

Scientific Contribution

## Non-consequentialist Theory of Proportionality: With Reference to the Ethical Controversy over Sedation in Terminal Care

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**Abstract:** In medical practice, ethical conflicts frequently occur between the principle of beneficence and the principle of non-maleficence, and if we accept these two principles without any modification, it is impossible for us to comply with both simultaneously in many cases. Thus, in order to make the two principles consistent, it is necessary to provide a means of interpretation, or a set of rules, that can be used to adjust between the two principles and prevent such conflicts or dilemmas from occurring. The “principle of double effect” was introduced to play this role. The theory of double effect, standing on the non-consequentialist and non-relativist viewpoint, has been a popular means of decision-making in medical practice, but has recently been criticized, especially by consequentialists, who have proposed the theory of proportionality instead. One topic that reflects the controversy between the two theories is the ethical evaluation of sedation for terminally ill patients with intolerable pain or suffering. The author examines the two theories with reference to discussion on sedation in palliative care, and though declaring the theory of proportionality the winner, proposes a revised theory of proportionality, or a relativized theory of beneficence, retaining a non-consequentialist perspective.

**Key words:** double effect, proportionality, non-consequentialist, relativist, sedation

Beneficence (Act to benefit a patient) and non-maleficence (Do not harm a patient!) are included among the well-known four ethical principles of medical activities. Though I assume that these are not two independent principles, but two aspects of the single principle of beneficence, as will be shown later in this paper, let us start from the standpoint of them as two independent principles. In medical practice, ethical conflicts frequently occur between them. If a certain treatment is recognized to bring about a good effect (benefit) to a patient but at the same time is

known (possibly) to bring about a bad effect (harm), such treatment complies with the principle of beneficence but not with that of non-maleficence. For example, though many anti-cancer drugs have good effects by attacking the cancer, they are accompanied by side effects, which are harmful to the patient. Nevertheless, if medical professionals, attending to the principle of non-maleficence alone, do not use anti-cancer drugs for the sake of avoiding their side effects, they will fail to benefit the patient by not bringing about the positive effects of such drugs against the principle of beneficence. Again, an abortion is sometimes performed in order to save the life of the mother. It brings the benefit of saving the life of the mother at the cost of terminating the life of the fetus. Nevertheless, if we don't perform it in such situations, the life of the mother cannot be saved; and what is even worse, neither can the life of the fetus be saved in cases where the mother's life comes to an end before the fetus has grown enough to survive on its own.

Therefore, if we accept these two principles without any modification, it is impossible for us to comply with both simultaneously in the cases referred to above. Thus, in order to make the two principles consistent, it is necessary to provide a means of interpretation, or a set of rules, that can be used to adjust between the two principles and prevent such conflicts or dilemmas from occurring. The "principle of double effect" was introduced to play this role.

The theory of double effect, which reportedly originated from traditional Christian ethics, has been the most popular means of decision-making in medical practice, but has recently been criticized, especially by consequentialists, who have proposed the theory of proportionality instead. One topic that reflects the controversy between the two theories is the ethical evaluation of sedation for terminally ill patients with intolerable pain or suffering.

In the present article, I shall examine the two theories with reference to discussion on sedation in palliative care, and though declaring the theory of proportionality the winner, propose a revised theory of proportionality, or a relativized theory of beneficence, retaining a non-consequentialist perspective.

## **1. Theory of double effect**

The theory of double effect has been supported in traditional Catholic teaching, and has been widely accepted in medical practice. It recognizes that when an

action, e.g., a treatment, aiming to bring good effects is foreseen to be accompanied by bad effects, the action can be ethically acceptable<sup>1</sup> under the following conditions, i.e., the principle of double effect (cf. Fagothey 1959, Gracia 1995, Sulmasy & Pellegrino 1999, Aulisio 2004).

- (1) the action itself should not be ethically improper;
- (2) only the good effect is intended, while the bad effect not intended, even though foreseen and permitted;
- (3) the good effect should not be brought about by means of the bad effect; and
- (4) there must be proportionately grave reason for taking the action despite the bad effect foreseen.

For example, in the case of deciding to administer anti-cancer drugs with possible side effects: (1) administering anti-cancer drugs itself is not ethically improper; (2) the medical practitioners intend to bring about good effects such as prolonging the patient's life and improving the quality of life by the drugs' effect of attacking the cancer, and do not intend to bring about painful side effects such as fatigue and nausea. Such bad effects are merely foreseen to occur and are permitted; (3) pain is merely a side effect and not a means to curtail the cancer or to prolong the patient's life; and (4) although bad effects such as side effects are predicted to occur, administration of the drugs will presumably prolong the patient's life with a fairly high quality of life, an outcome which cannot be achieved without such administration. There is thus a proportionately grave reason for administering such drugs despite their side effects.<sup>2</sup>

By contrast, in the case of euthanasia, (1) causing the patient to die, i.e., killing, is ethically improper; (2) the bad effect, i.e. death, is not only foreseen to occur but is intended; and (3) the good effect, the patient's relief from pain, is brought about by means of the bad effect, i.e., death; and at the same time, (4) it is presumed that maintaining life with unbearable pain does not bring any benefit to the patient and relieving the patient from pain by causing his or her life to end is more beneficial for him or her, so that there is good reason to perform euthanasia. Thus even though condition (4) is consistent with euthanasia, the other three conditions stand against it, and euthanasia is therefore judged ethically improper.

Notably, the theory of double effect is consistent not only with the non-consequentialist standpoint, as is well-known, but also with the non-relativist one<sup>3</sup>. First, as seen in the above examples, there seems to be a tendency in

applying the principle of double effect to ethical demarcation that evaluation of each effect can be made independently of the situation. For instance, regardless of the situation, and not relatively, “hastening of death” is always bad, “prolonging life” always good, and so on. This tendency is not only a fact of the matter but logically related to the theory of double effect, for if evaluation of each effect were situation-dependent and relative, the principle of double effect would be invalid in discerning ethically proper actions from improper ones. For instance, taking the relative view, we can warrant euthanasia as follows: death is not always a bad effect but indifferent or even good when prolongation of life brings only suffering to the patient, so that (1) killing a patient with intolerable and unrecoverable suffering is not an improper action; (2) though death is not only foreseen but also intended, death is not a bad effect in the present situation; and (3) relief from suffering is brought about by means of death, which is not a bad effect. Thus, the good and bad of effects being relative and dynamic, euthanasia can be ethically justifiable even by reference to the conditions of the principle of double effect. In similar fashion, any action might be justifiable by way of similar analysis, meaning that the theory of double effect loses its ability to differentiate proper from improper actions.

Second, advocates of the theory of double effect appear to base their reasoning on ethical norms such as “Thou shall not kill” with rigid and static interpretation, which is a traditional understanding of norms, e.g. God’s law. If ethical norms are given as “God’s directives” or derived from a certain basic principle through philosophical reasoning, they must as a whole be consistent, and, as a consequence, there must not arise situations in which two norms among them conflict with each other and people who try to fulfill both of them find themselves in a moral dilemma. From this standpoint, there should always be a correct selection of acts; as some say, “if Jesus Christ were present in this situation, he could make a right decision.” In other words, advocates of such a view must make their entire system of norms consistent, and in fact the principle of double effect plays the role of making the system consistent by adjusting the two norms, beneficence and non-maleficence. Thus, a non-relativist view of ethical norms lies in the background of the theory of double effect. By contrast, taking a relativistic viewpoint, one can argue that, as referred to above, euthanasia can be acceptable for relieving the patient from pain by causing his or her life to end should be *better*

than maintaining his or her life in a condition of unbearable pain. Thus, good and bad are not evaluated absolutely, but relatively, considering the alternatives that are available in the relevant situation. In conjunction with this view, the directive “Thou shall not kill” is not absolute either, but considered a directive that applies under certain conditions under higher and more general directives, or the term “kill” is reinterpreted as a term that does not refer to “positively cause a person to die” in isolation, but with some qualifications.

As shown later in detail, the theory of double effect has been challenged by the consequentialists, who have criticized the theory primarily for its consideration of “intention.” Non-relativism, however, is another important aspect of the theory, and this, and not its emphasis on intention, might be the principle aspect deserving criticism.

## **2. Theory of double effect in ethical evaluation of sedation for dying patients**

In this section, I shall examine how the theory of double effect works in detail in the light of recent discussion on the topic of palliative care for people terminally ill with cancer: ethical evaluation of sedation.<sup>4</sup> When a patient is in the terminal stage of cancer, every possible form of palliative care is given and pain is controlled as much as possible. In some cases, however, the closer the patient gets to the end, the more his or her pain or suffering becomes intolerable. In this situation, one alternative treatment is to relieve the patient of pain by sedation, i.e., by decreasing the level of consciousness with which the patient feels pain.

There are diverse grades of depth of depression of consciousness, and medical practitioners generally prefer to perform sedation as lightly as possible and as intermittently as possible to the extent that the patient’s pain is relieved; for the relief of pain is a good effect, while depression of consciousness is a bad effect: the patient cannot engage in any human activity without consciousness. Further, in some situations, continuous sedation until the patient’s death appears to be necessary because intolerable pain will certainly reappear if the sedative wears off. Some in Japan have argued that such continuous administration of sedative is the same as performing euthanasia (Hoshino 1996:270-289). These are ethical issues that medical practitioners must face.

The issue that is raised in relation to other pain control treatments also applies

to sedation: if such treatment has a side effect of causing earlier death, how should it be dealt with? Many medical practitioners hesitate to apply persistent sedation when it is likely to hasten the patient's death, for this appears to be the same as euthanasia, though they do not hesitate so much to apply usual pain control even when hastening of the patient's death is foreseen. Note, however, that reports of cases in which sedation's effect of hastening death was recognized are rare.

Daniel P. Sulmasy (1999), who is a medical professional and supports the principle of double effect, applies the principle to sedation and claims the following: The depression of consciousness is a "bad effect." Hence, sedation, which intends the bad effect, is ethically inappropriate according to condition 2 of the principle. Sedation is also inappropriate according to condition 3, for it attempts to obtain a good effect, i.e., relief of pain, through a bad effect. He also adds that, if a treatment intended to control pain depresses the patient's consciousness as a result, then such action meets the requirements of the principle of double effect and therefore is acceptable.

However, not all authors who adopt the theory of double effect reject sedation. Some do not consider the depression of consciousness a bad effect, but that only death is a bad effect. Thus they consider sedation acceptable (Mount 1996, Rousseau 2000, Bernat 2001). From this standpoint, however, provided that the depression of consciousness is not bad, the theory of double effect alone cannot provide any grounds for supporting the restriction that sedation should be avoided as much as possible. Bernat, for instance, believes that "if there is no better alternative, it is ethically acceptable" (Bernat 2001:978). He is thus assuming that pain control, or something else, is better if possible. For what reason, however, could such an alternative be better, if he did not think that sedation, i.e., the depression of consciousness, has a bad effect? His view is thus inconsistent in the sense that, on one hand he considers depression of consciousness a bad effect when determining which is better (this concerns the fourth condition), while on the other hand he does not consider it so when the first, second, and third conditions are examined.

### 3. Criticism of the theory of double effect

Thus, if one commits to the theory of double effect, Sulmasy's viewpoint against sedation seems to be the only consistent way of thinking. However, I shall argue against this viewpoint. Here, I would like to ask those who oppose sedation, "How would you treat patients who cannot be relieved of intolerable pain by any pain control treatment such as the administration of morphine?" There are two possible answers to this:

(1) To leave the patient with intolerable pain, understanding that "Sedation can relieve you from pain. But for ethical reasons, I cannot do it for you." In this case, although mental care, etc. will be provided as much as possible, such care will not relieve the patient from intolerable pain; for, if such care can make the pain not "intolerable", sedation is unnecessary from the outset. This response will thus leave the patient with uncontrolled intolerable pain.

(2) To conclude the following: "Let us increase the dosage if it is not enough to relieve the pain," and continue to increase the dosage of pain control drugs. If this response, however, resulted in the relief of pain, sedation would not be an alternative in the first place. Moreover, it is likely that the increased dosage would eventually cause earlier death as a side effect. Thus, as a consequence, unintentional death as a side effect is considered better than intentional depression of consciousness.

In case (1), a position is taken favoring ethical purity at the sacrifice of a patient suffering from pain. According to the theory of double effect, there might be cases, such as the denying of euthanasia looked at earlier, in which a certain treatment is acceptable under the fourth condition but not acceptable under the first, second, and third conditions. Medical professionals are thus considered presently bound by the directive, "Do not bring any harm to the patient," but not by the directive, "Bring benefits to the patient." In other words, they must "not positively or intentionally cause death," but are not bound "to help a human being in suffering." If they are asked, "Must the patient, then, live with such intolerable pain?" Their answer (at least as a matter of logic) must be, "Under these circumstances, we are freed from the directive to relieve the patient from pain and bring benefits to the patient." It is because the theory of double effect aims to avoid conflicts between the principle of beneficence and the principle of non-maleficence in such a way. In

such cases, for medical professionals to decide not to make use of a certain alternative is, in my opinion, to ignore (at least as a matter of logic) the pain of the patient.

We can recognize a similar logic and practice in certain religious traditions. The *Gospel According to St. Matthew* tells of an example of religious leaders who act in similar fashion. That is, Jesus is said to have criticized the interpretation of the Torah at the time as follows:

“God says, ‘Honor your father and mother.’ But you say, ‘Whoever says to his father or mother, ‘Whatever I have that would help you has been given to God,’ he is not to honor his father or his mother.’ And by this you invalidated the word of God for the sake of your tradition.” (*Matthew*, 15:4-6)

Here, Jesus criticizes a casuistic rule on how to deal with two seemingly conflicting norms, honor God and honor one’s parents, in a certain type of situation. The rule prescribes following one of the norms, “Honor God”, and ignoring the other, “Honor one’s parents.”

In regard to sedation, for the medical practitioners to say, “We are sorry but we cannot do anything which intends to depress consciousness,” is to prioritize not getting their own hands dirty over relief of a patient’s intolerable pain. Even in such a situation, however, I am of the opinion that not only the directive, “Do not bring harm,” but also the other, “Bring benefits,” is valid. Nevertheless, in this situation, the theory of double effect relieves medical practitioners of following the latter directive. This would result in the medical practitioners’ protecting their own purity and refusing to do what they can do, even though they would feel pain on leaving their patients in pain.

Further, if the response to the question of what to do after refusing sedation on the basis of the theory of double effect is the one stated in (2) above, i.e., “it is permitted if earlier death occurs as a result of increasing the dosage of pain control drugs,” this implies the view that a method that only intends to relieve pain even with the prediction of “earlier death” (i.e., strong pain relief) is better than one that intends to “depress consciousness” without prediction of “earlier death” (i.e. sedation). Consequently it is the view that the prediction and permitting of a large evil is ethically better than intentional performance of a small evil.

Again, in this case, can it really be said that “hastening of death” is merely a prediction? If medical professionals have selected a palliative treatment, knowing

that it will be accompanied by earlier death, and that there is an alternative without earlier death through intentional depression of consciousness, they should be said to prefer the earlier death to the depression of consciousness. Is the explanation valid here that the former is unintentional, while the latter intentional? It is not, since by preferring the former to the latter, the medical professionals not only permit but prefer the earlier death. In this sense, they should be said to have intentionally selected earlier death.

Thus, Sulmasy's argument, which rules out intentional performance of sedation based on the theory of double effect, is contrary to the intuition and the practice of medical professionals. Regarding this point, I am of the opinion that the intuition and practice of medical professionals is correct. If so, there must be logical defects in the theory of double effect.

Here, I would add one more example in which the first three conditions of the principle of double effect result in an outcome contrary to common sense. When a certain type of cancer (osteosarcoma) is found in a patient's right leg, it is a common practice to amputate the right leg to prevent the cancer from spreading. That is, the amputation brings both a good effect, preventing the cancer from spreading, and a bad effect, losing the right leg, of which the larger part is presumably healthy. This situation thus forces advocates of the theory of double effect to reject amputation of the leg by reasoning similar to Sulmasy's against sedation. It cannot be said that "bad effects are not intended but merely predicted to occur and tolerated (condition 2)," for amputating the right leg itself is done intentionally. Further, this is contrary to the provision that "good effects should not be brought about through bad effects (condition 3)," since medical professionals will attempt to prevent the cancer from spreading by amputating the right leg. In this situation, however, no one would deny such an operation on the basis of the theory of double effect. This result shows as well that the theory is invalid.

#### **4. Theory of Proportionality**

The theory of proportionality, discarding the first three conditions of the principle of double effect, accepts only the fourth condition of the principle of double effect, which is called the "principle of proportionality:" there must be

sufficient reasons for taking an action despite the fact that bad effects are also predicted. In this sense, this theory is supported by the consequentialists, who discard the “intention” accompanying the action from ethical consideration. It appears that advocates of this theory look at the result of weighing good effects against bad effects, or the result of comparing good effects and bad effects, i.e. whether the result (net good and bad effects) tends to fall towards good or bad. The principle of proportionality is explained, for instance, as a condition for a treatment can be applied: “the good effect must outweigh the bad effect” (Quill1997), “the intended good effect must be proportionately much greater than the bad effect” (Wein 2000), or as a proportional relationship between the patient’s condition and the predicted worse effect or risk of the appropriate treatment: “the greater the patient’s suffering, the greater is the risk...” (Wein 2000).

It is not sufficient, however, to explain the theory of proportionality simply as one that adopts the fourth condition of the theory of double effect. For by discarding the other conditions, the fourth condition adopted by the theory of proportionality seems to have changed in nature from that in the theory of double effect. For example, when denying euthanasia on the basis of the theory of double effect, the fourth condition has almost no effect. In this case, regardless of whether any positive effects exist that can outweigh the bad effect death, euthanasia is rejected because causing death is inappropriate (contrary to condition 1), the death is intended (contrary to condition 2), and relief of pain will be achieved through a bad effect, i.e., death (contrary to condition 3). Therefore, it is not seriously examined whether the fourth condition is met or not. Again, in the case in which anti-cancer drugs are administered while accepting potential side effects, this action is justified by the first three conditions, as shown above. So it is not seriously assessed with reference to the fourth condition, but tends to be permitted easily by such qualitative assessment as this: Even though there are side effects, the treatment produces good effects such as improvement of quality of life and prolonging the patient’s life. In fact, because this point has not been seriously considered, there has been a tendency, at least in Japan, for decisions to be made on the simple ground that “we do it because it still can be done,” without performing sufficient evaluation of the merits and demerits of administering such anti-cancer drugs. By contrast, if the theory of proportionality is embraced, the appropriateness of an action should be evaluated based solely on the principle of

proportionality. Accordingly, this principle needs to be enriched concerning its content in order to become able to play the expected role.

Advocates of this theory have in fact introduced ideas to enrich the content of proportionality. T. E. Quill, a leading advocate of the theory of proportionality, claims that the principle of proportionality “requires the agent to compare the net good and bad effects of potentially acceptable actions to determine which course would produce an effect of proportionately greater value” and also that “the agent should choose the action with the most favorable balance of good and bad effects” (Quill 1997<sup>5</sup>). Thus, he refers to the process that consists of the assessment of the good and the bad effects of each of all alternatives, comparison between them, and the choice of the alternative that would produce the “proportionately” best outcome. Use of this process itself is propounded by medical professionals in the field of palliative care as well, independently of the principle of proportionality (Pereira & Bruera 1997: chapter 1). In my view, Quill has proposed a revised interpretation of the principle of proportionality, in contrast to the process of making a decision on one single action by examining if its good effect outweighs the bad effect (in which proportionality appears to exist between good and bad effects of an action), or in contrast to the process of comparing the potential bad effect, or risk, of an action with the severity of the patient’s situation (in which the proportionality exists between the situation and a countermeasure for it, and this is the original usage of the term<sup>6</sup>). In the revised interpretation, proportionality appears to exist between the alternatives. Thus, with some reservation, I agree with Quill in recommending the process under the name of the principle of proportionality, for the usage is too different from its original one.

Further, Quill also proposes a transformation, or rather a consequence, of the revised interpretation as “choosing the least harmful alternative” (Quill 2000). That is, of various alternatives that produce the same benefit, the one that produces the least bad effect should be chosen. This formulation can certainly be called the principle of proportionality in its original meaning. According to this formulation, only when regular palliative care does not relieve the patient from unbearable pain any more, does sedation become an alternative that can be chosen, and only when there are no other ways to relieve pain without causing earlier death (bad effect), can an alternative that might produce such a bad effect be chosen (of course, whether the alternative is actually chosen or not requires an

informed decision by the patient).

To be fair, the second formulation of the principle, i.e., “choosing the least harmful alternative,” is not equivalent to the first formulation, which can be summarized as: “choosing the alternative with the most favorable balance of good and bad effects,” but the former is a qualified transformation of the latter. For, according to the second formulation, the comparison is made between the alternatives that have the same good effect determined as the target of medical intervention (e.g., the pain relief), and after the alternatives to be compared are selected with respect to the good effect, their bad effects are compared. By contrast, according to the first formulation, the alternatives to be compared are selected without such qualification, and then not only the bad effects but also the good effects are compared. Thus, the target is fixed by the second formulation, while not fixed by the first formulation.

The principal significance of the revised interpretation lies in its relativism. Whether an alternative is ethically proper is not determined absolutely by itself, but relatively by comparison with other alternatives, so that the same treatment with the same good and bad effects that was formerly appropriate could become inappropriate when a better alternative treatment is developed. The theory of proportionality with such a relativistic interpretation would, on the one hand, prevent accepting any alternative that has irreparable bad effects from being selected. On the other hand, it would relativize good and bad effects; for example, although causing earlier death is generally bad, it might be better than prolonging life with only suffering. Thus, the theory recommends us to evaluate which of various possible alternatives is relatively good.

According to the theory of double effect, a certain treatment will be determined to be inappropriate and then, by not performing it, the medical professionals might end up leaving the patient in pain. In contrast, according to the theory of proportionality, if the treatment will cause bad effects, then the following question will be always asked: “What will happen if the treatment is not adopted?” “Would it be better for the patient if the treatment is adopted than not?” “Are there no alternatives better than this one?” In short, medical professionals cannot say, “In such and such case, we are bound by the principle of non-maleficence, but not by the principle of beneficence.” They are always under obligation to follow the directive, “seek beneficence and avoid maleficence,” which is interpreted in a

relativistic sense, i.e., “seek less maleficence and more beneficence.”

## **5. From the dilemma between beneficence and non-maleficence to the balance between them**

The theory of proportionality can be understood as seeking “the best way between doing too much and doing too little.” This is what Pereira and Bruera (1997: chap.1) proposed as a way of thinking in palliative care. That is, if medical professionals, on the one hand, perform excessive treatment, aiming at the patient’s benefit, bad effects will increase. On the other hand, if they do too little for fear of bad effects, they will fail to obtain possible benefits for the patient. Thus, we are always bound by beneficence as well as non-maleficence, and must find a point of most favorable balance between them, or, in other words, between too much and too little.

Such an interpretation, as a consequence, leads to the understanding that beneficence and non-maleficence are not two principles, but two aspects of one principle, “beneficence,” relatively reinterpreted. Already in the explanation of the process according to the principle of proportionality, beneficence as well as non-maleficence are understood relatively as “the more benefit, the better,” and “the less harm, the better.” It is not necessary for the alternative that results in the most benefit to be selected, since it may result in the worst harm as well, and instead the balance of benefits and harms must be considered, as explained above. Thus, beneficence and non-maleficence do not work independently but in combination. If so, each of them cannot be a principle independent of the other, but in combination constitute a principle with the relativistic content: “the more benefit and the less harm, the better”, which we can also call the “principle of beneficence.”

Thinking back on the first formulation of the principle of proportionality, it is clear that the formulation is none other than the general practical explanation of the relativistic principle of beneficence, while the second formulation was a qualified transformation of the first, i.e., under the condition that a good effect as the target of medical intervention is fixed, and was appropriately called the principle of proportionality, sustaining its original meaning. From this perspective, I conclude that the first formulation is better called the “principle of beneficence

relativized,” though I shall use the term “principle of proportionality” for the formulation as well at the moment. The principle appears to suit actual practice in the medical field. Actually, this theory is one of the core theories in the clinical ethics examination system I have developed with medical professionals and proposed in the Japanese medical field, which I shall present in English as well elsewhere.

## **6. Effects plus intention**

Is the consequentialist theory of proportionality, or beneficence relativized sufficient without any theory of intention, which was included in the theory of double effect? If the outcome is the same whatever the intention, i.e. depression of consciousness, isn't the result of ethical evaluation also the same? No, we still need a theory of intention. Judging from medical professionals' remarks, even provided the theory of proportionality, they still need a theory of intention for ethical evaluation of their practice. Preceding theories, however, seem not to have provided any proper response to this need. Many of them refer to the theory of double effect as well as that of proportionality, but do not develop any argument concerning the controversy between them nor do they adjudicate between them (e.g., Wein 2000). My response to the above question is as follows.

Suppose a situation in which a patient's intolerable pain can no longer be relieved by regular means, and sedation becomes an alternative that can relieve the patient from pain, though by depressing his or her level of consciousness. When the parties concerned, i.e., the patient, family, and medical professionals, have selected sedation, the action selected will be, in most cases, described as “performing sedation and depressing the patient's level of consciousness in order to relieve the patient from pain.” This description, however, is not necessarily, or logically, associated with the performance of sedation in all similar situations. Suppose a case in which the description is “to perform sedation and depress the patient's level of consciousness in order to reduce the family's and medical professionals' distress caused by seeing the patient's suffering, and it is good for the additional reason as well that it relieves the patient's pain.” In this case, the main target is the benefit of surrounding individuals and not the patient. Thus, even if the actions performed, and their consequent effects, are the same, the

descriptions, and consequently the ethical evaluations, can be different.

The description of an action by its performer expresses his or her intention: what kind of action it is or what kind of effects the action is aiming at, so that the effect and the intention seem to be two sides of the same coin. The effect and the intention, however, do not correspond simply to each other, for the description of an action can be varied even though the effect is the same. When one is about to perform an action, she or he anticipates its various effects: for instance, relieving pain, depressing consciousness, reducing surrounding people's distress, and so on. She or he, however, does not take all of the anticipated effects into the description of the action but selects some of them and builds them into a structure: for instance, depressing consciousness for the sake of relieving pain, depressing consciousness for the sake or reducing people's distress, and so on. Whether she or he performs sedation with the former description or the latter one, the outcome is the same, while ethical evaluation varies. Thus, for ethical evaluation of an action, we need to know both its effects and the performer's intention; the former should be assessed by the principle of proportionality, or beneficence relativized, while the latter evaluated not only by the principle of beneficence, but also by other ethical principles.

It is important not to evaluate the intention by separating the intention of "relieving pain" and the intention of "depressing consciousness," as the theory of double effect does. The focus should be on understanding of the action as a whole, i.e. the intention "to depress consciousness in order to relieve the patient from pain." Here I should refer to a medieval philosopher, Peter Abelard, who presented the ethics of intention. He took an innocent man as an example, who has been chased by his cruel lord with a naked sword for a long time. The man, after fleeing and avoiding his own murder, at last unwillingly killed the lord lest he be killed." Here Abelard interprets:

"If perhaps someone says that he wanted to kill his lord for the sake of avoiding death (*uoluit interficere dominum suum propter hoc ut mortem euaderet*), he cannot therefore simply infer that he wanted to kill him (*uoluit eum occidere*). ..... That he wills this on account of that is the equivalent of saying that he endures what he does not will on account of the other things which he desires. Thus the sick man is said to want a cauterization or an operation in order to be healed and martyrs to suffer in order to come to

Christ...” (Luscombe 1971: 6-11)

I approve Abelard’s interpretation concerning one’s will or intention accompanied by one’s action. Generally speaking, when one’s intention can be described as “he wills A for the sake of B”, from this we should not infer that “he wills A *simpliciter*.” Similarly, when medical practitioners intend to depress a patient’s consciousness in order to relieve his or her pain, their intention should not be described as “depressing the patient’s consciousness,” but as “depressing the patient’s consciousness for the sake of relieving his or her pain.”

The apparent effects of the act of sedation are depression of consciousness, relief from pain, as well as relief among parties concerned, etc., but what is ethically crucial is which effects are selected and how they are structured as the description of intention associated with the act. The intention is appropriately described as its direct effect plus its purpose; the description as a whole shows the medical professional’s intention accompanied by the act, which is not evident if we attend to the apparent effects only. Thus the theory of proportionality needs to be accompanied by the theory of intention I have presented above.

## Conclusion

In this article, the theory of double effect and the theory of proportionality have been examined to clarify ways to resolve issues that might arise in cases in which beneficence and non-maleficence appear to conflict. The differences between the two theories lie not only in their approaches towards ways to avoid or mediate conflicts between principles, or aspects of a principle, but also in the ways they are perceived and the ways in which good and bad should be evaluated.

My conclusion in the present article is that the theory of double effect is not the sole alternative non-consequentialist solution, nor is the theory of proportionality for consequentialists alone. I have proposed a non-consequentialist theory of proportionality (or, rather, of beneficence relativized), which I would like to call the “theory of proportionality plus intention.”

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## Notes

<sup>1</sup> I say that such action “can be acceptable”, and not “is acceptable”, because even if such action fulfills all the following conditions, the action could be still not acceptable unless the patient and the medical practitioners come to an agreement and the latter obtain the informed consent by the former.

<sup>2</sup> The example of side effects is best for understanding the theory of double effect. Anscombe 1982 discusses this in combination with its own theory of intention and calls it a “principle of side-effects.”

<sup>3</sup> Some scholars argue about the theory of double effect with reference to the moral absolutism, according to which ethical norms are exceptionless (Boyle 1991, Donagan 1991). Reportedly there is a non-absolutist version of the theory, which does not presuppose absolute prohibitions of inflicting kinds of harms. In the present paper, however, when I refer to the theory of double effect as a non-relativist view, I do not mean that, according to the view, a norm itself is exceptionless, but that a set of norms as a whole, including rules adjusting between them as well, is exceptionless, and that the theory of double effect plays the role of an adjusting rule, making the whole system exceptionless (cf. Sulmasy 1999).

<sup>4</sup> Here I express my appreciation to Dr. Morita Tatsuya (Seirei Mikatagahara Hospital) of the Research Institute for Health Science, Group for “Study on the way palliative medicine and psycho-oncology in cancer treatment should be and dissemination thereof”, the Committee for establishing guidelines concerning sedation for the relief of pain, who provided me with useful information concerning ethical discussion on sedation.

<sup>5</sup> This statement is made by Quill as an explanation of the fourth condition of the theory of double effect. However, as stated in this article, this is not really appropriate as an explanation for the theory of double effect. Quill, in my opinion, attempts to apply the theory of double effect to explain his theory by extracting only this aspect and approving of it.

<sup>6</sup> The principle is used in international politics in this sense. It is expressed, for instance, in the *Treaty Establishing the European Community*, Article 5, paragraph 3: “Any action by the Community shall not go beyond what is necessary to achieve the objectives of this Treaty.”