even if

¹¹ “[W]hy is that effect of the doctor’s act [i.e., the patient’s death in a PAS case] bad? ...[I]t is surely plausible to think this person’s [medical] condition is such as to make it good for him to die.” Thomson (1999), p. 511.

¹² Thomson (1999), p. 511.

¹³ I have elsewhere argued against the thesis that someone can be better off dead, even if we can understand, and to some extent sympathize with, her preferring not to remain alive. See J.L.A. Garcia, “Better Off Dead?” in *APA Newsletter on Philosophy and Medicine* 92 (1993): 85-88. A revised, expanded version appears as “Are Some People Better Off Dead? A Reflection,” *Logos* 2 (1999): 68-81.

a lesser evil.¹⁴ Thus Thomson needs, but fails, to show that what matters morally is *how* bad a thing dying is on the whole, against her adversaries' contention that the issue is whether dying is itself a misfortune, something undesirable.

At least in the case of great suffering, Thomson might plausibly argue that dying is a lesser evil in the context, because it is compared with the evil of enduring pain. I have shown that it remains a significant evil by its nature and have pointed out that some reason needs to be offered for the claim that it is permissible to intend such an evil in order to avert another, greater one. The problem is not just that Thomson offers no such reason. Rather, more egregiously, she allows that PAS can be justified even to avoid extended *unconscious* life when the patient "might prefer not to live it." (Here she must mean that the patient *would have* preferred and chosen not to live it, had she been given that option in advance.) Against this, we should note, first, that it is not easy to see why such a choice about the unknown should be considered sufficiently informed to warrant such deference. Moreover, Thomson seems here to suppose that the patient's life is not even any kind of good at all, since we are justified in ending it though doing so brings the patient no good beyond the rather slight one of satisfying her personal preference (and therein, perhaps, also honoring the proper range of autonomy *if*, as I below show to be questionable, this sort of decision falls within that proper range).

Besides Thomson's failure to show that life is not a good in these cases, we should, in addition, observe two different special features of the

¹⁴ While I share Thomson's doubts about the intrinsically good or evil, I think we can construe the claim that a person's death is impersonally undesirable as, roughly, the claim that it would be immoral of someone to desire, delight in, or seek it. See J.L.A. Garcia, "Goods and Evils," *Philosophy and Phenomenological Research* 47 (1987): 385-412. In that way, it can be "disvaluable" in an impersonal way—bad/immoral for anyone to value it (that is, to want it, will it, take pleasure in it, and so on). However, to seek such a state, as in intending it to occur, is to adopt it as something to strive for, whether for itself or as part of or a means to something further. This grounds a shorter argument from the claim that death is undesirable to the conclusion that it is morally bad of someone to intend it and thus also wrong to act with that intention.

medical case that pull in the opposite direction by making more heinous (rather than justifying) the doctor's acting with intent to kill her patient.

First, there seems to be an additional reason why it is especially vicious (immoral) for a physician to intend (and thus to act intentionally) for her patient that complete destruction of even vestigial integral functioning that we call death. For the doctor is a member of a healing profession, one dedicated chiefly to preserving and restoring the health of certain human beings. (We can identify this with their integral functioning.) The commitment to act for the sake of preserving or increasing her patient's life and health is thus central to what makes someone to be a good physician. So, a doctor's intending her patient's death runs diametrically counter to special and morally significant professional commitments and role-virtues, even aside from the way in which *anyone's* intending an innocent person's death is vicious. That is not to say that someone's physician ought always be trying to extend her life, no matter what the situation. There are other ways for a doctor to serve her patient's health, and sometimes one of them can take precedence even over prolonging life. Thus a course of treatment may legitimately be initiated in desperate circumstances even though it is known to be more likely to hasten death than to cure illness. The physician, even though professionally a healer, need not always act in ways that restore health or even render it more probable. Still, it is hard to see how it can be part of the task of any physician to act purposely to destroy her patient's last remnants of health. That is a different and more radical turn way from her professional calling to heal.

Second, the way in which someone's dying puts a stop to her pain, etc., is not by bringing the sufferer something that can properly be called *relief* of pain, or even release from it, but instead only its cessation. Ending her pain cannot be a benefit to her for the usual reason, then, because here the patient does not experience relief and thereafter live pain-free. As the end of her pain here does not improve her experience, neither does it improve her life, her condition. Rather, she (her integrated human life) ends along with the pain, and *she* is in no condition at all during the period when she is lifeless. We cannot, then, meaningfully compare it with her condition over the same time had she lived. Whether or not her body (and even her soul) still exists, she does not. Thus, it is difficult to see just what benefit

our killing renders her, as it *improves* neither her experience, nor her life, nor her condition.¹⁵ This indicates that, while intending the patient to die is plainly intending her an evil, it may be that intending this sort of end to her pain, one that comes only from her dying, does *not* amount to willing her any significant good at all. “Mercy-killing” is a dubious mercy and so too is PAS.

Thomson breezily asserts that (at T_1) an agent can intend an innocent person’s death “and not do so out of malice,” and even that (at T_2) “if we love him [a suffering patient] we too want her [the doctor] to inject the [death-dealing] drug.”¹⁶ Yet, neither claim is well founded. We should allow, against T_1 , that there can be what we might reasonably designate an

¹⁵ One might say the benefit is that she is better off with a shorter life. So construed, the claim is not that, dying at time T_1 , she is better off at the later time T_2 than she is in the counterfactual situation where she still lives, pain-ridden, at T_2 . Rather, the claim is that she is better off living a life that stretches from B, the time of her birth, and ends at T_1 than with a life that stretches from B through T_1 and T_2 and, after an additional stretch of pain, eventually ends at T_3 . However, the thesis that the patient is better off dying early, though not better off at any time, is certainly an odd one. Nor is it clear in what way the life is a better one. If it is just that it has a more appealing pattern when it follows a certain course, that it makes a better story, for example, then this seems to be only an aesthetic consideration, and—even if it provides a sense of “better”—what Thomson elsewhere calls a “way of being good”—for its use in the phrase “better life,” it does not seem to be one rooted in a sort of goodness whose increase leaves a person better off. It remains to be shown, then, that killing a person to achieve this sort of improvement benefits her, helps her, or improves things for *her*.

The same holds true for the claim that, like Vonnegut’s Wanda June, the patient might be happier in some postmortal heaven. (Vonnegut, of course, derisively envisions a celestial world’s fair or amusement park. See Kurt Vonnegut, *Happy Birthday, Wanda June* (New York NY: Delacorte Press, 1971.) Even in traditional Christian thought about the afterlife, however, it is only the person’s soul that survives death. Still, her soul is not the person herself and even such experiences as those of which it might be capable are still not the person’s own. I have above described death as “the unknown,” but it seems to me we do know at least that much about it. What matters is that it is not enough to warrant talk of being better off dead.

¹⁶ Thomson (1999), pp. 514, 516.

instrumental malice (at least, an instrumental *male-volence*—a willing of something evil, which is therefore itself an evil willing) when someone intends another an evil (at least an undeserved evil), whether as an ultimate goal or instrumentally.¹⁷ Similarly, contra T₂, Thomson moves too fast in talking as if anyone who loves a patient so situated must want her to die. Surely, the love that consists in goodwill can and does take the form of wishing the other person the continuing good of continued life. In fact, what is harder to justify is the claim that an agent can act lovingly toward someone in striving for her to lose even the remaining traces of health. What seems certain is that it cannot be professionally responsible for a doctor (or other healthcare worker) to do that.

ALISON MCINTYRE

McIntyre thinks that we misleadingly employ the language of DER's intention/foresight distinction to mark a number of morally salient differences, only some of which seem to hinge on the agent's intentions and not always in such a way that depends on the distinction between instrumentally intended and merely "incidental" (unintended but anticipated) effects. She also attacks both certain applications of DER and its theoretical analysis and justification. I here treat just the arguments against DER's application to issues in medical ethics, deferring to a separate treatment my response to the more narrowly theoretical arguments that she and some others have recently offered.

McIntyre interprets the U.S. Supreme Court's 1997 opinions in *Vacco*

¹⁷ I will not go into the matter here because it would take us too afield, but it is obvious that the fact that a person deserves to suffer a certain type of evil is relevant to whether someone acts permissibly in doing something with the intention that she suffer it. The original and central idea of desert, as indicated by its etymological roots in words meaning "from serving," is that someone deserves something when that response to her is permitted or required because of what she has done. (For more on my view of desert, see J.L.A. Garcia, "Two Concepts of Desert," *Law and Philosophy* 5 (1986): 219-35 and "The Intentional and the Intended," *Erkenntnis* 33 (1990): 191-209. What is more pertinent, and remains to be shown, is that the opportunity to bring the person herself or someone else a greater benefit also serves to justify or vindicate such action.

v. *Quill* as combining DER with “a distinction between causing death and merely allowing it” in this way: “when the physician [in what she calls ‘terminal sedation’ (hereinafter TS)] causes death to be hastened he is assumed not to intend this result...and when he intends to allow a death to occur when life-sustaining treatment is withheld, he doesn’t cause this result (because death is caused by the underlying disease).”¹⁸ Her chief complaint seems to be that people using DER both to justify palliative terminal sedation and to condemn PAS move too confidently both in (a) acquitting the physician in TS of an intention to kill and in (b) imputing such intent to the one in PAS. McIntyre suggests that the patient’s death may be a part of the physician’s licit means to a good end in both cases, comparing both doctors to dentists who probe in order to locate pain.

As for (a), I agree with her that some are too quick to use the mere possibility of morally permissible TS to permit TS also in situations where life-saving alternatives may be available but are left unexplored. TS can be permitted only where there are no such alternatives. As McIntyre rightly says, DER both “rules out the possibility of choosing not to minimize or avoid the hastening of death when providing palliative care” and “requires the agent to minimize the unintended harmful effect and to avoid causing it altogether when that is possible.” Perhaps she is also right to say: “We have been so transfixed by the simplified idea that hastening death is permissible [i.e., it is *open* to being permitted, rendered licit, acceptable by other factors] that we have failed to consider...that the hastening of death as a side-effect of relieving pain may sometimes be impermissible.”¹⁹ Indeed, DER indicates that administering so strong a dosage of a potentially lethal analgesic is immoral when it is unnecessary for palliation. Still, none of that shows that when terminal sedation is morally permissible, the patient’s death is part of the physician’s intended means to relieve pain. What she intends, when acting licitly, is to give such dosage as will relieve pain, merely foreseeing that the dosage will also hasten death. That is a side effect, not a part, of her chosen means.

¹⁸ Alison McIntyre, “The Double Life of Double Effect,” *Theoretical Medicine and Bioethics* 25 (2004): 61-74, at p. 65.

¹⁹ McIntyre (2004), p. 72.

With respect to (b) above, surely, the probing dentist does expect pain to result and she intends to find it if it occurs. However, I think DER best understood as claiming that there are certain evils that may never be intended, not that all evils are like that. I suspect that McIntyre is also too confident that dentists bring about the evil of pain “as a means to their diagnostic end.” Surely, she does not simply intend to cause pain. She intends, by probing, to find the location and condition of a sensitive area where pain has previously occurred. She may, consistent with her probing, hope the sensitivity is nowhere to be found. If she causes (and finds) no pain at all, she need not have failed in any part of her plan of action, though it leaves her investigation incomplete. It might be contended that she first *conditionally* intends to cause pain at location L_1 if that is the sensitive spot, then conditionally intends to cause it at L_2 if that is instead the sensitive area, and so on.²⁰ However, even that may not be the most accurate description of her plan. After all, the dentist can and should be pleased if she causes and finds no pain whatever from her probes, though she may also be thereby perplexed and further burdened. Neither her intending to locate a pain that she thinks her patient already experiences, nor her testing to see whether a certain probe causes pain entails that this agent intends pain to result from her series of actions, severally or collectively, let alone that this is something she means unconditionally to cause. It is unqualifiedly true neither that she does something in order to cause the pain nor that she seeks to cause the pain in order to derive some good from it.²¹

²⁰ In conversation with me, Mary Geach suggested that a defender of what I call DER could also maintain that McIntyre’s probing dentist does not intend evil, even if she intends pain, on the ground that insofar as pain is an indicator of dysfunction, it is not a bad thing. I will not make that case here. Of course, a physician who amputates my mangled foot intends me to lose my foot, but there it does seem right to say that this loss is not an evil, since my having a nonfunctional but harmful foot is not a significant good (not a great good for me, not a major benefit to me) and being rid of it therefore not a significant (privative) evil.

²¹ McIntyre concedes that “In our ordinary talk we say that the dentist did not intend to hurt you” but insists this is only “because in our ordinary talk an

In contrast, the physician in a genuine case of PAS does intend to cooperate in the patient's suicide as such, by facilitating it.²² This latter physician acts in order to help her patient secure death, at least insofar as the latter so chooses, and, though less important, she does in fact help to cause that death, when the patient puts this assistance to use, in order to derive from it a (supposed) good. Insofar as she really means to assist, to aid and abet, the patient's suicide, then this physician and her plan of action have to be at least partial failures should the patient live to a natural death. When the physician means her actions only to enable an option for suicide, which is not really assisting suicide in the proper sense, then things are somewhat different with respect to intentions and thus to morality. Still, while a patient certainly has a right to refuse bodily interventions, to which physicians and others must normally defer no matter the patient's reasons, that does not entail any right to others' cooperation and enablement. Because, as I have argued, the patient's death remains an evil, something that anyone *ceteris paribus* ought to combat, and because, as I have also

unattractive feature of one's means can be described as merely foreseen if this feature is not needed for one's means to be effective and if the agent's reasons for adopting the means involved regret about using it" (McIntyre, 2004, p. 71). However, McIntyre offers no compelling reason for classifying this aspect (result) of one's means as a "part" of it, nor for her speculation about our linguistic practice. The agent does not "need" this result and, what is more important, it is not clear in some of the cases that she has in mind that or how she *uses* it in her plan of action. But a means, as the term indicates, is an intermediate element between an undertaking and some state of affairs or event at the end of or at a later stage along an actual, envisioned, or planned (that is, intended) course. It is this that is crucial for what is intended as a means, and McIntyre shows neither that the patient's pain is part of the dentist's plan nor that the patient's death is not such a part of the physician's plan in a case of PAS. Note that my approach has the advantage of allowing us to vindicate the accuracy of our ordinary judgment, with which McIntyre unsuccessfully wrestles, that the dentist does not normally intend the pain that she may cause her patient to suffer.

²² I introduce this test of intentional content in Garcia (1990) and "On the Irreducibility of the Will," *Synthese* 86 (1991): 349-60, and I return to it below, now refining it.

argued, the physician has a separate and special professional responsibility to try to bring health, to which aiming to enable death stands diametrically opposed, such intentional enablement is not permitted her. I conclude that the distinction central to DER is also central to showing why the immoral actions in these situations are immoral.

FRANCES KAMM

Kamm's chief arguments against DER in its application to PAS work from the premises that (a) doctors have a moral prerogative and even a duty to intend certain other medical evils (when they are either lesser or already inevitable), and (b) death is sometimes a lesser evil or already inevitable, to the conclusion that physicians sometimes have a moral prerogative or duty intentionally to kill their patients.²³

However, once we take for granted the truisms that (1) medicine is a healing profession, therein essentially directed to the preservation and restoration of that integrated functioning of some human body's organs and systems that we call the person's health, and (2) to die is to lose even the last vestiges of such functioning, then it is unclear how there could be such a homicidal prerogative for doctors, let alone such a duty. Extending the kind of reasoning that purports to permit or require PAS seems also to commit us to affirming such absurd possibilities as a medical role-duty (or role right) to torture and torment, and, for that matter, comparable duties of teachers and journalists purposely to spread lies, of accountants to defraud their clients, and so on. What, for the defender of PAS, keeps it from being permissible so to act in violation of those other duties even for good ends, despite the fact that it is permitted for a healing professional to destroy the last traces of her patient's health in pursuit of other objectives? If someone's life itself may be targeted for termination by a health professional because it has become unpleasant or is no longer desired, then what ensures that the lesser matter of her suffering is always an evil and, moreover, an evil of such a sort that she is not permitted to aim at? And, for that matter, what keeps it from being ethically licit, even required, for

²³ Frances M. Kamm, "Physician Assisted Suicide, the Doctrine of Double Effect, and the Ground of Value," *Ethics* 109 (1999): 586-605, at p. 589.

teachers and journalists sometimes intentionally to act contrary to their professions' constitutive and defining commitments, once physicians are ethically licensed to kill those they are to heal? Must we, then, present a moral imprimatur to mendacious journalists and lying teachers—and, while we are at it, to cruel, stunting parents, stealing accountants, uglifying architects, and so on—contingent only on “greater goods” for this one or that coming into play here or there?

The defender of Kamm's position might here invoke a line of reasoning presented by Gerald Dworkin, who objects to Leon Kass's appeal to the internal goals of medicine in arguing against PAS. That response is interesting chiefly because its inadequacies highlight the importance of DER.²⁴ Where Kass had complained that allowing a physician to strive to kill patients would be like permitting teachers to give up on students (or parents to abandon their children), Dworkin notes that a teacher may licitly “withdraw” from a student who chooses to pursue athletic rather than intellectual advancement.²⁵ However, Dworkin's grasp of the analogy is flawed precisely because the doctor who participates in PAS does not merely withdraw from her patient by withholding healing care, but turns against her chief professional task of seeking to restore and protect her patient's health, instead striving to destroy it. This is not like the withdrawing teacher Dworkin envisions, but is more similar to one who seeks to deceive or spread ignorance among her students, or to a parent who strives to infantilize and retard her offspring, when they can similarly do some apparent good by betraying their callings. That is, what is crucial morally is precisely that the physician in the case of PAS intends her patient to lose her last vestiges of (the good of) health. She does not merely restrain herself from doing more to restore it, which might sometimes be justifiable, but goes far beyond that.

²⁴ Gerald Dworkin, “The Nature of Medicine,” in G. Dworkin, R. G. Frey, and S. Bok, *Euthanasia and Physician-Assisted Suicide* (Cambridge UK: Cambridge Univ. Press, 1998), pp. 6-16.

²⁵ Dworkin dismisses the analogy with the parent, saying only that we have enough problems with physicians who think they are gods or act paternalistically. I ignore this response as merely rhetorical.

Moreover, returning to Kamm's and Thomson's position, we should also recognize that death may be significantly different from many other things that are bad for a person. Making life something not worth saving when it threatens discomfort, failure, or the loss of reciprocity, of friendship, and so on, appears to make its value merely contingent and instrumental. This presupposes a disdainful, even contemptuous, stand towards human life, especially in comparison with positions, like Kant's, that accord it inherent dignity or non-instrumental worth.²⁶

Kamm denies this. Responding to a similar charge by Velleman,²⁷ she insists that her view does not commit her to seeing life as merely instrumen-

²⁶ I used the rubric "biophobic ethics" for such a contemptuous position when I made this point in debate with Kamm at a session in the Boston meeting of the World Congress of Philosophy. My remarks were published as "Beyond Biophobic Medical Ethics" in *Proceedings of the Twentieth World Congress of Philosophy*, Vol. 1: *Ethics*, ed. Klaus Brinkmann (Bowling Green OH: Philosophy Documentation Center, 1999), pp. 179-89. Kamm's remarks on that occasion were not included in the Congress's volume, and parts of them appear since to have become the gist of Kamm (1999) and Kamm, "The Doctrine of Triple Effect," *Proceedings of the Aristotelian Society, Supplementary Volume* 74 (2000): 21-39.

Kamm complains that many of us who condemn PAS have difficulty in explaining why it is permissible, admirable, and a merciful service to have a sick pet put to death (Kamm, 1999, p. 596). However, I do not see this as troubling. It seems likely that the practice of putting sick or disabled animals to death arose as a labor- and resources-saving measure for farmers, ranchers, and the like. The rationalization that it also was good for the deceased to "put them out of their misery" was probably something to tell children and also to help some adults to live with themselves for thus subordinating to their own financial interests the lives of animals who had become attached to them. It is likely that this rationalization then came to be extended to pet animals. The suffering of animals is an unwelcome thing and it is understandable that we try to end it, especially since there is no comparable moral violation involved in killing them. It does not follow that, when we put animals to death to end our sympathetic misery, we perform an act of merciful service. So, I suspect there is little in this late and fishy "intuition" that needs to be accommodated within sound ethical theory.

²⁷ J. David Velleman, "A Right to Self-Termination?" *Ethics* 109 (1999): 606-28.

tally valuable because, she insists, the issue is properly not whether a PAS patient's life lacks value entirely but whether it is sufficiently valuable both to be worth saving and morally to immunize it against targeting for destruction.²⁸ Perhaps she is right about that. But even if so, she then owes a fuller account of how life can be inherently valuable to a substantial extent (and thus in a meaningful way) when its value so waxes and wanes according to whether it is a source of the good things it usually offers. Is life's intrinsic value real but negligible, and only its instrumental value sizable?

Velleman had also complained that Kamm's pro-PAS position must run counter to Kant's view by according life only a price, rather than dignity, making it something to be traded in order to gain other benefits such as pain relief. Kamm replies that the situation in PAS is not different from that in morphine pain relief (MPR), in (TS), and in other cases where she also sees trade-offs of life for cessation of pain.²⁹ However, there is a significant difference that derives from the fact that a party's *intent* to alienate one thing (and gain another) is part of and essential to any real trade. So, likewise, an intention to terminate life (that is, to cause the end of the patient's possession of life) is internal to both suicide and euthanasia. Here, life is "traded" for comfort in a more nearly literal sense. In contrast, this need not be at all true in MPR or other TS, where there is no such intent and, while the loss of life is real, its "trade" is merely metaphorical.

DER IN APPLICATION TO PVS

In a controversial document on withholding or terminating artificially provided nutrition and hydration from patients in what is often (though misleadingly and insultingly) called a "persistent vegetative state," the late Pope John Paul II classified provision of nutrition and hydration as within "the right to basic health care (nutrition, hydration, cleanliness, warmth)"

²⁸ Kamm (1999), pp. 595-99.

²⁹ Kamm (1999), pp, 599-601. Note that we cannot properly talk of "relieving" someone's pain, or even of "releasing" her from it, unless we think that she survives death to live pain-free.

and thus as within “the normal care due to the sick.” He insisted that “the administration of water and food, even when provided by artificial means, always represents a natural means of preserving life, not a medical act.” Maintaining that they represent a minimal required response to “the intrinsic value and personal dignity of every human being [which] do not change, no matter what the concrete circumstances of his or her life,” the papal document declares that their “use...should be considered, in principle, ordinary and proportionate, and as such morally obligatory.” He cautioned against a morality of cost-benefit calculation: “The evaluation of probabilities, founded on waning hopes for recovery...cannot ethically justify the cessation and interruption of minimal care for the patient, including nutrition and hydration.” Again, “no evaluation of costs can outweigh the value of the fundamental good which we are trying to protect, that of human life.”³⁰

This papal remark raised alarm because it seemed to some to require indefinite artificial feeding, irrespective of its costs to the patient in discomfort, money, or burdens on the minds and time of loved ones. However, the costs of an intervention may always justify its termination, whether or not it is one classified as “medical” or “extraordinary.” So, I see nothing in the new statement that entails that artificial nutrition and hydration are obligatory in all circumstances and regardless of their costs. They are, rather, required, as the document says, “in principle,” but not always required in fact. What is important is that it would never be morally licit (non-vicious) to withdraw such care in order to hasten (i.e., intending to speed) the patient’s death. Moreover, only the burdens narrowly attributable to the provision of food and drink itself count, not those owing

³⁰ All quotations in this paragraph are from Pope John Paul II, “Address before the International Congress on Life-Sustaining Treatments and Vegetative State: Scientific & Ethical Dilemmas,” Rome, Italy: Pontifical Academy for Life & World Federation of Catholic Medical Associations (March 20, 2004), §4-5, available at: www.vatican.va/holy_father/john_paul_ii/speeches/2004/march/documents.

simply to living additional life. Otherwise, euthanasia lurks.³¹ The death of a person is still an evil (something undesirable), and only the minimally dangerous pursuit of such a countervailing good as that of relieving or sparing someone pain can justify failing to act so as to preserve a patient's life.³²

WHY DOUBLE EFFECT REASONING?

Why bother defending DER against this or that specific line of criticism, if it is not even plausible on its face? Though my focus here has been on DER in application to certain issues in medical ethics, before concluding we do well very briefly to indicate some larger theoretical issues about its moral importance. First, several moral theorists have agreed with Bernard Williams on the centrality of so-called "thick" moral terms, such as "malice" or "homicide," over such "thin" ones as "right" and "wrong," the "permitted" and "forbidden."³³ However, many of the "thick" terms either themselves involve intentions (e.g., "malevolent") or imply further claims about intent (as does "lie"). That already indicates the difference between what an agent does and does not intend will carry moral weight. Second, theorists such as Thomson increasingly stress the virtues and vices as central to the moral categorization and assessment of actions. No modern account of the virtues, however, can be plausible unless it gives pride of

³¹ This seems to me a crucial distinction, and one that needs more elaboration than I have yet seen it given in the literature on withholding and terminating life-sustaining interventions.

³² Fr. Kevin O'Rourke, O.P., seems to take encouragement from what he claims to be the fact that "[t]he magisterium has never maintained that prolonging the life of a patient in PVS 'is beneficial to the patient'," quoted in "Reactions Vary to Pope's Comments on Feeding," *America: National Catholic Weekly* (May 3, 2004), p. 4. We need not here enter a denominational, theological dispute about what Catholic moral teaching has explicitly affirmed. My claim here is that life is always and inherently a benefit to a living thing and can be threatened only incidentally (without intending to), and by acts justified by their necessity if patients or others are to be saved from serious harms.

³³ Bernard Williams, *Ethics and the Limits of Philosophy* (Cambridge MA: Harvard Univ. Press, 1985).

place to benevolence and malevolence. But, as even these terms' etymologies show, the imputation of such virtues and vices again points to the agent's will and thus to what she does and does not intend to do in acting. Third, the very importance in medical ethics of health and life, and of illness, death, and pain is frequently expressed in such claims as that the former conditions are intrinsically desirable, impersonally valuable, or some such, and the latter states are at the opposite value-poles. Yet, insofar as actions are right or wrong according to how their agents respond to what is thus valuable or undesirable, as consequentialists insist, it follows that what matters morally is what those agents value, desire, and otherwise "favor" (as Michael Zimmerman puts it³⁴) in doing what they do. Plainly, their intentions will be crucial indicators and loci of their valuational stance, of what they value and how and why they value it, in their behavior. These considerations do not, I realize, suffice to prove that intentions matter to what is morally licit, let alone that they matter in just the complex ways that DER requires. But they should direct attention to double effect as at least dealing with what is of central moral import, unlike utilitarianism and its benighted descendants, and offering a sophisticated account of these complex phenomena. My aim in this short section has not been to prove the adequacy of DER but simply to indicate some promising and under-examined directions from which a fuller defense of DER might be undertaken. There are, I think, many others beside these.

CONCLUSION

Of course, "the doubling" of mind and body cannot be "undone"—not in this life. And because the "two are one, and one is you," there can be no answer to what is meant by the poet's final query, with which we began: "Which one?" We are, rather, the one that comprises the two, body and mind, not one of the two constituents separable in thought. Still, whatever the metaphysics, we face the question of the location and nature of what we might call, albeit somewhat hyperbolically, our moral identity. DER enables us to acknowledge our bodily involvement in causing (especially,

³⁴ Michael Zimmerman, *Nature of Intrinsic Value* (Lanham MD: Rowman & Littlefield, 2001).

undesirable) physical effects, while it makes the moral substance of that causing hang on how the mind stands in relation to them.

We are inclined to think that different stances of mind are virtuous or vicious according to the ways in which we are connected one to another, in the roles we occupy. What matters morally, however, is how we stand one to another, and that is largely a matter of what we want and hope and choose and seek for them. People have preferences for, and expectations about, the aims of the medical profession and of the professionals who occupy medical roles, and they are adversely affected, severally and collectively, insofar as these role-expectations and preferences are left unsatisfied. They have still graver grounds for complaint when medical people act in ways diametrically opposed to these legitimate and constitutive preferences, as when doctors' assume projects and plans that, no matter how kindly motivated, run counter to the aims internal to the healing professions as such. Indeed, each patient is entitled to protection from such plans, even when her despair inclines her not to claim that right.

I have also argued that the division between states that are desirable or undesirable for any human being cannot be so collapsed that paradigmatic bad ones, such as her death, might be changed by circumstances into unambiguous goods. That bifurcative doubling within the realm of the valuable also cannot be thus undone.

Still, there are dualities in this area that we would do well to scrap. I believe that philosophers like the three thinkers whose criticisms of DER I have treated here, thinkers allied with the proponents of DER against consequentialism but adversaries on DER itself and on the central moral significance of its distinction between what is and is not intended, would be wise to take a less equivocal position and join decisively in the defense of DER against effects-driven moral thinking.

To do this, they will need to dispense with the unfortunate and confused distinction between so-called "first-order" and "second-order morality," among other things. It is now commonplace to insist that DER is mistaken because it treats an agent's intentions as relevant to the moral status of her action, which is said to be an issue of "first-order morality." Instead, these thinkers maintain, an agent's intentions are relevant, not to judging the moral permissibility of her actions, but only to what they see

as the second-order matter of how to judge and treat the agent herself, especially, to whether and how much to blame her.³⁵ This whole way of thinking is, I think, deeply confused. It ignores two crucial facts. First, what gives someone the character of a good physician, nurse, or other *healthcare* worker—a good doctor, etc., in a sense that has moral bite—is chiefly her devotion to the health and life of her patients. Second, we can understand her chief responsibility, insofar as she occupies that role, as a commitment to act in ways that manifest that commitment. We need not deny that to assess a person is one thing and to assess her behavior is another. However, we morally evaluate actions precisely as exercises of agency, and the factors relevant and decisive to evaluating her conduct will be facts about her mind at the time of acting that will also be pertinent to evaluating her as a person when they are deep-seated and characteristic. The logical distinction between the two subjects of assessment is misunderstood and misapplied when it is thought to follow that it cannot be largely the same kind of fact that is decisive to both.

I cannot here delve further into these theoretical issues. My project has been critically to examine some recent arguments by anti-consequentialists against the tenability of DER in some of its more specific applications to certain controversies within medical ethics.³⁶

³⁵ This distinction and the related line of argument can be found in Bennett (1995), who borrows the distinction from Donagan, and in many others. For one recent attempt to invoke it to the detriment of DER, see David McCarthy “Intending Harm, Foreseeing Harm, and Failures of the Will,” *Nous* 36 (2002): 622-42.

³⁶ I am grateful to Profs. Neil Delaney, Frances Kamm, and Alison McIntyre for bibliographical suggestions, to Profs. Delaney and McIntyre for sharing their published and pre-published work with me, to Prof. Keith Cassidy and University Faculty for Life for an invitation that stimulated me to revisit this project, to Drs. Mary Geach and Luke Gormally, Rev. David Jones, and other members of a March 2005 audience at London’s Linacre Centre for Healthcare Ethics, as well as to Prof. Daniel Sulmasy and some anonymous referees, for vigorous and constructive criticism of some claims I made in earlier versions of this paper. Prof. Thomas Cavanaugh kindly shared with me his book manuscript on these topics and offered helpful suggestions and remarks, as did a June 2004 audience at the University of St Thomas Law School in Minneapolis.