The Principle of Double Effect in End-of-Life Care

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Abstract: In Catholic moral theology, the principle of double effect has been an effective normative tool for centuries, and it can be used to determine the ethicality of actions that contain both good and evil consequences. The principle of double effect is especially useful in end-of-life care, because many end-of-life treatment options inherently have both good and evil consequences. The principle of double effect can be used to make both practical and moral distinctions between the acts of euthanasia, physician-assisted suicide, palliative sedation, and the withholding and withdrawal of life-sustaining treatment, which can be classified as either unjustified acts of killing or justifiable acts of allowing to die. National Catholic Bioethics Quarterly 15.3 (Autumn 2015): 515–529.

Like abortion at the beginning of life, euthanasia has been the defining bioethical issue at the end of life. Advances in medical technology have brought additional end-of-life options, which have been of great interest in both bioethics and law. Cases such as those of Karen Ann Quinlan (1976), Nancy Cruzan (1990), Terri Schiavo (2005), and Brittany Maynard (2014) have been widely publicized, but the moral and practical distinctions between end-of-life practices—euthanasia, physician-assisted suicide, the withholding or withdrawal of care, and palliative sedation—have not always been clear. This is partly because terms and concepts in end-of-life care are often confused. For example, although passive euthanasia, often referred to as the process of allowing to die, is generally accepted as ethical, many people confuse it with active euthanasia, which is the illicit and active killing of patients. 1

In this essay, I analyze the acts of euthanasia, physician-assisted suicide, the withholding and withdrawal of care, and palliative sedation. Using the principle of double effect, I make both moral and practical distinctions between the different acts. I begin by analyzing the principle of double effect, reviewing its history and the four conditions for its employment. Next I discuss the principle of double effect in relation to euthanasia and physician-assisted suicide, lay out some positive applications of the principle of double effect, and analyze its role in distinguishing between killing and allowing to die. Last, I apply the principle of double effect to palliative sedation and examine recent literature that suggests that the ethics of this practice are not as clear as once thought.

The Principle of Double Effect

The principle of double effect has been used in traditional Catholic medical ethics since the time of St. Thomas Aquinas. It greatly influenced the field in the first half of the twentieth century, and it is still widely employed in Catholic bioethics today, especially in cases involving care at the beginning and the end of life. The principle has four main conditions that must be satisfied for an act to be considered morally licit.2

History and Conditions of the Principle of Double Effect

In essence, the principle of double effect is a microcosm of normative ethics as a whole. Its main purpose is to identify as justifiable (or not) acts that have both good and bad effects. Neither normative ethics nor the principle deals with actions that contain only good or bad consequences, because these acts generally do not cause disagreement. Normative ethics and the principle of double effect deal almost exclusively with controversial acts or judgments, the main difference between them being scope. While normative ethics is a whole area covering how one should act in a variety of circumstances, the principle of double effect is applied only in singular instances under specific circumstances.3

Traditionally, Aquinas is thought to have been the first to formulate the principle of double effect. Some argue, however, that the principle originated much earlier in implicit moral reasoning, possibly dating back to the times of the Old Testament. Several biblical tales involve moral reasoning that conforms to the conditions of the principle. One Old Testament story is that of Eleazar in First Maccabees, who takes advantage of an opportunity in war to kill the enemy king, fully knowing that doing so will mean losing his own life. This brave deed is an example of a justifiable act that causes both good and bad effects, and is an early example in Scripture of normative moral reasoning akin to that of the principle of double effect.4

Although the principle was implicitly understood in ancient times, Aquinas was the first to formulate the doctrine of double effect. He did this by analyzing the case

4 Mangan, “Historical Analysis of Double Effect,” 41–42.
of self-defense against an unjust aggressor, from which two effects, one good and one bad, would inevitably follow. Although he explicitly applied the principle only to this situation, some evidence suggests its presence in his other work, too. The following passage is Aquinas’s analysis of self-defense, from which the principle is formulated:

There is nothing to prevent one act from having two effects, of which only one is intended by the agent and the other is outside of his intention. Now, moral actions receive their character according to what is intended, and not from what is outside of the intention, since that is “per accidens,” as has been stated (q. 43, a. 3; and I-II, q. 1, a. 3, ad 3m). Therefore, from the act of a person defending himself a twofold effect can follow: one, the saving of one’s own life; the other, the killing of the aggressor. Such an act, therefore, insofar as the conservation of one’s own life is intended, is not illicit, since it is natural to every being to preserve its life as far as possible. Nevertheless, an act which proceeds from a good intention may be rendered illicit, if it is not proportioned to the end intended. Hence, if one uses greater violence than is necessary in defending his own life, his act will be illicit. But, if with due moderation he repels the violence offered him, his defense of himself will be licit; for according to law one may repel violence with violence, if he observes the moderation of a blameless self-defense. And it is not necessary for salvation that a man when attacked should forego such an act of moderate defense in order to avoid slaying the aggressor; for a man is under stricter obligation to protect his own life than another’s. Yet, since it is unlawful to kill a man except by public authority for the common good, as explained above (a. 3 of this question), it is, therefore, wrong for a man to intend to kill another as a means to defend himself, except in the case of one invested with public authority, who, in intending to kill another in defense of his own life, refers the act to the common good, as for example when a soldier fights against the enemy or an officer of the law fights against robbers. However, even these would commit sin, if they acted on motives of private spite.

Thus, using the concept of legitimate self-defense as his medium, Aquinas analyzed the concepts of dual effects, intentions, and proportionality to formulate the first rudimentary version of the principle. It would take several centuries for the principle to start gaining attention as a potential normative tool. Two centuries later, Cardinal Cajetan’s commentary on Aquinas’s Summa theologiae brought further clarity and attention to the principle’s effectiveness in certain situations, and in the modern period, Jean-Pierre Gury’s Compendium theologiae morali brought awareness of the principle’s potential as a total normative tool for moral theology as a whole.

The principle itself contains four main conditions that must be satisfied for its employment as justification for an action that indirectly causes some bad effects in addition to its directly caused good effects. The conditions are usually listed in a logical serial order to help in applying the principle to an action. The serial order does not necessarily favor one condition over another, however, since they all must be satisfied for the principle to be correctly applied.
The first two conditions deal with the act itself and its relation to the bad effect caused; the latter two conditions are concerned more with intentionality and consequences. The formal conditions of the principle are as follows:

1. The action, considered by itself and independently of its effects must not be morally evil. …
2. The evil effect must not be the means of producing the good effect. … The evil effects … are simply unavoidable by-products of [actions] designed to produce the good effects …
3. The evil effect is sincerely not intended, but merely tolerated.
4. There must be a proportionate reason for performing the action, in spite of its evil consequence. … According to a sound prudential estimate, the good to be obtained is of sufficient value to compensate for the evil that must be tolerated.

When an action passes all four conditions, it is considered ethically justifiable by the principle of double effect.

**Euthanasia, Physician-Assisted Suicide, and Double Effect**

With the principle of double effect defined, it is now possible to apply it to end-of-life options that cause both good and bad effects. The most infamous and best known of these end-of-life options is euthanasia, which has been well discussed in its many different forms: active, passive, direct, indirect, voluntary, nonvoluntary, and involuntary. More recently, though, physician-assisted suicide has been the hot-button end-of-life issue, and several US states have passed laws for PAS or dealt with issues of PAS as it has grown in popularity and controversy.

**Euthanasia**

The term *euthanasia* literally means “good death,” but in modern times it refers to different ways of medically inducing death. In the Netherlands, one of the few countries that has laws allowing its use, *euthanasia* is defined as the act of deliberately and actively terminating the life of a suffering patient, done by a physician in response to

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a voluntary request from the patient.\textsuperscript{11} As previously mentioned, various distinctions are made between different types of euthanasia, the most common being between active euthanasia and passive euthanasia, or between killing and allowing to die. \textit{Active euthanasia} refers to inducing death intentionally by medical means, whereas \textit{passive euthanasia} refers to withholding or withdrawing life-sustaining treatment. These two terms—\textit{active} and \textit{passive euthanasia}—are being used less and less, however, because the intentionality implicit in “active euthanasia” makes people think that passive euthanasia is also meant to cause death, whereas the withholding or withdrawal of treatment is almost universally held to be ethically justifiable in some cases.\textsuperscript{12}

Several other distinctions are made among forms of euthanasia. The first is \textit{voluntary euthanasia}, which is a death medically induced at a patient’s explicit and informed request. The second is \textit{nonvoluntary euthanasia}, which is the medically induced death of an incompetent patient, done without the patient’s consent, usually in a case of persistent vegetative state or permanent unconsciousness. \textit{Involuntary euthanasia} is the medically induced death of a patient who explicitly wished not to be put to death.\textsuperscript{13}

Active, voluntary euthanasia dominates the discussion of euthanasia in the literature, and is generally defended under two principles: beneficence and autonomy. Arguments from beneficence center on doctors doing “good” for their patients and having mercy. If the patient has a terminal illness and suffering that cannot be relieved, it is argued that doctors should have the ability to relieve the suffering by performing a merciful death. On the other hand, arguments from autonomy argue that patients with terminal illnesses are autonomous agents, and that respect for autonomy obligates doctors to follow their patients’ wishes. Proponents of euthanasia claim that both arguments provide sufficient justification for allowing it in cases of terminal illness.\textsuperscript{14}

When the principle of double effect is applied to euthanasia, the ancient Greek notion of a “good death” does not seem so apt. It is immediately apparent that this end-of-life option cannot be justified by the principle, because the very act of purposefully and directly ending life is morally evil and so is explicitly prohibited by the first condition. Euthanasia also does not fulfill the second condition, because the evil effect, the death of the patient, is the means of producing the good effect, the relief of the patient’s suffering. These first two conditions are meant to limit any consequentialist rationalizations of evil actions, so this principle labels the act of euthanasia as a morally evil act.

\textit{Physician-Assisted Suicide}

Physician-assisted suicide (PAS) is also a kind of medically induced death, but the main actor is different. In euthanasia, a physician initiates the request and accomplishes the act; in PAS, a legally competent patient asks a physician to provide

\textsuperscript{12} Kelly, \textit{Medical Care at the End of Life}, 15.
\textsuperscript{13} Ibid., 122.
a lethal drug. In PAS, the physician is the source of the fatal drugs, but the patient asks for them and consumes the dose himself, which is why the act is described as a suicide.15 In most places where it is legal, PAS is permitted only for a patient who is terminally ill, and most laws governing PAS set this condition even though it is not technically or formally part of the definition.

As with euthanasia, the ethical principles of beneficence and autonomy are used by PAS proponents to argue for its ethical justification. Proponents argue that just as doctors should do “good” for their terminal patients by performing euthanasia, they should also do “good” for their patients by aiding them in their search for a merciful death. Proponents also argue, perhaps even more strongly than with euthanasia, that respect for the bodily autonomy of terminal patients also requires physicians to help them in their wishes.16 This notion is thought to be strengthened by the positive obligation of autonomy, which requires some people (in this case physicians) to perform actions that foster autonomous decision making in others.17

Some still consider PAS to be self-administered active euthanasia. However, because of the patient’s right to bodily autonomy and the lack of the physician’s direct role in the act, PAS is generally perceived to be a lesser evil—or less ethically questionable—than physician-administered active euthanasia. This is highlighted by the fact that some ballot initiatives for PAS have passed in the United States, whereas every ballot initiative for euthanasia has been defeated thus far.18 Many argue that, because it is the responsibility of the medical profession to save lives and because actively causing death violates the profession’s character and goals, euthanasia is the more serious ethical issue.19

When PAS is analyzed by use of the principle of double effect though, it is shown to be the same as euthanasia: it is ethically unjustifiable. PAS fails the same conditions—conditions 1 and 2—as euthanasia. It fails to meet the first condition because the action, suicide or direct self-killing, is a morally evil act in itself, and it fails to meet the second condition because the evil effect of the action, the death of the patient, is what causes the good effect of the action, the relief of the patient’s suffering. As mentioned earlier, these first two conditions are included in the principle to ensure that evil actions are not justified by consequentialist rationalizations. Thus, the principle of double effect judges the actions of euthanasia and physician-assisted suicide to be morally evil; they are not ethically justifiable.

15 Kelly, Medical Care at the End of Life, 20.
Life-Saving or Life-Sustaining Treatment
and Double Effect

Another end-of-life option is passive euthanasia, or the withholding and withdrawing of life-saving or life-sustaining treatment. This is one of what David Kelly calls the pillars of the American consensus on end-of-life issues. The question of forgoing treatment is a very dense area of end-of-life ethics, and it involves interrelated concepts of several end-of-life stratagems, including the distinctions between ordinary and extraordinary treatment, between killing and allowing to die, and between withholding and withdrawing treatment.

The Pillars of Consensus

Kelly’s pillars of consensus on end-of-life care provide a fairly accurate overview of the current thinking in Catholic moral theology on end-of-life treatment decisions, which includes the principle of double effect. The first pillar of the consensus is the recognition that not all life-prolonging treatments benefit every patient. In the Catholic tradition, this is known as the distinction between the ordinary and extraordinary means of preserving life. The second pillar is the moral distinction between killing and allowing to die. In this category are five basic types of actions: withholding of treatment, withdrawal of treatment, palliative sedation, physician-assisted suicide, and active euthanasia. According to the consensus, the first two actions are considered allowing to die, the last two actions are considered killing, and the remaining action is in a middle state of indirect killing.

The traditional Catholic distinction between ordinary and extraordinary treatments occupies a middle ground between two opposing extremes. At one extreme is vitalism, which advocates for sustaining life at all costs. On this view, life intrinsically has the greatest possible value, and no forgoing of care is allowed. At the opposite extreme is subjectivism, which holds that the value of a human life is determined by each individual. Since in this view a human life has no intrinsic value, an individual who does not find his life valuable may forgo life-sustaining or life-saving care. Between these two extremes, the ordinary/extraordinary distinction recognizes the sanctity of life on the one hand and certain important aspects of quality of life on the other.

Like the principle of double effect, the distinction between ordinary and extraordinary treatment separates end-of-life treatments that are ethically mandatory from those that are optional, which in practice boils down to a human burden-to-human benefit analysis. In other words, it is a moral distinction rather than a medical distinction.

This is an important difference, because many treatment options that appear positive in a medical burden-to-benefit analysis would not be positive in a moral

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20 Kelly identifies two moral pillars and one legal pillar. Kelly, Medical Care at the End of Life, 53. Only the moral pillars are discussed here.
21 Ibid., 12–14.
22 Ibid., 11–20.
23 Kelly et al., Contemporary Catholic Health Care Ethics, 127–128.
burden-to-benefit analysis. In the past, a restrictive approach was used, which dis­tinquished between ordinary and extraordinary treatments almost exclusively by the burdens of the treatment. For example, a treatment had to cause much hardship, pain, or expense to be considered morally extraordinary. Today, both the burdens and the benefits of a treatment are taken into consideration, and a treatment with relatively mild burdens as well as meager benefits may be considered morally extraordinary.

This is the current position of the Vatican, as laid out in 1980 in the Declaration on Euthanasia, where it states, “It will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources.”

Withholding or Withdrawing Treatment

The first pillar of the consensus establishes the notion that not all life-prolonging treatments are in the patient’s best interests, which allows certain medical treatments to be forgone under certain circumstances. The second pillar establishes that certain acts of allowing to die are morally different from acts of killing. As noted above, acts of active euthanasia and physician-assisted suicide are acts of killing, which do not meet the conditions of the principle of double effect and are ethically unjustifiable.

According to the consensus, some acts of “allowing to die” are ethically justifiable in some cases, in contrast to the direct killings of euthanasia and physician-assisted suicide. But what exactly are acts of allowing to die? The terminology of allowing to die has been described as passive euthanasia. While active euthanasia means directly causing a death by a life-shortening intervention, passive euthanasia means letting someone die by withholding or withdrawing life-sustaining treatment. These are ethically different acts. The terms active and passive euthanasia are often conflated and confused, however, and will not be used here.

Many different treatments and procedures can come under the umbrella of morally extraordinary treatments. Examples include cardiopulmonary resuscitation, the use of ventilators, chemotherapy, and even assisted nutrition and hydration. This is not to say that these treatments are always morally extraordinary. In fact, because the distinctions between ordinary and extraordinary treatments are generally blurry, decisions on whether a treatment is ethically obligatory are based on the context and the details of individual cases. For example, cardiopulmonary resuscitation is unequivocally a morally ordinary treatment for an otherwise healthy teenager who needs it during an appendectomy, but it could very well be morally extraordinary for a ninety-five-year-old patient with stage IV lung cancer who has been unconscious for several weeks.

24 Congregation for the Doctrine of the Faith, Declaration on Euthanasia (May 5, 1980), part IV.
25 Kelly et al., Contemporary Catholic Health Care Ethics, 8–10.
Even though the withdrawal of treatment is generally viewed as an active and different action than the withholding of treatment, there is no moral distinction between the two means of forgoing treatment. Any treatment must meet two conditions: it must be medically indicated and the patient must consent to it. These conditions hold in both the withholding and the withdrawal of treatment as well, because both require patient consent that can be retracted at any time. Also, if a treatment is not effective in the ways it was meant to be, then it is no longer medically indicated, the first condition is no longer being met, and its withdrawal is ethically called for.26

Drawing a distinction between the withdrawal and the withholding of treatment could also result in undertreatment of patients in emergencies and at the end of life. If a treatment, once initiated, could not ethically be withdrawn, more families would withhold potentially life-saving treatments and therapies for fear that they would not be able to withdraw those that were no longer beneficial to the patient.27

We have seen that use of the principle of double effect is consistent with the ethical distinction between morally ordinary and extraordinary treatments and that use of the principle to analyze euthanasia and physician-assisted suicide shows them to be acts of killing. It then stands to reason that the act of forgoing morally extraordinary treatment at the end of life will meet the conditions of the principle. Using the principle to analyze a case of forgoing treatment will check its validity as an ethically sound option. We will posit that a sixty-year-old woman forgoes her fourth round of chemotherapy because it would provide only a slim chance of remission and a marginally longer life span while burdening her with great expense and much pain and discomfort.

In terms of the first condition of the principle of double effect, it is clear that forgoing chemotherapy is not a morally wrong act in itself, especially since chemotherapy drugs are essentially poisons. The second condition is also easily met in this case, because the evil effect (permitting death to occur somewhat sooner) does not cause the good effect (the absence of suffering from another round of chemotherapy). As for the third condition, the patient does not intend the evil effect but intends to avoid more suffering from unwanted treatment; she would more than likely prefer to live longer if the difficulties were not so great. Finally, the slight hastening of her death does not outweigh the good of being able to avoid the pain and discomfort of more chemotherapy in the time she has left. Thus, the principle of double effect does support some, but not necessarily all, instances of forgoing life-sustaining treatment at the end of life.28

One of the main criticisms of the distinction between morally ordinary and extraordinary treatment is its lack of practicality, because it seems in practice to be

28 Kelly et al., *Contemporary Catholic Health Care Ethics*, 107–108.
little more than a rudimentary burden-to-benefit analysis, making it a more descriptive than normative tool for distinguishing between two acts: one obligatory and ordinary and the other optional and extraordinary.\textsuperscript{29} One way to answer this objection is to think of the distinction as implicit in the principle of double effect, specifically its fourth condition. The fourth condition essentially states that the bad effect of an act must not outweigh the good effect. This makes the fourth condition very similar to a burden-to-benefit analysis; in fact, it is a burden-to-benefit analysis that merely uses different terms in its proportionality, that is, good effects outweighing bad effects rather than burdens outweighing benefit. For an act to pass the fourth condition of the principle of double effect, the good effect (e.g., the analog to burden in the ordinary versus extraordinary distinction) must outweigh or at least equal the bad effect (e.g., the analog to benefit in the ordinary versus extraordinary distinction). In the distinction, extraordinary treatment entails a higher ratio of burden to benefit, with the opposite being true in ordinary treatment.\textsuperscript{30}

If we then equate the burdens and benefits of the distinction to the concepts of good effect and bad effect, respectively, in the fourth condition, we can see that the distinction is inherent in the principle of double effect. A treatment that is morally extraordinary is one with a higher burden-to-benefit ratio that has passed the fourth condition of the principle of double effect, because the good effect (the avoidance or elimination of excessive burden) of the action (forgoing life-sustaining treatment) outweighs the bad effect (the lack of treatment benefit). So actions of forgoing life-sustaining treatments that have met the criteria of the principle of double effect are necessarily morally extraordinary because of the burden-to-benefit analysis that is inherent in the fourth condition of the principle.

The fit between the two concepts is not perfect, of course, because the inverse use of the language of burden and benefit makes it seem forced, though it is logically consistent. However, this way of viewing the distinction adds another level of practicality to the distinction between morally ordinary and extraordinary treatment while addressing a common objection to its use.

\textit{Killing and Allowing to Die}

Although the application of the principle of double effect to some instances of forgoing life-sustaining treatment seems fairly uncontroversial, some have argued against this claim. For example, one of the arguments against the use of the principle to justify forgoing some treatment at the end of life is the virtual inability of physicians, and people in general, to know the true intentions of others. Some critics assert that the principle is not helpful because physicians are unable to know the reasons patients and their families want to forgo life-sustaining treatment.\textsuperscript{31} The main argument, though, suggests that the principle cannot be used to distinguish between killing and allowing to die, because both concepts include an actual intent


\textsuperscript{30} Kelly, \textit{Medical Care at the End of Life}, 3–4.

\textsuperscript{31} Kelly et al., \textit{Contemporary Catholic Health Care Ethics}, 140.
to hasten death to relieve a patient’s suffering. This intent seems to violate the third condition of the principle of double effect, which states that “the bad effect, such as death, must not be a means to the good effect, such as the relief of suffering”; it thus equates the notions of killing and allowing to die, justifying the practices of euthanasia and physician-assisted suicide as it justifies palliative sedation and the occasional forgoing of life-sustaining treatment at the end of life.32

The flaw in this argument is its misinterpretation of the third condition. Throughout the Catholic tradition, this condition has been understood to mean that “the agent must not intend the bad effect as an end to be sought.”33 In contrast, the critics argue that it should be understood to mean that “neither the patient nor the physician intends the patient to die, either as a means or as an end.”34 But there is a major difference between these two interpretations. In the latter, any involvement in the process of death as a means or an end would invalidate the justifiability of the action according to the condition and, ultimately, equate killing and allowing to die. The correct interpretation requires only that the bad effect not be an end to be sought and so allows for unintended but foreseen consequences of the act, so long as the means of direct death is not the intention. This justifies the act of allowing to die as a proper means to an intended end.

Proponents of euthanasia and physician-assisted suicide actually have the same intentions as proponents of forgoing life-sustaining treatment: to palliate the patient’s suffering. But the main difference between the two is the means of bringing about the intended end. Since the first two conditions rule out the means of euthanasia and physician-assisted suicide as morally evil acts in themselves, the principle of double effect does indeed draw a distinction between killing and allowing to die, and it also justifies its positive application to some instances of forgoing life-sustaining treatment at the end of life. Furthermore, under the traditional interpretation of “intend as an end to be sought,” the practical cases of worrying about the ability to know family motives and intention are much reduced in comparison with the interpretation of “intend as an end or as a means.”35

**Palliative Sedation and Double Effect**

In addition to euthanasia, physician-assisted suicide, and the withholding and withdrawal of life-sustaining treatment, the final act in the realm of killing and allowing to die is palliative sedation, which is a potential end-of-life approach for those with intractable suffering who require great dosages of pain medication to ease their pain. Although traditionally accepted as ethically justifiable by the principle

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33 Kelly et al., *Contemporary Catholic Health Care Ethics*, 107, emphasis added.
34 Quill et al., “Rule of Double Effect.” 1768.
35 Kelly et al., *Contemporary Catholic Health Care Ethics*, 137–140.
of double effect, both its intentional uses and its correct application have recently come into serious question.36

Palliative Sedation

Palliative care has a long and storied use, and is generally thought of as a type of care that evolved outside the traditional history of care.37 The term “palliative care” is derived from the term *palliation*, which means “to cloak,” and it refers to the management of pain and its symptoms.38 It is given when medical therapies have proved futile or a focus on pain and symptom management is desired, or both, although it is not necessarily limited to patients at the end of life. For managing symptoms, palliative medicine has been in use for centuries. But as a specialized discipline, palliative care was developed only recently. In general, palliative care addresses the total comfort of the patient and necessarily goes beyond mere palliative medicine, involving the cooperation of physicians, nurses, social workers, clergy, and the family.39

For patients who experience immense suffering at the end of life, extreme measures sometimes have to be taken to control that suffering. One extreme measure is sedation, which can render the patient unconscious, depending on the dosage administered. This is known as palliative, or terminal, sedation, though, like “passive euthanasia,” the phrase “terminal sedation” often causes confusion: while it is meant to describe sedation given to a patient who is already dying (a patient in a terminal condition), it is easily misunderstood to mean sedation that causes death. Palliative sedation, then, is “the intentional administration of sedative drugs in dosages and in combinations required to reduce the consciousness of a terminal patient as much as necessary to adequately relieve one or more refractory symptoms.”40 While thus sedated, the patient almost always ends up passing away, which has led some individuals to label this as “slow euthanasia.”41

However, palliative sedation is different from active euthanasia in several ways. Most importantly, the aims and intentions of each are much different. In active euthanasia, the patient asks a physician to administer a lethal dose to the patient with the intention of deliberately and actively terminating the patient’s life.42 Euthanasia thus

37 Diego Gracia, “Palliative Care and the Historical Background,” in ten Have and Clark, *Ethics of Palliative Care*, 18.
39 Gracia, “Palliative Care and the Historical Background,” 29–32.
involves (1) a direct intention to end the patient’s life, (2) a disproportionate dosage of medication given to achieve this aim, and (3) by definition, the patient’s actual death. In palliative sedation, the direct intention is not to end the patient’s life, but rather to control otherwise refractory symptoms. Furthermore, palliative sedation requires a drug dosage proportional to the pain relief needed by the patient. The administered dose of the drug is the bare minimum needed to control symptoms, whereas in active euthanasia, the administered dose is intentionally lethal. Finally, the patient necessarily dies by active euthanasia, but not necessarily by palliative sedation.43

The distinction between active euthanasia and palliative sedation is also a reason why palliative sedation can pass the conditions of the principle of double effect while active euthanasia cannot. First, active euthanasia is regarded as morally evil by the first two conditions of the principle, whereas palliative sedation meets the first two conditions without issue. This is because the act of sedation is not evil in itself, and the evil effect of the act (a possible hastening of death) does not cause the good effect (relief of pain). This is the main distinction between killing and allowing to die, which was discussed earlier in the review of arguments against the usefulness of principle as a normative tool.

Second, palliative sedation also meets the latter two conditions, because the evil effect is proportionate to the good effect (relief of pain) and the good effect (pain relief) rather than the bad effect (a possibly hastened death) is intended. Any manipulation or changing of the intents and motives of the act could change certain instances of palliative sedation into forms of “slow euthanasia.” However, theoretically and by definition, palliative sedation is fundamentally opposed to active euthanasia, and only corrupted acts of palliative sedation are on the same moral plane as active euthanasia. Palliative sedation is, then, an ethical act that is justified by the principle of double effect.44

Issues in Applying the Principle of Double Effect to Palliative Sedation

Two objections have recently been made against the ethical justification of palliative sedation by the principle of double effect. It has been argued, first, that while the intent to relieve suffering is the basis of palliative sedation in theory, it is not the case in practice, since many doctors purposefully choose this route to hasten the deaths of their patients. This has actually been well recorded empirically in the Netherlands and Belgium.45

There is a distinct difference, however, between intending the death of a patient and being happy that their suffering is over. Just because a physician or family is relieved that a patient has finally found peace in death does not mean that they intended the death to occur.46 This worry about intent can have ramifications for physicians with patients who are terminally ill, because their use of palliative

43 Broeckaert and Núñez Olarte, “Sedation in Palliative Care,” 175–176.
45 Broeckaert and Núñez Olarte, “Sedation in Palliative Care,” 169.
46 Kelly et al., Contemporary Catholic Health Care Ethics, 135–136.
sedation as a last resort for refractory symptoms, if misunderstood, may expose them to threats of legal action.

If the intention and motivation for palliative sedation truly are the hastening of death rather than the management of pain, then the threat of legal action is a legitimate concern. The principle of double effect is the main normative tool that guides ethical recommendations for palliative sedation. Thus, if palliative sedation is administered to hasten death, the intention is evil and the act does not meet the criteria for the principle, which essentially equates it with euthanasia.47

A second objection to the practice of palliative sedation involves the intention and the use of full sedation. Opponents of palliative sedation argue that when full sedation, rather than minimal sedation, is the first level tried, the intention is called into question. Is it the goal of palliative sedation to bring the patient to full, unconscious sleep, or is it to reduce the patient’s consciousness as little as possible for as short a time as possible to relieve their symptoms? The problem in practice, opponents argue, is that patients are sedated from the outset to full unconsciousness.48

Research has linked this type of palliative sedation abuse to inexperience, fatigue, and burnout in the operator.49 Furthermore, it suggests that palliative sedation does not have the negative effect on the patient’s condition that it was once thought to have—that is, it does not hasten a patient’s death—which brings into question the need for the principle of double effect in assessing its use. Also, these issues with the questionable effect of sedation on hastening death emphasize the importance of using minimal sedation whenever possible, because more sedation might terminate a patient’s life in a type of accidental euthanasia.50 Thus, for palliative sedation to be ethically justified by the principle of double effect and distinguished from evil acts like euthanasia, the intent in its use must be the management of pain and not the death of the patient, and the goal should be to administer the minimal amount of effective sedation to achieve pain relief without inducing the undesirable state of full unconsciousness.51

An Effective Tool

The principle of double effect is an effective normative tool that can be used to morally distinguish between various different end-of-life options. Although used implicitly in ancient times, the principle was formulated explicitly in the Middle Ages by Aquinas, and its four conditions give us a filter by which actions with both good and evil consequences can be normatively judged. The principle can morally distinguish between the acts of euthanasia, physician-assisted suicide, the forgoing

50 Ibid., 1164.
of life-sustaining treatment, and palliative sedation, putting each act into the realms of killing or allowing to die. Euthanasia and physician-assisted suicide are examples of direct killing, while in at least some cases, the forgoing of life-sustaining treatment and the use of palliative sedation are acts of allowing a patient to die. Although many centuries old, the principle remains one of the most useful normative tools of Catholic moral theology, and it is available and effective for both practical and theoretical uses in ethical decision making at the end of life.