

Two Ways to Kill a Patient

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According to the Standard View, a doctor who withdraws life-sustaining treatment does not kill the patient but rather allows the patient to die—an important distinction, according to some. I argue that killing (and causing death) can be understood in either of two ways, and given the relevant understanding, the Standard View is insulated from typical criticisms. I conclude by noting several problems for the Standard View that remain to be fully addressed.

Keywords: *death, euthanasia, killing, letting die, withdrawing life-sustaining treatment*

I. INTRODUCTION

According to what I will call the *Standard View*:

(SV) Withdrawing life-sustaining treatment is an act of *letting die* rather than *killing*.

There is a widespread prohibition on doctors killing their patients, a prohibition that precludes practices such as euthanasia ([Council on Ethical and Judicial Affairs, 1992](#), 2232; [World Medical Association, n.d.](#)). Of course, withdrawing treatment can also lead to a patient's death—for example, when mechanical ventilation is discontinued. Yet, even when it results in death, withdrawing treatment is not usually thought to be an act of killing.

Both critics and advocates of the Standard View typically equate killing with causing death ([Brock, 1992](#), 12; [Miller and Truog, 2008](#), 38; [Miller, Truog, and Brock, 2010a](#), 456–57; [2010b](#), 303; [Cochrane, 2011](#), 143n10; [McGee, 2014](#), 30n19; [2015](#), 78). This approach results in an alternative formulation of the Standard View:

(SV₂) Withdrawing life-sustaining treatment does not *cause* but merely *allows* the patient to die.

As we will see, critics have focused on this second formulation of the Standard View.

I will argue that the reference to killing in SV and to causing death in SV₂ must be understood in a particular way (§§II–III). I then argue that, so understood, the Standard View is insulated from typical criticisms (§IV). I conclude by noting several criticisms that may yet succeed (§V).

To be clear, my argument is descriptive rather than normative. I will address the question of whether withdrawing life-sustaining treatment is *in fact* a matter of letting die. I will not consider whether the distinction between killing and letting die is, in the circumstances, *ethically relevant*. That is a further issue, which is beyond the scope of this paper.

II. UNDERSTANDING THE STANDARD VIEW

In this section I argue that the Standard View should be understood as claiming:

(SV₃) When a doctor withdraws life-sustaining treatment, the doctor's involvement in the patient's death falls on the 'allowing' side of the doing/allowing distinction.

In other words, I argue that SV and SV₂ should be understood as *equivalent* to SV₃. We will see in §IV that understanding the Standard View along the lines of SV₃ undermines most criticisms of the view.

Two Notions of Causation

There is a perfectly familiar sense in which withdrawing life-sustaining treatment causes death. Suppose mechanical ventilation is discontinued at the request of a patient, and the patient soon dies. Suppose also that continued ventilation would have prevented the patient's death. Someone unaware of that last fact might ask whether discontinuing ventilation caused the patient's death, or whether the timing was instead coincidental. Given my description of the case, the timing was not coincidental. Rather, discontinuing ventilation caused the death.

There is also a familiar sense in which withdrawing treatment can kill. Again, suppose a patient requests that mechanical ventilation be withdrawn, knowing that he is dependent on ventilation for continued life. A family member hears the request that ventilation be discontinued and asks the doctor, "Would that kill him?" The doctor can truthfully answer "yes."

It can seem puzzling, then, why there is any question as to whether withdrawing life-sustaining treatment causes death or kills. However, when discussing the withdrawal of life-sustaining treatment, "causing death" and "killing" are often used in a particularly *narrow* sense. In *that* sense, there is good reason to believe that withdrawing life-sustaining treatment does not cause death, or kill. Before turning to this narrow sense, I consider the broad sense with which it contrasts.¹

We have seen that there is a familiar sense in which withdrawing life-sustaining treatment kills/causes death—as illustrated by the two scenarios presented just above. In such contexts, we tend to think of *causing death* and *killing* in a relatively expansive sense: roughly speaking, something causes death (or kills) when it *makes the difference* between life and death. More generally, we tend to think of an event's causes—whether or not that event is *death*—as things that make a difference to whether or not the event occurs. I will call this conception of causation “causing as difference-making.”

Matters are different when we discuss the Standard View on withdrawing life-sustaining treatment. Unlike the second scenario above, we are not asking *whether* the patient will die—we assume the patient will die (when life-sustaining treatment is withdrawn). Unlike the first scenario, we are not asking *why* the patient dies—we know that the patient dies because disease prevents spontaneous breathing and mechanical ventilation has been withdrawn, for example. So rather than try to answer the questions raised in the two stories above, we *begin* with answers already in hand.

Having answers to those questions, we then ask about the doctor's *role* in the patient's death. In this context, causing death and killing are often construed narrowly: something causes death (or kills) just in case its role in producing death falls on the “doing” side of the doing/allowing distinction. As before, the notion generalizes to events other than death. I will call this conception of causation “causing as doing.”²

Clarifying the Notions

Before proceeding, our two notions of causation should be clarified in a number of respects. After doing so, I will put the two notions to work.

First, in speaking of causing as doing, I appeal to the doing/allowing distinction. The distinction between doing and allowing harm is often invoked in ethics. (For overviews, see [Woollard, 2012a, 2012b](#); [Woollard and Howard-Snyder 2016](#).) There is no uncontroversial *analysis* or *account* of the distinction—that is, no uncontroversial specification of the conditions under which something is a doing or is an allowing. Nevertheless, the distinction should be intuitive and can be grasped with the help of examples. Standing around while someone drowns in the bathtub is a case of allowing harm; holding them under the water is a case of doing harm. Failing to give food to the starving is allowing harm; taking food from the starving is doing harm. The distinction between doing and allowing can also be drawn more generally, whether or not *harm* is involved. Examples that fall on the “doing” side include: tearing up your homework, pushing your friend into the pool, and speaking up at a meeting. Examples that fall on the “allowing” side include: standing around while the dog tears up your homework, declining to catch your friend as he falls into the pool, and refraining from interrupting someone else at the meeting.

The doing/allowing distinction should not be confused with the intention/foresight distinction. Doing need not involve intending, as when an agent kills while merely foreseeing that death will result (from turning the runaway trolley, for example). Allowing can involve more than foresight, as when an agent lets someone die while intending that death (to secure an inheritance, for example).

Next, the notion of causing as difference-making requires a qualification. Sometimes an individual's *act* makes a difference to an outcome. For example, my eating the cookies can make a difference to whether or not the cookies are eaten. Sometimes it is an individual's *omission* that makes a difference. My omitting to eat the cookies can also make a difference to whether or not the cookies are eaten. The critics of the Standard View discussed in §IV understand causes as acts, events, or circumstances—but not omissions—that make a difference to an outcome. I would like to engage with these critics by discussing their notion of causation. So, when I speak of causing as difference-making, I will assume that omissions are not causes.

A second qualification should be noted. In formulating the notion of causing as difference-making, I put aside certain exceptions. I put aside, for example, cases of overdetermination. Suppose doctor 1 administers a lethal injection to a patient, but doctor 2 *would have* administered the lethal injection if doctor 1 had not. Then doctor 1's action did not make the difference between the patient living and dying—for the patient would have received a lethal injection (and died) regardless of doctor 1's action. Yet, the authors who explicitly adopt the notion of causing as difference-making would surely say that doctor 1 caused the patient's death. Perhaps the relevant fact is that doctor 1's action *would have* made the difference between life and death if doctor 2 were absent. In any case, such exceptions will not be relevant to the following discussion, so I will ignore them when speaking of causing as difference-making.

Putting the Two Notions to Work

We now have two notions of causation. Putting aside certain exceptions, we can formulate these two notions as follows.

(Causing as difference-making) X causes Y *if and only if* X makes the difference to whether Y occurs—that is, had it not been for X, then Y would not have occurred.

(Causing as doing) X causes Y *if and only if* X's involvement in Y's occurrence falls on the 'doing' side of the doing/allowing distinction.

I will now argue that when evaluating the Standard View, causing should be understood as doing rather than as difference-making. (For ease of exposition, I will mainly speak of "causing death" rather than "killing." Most of what I say could also be put in terms of the latter locution.)

Why do we care whether the Standard View is correct? In other words, why do we want to know whether a doctor who withdraws life-sustaining

treatment thereby causes the death that follows? A large part of the answer is that we want to know whether a doctor who withdraws life-sustaining treatment violates the widespread prohibition on causing the death of patients.

That prohibition is not concerned with causing as difference-making. For example, suppose a patient dies who could have been saved, but the patient is not saved because a doctor (appropriately) wrote a do-not-resuscitate (DNR) order. The doctor's writing of the order is an *act* that *makes the difference* to whether the patient lives or dies. Hence, the doctor causes the patient's death if causing is understood as difference-making. Yet, there is no question about whether the doctor has violated the prohibition on causing the death of patients—even the critics of the Standard View do not claim otherwise. It follows that the prohibition on causing the death of patients is not concerned with causing as difference-making.

Rather, the prohibition is concerned with causing as doing. With some exceptions relating to the doctrine of double effect, it is prohibited for a doctor's involvement in a patient's death to fall on the "doing" side of the doing/allowing distinction. Interpreting the prohibition in this way makes sense of the fact that a doctor who writes a DNR order does not violate the prohibition. (To be precise, interpreting the prohibition in this way makes sense of the fact that we can know that (i) a doctor who writes a DNR order does not violate the prohibition, without needing to consider whether (ii) the doctor's act qualifies as an exception under the doctrine of double effect.)

Additional examples of this sort can be generated. Suppose that the following is true. A blood transfusion is started for an unconscious patient who was brought into the emergency room. Perhaps from a family member, the doctor then receives documentation that the (adult) patient is a Jehovah's Witness and does not want to receive blood transfusions under any circumstances. If the blood transfusion is continued the patient will live, but if it is discontinued the patient will die. Given these facts, stopping the blood transfusion would be an act that makes the difference between life and death. Yet, I suspect that even critics of the Standard View would say that stopping the transfusion is not a case of medical killing.

As a final example, suppose that a doctor inserts her fingers into the bullet holes of a shooting victim in order to stop the bleeding. (For a real-life case, see [Deseret News, 1989](#).) Assume that if the doctor leaves her fingers in the wounds, then the victim will survive; while if the doctor removes her fingers, then the victim will die. Finally, suppose that the wounded individual then demands that the doctor not touch him, and the doctor complies by removing her fingers from the individual's wounds. (Fill in the rest of the story in whatever way might be necessary: the victim is known to be competent to make his own medical decisions, the desire not to be touched stems from a deeply held religious belief, etc.) By removing her fingers, the doctor performs an act that makes the difference between life and death. Again, there is no question about whether the doctor causes the individual's death *in the*

sense that is relevant to the prohibition on medical killing. The doctor *allows* lethal harm to befall the patient, but she does not *do* lethal harm to him (see §III for elaboration).

So, our interest in the Standard View is largely due to our interest in the prohibition on causing the death of patients. That prohibition concerns causing as doing, not causing as difference-making. Hence, the Standard View should be understood as the claim that when a doctor withdraws life-sustaining treatment, the doctor's involvement in the patient's death falls on the "allowing" side of the doing/allowing distinction.

We might say that the Standard View should be understood as the claim that a doctor who withdraws life-sustaining treatment merely *allows* rather than *does* lethal harm. Indeed, for convenience I sometimes speak in this manner. It must be kept in mind that I am talking about *physical* harm. The patient's death need not be a harm in the sense of being contrary to the patient's *interests*. It is plausible that for certain patients life is no longer a benefit, and so death is no longer a harm in the latter sense.

III. OBJECTIONS

In this section, I consider various objections to the argument presented in §II. In the course of doing so, I elaborate on how the doing/allowing distinction is to be understood in relation to my argument. In the next section I explain how the Standard View can handle typical criticisms.

First Objection

It might seem that the Standard View is *obviously false* when it is understood in the manner indicated just above. After all, withdrawing life-sustaining treatment is *doing* something that results in death—for example, *turning off* a ventilator—so it might seem mistaken to say this is a case of merely *allowing* death.

The Standard View is not, however, obviously false when understood in the manner I suggest. As McMahan (1993, 269; emphasis added) says, "it is often necessary to *do* some quite specific act in order to let a person die" (see also Kuhse, 1987, 49–50; Jensen, 2011, 175–76; McGee, 2015). One example would be the little Dutch boy who pulls his finger out of a dike that is beginning to crack (see §IV, below). The boy *allows* the villagers to drown by *doing* a particular act (namely, pulling his finger from the hole in the dike). Similarly, a doctor's involvement in *the ventilator being turned off* falls on the "doing" side of the doing/allowing distinction. But, the doctor's involvement in *the patient's death* might nevertheless fall on the "allowing" side.

Indeed, it seems that the doctor's involvement in the patient's death *actually does* fall on the "allowing" side of the doing/allowing distinction. To provide aid to someone is to *prevent* them from suffering harm. To withdraw

ongoing aid is to *stop* preventing them from suffering harm. And if you stop preventing someone from suffering harm, that is to allow *something else* (other than yourself) to harm them. In short, to withdraw ongoing aid is to *allow* rather than to *do* harm. Since a doctor who withdraws life-sustaining treatment thereby withdraws ongoing aid, the doctor allows rather than does lethal harm (Kuhse, 1987, 49–50; McMahan, 1993; Kamm, 1996, 28–30; Jensen, 2011; McGee, 2014, 2015).

Second Objection

I have argued that when considering the Standard View, we should not understand causing as difference-making. I pointed out that writing a DNR order is an *act* that *makes the difference* between life and death, but that writing such an order cannot be understood as causing the patient's death (in the relevant sense). A reviewer for this paper raised a two-part objection to this example (and similar objections might be leveled against the other examples from §II).

First, I say that the relevant notion of causation is causing as doing. Since *writing* an order is a *doing* (rather than an allowing), must we say (absurdly) that the doctor who writes such an order kills the patient? No, we are not forced to say any such thing. I have noted that “it is often necessary to *do* some quite specific act in order to let a person die” (quoting McMahan, 1993, 269). The writing of a DNR order is just one more example.

Second, it might be objected that while writing a DNR order is an act, the *effect* of that act is simply an omission—namely, the omission of treatment—and hence that writing a DNR order is like an omission insofar as it is precluded from causing the patient's death. However, just as the *act* of writing a DNR order results in the *omission* of treatment, it is also true that the *act* of turning off a ventilator results in the *omission* of further ventilation. So, if the former act does not count as killing because it results in an omission, then the same is true of the latter act. In that case, the act of withdrawing life-sustaining treatment does not kill the patient. Hence, the objection in question leads straightaway to a vindication of the Standard View—and so I assume opponents of the Standard View will not endorse this objection.

Third Objection

According to the Standard View, by withdrawing life-sustaining treatment the doctor does not cause the patient's death. Rather, (a) disease causes the patient's death. I have said that when assessing the Standard View, (b) causing should be understood as doing rather than as difference-making. Together, a and b imply that the disease's involvement in the patient's death falls on the “doing” side of the doing/allowing distinction. It might be thought that this result is absurd, as only *people* can do things.

There is, however, no absurdity. Various entities (and not just people) can both do and allow things. For example: the fire *destroyed* the forest, while the lack of rain merely *allowed* the forest to be destroyed. In the relevant sense, the former is a doing. Similarly, when a patient dies following the withdrawal of life-sustaining treatment, the disease's involvement in the patient's death falls on the "doing" side of the doing/allowing distinction.

This completes my defense of the argument presented in §II. I conclude that the Standard View should be understood as claiming: when a doctor withdraws life-sustaining treatment, the doctor's involvement in the patient's death falls on the "allowing" side of the doing/allowing distinction.

IV. TYPICAL CRITICISMS OF THE STANDARD VIEW

I will now argue that understanding the Standard View as a claim about *doing* (rather than *difference-making*) insulates the view from typical criticisms. I proceed by examining the first chapter of Miller and Truog's (2012) *Death, Dying, and Organ Transplantation*. The chapter is devoted to criticizing the Standard View and includes a number of arguments found elsewhere (Brock, 1986, 1992; Buchanan, 1996; Persson and Savulescu, 2005; Miller and Truog, 2008; Miller, Truog, and Brock, 2010a, 2010b; Cochrane, 2011; Savulescu, 2013). As a result, it is currently the most comprehensive critique of the Standard View available.

Miller and Truog (2012) are explicit that their case against the Standard View is based on thinking of causing as difference-making. They write:

In arguing that withdrawing [life-sustaining treatment] causes a patient's death . . . we appeal to our common-sense understanding of the causes of particular events . . . Causes are events or circumstances that *make the difference* in explaining a particular occurrence. (Miller and Truog, 2012, 6)

To be sure, Miller and Truog are not thinking of causing *merely* as difference-making. If they were, then they would regard the *withholding* of *initial* treatment as causing death, just as they do the *withdrawal* of *ongoing* treatment. Yet, they write that "withholding mechanical ventilation from a patient who has refused it merely allows the patient to die," since this is "an *omission* of treatment" (Miller and Truog, 2012, 5–6; emphasis added). So, as I noted above, when I speak of causing as difference-making, I will take it for granted that omissions are not causes. (I ignore special cases in which Miller and Truog say omissions *can* be causes, since these cases are not relevant to the present discussion; see their 2012, 13–14.)

We can already see that Miller and Truog's case against the Standard View is based on a misunderstanding: it is based on the assumption that causing should be understood in this context as difference-making. I will now show that this assumption illicitly provides Miller and Truog's

arguments with plausibility, and that rejecting the assumption undermines their arguments.

Acts (or Interventions) That Make a Difference

Miller and Truog's (2012) first argument simply applies their definition of causation. The authors note that turning off the ventilator of a ventilator-dependent patient is an act, not an omission, and that it makes the difference between whether the patient lives or dies (see, e.g., Miller and Truog, 2012, 14). On this basis, they conclude that turning off the ventilator causes the patient's death.

I have argued that Miller and Truog's definition of causation is mistaken—that in the present context, causation should be understood as doing rather than as difference-making. Hence, Miller and Truog cannot argue against the Standard View by simply applying their definition of causation.

That criticism might be countered, however, by recognizing that Miller and Truog's definition of causation is perhaps a bit more complicated than I have suggested. Miller and Truog sometimes say that the withdrawal of life-sustaining treatment is an *intervention* (rather than an *act*) that makes the difference between life and death. They mostly speak interchangeably of acts and interventions (see, e.g., Miller and Truog, 2012, 14). Sometimes, however, Miller and Truog can be read as suggesting that an intervention requires more than just an act. For example, they quote Hart and Honoré (1985, 29) as saying that “a cause is essentially something which interferes with or intervenes in the course of events which would *normally* take place” (Miller and Truog, 2012, 6; emphasis added). It might be claimed, then, that Miller and Truog's account does *not* have the unacceptable implication that the writing of a DNR order kills the patient: for while the writing of a DNR order is an *act* that makes the difference between life and death, perhaps it is not an intervention in the normal course of events. Indeed, it would seem that the whole point of writing a DNR order is to *prevent* medical intervention.

We can see that this response does not succeed, as follows. If a given treatment will make the difference between life and death, then that treatment will normally be administered. Because of the DNR order, our hypothetical patient does not receive such life-saving treatment. So, not only does the DNR order make the difference between life and death, it also “interferes with or intervenes in the course of events which would normally take place” and save the patient's life (Miller and Truog, 2012, 6). So, if we assume that a cause is an intervention or interference in the normal course of events, then the writing of the DNR order counts as causing the patient's death. However, the doctor who writes the DNR order does not cause the patient's death *in the sense* that is relevant to the prohibition on causing the death of patients. Thus, we cannot define a cause as an intervention in the normal course of events. *That* is not the relevant notion of causation.

In response, a defender of Miller and Truog might claim that the DNR order does *not* interfere with the normal course of events. For it might be claimed that: a patient will not normally receive life-sustaining treatment *when a DNR order is appropriate*; hence, for the patient in our hypothetical case, the normal course of events does not involve life-sustaining treatment; hence, the DNR order does not interfere with the normal course of events.

As before, this response is inadequate. For, it can similarly be claimed that: a patient will not normally receive continued ventilation *when treatment withdrawal is appropriate*; hence, for such a patient, the normal course of events does not involve continued ventilation; and hence, withdrawing ventilation does not interfere with the normal course of events. It follows that withdrawing ventilation does not cause death, given the assumption that to cause death is to intervene in the normal course of events (in a way that makes the difference between life and death).

In sum, the idea that causes are interventions will not differentiate the writing of a DNR order from the withdrawal of mechanical ventilation. Hence, that notion of causation cannot be used to claim that withdrawing life-sustaining treatment causes death (in the sense that is relevant to the prohibition on causing the death of patients). Miller and Truog cannot simply appeal to their definition of causation—whether or not that definition is stated in terms of interventions in the normal course of events.

In addition to simply applying their definition of causation, Miller and Truog offer a number of other arguments against the Standard View. As we will see, those arguments are also undermined by Miller and Truog's assumption that causing is difference-making.

Comparing Patients

Miller and Truog compare two patients, A and B, both of whom have a medical condition that prevents spontaneous breathing. Patient A is taken off mechanical ventilation and dies, whereas patient B continues ventilation and lives. Miller and Truog (2012, 7) “contend that it is incoherent to hold that it is not withdrawal of [life-sustaining treatment] but the underlying medical condition that causes the death of A, as B with the very same medical condition continues to live.”

Miller and Truog (2012, 7) claim it is incoherent to deny that treatment withdrawal causes the death of patient A because they believe (i) causing is difference-making, and (ii) “the treatment withdrawal makes the difference” in this scenario between life and death. As I have argued, however, in this context causing should not be understood as difference-making. So, Miller and Truog lack grounds for making the claim of incoherence.

Furthermore, there is a perfectly natural way to maintain the position that Miller and Truog reject as incoherent. We can claim that the withdrawal of mechanical ventilation allows the underlying medical condition to cause

patient A's death. We can explain why patient B continues to live by noting that ventilation is preventing B's medical condition from causing B's death. This account is not only coherent but is plausible—as long as we are not thinking of causing as difference-making.

The Leaky Sailboat

“A sailboat springs a leak and begins to take on water. The sailor turns on a battery-operated pump that keeps the boat from filling up with water. The battery, however, becomes drained and the pump stops working” (Miller and Truog, 2012, 6). Miller and Truog claim that the pump's failure is a cause of the boat filling up with water. They continue: “Once a mechanical device intervenes to arrest a natural process, the stopping of the device causally explains, at least in part, the outcome.” They suggest that such an account likewise applies to the case of withdrawing life-sustaining treatment.

Suppose, however, that the pump malfunctions before it is able to remove any water from the sailboat. In that case, it is just as plausible as before to say that the pump's failure is a cause of the boat filling up with water. Now the case is just as analogous to the *withholding* of *initial* treatment as the original case was to the *withdrawal* of *ongoing* treatment. Hence, the sailboat analogy suggests that, by withholding initial treatment, a doctor causes the patient's death rather than merely allowing the patient to die. Even Miller and Truog reject that view, however, saying that the withholding of initial treatment “merely allows the patient to die” (as long as there is no duty to provide treatment; Miller and Truog, 2012, 5–6). So, we cannot use the sailboat case, in the manner that Miller and Truog suggest, to draw conclusions about forgoing life-sustaining treatment. Using the sailboat case in this manner produces the wrong answers.

When we focus on explaining the occurrence of an event, we often think of causes as things that make a difference to whether the event happens. Such a focus is induced by Miller and Truog's (2012, 6) claim that the pump's failure “causally explains, at least in part, the outcome.” The same is true of their claim that we frequently “explain the cause of an outcome in reference to the stopping of a mechanical intervention” (Miller and Truog, 2012, 6). We must remember that when evaluating the Standard View we are not interested in causing as difference-making. We are interested in the distinction between doing and allowing. Hence, we cannot straightforwardly translate our judgments about the sailboat case into judgments that bear on the Standard View.

Threats and Barriers

Citing Foot (1994a), Miller and Truog (2012, 4) claim that in withdrawing life-sustaining treatment “the agent initiates the fatal sequence” that ends in the patient's death. In fact, Foot explicitly denies this claim. She writes

that in removing someone from life support, “the fatal sequence resulting in death is not initiated but is rather allowed to take its course” (Foot, 1994a, 288).³ More generally, Foot distinguishes between setting in motion a new sequence of events and removing a barrier that is “holding back” a preexisting sequence (Foot, 1994b, 273). Withdrawing life-sustaining treatment is an example of the latter.

The distinction is crucial. For, removing a barrier is often a case of merely *allowing* a preexisting threat to cause harm. As an example, consider the following case:

A little Dutch boy, seeing that the dike is beginning to crack, valiantly sticks his finger in the crack to prevent the dike from breaking and flooding the town. He waits patiently but after many hours no one has come along who can help. Eventually succumbing to boredom and hunger, the boy withdraws his finger and leaves. Within minutes the dike bursts, and a flood engulfs the town, killing many. (McMahan, 1993, 257)

The little Dutch boy removes a barrier that was holding back a threat. Yet, it seems clear that he does not flood the town. He merely *allows* the town to flood. Because of cases like this, Miller and Truog cannot criticize the Standard View by appealing to the fact that in withdrawing treatment, the doctor removes a barrier that had arrested the progress of disease or injury.

That point is obscured when Miller and Truog make claims that are eminently plausible if we think of causing as difference-making. For example, they write: “Removing a barrier to a causal process is itself a cause of the outcome that ensues after the barrier is removed” (Miller and Truog, 2012, 5). This is true if causing is difference-making. However, if we are thinking of causing as doing, claims such as the one just quoted are often false—as shown by cases such as that of the little Dutch boy.

The Concept of Life-Sustaining Treatment

Miller and Truog (2008, 40) claim that the “very concept” of life-sustaining treatment entails that withdrawing such treatment causes death (see also Miller and Truog, 2012, 5). “A medical intervention works to produce a given clinical outcome by means of a causal process,” they write. “It follows that when mechanical ventilation is stopped, a patient who is incapable of breathing spontaneously will die. Stopping the ventilator contributes causally to the occurrence of death” (Miller and Truog, 2012, 5).

We can reject these claims by again considering the case of the little Dutch boy. The boy’s intervention works to prevent the flood “by means of a causal process” (to use Miller and Truog’s phrase). When the boy puts an end to that process by pulling his finger out of the hole in the dike, the boy does not himself flood the town but merely allows the town to flood. Similarly, a doctor who turns off a ventilator merely allows the patient to die—at least, Miller and Truog have not given us any reason to believe otherwise.

We can all agree with Miller and Truog that life-sustaining treatment prevents death by means of a causal process. It does not follow that the cessation of that causal process itself causes death rather than merely allowing the underlying medical condition to cause death—unless, of course, we are thinking of causing as difference-making.

Light Switches and Such

Miller and Truog present the following line of reasoning. They note that “turning off the ignition of a car causes it to stop running and pushing a light switch causes the lamp to go out” (Miller and Truog, 2012, 10). Similarly, they claim, turning off a ventilator causes the patient to die. Of course, the patient would not die in the absence of disease or injury. Similarly, the car or the lamp would not turn off in the absence of appropriate electrical wiring. Thus, the patient’s underlying medical condition is not what causes death, or at least is not the *only* cause of death—just as the electrical wiring is not what causes the car or lamp to turn off, or at least is not the *only* cause. Or so Miller and Truog say.

Of course, pushing a light switch causes the lamp to go out—at least in the difference-making sense of causation, and perhaps in the doing sense of causation (and similarly for the car example). Analogously, flipping the switch on a ventilator causes the ventilator to turn off. That, however, is not the point in dispute. Rather, the question is this: by causing the ventilator to turn off, does the doctor cause the patient to die? Given that the relevant notion of causation is *causing as doing*, the question becomes: by causing the ventilator to turn off, does the doctor *make* the patient die or merely *allow* the patient to die? We might try to answer this question by looking again to the lamp case, where the analogous question is: by causing the lamp to go out, do you *make* the room darken or merely *allow* the room to darken?⁴

I think it may be correct to say you merely allow the room to darken, but I do not think it really matters. For, I see no reason to believe that the light-switch case is a more appropriate analogy than the following case: You turn on the stove to heat a pot of water, but soon turn the stove off (Jensen, 2011, 175; see also McGee, 2015, 77). By turning off the stove, do you *make* the water cool down or instead *allow* the water to cool? It seems correct to say the latter. (You might *make* the water cool down by putting ice cubes in it.) In other words, it seems right to say that with respect to the water cooling down, your conduct falls on the “allowing” side of the doing/allowing distinction. So, there is no problem for the Standard View until we have reason to believe that turning off a ventilator is more like the lamp case than the stove-top case—as well as reason to believe that by causing the lamp to go out, you do not simply allow the room to darken.

The Interloper

Finally, [Miller and Truog \(2012, 5\)](#) follow [Brock \(1986, 1992\)](#) in imagining an individual (the interloper) who wants a patient dead. The interloper enters the patient's hospital room, turns off the patient's ventilator, and the patient dies. Surely the interloper *causes* (and does not merely *allow*) the patient to die. Hence, it is asked: how could turning off a ventilator cause the patient's death when the act is performed by an interloper, but not when it is performed by a doctor? After all, are we not dealing with the *very same action* in either case?

The best response runs as follows ([McMahan, 1993](#); [Kamm, 1996](#), 28–30; [Thomson, 1996](#), 106–7; [Jensen, 2011](#); [McGee 2014, 2015](#)). Medical personnel use a ventilator to provide treatment. So, if a doctor turns off a ventilator that amounts to the doctor refraining from providing further treatment. By refraining from providing further treatment, the doctor simply stops preventing the patient's death—and hence merely *allows* the patient to die. However, if an interloper turns off the ventilator that cannot amount to the interloper refraining from providing further treatment, as the interloper was not providing the treatment in the first place. Rather, by turning off the ventilator, the interloper prevents another individual from providing treatment. That is to do more than merely refrain from providing treatment. So, we can say that the interloper causes death while the doctor does not—as long as we are thinking of causing as doing rather than as difference-making.⁵

I have assumed that the doctor who withdraws treatment does so at the request of the patient (or a surrogate). We must also address the case in which a doctor withdraws life-sustaining treatment without a prior request, and indeed without consent. Would *that* cause the patient's death? If so, how are matters different when the withdrawal of treatment is consensual?

There are two plausible ways to go here. First, it can be claimed that a doctor acting without consent *wrongfully allows* the patient to die, though the case would be treated as homicide for legal purposes (Andrew McGee, personal communication). In that case, there would be no pressure to say that a doctor who acts *with* consent does more than allow the patient to die. Second, it can be claimed that a doctor acting without consent thereby becomes an interloper, interfering with the treatment that the rest of the medical team or the hospital is attempting to provide the patient (see [McMahan, 1993](#), 265). The latter response, of course, will not be available if it is stipulated that the doctor is the only individual providing treatment, owns the ventilator or other medical equipment, and so forth.

Miller and Truog insist that if withdrawal of life-sustaining treatment causes death when performed by an interloper or rogue doctor, then the same must be true when treatment is withdrawn by a doctor at the patient's request. I have indicated why this view is mistaken, but I would like to note how compelling the view is when causing is understood as difference-making.

For, withdrawing life-sustaining treatment makes the difference between life and death, whether or not treatment is withdrawn by a doctor, and whether or not it is withdrawn with consent. When we view causing as doing, we need not group all these cases together. For, we can then ask whether withdrawing treatment is to refrain from providing further treatment and hence is to *allow* the patient to die, or is instead to prevent another individual from providing treatment and hence is to *do* lethal harm.

Summing Up

Miller and Truog (2012, 2, 2010a, 456) have suggested that their position is “obvious” and the Standard View is “patently false” (2010a, 454), a “dogma” that is “patently contrary to the common-sense conception of causation” (2012, 9). We can now understand these brash claims. For on Miller and Truog’s “common-sense conception of causation,” causing is difference-making. The Standard View *would* be obviously and patently false if it were a claim about causing as difference-making. Turning off the ventilator of a ventilator-dependent patient, for example, obviously *makes a difference* to whether the patient lives or dies.

By contrast, the Standard View is quite plausible when causing is understood as doing. For as we have seen, Miller and Truog’s arguments do nothing to establish that when life-sustaining treatment is withdrawn, the doctor’s involvement in the patient’s death falls on the “doing” side of the doing/allowing distinction.

As I said at the beginning of this section, the first chapter of [Miller and Truog’s \(2012\)](#) book is simply the most comprehensive critique of the Standard View, containing arguments found in a number of other places. Most obviously, it contains arguments found in the previous work of Miller and Truog, as well as in the work of Brock, their frequent collaborator ([Brock, 1986, 1992](#); [Miller and Truog, 2008](#); [Miller, Truog, and Brock 2010a, 2010b](#)). Appeals to the interloper argument are also made by [Buchanan \(1996, 30\)](#), [Cochrane \(2011, 144–45\)](#), and [Savulescu \(2013, 257\)](#), among others. Finally, Persson and Savulescu appeal fairly explicitly to the conception of causing as difference-making. They write:

When you remove life-supporting aid, with the result that the Victim dies of an underlying disease, you cause him to die of this disease rather than let this occur, irrespective of whether the aid is yours to remove. For there is a change you make occur such that, if it had not occurred, the Victim would not have died when he did. ([Persson and Savulescu, 2005, 20](#))

The last sentence of this passage points out that the change in question *made the difference* between the patient living and dying. We have seen that if causing is understood as doing, then neither this argument nor any of the arguments just mentioned are successful.

V. REMAINING PROBLEMS

I have argued for two claims. (1) The Standard View should be understood as holding that when a doctor withdraws life-sustaining treatment, the doctor's involvement in the patient's death falls on the "allowing" side of the doing/allowing distinction. (2) Criticisms of the Standard View typically fail because the critics interpret the Standard View in another way.

Of course, it is possible that *other* criticisms of the Standard View can succeed. In this final section, I mention several problems that remain for the Standard View.

First, I have argued elsewhere that the Standard View is mistaken in the case of deactivating a patient's total artificial heart (Bronner, 2016). Deactivating an artificial heart is an instance of killing, even if discontinuing *other* forms of life-sustaining treatment is merely letting die.

The Standard View might also be challenged in a wider range of cases. As we have seen, the Standard View largely depends on the following line of reasoning: to withdraw life-sustaining treatment is to stop preventing death; to stop preventing death is to let die; hence, to withdraw life-sustaining treatment is to let die. Kuhse (1987, 50) exemplifies this reasoning:

I can refrain from preventing the drowning swimmer's death by removing my hand that held her head above water . . . I have not killed her if she drowns following the removal of my hand: I let her die. The same applies in the medical setting: if a physician turns off an artificial respirator sustaining the victim of an accident, who is unable to breathe by herself, she has not killed the patient but let her die. In turning off the respirator, the physician refrains from continuing to prevent the patient's death.

There is another analogy to consider. After hauling a drowning swimmer to shore, a lifeguard cannot be said merely to stop preventing death if she then throws the swimmer back into the water and the swimmer dies. The question, then, is whether withdrawing life-sustaining treatment is more like removing your hand from under the head of a drowning swimmer, or more like throwing the swimmer back into the water after hauling her out. I have assumed the former in this paper, but the issue is debatable. McMahan (1993, 266–267), for example, expresses ambivalence.

I have made another debatable assumption, which relates to the following case. Suppose a doctor withdraws life-sustaining treatment that other medical personnel had initiated, monitored, and periodically adjusted. Since *others* were providing the treatment in question, it seems the doctor does more than simply refrain from providing further treatment. Rather, the doctor *prevents others* from providing life-saving treatment—as does the interloper who withdraws treatment from his hospitalized enemy.

Now there appears to be a dilemma: either preventing others from providing life-sustaining treatment is an instance of *killing*, or it is not. If the latter, then the interloper does not kill his enemy (a counterintuitive result). If the

former, then the Standard View is mistaken in a range of cases: withdrawing life-sustaining treatment *kills* whenever the treatment is withdrawn by an individual who was not previously providing it—even when that individual is a doctor acting on the valid request of a patient.

I have, however, tacitly assumed something like the following. When a doctor withdraws life-sustaining treatment being provided by others, the result is that the medical team or hospital refrains from providing further treatment, hence refrains from preventing death, and merely *allows* the patient to die. Since the doctor is acting as *part* of the medical team, or as an *agent* of the hospital, the doctor also counts as merely allowing the patient to die (see McMahan, 1993, 264–65). In other words, I have assumed that whether an individual counts as *killing* or *letting die* can depend on the actions of others who belong to the *collective* within which the individual is acting. Call this *the collectivist assumption*. (This assumption also allowed me to claim that the doctor who writes a DNR order merely *allows* the death that follows, even though by writing the DNR order the doctor does not merely refrain from saving the patient, but actually *prevents others* from saving the patient.)

Perhaps, however, we must focus more on what the doctor does as an *individual*. While the medical team (as a *group*) or the hospital (as an *institution*) merely allow the patient to die, the doctor herself seems to do *more* than merely allow the patient to die. As I have said, the doctor *prevents others* from continuing to provide life-sustaining treatment. Since I am not sure whether the collectivist assumption is correct, I view this as another unresolved issue that may be a problem for the Standard View.

Finally, consider a patient who turns off the ventilator being used to keep her alive, with the result that she dies. Those who accept the Standard View will likely say that the patient does not *kill* herself, but merely *allows* herself to die. Indeed, with respect to the killing/letting die distinction, the situation seems similar to the case where a doctor withdraws treatment at the patient's request. How can this position be maintained? After all, it seems the patient is not refraining from providing herself with further treatment, but is instead *preventing others* from providing life-saving treatment. (This seems true, at least, if it is *others* who own the ventilator, monitor it, and adjust it as needed—and hence it really is *others* who were providing the treatment.) The collectivist assumption does not seem to help here, since the patient is not part of the medical team or the hospital that is providing treatment.

The problem might be resolved as follows. Consider a person whose circulatory system has been connected to that of another; the first person's body is being used to provide life-saving dialysis to the second, who has kidney disease (Thomson, 1971). If the first person severs the connection, she thereby refuses to allow her body to be used to save the second. Hence, she *refuses to save* the second person and so merely *allows* the second person to die. Now return to the case where a patient withdraws the treatment doctors are providing her, for example, by turning off a ventilator. Perhaps by refusing

to allow her body to receive the treatment, the patient refuses to allow her body to be used to save *herself*. If so, then this case would also appear to be one of letting die rather than killing. Again, however, the case deserves more thought than I can give it here, and so I consider it a potential problem for the Standard View that awaits a full resolution.

So, there remain problems (or *potential* problems) for the Standard View. Hence, the upshot of the present paper is not that withdrawing life-sustaining treatment merely lets the patient die. Rather, the upshot is that different arguments against the Standard View are required—arguments that do not assume that causing is to be understood as difference-making.

NOTES

1. For convenience, I sometimes speak of the different *senses* of terms such as “cause,” but this is perhaps a loose manner of speaking. For, it might be that the word “cause” has only one sense. Perhaps the diverging uses of “cause” that I highlight are explained, not by ambiguity or polysemy, but by contextually variable standards for what counts as causation. I take no stand on such issues.

2. The notion of causing as doing—and of killing as a *type* of doing—is not at all unusual. McMahan (1993, 250), for example, writes that “killing is an instance of *doing*, or directly causing an event to occur.” In circumstances where death is a harm, killing is widely understood as an instance of doing harm (Woollard, 2012a, 2012b; Woollard and Howard-Snyder 2016).

3. Foot (1994a) is discussing a case from Thomson (1971) in which one’s own body is being used as life support “in the way a respirator or a kidney machine is used” (Foot, 1994a, 288).

4. The doing/allowing distinction is sometimes referred to as the *making*/allowing distinction. In some contexts, I find it less awkward to speak of “making” an outcome occur than to speak of “doing.” No difference in meaning is intended.

5. Kagan (1989, 102) considers the suggestion that the doctor refrains from providing aid (and hence merely lets die) while the interloper does not. He is skeptical, however: “What the doctor did was turn some machines off—and this is just what *I* [the interloper] did when I *killed* my rival . . . How can we treat the cases differently?” It can, however, be denied that the doctor does “just what” the interloper does. For while both individuals turn off the machines in question, only the doctor thereby ceases providing treatment. The interloper does something different, namely, prevents another individual from providing treatment.

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REFERENCES

- Brock, D. W. 1986. Forgoing life-sustaining food and water: Is it killing? In *By No Extraordinary Means: The Choice to Forgo Life-Sustaining Food and Water*, ed. J. Lynn, 117–31. Bloomington: Indiana University Press.
- . 1992. Voluntary active euthanasia. *Hastings Center Report* 22:10–22.
- Bronner, B. 2016. The total artificial heart and the dilemma of deactivation. *Kennedy Institute of Ethics Journal* 26:347–67.

- Buchanan, A. 1996. Intending death: The structure of the problem and proposed solutions. In *Intending Death: The Ethics of Assisted Suicide and Euthanasia*, ed. T. L. Beauchamp, 23–41. Upper Saddle River, NJ: Prentice Hall.
- Cochrane, T. I. 2011. Allow the dying to donate: Replace the dead donor rule. In *The Ethics of Organ Transplantation*, ed. S. J. Jensen, 135–54. Washington, DC: Catholic University of America Press.
- Council on Ethical and Judicial Affairs. 1992. Decisions near the end of life. *Journal of the American Medical Association* 267:2229–33.
- Deseret News. 1989, May 27. Doctor uses fingers to plug holes in man's heart during rescue flight [On-line]. Available <https://www.deseretnews.com/article/48641/DOCTOR-USES-FINGERS-TO-PLUG-HOLES-IN-MANS-HEART-DURING-RESCUE-FLIGHT.html> (accessed November 19, 2017).
- Foot, P. 1994a. Killing and letting die. In *Killing and Letting Die*, eds. B. Steinbock and A. Norcross, 280–9. New York: Fordham University Press.
- . 1994b. The problem of abortion and the doctrine of the double effect. In *Killing and Letting Die*, eds. B. Steinbock and A. Norcross, 266–79. New York: Fordham University Press.
- Hart, H. L. A. and T. Honoré. 1985. *Causation in the Law*. Oxford, United Kingdom: Oxford University Press.
- Jensen, S. J. 2011. Killing and letting die. In *The Ethics of Organ Transplantation*, ed. S. J. Jensen, 170–91. Washington, DC: Catholic University of America Press.
- Kagan, S. 1989. *The Limits of Morality*. New York: Oxford University Press.
- Kamm, F. M. 1996. *Morality, Mortality Volume II: Rights, Duties, and Status*. New York: Oxford University Press.
- Kuhse, H. 1987. *The Sanctity-of-Life Doctrine in Medicine: A Critique*. Oxford, United Kingdom: Oxford University Press.
- McGee, A. 2014. Does withdrawing life-sustaining treatment cause death or allow the patient to die? *Medical Law Review* 22:26–47.
- . 2015. Acting to let someone die. *Bioethics* 29:74–81.
- McMahan, J. 1993. Killing, letting die, and withdrawing aid. *Ethics* 103:250–79.
- Miller, F. G. and R. D. Truog. 2008. Rethinking the ethics of vital organ donation. *Hastings Center Report* 38:38–46.
- . 2012. *Death, Dying, and Organ Transplantation: Reconstructing Medical Ethics at the End of Life*. New York: Oxford University Press.
- Miller, F. G., R. D. Truog, and D. W. Brock. 2010a. Moral fictions and medical ethics. *Bioethics* 24:453–60.
- . 2010b. The dead donor rule: Can it withstand critical scrutiny? *Journal of Medicine and Philosophy* 35:299–312.
- Persson, I. and J. Savulescu. 2005. McMahan on the withdrawal of life-prolonging aid. *Philosophical Books* 41:11–22.
- Savulescu, J. 2013. Abortion, infanticide and allowing babies to die, 40 years on. *Journal of Medical Ethics* 39:257–9.
- Thomson, J. J. 1971. A defense of abortion. *Philosophy and Public Affairs* 1:47–66.
- . 1996. Killing and letting die: Some comments. In *Intending Death: The Ethics of Assisted Suicide and Euthanasia*, ed. T. L. Beauchamp, 104–8. Upper Saddle River, NJ: Prentice Hall.
- Woollard, F. 2012a. The Doctrine of Doing and Allowing I: Analysis of the doing/allowing distinction. *Philosophy Compass* 7:448–58.

- . 2012b. The Doctrine of Doing and Allowing II: The moral relevance of the doing/allowing distinction. *Philosophy Compass* 7:459–69.
- Woollard, F. and F. Howard-Snyder. 2016. Doing vs. allowing harm. In *The Stanford Encyclopedia of Philosophy*, summer 2016 edition, ed. E. N. Zalta [On-line]. Available: <http://plato.stanford.edu/archives/sum2016/entries/doing-allowing/> (accessed October 1, 2016).
- World Medical Association. n.d. WMA resolution on euthanasia [On-line]. Available: <https://www.wma.net/policies-post/wma-resolution-on-euthanasia/> (accessed October 20, 2017).