

Two challenges to the double effect doctrine: euthanasia and abortion

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The validity of the double effect doctrine is examined in euthanasia and abortion. In these two situations killing is a method of treatment. It is argued that the doctrine cannot apply to the care of the dying. Firstly, doctors are obliged to harm patients in order to do good to them. Secondly, patients should make their own value judgments about being mutilated or killed. Thirdly, there is little intuitive moral difference between direct and indirect killing. Nor can the doctrine apply to abortion. Doctors kill fetuses as a means of treating the mother. They also kill them as an inevitable side effect of other treatment. Drawing a moral distinction between the direct and the indirect killing gives counterintuitive results. It is suggested that pragmatic rules, not ethics, govern practices around euthanasia and cause it to be more restricted than abortion.

It is often impossible to do good to patients without also causing them some harm, because treatments have side effects. It may also be necessary to do something to a patient which would be harmful and wrong outside a medical context. It is done because it will benefit the patient.

The double effect doctrine forbids the achievement of good ends by wrong means but it permits actions with a double effect, both good and bad, under certain conditions.^{1,2}

1. The act performed is not itself morally evil.
2. The good effect does not result from the evil effect.
3. Only the good effect is intended.
4. There is a proportionate reason for causing the harm.

Killing innocent humans is inherently wrong but there are two clinical situations in which doctors sometimes do kill innocent humans, abortion and euthanasia. However, the doctrine forbids doctors both to relieve the distress of a dying patient by killing him or her, and to help a woman by killing her fetus.

On the other hand, it permits the use of drugs which relieve the distress of the dying, even when they hasten death. It also allows a surgeon to remove a uterus with a cancer, even though it contains a live fetus. Death is then a side effect of the good action, not the means of achieving it.

The doctrine may originate in a letter of Saint Paul and is closely associated with the Roman Catholic Church.³ The Hippocratic oath, formulated twenty five centuries ago, also specifically proscribes both euthanasia and abortion. Until recently most societies forbade both practices. However, many countries now permit direct killing of the fetus when pregnancy is unwanted. But most of those countries still forbid euthanasia and adhere to the doctrine, when dealing with distress in the dying.

In this paper I will present arguments that it is illogical to use the doctrine to forbid either euthanasia or abortion. Many societies permit abortion but not euthanasia. I will further argue that these societies really base practice on pragmatic reasons, unrelated to the double effect doctrine.

EUTHANASIA

The first argument is that doctors must inevitably harm patients to provide them with a benefit. Good effects in medicine do result from evil effects. A doctor does not do wrong to

a patient, when she harms him to benefit him, with his consent. These actions would usually be wrong but they are made right by the end in view. But the doctrine specifically forbids the achievement of good ends by bad means. I will argue that euthanasia is no different from these other practices.

Surgery provides common examples of harming to confer benefit. Nobody sees any immorality when a surgeon makes a large cut in an abdomen to remove a cancer.

Two objections are made to the application of the doctrine to surgery. It is claimed that the operation is a single action, in which the good predominates. But the incision must be performed at a prior point in time and it only facilitates the surgeon performing a separate act—the excision of the cancer. They are different acts in space and time. The opening of the abdomen by itself does not have good effects. It merely sets the stage for another act, which itself has the good effect—excision of the cancer. According to the double effect doctrine, opening the abdomen should be impermissible, because it is a harmful act. But it is obviously permissible.

One might still argue that the excision of the tumour is somehow a good effect of the abdominal incision. But pain relief follows a fatal injection more surely and more quickly than tumour removal follows an abdominal incision. So by that argument, both pain relief and killing are also effects of the same action and euthanasia is as permissible as removal of the cancer. In reality, in both cases the good can only be achieved by first doing the harm.

Another way of defending double effect is to argue that a physical harm is not always a moral evil.⁴ A robber may make a similar cut to the surgeon and that is both a physical and a moral evil, because he wants to steal money. But the surgeon wants to save life. Therefore it is the reason why harm is inflicted which determines whether it is a moral evil. But the doctrine does not permit actions which would usually be wrong, because they are a means to a good end, in a particular situation. Opposition to euthanasia cannot be based on an objection to achieving good effects through bad effects.

The second argument against the doctrine is that the patient's own ethical evaluation of a method or an outcome should determine whether it is good or bad.

Patients reluctantly agree to mutilation by the removal of normal tissue. Thus someone might be in imminent danger of death from fire, because a viable limb was trapped by fallen masonry. He would allow a doctor to amputate his healthy

limb to save his life. Patients with a genetic predisposition to breast cancer may choose to have their normal breasts amputated.⁵ It is argued that the doctrine should not apply when a part is excised to save life, even if the part is healthy.⁶ But it is the patient who decides that amputation is justified. Conversely, a patient with a cancerous limb may prefer to keep it and die, rather than lose it and live.⁷

Surgeons also perform mutilations, not necessarily to save life. They sew up the normal stomachs of patients with severe obesity. The colon is sometimes removed in laxative addicts, because nothing else can terminate the addiction.⁸ Surgeons cut off normal genitals in sex change operations for patients with gender dysphoria. In other circumstances, that would be horrific torture. Normal limbs are occasionally removed to benefit patients with unusual mental disorders, in which they regard the normal limb as supernumerary.⁹ The mutilation makes that particular patient feel better.

The doctrine does not allow doctors to kill a patient, even if he has reasons for wishing to die quickly with which we can all sympathise. It does allow them to perform terrible mutilations because a particular patient sees them as a benefit to him, although they would horrify other people.

The doctrine is applied in a selective and arbitrary way. The prohibition of euthanasia must derive from a belief that direct killing of the innocent is supremely and always wrong, in a way that dreadful mutilations are not. That belief may or may not be true. The patient should decide for himself. The doctrine makes no sense in the context of the treatment of a single patient capable of making his own value judgments.

A third argument against the doctrine is that there is little intuitive moral difference between indirect killing, permitted by the doctrine, and direct killing, forbidden by it. Confusion arises, because good analgesia may lengthen, not shorten, the life of a dying patient. A thought experiment simplifies and clarifies the situation.

Suppose the only drug able to relieve the distress of a particular dying patient inevitably caused death an hour later. Would using this drug be morally different from killing the patient to relieve distress? One intuitive answer is that patients should be treated as they wish, provided the law, which protects us all, allows it.

For these three reasons the doctrine is irrelevant to euthanasia. A doctor does not do wrong to a patient when she harms him or kills him to benefit him, if the patient judges that the benefit outweighs the harm.

ABORTION

At first sight, the doctrine seems to stand on more reasonable ground when it forbids killing one human to benefit another. The sole issue, however, is the moral difference between killing the fetus as a means of treating the mother, and killing it as a side effect of treating her. The contention is that reasons adequate to justify indirect killing, will also justify direct killing.

The first argument is that making a moral distinction between direct and indirect killing gives obviously counter-intuitive results. Consider a woman who will die with her fetus from eclampsia or malignant hypertension within hours, unless the fetus is aborted. An abortion will save the mother and deprive the fetus of just a few hours of intrauterine life. This, the doctrine forbids. It is hard to justify a principle which demands an avoidable extra death.

In contrast, the doctrine allows a doctor to remove a cancerous uterus containing a fetus, because the death of the fetus is just a side effect of the hysterectomy. If the hysterectomy was delayed, however, until the fetus was viable, a life might be saved. A doctrine which allows the fetus to be killed in this case but not in the previous case, is implausible.

Consider ectopic pregnancy. The doctrine permits the removal of the fetus with the fallopian tube. But it is

sometimes possible to spare the woman surgery by giving her an intramuscular injection of methotrexate to kill the fetus. The doctrine does not allow this. It insists on the surgery. A principle which makes the mother suffer extra harm without any advantage to the fetus, is unreasonable. Some followers of the doctrine concede this last point.¹⁰ A principle is weak if it is frequently abandoned because it gives counterintuitive results.

The second argument is that intuitive responses to causing death as a means and causing it as a side effect, are similar, when the total effect on the mother and the fetus is the same. Another thought experiment examines these responses.

A dangerous disease is sometimes triggered by pregnancy. It can be cured only by abortion. A new drug specific for the disease is introduced. It is quite safe outside pregnancy but it always promptly aborts a fetus. Some might feel more comfortable using the new drug than with abortion. It would nevertheless be illogical to refuse an abortion, if one were prepared to kill the fetus just as surely with the new drug.

I conclude that the total effect on mother and fetus is ethically more important than whether the fetus is killed as a means of treatment or as a side effect of it.

COMPARING EUTHANASIA TO ABORTION

It is strange that abortion is more widely permitted than euthanasia. A woman can choose to have her fetus killed but not herself. The euthanasia patient is already dying and requests death in his own interest. The doctor kills a healthy fetus in the interest of a third person. The paradox is partly explained by the lower value which society puts on prenatal—as opposed to postnatal—life. However, that may not fully justify killing one human (the fetus) to help another (the mother). Pragmatic reasons may be important. It can be difficult to solve some problems of pregnancy without abortion but good palliative care can usually manage the distress of the dying.

WHY HAS THE DOCTRINE SURVIVED?

The double effect distinction may be psychologically relevant to the doctor. When she kills as a means, she must ensure that death occurs. When she kills as a side effect, she can occasionally hope that it will not follow. She might also feel more comfortable with indirect killing. It could not, however, be an overriding moral principle. A fundamental flaw is its failure to recognise that the person affected by an action is the one who must evaluate the harm and benefit arising from it.

I also suggest that doctors and lawyers, when thinking they are applying the doctrine, may really be following three pragmatic rules, not the doctrine. Two are restrictive and one is permissive.

Firstly, many societies do not permit treatments which hasten death, even though they relieve symptoms. Thus, the drug flosequinan relieved the symptoms of heart failure but was withdrawn because it shortened life.¹¹ Secondly, an exception is made to that rule, when a patient is dying. We then accept treatments which relieve symptoms but shorten life. Thirdly, we forbid doctors to kill as a tool of treatment. It is not less moral than mutilating a patient or killing him as an inevitable side effect. It is just against the general interest to accept killing as a treatment method, even if that deprives a few patients of benefit.

This alternative explanation of current practices around the end of life has practical relevance. We cannot easily change practices if they are based on moral principle. We might do so, in the light of experience, if they are just based on pragmatic rules. I suggest that our practices regarding euthanasia are based on such pragmatism, not on ethics.

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- 3 *Holy Bible. Paul. Romans II, 7*. “Why not say, then, ‘Let us do evil so that good may come’? Some people, indeed have insulted me by accusing me of saying this very thing!”
- 4 **See reference 2: 48**.
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