

The Rule of Double Effect

Clearing Up the Double Talk

RECENTLY, the rule of double effect, which has a long history in ethics, especially medical ethics, has come under serious criticism in the medical literature.^{1,2} Because of its immense practical importance in the care of dying patients, any attack on this rule must be taken seriously. In this article, therefore, we present a systematic rejoinder to what we take to be serious misunderstandings of the nature and use of this rule.

A clear understanding of the proper use of the rule of double effect is essential if health care professionals are to maintain their opposition to euthanasia and assisted suicide and yet provide adequate pain relief to dying patients. Many Americans, including health care professionals, are fearful of unwittingly participating in euthanasia if a patient's death is hastened, however unintentionally, as a side effect of attempts to relieve pain and suffering. For such individuals, the rule of double effect provides moral reassurance and thus encourages optimal care of the dying. This is why the rule figures prominently in the opinions of the American Medical Association.^{3,4}

NATURE AND CONTENT OF THE RULE OF DOUBLE EFFECT

Although variously formulated, the traditional rule of double effect specifies that an action with 2 possible effects, one good and one bad, is morally permitted if the action: (1) is not in itself immoral, (2) is undertaken only with the intention of achieving the possible good effect, without intending the possible bad effect even though it may be foreseen, (3) does

not bring about the possible good effect by means of the possible bad effect, and (4) is undertaken for a proportionately grave reason.⁴⁻⁸ This moral rule has wide application, but has played a particularly important role in the care of the dying, allowing those who are morally opposed to euthanasia and assisted suicide to provide adequate pain relief without violating traditional medical morality or their consciences.

Treating dying patients in pain with appropriate doses of morphine is generally done in a manner that satisfies the criteria for double effect. The use of morphine (1) is not in itself immoral; (2) it is undertaken only with the intention of relieving pain, not of causing death through respiratory depression; (3) morphine does not relieve pain only if it first kills the patient; and (4) the relief of pain is a proportionately grave reason for accepting the risk of hastening death. Some physicians, who are opposed to euthanasia and assisted suicide, might avoid giving opioid analgesics to dying patients out of fear of hastening death and committing euthanasia. According to the rule of double effect, however, the appropriate and compassionate use of morphine is morally permissible even for those who are morally opposed to euthanasia and assisted suicide. This rule allows physicians opposed to euthanasia and assisted suicide to treat pain adequately in these situations with a clear conscience.

THE UNDERLYING ISSUE

If one believes that euthanasia and assisted suicide are sometimes morally permissible, then the rule of double effect has no role to play in the care of dying patients. If it is not

wrong to intend that a patient die by way of one's clinical act, then there is no need to bother with the rule of double effect. However, millions of American health care professionals and patients are morally opposed to euthanasia and assisted suicide. For such individuals, we argue, the rule of double effect is perfectly coherent and of great clinical importance.

LOGICAL INCONSISTENCIES WITH POTENTIALLY DELETERIOUS EFFECTS ON PATIENT CARE

Undermining the rule of double effect has the potential to affect the care of the dying adversely, since most physicians report that they are personally reluctant to perform euthanasia or assisted suicide even if it is legalized.⁹⁻¹² Some of the critics of double effect seem to want things both ways. They acknowledge that "the rule of double effect may be useful as a way of justifying adequate pain relief and other palliative measures for dying patients."¹ But at the same time, they argue that this moral rule is not credible.

The rule of double effect is either valid or invalid. It cannot be both. If the rule of double effect is, in fact, logically and morally valid, then the most helpful policy for patients would be to educate physicians about its proper application. Those who already approve of euthanasia and assisted suicide cannot logically be opposed to giving drugs in a manner consistent with the rule of double effect. They might, in addition, want to give lethal doses or administer other lethal treatments, but they cannot be opposed to relieving pain. By educating phy-

sicians about the rule of double effect, more patients will receive adequate pain control from physicians who are opposed to euthanasia and assisted suicide and might otherwise be reluctant to provide such treatment.

On the other hand, if one believes that the rule of double effect is somehow incoherent, how can one argue that physicians who are opposed to euthanasia or assisted suicide should use it in the care of patients? If this rule really makes no sense, then it follows logically that those physicians who are conscientiously opposed to euthanasia and assisted suicide should not prescribe opioid analgesics for the dying. They would have no choice but to refrain from using these drugs, because without the rule of double effect, they would be forced to consider all actions that risk hastening the death of the patient to be euthanasia. And this would be a horrifying consequence for patients.

If, however, as we argue later, the rule of double effect is valid, then those opposed to euthanasia and assisted suicide can feel morally reassured when using appropriate doses of opioid analgesics in the care of dying patients.

MISCONSTRUING DOUBLE EFFECT

Critics misconstrue this moral rule when they suggest that it is simply a rule that enables one to decide whether one potentially harmful action is preferable to another.^{1,2} This is not true. The rule of double effect is not simply an instrument of consequentialist reasoning, ie, determining the moral status of an action on the basis of net utility. One does not begin double effect reasoning by first examining the consequences of a proposed action and then deciding whether the net consequences are such that there might be a good reason to override some *prima facie* prohibition against the action. Rather, one sets out to do a morally good action, taking full account of the foreseeable consequences. If the action conforms to the conditions of the rule of double effect, one may proceed even under circumstances in which that ac-

tion might have dangerous side effects. This is a different idea from the notion that one simply picks the lesser of 2 evils.

DOUBLE EFFECT AND ASSISTED SUICIDE

The critics have created a straw man when they suggest that if the rule of double effect were true, then physician-assisted suicide should be permitted by its adherents.¹ They provide no citation of such an argument by anyone who subscribes to the rule of double effect.

They also make a category mistake by applying this rule to the situation of assisted suicide. The rule of double effect is only 1 moral rule among many. It is only designed to cover certain kinds of actions, while other rules cover other kinds of actions. According to the standard account, the rule does not apply to situations in which the effects under consideration involve the intentions of intervening agents. The rule of double effect can only be applied to situations in which the possible good and bad effects follow directly on an agent's actions.¹³ For example, Quill et al¹ claim that the physician writing a lethal prescription might only intend to "reassure the patient by providing a potential escape from suffering that the physician hopes or expects will not be used." Assisted suicide, however, requires that a patient form an intention to bring about the bad effect that the physician is allegedly claiming to intend to avoid, ie, suicide. The suicidal death of the patient does not follow directly from the writing of the prescription, but from the patient's intentional use of that prescription. Therefore, the rule of double effect does not apply.

Presuming, as proponents of the rule of double effect do, that euthanasia and suicide are morally wrong, the moral question for the physician in cases of assisted suicide is whether the physician's assistance in the suicide is morally acceptable. Therefore, the proper moral category for such physicians is not double effect but cooperation (ie, whether the physician is an accomplice and therefore morally culpable).^{14,15} The patient is asking

for the physician's assistance in providing "a possible way out." The physician writes the lethal prescription knowing that the patient has already formed a provisional commitment to the possibility of taking these drugs. Without the physician's cooperation, this possible intent could not be carried out in the way the patient intends it. If the physician is morally opposed to euthanasia and suicide, the physician has thus cooperated in the death if the patient goes on to commit suicide.

Double effect would apply here only if the patient expressed no intention either to commit suicide or to have a lethal dose available "just in case." A physician might write a prescription for an opioid analgesic to treat pain, and the patient might surreptitiously stockpile the pills and take them in a suicide attempt. This is always a possibility with any drug that is used clinically, whether it is an opioid analgesic or digitalis. If one recognizes that this is a possibility, but has no indication that this is the patient's intention, one is not an accomplice in the suicide. However, if the patient clearly signals such a possible intention, one is an accomplice if the patient commits suicide.

To illustrate this, consider someone who is asked to give a stick of dynamite to a distraught employee who has recently been fired and is expressing a vague wish to blow up his place of former employment. It is hardly plausible in such a situation to invoke the rule of double effect and say that one would only be intending to ease the employee's anxiety by giving him the dynamite. It is true, he might or might not blow up the building. But if the employee does blow up the building, one is a moral accomplice because one has supplied the means, knowing of the former employee's possible intention. The same is true of assisted suicide. If one knowingly supplies the means, one is an accomplice.

Furthermore, suppose one were to try to stretch the rule of double effect to cover the situation of assisted suicide. Even so, the rule of double effect would prohibit this action, provided one were morally opposed to suicide in the first place. To

try to make assisted suicide fit under the rule of double effect, one would need to make the claim that one was giving pills without intending the patient's possible suicide. However, the third condition of the rule of double effect requires that the possible bad effect not be the means of producing the possible good effect. In this case, what one would be claiming not to intend, the possibility that the patient might actually take the overdose and die, is, in fact, the very means by which the patient is reassured. Therefore, the rule of double effect would not justify assisted suicide.

DOUBLE TALK ABOUT TERMINAL SEDATION

Terminal sedation, in which dying patients may be given doses of drugs to treat specific symptoms, but subsequently lapse into coma and die, is an extraordinarily rare event in the hands of experts in hospice and palliative care.¹⁵ Good palliative care physicians aim at maximizing symptom control and function at the same time. Under the rule of double effect, however, they sometimes can accept sedation to the point of unconsciousness as a side effect of a specific treatment aimed at a specific symptom. That is, they accept sedation that may happen to be terminal. They do not sedate as part of a plan to terminate. However, some authors^{2,16} are now erroneously suggesting an extension of the meaning and scope of this practice to include the practice of certain forms of euthanasia under the legal cover of what has traditionally been permitted as double effect.

To use the rule of double effect properly, one must be careful to specify the effects one is aiming at, and be reasonably sure that the proposed intervention can possibly achieve this effect. "Relief of suffering" is far too broad an effect to have practical clinical meaning. Good clinicians use specific drugs to treat specific symptoms, and under the rule of double effect, can, at times, accept the possibility of loss of patient consciousness as a side effect of treating these symptoms. For example, consider a patient who is days away from death, already beginning to experi-

ence diminished consciousness as a consequence of the natural progression of her disease, in extreme pain, and asking for relief. Under the rule of double effect, it is perfectly appropriate to treat the patient's pain with an opioid analgesic, recognizing that the patient may subsequently lose consciousness as an unintended side effect, consequently not eat, and die sooner.

This is a different case from a patient with early Alzheimer disease who is suffering because of fear of what the future might bring, asking for help in hastening death. In sedating such a patient to the point of unconsciousness, the intention is to hasten death. This would therefore not be permitted under the rule of double effect and ought not be permitted on that basis under law so long as euthanasia remains illegal.

Or consider an elderly patient without pain but with severely limited mobility because of inoperable degenerative arthritis, who may be experiencing a kind of existential angst, or what the Dutch euthanists call "tiredness of life."¹⁷ The only way that a barbiturate could relieve the symptoms of tiredness of life would be by causing the unconsciousness and death of the patient. But this violates the rule of double effect, since the allegedly unintended possible bad effect (unconsciousness and death) is the means of achieving the possible good effect (relief from tiredness of life). Therefore, this sort of "terminal sedation" is simply a form of active euthanasia and would not be permitted under double effect.

However, consider the sort of case in which a patient with metastatic cancer has been treated for many months with opioid analgesics and has developed myoclonus as a side effect of these drugs. Suppose the patient has been treated with benzodiazepines for the myoclonus, but the myoclonus persists. Suppose the patient has also been treated with adjunctive tricyclic antidepressants, a nerve block, and biofeedback and the pain is still not relieved. Under such extraordinary circumstances, one could consider the use of barbiturates as a way to suppress the myoclonus and bring the patient relief from anxiety that may be exacerbating the pain.

As long as these were one's intentions, and one were only to use as much barbiturate as was necessary to suppress these symptoms, having established with the patient that unconsciousness might result as an unintended side effect, one could proceed with such measures under the rule of double effect. This should be a measure of last resort, but one that might, in extremely rare circumstances and in careful hands, be necessary. This is the sort of case of terminal sedation that has traditionally been permitted but rarely performed under the rule of double effect.

Thus, some kinds of terminal sedation are permitted under the rule of double effect, and some are not. In those kinds that are permitted, sedation is an unintended but foreseen side effect. In those kinds that are not permitted, the intended purpose of the sedation is the termination of the patient's symptoms by means of the termination of the patient's existence.

WITHDRAWING LIFE-SUSTAINING TREATMENT IS NOT AN APPLICATION OF DOUBLE EFFECT

A further mistake is the suggestion that the withdrawal of life-sustaining treatments is traditionally justified by the rule of double effect.¹ Once again, this is a misapplication of the rule of double effect, albeit one that has been perpetuated in the literature.¹⁸ Once more, it pays to understand that the rule of double effect is but one rule among many. Traditionally, the refusal of life-sustaining treatments has been justified under the rule that one is permitted to withdraw life-sustaining treatments in circumstances in which their use is considered "extraordinary" or "disproportionate."^{19,20} Like the rule of double effect, the ordinary vs extraordinary distinction requires a proportionately grave reason, but it is a distinct moral rule.²¹ Morally cautious patients or health care professionals who do not support euthanasia or assisted suicide have been permitted to withhold and withdraw life-sustaining treatments that are futile or disproportional.

tionately burdensome under Roman Catholic moral theology since at least the 1500s,¹⁹ years before the rule of double effect had ever been explicitly formulated in the moral literature.²² Under this rule, one is permitted to refuse life-sustaining treatments that are of no benefit or are disproportionately burdensome. It is a rule for refusing treatment, not a rule to guide active treatment.

There is no need to invoke the rule of double effect in withdrawing life-sustaining treatments. One need only invoke the dictum that there is no moral obligation to use futile or excessively burdensome treatments.

THE DISAMBIGUATION OF CLINICAL INTENTIONS

Quill²³ has argued forcefully that clinical intentions are inherently ambiguous, and cannot be used to evaluate the morality of clinical actions. This is an extremely problematic position, reiterated in the recent attacks on the rule of double effect.^{1,2} Common sense and the law place important weight on intentions in evaluating the morality of human actions, and properly so. Intentions are vital to our understanding of virtuous actions, and in explicating what it means sincerely to act with respect for another's dignity.⁵ Careful distinctions are also drawn, for instance, between manslaughter, murder in the first degree, and so forth, purely on the basis of judgments about human intentions. What is done with "malice aforethought" is deemed far more troubling morally than what is done unintentionally.

The morality of everyday clinical practice depends heavily on the concept of intention, and clinicians have an unarticulated, intuitive grasp of the rule of double effect in almost all their therapeutic interventions. This is because the whole notion of a side effect is totally dependent on the rule of double effect and the concept of intention.²⁴ For instance, when physicians treat streptococcal pharyngitis with penicillin, they foresee the possibility that the patient might develop an anaphylactic reaction and die. But they only intend to kill the

bacteria, not to kill the patient. The death of the patient is not the cause of the death of the bacteria, and the rarity of anaphylaxis and the harm of not treating makes the risk proportionate and worth taking. Even so simple an action as prescribing penicillin already presumes something about intention and is actually an application of the rule of double effect. This is the case with any powerful drug.

At times, of course, it can be difficult to judge human intentions. But as Samuel Johnson once said, "The fact of twilight does not mean there is no difference between night and day."²⁵ If a clinician gives 10 mg of morphine intravenously over 5 minutes to a nonopioid-tolerant patient with significant pain, this action is consistent with an intention to relieve pain and not to kill the patient. But if a clinician were to give 5000 mg of morphine intravenously over 15 seconds to a nonopioid-tolerant patient to relieve the patient's "suffering," knowledgeable clinicians would have no doubt about that clinician's intentions. This difference is as clear as the difference between night and day.²⁶

Contrary to the contentions of the critics, a great deal of contemporary work in the philosophy of action shows how intentions differ from beliefs and desires and supports the importance of distinguishing between the foreseen and the intended.²⁷⁻³¹ Space requirements prohibit a full discussion of this matter herein. The application of this intention theory to bioethical discourse is only just beginning.³²

LAW DOES NOT SETTLE THE MORAL QUESTION

Legal arguments do not settle moral questions. It is a truism to state that all that is legal is not moral, and that all that is moral is not necessarily legal. Therefore, legal opinions about assisted suicide or euthanasia really only have moral weight to the extent that they are morally persuasive. The legal arguments of the critics do not address the moral issues.

The recent US Supreme Court decision regarding assisted suicide invoked double effect reasoning.^{33,34} An interesting legal argu-

ment has been offered that this might lay the groundwork for establishing a constitutional right to adequate pain relief for the dying.³⁵ But the justices made no moral arguments for accepting the rule of double effect, and the recent discussions of the court's decision in the medical literature do not attempt to find such a moral argument. Furthermore, the fact that critics of prohibitions on assisted suicide and euthanasia point out that physicians accused of assisted suicide are often acquitted is not an argument against the logical and moral validity of the rule of double effect. Judges and juries and legislators may make decisions within the bounds of law and yet make morally incorrect judgments.

RELIGION, MORALITY, AND SOCIETY

Quill et al¹ suggest that among the "shortcomings" of the rule of double effect as a guideline for medical morality in a pluralistic society is the fact that "the rule originated in the context of a particular religious tradition." This is a very odd position. Should the commonly held position that stealing is morally wrong be rejected simply because it can be found (Exodus 20:15) in the commandments of a particular religious tradition? The religious origins of a moral principle or rule should not preclude its discussion in civil society. Nor should the congruence between a moral argument's conclusions and the teachings of a religion undermine the validity of the argument. An exhortation to exclude such rules and principles in the name of tolerance seems itself highly intolerant.

There is nothing about the rule of double effect that is inherently religious. The fact that it was developed by theologians does not vitiate the fact that it might be morally true. Nothing about the rule presumes any knowledge of scripture or the teachings of any religion. All that is required is a belief that certain actions are absolutely morally prohibited, or, more controversially, at least a belief that consequences are not the sole determinants of the morality of an action.³⁶ Many clinicians be-

lieve, for a variety of reasons, some religious and some not, that euthanasia and assisted suicide are always morally wrong. Such clinicians need a rule of double effect.

A logically rigorous argument against the rule of double effect would deal with the rule on its own terms. To raise the question of the origin of the rule as a reason to discredit it is a form of the logical fallacy of the *ad hominem* argument—to claim to discredit an argument because of who states it.

Moreover, while it has had its origins in a particular religious tradition, the rule of double effect has been widely discussed and defended in the philosophical literature apart from its origins.³⁶⁻³⁹ Its applications are far wider than medicine. For instance, it is the basis of the distinction between terror bombing and strategic bombing in just-war theory.^{7,25,27,40} The argument that it should be rejected out of hand simply because it originated with a particular religious tradition is completely unwarranted.

PATIENT AUTONOMY: A MORAL ABSOLUTE?

While we agree with the critics that autonomy holds an important place in Western medical ethics and law, we fail to see how this justifies the conclusion that the patient's autonomous preference for death is more fundamental than whether the physician intends to cause death.^{1,2} These authors³⁶ simply assume that there can be no moral absolutes, such as a prohibition on the direct killing of patients by physicians. This begs the central moral question in the debate over assisted suicide. We, on the other hand, are making a more limited claim, and making our assumptions explicit. We are only arguing that if one believes, for whatever reasons, that euthanasia and assisted suicide are always morally wrong, even if requested by a patient, then the rule of double effect can be used sensibly and coherently to examine important cases in the practice of medicine, particularly the care of the dying.

The US Supreme Court has recently decided that there is no constitutionally guaranteed legal right

to actions that cause death,^{33,34} but the *moral* question remains the central one that must be debated. Certainly, no one has yet seriously argued that physicians have a moral obligation to provide assistance with suicide or euthanasia on demand even if they conscientiously object to these practices. This would violate the autonomy of the clinicians.

While space considerations preclude a full discussion, multiple arguments about the nature of the practice of medicine,⁴¹ the value of preserving life,⁴² and concerns about the slippery slope consequences of legalizing euthanasia and assisted suicide⁴³ have been made to argue against allowing patients the autonomy to demand these practices. Others⁴⁴ have argued that assisted suicide can never itself truly be autonomous. The central moral issue in the debate about euthanasia and assisted suicide is whether these are good arguments.

As the critics point out, the rule of double effect is only morally important if euthanasia and assisted suicide are considered immoral. An attack on the rule of double effect therefore only makes sense when viewed as part of a strategy to promote the legalization of physician-assisted killing by undermining physicians' confidence in a commonly accepted moral rule that depends on the presumption that killing patients is morally wrong. But if the arguments against double effect are themselves inadequate, mistaken, or confused, then one must face squarely the real question at stake—whether patient autonomy is such a moral absolute that countervailing considerations will not stand.

CONCLUSIONS

The rule of double effect has traditionally played an important role in medical ethics. It is the philosophical underpinning for the critically important concept of a side effect. The rule of double effect needs to be accurately understood and carefully specified, so that clinicians opposed to euthanasia and assisted suicide can understand that they might conscientiously use potent drugs to treat terminally ill patients under circumstances in which hastening the

death of the patient can be considered a morally permissible side effect. Recent attacks on this moral rule therefore do the medicomoral community a disservice, since these attacks have been fraught with misinterpretations, misapplications, hasty generalizations, and logical fallacies.

It goes without saying that those who accept the moral permissibility of euthanasia and assisted suicide have no need for a rule of double effect. For them, hastening the patient's death is not a "bad" effect to be avoided. But for most physicians, who report that they personally would not perform euthanasia, the rule is important. It allows them to treat specific symptoms of dying patients even at the risk of hastening death while preserving their conscientious objection to euthanasia. The importance of the rule of double effect needs to be underscored at a time when the public is clamoring for improved care of the dying and the US Supreme Court has declared that there is no constitutional right to assisted suicide. Recent attacks on this rule are therefore not only to be faulted as ill-conceived, but also as ill-timed. For the benefit of patients, we hope that this article addresses these objections to the rule of double effect and that clinicians will understand and apply that rule properly.

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