Adam Omelianchuk
Forthcoming in *Bioethics* – please cite published version

Can Double-Effect Reasoning Justify Lethal Organ Donation?

Abstract: The dead donor rule (DDR) prohibits retrieval protocols that would be lethal to the donor. Some argue that compliance with it can be maintained by satisfying the requirements of Double-Effect Reasoning (DER). If successful, one could support organ donation without reference to the definition of death while being faithful to an ethic that prohibits intentionally killing innocent human life. On the contrary, I argue that DER cannot make lethal organ donation compatible with the DDR, because there are plausible ways it fails DER's requirements. A key takeaway is that the theories of intention and proportionality assumed in DER matters for its plausibility as a constraint on practical reasoning.

The dead donor rule (DDR) prohibits retrieval protocols that would be lethal to the donor (i.e., lethal organ donation, LOD). Donors are typically declared dead before surgery begins to avoid killing them for their organs; the DDR is a specification of the more general rule against killing the innocent.[1] Those who reject the DDR favor legalizing euthanasia.[2] Where euthanasia is legal, controversy over mixing organ donation and euthanasia is growing.[3] Where it is illegal, controversy over the criteria for determining death persists.[4] But what if one could cause the death of the donor via

[1] Omelianchuk, A. (2018). How (not) to think of the 'dead-donor' rule. *Theoretical Medicine and Bioethics*. *39*(1), 1–25. https://doi.org/10.1007/s11017-018-9432-5

[2] Miller, F.G., & Truog, R.D. (2012). *Death, dying, and organ transplantation: Reconstructing medical ethics at the end of life*. Oxford; New York: Oxford University Press.

[3] Ball, I.M., Sibbald, R., & Truog, R.D. (2018). Voluntary Euthanasia — Implications for Organ Donation. *New England Journal of Medicine*. https://doi.org/10.1056/NEJMp1804276Ely; E.W. (2019). Death by organ donation: euthanizing patients for their organs gains frightening traction. *Intensive Care Medicine*. *45*(9), 1309–1311. https://doi.org/10.1007/s00134-019-05702-1; Bollen, J., Shaw, D., de Wert, G., Hoopen, R. ten, Ysebaert, D., van Heurn, E., & van Mook, W. (2020). Organ donation euthanasia (ODE): performing euthanasia through living organ donation. *Transplantation*. *104*(S3), S298. https://doi.org/10.1097/01.tp.0000700004.43157.0a

[4] Lewis, A., & Greer, D. (2017). Current controversies in brain death determination. *Nature Reviews Neurology*. *13*(8), 505–509. https://doi.org/10.1038/nrneurol.2017.72

transplant surgery yet remain in compliance with the norm against killing the innocent? Some argue this is possible by satisfying the requirements of Double-Effect Reasoning (DER). If successful, one could support organ donation without reference to death criteria while being faithful to an intention-sensitive ethic that prohibits intentionally killing the innocent; organ donation would be effectively disentangled from debates over euthanasia and the definition of death.

On the contrary, I argue that DER cannot make LOD compatible with the moral framework of the DDR, because there are plausible ways it fails DER's requirements. In what follows, I outline the key criteria of DER, the case for making LOD compatible with the DDR via DER, and the refutation of it. A significant takeaway of the argument is that our understandings of proportionality and intention matter for the moral relevance of DER in clinical practice.

Criteria for Double-Effect Reasoning[5]

DER permits an action that has two effects, one good and one evil, if and only if three criteria are met:

1. The good effect cannot be caused without also causing the evil effect (Unavoidability criterion).
2. The evil effect must not be intended as an end or a means to an end (Pure Intention criterion).
3. The good effect must be on par with the evil effect (Proportionality criterion).[6]

---

[5] I prefer this name coined by Cavanaugh, T.A. (2006). *Double-effect reasoning: Doing good and avoiding evil*. Oxford; New York: Oxford University Press.

[6] The number of requirements varies depending on how they are lumped together or split apart. Sulmasy thinks there are at least nine while Reed thinks there are at least two. Traditionally, DER requires that "the act itself" (the one with two effects) be "good or indifferent." I lump this into the Pure Intention criterion to avoid, for reasons explained later, talk about "the act itself." See Sulmasy, D.P. (2018). The last low whispers of our dead: When is it ethically justifiable to render a patient unconscious until death? *Theoretical Medicine and Bioethics*. *39*(3), 233–263. https://doi.org/10.1007/s11017-018-9459-7; Reed, P.A. (2015). How to gerrymander intention. *American Catholic Philosophical Quarterly*. *89*(3), 441–460. https://doi.org/10.5840/acpq201561557

For example, intending the death of a dying patient is wrong but intending adequate symptom-relief through a high-dose analgesics regimen is permissible even if we foresee that the increased dosages will depress the patient's respiratory drive and cause death. Though empirical evidence shows this does not happen — properly administered analgesics tend to extend life, not shorten it[7] — the casuistry of DER permits end-of-life palliation so long as (1) death cannot be avoided if adequate symptom-relief is to be achieved, (2) death is not intended as an end or a means to symptom-relief, and (3) the good of symptom-relief is on par with the evil of death. Now consider LOD. So long as (1) the donor's death cannot be avoided if organs are removed, (2) death is not intended as an end or a means to vital organ removal, and (3) the good of saving the lives of those in need of organs is on par with the evil of the donor's death, LOD is permissible. The function of the DDR, then, is to prohibit using organ donation as a means to euthanasia; the function of DER, however, is to allow for the acceptance of heroic self-sacrifice through organ donation. This argument has been made fully or partially by Tännsjö, Bronner, and, writing together, Camosy and Vukov.[8]

[7] Chan, J.D., Treece, P.D., Engelberg, R.A., Crowley, L., Rubenfeld, G.D., Steinberg, K.P., & Curtis, J.R. (2004). Narcotic and benzodiazepine use after withdrawal of life support: association with time to death? *Chest*. *126*(1), 286–293. https://doi.org/10.1378/chest.126.1.286; Mazer, M.A., Alligood, C.M., & Wu, Q. (2011). The infusion of opioids during terminal withdrawal of mechanical ventilation in the medical intensive care unit. *Journal of Pain and Symptom Management*. *42*(1), 44–51. https://doi.org/10.1016/j.jpainsymman.2010.10.256

[8] Tännsjö, T. (2015). Taking life: three theories on the ethics of killing. New York, NY: Oxford University Press; Bronner, B. (2019). Lethal organ donation: Would the doctor intend the donor's death? *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*. *44*(4), 442–458. https://doi.org/10.1093/jmp/jhz008Camosy, C.C., & Vukov, J. (2021). Double effect donation. *The Linacre Quarterly*. *88*(2), 149–162. https://doi.org/10.1177/0024363921989477. Interestingly, these authors represent conflicting normative systems of ethics: Tännsjö is an act-utilitarian; Bronner, a deontologist; Camosy and Vukov, Catholic moral theology. It must be noted that Bronner is only concerned with the Pure Intention part of the argument.

The Case for Compatibility

Tännsjö's believes those who are not committed to Kant's Categorical Imperative, yet are committed to the sanctity of human life and DER "must concur" with the claim that it would not be wrong to cut up and distribute the organs of an unsuspecting patient provided that no one finds out about it.[9] His point is that one must additionally be committed to a rule against the wrongful use of another if we are to explain why such an action is wrong. Even so, how could the Pure Intention criterion be satisfied? "When the doctor cuts up the patient," he writes, "the intention need not be to kill him. The idea is just to use his organs to save lives. If the doctor could take the organs without killing the patient, then he would do so."[10] Similarly, Bronner says, "if the doctor were to believe that a donor might survive the operation (perhaps on dialysis, perhaps by a miracle), he would not alter his procedure to ensure death—by removing additional, non-transplantable organs, for instance."[11] Camosy and Vukov, inspired by the film *John Q*,[12] imagine a hypothetical in which a surgeon transplants a heart from a father to his child. While he is lying on the operating table, heartless, and on extracorporeal membrane oxygenation (ECMO), another heart becomes available and the surgeon saves them both. Hence, the act of removing a vital organ for transplant "does not of its very nature aim at death."[13] Counterfactual tests like these supposedly show that one does not intend the evil effect as a means if one's choice of action would achieve one's goals without causing the evil effect.

[9] Tännsjö (op. cit. n. 9) : 205
[10] Ibid.
[11] Bronner (op. cit. n. 9) : 447
[12] Cassavetes, N., Washington, D., Duvall, R., & Oltean, G. (2002). John Q. New Line Cinema, Burg/Koules Productions, Evolution Entertainment.
[13] Camosy, Vukov (op. cit. n. 9) : 157

Furthermore, the surgeon need not intend the death of the donor if one's intention is specified only by the descriptions under which a proposal for action is chosen. Consider the soldier who jumps on an incoming grenade to shield his buddies from the blast. "The case of lethal organ donation is relevantly similar," says Bronner:

> [I]ntending (1) *that one's organs be extracted* no more involves intending death than intending (2) *that one's body absorb a grenade blast*. Both (1) and (2) may be foreseeably lethal, but in both cases, death is not what one aims to bring about. Now if the organ donor need not intend her own death, then the doctor performing the surgery need not intend the donor's death. For the doctor, like the donor, intends to benefit the transplant recipients by extracting organs from the donor. The doctor aims at the patient's death neither as an end nor as a means.[14]

What is intended as a means is just one's description of what is necessary to achieve one's goals. If one's reason for acting is "to save the lives of those who need a healthy organ," and to do that, one chooses "to extract these organs for transplant," and to do that, one chooses "to cut into the donor and surgically remove them," then it does not follow that one chooses to kill the donor, because the donor's death appears nowhere in the descriptions of the means chosen. Since death plays no causal role in the survival of the recipient(s), it need not be chosen by the donor or the surgeon to accomplish their goals.

These accounts of intention are narrow because they rely exclusively on the first-person standpoint of the acting agent to specify the description of the means chosen. By contrast, wider accounts of intention combine information from both the first- and third-person standpoint — the standpoint of an observer — to specify the description.[15]

[14] Bronner (op. cit. n. 9) : 445–46, emphasis original.

[15] A narrow view that relies almost exclusively on the standpoint of an observer comes from Sidgwick, H. (1893). *The methods of ethics* (5th ed.). London; New York: Macmillan.: 202. He writes, "I think, however, that for purposes of exact moral or jural discussion, it is best to include under the term 'intention' all the consequences of an act that are foreseen as certain or probable."

A wider account of intention is presupposed in Foot's classic discussion[16] of how DER adjudicates removing a baby stuck in the birth canal by way of a craniotomy, which involves cutting into the baby's skull, removing the brain, and collapsing the skull to achieve a life-saving delivery for the mother. Foot believes DER rules out the craniotomy because the procedure and the baby's death are "much too close," meaning one cannot intend the procedure without intending death.[17] A narrow agent-centered view of intention, however, permits it. Finnis, Grisez, and Boyle[18] believe the doctor need not intend the baby's death because death plays no causal role in achieving safe delivery and therefore need not be referenced in the means chosen.[19] In their view, the choices made from the first-person standpoint of the acting agent exclusively determines the descriptive content of both intention and action. Nothing from the third-person standpoint of an observer whether it be natural facts about the world, social contexts in which shared practices emerge, the proximity of causes to one another or their impressive effects, specifies our actions or intentions.

A narrow agent-centered view of intention is assumed by Tännsjö for the sake of augment, asserted more carefully by Bronner, but curiously denied by Camosy and Vukov who think, "the craniotomy of a living human being has death built into the nature of the act itself and nothing about the agent's intentions can change that."[20] In their view, facts about the world do not permit descriptions of a craniotomy to be

[16] Foot, P. (1967). The problem of abortion and the doctrine of double effect. In R. Shafer-Landau (Ed.), *Ethical theory: An anthology* (pp. 536–542). Malden, MA: Blackwell Pub.

[17] Foot (op. cit. n. 21) : 537.

[18] Finnis, J., Grisez, G., & Boyle, J. (2001). "Direct and 'indirect': A reply to critics of our action theory. *The Thomist*. *65*(1), 1–44.

[19] They prefer to speak of "changing the dimensions of its skull." Ibid. : 32. A reviewer asks if the first-person view could rule out the craniotomy just as well as Foot's view, which would mean Finnis and friends are mistaken. To my knowledge, no one who adopts the first-person view has refuted them.

[20] Camosy, Vukov (op. cit. n. 8) : 158 Bronner confirmed by personal communication (March 24, 2021) that his view of intention would allow one to perform a craniotomy.

anything less than an act of killing. Nonetheless, their view of intention is narrow enough to claim that death is not built into the nature of an act that removes all the vital organs from a healthy body without replacing them or supplementing their function.[21] We will revisit these differences later since they raise their own set of problems, which will support the case against compatibility, to which we now turn.

The Case Against Compatibility: No Proportionality

Let's suppose the Unavoidability and Pure Intention criteria are satisfied and the donor consents. Is Proportionality satisfied? I think not. The Proportionality criterion is often undertheorized and interpreted in a crude consequentialist manner where the only concern is whether the impact of the good effect outweighs the evil effect. Tännsjö assumes that the goods and evils are commensurable with one another, but they may not be. Non-consequentialist philosophers deny that one life can be traded for another, so more must be said about why we should think the death of the donor is on par with the survival of the recipient(s).[22] Moreover, there are other interests at stake, many of which concern DER advocates in debates over euthanasia, that need to be addressed.[23]

The implications for the goods of human life and human equality ought to be considered. Since proposals for LOD treat the donor's organs as being more valuable than the life of the donor, they would have physicians instrumentalize human life to the

[21] For a vivid description of organ retrieval as currently practiced, see Mezrich, J.D. (2019). *When death becomes life: Notes from a transplant surgeon*. New York, NY: Harper.

[22] Nagel, T. (1972). War and massacre. *Philosophy & Public Affairs*. *1*(2), 123–144; Kamm, F.M. (1992). Non-consequentialism, the person as an end-in-itself, and the significance of status. *Philosophy & Public Affairs*. *21*(4), 354–389.

[23] Gorsuch, N.M. (2009). *The future of assisted suicide and euthanasia*. Princeton, NJ: Princeton University Press; Keown, J. (2018). *Euthanasia, ethics and public policy: An argument against legalisation* (2nd ed.). New York, NY: Cambridge University Press.

point of death for the sake of protecting human life.[24] This creates a self-defeating paradox like the one that arises when we consider whether people should be permitted to sell themselves into slavery. Permission to do so presumably requires that we respect their autonomous choice. But if that choice is respected, the autonomy of the slave is no longer something that merits respect since it is destroyed for the sake of enhancing the autonomy of the slaveholder. To permit such a practice for the sake of respecting autonomy is to undermine autonomy as a good we ought to respect. Likewise, to permit LOD for the sake of protecting life is to undermine life as a good we ought to protect.

Objection: the goodness of life is relative to its quality and an autonomous choice to end a life of poor quality is worthy of respect. LOD proposals are typically reserved for the sick and dying, which assumes that protections against killing can be relaxed insofar the quality of one's life diminishes.[25] Yet this assumption is inimical to our egalitarian commitments. No one should have to face the rational burden of explaining why they think their lives still have value despite falling below some arbitrarily imposed "quality of life" threshold that empowers the choice to die by transplant surgery.[26] Worse yet, these assumptions are stigmatizing to those who would not sacrifice themselves for transplant. Since, as the policy assumes, the lives of the sick and dying are deemed to be of such a low worth, they are empowered to give up their lives by donating their organs to people above the threshold who would thereby benefit more from them; to not donate is to not benefit a life that is worthier of life. Guarding against an ethic that treats one

[24] One might think the autonomy of the donor is being treated as more valuable than the life of the donor, yet one must remember the autonomous choice is guided by the assumption that the donor's life is less valuable than his organs.

[25] Miller, Truog (op. cit. n. 2)

[26] Velleman, J.D. (1992). Against the right to die. *Journal of Medicine and Philosophy*. *17*(6), 665.

class of patients as being less worthy of life than another is a compelling interest egalitarian societies have, and so Proportionality is not satisfied.

To avoid this problem, one could follow Camosy and Vukov by making LOD open to everyone but that just invites, and exacerbates, the regulatory difficulties that already beset euthanasia policy.[27] Double-Effect Donation will need to be both accessible and safe. The urgency to donate will likely be high if healthy people are motivated to give up their lives. Yet, the more accessible it is, the less safety it will provide against manipulation, coercion, negligence, and other forms of abuse involving undue influences or psychiatric conditions that undermine decision-making capacity. Furthermore, Double-Effect Donation needs way to rule out those who are simultaneously pursuing euthanasia. Perhaps donors will have to wait two weeks, a month, or longer between their request and their surgery to avoid these problems. But the more safeguards there are, the less accessible it will be, which will adversely impact waitlist mortality. If we err on the side of safety, we endanger those who need the organs; if we err on the side of accessibility, we increase the danger of abuse. Either way, the goal of safeguarding and promoting the good of life through Double Effect Donation is encumbered in ways that count against its justification.

The medical goals of transplant medicine are also under-described. True, transplanters are committed to saving the lives of those who need organs, but removing a heart from a healthy person changes the donor's health-status to someone who needs an organ to live, which fails to solve the original problem of "saving the lives of those who need organs." What transplanters are actually committed to is "saving the lives of

[27] Kamisar, Y. (1957). Some non-religious views against proposed mercy-killing legislation. *Minnesota Law Review*. *42*, 969.

those who need organs without making others needy in the process." Transplanters are wise to avoid promoting practices that merely facilitate the transfer of organs from one person to another without satisfying the goals of medicine, which includes the broader goal of protecting and promoting the health of their patients, whoever they might be. These goods cannot just be set aside in the pursuit of saving lives as if they were neatly commensurable as consequentialists assume. To take up such a view is to undermine the non-consequentialist moral framework in which Double Effect is ethically relevant.

While it may be that the death of a donor who consents to die by LOD is on par with saving the lives of those who need organs, the case for Proportionality remains incomplete.[28] Broader considerations of the goods of life and health are at stake which are of interest to the medical profession and society as a whole.

The Case Against Compatibility: No Pure Intention

It seems that to intend LOD is to intend death. Yet those who affirm sufficiently narrow agent-centered theories of intention deny this. The only constraint Tännsjö and Bronner place on their theories is that the agent must believe that the chosen means will bring about the desired end, which affords enough flexibility to believe that death does not contribute to those ends. Camosy and Vukov's theory is less flexible as they acknowledge that there are actions that have death built into them, though LOD is not one of them. Are these accounts correct? I think not for three reasons.

First, the counterfactual tests used to justify them are insufficient to distinguish what is intended as a means, and what is foreseen, but not intended as a side-effect. Counterfactual tests reveal what we would do if the chosen means were to fail or what

[28] To his credit, Bronner acknowledges this at the end of his paper.

our attitude towards the evil effect is if we could achieve our goals without it. As such, they can help clarify our intentions. Yet they cannot show that we do not will the evil effect as a means in the actual world where it is unavoidable. The actions we can enact for the execution of our plans are constrained by the circumstances of the actual world, not those of some possible world that presents the agent with no problems. We may not believe our plans are frustrated if the donor resurrects or is pitifully supported by ECMO or dialysis (or both) for however long that lasts, but this just shows that our end did not include the death of the donor, which does not show that death was not part of the means chosen to reach that end. Similarly, I may not believe my plans for traveling to Berlin are frustrated if, by some miracle, the money I spent on the flight is refunded; all this shows is that my goal does not include spending money, which does not show that spending money was not part of the means chosen to reach it. Counterfactual tests often confuse what we intend with what we value. Since what we value is determined by our end, and since the means to our end only have instrumental value, it is mistakenly thought that we do not intend the evil effect as part of the means if the circumstances were different and we would do something else to achieve our end or if our end would be accomplished without it. Miracles or the misuse of medical therapies are not things we can plan on. What is needed is a way to soundly distinguish between what is intended as a means, and what is foreseen, but not intended as a side-effect given the constraints we act under.

Second, there is no compelling reason why we should exclusively privilege the acting agent's perspective on the description under which a proposal for action is selected, because (1) the proposal selected is not the same as the action enacted, and (2) the action enacted can, as Camosy and Vukov know, have death built into it as observers

rightly recognize. Practical reason demands intelligible answers to the "What is done?" question, not just the "What is proposed?" question. Observers can plainly see that the actions enacted have *vital* organs as their object. The objection that, "Lethal harm is done to the donor by removing his vital organs," cannot be reasonably met with the reply, "No, I am only removing organs; in no way do I intend to lethally harm the donor; both the lethality, and the harmfulness are outside of my intention since they are not needed to bring about the transfer of vital organs from the donor's body to the recipient's body." Lethality and harmfulness are built into what is done because the desired organs function in a vital capacity for supporting the donor's life. While an action may be chosen under a description that best promotes our goals, we should not believe that other descriptions of the same action are excluded from the definition of what we do just because we do not choose them under those descriptions.[29] It is one thing to say we do not intend to kill the donor if we do not know that removing them for transplant would cause the donor's death. It is quite another to say we do not intend the donor's death if we know better but choose to act on the basis of a description that fails to represent our knowledge of other un-choiceworthy descriptions that identify the same act. These descriptions exist by virtue of the language agents and observers share in terms of words and actions that together structure our social world. Our social world is further constrained by the causal relationships of the natural world that limit the actions we can enact. In this view (the pragmatic conventions view explained below), we can say that LOD lethally injures the donor "by its very nature."

[29] Anscombe, G.E.M. (2005). Murder and the morality of euthanasia. In M. Geach & L. Gormally (Eds.), *Human life, action and ethics: Essays by G.E.M. Anscombe* (pp. 261–277). Exeter, UK: Imprint Academic.

Those who deny that death is built into LOD will have a harder time denying that injury to the donor is built into it. The hypothetical to which Camosy and Vukov appeal in order to show death is not involved does not show injury is not involved; to go from being healthy to being heartless and on ECMO is to be gravely injured. At best, Double Effect Donation runs afoul of the first rule of medicine: do no harm. The tradition this rule was formulated in does not define "harm" in the modern terms of causing a setback to one's interests, but in terms of permanently injuring one's health, the fundamental good every physician is to safeguard and promote. Classically understood, iatrogenic harm is to be avoided, and whatever wounds are introduced into the body must be ordered towards healing, relief, or comfort.[30] To remove vital organs from the body is to wound the body in a way that cannot benefit the body, which renders the act an injury to the body, specifically to the function of the body's musculoskeletal and vital organ systems. Since the organs removed are vital and the chest wound is not designed to be conducive to healing, injury to the body is the means chosen for the sake of transplant, which is forbidden.

Third, there is a plausible way to conceptualize death as being part of the means chosen, not just the result of them.[31] Imagine someone saying, "Come on, death is built into an act that would have a surgeon remove the kidneys, liver, lungs, and heart from a living body without any plan to replace them or supplement their function — that's why it's called 'lethal organ donation' — no one could honestly intend that sort of thing without intending death." The impulse behind the interjection is shaped, as Chappell[32]

[30] Cavanaugh, T.A. (2017). *Hippocrates' oath and Asclepius' snake: The birth of the medical profession*. Oxford, New York: Oxford University Press.
[31] Space does not permit a full treatment of this issue, so a sketch will have to do. For a full treatment, see the next citation.
[32] Chappell, T. (2013). What have I done? *Diametros*. *38*, 86–111.

explains, by "our shared framework for understanding actions."[33] This is what Wittgenstein[34] referred to as "the common behaviour of mankind," that is, "the system of reference by means of which we interpret an unknown language."[35] It allows observers to know what people are doing apart from what they say. Just as linguistic utterances are governed by publicly available linguistic conventions, so too are human actions governed by what Chappell calls "pragmatic conventions."[36] These conventions specify an objective, publicly available set of facts that delimit the range of intelligible actions a person can choose to do, and thereby permit observers to correctly interpret an agent's behavior as expressing certain intentions that competent agents are responsible for acknowledging. Like linguistic conventions, pragmatic conventions structure and are structured by human activity. So, for our case, the practice of surgery with its scalpels, saws, and spreaders, the nature of the mammalian body, the expectation of doctors to do no harm, the various ways in which homicide law is interpreted, the limits on what consent can authorize, and the numerous ways the goods of life and health demand to be treated give us strong reasons to believe that, apart from extraordinary countervailing evidence from the perspective of the agent, one could not intend LOD without intending its lethality. Protests to the contrary tend to invite incredulous stares, accusations of self-deception, and perhaps the sort of mockery Pascal[37] used to lampoon the casuists of his day who said one could participate in a duel without "the express intention of fighting a duel, but merely with that of self-defence if his challenger comes

[33] Ibid. : 105
[34] Wittgenstein, L. (1968). *Philosophical investigations*. (G. E. M. Anscombe, Trans.) (3rd edition). Cambridge, Mass: Basil Blackwell.
[35] Ibid. : 82, 83
[36] Chappell (op. cit. n. 42) : 104
[37] Pascal, B. (1967). *The provincial letters*. (A. J. Krailsheimer, Trans.). Penguin Books: Harmondsworth.

there to attack him unjustly."[38] Such responses are not grounded in a bare assessment of whether an effect is "too close" to "the act itself" as if there could be an identifiable, value-neutral, ahistorical, abstract description of some "unit of action" separable from volitional attitudes, social practices, and the causal constraints of the natural world. Nothing of the sort exists. Rather, we identify actions-as-charactered by what Chappell calls a "pragmatic lexicon"[39] that allows for multiple descriptions — not just *the* description — that reflect our understanding of what it means to act on a living body, that to decapitate, to blow up, to incinerate, to impale, to brain, to crucify, to crush the skull of, to shoot in the head, to hang, to eviscerate, or to push in front of an oncoming trolley, is to intend death full stop. Pragmatic conventions name the actions we can enact and constrain the descriptions of what we can choose to do.

None of this is to say there is no ambiguity. For example, withdrawing life-support requires a broader understanding of the agent's perspective and the circumstances in which it is done. We need to know why it is being withdrawn, what sort it is, who is involved, and in what capacity. This is because human agents operate within spheres of responsibility constituted by duties and goals. True, a murder could remove life-support by performing the same set of movements as a nurse. Yet there is a clear difference between removers who intend death and removers who initially provided life-support for goals that can no longer be achieved.[40] While patients can intend death by refusing life-support, providers need not share in this intention but can accept death as

[38] Ibid. : 106
[39] Chappell (op. cit. n. 42) : 104
[40] McMahan, J. (2002). The ethics of killing: Problems at the margins of life. New York: Oxford University Press.: 381-82.

a concomitant of their intention to satisfy their duty to withdraw validly refused treatment.

Technology, whether in the form of device, medication, or biochemical tool (like CRISPR), often poses problems for knowing what our intentions really are with it, because we often lack the pragmatic conventions necessary for understanding them. Developing conventions that provide guidance for our choices takes time. In addition to analyzing the intentions embedded within the technology itself,[41] we must define the roles and responsibilities of those who would use it, what sort of training or credentials the users should have, and what counts as legitimate use of it. As time goes by, we accrue thicker pragmatic conventions and move past simplistic ones that probe our actions only in terms of the causal relations they produce. Unless we are committed to a shallow action theory that analyzes intention solely in terms of the foreknown results of causal activity,[42] we know that withdrawing life-support is not necessarily an act of killing. The best we can say in the case of LOD is that we do not know this.

The comparison with the sacrificial soldier who jumps on a grenade does little to help as the pragmatic conventions of soldiering and organ donation reveal. Soldiers, in contrast to civilians, answer a call to take on the responsibility of being targets of violence in armed conflict and are provided with protective equipment in return. While it is not their duty to jump on live grenades, doing so exemplifies the noblest virtue a soldier can perform *qua* soldier: valor. By contrast there is no special honor among donors that distinguishes the greatest among them as those who would sacrifice their

[41] Reed, P.A. (2013). Artifacts, intentions, and contraceptives: The problem with having a plan B for Plan B. *Journal of Medicine and Philosophy*. *38*(6), 657–673. https://doi.org/10.1093/jmp/jht051

[42] Sidgwick (op. cit. n. 20)

lives for the sake of donating. Indeed, we have more reasons than not to think that those who would sacrifice their lives to donate are tragic figures (if films like *Seven Pounds*[43] and *John Q* are any guide) because there is no call on them to do so or they feel compelled to do so because of horrible circumstances (or both). But even if the donor is heroic, the act the donor chooses is not analogous to the act the soldier chooses, which is an act of *shielding*. Shielding has its own pragmatic conventions that structure our intentions. In general, the function of shielding is satisfied if the intended harm does not occur.[44] Covering a live grenade that fails to detonate satisfies the function of shielding as much as absorbing the blast does. The same is true of other acts of shielding whether they involve placing oneself between a bullet or a bully's fists. The assailant need not fire the gun or throw a punch for the act of shielding to succeed. The function of shielding depends on the capacity of the shield to block the harm regardless of whether the harm occurs. Therefore, the choice to use one's body as a shield to save others from harm does not demand the choice to be harmed *as a means* to protect others. Rather, it only demands the choice to accept harm as a foreseen consequence of one's choice. Whether the harm is inflicted or not, valor is demonstrated. By contrast, the function of LOD is unsatisfied if the surgery is stopped or not offered. The choice to lethally donate demands a choice to be harmed as a means to save others. The soldier does not request that lethal injury be done to his body whereas the donor does. The altruistic motivations

[43] Muccino, G., Smith, W., Dawson, R., & Harrelson, W. (2008). Seven Pounds. Columbia Pictures, Relativity Media, Overbrook Entertainment.

[44] It is important to stress that I am not interested in the soldier's mental states that would result (surprise, disappointment) if the grenade were not to detonate. That is of interest to the counterfactual test of intention which I set aside. Here I am talking about the functions of the actions that are open to the agent to choose and the demands those functions place on the agent's intentions.

of the donor, like the soldier's, might be similarly admirable, but the means chosen to express them are not.

From the doctor's side, the pragmatic conventions of palliative medicine undermine the analogy between end-of-life palliation and LOD. As mentioned earlier, palliative medicine has developed dosing methods that do not hasten death. But even if hastening death were unavoidable, the Pure Intention and Proportionality criteria would be satisfiable. The pragmatic conventions defining the proper use of analgesics shape, and are shaped by, the design of the medication for specific benefits, creating the logical space for a description of action that makes death a side-effect. Both agents and observers recognize that analgesics are designed to benefit the body insofar as they (1) relieve refractory pain- and distress-symptoms in the neurocognitive system, and (2) facilitate a more peaceful dying process. These two goods are on par with the evil of injuring respiratory function. The (hypothetical) injury to respiration need not be chosen for the sake of symptom-relief since analgesics are not designed to benefit the neurocognitive system in that way. Yet to remove unpaired vital organs from the body destroys the functioning of the musculoskeletal system and the vital organ systems, which is to fatally injure the body. A fatal injury to the body just is the means chosen for the sake of transplant.

Conclusion

I have argued that DER cannot be used to justify LOD, because the Proportionality and Pure Intention criteria remain unsatisfied. Other goods besides saving lives are at stake, and a view of intention that balances propositional content from both first- and third-personal standpoints for the description of our actions cannot be set aside.

Although the practical import of this argument is limited since LOD is not currently practiced, one significant takeaway is that our understandings of proportionality and intention matter for the moral relevance of DER in clinical practice. For Proportionality, the more we treat the competing goods at stake as commensurable or neglect broader stakeholder interests, the easier it is to satisfy; if the goods are incommensurable and broader interests are considered, it is more demanding. For Pure Intention, the more we favor specifying intention according to descriptions of causal activity from an observer's standpoint, the harder it is to satisfy, which makes complying with rules against maiming and murdering surprisingly hard. One could not even withdraw life-support at patient request and use a donation-after-circulatory death protocol to remove a single kidney. The more we favor specifying intention according to descriptions chosen from the acting agent's standpoint, the easier it is to satisfy the Pure Intention criterion, which makes complying with rules against maiming and murdering surprisingly easy. One could engage in LOD and claim compliance with the DDR. Either way, the ethics of the DDR are in trouble and DER becomes a dubious form of practical reasoning if these unbalanced approaches to intention remain in place. My effort has been to avoid these outcomes.