

Does the doctrine of double effect apply to the prescription of barbiturates? *Syme vs the Medical Board of Australia*

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ABSTRACT

The doctrine of double effect (DDE) is a principle of crucial importance in law and medicine. In medicine, the principle is generally accepted to apply in cases where the treatment necessary to relieve pain and physical suffering runs the risk of hastening the patient's death. More controversially, it has also been used as a justification for withdrawal of treatment from living individuals and physician-assisted suicide. In this paper, I will critique the findings of the controversial Victorian Civil and Administrative Tribunal (VCAT) hearing *Syme vs the Medical Board of Australia*. In that hearing, Dr Rodney Syme, a urologist and euthanasia advocate, was defending his practice of prescribing barbiturates to terminally ill patients. Syme claimed that he prescribed the drugs with the intention of relieving their existential suffering and not to assist in suicide; he argued that the DDE could be applied. *Pace* VCAT, I argue that this is an illegitimate application of DDE. I argue that a close scrutiny of Syme's actions reveals that, at the very least, he intended to give patients the option of suicide. He furthermore used what on a traditional definition of DDE would be considered a 'bad' means—the prescription of Nembutal—to achieve a 'good' end—the relief of suffering. The case demonstrates the crucial importance of analysing an agent's 'intention' and the 'effects' of their actions when applying DDE. Ethicists and, indeed, the judiciary need to attend to the ethical complexities of DDE when they assess the applicability of DDE to end of life care. If they fail to do this, the doctrine risks losing its legitimacy as an ethical principle.

The doctrine of double effect (DDE; also known as the principle of double effect or just double effect) is a principle of crucial importance in law and medicine. In medicine, the principle is generally accepted to apply in cases where the treatment necessary to relieve pain and physical suffering runs the risk of hastening the patient's death. More controversially, it has also been used as a justification for withdrawal of treatment from living individuals¹ and physician-assisted suicide.²

This paper analyses the findings of the controversial Victorian Civil and Administrative Tribunal (VCAT) hearing *Syme vs the Medical Board of Australia*.³ In that hearing, Dr Rodney Syme, an Australian urologist and euthanasia advocate, was defending his practice of prescribing Nembutal to terminally ill patients. Syme claimed that he prescribed the drugs with the intention of relieving their existential suffering and not to assist in suicide; he argued that the DDE could be applied. *Pace* VCAT, I will argue that there are good reasons

to see this as an illegitimate application of DDE. I will argue that a close scrutiny of Syme's actions suggests that he intended to give patients *the option of suicide*. In doing this, we have reason to say he intended a bad effect, and, therefore, that DDE did not apply. Furthermore, it could be argued that Syme was achieving a good effect by means of the bad effect when he prescribed Nembutal. On the traditional formulation of DDE, this is impermissible. I conclude my analysis with a brief discussion of the comparison made by the Tribunal between Syme's actions and the practice of palliative sedation.

The case demonstrates the crucial importance of analysing an agent's 'intention' and the 'effects' of their actions when applying DDE. Ethicists and, indeed, the judiciary need to attend to the ethical complexities of DDE when they assess the applicability of DDE to end of life care. If they fail to do this, the doctrine risks losing its legitimacy as an ethical principle.¹

THE DOCTRINE OF DOUBLE EFFECT

DDE is a philosophical concept often employed when evaluating the morality of actions. It rests on the basic conviction that in morality *intentions matter*, and that a person's intentions to some extent determine whether their actions are moral or immoral. There are various formulations of the doctrine, depending on which ethical or legal tradition you are approaching it from. We can nevertheless posit a generic definition along the following lines:

The doctrine of double effect states that, where certain criteria are met, a person acts ethically when acting to bring about a good or morally neutral effect, even if her action also has certain foreseen, though not intended or desired, bad effects.

An important phrase in the above definition is 'where certain criteria are met'. Depending on the tradition you work in, these criteria will vary. The traditional formulation of the doctrine, adopted by Beauchamp and Childress⁴ McIntyre and Zalta,⁵ Bennett⁶ and Uniacke,⁷ is accompanied by the following criteria:

1. The act itself must be good or at least morally neutral.
2. The agent must not intend the bad effect.
3. The bad effect must not be used as a means to achieve the good effect.

¹Importantly, I will be approaching this particular case from a philosophical perspective and I do not intend for my remarks to constitute a legal exegesis.



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4. The 'goodness' of the good effect must outweigh the 'badness' of the bad effect, and there must be no other reasonable way to attain the good effect.

In the case in question, VCAT was working with a traditional formulation of double effect rather than positing a consequentialist variety of the doctrine. Specifically, the Tribunal took double effect to refer to the pursuit of a good, 'primary (intended) purpose', despite the fact that there is a negative, 'secondary (unintended) consequence' that follows from it. A consequentialist view of double effect might involve a rejection of premise 3 of the aforementioned criteria, as according to consequentialism, it is permissible to achieve a good effect by means of a bad effect. Indeed, there are commentators in the double effect literature who advocate this view.⁸ Yet from the discussion of double effect in the hearing, it is clear that the Tribunal accepted all the premises of the traditional formulation of the doctrine. In the interest of fairness, I will adopt the traditional formulation of the doctrine for my discussion, as this was the formulation that the Tribunal intended to apply.

Unfortunately, the DDE is often carelessly summarised, and important criteria are omitted.ⁱⁱ Granted, there is much disagreement about the nature of double effect, but many commentators will not even acknowledge the relevant debates.ⁱⁱⁱ

A legitimate application of the doctrine in a medical context would be chemotherapy. In chemotherapy, a care team administers toxic drugs to the patient that may lead to the patient's death through the suppression of their immune system. The aim of the treatment, nevertheless, is to cure cancer or reduce symptoms, and the inimical side effects for the patient are foreseen but *unintended*. In this case, it is appropriate to describe chemotherapy as a treatment (something aimed at improving the patients' prognosis) rather than a deliberately harmful intervention. The primary intent of the doctor is to cure or treat rather than to harm.

Suffice to say that the intentions of an agent are highly significant in the way we choose to characterise their actions. Action descriptions are more than just categorisations of physical events, and we always should think about what the intention of an agent is. The question I want to consider, however, is 'does DDE apply to the prescription of Nembutal?'

Syme vs the Medical Board of Australia

The VCAT hearing *Syme vs the Medical Board of Australia*³ centred on Melbourne urologist and euthanasia activist Rodney Syme. The Medical Board of Australia (MBA) had been made aware that Syme was prescribing barbiturates (specifically, Nembutal) to patients who were terminally ill, so as to give them 'a sense of control' over the end of their lives. The MBA's Immediate Action Committee found that Syme posed 'a serious risk to persons' and placed a condition on Syme's license that prevented him from engaging in medical care 'that has the primary purpose of ending a person's life'[4]. This was intended to prevent him from prescribing Nembutal to any more patients.

Syme appealed the ruling to the VCAT. Syme's essential claim was that in administering Nembutal to patients she was not acting with the intent of ending their lives but merely giving them a sense of control over their own deaths. Death, he suggested, was only a foreseen, unintended side effect of his actions. His primary intent was to relieve their existential suffering.

Despite MBA's arguments to the contrary, VCAT found in favour of Syme. The Tribunal ruled that his actions were consistent with the principle of double effect, and that the MBA was wrong to suggest that Syme, in administering Nembutal, was causing (or at least intending to cause) the death of the patient.

In the ruling, the Tribunal said that Syme's intention was 'to give the patient control' over the end of their lives, rather than to assist them in suicide. Syme told the Tribunal that patients were known not to consume Nembutal even when it was readily available to them, and that the mere possession of the drug was enough to allay their fears of a painful death. The Tribunal saw this as convincing evidence that he was not intending for them to ingest the drug. Furthermore, the Tribunal saw Syme's actions as being analogous to the practice of terminal sedation in palliative care:

"The Tribunal agrees that there is a logical analogy between the principle of double effect used in palliative care; and the prospect that a patient may elect to ingest Nembutal, the latter effectively representing the same kind of secondary effect as the hastening of death which... occurs when terminal sedation is used. The only real difference is one of timing. When Nembutal is ingested in the requisite dose, the process leading to death is quick and without the further trauma or complications which can be associated with terminal sedation".

A CRITIQUE

The problems raised in this case are significantly more complex than VCAT has acknowledged. In particular, it raises questions about the nature of intention and the relationship between the bad effects and good effects of our actions. In media commentary on the case, the comparison was made between Syme's actions and the supply of a loaded gun to someone so they could 'shoot themselves if they wanted to'.¹¹ While there are limitations to this analogy, there are, nevertheless, good reasons to view Syme's actions as similar, if not morally equivalent, to more salient cases of assistance in dying.

It is important to clarify what Syme believed the patients would do once they had access to Nembutal. After all, if we are considering what Syme 'intended', we need to consider how he thought the patients would act in conditions where they had ready access to the drug. Syme stated that he believed the drug would not be used for suicide unless it was absolutely needed to end unbearable pain or suffering. What's more, he had given Nembutal to hundreds of patients over the years, and only 40% had consumed it. He described his practice in this way:

"I can say that categorically, that (sic) my intention is to give a sense of control and by so doing to ease their suffering... by the time I make the assessment that they need to have possession of the medication I am confident that they will not do that unless they feel it absolutely necessary to use it".[17]

He believed, in other words, that the majority of patients would not ingest the drug.

The problematic 'flip-side' of this statement is that he *also* believed a significant minority of patients *would* ingest the drug. Of the dozens or hundreds of patients he prescribed Nembutal to, there was an expectation that at least several of them would, where it had become 'absolutely necessary', consume the barbiturates.

Syme claims, however, that even in these cases, his primary intention was to relieve suffering and not to assist with death. Death was only even an unintended, secondary consequence[16,19]. In testing Syme's claims, then, we need to ask,

ⁱⁱKomesaroff and Charles⁹ make no mention of criteria 3, nor do they give due attention to the difference between intending to relieve pain and intending to kill a patient

ⁱⁱⁱFor an overview of these debates, see Woodward.¹⁰

'did he ever intend for patients to take the drug, or, at least, have the possibility of taking the drug?'

To answer this, we should describe Syme's intention in the most specific way possible, rather than staying at the level of generalities. Descriptions of intention, just like descriptions of action, should be sufficiently specific to perform the explanatory function that they are intended to do.^{iv} By way of example, I could describe the intention as an act of rescue 'to help another person'; yet this description is far too abstract and ambiguous. A more appropriate, specific description, would be something like, 'to pull the drowning child out of the pool' or 'to rescue the elderly man from the burning house' (or whatever the act of rescue is aimed at achieving).

Syme provided a generic description of his own intention when he stated that he aimed to 'give patients a sense of control'. The trouble with this description is that it does not pick out what makes his actions different from other ways of 'giving patients a sense of control', such as by allowing them to choose between different treatment options that may or may not increase their life expectancy or by ensuring that they have the opportunity to die at home if they so wish. Presumably, if we are looking for an account of intention that picks out what is distinctive about the act of prescribing Nembutal, we are warranted in providing a more specific description. Relieving suffering was the indirect, general goal of prescription; yet 'giving the patient the option of suicide' was the *particular means* by which a sense of control was attained. And Syme himself indicated that when he prescribed Nembutal to patients, he did so knowing that 'the person could use this drug to end their life'[17]. At the most basic level, then, we can say that Syme's *specific aim* at the time of prescription was to 'give patients the option of committing suicide'. While it may be true that his ultimate, generic aim was to give patients a sense of control, Syme's immediate, particular aim at the time of prescription was to 'give patients the option of suicide'.

But is an agent's *immediate, particular aim* equivalent to the *intended* effect of their actions? Yes, I argue. Intended effects *just are* aims, and insofar as something is intended as a direct and immediate consequence, then it can be said to be part of the intent of an agent. Importantly, this is not to *deny* Syme's own description of his actions; it is merely to cash out his description in a more specific way, a way that appropriately captures what is distinctive about the act of prescribing Nembutal.

The problem for VCAT is that, if I am correct, Syme was intending a bad effect, namely, 'giving patients the option of committing suicide'. This being the case, he violated criterion 2 of the principle of DDE.

An interlocutor may, however, claim that there is a difference between giving a patient *the possibility of suiciding* and *actually assisting them in suicide*. In the former, you are merely intending that someone has the possibility of doing something, whereas in the latter, you have the intention that they actually do it. If we accept this distinction, then it is not clear that criterion 2 is violated. Intending that 'someone might commit suicide' need not be taken to be equivalent to intending a bad effect. Or so it might be argued.

One way to respond to this objection would be to reject the intention-splitting that is involved in it. We might say that there is no real distinction between modal intentions and real intentions. It is mere casuistry, we might suggest, to claim that there is a difference between willing that an evil *might* occur and willing that it *actually* occurs.

An alternative response, and the one I would advocate, is to suggest that a bad effect is still being intended. I would concede that in the two cases the agent has a different object in view. In one case, the intention is 'that the patient commit suicide'; in the other case, the intention is that 'the patient might commit suicide'. Yet even so, both of these states of affairs are *bad*. Even though in the latter case the patient might not commit suicide, it is still *bad* that he 'might commit suicide'. If suicide is taken to be something bad—and this seems to be presupposed by anyone who takes the traditional account of DDE not to apply to active euthanasia—then the state of affairs in which one 'might commit suicide' should also be considered as something bad. And this is precisely what Syme was intending in this case.

Even if—for argument's sake—we take Syme's intentions to be benign, it seems that he fails to meet criterion 3 of the traditional formulation, namely, that *the good effect must not be produced by means of the bad effect*. Let's suppose that Syme's intention was solely to minimise suffering by virtue of 'giving the patient a sense of control'. We might, like the Tribunal, give Syme the benefit of the doubt. Even in this situation, it seems that 'the good effect is being achieved by the bad effect'. Syme relieved patients' suffering by giving them the possibility of committing suicide. This good effect—gaining a sense of control—is brought about by the bad effect—providing patients with the possibility of suicide. Or, to be more specific, the good effect is *rationaly dependent* on the bad effect. The patient's belief that they are in control of their lives is grounded in the fact that they can consume a lethal dose of Nembutal if they wish. And this state of affairs is something bad. It would be different if pain relief were achieved by helping the patient to accept the loss of control that they were experiencing. Yet in this case, the relief of suffering is achieved by providing them with the option of suicide and not through some form of existential therapy.

More could be said about intention and rational dependency. And I do not purport to have provided a knockdown demonstration of the invalidity of DDE in Syme's case. This is in part because it is difficult to say with absolute certainty what he intended. Yet I take it that there are good reasons to at least *doubt* VCAT's application of the doctrine. And this in itself is significant, considering that Tribunal was fairly unequivocal in its application of DDE.

In its ruling, the Tribunal relied heavily on an analogy between 'palliative sedation' and the prescription of Nembutal for patients with existential distress. It is appropriate, therefore, to conclude with a brief discussion of the notion of 'palliative sedation'.

Palliative sedation, in a clinical context, refers to the monitored use of medications to induce a state of decreased or absent awareness in a patient experiencing otherwise intractable suffering.¹³ It is typically used in an end-of-life context, where other treatments have proved insufficient and the goals of care legitimate its use. Pharmacological interventions are used to bring about levels of sedation ranging from mild (patient is somnolent) to intermediate (patient is in a stupor) to deep (patient is comatose). In such states, refractory symptoms, delirium, dyspnoea, pain and convulsions can be significantly relieved or entirely eradicated. When conducted in conformity with professional ethical standards such as those of the European Association of Palliative Care,¹⁴ the drugs are titrated to achieve relief of symptoms and not to hasten death.

In its ruling, the Tribunal attempted to distinguish between *licit* and *illicit* forms of palliative sedation. They held that sedation is permissible where the primary intention is the relief of

^{iv}For an account of 'basic actions', see Danto.¹²

suffering; the hastening of death must only ever be a 'secondary (unintended) consequence' of the treatment [32]. Where the hastening of death is the primary intention, sedation is impermissible [41–42]. The Tribunal compared Syme's actions to *licit* forms of palliative sedation. Just as in *licit* palliative sedation, there is a potential though unintentional hastening of death, so in Syme's case, there is a potential though unintentional hastening of death.^v 'The only real difference', to quote the ruling, 'is one of timing'.

The use of an analogy involving palliative sedation by the Tribunal is problematic, in part because palliative sedation itself has been described as a 'source of restless ethical debate'.¹⁴ While the Tribunal attempted to make a generalisation about intentions in palliative sedation, there is significant controversy about what cases of sedation count as intentional hastening of death, and what cases count as mere symptom relief. Some may, for example, believe that palliative sedation coupled with the withholding of hydration is ethically unproblematic.^{15 16} Others, however, would argue that, for patients who are only afflicted by existential suffering and have no terminal illness, palliative sedation coupled with the withholding of hydration counts as an intentional hastening of death.¹⁷ The effects of dehydration will cause death, and such results of a treatment decision should be considered intentional if not carried out within the context of a terminal illness and/or a situation of medical futility.¹⁸

But aside from this controversy, there is a clear *disanalogy* between the drugs and doses typically involved in palliative sedation and those involved in Syme's prescriptions. In palliative sedation in Australia, benzodiazepines, general anaesthetics and (rarely) barbiturates are used to induce a state of mild to deep sedation in the patient. The doses are *titrated*, such that the appropriate amounts of the drug are administered to treat symptoms, while not, for example, causing cardiac or respiratory arrest. The drug provided by Syme, in contrast, was Nembutal—a drug that when provided in a sufficient dose is lethal. And in the dosage that was prescribed by Syme (9g capsules), it was capable of doing *nothing other than killing the patient*. To quote Ian Maddocks' expert testimony, 'there is no other purpose for ingesting [a 9g dose of Nembutal] and whenever taken, it will cause death'.

I, therefore, would argue that it is unhelpful to attempt (as the Tribunal attempted) to justify Syme's actions by reference to an analogy with palliative sedation. The distinction between the application of double effect in palliative sedation and the application of double effect in Syme's case is far more than mere 'timing'. It concerns the fundamental difference in the nature (or, to use the term of the Tribunal, 'purpose') of the treatment involved. In one case, the intervention is by its very nature palliative. Studies suggest that in an Australian context the practice is not used to shorten life (if anything, it may in

fact prolong it).¹⁹ In Syme's case, the very drug prescribed, when consumed, does nothing other than cause death.

CONCLUSION

The aim of this paper was not to provide an analysis of the ethics of euthanasia or assisted suicide, but rather to consider where double effect might apply in end of life care. I have argued that, in the case of Syme, there are good reasons to suggest that DDE does not apply. I argued that Syme's intention was not merely to relieve pain, but also to give the patient the option of committing suicide. I also suggested that he was attempting to achieve a good effect by means of a bad effect. This being the case, it is impermissible to apply DDE to Syme's actions. His actions violate key criteria of the traditional definition of DDE.

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^vTo quote the Tribunal, "...there is a logical analogy between the principle of double effect used in palliative care; and the prospect that a patient may elect to ingest Nembutal, the latter effectively representing the same kind of secondary effect as the hastening of death".



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