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MORAL FICTION OR MORAL FACT? THE DISTINCTION BETWEEN DOING AND ALLOWING IN MEDICAL ETHICS

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ABSTRACT
Opponents of physician-assisted suicide (PAS) maintain that physician withdrawal-of-life-sustaining-treatment cannot be morally equated to voluntary active euthanasia. PAS opponents generally distinguish these two kinds of act by positing a possible moral distinction between killing and allowing-to-die, ceteris paribus. While that distinction continues to be widely accepted in the public discourse, it has been more controversial among philosophers. Some ethicist PAS advocates are so certain that the distinction is invalid that they describe PAS opponents who hold to the distinction as in the grip of 'moral fictions'. The author contends that such a diagnosis is too hasty. The possibility of a moral distinction between active euthanasia and allowing-to-die has not been closed off by the argumentative strategies employed by these PAS advocates, including the contrasting cases strategy and the assimilation of doing and allowing to a common sense notion of causation. The philosophical debate over the doing/allowing distinction remains inconclusive, but physicians and others who rely upon that distinction in thinking about the ethics of end-of-life care need not give up on it in response to these arguments.

While physician assisted suicide (PAS) has made some small steps forward in the United States in the past twenty years, the contours of debate about this issue have altered little. Opponents of PAS have often defended its prohibition by asserting a moral difference between withdrawing life-sustaining treatment and active euthanasia – between allowing-to-die and beneficently-intended killing.[1] Such arguments often invoke distinctions between doing and allowing and between actions intended and actions merely foreseen. Those favoring PAS have argued that such distinctions do not withstand scrutiny; that patient self-determination is of great importance; and that there should be no bar to physicians killing patients when patients wish to die and death is in a patient's interest.

The debate stands at a different point in the public discourse and in the courts than it does in the ethics literature. While public opinion and the courts have generally maintained the importance of a moral distinction between the withdrawal of life-sustaining treatment and active euthanasia, grounded in a distinction between doing and allowing, that distinction has been vigorously attacked (and defended) by philosophers. Miller et al., in a recent paper,[2] note the continued resistance in the medical community to dissolving the distinction and conclude that those who defend it are entertaining a 'moral fiction'– moral fictions being '*motivated false* statements, endorsed in order to uphold a position felt to be important'(italics in original).

Psychological explanations for beliefs are, of course, of great interest if the belief in question is clearly in error. What I hope to show in this paper is that Miller et al.

[1] Or, between allowing-to-die and beneficently-intended ending of life. 'Killing' in this paper refers to 'active (rather than passive) action taken to end life'; I do not intend any morally freighted disapprobation to accompany the word in the context of the debate over the doing/allowing distinction.

[2] F.G. Miller, R.D. Truog & D. Brock. Moral Fictions and Medical Ethics. *Bioethics* 2010; 11: 453–460 at 454.

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have not demonstrated that the moral distinction commonly drawn between passive and active ending of life, in cases of withdrawing life-sustaining treatment and active euthanasia is invalid. Their strategy for showing the distinction to be mistaken is two pronged; first, they cite previous work attacking the distinction between doing and allowing through a strategy of contrasting pairs of cases differing only in that one case involves doing and the other allowing. This strategy of undermining the distinction, they appear to believe, has been so successful that resistance to it must be due to an embrace of moral fictions. Secondly, they assert that a 'common sense understanding of causation' assimilates withdrawal of support and active euthanasia to causing death. As both acts cause death, it is incoherent to suppose that there may be a moral difference between them grounded in the difference between doing and allowing. Once withdrawal of support is so far equated, *ceteris paribus,* to active euthanasia, it follows that physicians cannot coherently deny intending the death of patients whose life-sustaining treatment they withdraw. Many physicians do intend the death of such patients and those who do not are in the grip, once again, of a moral fiction.

In what follows I will suggest that the 'contrast strategy' (so called following Shelley Kagan) of attacking the distinction between doing and allowing is unpersuasive for reasons that have been extensively discussed in the ethics literature. This debate remains inconclusive and there are no grounds for declaring it settled on the basis of contrasting pairs of cases. I will then discuss Miller et al.'s account of causation, suggesting that it is not, in fact, commonsensical and that it mistakes the relation between moral judgment and causal attribution. It therefore cannot dissolve the distinction between doing and allowing. The debate over the doing/allowing distinction will continue and those who seek to undermine the distinction will do better to proceed by argument with than by diagnosis of their opponents.

THE CONTRAST STRATEGY OF ATTACKING THE DOING/ ALLOWING DISTINCTION

The contrast strategy for undermining the distinction between doing and allowing proceeds by comparing cases said to be of similar moral import except that one involves a 'doing' and one an 'allowing'. If the difference between doing and allowing is unimportant in morally distinguishing two such cases, it is contended, that difference could never of itself make a moral difference. This is the conclusion drawn by James Rachels in regard to his cases of Smith drowning his nephew in the bathtub and Jones merely allowing his nephew to drown in the bathtub unaided.[3] Both acts (construing an omission in the case of Jones as an act) are vicious; that one is a doing and one an allowing is of no moral importance. Hence the conclusion that the character of acts as doings or allowings is by itself of no moral significance.

Dan Brock offers a similar argument in regard to several pairs of cases. A man is terminally ill and wishes to die; his wife asphyxiates him with a pillow while he is unconscious. Or, the same man's wife withholds mechanical ventilation when he requires it to remain alive.[4] Brock notes that in each case the wife furthers the man's intentions and the outcomes are similar. He contends that the cases are therefore morally similar and the wife's active role in one and her passive role in the other do not engender a moral difference between the cases. Another pair of cases[5] involves a woman with amyotrophic lateral sclerosis (ALS) on a ventilator who wishes to die. In one case, her doctor removes the ventilator at her request and she dies. In the other case, a greedy nephew hoping for an inheritance sneaks into her room while she's asleep and disconnects the ventilator, not knowing that the woman planned to have it disconnected by her physician. These cases are morally dissimilar but both are, in the traditional view, cases of withdrawal of a treatment and thus of an allowing to die (even if the nephew is guilty of murder). Brock suggests that the differing moral import of these cases follows from the differing intentions of the physician and the greedy nephew; no moral significance is added by the active or passive character of the acts (whether one views them as active or passive). If the nephew killed his aunt, then so did the doctor; and the means of the killing is not a morally interesting factor.

The most important response to such arguments was pioneered by Philippa Foot, who pointed out that the morally vicious acts of Rachels'Smith and Jones offended against different moral norms.[6] Drowning the nephew was an offense against justice, whereas not rescuing the nephew offended against charity. Our rights not to be drowned extend further than our rights to be rescued from drowning. Hence in these cases, while actively drowning the nephew or passively allowing him to drown are both condemnable, the offenses are different and analogous offenses need not in other pairs of cases warrant equal blame – as in Foot's example of the wounded soldier who had to be left by the retreating army. That soldier would soon die in any case but faced a cruel end at the hands of the enemy if left alive by his fellow soldiers. He would have been better off dead but insisted that his squad mates leave him alive. In this case,

[3] J. Rachels. Active and Passive Euthanasia. *NEJM* 1975; 292: 78–80.
[4] D. Brock. Taking Human Life. *Ethics* 1985; 95: 851–865.
[5] D. Brock. Voluntary Active Euthanasia. *Hasting Cent Rep* 1992; 22: 10–22.
[6] P. Foot. Euthanasia. *Philos Public Aff* 1977; 6: 85–112.

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they are required to leave him to die rather than to kill him and it makes all the moral difference in the world which alternative they choose; as the soldier's negative right not to be killed against his wishes defeats his positive right to aid (which in this case would be a bullet).

The broader point suggested by Foot's analysis is that although the moral valence of active or passive involvement in an outcome may not differ across some otherwise similar cases, it does not follow that an agent's active or passive role in action never makes a moral difference. Contra Brock and Rachels, the moral valences of killing or allowing to die are not invariable accompaniments of active or passive involvement in causal chains (or webs) leading to someone's death. They are instead determined by the moral norms against which activity or passivity must be gauged. These will differ sometimes even across situations that are otherwise similar, as they are determined not by individual natural facts about situations but at the higher level of an entire situation with moral import.

If that is true, the moral factors we pick out as salient in situations with moral import do not necessarily play their roles independently of one another and do not necessarily combine additively as they indicate a moral course of action.[7] Those who oppose the distinction between doing and allowing through use of the contrast strategy presume the converse – that factors such as an act being a doing or an allowing contribute the same moral weight across situations and do so additively. Shelley Kagan suggests that the first presumption, which he calls the ubiquity thesis, rests upon the second, the 'additive assumption': that is, the assumption that in analyzing the moral demands of a situation, one may sum the positive and negative contributions of the moral factors that weigh in determining the moral valence of a possible act.[8] Advocates of the contrast strategy have affirmed the additive assumption[9] and it seems plausible for many simple cases. But as Kagan shows, the assumption leads to deeply counterintuitive results in other cases. One such case is the common judgment that while suffering ought to be alleviated, there are times when someone suffering less has priority over someone suffering more – such as when she who is suffering more is guilty and she who is suffering less is innocent. The magnitude of suffering as a spur to its relief may not weigh equally across cases.

It is, of course, open to advocates of the contrast strategy simply to deny the force of Kagan's examples and of Foot's distinction between positive and negative rights. Our intuitions in the cases they offer that doing and allowing do not necessarily contribute the same moral weight across situations may be taken as a mere default position of our common morality. As such, our intuitions may seem vulnerable to the contrast strategy; why after all, should doing or allowing, isolated from other moral factors, *not* contribute identical moral weights from case to case? The point to make is that a presumption that they do (and that that weight is zero), as held by advocates of the contrast strategy, seems at best no more warranted than the opposing presumption that they do not. In the face of evidence that the additive assumption does not hold for many common moral judgments, its advocates need to justify it rather than merely presume its veracity.

Foot's analysis does not suggest that voluntary active euthanasia is necessarily wrong; she would probably have accepted the moral legitimacy of the wife's act asphyxiating her dying husband in Brock's pair of cases.[10] But she would not have done so on the grounds that doing and allowing, as such, inevitably contribute equivalent moral weights to the overall moral valence of an act. She would have held that negative rights made more stringent demands in the asphyxiation case than in the withdrawal case; and that these demands were satisfied. Foot's stance, however, leaves open the possibility of other kinds of objections to voluntary active euthanasia. Once it is established that there may be a moral difference between doing and allowing in such cases, the difference between negative and positive rights may not be the only available ground for morally distinguishing between them.

CAUSATION AND THE DOING/ ALLOWING DISTINCTION

In the eyes of many the contrast strategy of dissolving the distinction between doing and allowing has not succeeded. Advocates of PAS, however, have recently supplemented it with an argument aimed at demonstrating that common sense notions of causation imply an equally causal role for doing or allowing in pairs of cases such as those previously cited against the distinction. Miller et al. offer a pair of cases: 1) a ventilator-assisted quadriplegic, John, who wishes to die and requests removal of the ventilator and 2) a non-ventilator dependent quadriplegic, Sam, who wishes to die and requests lethal medication. Miller et al. contend that removing John's ventilator or administering lethal medication to Sam would, in the respective cases, be the cause of death.

[7] A position elaborated by Luke Robinson as moral holism: '*moral holism* maintains that what is a moral reason to φ in one case may not be one in another, and may even be a moral reason not to φ given suitable circumstances. It holds that the moral polarity or valence, as it were, of a moral reason is not fixed independently of and so may be altered by – factors other than itself.' L. Robinson. Moral Holism, Moral Generalism, and Moral Dispositionalism. *Mind* 2006; 115: 331–360 at 332.

[8] S. Kagan. The Additive Fallacy. *Ethics* 1988; 99: 5–31.

[9] For instance, Brock, *op. cit.* note 3, p. 861.

[10] See Foot, *op. cit.* note 5, pp. 107–108.

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And if removing the ventilator causes death (just as administering a lethal medication would), it is mistaken to suggest a possible moral difference between the two acts on the ground that one is an 'allowing,' the other a 'doing.'

The claim here is that a 'common sense notion of causation' underwrites our attributing causation of death to disconnecting the ventilator in the case of John or administering a lethal drug in the case of Sam. The moral import of acts (such as doings or allowings) from which follow morally significant outcomes (such as death) is then a function of the causal relation between the acts and the outcomes. As disconnecting the ventilator for John and administering a lethal drug to Sam respectively cause their deaths, the moral import of these acts, one a doing and one an allowing (according to traditional parlance), must be identical.

Miller et al. identify their 'common sense notion of causation' with that advanced by H.L.A. Hart and Tony Honore in *Causation in the Law.*[11] Hart and Honore sought to elaborate an account of causation which, in their view, underwrites both common sense talk about causation and also legal doctrine regarding it. Their account of causation, which certainly covers a great deal of common usage, begins with the idea of cause as a 'causally relevant factor'; that is, as a necessary one of a set of factors jointly sufficient for an outcome.[12] Causally relevant factors are generally (but not always) the same as those which meet the test of cause as a *sine qua non:* a causes b if 'but for' a, no b. But being a causally relevant factor or a *sine qua non* is necessary but not sufficient for being a cause in common parlance; as any event is caused (by these tests) not by one but by a set of antecedent conditions necessary to produce that event. The oxygen in the air is just as much a necessary condition for the fire as the dropping of a lighted cigarette which we identify as the fire's 'cause.'[13] What distinguishes the cause we identify from mere conditions, which are also causally relevant factors or *sine qua non's*?

Hart and Honore suggest that causes are distinguished from conditions through being either abnormal or unusual in the context of the event – as the lighted cigarette is, but the ambient breeze is not, among the conditions necessary for the fire – or voluntary human actions. If the flames from Tom's lighted cigarette would have died away had not Joe deliberately fanned them, we would hold Joe rather than Tom responsible for causing the fire.[14] The account deals with many further complexities, but the specification of causes among conditions through the consideration of contextual abnormality or deliberate human action is its core.

Hart and Honore explain causal judgments in cases like those of disconnecting a ventilator by a principle of excluding pre-existing abnormalities in the explanation of outcomes precipitated by wrongful acts:[15]

> The basic principle is that normal physical events, even subsequent to the wrongful act, do not relieve a wrongdoer of responsibility but that an abnormal conjunction of events (in this case the wrongful act and the third factor) negatives causal connection, provided that the conjunction is not designed by human agency. The third factor must, however, be an event later in time than the prior contingency. Abnormal circumstances of the thing or person affected, existing at the time of the prior contingency, do not negative causal connection. The third factor must also be causally independent of the prior contingency.

Thus if A is injured by B's negligence in an auto accident (the wrongful act) and a tree falls on A's ambulance on the way to the hospital (the 'third factor'), killing him, B is not liable for A's death (causal connection between the negligent act and the bad outcome is 'negatived').[16] On the other hand, if injuries due to negligence or malice are especially severe due to a victim's pre-existing condition, that condition is held not to lessen the malicious act's causal role in determining the injury's severity; as in the case of the perpetrator held fully liable for the death of a victim who died from a 'tap' on the head because said victim had an 'eggshell' skull.[17]

Miller et al. rightly suggest that this 'common sense' account of causation would find disconnecting John's ventilator to be the cause of his death. That conclusion is inevitable if pre-existing conditions play no role in the cause of outcomes such as death that follow acts tending to diminish life-maintaining processes. The difficulty with Miller et al.'s argument here is that in fact, there is no such regularity in the effect of pre-existing conditions on causal attributions as they suppose and as Hart and Honore suggest there to be. A closer look at Miller et al.'s case of disconnecting John's ventilator reveals that moral judgments and, hence, causal attributions might well vary across cases with a causal structure generally similar to this one.

As many have observed, common usage is equivocal in regard to such acts; many might designate disconnecting a ventilator to be a 'killing'; physicians usually call this act an allowing to die when it is performed by them. Philippa Foot sought to clarify the debate by introducing a special vocabulary for doings and allowings in such

[11] H.L.A. Hart and T. Honore. 1985. *Causation in the Law.* New York, NY: Oxford University Press.
[12] Ibid: 112–113.
[13] Ibid: 34–35.
[14] Ibid: 72.
[15] Ibid: 162–163.
[16] Ibid: 164–165.
[17] Ibid: 173.

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cases.[18] She suggests that the critical difference between doing and allowing for the present purpose is that between allowing a fatal sequence of events to proceed (an 'allowing') and either initiating it or maintaining it when it otherwise would have petered out (a 'doing'). Allowings may be subdivided into passive allowings, when one is a bystander to a fatal sequence, and enablings, when one removes an obstacle impeding a fatal sequence. Using Foot's terminology to clarify the structure of cases of interest, we might characterize the physician removing John's ventilator as a beneficent enabling. In contrast, the greedy nephew who disconnects his aunt's ventilator in Brock's case engages in a malicious enabling. Of course Miller et al. would contend that no appeal need be made to the differences between enabling, passive allowing, or doing to explain the moral difference between these cases, which in their view would be sufficiently accounted for by the respective intentions of the physician and the greedy nephew.

Consider, however, a case of Jeff McMahan's cited by Samuel Rickless.[19]

> *Burning Building II.* A person trapped atop a high building that is on fire leaps off. Seeing this, a firefighter quickly stations a self-standing net underneath. But he then immediately notices that two other persons have jumped from a window several yards away. He therefore repositions the net so that it catches the two. The first jumper then hits the ground and dies.

The causal structure of this case in terms of Hart and Honore's scheme is similar to that of Brock's greedy nephew case. In both cases we have an act (disconnecting the ventilator, removing the net), a fatal outcome, and a preexisting condition (the aunt's fatal disease, the first jumper's trajectory toward the ground). If Hart and Honore's analysis is correct, the first jumper's trajectory toward the ground, being a 'preexisting condition,' ought not to 'negative' the causal connection between the fireman's pulling away the net and the first jumper's death. But in this case, any such causal connection is clearly defeated. We do not say that the fireman killed the first jumper; rather, the fireman allows him to die.

What these cases suggest is a different relation between causal attribution and moral judgment than is presumed by Hart and Honore's scheme. Hart and Honore undertook their project in opposition to 'causal minimalism,' a view of causation in the law according to which the law sought answers to empirical questions only so far as regarded 'causally relevant factors' or *sine qua non*s. Once it was determined that a given factor was causally relevant, the law might choose to regard it as a 'proximate cause' ('the cause' for legal purposes; analogous to Hart and Honore's 'causal connection') or not for normative or policy reasons. According to causal minimalism, causal attributions followed from normative or policy judgments (once a candidate cause was established as a causally relevant factor). Hart and Honore reversed this order, claiming that their common sense notion of causation was primary. While that notion clearly had normative components, it offered a given picture of causation which explicitly normative reasoning could then build upon. This is the role played by Hart and Honore's notion in Miller's argument; we can empirically decide that disconnecting the ventilator caused John's death. Normative judgments about the act of disconnecting the ventilator then follow from the facts about causation.

Our contrasting causal attributions in Brock's greedy nephew case and 'burning building II' suggest that normative judgments condition causal attributions rather than vice versa. As such judgments vary in differing contexts, our causal attributions will differ accordingly, even sometimes across cases with similar causal structure. That this is so suggests that Hart and Honore's notion of causation, far from being 'common sense,' is in fact germane to a given range of contexts for which it corresponds to our moral judgments and simply irrelevant for other contexts which it fails to illumine. This is the conclusion reached by many of Hart and Honore's critics.[20] It is also the conclusion suggested by a range of experiments performed in recent years to elucidate common intuitions in regard to doing and allowing. These strongly suggest that moral judgments condition attributions of doing and allowing and of causation.[21] While there is at present a lively controversy as to the best explanation of this finding,[22] it inescapably tells against regarding a given answer to the question as to the cause of John's death to be empirical 'common sense.'

Hart and Honore's notion of causation cannot serve to underwrite normative judgments about the disconnection of John's ventilator in the manner Miller et al. wish to suggest. It can at most indicate a normative judgment implicit in the assertion that John's death was caused by the ventilator's disconnection in the same manner that a physician administering a fatal drug causes Sam's

[18] P. Foot. Killing and Letting Die. In *Moral Dilemmas and Other Topics in Moral Philosophy*. New York, NY: Oxford University Press: 78–87.

[19] S. Rickless. The Moral Status of Enabling Harm. *Pac Philos Q* 2011; 92: 66–86.

[20] Cf. P. Foot. Hart and Honore: Causation in the Law. *Philos Rev* 1963; 72: 505–515; P. Lipton. Causation Outside the Law. In *Jurisprudence: Cambridge Essays*. H. Gross & R. Harrison, eds. New York, NY: 1992: 127–148; J. Stapleton. Choosing what we mean by 'Causation' in the Law. *Miss Law Rev* 2008; 73: 433–480.

[21] F. Cushman, J Knobe & W. Sinnott-Armstrong. Moral Appraisals affect doing/allowing judgments. *Cognition* 2008; 108: 281–289.

[22] See J. Knobe. Person as Scientist, Person as Moralist. *Behavioral and Brain Sciences* 2010; 33: 315–329; and open peer commentaries following on pp. 329–365.

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death. Those who take the opposing position that John's physicians allowed the death caused by his disease through disconnecting his ventilator assert a different moral judgment.

CONCLUSION

Both of the strategies discussed here of debunking the doing/allowing distinction begin by appealing to shared assessment practices; in one case of moral judgment, in the other of causal attribution from which moral judgment ostensibly follows. Advocates of these strategies take the practices to which they appeal as evidence for a given account of how morality works. For the contrasting cases strategy, we are to infer from the cases cited that aliquots of rightness and wrongness attach to (putatively) natural aspects of an action (such as whether said action is a doing or an allowing) in an invariable and additive fashion. And that such aliquots add up to an overall moral status that the action bears in given moral contexts. If these two propositions are true, the fact of moral condemnation attaching to human action in otherwise similar cases differing only as to whether said action is a doing or an allowing implies that the doing/allowing distinction has no moral relevance.

The 'common sense notion of causation' strategy presumes that moral judgment is a function of causal attribution; and that the way in which we pick out causally relevant human agency as 'the cause' (or not) of an outcome in a given range of cases will extend to all cases. So that we should first adjust our causal attributions to a 'common sense' causal notion – and then acknowledge that in cases of withdrawal of support and PAS, the common presence of physician causal agency precludes the possibility that these two practices can be morally distinguished in terms of doing and allowing.

The difficulty encountered by both strategies is that the range of cases invoked by each in support of its account of morality is not, in fact, representative of all cases. Rather than identifying the rationality behind a comprehensive set of shared moral practices in the form of a moral theory that makes these practices coherent, the strategies for debunking the doing/allowing distinction discussed here offer moral theory generated from some shared practices as a rationale for jettisoning others – in this instance, the moral judgments we typically make in many cases that there may be profound moral importance in whether an outcome to which we are causally relevant comes about through our doing or allowing it. Morality as we actually practice it is far more complex than either strategy acknowledges.

Moral theory does, of course, commonly serve to endorse some moral practices at the expense of others. And advocates of the doing/allowing distinction would surely acknowledge that the distinction is undertheorized – as advocates have not so far succeeded in capturing the distinction in a clear and descriptive specification that is both true to all of the ways in which it is commonly drawn and properly exclusive of counterexamples. That may be due to the distinction's fundamental incoherence, as its opponents would likely suggest; or, to the complexity of the ways in which human agency can involve moral responsibility in differing ways – as the distinction's adherents would maintain.

It is likely, perhaps, that fault lines in this debate go deeper than any conceptual analysis of doing and allowing can bridge. The kinds of moral theory friendly to the doing-allowing distinction or to its elimination track, more or less, deontology and consequentialism. The gulf between these approaches to moral theory remains wide and we should not, perhaps, expect a resolution of debate over the doing-allowing distinction sooner than that broader debate is resolved – if, indeed, we should expect any such resolution. Certainly, critics of the doing-allowing distinction have overreached in supposing that their views have so decisively undermined the distinction in medicine that psychological explanations for adhering to it can substitute for reasoned argument.

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