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The Doctrine of 'Double Effect' and its Limitations

Since the 13th century moral theologians have invoked the doctrine of 'double effect' to justify actions which result in both good and bad outcomes. It derives from the view that human life is a gift from God who alone may determine its span. It is used to support medical decisions designed to relieve suffering, where death becomes an unintended, albeit foreseeable consequence. For instance the *Consent to Medical Treatment and Palliative Care Act 1995* states there is:

... no civil or criminal liability by administering treatment with the intention of relieving pain or distress ... even though an incidental effect of the treatment is to hasten the death of the patient.

Its application relies heavily on a medical practitioner *foreseeing* but not *intending* such an outcome. Its purpose is to reassure doctors who might otherwise give inadequate pain relief for fear of being held responsible for hastening death.

Some argue that there is a fundamental distinction between foreseeing and intending, contending that any two actions which are the same in all respects including their outcomes, but differ in the agent's intention, are two different actions¹. It is also argued that to intend something is to aim to make it happen, whereas this is not the case when an outcome is merely foreseen. The doctrine of 'double effect', in respect of end-of-life care, is therefore seen as a way of acknowledging that medical treatments involve risks which cannot be precisely assessed.

Yet in end-of-life decision making, this principle assumes that death is a 'bad' outcome, whereas in reality it is sometimes the outcome desired by the patient, their loved ones and doctor in the absence of any acceptable alternative. Therefore does reliance on the principle of 'double effect' lead to hypocrisy, rather than a focus on the duty to always act in the best interest of the patient?

Intentions are often ambiguous, and while a clinician's intention is of moral relevance, it is very subjective. It should not be the pivotal consideration for judging whether a particular treatment is right or wrong, for there are other factors crucial to this moral judgement. These include the motivation of compassion - a central tenet in palliative care, as well as the fundamental right to self-determination, based on informed consent².

A doctor's subjective intentions are hardly susceptible to legal proof, so any regulation based upon them must be compromised. As has been argued elsewhere:

Even if distinctions between directly intended and merely foreseen consequences make some sense in scholastic, philosophical or theological discussion, they make little sense at the bedside³.

This is because the whole decision-making process is so 'situation determined', that isolating one moment at which the doctor's intention may change from relieving pain

to assisting death is completely arbitrary. What is crucial however is that entirely different legal controls come into effect at this point. Obviously these legal controls do not encourage openness and honesty between the doctor and patient, and what is particularly disturbing is that reliance on a clinician's intention tends to reinforce a paternalistic regime of care, undermining patient autonomy and informed consent.

Many people regard the intention-foresight distinction as seriously flawed, for it is not consistently applied. When serious suffering cannot be relieved 'terminal sedation' is legally permissible, even though this renders the patient unconscious until death occurs. Life-preserving measures are withheld so that death is hastened. It is reasonable to argue that in these instances the accelerated dying process is intended. It is not only foreseeable but also an inevitable consequence of the decision.

While the intrinsic moral significance of the intention-foresight distinction remains controversial it does not mean that formulation of sound public policy should be abandoned. As one commentator argues:

We should stop asking whether a doctor 'intends' death or merely 'allows' it to occur, whether death comes about as the result of an act or an omission, or as a result of a doctor administering a slow-acting therapeutic or a quick acting non-therapeutic drug. While some of these distinctions may have moral relevance in the context of some religious or moral views, they are not a proper basis for public policies regulating medical end-of-life decisions⁴.

Instead what should be sought is a regulatory framework based upon compassion and the procedural requirement of informed consent. It should be focussed on the severity of a patient's suffering and respect for their autonomy and bodily integrity.

Once it is understood that it is informed consent of patients, not the subjective intentions of attending doctors, which is of primary importance in end-of-life decision making, it becomes even more difficult to argue against the legalisation of voluntary euthanasia. Never-the-less vested interests of the powerful minority still prevail over those of the hopelessly ill who continue to be denied self-determination.

It is time that we stopped pretending that the principle of 'double effect' will somehow answer difficult moral questions for us - it will not.

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References:

1. Gillon, R., 1999, British Medical Journal, Sept 319:639
Hunt, R., 1998, 'A Critique of the Principle of Double Effect in Palliative Care' Progress in Palliative Care, Vol 6, No 6, p. 214
2. Griffiths, J., 'The Regulation of Euthanasia and Related Medical Procedures that Shorten Life in the Netherlands', Medical Law International, 1 (1994) 137-58
3. Kuhse, H., 1997, " 'No' to the Intention / Foresight Distinction in Medical End-of-Life Decisions", Journal of Medicine and Law 16: 643-649

See also SAVES Fact Sheet on the [Principle of Double Effect](#)