Last Words: Seeking Understanding, If Not Agreement, on Killing and Allowing-to-Die

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Those skeptical that the doing/allowing distinction can be helpful in making moral determinations about action might be heartened that advocates of the distinction in this exchange not only cannot agree on what ought to be basic issues (e.g., the target of the distinction, and how it ought to be drawn in a given practice such as medicine); we cannot even state our opponents' position to their satisfaction. The following brief response to Sulmasy and Courtois's second paper will, I hope, bring us closer to mutual understanding, if not to agreement.

Intention is indeed integral to the Sulmasy definition of killing. It is, however, conceptually separate from the causal relationships in the definition, which given proper intention, suffice to determine proper act description as killing or allowing-to-die. The contrary point of both my and of ordinary language use of "killing" when opposed to "allowing-to-die" is to suggest by use of the word "killing" that there is moral importance in relating to the outcome of death actively versus passively, "active" and "passive" here referring not to causal relations (alone) but to positive or negative agency. Similar intentions and causal relations may be labeled positive or negative agency differently in different practices, as the comparison between fire rescue and medicine demonstrates. The failure of Sulmasy and Courtois to see this may stem in part from misreading the Burning Building II case—the jumper is not "about to jump from a building." The jumper is falling; hence the net is indeed a "completed treatment" once placed, and the analogy with medicine goes through. My own view of "killing" is not "any intentional action that both results in death and is morally wrong," a suggestion that seems to me far not only from ordinary language usage but from any usage of which I am aware—do Sulmasy and Courtois suppose that I believe that justifiable homicide is not "killing"? "Killing" (versus allowing-to-die) is the bringing about of death through positive agency, whether morally warranted or not.

I do not seek "a bright line where none can be drawn"; I seek a distinction that classifies treatments in accordance with the medical killing/allowing-to-die (K/ATD) distinction—that is, as distinguishing positive and negative physician agency in relation to patient death. We all agree that the medical K/ATD distinction turns upon the distinction between homeostasis and pathophysiology. The treatment distinction that accords with the medical K/ATD distinction is between treatments in which physician agency is ongoing (hence, interference may be withdrawing agency and thus allowing) and those in which it is absent (completed) such that interference is necessarily doing (killing if leading to death). Of course all life sustaining treatments contribute to homeostasis, but only completed treatments can be constitutive of homeostasis (an internally-stable dynamic state) such that interference

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with them introduces new pathophysiology. The ongoing/completed (O/C) distinction thus properly connects to the medical K/ATD distinction; the replacement/substitution (R/S) distinction does not. I take Sulmasy's contention that his version of K/ATD "is not a doing/allowing distinction" to mean that he views doing/allowing distinctions as morally freighted by positive and negative agency, whereas his K/ATD distinction is purely descriptive, with normative considerations entering the picture after the distinction has been made. My account, in contrast with Sulmasy's, contends that the normative goes all the way down as one draws the K/ATD distinction in any practice.

Sulmasy and Courtois suppose that if I countenance removing an infected ventriculo-peritoneal (VP) shunt as permissible, I cannot redescribe that removal of a completed treatment as other than killing through invoking the doctrine of double effect (DDE). The DDE is apt for scrutinizing actions leading to both good and bad outcomes, some intended and some merely foreseen. We agree that much turns on the apposite description of the act to be scrutinized.[1] The thrust of my position is that the propriety of a given act description is practice-dependent, rather than purely a matter of causal relations and/or intentions. It is therefore quite conceivable that a line might be drawn between intended and unforeseen effects in medicine, that matches a line between immediate good effects (removal of infection) and more distant ill effects (death). Physicians draw such lines, it appears to me, both in removing infected VP shunts and in effectively deactivating transplants through removal of immunosuppression in the right circumstances. That the DDE is inapplicable to the withdrawal of most life sustaining treatment is true but not germane to this point.

I am sorry that Sulmasy and Courtois suppose that I "[seem] to" suggest they have rigged their analysis. I did not. They suggested that increased suffering resulting from use of my, rather than their, distinction told against my distinction. That suggestion drew the necessary response that the cogency of the distinction must not depend on its outcome. I am glad that they agree. I hope that we can be friends as well as intellectual allies, even if we disagree on other matters.

Notes

1. For an analysis of possible positions on apposite act description for purposes of analysis by the DDE, see Huddle TS. Suicide, physician-assisted suicide, the doing-allowing distinction, and double effect. In: Davis JK, ed. *Ethics at the End of Life: New Issues and Arguments* New York: Routledge, 2017;171–97, at 188–93.