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Why do we use a shell (*Nautilus pomplilus Linnaeus*) to symbolize *vera lex*? The logarithmic spiraling and overlapping chambers of the shell are endless. They suggest a patterned development and evolution that, by its radial and circular design, never comes to an end. This means that the shell is at once specific and real, while its form, like law, is abstract and ideal.

The pattern of a shell is, like good law, uniform, regular and reliable. It can therefore be anticipated and known. The pattern of a shell is balanced, like justice. *Una iustitia.*

A shell is a biological being. Like law, it has life and dynamic. It grows. (There is an average of thirty growth lines per chamber, one for every day in the lunar cycle, suggesting that a new chamber is put down each lunar month and a new growth line each day, thus recording two different natural rhythms, lunar and solar.)

The shell is a universal and common object known to everyone. A shell is not soft tissue easily destroyed. And yet, like liberty, it is fragile in certain respects if stepped on with an iron boot. It has to be guarded with vigilance or it is crushed.

In every shell lives a nautilus. If the shell is law, the nautilus (snail) is a person—it is alive—person and law. Their destinies, like person and law, are interdependent.

Vera Lex

leges innumerae, una iustitia

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force and causing no more harm than is necessary for bringing about her good end (i.e., of protecting the world from the alien); under the circumstances she judges she needs to kill the alien; since it is growing rapidly inside Sebastian's chest, and since she has good reason to fear that if it bursts out she will be unable to stop it before it overtakes her, she judges that she needs to shoot it while it is still in Sebastian; she accepts the harm to Sebastian. If there was a reasonable alternative, that included preserving Sebastian's life and killing the alien, and had Alexa apprehended that alternative, she would have been morally obliged to choose it; in other words, Alexa would not have been justified in shooting the alien while still inside Sebastian, *not* because she would have thereby intended Sebastian's death, but because unintentionally, but with foreknowledge, she would have caused more harm than was necessary to bring about her good end. This would be a grave injustice against Sebastian and hence a grave moral wrong.

The assertion, therefore, that the baby's death in the case of the craniotomy can be unintended, does not imply that it would always—or ever—be morally legitimate to accept.

DOUBLE EFFECT REASONING AND CARE AT THE END OF LIFE: SOME CLARIFICATION AND DISTINCTIONS

Daniel P. Sulmasy, OFM

The Church has no philosophy of her own nor does she canonize one particular philosophy in preference to others.
Fides et Ratio, n. 49.

From different quarters, then, modes of philosophical speculation have continued to emerge and have sought to keep alive the great tradition of Christian thought which unites faith and reason.
Fides et Ratio, n. 59.

No less important is philosophy's contribution to a more coherent understanding of Church Tradition, the pronouncements of the Magisterium and the teaching of the great masters of theology, who often adopt concepts and thought-forms drawn from a particular philosophical tradition. Fides et Ratio, n. 65.

INTRODUCTION

The distinction between ordinary and extraordinary means of care (O/E) is often considered an application of the rule of double effect (RDE). This has become a common contemporary belief, shared by parties on both sides of some recent debates within the Church about care at the end of life.

Frs. Benedict Ashley and Kevin O'Rourke, for instance, write that, "... 'letting die' when therapy will not benefit the patient (indirect killing in accord with the principle of double effect) is ethically justifiable."[1]

They make a similar claim that forgoing extraordinary means of care can be distinguished from suicide by the invocation of the rule of double effect.

> Therefore, by the principle of double effect, the choice of another good may justify the *indirect* surrender of human life either for oneself or for another. In these circumstances, one

[1]Benedict Ashley, O.P. and Kevin O'Rourke, O.P., *Health Care Ethics: A Theological Analysis*, 4th ed. (Washington, DC: Georgetown University Press, 1997), p. 421.

> does not choose death. Rather, one chooses another good, foreseeing that death will result as an unwanted and indirect result of that choice.[2]

The same conflation of O/E and RDE appears in the so-called New Natural Law theory, although less explicitly stated. These authors sometimes treat the O/E distinction with grave suspicion because of the potential they see for its abuse.[3] But their treatment of the O/E distinction is distinctive in other ways. They tend to treat it ahistorically. They cite no sources prior to Pius XII in their discussions of this topic, and frequently cite late 20th century U.S. legal opinions that *do* distort the meaning of the O/E distinction, lending credibility to their suspicions about its potential for abuse. At the very least, they caution that we should be very clear about what the O/E distinction means.

When the New Natural Law theorists do discuss the O/E distinction, however, they tend to translate it into their "basic reasons for acting" theory, in which the rule of double effect plays a critically important role. To notice this, one must be a very careful reader. Perhaps more importantly, one should pay attention to what is lost in this translation. As an example of how subtly this happens, consider the following passage from Grisez. In discussing the case of a man's duties to his wife who suffers from a condition of post-coma unresponsiveness, he writes:

> Since life is inherently good, there is still a reason to sustain and care for the gravely debilitated person in every appropriate way; but this reason cannot be considered decisive in determining moral responsibility. Otherwise, everyone would always be obligated to use every available means to sustain every person's life. But sound principles of morality do not entail such an exceptionless obligation, in practice nobody acts on it, and the Church implies that it does not exist because some means can be considered extraordinary and nonobligatory. Therefore, when resources that could be used to sustain someone's life are needed to meet some other serious responsibility, one may use them for that other purpose, provided

[2] *Ibid.* at 425.

[3] Germain Grisez and Joseph Boyle, *Life and Death With Liberty and Justice* (South Bend, Indiana: University of Notre Dame Press, 1979), pp. 105-7; 257; 418.

> there is not some reason in addition to human life's inherent goodness for using them to sustain life.[4]

The move between the last two sentences is interesting. Grisez interprets the O/E distinction in terms of a conflict between competing moral obligations to promote the basic human goods. His move is understandable since this view is fundamental to the New Natural Law theory.[5] However, there is a suppressed premise. Framing the case as a conflict between a positive duty to promote one basic human good and a negative duty not to violate another basic human good involves one immediately in the double effect reasoning that is fundamental to the New Natural Law theory. Double effect has a special preeminence in this theory because New Natural Law theorists posit that one may never act except to instantiate one of the basic goods (life, knowledge, play, aesthetic experience, friendship, practical reasonableness, religion, and marriage), and one cannot act against one of these goods except as an indirect consequence of acting to promote another. All the principles of Catholic medical morals appear to become applications of the RDE in this theory.[6] Thus, the moment one casts the O/E distinction in terms of the New Natural Law theory, one has cast that distinction in terms of double effect reasoning.

Here is another treatment of the topic by another member of this school, John Finnis. In describing the difference between refusing "ordinary" care and "abstaining from excessive measures," he writes:

> ...it is not suicide to choose to refuse treatment precisely because it—having the treatment and undergoing its aftereffects—is burdensome, and one chooses to reject the burden. One's death is not chosen, for it is neither one's end, nor a

[4] Germain Grisez, *Difficult Moral Questions*, vol. 3. (Quincy, Illinois: Franciscan Press, 1997), p. 222.

[5] See, for instance, John Finnis, *Natural Law and Natural Rights* (Oxford: The Clarendon Press of Oxford University Press, 1980), pp. 118-125; Joseph Boyle, "Medical Ethics and Double Effect: The Case of Terminal Sedation," *Theoretical Medicine and Bioethics* 25 (2004): 51-60.

[6] Even the amputation of a gangrenous limb to save a life is construed, on this account, to be an unintended side-effect at a 3rd order level of moral abstraction. Thus, the Principle of Totality becomes explicitly re-interpreted as an application of the RDE (see John Finnis, *Aquinas: Moral, Political, and Legal Theory* (New York: Oxford University Press, 1998), pp. 279-80.)

> means to one's end, but a side-effect, foreseen and accepted (but not intended, not chosen), of one's choice to reject the burden. Such choices may in certain cases, perhaps many cases, be unjustified (cowardly, selfish), but need not be suicidal (homicidal).[7]

Again, while not explicit, Finnis' language implies that what he is offering the reader is an interpretation of what has come to be known as the distinction between ordinary and extraordinary means. The language he uses to interpret that distinction, with its talk of "means" and "side-effect," however, is the language of double-effect. While he may want to distance himself from the label 'double effect',[8] it seems fairly certain that he is interpreting the O/E distinction using double effect reasoning.

So, despite their differences, Ashley and O'Rourke and Grisez and Finnis appear to have at least this much in common. They appear to consider the withholding and withdrawing of extraordinary means of care an application of the rule of double effect.

I want to argue that it is mistaken, however, historically and logically, to consider the forgoing of extraordinary means of care to be an application of the RDE. The RDE and the O/E distinction are distinct, have different historical origins, and the latter is not reducible to the former. Not all moral reasoning that involves a condition of proportionality and a division between intention and foresight is an application of the Rule of Double Effect. As Anscombe once observed, the denial of the RDE "has been the corruption of non-Catholic thought, and its abuse the corruption of Catholic thought."[9] The idea that the O/E distinction is an application of the RDE may be an instance of that corruption.

THE HISTORICAL ARGUMENT

In his definitive history of the O/E distinction, Cronin catalogues possible principles and circumstances that might excuse an individual from

7 John Finnis, "The 'Value of Human Life' and 'The Right to Death': Some Reflections on Cruzan and Ronald Dworkin," *Southern Illinois University Law Journal* 17 (Winter, 1993): 559-571, at 565.

8 Finnis, Natural Law and Natural Rights, op. cit., at 123-4.

9 G. E. M. Anscombe, "War and Murder," in *War and Morality*, ed. Richard A. Wasserstrom (Belmont, CA: Wadsworth Publishing, 1970), pp. 42-53.

the precepts of natural law regarding self-conservation.[10] This list includes non-culpable ignorance,[11] physical impossibility,[12] and the rule of double effect.[13] But he dismisses each of these as the source of the O/E distinction. His historical analysis suggests that it is derived from the last category on his list, "moral impossibility."[14] He writes:

> It is a rational presumption then that since man is not always and everywhere, under every circumstance, bound to do something positively good, he would not be always and everywhere bound to fulfill an affirmative precept. Hence, moral impossibility, while not freeing an individual from the basic obligation of the natural law, excuses him from the present observance of an affirmative precept of that law.[15]

Cronin states that what constitutes a moral impossibility is that circumstances have made the obligation one "not commonly experienced by men in general,"[16] fraught with fear, repugnance, difficulty, danger, or inconvenience. Hence,

> The law that demands the conservation of one's own life also commands that he employ the means necessary to conserve life. Since, however, this law is an affirmative law and a licit application of the doctrine on moral impossibility may be made, theologians commonly divide the means of conserving life into two categories. The first includes those which are obligatory for everyone. The second is comprised of those whose use would constitute a moral impossibility either for human beings in general or for one particular individual. The former they term *ordinary means*; the latter, *extraordinary means*.[17]

10 Daniel A. Cronin, "Conserving Human Life," in *Conserving Human Life*, ed. Russell E. Smith (Braintree, Massachusetts: The Pope John Center, 1989), pp. 1-145, at 23-31.

11 *Ibid.*, pp. 23-25.

12 *Ibid.*, p. 30.

13 *Ibid.*, pp. 26-29.

14 *Ibid.*, pp. 29-31.

15 *Ibid.*, p. 30.

16 *Ibid.*, p. 31.

17 *Ibid.*, p. 31.

Thus, Cronin suggests the derivation of the O/E tradition is from a principle that he distinguishes from double effect—namely—the tradition of moral impossibility as an exculpatory factor in the fulfillment of a positive precept of natural or human positive law.

ST. THOMAS AND THE SCHOLASTICS

In considering whether the Catholic moral tradition of ordinary and extraordinary means has been an application of the RDE, it is also important to remember that the RDE arose in a historical line of scholastic and casuistic commentary completely distinct from the O/E distinction. Aquinas is silent on the topic of extraordinary means of care. However, both the O/E distinction and the RDE arose from commentary on his work. Nonetheless, the histories of these discussions are distinct. The RDE arose in discussions regarding Thomas' treatment of the morality of killing in self-defense.[18] As Magnan has pointed out in his classical work on the RDE, it was not until the first edition of Gury in the 19th century that there was such a well-formed principle.[19] The RDE was not applied to medical care in Catholic discussions until the 20th century—in discussions of the use of morphine at the end of life and discussions of surgery for ectopic pregnancy.

By contrast, the O/E distinction arose from commentary on Thomas' treatment of suicide,[20] and mutilation.[21] It is also invoked in discussions of the virtue of temperance and about the limits of fasting.[22] Neither

[18] St. Thomas Aquinas, *Summa Theologiae*, II-II q. 64, a. 7.

[19] Joseph T. Mangan, S.J., "An Historical Analysis of the Principle of Double Effect," *Theological Studies* 10 (1949): 41-61.

[20] St. Thomas Aquinas, *Summa Theologiae*, II-II q. 64, a. 5.

[21] St. Thomas Aquinas, *Summa Theologiae*, II-II, q. 65, a.1. It seems plainly obvious that Finnis interprets this passage though the heuristic of the New Natural Law theory by claiming that this is an application of the RDE (Finnis, *Aquinas*, pp. 279-280). Just two articles before this in the *Summa*, in discussing self-defense, Aquinas uses the phrases *duo effectus, duplex effectus, bona intentione, praeter intentionem,* and *proportionatus fini*. This is the language of double effect. It seems quite a stretch to claim that this was the reasoning Aquinas was employing in his defense of amputation of a gangrenous limb when none of these phases or anything remotely resembling them is used in his argument.

[22] See Cronin, *op. cit.* at 38; 45-46; also Francisco de Vitoria, O.P., *Reflection on Homicide and Commentary on Summa Theologiae* II^a-II^{ae} *Q. 64*, John P. Doyle (Milwaukee, Wisconsin: Marquette University Press, 1997), pp. 172-3.

Thomas' discussion of killing in self defense nor the RDE are ever mentioned in these discussions. The O/E distinction became an explicit moral principle beginning in the 16th century, 300 years before the RDE became an explicit principle.

CRONIN'S HISTORY OF THE SCHOLASTIC DISCUSSION

In Cronin's study of the history of the O/E distinction, not a single author cites the RDE or uses the phrase 'double effect.' Not one of them casts this as a conflict of obligations between the duty to conserve one's life and some other obligation. One's duty to conserve one's life is limited by various aspects of one's finitude as a creature.

For more than five centuries, the question has always been, as Kelly would later put it, "How much does God demand that I do in order to preserve this life which belongs to God and of which I am a steward?"[23] The answer has been, as Cronin amply documents through several centuries, "No more than is reasonable." And "reasonable" has never been defined as "until you reach the point of a conflict with other duties," but in terms of a frank recognition of the limits of human physical, mental, emotional, and spiritual resources. That is to say, the duty holds to the point of "moral impossibility," which has been defined as "a proportionately grave inconvenience which excuses from the present observance of the law."[24] Although Cronin suggests that this line of reasoning is at the root of every discussion of the O/E distinction, he attributes the explicit use of the language of moral impossibility to Vitoria, Sayrus, Mazzotta, Tournley, Marc-Gestermann, Aertnys-Damen, Lehmkuhl, Kelly, and Paquin.[25]

What counted as proportionately grave inconveniences during this history? According to Cronin, Catholic casuists suggested that treatments could be considered to have associated with them disproportionately grave inconveniences (i.e., to be "extraordinary") under the following conditions: (1) when there is a lack of hope of benefit or (2) the treatments are associated with too much difficulty, (3) lack simplicity, (4) are

[23] Gerald Kelly, SJ, *Medico-Moral Problems*, St. Louis, MO: The Catholic Hospital Association of the U.S. and Canada, 1958, p. 132.

[24] Cronin, *op. cit.* at 100.

[25] *Ibid.* at 100-101.

not commonly used, (5) are out of proportion to one's physical, psychological, financial, or social condition; (6) when there is intense pain associated with the treatment or its aftermath, or (6) excessive hardship in attaining or undergoing the treatment; (7) when one has great fear of the treatment or the condition in which one would be left by it, or (8) repugnance at the treatment or the condition in which one would be left by it; and (9) when the treatment requires great effort or (10) is very costly.[26]

These do not seem to constitute some set of inchoate, enthymatic double-effect arguments. These are a set of justified limits to a duty. They are invoked without reference to double effect reasoning. The mere fact that there is a condition of proportionality in the O/E distinction does not imply that it is an instance of double effect reasoning. As I shall discuss in greater detail below, the proportionality considered in the tradition regarding ordinary and extraordinary means of care is between the burdens and the benefits associated with undergoing the treatment, relative to reason, given one's condition, granting that the treatment might conserve one's life. It is most certainly not a proportion between the good effect of the treatment (conserving one's life) and the associated burdens of the treatment. Nor was it ever historically construed as a proportion between the expected good effects of discontinuing a treatment (i.e., relieving one of the burdens caused by the treatment) and the bad effect of causing one's earlier death.

This difference is subtle but crucial to understanding the tradition. The tradition has appropriately applied double effect in addressing various *other* questions in the ethics of care at the end of life. The case of morphine is one appropriate application of the RDE. So is the case of so-called "terminal sedation," at least when it is done appropriately and licitly.[27] But the questions raised in these cases are distinct from the question of when it is appropriate to forgo a life-sustaining intervention.

[26] *Ibid.* at 84-112.

[27] See Daniel P. Sulmasy, OFM and Edmund D. Pellegrino, "The Rule of Double Effect: Clearing Up the Double Talk," *Archives of Internal Medicine* 159 (1999): 545-50; also Lynn A. Jansen and Daniel P. Sulmasy, "Sedation, Hydration, Alimentation, and Equivocation: Careful Conversation About Care at the End of Life," *Annals of Internal Medicine* 136 (2002): 845-849.

GURY AND THE MANUALIST TRADITION

Over centuries of reflection and refinement, Catholic natural law casuistry has carefully distilled a panoply of important moral principles and distinctions. They are actually quite numerous and various. Within that tradition, the RDE and the category of moral impossibility were never treated as the same thing, nor was it ever suggested that one could be reduced to the other. In the 1946 edition of Gury's *Theologia Moralis*, the RDE is treated as a general principle of morality for managing conflicting moral obligations.[28] Among the cases referenced are ectopic pregnancy and the unintentional killing of non-combatants in war. There is no mention of end-of-life care. Many pages later, in the exposition of general ethical principles catalogued in Volume I of the *Theologia Moralis*, the conditions that excuse one from carrying out one's duties under human positive law and natural law are laid out for the reader. These include external causes, invincible ignorance, physical impossibility, and moral impossibility.[29] It is clearly specified that the condition of moral impossibility applies only to affirmative precepts, not to negative precepts. The examples that follow are about the conditions under which one could be exempted from the Lenten fast, and when a religious could be exempted from reciting the breviary.

In Vol. II of Gury's *Theologia Moralis*, in discussing suicide, there is a brief discussion of extraordinary means of care,[30] suggesting that one may forgo these interventions licitly "by reason of the fact that one is required to serve life only by ordinary means." The text then lists some possible reasons a treatment may be considered extraordinary, such as cost, pain, etc. The classic case of forgoing an amputation is given as an example of an extraordinary means of care. There is also a discussion of

[27] See Daniel P. Sulmasy, OFM and Edmund D. Pellegrino, "The Rule of Double Effect: Clearing Up the Double Talk," *Archives of Internal Medicine* 159 (1999): 545-50; also Lynn A. Jansen and Daniel P. Sulmasy, "Sedation, Hydration, Alimentation, and Equivocation: Careful Conversation About Care at the End of Life," *Annals of Internal Medicine* 136 (2002): 845-849.

[28] Thomas A. Iorio, SJ, *Theologia Moralis*, 3rd ed., vol. I, § 23 (Napoli, Italy: M. D'Auria, Holy See Apostolic Publishers, 1946), pp. 104-105.

[29] *Ibid.* at § 122, pp. 94-96.

[30] Thomas A. Iorio, SJ, *Theologia Moralis*, 3rd ed., vol. II, §165, no. 3 (Napoli, Italy: M. D'Auria, Holy See Apostolic Publishers , 1946), p. 104.

how it is licit for a consecrated virgin to refuse medical examinations or treatments involving her genitalia by virtue of her repugnance at the idea that a man might touch her there. The text of this section on extraordinary means does not mention the RDE. Ten sections later, the RDE is referenced with respect to the use of morphine under a discussion of one's duty not to kill the innocent.[31]

GERALD KELLY: 20TH CENTURY CATHOLIC CASUISTRY

In the middle of the 20th century, Gerald Kelly's *Medico-Moral Problems* affirms this historical distinction of the O/E from the RDE, and their distinct justifications. In the first chapter of this book, he sets forth "Basic Notions and Principles," including fundamental principles such as "Totality," and "Bodily Integrity." In this chapter, he addresses as his second separate principle the distinction between "doing good" (*affirmative* precepts) and "avoiding evil" (*negative* precepts), and notes that while negative precepts always bind, "there is a limit to the duty of doing good." He explicitly states that "there is a reasonable limit to a man's duty to care for his health," and promises that "practical applications of these limits to the duty of doing good will be found particularly in the [chapter] concerning means of preserving health and life."[32] One must bear in mind that this book was intended for medical professionals and not professional theologians. It may be for this reason that he does not use the explicit phrase "moral impossibility" here. But his meaning is clear enough.

Later in this chapter, he treats the RDE as his fourth distinct principle, and gives examples such as operations for ectopic pregnancy. He does not mention the O/E distinction in the context of discussing the RDE.[33] Obversely, his chapter on ordinary and extraordinary means makes no mention of the RDE, but justifies it by stating "there are reasonable and proportionate limits to one's duty of doing good."[34] In his chapter on euthanasia he refers to the RDE obliquely in his defense of the distinction

[31] *Ibid.* at § 176, p. 122.

[32] Kelly, *Medico-Moral Problems*, *op. cit.*, at 4.

[33] *Ibid.* at 12-16.

[34] *Ibid.* at 131.

between using sedatives to "kill pain" and euthanasia to "kill the patient."[35]

Kelly explicitly invokes the phrase "moral impossibility" in his famous scholarly article on this topic in *Theological Studies*, stating simply, "an extraordinary means is one which prudent men would consider at least morally impossible with reference to the duty of preserving one's life."[36]

CONTEMPORARY CHURCH DOCUMENTS

Contemporary Church documents discuss both the RDE and the O/E distinction, but none of these treat the O/E distinction as an application of the RDE. The *Catechism*, for instance, cites the RDE in its discussion of self-defense,[37] but make no mention of it in its discussion of ordinary and extraordinary means of care.[38] *Evangelium vitae* (no. 65) states that extraordinary means may be foresworn if they "are disproportionate to any expected result or impose an excessive burden on the patient and his family."[39] There is no mention of competing moral obligations or the RDE. The reason given to explain why forgoing extraordinary care is not the equivalent of suicide or euthanasia is, in accord with the discussion above, the acceptance of human finitude—an "acceptance of human finitude in the face of death." The *Declaration on Euthanasia* (§ 4) states that one must use "due proportion in the use of remedies." In accord with centuries of tradition, the justification for distinguishing the abatement of extraordinary means of treatment from euthanasia or suicide is neither that one has a conflicting obligation, nor because one can appropriately apply the RDE to such cases. The Declaration grounds the non-suicidal nature of the abatement of extraordinary means of treatment in the recognition of human finitude and in the virtue of charity, stating, it represents either the "acceptance of the human condition, or a desire to avoid the

[35] *Ibid.* at 115.

[36] Gerald Kelly, S.J., "The Duty of Using Artificial Means of Preserving Life," *Theological Studies* 11 (1950): 203-220.

[37] *Catechism of the Catholic Church*, § 2263 (Cittá del Vaticano: Libreria Editrice Vaticana, 1994), p. 545.

[38] *Ibid.*, § 2278, p. 549.

[39] Pope John Paul II, *Evangelium vitae*, March 25, 1995, no. 65. http://www.vatican.va/edocs/ENG0141/_INDEX.HTM

application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive costs on the family of the community."[40] These reasons are clearly consistent with casting the O/E distinction squarely within the tradition—as an application of "moral impossibility," not the RDE.

The only official Church document I could find that invokes the RDE with respect to the O/E distinction is in the Allocution of Pius XII to anesthesiologists in 1957 in which he states (in an infrequently quoted passage),

> ...even when it causes the arrest of circulation, the interruption of attempts at resuscitation is never more than an indirect cause of the cessation of life, and one must apply in this case the principle of double effect and of *voluntarium in causa.*[41]

Yet he did not invoke the RDE in the first and more detailed explanation of the O/E distinction within the same allocution, in which he famously stated,

> But normally one is held to use only ordinary means—according to circumstances of persons, places, times, and culture—that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult. Life, health, all temporal activities are in fact subordinated to spiritual ends.[42]

In addition, it must be noted that this was neither an encyclical nor a serious work of theological scholarship, and so the utmost care might not have been devoted to every word. For example, most scholars distinguish sharply between double effect and *voluntarium in causa.* It is uncertain why these phrases are in this document. One might speculate that since

[40] Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, May 5, 1980, §4. http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html

[41] Pope Pius XII, "The Prolongation of Life: An Address of Pope Pius XII to an International Congress of Anesthesiologists," *The Pope Speaks* 4 (1958): 393-398, at 397.

[42] *Ibid.* at 395-6.

the pope had invoked the RDE in his discussion of morphine in February, 1957,[43] it was still on his mind when he discussed forgoing ventilator support in November, 1957. This reference to double effect may represent an early instance of the conflation of the RDE and the O/E distinction that has, as I have suggested, deviated from the Tradition, apparently unwittingly. All told, I am not inclined to think that this isolated, almost offhand reference, was a serious and well-thought out attempt to alter the theological grounding for the O/E distinction as I have outlined it.

HISTORICAL CONCLUSIONS

These considerations suggest that the O/E distinction has been cast as a natural limit to one's duty to carry out an affirmative precept of the natural law, not as an application of the RDE in a situation in which one's duty to carry out an affirmative precept clashes with one's duty never to violate a negative precept. The casting of the question is crucial. The tradition treats these as distinct modes of moral reasoning, and does not consider one reducible to the other. Moral impossibility is a limiting principle based upon an acceptance of natural limits and a recognition of the finite physical, intellectual, emotional, and spiritual resources of human beings. It does not require a conflict with another duty to establish this limit. In other words, it is sufficient to decide that a treatment is extraordinary by judging that one has met the limits of reasonability in doing what is necessary to fulfill one's duty to preserve life. In other words, "Enough is enough," is a good enough answer. The duty to preserve life has never been construed in Catholic thought as requiring that one meet the much higher standard of judging a proposed life-preserving intervention to be extraordinary (morally optional) only when it conflicts with some other, competing basic reason for acting. The historical basis of the O/E distinction in the Catholic tradition is moral impossibility (i.e., grave inconvenience), not the RDE.

A misinterpretation of the Catholic tradition can cause one's evaluation of cases to go awry, and might either make one's evaluation of what

[43] Pope Pius XII, "Allocution to Doctors on the Moral Problems of Analgesia," Feb. 24, 1957. http://www.acim-asia.com/Allocution_To_Doctors.htm

Catholics are bound to do under penalty of mortal sin too lax or too harsh. Revisionism is dangerous whether it is liberal or conservative. Tradition serves to keep us in check. There are times when it is necessary to adjust the tradition to new circumstances, but we must be careful not to do so without extremely good reasons and the utmost of care.

DIFFERENCES BETWEEN THE RDE AND TRADITIONAL O/E REASONING

I will next argue that, historical considerations aside, from a purely structural point of view, when one applies the RDE correctly and consistently to cases involving end of life care, cases are classified differently than they would be under a traditional understanding of the O/E distinction. Among the reasons for this are that O/E reasoning and double effect reasoning differ in the content of their respective proportionality conditions, in how intention and foresight are distinguished, and in the focus of moral agency when considering surrogate decision making.

A CASE

To see why classical O/E reasoning and double effect reasoning differ, consider the following hypothetical case. A wealthy man develops a rare neurological condition that does four things: (1) It produces a complete expressive aphasia in which he is awake and alert but is totally unable to express himself in any communicative form—spoken, written, hand signals, etc. (2) Although it is hard to tell because of his aphasia, he appears to have problems with information processing and decision making. He is simply docile. The MRI shows some frontal lobe abnormalities of uncertain significance. (3) The condition is also associated with a severe, lancinating, neuropathic facial pain syndrome similar to that of *tic doloureaux*, completely unresponsive to all forms of medical therapy. This is often described as the most severe, agonizing pain syndrome to affect the human species. Thirty-minute episodes of this pain occur at random, multiple times each day. (4) The condition also attacks the medullary respiratory centers and renders him unable to breathe on his own. The condition came on suddenly, but is now stable and has not progressed over the last year. He has undergone a tracheostomy and is cared for at home on a portable ventilator. After the initial expenditure, this is very inexpensive to maintain. He has a home oxygen concentrator, so

that he need not purchase oxygen, and really only uses this at night. During the day the ventilator just pumps air. He is not paralyzed, so he can accomplish most of his own care without burdening others. He left no advance directive and we have no direct evidence about what his beliefs would have been about continuing this treatment, and no way of finding out now due to his aphasia and organic brain syndrome. Is it morally permissible to discontinue his ventilator?

The patient must, sadly, be declared lacking in decision making capacity since he cannot communicate any decisions, even if it seems that he has at least a rudimentary understanding of what is going on. Accordingly, the decision whether to forgo ventilator support must be made by surrogates. Suppose the surrogate, his wife, is instructed to look to the RDE for guidance about how to proceed. According to the classical formulation of the RDE, one may undertake an action that has two effects, one good and one bad, only if:

1. the act is not intrinsically evil;
2. one sincerely intends only the good, foreseeing but not intending the bad;
3. the bad effect one claims not to intend is not the cause of the good one claims to intend;
4. the good effects are disproportionately greater than the bad effects.

How would our case be analyzed under the RDE if it were asked whether his wife could authorize the physicians to discontinue the ventilator? The first condition of the RDE is easily satisfied—discontinuing the ventilator is not intrinsically evil. Second, let us suppose that his wife really does not want him to die,[44] but merely foresees his death. Third, relieving his pain would seem to be a good reason for acting, so she might seem on her way to stopping the ventilator. However, straightaway there is a problem. How could she stop his pain except by making him dead? The ventilator is not causing the pain, so no pain relief follows as a direct consequence of stopping the ventilator. She could only be construed as intending to relieve his pain by making him dead, and thereby disvaluing

[44] Desire and intention are not the same, but let us grant this conflation for present purposes.

the quality of his life as not worth living. And this would be homicide, pure and simple. Under the RDE, she could not authorize discontinuing the ventilator.

Could this be construed otherwise under RDE reasoning? Let us suppose that she does not intend to relieve the neuropathic pain by discontinuing the ventilator, but intends to relieve the burdens of the ventilator itself, foreseeing his death as a side-effect. However, what sort of suffering does the ventilator itself cause in this case, and how does it compare in proportion to the value of keeping the patient alive? Positive pressure breathing is a bit of an unusual feeling at first, but people get used to it. In fact, hundreds of thousands of persons now manage to sleep through the night using continuous positive airway pressure (CPAP) as treatment for obstructive sleep apnea. The tracheostomy is not uncomfortable, and plenty of people live with one for many years after major head and neck operations. Maintaining it requires little effort once it is in place. How does the wife's duty to relieve her husband of these very minor discomforts compare in proportion to the wife's duty to preserve his life? The discomforts of the ventilator itself pale in comparison. In fact, by discontinuing the ventilator, she would actually increase his discomfort since he would then experience shortness of breath, so it is implausible, under the RDE, to suggest that she would have a proportionate reason for discontinuing the ventilator if her intention were to relieve him of the discomfort caused by the ventilator.

What about burden to others? Suppose she were to argue that care for her husband was conflicting with her duties to others? Well, the care her husband requires is actually minimal. He is mostly a "self-care" patient and can even feed himself, although he is not able to cook for himself. She and her children have no need for any specialized nursing assistance to help them in caring for him. The expenses are minimal, and he is rich anyway. So the burdens of caring for him seem small compared with the value of his life, and not a proportionately grave reason for discontinuing the ventilator.

But she is deeply troubled. She wishes something could be done to stop her husband's pain. She becomes distraught watching as the episodes of neuropathic pain bring him to tears multiple times each day. His pain has not responded to opioids, non-steroidal anti-inflammatory drugs, antidepressants, anti-epileptics, or even the surgical severing of his

facial nerve root. She considered sedating him permanently, again invoking the RDE, but realizes that this would deprive him of all consciousness indefinitely. Because he is on a ventilator, she realizes the RDE would not even apply to a possible plan to sedate him since sedation would not stop him from breathing and could not thereby hasten his death. It would only make him persistently unconscious and alive on a ventilator, and she is not certain that would really be better. Nor would such a move relieve her of her duty to continue the ventilator support because it would not change the conditions for the correct application of the RDE to the decision about discontinuing the ventilator. And so, she feels that she has misunderstood Catholic moral tradition, which she previously took to have permitted patients to forgo extraordinary means of care. As it has now been explained to her using the RDE, the continued use of the ventilator is ordinary care and must be continued.

A TRADITIONAL READING OF THIS CASE AS EXTRAORDINARY CARE

A traditional reading of the case would invoke the O/E distinction, however, and not the RDE. The moral and spiritual advisor would ask the wife to consider how much she thought her husband could reasonably be asked to bear in order to satisfy his obligation to conserve his life. Would he have wanted to be kept alive in this condition? How much pain would he need to bear? Having tried everything to stop the pain, having given ample time to see if the condition would reverse itself, realizing that the ventilator did nothing to reverse the underlying condition but only supported one of several neurologically damaged functions, would he be prepared to say, with St. Paul, "I have fought the good fight, I have finished the race, I have kept the faith" (2Tim 4:7)? Does she think he would consider all of the burdens and benefits associated with the condition and its treatment proportionate to the reasonable fulfillment of his duty to preserve his life? The ventilator supports his breathing and that keeps him alive. But it does not reverse the aphasia, the dementia, or the pain. There are no prospects for its success in doing anything more. Her intention would never be to make him dead, but simply to discontinue a treatment that only partially treats an underlying lethal pathophysiologic condition. She values him, loves him, cherishes him, prays for him, and despite his dementia tries to get him to pray with her. She would rather

that he be cured. But she can't bear to see what this disease has done to him—for his sake. She realizes it would be selfish of her to make him persist under such heroic conditions merely because she does not want to lose him. She authorizes the discontinuation of the ventilator as an extraordinary, disproportionate means of care.

This analysis seems a correct one, consistent with the tradition. The RDE analysis of the case, by contrast, seems incorrect. Perhaps there are those who believe the traditional analysis is incorrect, and would put more faith in the RDE than in the Tradition. But I think this would only demonstrate a revisionist tendency to interpret the entire Catholic moral tradition through the RDE, even if it demands more of the faithful than the Tradition would demand. It therefore pays to look more closely at precisely how the RDE analysis and the Tradition differ in their application to cases.

DIFFERING VIEWS OF PROPORTIONALITY

Not every moral principle that contains a condition of proportionality is an application of the rule of double-effect. For example, in the *jus ad bellum* aspect of just war theory, a nation is required to meet a condition of proportionality before undertaking armed conflict. Traditionally, this means that not only must the cause be just and the prospects of success reasonable, but the anticipated results must be worth the anticipated bloodshed. Such an invocation of proportionality is obviously not reducible to an application of the RDE. Clearly, in war, the good effect can only be achieved by means of the bad effect. Factories are destroyed. Ships are sunk. Soldiers are killed. Ultimately, one hopes, the war will thus be won and the injustice righted. But if this is how proportionality works in the theory of *jus ad bellum*, it cannot be the case that it is an application of the RDE. Standard discussions of *jus ad bellum* do not invoke the RDE.[45]

One should not be confused by the use of the RDE in other aspects of just war theory, however. Once a nation has undertaken armed conflict in a morally justified war, discussions of *jus in bello* appropriately invoke double-effect reasoning to discuss whether one may endanger non-combatants in carrying out attacks on combatants.[46] Since there is an agreed upon negative precept that one cannot directly attack innocent civilians, but the attacking of armed combatants and/or the destruction of the means of making war are justified in a just war, double-effect reasoning can be invoked in evaluating how one conducts a just war. The upshot is that one may not make the death of civilians one's direct intention, nor can one accept their being killed as the means by which one will wear down the will of the people and thus end the war.

This invocation of the RDE is but one aspect of *jus in bello* theorizing. My main point is that in just war theory, the proportionality condition invoked in discussions of *jus ad bellum*, as described above, is not an application of the RDE. And one exception is sufficient to prove that not every invocation of proportionality implies the RDE.

Therefore, one of the first differences to note is that the concrete content of the proportionality conditions of the traditional O/E distinction and the RDE differ. Under RDE, one may only consider the effects that flow directly from one's action. In the classical morphine example, these effects are analgesia and respiratory depression. In applying the RDE to the withdrawal of extraordinary means of life-sustaining care, one can only consider the direct effects of this action. The good effect that results directly from the discontinuation of the treatment is the cessation of pain or other discomfort caused by the treatment itself. The bad effect is death. This sets an extremely high standard for determining that the discontinuation of life-sustaining treatment is morally licit. It would seem that one could only consider a treatment "extraordinary" if the treatment itself caused suffering proportionately graver than the evil of shortening life.

Alternatively, one could construe the discontinuation of life-sustaining treatment as a double-effect dilemma for an agent with some responsibility for distributing scarce resources. One could say (after the insurance had run out, but not before), "I only have so much money. I can either feed my children or care for my loved one. All human lives are equally valuable, but I have three young children and therefore it seems that I

[45] Robert L. Holmes, "Just War Theory," *Cambridge Dictionary of Philosophy*, ed. Robert Audi (Cambridge, UK: Cambridge University Press, 1995, p. 397.

[46] See Iorio's discussion in Gury's *Theologia Moralis*, vol. I, *op. cit.*, § 23, pp. 104-105 and John C. Ford, S.J., "The Morality of Obliteration Bombing," *Theological Studies* 5 (September 1944): 261-309.

have a proportionately grave reason for stopping the life-sustaining treatment. By choosing to feed my children, I forsee but do not intend the death of my loved one." Of course, this also sets an enormously high standard—the treatment must be so expensive that it consumes enough resources to threaten the lives of others from whom those resources are being siphoned. By such standards, almost every Western person who has ever authorized the discontinuation of life-sustaining treatments for a comatose loved one since the 1970s has committed a grave moral error.

By contrast, the genuine Roman Catholic tradition regarding ordinary and extraordinary means is much more organic and natural in its considerations of what constitutes a proportionately grave inconvenience—moral impossibility. The burdens and the benefits are not considered as competing direct effects of the act of discontinuation balanced against each other, but are considered together with the condition of the patient, in proportion to practical reason.

> Since the dictate of the natural law which commands a man to conserve his life is obviously a reasonable law, the means to fulfill it need only be within reason. Hence, any inconvenience or difficulty that is unreasonable is not obligatory.[47]

So, the proportionality of the O/E distinction is not between the benefits caused by the treatment (preserving life) and the burdens caused by the treatment (pain, cost, etc.), but the proportion of the burdens and the benefits associated with the treatment considered together in proportion to practical reasonability, given the fact that one accepts that there is a natural duty to preserve one's life.

What constitutes this standard of practical reasonability beyond which an intervention becomes extraordinary? It will obviously not be possible to give a precise definition, and it will vary according to the physical, intellectual, emotional, spiritual, social, and economic resources of the individual. Those considerations Cronin cites include "a difficulty...not commonly experienced by men in general,"[48] or what "exceeds the normal strength of men in general,"[49] or "the common estimate of men"[50] or what is deemed not to be a "reasonable and moderate means."[51] Kelly calls this standard "a prudent communis aestimatio."[52] To the consternation of those who demand more precision than this, one can only cite Aristotle's famous observation in the Nichomachean Ethics that one can only demand from a science the precision that its subject will allow.[53]

Traditional writers never imagined the possibility of contemporary life-sustaining treatments. They discussed treatments that were generally performed only once, such as an amputation. They concentrated on the expenses and pains caused by the treatments themselves, with the general presumption of cure or death. They did not say much about treatments that would not cure the disease but would be continuously or recurrently needed to sustain life in a condition of great suffering. For the most part, this simply did not happen before the great medical developments of the latter half of the 20th century.

However, the scholastics and later casuists were not completely silent about whether the state of the patient, independent of the treatment, could be included in their calculus of the benefits and burdens of treatment with respect to reason. Bañez, for instance, writes simply that one need not preserve one's life in the face of "certain and horrible pain," without necessary reference to the fact that the treatment itself would cause the pain.[54] According to Cronin, these classical casuists also took into account "the quality and duration" of the state one would be in after treatment.[55] One's condition after the treatment could render the treatment extraordinary—for example, a "troublesome convalescence."[56] Repugnance at the state one would be in after treatment, such as of living

47 Cronin, *op. cit.*, at 102-103.

48 *Ibid.*, at 31.

49 *Ibid.*, at 73.

50 *Ibid.*, at 73.

51 *Ibid.*, at 99.

52 Kelly, "The Duty of Using Artificial Means of Preserving Life," *op. cit.*, n. 35.

53 Aristotle, *Nichomachean Ethics* 1098a.26;1137b.29, Terence Irwin, trans. (Indianapolis, Indiana: Hackett, 1985), pp.18; 145.

54 quoted in Cronin, *op. cit.* at 42.

55 Cronin, *op. cit.* at 88.

56 *Ibid.*, at 75.

without a limb, could also render a treatment extraordinary.[57] Finally, discussions of "reasonable hope of benefit" contained some consideration of the difference between sustaining life with a disease and curing the disease, however speculative that discussion might have been given the science of the day.

The most definite classical consideration of the idea that the suffering associated with the condition itself, independent of the treatment, is part of the burden to be considered in judging whether a life-sustaining treatment is ordinary or extraordinary is found in the writings of the 17th century Cardinal DeLugo.[58] He draws an elaborate analogy based upon a man trapped in a fire. The man in the fire is said to have easy access to water, certainly something common, inexpensive, and natural. He is certain that he can calm the flames, extend his life, and even give himself some temporary relief by dousing himself with water. But he is certain that he cannot extinguish the fire and cannot ultimately escape. Must he use the water? DeLugo's answer is a resounding, "No." If he could extinguish the flames and effect a "cure" it would be obligatory, but if it only prolonged the suffering, it would be an "extraordinary means." It is critical to note that the suffering in this example is caused not by the treatment, but by the condition in which he finds himself. The "therapy" that is declined in this case does not cause suffering, and, in fact, will temporarily relieve it. In this sense, the proportionality condition of the O/E distinction differs dramatically from the proportionality condition of the RDE. O/E proportionality permits consideration of the suffering associated with the patient's condition, not merely the suffering caused by the treatment itself.

Thus, in the 20th century, Sullivan concluded that the tradition would permit the discontinuation of intravenous feeding as "extraordinary" if it merely prolonged the pain of a man dying of cancer.[59] Likewise, Kelly could judge, "There are degrees of 'success.' It is one thing to use oxygen to bring a person through a crisis; it is another merely to prolong life when hope of recovery is practically negligible."[60]

[57] *Ibid.*, at 73-74.

[58] *Ibid.*, at 49-55.

[59] Joseph Sullivan, *Catholic Teaching on the Morality of Euthanasia* (Washington, DC: Catholic University of America Press, 1949), p. 72.

The observations of Sullivan and Kelly, who wrote 50 years ago, are only more correct today. And DeLugo's 17th century analogy aptly describes much of what medicine faces today—many treatments that sustain life do not cause suffering in themselves, but neither do they cure the disease. Rather, they prolong a state in which at least some of the suffering caused by the disease persists. In some cases, such as the use of insulin by an 18 year old newly diagnosed Type I diabetic, the burdens and benefits of treatment seem clearly proportionate to a prudent *communis aestimatio*, and anyone who said otherwise would be beyond the bounds of reason unless other circumstances or moral considerations came to bear upon this 18 year old's duty to preserve his life. But the situation facing the man in our case of aphasia, dementia, neuralgia, and ventilator care would seem to be well beyond the limits of what most prudent people would judge a reasonable expectation of what a good man must do in fulfilling his duty to preserve his life. His wife would be justified in using this standard to stop the ventilator. She does so by relying upon a traditional Catholic O/E analysis, not the very narrowly constrained proportionality condition of the RDE.

DIFFERING VIEWS OF THE INTENTION/FORESIGHT DISTINCTION

The distinction between the foreseen and the intended is critical to good moral thinking. Intention is, as Aquinas taught, the "form" of the moral act. Acting with the intention of making someone dead (prescinding from discussions about war and capital punishment, and from debates about self-defense and rescue) is morally wrong. To create a new lethal pathophysiological condition in a patient with the specific intention-in-acting of making a patient dead is euthanasia. However, to forgo an intervention that interferes with a pre-existing lethal pathophysiological condition in a patient could also be morally wrong, precisely if one does so with the specific intention in acting of making the patient dead. Nonetheless, the O/E tradition holds that such forgoings of treatment are

[60] Kelly, "The Duty of Using Artificial Means of Preserving Life," *op. cit.*, n. 35.

not morally wrong (provided certain other conditions are met) if one's intention in acting is not to end the patient but to end the treatment. One foresees death, but one's intention is that there should be no such treatment, not that there should be no such patient. This is the traditional way of understanding the intention/foresight distinction in the O/E tradition.

The RDE formulates the distinction differently. I cannot overestimate the importance of seeing this subtle but crucial distinction. According to the RDE, two effects must follow directly from one's action. One must intend the good effect, but not the bad, which is merely foreseen. In the case of using morphine for dying patients, this fits perfectly. Morphine has at least two effects—easing pain and slowing respiratory drive. One can act intending to ease pain, foreseeing the possibility of slowing respiratory drive as an unintended side-effect, provided the pain is great enough, the life expectancy short enough, etc.[61]

Nonetheless, it is inappropriate to apply the RDE to the withdrawal of life-sustaining treatments, for the reasons I have already given in detail. But one further consequence of conceiving of the withdrawal of extraordinary means of treatment as an application of the RDE is that the way its framing of the intention/foresight division under the RDE differs from that in the traditional O/E distinction. The RDE demands that one see one's action as a causal fork, leading to two outcomes, one intended and the other unintended. One asks the physician or surrogate, "What are you doing?" and demands that the answer be framed as, "I am intending to p, foreseeing that doing p will have two effects, q and r. I intend r, foreseeing but not intending q," where:

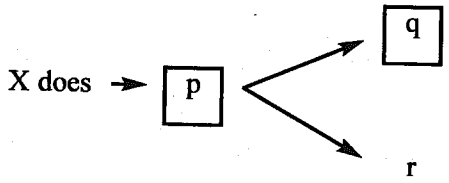
p = withholding or withdrawing of the life-sustaining treatment
q = the death of the patient
r = the good one is aiming to accomplish, e.g., relief of suffering, redistribution of these resources to help others, etc.

 = the event is intended by the agent

[61] I should in no way be construed as arguing against the importance of the RDE in medicine and elsewhere. I am arguing only that its use be limited to cases in which it is appropriate and necessary. The RDE is indispensable to morally sound medical practice.

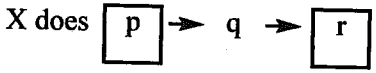
This is depicted in Figure I, below:

I Causal Fork of the RDE



When this construal of causation, intention, and foresight is applied to the ventilator case described above, and the conditions are such (as they often are) that the treatment is not causing much suffering in itself, is not very expensive relative to one's resources, and one's motive is to relieve the suffering of the patient or to cause the resources to be used elsewhere, then one is led to the conclusion that the conditions for the RDE's division of intention and foresight cannot be met. The RDE requires a causal fork, and there is none in this case. One could only bring about the intended good by means of the death of the patient, violating the 3rd condition of the classical RDE. The agent could only claim the intentional stand depicted in Figure II, below:

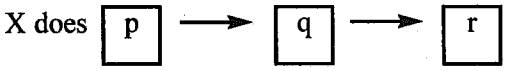
II Causal Chain Precluded by the RDE as Irrational



In other words, the agent would need to say, "In stopping the ventilator, I intend to relieve the patient's suffering, but don't intend the patient's death." However, the RDE would hold that this construal of causation, one's intentions, and one's foresight is simply irrational. One cannot reasonably claim to intend to do p, knowing that it brings about q as the means by which r comes about, intending r but not intending q. In other words, if someone claims II, he or she is either self-deceived or disingenuous. One cannot say I intend to relieve the patient's suffering by way

of the patient's death without also intending the patient's death as one's chosen means. One must interpret anyone who claims II to really be claiming III.

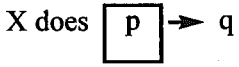
III Rational Casual Chain Precluded by the RDE as Immoral



One is intending the bad event (the death of the patient) as the very means by which one achieves the good effect (relief of suffering, re-distribution of resources, etc). The powerful argument that one can never claim to foresee but not intend an admittedly bad means by which one brings about a desired end is at the heart of the RDE. It seems indisputable. But if it is applied to the ventilator case, then one must conclude that one cannot claim to be relieving the patient of his or her suffering except by causing his death. And this is precluded by the RDE. Thus, in the hypothetical case I have described, one could not stop the ventilator.

However, the intention/foresight division of the O/E distinction does not require any double effect, and never has historically, as I have explained above. One's intention, simply stated, is to stop the treatment, not in order to do anything else, but because one has reached a limit; because one has done enough to fulfill one's duty to preserve one's life. In other words, one intends p, foreseeing but not intending q. This intentional stand is depicted in IV:

IV Rational Causal Chain Invoked in the O/E Distinction



This is a causal chain, not a causal fork. One intends to remove the ventilator (p), because continuing it is more than what one reasonably believes the patient would need to do to fulfill his duty. This is the object of the act. The outcome (q, death) is foreseen and unintended. Yet it is

not properly described as a side-effect since there is no causal fork. This is how all the classical authors described the difference between forgoing extraordinary means and suicide. Vitoria says, "it is one thing not to protect life, and it is another thing to destroy it."[62] Suarez says, "The reason is that although a man may never kill himself, he is not bound, however, to conserve his life always and by every means..."[63] De Lugo says,

> ...the "bonum" of his life is not of such great moment, however, that its conservation must be effected with extraordinary diligence: it is one thing not to neglect and throw it away, to which a man is bound: it is another, however, to seek after it and retain it by exquisite means as it is escaping away from him, to which he is not held; neither is he on that account considered morally to will or seek his death.[64]

One can rationally intend one event along a causal chain while foreseeing but not intending events that follow it. If the unintended event that one foresees were not to come about, one would not say, "I have failed, let me try another way." Karen Ann Quinlan's parents expected her to die if her ventilator were discontinued. But their aim (their intention) was to eliminate the ventilator, not to eliminate their daughter. They had no other aim. The resources were not an issue. They merely thought that her dying was being averted by a means that went beyond what a reasonable person could be expected to do to sustain her life. When she started breathing after the ventilator was turned off they were surprised; perhaps even disappointed. But they did not fail in fulfilling their intention.

This sort of moral psychology is ancient. Aquinas for instance, writes,

> As stated above, intention regards the end as a terminus of the movement of the will. Now a terminus of movement may be taken in two ways. First, the very last terminus, when the movement comes to a stop; this is the terminus of the whole movement. Secondly, some point midway, which is the beginning of one part of the movement, and the end or terminus of the other. Thus in the movement from A to C through B, C is

[62] Cronin, *op. cit.* at 36.

[63] *Ibid.*, at 44.

[64] *Ibid.*, at 53.

> the last terminus, while B is a terminus, but not the last. And intention can be of either. Consequently though intention is always of an end, it need not be always of the last end.[65]

It is common for human beings to adopt this sort of intentional stance. One recognizes a limit and ceases effort, foreseeing but not intending some further consequence along a chain of consequences. One need not have another intention, something else that one intends to accomplish by way of having ceased the effort (i.e., a double effect), but merely an acknowledgment that one has done enough. For instance, suppose I am taking a math test. I come to the last problem that I just can't figure out. I'm pretty certain that I didn't answer everything else on the test perfectly, and I know that this problem counts for 25% of the grade on the test, while the passing grade is 75%. Thus, I foresee that if I don't answer it I will almost certainly fail. Suppose it is the final exam and I have been given 8 hours to take the test. I answered everything else in an hour. After two hours puzzling over this last question I am the only person left in the room. I reason that perhaps with more time I could figure it out, but after 3 ½ hours I just give up. I need give no other reason than that I think it is too hard. I do not need to invoke a double effect. I do not need to say that I can better use my time studying for another course or helping little old ladies to cross the street. I can simply decide, "I give up." And in doing so, did I thereby intend to fail the test? I think the answer is no. I *did* intend not to answer this question, foreseeing the likelihood that I will fail as a consequence, but I did not intend to fail the test. If, by some miracle, I were to pass, I would be delighted. Perhaps by some miracle the teacher will be merciful and throw out that question or assign a few extra points for any scribble in attempting to answer that question that I committed to paper, so that I will pass. But I know such miracles are unlikely, and I foresee that I will fail.

This is all the intention/foresight division that is necessary for invoking moral impossibility. This is all the intention/foresight division that is needed for the O/E distinction. It is a mistake to force the forgoing of life-sustaining treatments into the intentional constraints of the RDE.

[65] St. Thomas Aquinas, *Summa Theologiae* I-II, q. 12, a. 2.c.

THE LOCUS OF AGENCY IN SURROGATE DECISION MAKING

The classical casuists never considered making decisions about discontinuing life-sustaining treatments for persons lacking decision making capacity. Before the mid-20th century, coma was simply fatal. People who could not breathe or swallow due to neurological impairment simply died. The questions that concern us now are iatrogenic—they concern not just powerful but far from perfect treatments, but also medical conditions caused by medical treatment. Many contemporary treatments are powerful in sustaining particular impaired natural functions, but not powerful enough to cure. In other cases, the condition rendering the person incapable of making decisions has come about as a side effect of medical treatment. Our contemporary epidemic of Alzheimer's disease, for example, has come about because more people are living long enough to develop this disease, at least in part because they are not dying earlier of other diseases such as myocardial infarction or cancer. Anoxic post-coma unresponsiveness is most commonly the result of heroic efforts undertaken to resuscitate someone who had already met the cardiopulmonary definition of death. No one receives the diagnosis of anoxic post-coma unresponsiveness without huge sums of money first having been spent on cardiopulmonary resuscitation, ventilator support, and intensive care necessary to bring the person (who could have been declared dead at the start and subsequently could have had extraordinary means of treatment stopped at innumerable junctures along the way) to the point of being alive in a state of post-coma unresponsiveness.

Because they never imagined such conditions or treatments, the classical casuists only considered the point of view of the patient. There was almost no medical surrogate decision making in their societies. So, they asked whether *the patient* had the obligation to undergo the treatment, given his physical, intellectual, emotional, social, economic, and spiritual resources? They put the question to the patient. In considering whether the religious superior could direct a monk or nun to undergo extraordinary treatments, the classical casuists answered no. The question was not framed in terms of the superior's duty to preserve the life of the religious, but from the perspective of the monk or nun.

In the 20th century, millions of persons now face the burden of deciding for others. And what moral perspective should they assume in discerning whether a treatment is ordinary or extraordinary? Long before

lawyers developed the legal doctrine of substituted judgment, the Catholic medico-moral tradition taught that third parties should assume the perspective of the patient. They were advised to ask questions of the following form: Would the patient deem this burden extraordinary? Is this proposed treatment, as best you know the patient, more than he or she could reasonably be expected to bear? Cronin summarized this nicely in the mid-20th century,

> Since the doctor is unable to ascertain the patient's own wishes in the matter, he should make a reasonable effort to determine what the patient's wish would be if the patient personally could respond. In the event that relatives are present, they should try to make the decision in the name of the patient, and the doctor is obliged to follow their wishes. If there are present no relatives nor persons entrusted with the care of the patient's welfare, then it is up to the doctor to make the decision. His obligation in justice to the patient binds him to take reasonable care of the patient. He must consider the spiritual, physical, financial and social condition of the patient. Perhaps, the doctor will require the aid of others in making this consideration, but in the last analysis, it is the doctor's duty to do what he thinks will bring about the greater good of the patient.[66]

However, some recent writings have drifted from traditional analysis to concentrate not on the physical, intellectual, emotional, social, economic, and spiritual resources of the patient but on those of the caregivers. Perhaps in part this is due to unvoiced suspicions about the moral legitimacy of substituted judgments, or due to a deontological focus on the duties of the decision-maker. This is not clear. But for these commentators, when patients are unable to participate in decision making and have left no directives about their wishes regarding life-sustaining treatments, the question changes from, "Is it reasonable to judge that the patient has reached the limits of his obligation to preserve his life?" to "Have I reached the limit of my obligations to keep the patient alive?" If I have not reached these limits, then I must continue to do so unless doing so conflicts with other obligations. Then, using RDE analysis, one simply calculates the benefits and the burdens that flow directly from the provision of the treatment by the third party. As Grisez puts it, if one is not

[66] Cronin, *op. cit.* at 130.

certain of the patient's wishes, the question becomes simply whether providing a treatment for incompetent patients "significantly benefits them and others concerned without still more significantly burdening either [them] or others concerned," without any reference to the patient's point of view.[67] Finnis argues that in the absence of clearly expressed patient wishes to forgo a treatment, one should presume an intention on the part of third parties to "terminate" the patient unless proven otherwise.[68]

Once again, this drift in perspective is subtle but critical. People who are healthy always have more resources than the sick. This change in perspective makes the standard for declaring a treatment extraordinary higher than the standard proposed by the Tradition.

Proponents of the New Natural Law worry about allowing third parties to construe altruism on the part of patients who lack capacity. Their concerns are well-placed. It does seem to invite abuse to allow people to say, "Aunt Tilly wouldn't have wanted us to have spent her whole inheritance on her health care, right?" However, it does *not* seem disingenuous to say, "Aunt Tilly never said what she would have wanted, but we just don't think she would ever have wanted to have been kept alive indefinitely in this state, cut off from all the rest of us, unable to speak to us or understand us. She has suffered enough. She has lived a good life. She has done more than enough to try to care for the gift of her life. We'd love to keep her with us, but it is time for us to let go. *Nolo tangere.* Let God take her." This reasoning, however, is not permitted by some current analyses.

Further, an additional peculiarity is added when one turns to the perspective of the caregivers. Some writers emphasize the witness value of the care provided by family members as a reason for continuing care.[69] This seems to me to be at least as worrisome as attributing altruism to incompetent patients as a reason to discontinue their life support. On this analysis, Aunt Tilly becomes instrumentalized. She becomes a pretext for others to use their care for her in order to witness to the world regarding their commitment to Christian reverence for life. If the focus is on the

[67] Germain Grisez, "Should Nutrition and Hydration be Provided to Permanently Comatose and Other Mentally Disabled Persons?" *Linacre Quarterly* 57(May, 1990): 30-43.

[68] John Finnis, "Bland: Crossing the Rubicon?" *Law Quarterly Review* 109 (1993): 329-337.

caregivers, this might seem reasonable. But if the focus is on the patient, one would hesitate to say, "Aunt Tilly would have wanted us to keep her alive in this state so that we could show the world how much we care about the vulnerable." I think one must be extremely cautious about invoking this rationale for continuing care.

The locus of analysis in the O/E tradition has always been on the moral obligation of the patient to continue treatment. This was extended in the 20th century, in considering patients unable to speak for themselves, to judgments made by the family about the reasonable limits to that obligation as the patient would judge them. Shifting the moral analysis to the RDE moves the focus to the moral obligations of the third parties authorizing or performing the act of forgoing treatment. This has affected the analysis of what constitutes an extraordinary means of care in ways that have not been fully appreciated.

SOME POTENTIAL COUNTER-ARGUMENTS

Let me consider several potential counterarguments. One such counterargument would be that while it can be granted as historically true that O/E distinction preceded the formalization of RDE, the idea of the RDE, *ex hypothesi*, has been central to Catholic thinking about forgoing care at the end of life since at least the time of Basil the Great. One could argue that it was there all along, standing as the silent but central tenet from which other principles were derived, but was simply never codified or made explicit. Therefore it is wrong to argue that the RDE is not the basis for the O/E distinction.

This hypothesis is certainly possible. Yet no one has presented the case for this. The New Natural Law theory *does* present itself as an authentic interpretation of St. Thomas' moral teaching,[70] although not without substantial controversy.[71] And Ashley and O'Rourke have claimed the Thomistic tradition as well. But Thomas never discussed the O/E distinction. And many debate whether his discussion of self-defense is the actual origin of the rule of double effect. So, it is hard to claim St. Thomas as the basis for deciding that the O/E distinction is an application of the RDE. And none of these authors (nor any others of whom I am aware) have attempted to establish by any sort of logical or historical argument that the O/E distinction sprang from the inchoate idea of the RDE. Rather, I think these authors have simply assumed what I take to be a conflation. In the absence of evidence to the contrary, the mere possibility that it might be mistaken provides no sound reason to doubt the historical analysis I have provided.

Further, the prospects for an historical analysis that would refute mine seem slim. If the differences in moral justification, logical structure, treatment of proportionality, manner of distinguishing between intention and foresight, and focus of moral agency differ between the Tradition's understanding of the forgoing of extraordinary means and the application of the RDE, then it would not seem possible to make such a claim on any grounds. On the basis of these structural arguments, any historical claim that the O/E distinction was derived from the RDE would only seem to indicate that history had been mistaken.

A variation on this argument might be that the RDE is a necessary doctrinal development that finally allows one to make sense of what "moral impossibility" means. How does one know when one has done "enough" in fulfilling a moral duty to conserve one's life? According to this analysis, one knows one has reached one's limits when doing one's duty interferes with one's other duties so that, on proportionate balance, more harm is done. But as I have pointed out, such clarity comes at too high a price. Its abstract, deontological emphasis obscures the human reality of finitude. Given the intrinsic value of life and the anti-dualistic, hylomorphic conjunction of person and body, respect for the value of human life would entail an almost absurd priority for the use of life-sustaining treatment. On the one hand, it seems to signify an undignified reluctance to accept one's creaturehood and attendant finitude. On the other hand, it demands

69 Grisez, "Should Nutrition and Hydration be Provided?" *op. cit.*

70 John Finnis, *Aquinas*, *op. cit.*, n. 6.

71 See, for example, Russel Hittinger, *A Critique of the New Natural Law* (Notre Dame, IN: University of Notre Dame Press, 1987); Ralph M. McInerny, *Aquinas on Human Action: A Theory of Practice* (Washington, D.C.: Catholic University of America, 1992); Anthony J. Lisska, *Aquinas' Theory of Natural Law: An Analytic Reconstruction* (New York: Oxford University Press, 1996). McInerny once wrote: "Whatever fallacy there may be in passing from Is to Ought—and no one seems able to say what precisely the fallacy is—Grisez's insistence on it threatens to undercut his own procedure as well as St. Thomas's." (*Ethica Thomistica: The Moral Philosophy of Thomas Aquinas* (Washington, D.C.: Catholic University of America, 1982), p. 56).

too much—more than the faithful can reasonably be expected to bear. What a person can reasonably be expected to do is not merely determined by duties external to the person. It is determined by the individual's makeup as a human person integrally considered, including the individual's physical, moral, intellectual, emotional as well as social and economic resources. And those sorts of limits are not the stuff of competing, abstract, deontological duties, but the stuff of moral impossibility, which depends on a robust philosophical anthropology.

A second potential counter-argument would be that the case example I gave is fictional, and that the claims I have made have nothing to do with the real world. One might argue that this was simply a philosopher's "burning lorry" case, one that, if not completely fictional, is of so rare a type as to be not worth considering. However, this charge can be readily dismissed. The case was designed to keep certain other controversies fixed in order to concentrate on the issue at hand. Questions such as whether comatose persons can suffer, or how the foregoing analysis is applied to feeding tubes are important. But if these were made features of the case, discussion would likely become bogged down in addressing these controversies rather than the narrower question of whether the withdrawal of extraordinary care is an application of the RDE. Further, all of the individual features of the case are genuine. Patients, sadly, often are rendered awake and aphasic by neurological diseases. There are such things as untreatable neuropathic pain syndromes. Home ventilators and oxygen concentrators are already in widespread use, and they are inexpensive to operate once purchased.

But most importantly, the argument works in much simpler cases. If a patient is comatose and on a home ventilator, and has left no advance directives, then the ventilator in itself causes no suffering. If it is cheap and the family has the means, then the only way to discontinue the treatment under double effect analysis would be by way of deciding that the state of being in coma was in itself a source of suffering, and that the only way to relieve a patient of that suffering would be by means of the patient's death. This intentional stance would be homicidal and wrong, and not permitted by the RDE. And this seems a very different analysis than one would arrive at by way of the O/E analysis.

Third, the authors I have cited might claim that I have misunderstood their positions. Ashley and O'Rourke are explicit in explaining the withholding and withdrawing of extraordinary means of treatment as an application of the RDE, so it would be hard to be accused of misinterpreting them. I think they would be better off admitting that I am correct and that their references to the RDE as the basis of forgoing extraordinary means were too hastily considered. They are generally quite traditional in their analyses and would be better off, in my judgment, emphasizing the tradition of moral impossibility as their justification for forgoing extraordinary care. Importantly, this would allow them to escape criticisms that in certain of their analyses they are disvaluing human life or instrumentalizing human life—criticisms leveled at them when they say that treatments for certain classes of patients are of no benefit or futile. They would not need to make this claim. They would only need to say that it is reasonable to construe that at least some patients lacking capacity would consider the state they are in to be a state of suffering, and that if they were able to speak for themselves would consider continued treatment in this condition more than they could be expected to do in order to fulfill their duties to conserve their lives.

The situation of the New Natural Law perspective is a bit more complicated. These authors are not so explicit about linking the RDE to the forgoing of extraordinary means. If they were to say that I have misconstrued them as holding that the forgoing of extraordinary means is an application of the RDE, I would be delighted. I would encourage them to commit to that position in writing because I think I have at least made the case that their writings on the topic to date certainly suggest the conflation of the RDE and the O/E distinction.

Yet I fear they would resist this, because I do not think they are prepared to say that the intention/foresight distinction applies to causal chains as well as to causal forks. I also suspect they would resist the idea that the scope of the proportionality condition invoked when forgoing extraordinary treatments includes the suffering associated with the patient's medical condition in addition to the suffering caused by the treatment itself.

But if that is the case, and if they do wish to argue that the forgoing of extraordinary means of care is an application of the RDE, then I think their judgments about the moral permissibility of forgoing treatments such as ventilator care may have been based upon overestimates regarding the costs and the amount of suffering caused directly by many life-

sustaining treatments in themselves. If patients have permanently implanted intravenous catheters for parenteral medication or alimentation, or are treated with home ventilators, the principles put forth by the New Natural Law theorists should lead them to insist that these relatively cheap and non-burdensome treatments must almost always be considered ordinary and morally obligatory in cognitively impaired patients who have left no advance directives. Many, many more treatments that are currently considered extraordinary will become ordinary according to their analyses. And medical progress and increasing wealth will only lengthen the list of "ordinary" care. To the extent that this widens the gulf between their philosophy and traditional Catholic thinking, they would need to consider whether they might wish to adjust their philosophy to align more with traditional Catholic thought regarding these matters.

Presuming they would wish to do this, at least two courses would be open to them. One would be to reject the naturalistic fallacy, accept a full-bodied, ontologized natural law theory, and with it a wider number of rules and principles upon which to draw, including a recognition of something like a principle of moral impossibility that could be applied even to persons who cannot speak for themselves because one would be able to appeal to an ethical standard based on a robust philosophical anthropology—a conception of the kind of thing these patients are—finite human beings.

However, this would be a marked revision of their philosophical system and would be an unattractive option for proponents of the New Natural Law. The only other option would be to tweak their system of basic human goods to reflect more fully an appreciation of human finitude. One way to accomplish this might be to expand the list of basic human goods to include the recognition of one's physical, intellectual, emotional, social, economic, and spiritual finitude as a basic human good. Then one could construe the decision to withdraw life-sustaining treatment from the severely cognitively impaired not as intending the patient's death in order to achieve relief from suffering, but as a double effect—promoting the good of recognizing human finitude, foreseeing but not intending the patient's death. But it seems a stretch to call the recognition of human finitude a basic human good, and this solution seems very ad hoc.

Perhaps a principle akin to the traditional category of moral impossibility could be teased out of one of their already existing basic goods—e.g.—the basic human good of practical reasonability. One could surmise that practical reasonability encompassed a recognition not just of financial resources, but of inner human resources as well. Towards this, proponents of the New Natural Law theory do seem to recognize the category of "repugnance" as a reason to call a treatment extraordinary, and repugnance has long been one of the criteria for moral impossibility according to the classical O/E tradition. These authors allow a conscious patient's expression of repugnance at the thought of being fed by a feeding tube to serve as a sufficient reason to forgo that treatment.[72] But they seem to limit this to repugnance at the idea of the treatment in itself, and seem strongly to resist the thought that one could be repugnant about the state in which the treatment left one as a patient. But it seems plain that what horrifies most people about the prospect of an amputation is not so much the operation (for which they can now be anesthetized) as the thought of being left limbless. Should it be possible for a patient to express such *vehemens horror*, should it not also be possible to make a substituted judgment that an incapacitated spouse or child would harbor such repugnance? The O/E tradition has long permitted this view, without worry that this necessitated the belief that one's life was not worth living, or that limbless or otherwise damaged human beings were thereby devalued as human beings, or that they would therefore no longer be counted as persons. If that view has seemed practically reasonable and faithfully Catholic for 500 years, shouldn't our 21st century philosophies be able to embrace a similar view? At the very least, accusing those who hold this traditional view of a heretical disvaluation of human beings and demanding that all Catholics adopt the views of a philosophical system that departs from that tradition seems to privilege one philosophical view over the tradition. And that does not seem very Catholic.

POTENTIALLY WORRISOME QUESTIONS

At least two potentially worrisome issues need yet be addressed. The first concerns the slippery slope considerations invoked by many who favor taking a very hard line about abating treatment as a way of protecting vulnerable individuals from being euthanized. Certainly, it is possi-

[72] Grisez, "Should Nutrition and Hydration be Provided?" *op. cit.*

ble to euthanize a patient either by performing a motor action or by omission. One might refrain from performing the motor action of starting a life-sustaining treatment with the specific intention-in-acting of making the patient dead, or one might perform the motor action of withdrawing a life-sustaining treatment with the specific intention-in-acting of making the patient dead. Both would be intentional human acts, for which their agents would be morally responsible. These acts of allowing to die would be every bit as morally wrong as active euthanasia, in which one created a new, lethal pathophysiological state with the specific intention-in-acting of making the patient dead.[73] Since the morality of these acts depends heavily (but not exclusively) upon the intention of the agent, the problem in acts of withholding and withdrawing becomes one of judging intentions. For active euthanasia, judging intentions is easy. The burden of proof is overwhelmingly upon the agent to say that his intentions were anything other than making the patient dead if he injects 100 mEq of KCl into the right ventricle of a patient. In allowing to die, it is much harder to discern intentions from the outside. One can withhold or withdraw an intervention intending only the cessation of a treatment that is appropriately judged extraordinary, or one can withhold or withdraw the same intervention in a similar case intending the death of the patient, perhaps even with a nefarious motive. But from the position of the outside observer, both look the same. Thus, it is reasonable for society to show its respect for the dignity of all human beings by an absolute ban on active euthanasia. This is an enforceable moral absolute—a negative precept. However, with respect to passive euthanasia, one is dealing with a question of the limits of a positive precept. How far one must go in conserving one's life? A just society must rest content to educate people about the importance of intentions in their own moral lives, of understanding the seriousness of the duty to preserve life, but leaving a wide berth for individual discretion, and reserving the right to prosecute in egregious cases of abuse of the withholding and withdrawing of medical treatment. The policy of prohibiting active euthanasia while generally refraining from judging the intentions of those who withhold or withdraw care has proven enforceable, long-standing, and sustainable without leading to

73 See my "Killing and Allowing to Die: Another Look," *Journal of Law, Medicine, and Ethics* 26 (1998): 55-64.

active euthanasia. I think we can continue to hold the line there, and fear that attempts to ban certain kinds of treatment abatement may, ironically, lead to more support for active euthanasia.

The second potentially worrisome question concerns knowing when to apply which moral principles. It is admittedly much tidier to have just a handful of basic reasons for acting and a single master-principle such as double effect to adjudicate potential conflicts. But the real moral life is considerably more complex. It is not chaotic or unprincipled, but it is not algorithmic. Natural law has moral absolutes, but is also responsive to the finitude of human beings and their complexity. Genuine natural law, like the natural creatures who ought to be guided by it, is an organic theory (at least that form which has been embraced by the Roman Catholic Church for centuries). The question of when to apply which principles is a problem for practical reasoning in general that I cannot discuss in detail in an already lengthy article. Suffice it to say that similar problems in practical reasoning arise not only in ethics, but in jurisprudence and in medicine. When does a judge apply the principle of *stare decisis*? When ought the principle of *nulla poena sine lege* be invoked? When does a physician justly apply Occam's razor? When invoke the principle of *primum non nocere*? When invoke the diagnostic aphorism, "If you hear hoofbeats, don't think of zebras"? There is deep rationality and wisdom in these rules and principles, but a discussion of when which ones apply is extraordinarily complex and beyond the scope of this essay.[74]

CONCLUSION

The forgoing of extraordinary means of treatment is not an application of the RDE. The O/E distinction has a different history, justification, view of proportionality, way of framing the intention/foresight division, and moral focus in making decisions for incapacitated patients. Hence, cases are classified differently by the two approaches. This analysis might help to clarify some points of agreement and disagreement in discussing cases that have proven controversial for Catholic moral thinking.

74 I have proposed a set of conditions for the correct application of the rule of double effect in "'Re-inventing' the Rule of Double Effect," In: *Oxford Handbook of Bioethics*, Bonnie Steinbock, ed. (Oxford: Oxford University Press, forthcoming, 2006).