Washington Law Review

Volume 42 | Number 4

6-1-1967

Prolonging Life

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PROLONGING LIFE

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A physician decides not to prolong the life of a terminal patient. What are the legal consequences? Is it murder, akin to a gunman's pulling the trigger? Or is the law more sensitive? Professor Fletcher proposes that a decision to interrupt life-sustaining therapy, such as that to turn off a mechanical respirator, should be classified as an omission, not an act. He arrives at this conclusion by analyzing the common sense usages of "cause" and "permit." If the decision is an omission then the law must focus on the doctor-patient relationship to define legal consequences, allowing customary standards of the relationship to be the controlling criteria. Thus a heavy responsibility is placed on the medical profession to develop humane and sensitive standards for guiding decisions about prolonging life.

New medical techniques for prolonging life force both the legal and medical professions to re-examine their traditional attitudes toward life and death. New problems emerge from the following recurrent situation: A comatose patient shows no signs of brain activity; according to the best medical judgment, he has an infinitesimal chance of recovery; yet he can be sustained by a mechanical respirator. How long should his physician so keep him alive? And in making his decision, how much weight should the physician give to the wishes of the family, to the financial condition of the family and to the prospect that his time might be profitably used in caring for patients with a better chance of recovery?[1]

According to one line of thought, the physician's leeway in caring for terminal patients is limited indeed. He may turn off the respirator but only at the risk of prosecution and conviction for murder. The insensitive logic of the law of homicide, disregarding as it does the context of the purpose of the physician's effort, would prompt some to equate the physician's turning off the respirator with a hired gunman's killing in cold blood. The acts of both result in death; the actors intend that death should follow; and in neither case is the killing pro-

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[1] As evidenced by the extent of open and frank discussion of the problem, the medical community is deeply concerned about the extent of its legal and moral obligation to terminal patients. *See* Williamson, *Should the Patient be Kept Alive?*, 44 MEDICAL ECONOMICS 63 (1967); Ayd, *When is a Person Dead?*, 18 MEDICAL SCIENCE 33 (1967).

voked, excused or justified. Thus like the gunman, the physician is guilty of first degree murder.

The approach of equating the physician's turning off a mechanical respirator with the gunman's killing for hire is, to say the least, askew with reality. It totally misses the demands of the medical mission. It means that physicians must use modern devices for sustaining life with trepidation; they must proceed haltingly, unsure of the legal consequences of discontinuing therapy. It is of little solace to the medical practitioner that institutional facts check the cold rigor of the common law. True, his decisions in the operating room are minimally visible; not even the patient's family need learn whether death came "naturally" or upon the disruption of therapy. And even if it should become known to the family and the community that the physician's decision shortened the life span of the patient, it is unlikely that the physician should suffer. Common law courts have never convicted a medical practitioner either for shortening the life of a suffering, terminal patient or for refusing to render life-sustaining aid.[2] Yet men of goodwill wish to proceed not by predictions of what will befall them but by perceiving and conforming to their legal and moral obligations. No amount of Holmesian realism can persuade a physician that a prosecutor's willingness to look the other way may weaken his legal obligations.[3]

The apparent rigidity of the common law of homicide has evoked demands for reform. The proposals for vesting physicians with greater flexibility in caring for terminal patients are of two strands. The first is a movement toward instituting voluntary euthanasia, which would permit the medically supervised killing of patients who consent to

[2] The one known case in which a physician was brought to trial in a common law court for a "mercy-killing" occurred in 1950, when Dr. Norman Sanders was indicted for injecting air in the veins of his cancer-stricken patient. He confessed the deed, and the attending nurse testified that the patient was still "gasping" when the doctor injected the air. Nonetheless, the motive of mercy prompted the jury of laymen to acquit Dr. Sanders. *See* TIME, March 6, 1950 at 20 and New York Times, March 10, 1950 at 1, col. 6-7. As to omissions of doctors to render aid in the final stages of a patient's life, the record apparently is clear even of prosecutions. This is Kamisar's conclusion—based on extensive research. Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation,* 42 MINN. L. REV. 969, 982-83 n.41 (1958).

[3] The conflict is between Holmes' helpful but exaggerated insight that law is "what the courts will do in fact," O. W. HOLMES, *The Path of the Law* in COLLECTED LEGAL PAPERS 167-203 (1920), and the view that legal obligations present a standard for evaluating the conduct of others. Note H. L. A. Hart's succinct reply to the Holmes-inspired "realistic" definition of law: "So we say that we reprove or punish a man *because* he has broken the rule: and not merely that it was probable that we would reprove or punish him." H. L. A. HART, THE CONCEPT OF LAW 11 (1961).

death.[4] These proposals warrant continued discussion and criticism, but they apply only in cases of patients still conscious and able to consent to their own demise. Separate problems adhere to the cases of doomed, unconscious patients who may be kept alive by mechanical means. In the latter area, the movement for reform has stimulated the pursuit of a definition of death that would permit physicians to do what they will with the bodies of hopeless, "legally dead" patients. In France[5] and Sweden[6] as well as in the United States,[7] proponents of reform have urged the cessation of brain activity—as evidence by a flat electroencephalograph (EEG) reading—as the criterion of death. Setting the moment of legal death prior to the stilling of the heart is critical to those pressing for greater legal flexibility in transplanting vital organs from doomed patients to those with greater hopes of recovery. Waiting until the heart fails makes transplanting difficult, if not impossible. At stake in the pursuit of a legal definition of death is the prospect of a vast increase in the supply of kidneys and some day, of livers, hearts and ovaries for the purpose of transplanting. The reliance on the concept of death, however, is a verbal detour. The reformers are concerned about two practical decisions: (1) when can a physician legally discontinue aid to a patient with an infinitesimal chance of recovery; and (2) when can a physician legally remove organs from a terminal patient. To resolve these problems, one need not construct a concept of legal death. Concern for the moment of death presupposes: (1) that both of these decisions should depend on the same criteria; and (2) that the controlling criteria should be medical facts, rather than the host of criteria relating to the patient's

[4] For a current debate on the problem see Williams, *Euthanasia and Abortion*, 38 U. COLO. L. REV. 178 (1966); Williams, *"Mercy-Killing" Legislation—A Rejoinder*, 43 MINN. L. REV. 1 (1958); Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969 (1958). Those interested in a general survey of this and related problems might consult either G. WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW (1957) [hereinafter cited as WILLIAMS] or N. ST. JOHN-STEVAS, LIFE, DEATH AND THE LAW (1961).

[5] The recommendation of the French Academy of Medicine is reported in Gould, *When is Death?*, 71 NEW STATESMAN 841-42 (1966).

[6] Professor Clarence C. Crafoord of the Karolinska Institute in Stockholm is a leading advocate of the cessation of brain activity as the criterion of death. A team of surgeons at his clinic recently trasplanted a kidney from a dying woman with "irreparable" brain damage into a patient with kidney disease. *See* Note, 34 MODERN MEDICINE 88 (1966). *Compare* the case of Potter in England, in which a kidney was similarly removed from a patient "living" on an artificial respirator. Note, 31 MEDICO-LEGAL JOURNAL 195 (1963).

[7] *See* Hamlin, *Life or Death by EEG*, 190 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 112 (1964) for a multi-factoral approach to the concept of death, which turns primarily on the absence of spontaneous respirator and brain activity for a

financial condition and to the importance of the physician's time and of the machinery used in sustaining life.

Rather than promote either the movement for voluntary euthanasia or the search for a new definition of death, this paper shall propose a third technique for loosening the legal vice currently worrying the medical community. We can furnish practicing physicians at least some flexibility in the operating room by invoking a more sensitive interpretation of the law as it now stands. To loosen the legal vice of the law of homicide, we need only take a closer look at its pinions. We need to question each of the steps leading to the view that the physician's turning off a respirator or a kidney machine is an act subjecting him to tort and criminal liability for homicide.

There are only a few points at which the structure can give. Consider the applicable elements of common law murder: (1) an act resulting in death, (2) an intent to inflict death, (3) malice aforethought, (4) absence of defenses. Beginning at the end of the list, one is hard pressed to justify or excuse the killing by invoking a recognized defense. If the common law courts were more amenable to a general defense of necessity in homicide cases,[8] one could argue that if another patient had a superior likelihood of recovery using the machine, the attending physician would be warranted in removing a patient from the machine who was then dependent upon it for his life. A defense of this sort could serve as a welcome guide to those concerned about the legal limits of allocating the use of kidney machines. The appropriate foothold for the defense would be a physician's common law prerogative to abort a fetus when necessary to save the life of the mother.[9] Yet that defense is premised on the judgment that the life of the mother represents a more worthy interest than that of the unborn child; when it comes to a choice between the two, the mother has a superior right to live. One is advisedly wary of the analogical claim

period of 60 minutes. Cautiously, Dr. Hamlin advises medical practitioners: share the responsibility for pronouncing death with your colleagues. *See also* Wasmuth, *Legal Aspects of Organ Transplantation*, 46 ANESTHESIA & ANALGESIA 25 (1967).

[8] Since the cases of The Queen v. Dudley and Stephens, 14 Q.B. 273 (1884), and United States v. Holmes, 26 Fed. Cases 360, (No. 15,383) (E.D. Pa. 1842), one can hardly speak of a common law defense of necessity in homicide cases. The reason seems to be the common law insistence that defenses be based on moral considerations; it is not enough to ground a defense to say that upright people would have acted the same way under the same circumstances. German criminal theory, on the other hand, is much more amenable to excusing behavior that is morally and socially wrongful. A present danger to the life or limb of the actor will excuse his killing to avoid the danger. SCHOENKE-SCHROEDER, STRAFGESETZBUCH § 54.

[9] Rex v. Bourne, [1939] 1 K.B. 687 (1938) (recognizing the defense of therapeutic abortion as a matter of common law). WILLIAMS, *supra* note 4, at ch. 5; R. PERKINS, CRIMINAL LAW 106 (1957).

that the patient with the greater likelihood of recovery has a superior right to live. We have lived too long with the notion that all human beings have an equal claim to life.[10]

If the prospects of a defense are questionable, forays on the issues of intent and malice seem hopeless. The aim of the physician's behavior may not be to kill, yet he knows that death is certain to follow if he interrupts therapy to free the respirator for another patient. And knowledge that death is certain to follow is enough to say, at least according to the dictionary of the law, that he "intends" death to result from his conduct.[11] Also, it is too late in the evolution of the common law to make the concept of malice mean what it purports to mean, namely ill will, base motives and the like. Surely, the man on the street would not say that a physician is malicious in breaking off his care of a fated patient. Indeed, in the interest of saving the family from financial ruin or directing his efforts more profitably, it might be the humane thing to do. Yet the common law long ago betrayed the ordinary English background of its rule that a man must kill "maliciously" to be guilty of murder. The rigors of distinguishing good motives from bad and the elusiveness of motive as an object of prosecutorial proof gave way nearly four centuries ago to the concept of implied malice and thus to the functional demise of malice as a tool for drawing important distinctions in the law of homicide.[12]

It appears that there is only one stage in the structure that might

[10] Judicial support for the defense may be found in decisions by the High Court for the British Zone in Germany, which established a defense for doctors who participated in Hitler's program of voluntary euthanasia for mental defectives. The doctors could escape punishment (though they were deemed morally guilty) by proving their claim that they exercised special efforts to minimize the number killed in the program, and that if other doctors had been in charge more would have died. 1 Entscheidungen des Obersten Gerichtshofs für die Britische Zone 321 (1949); *2 id.* at 117 (1949). From these decisions, the legal writers extrapolated a new defense, called extralegal excuse, which would excuse anyone caught in a conflict of moral duties, *e.g.*, to a patient on the machine and to another who was more likely to be saved by its use. H. WELZEL, DAS DEUTSCHE STRAFRECHT at 163 (1963). *Compare* the MODEL PENAL CODE § 3.02 (choice of evils) (Prop. Off. Draft. 1962).

[11] As a matter of ordinary usage, one would not say that the physician intended to kill when he turned off the machine in order to make it available for another patient. Yet the law treats cases of acting with the belief that consequences are substantially certain to follow as cases of intending those consequences. RESTATEMENT (SECOND) OF TORTS § 8A (1965). The Catholic doctrine of double effect is sensitive to the distinction between the aim of conduct and its unavoidable consequences; presumably, the doctrine supports the view that the physician's turning off the respirator in order to help someone else was an indirect, and thus a permissible, killing. *See* WILLIAMS, *supra* note 4, at 200-05.

[12] The leading case is Mackalley's Case, 9 Co. Rep. 65b, 77 E.R. 828 (1611), which held that the prosecution was not required to produce evidence of malice in order to secure a conviction of murder. This was the first step toward equating the concept of malice with the absence of malice-defenses, *e.g.*, provocation. *See generally* R. PERKINS, CRIMINAL LAW 31 (1957).

readily yield under analysis. That is the initial claim that the turning off of a mechanical respirator is an act resulting in death. The alternative would be to regard the flipping of the switch as an omission, a forebearance—a classification that would lead to a wholly different track of legal analysis. It seems novel to suggest that flipping a switch should count as an omission. For like the act of the gunman in pulling a trigger, flipping a switch represents an exertion of the will. It is bodily movement, and for many, that would be enough to say that the behavior constitutes an act, not an omission.[13] Yet as I shall argue in this essay, the turning off of a mechanical respirator should be classified as an omission. It should be regarded on a par with the passivity of that infamous passerby who gleefully watches a stranded child drown in a swimming pool. As we shall see, this view of the problem has vast implications for advising physicians of their legal leeway in rendering therapy to terminal patients.

Much of what follows is an exercise in conceptual analysis. It is an effort to devise a test for determining which of two competitive schemes —that for acts or that for omissions—should apply in analyzing a given question of responsibility for the death of another. It is significant inquiry, if only to add a word to the discussion of the ponderous legal quandaries of physicians who care for terminal patients. The problem is also of wider significance for the theory of tort and criminal liability. The area of liability for omissions bristles with moral, analytic and institutional puzzles.[14] In the course of this inquiry, we shall confront some of these problems and others we shall catalogue in passing.[15]

[13] This would follow from Holmes' definition of an act as a "muscular contraction resulting from an operation of the will." O. W. HOLMES, THE COMMON LAW 54 (1938 ed.). The definition is of continuing prestige. *See* RESTATEMENT (SECOND) OF TORTS § 2 ("external manifestation of the actor's will") (1965); R. PERKINS, CRIMINAL LAW 475 n.20 (1957) ("exertions of the will manifested in the external world"). For a masterful critique of this definition of acting see H. Morris, Book Review, 13 STAN. L. REV. 185 (1960). *See also* Prosser's insightful comments on the difficulty of drawing the line between acts and omissions. W. PROSSER, TORTS 335 (3d ed. 1964).

[14] Bohlen, *The Basis of Affirmative Obligations in the Law of Tort*, 53 AM. L. REG. 209, 237, 337 (1905); Gregory, *Gratuitous Undertakings and the Duty of Care*, 1 DE PAUL L. REV. 30 (1951); Rudolph, *The Duty to Act: A Proposed Rule*, 44 NEB. L. REV. 499 (1965) (a well-considered and thoughtful proposal for reform of the common law rule); Hughes, *Criminal Omissions*, 67 YALE L. J. 590 (1957); Kirchheimer, *Criminal Omissions*, 55 HARV. L. REV. 615 (1942) (including interesting comparative and historical notes). Of special interest is the excellent collection of articles in THE GOOD SAMARITAN AND THE LAW (J. Ratcliffe ed. 1966).

[15] A catalogue of unresolved problems in the area of omissions would include the following:

1. As a matter of principle, should the area of omissions be regarded as instances of negligent or of intentional behavior? The law of torts opts the

II

The question is posed: Is the physicians' discontinuing aid to a terminal patient an act or omission? To be sure, the choice of legal track does not yield radically different results. For some omissions, physicians are liable in much the same way as they are for unpermitted operations and negligent treatment. One need only consider the following turn of events. Doctor Brown is the family doctor of the Smith family and has been for several years. Tim Smith falls ill with pneumonia. Brown sees him once or twice at the family home and administers the necessary therapy. One evening, upon receiving a telephone call from the Smith family that Tim is in a critical condition, Dr. Brown decides that he should prefer to remain at his bridge game than to visit the sick child. Brown fails to render aid to the child; it is clear that Brown would be liable criminally and civilly if death should ensue.[16] That he has merely omitted to act, rather than asserted himself intentionally to end life, is immaterial in assessing his criminal and civil liability. Of course, the doctor would not be under an obligation to respond to the call of a stranger who said that he needed help. But there is a difference between a stranger and someone who has placed himself in the care of a physician. The factor of reliance and reasonable expectation that the doctor will render aid means that the doctor is legally obligated to do so.[17] His failure to do so is then

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former; the law of crimes admits of both. Why the discrepancy? And which approach is preferable?

2. Does the criminal law of omissions function to single out malicious wrongdoers or does it function rather to isolate those individuals who are simply unable to stay abreast of their responsibilities? The latter suggestion, novel as it is, acquires plausibility upon an examination of the cases. *See, e.g.*, Stehr v. State, 92 Nebr. 755, 139 N.W. 676 (1913) (D allowed his bed-wetting child to sleep, wet and freezing, without building a fire or providing blankets; conviction of manslaughter sustained); People v. Chavez, 77 Cal. App. 2d 621, 176 P.2d 92 (1947) (D thought labor pains were cramps, gave birth on toilet, allowed child to die in bowl; conviction of manslaughter sustained). Are these defendants wrongdoers? Or are they people simply incapable of functioning in organized society?

3. In determining whether one has a duty to act, should one distinguish between tort and criminal liability? The courts and the commentators interbreed duties from one area of law to the other; should not there be distinctions based on the divergent functions of compensation and of correction?

[16] The Queen v. Instan, [1893] 1 Q.B. 450 (D had undertaken to care for her aged aunt. The aunt suffered from gangrene of the leg. D failed to provide assistance or to advise others of her aunt's condition. Conviction for manslaughter affirmed.). Mehigan v. Sheehan, 94 N.H. 274, 51 A.2d 632 (1947) (a physician, D, failed to respond promptly to the call of his patient, P, who complained of labor pains. P gave birth alone, and she sought damages in tort for the pain resulting from D's nonattendance at the birth. Nonsuit reversed.).

[17] Other relationships of reliance giving rise to duties of care are those of carrier and passenger, innkeeper and guest, ship captain and seaman, school master and pupil. W. PROSSER, TORTS 337 (3d ed. 1964).

tantamount to an intentional infliction of harm. As his motive, be it for good or ill, is irrelevant in analyzing his liability for assertive killing, his motive is also irrelevant in analyzing his liability for omitting to render aid when he is obligated to do so.

Thus, it makes no difference whether a doctor omits to render aid because he prefers to continue playing bridge or if he does so in the hope that the patient's misery will come quickly to a natural end. A doctor may be criminally and civilly liable either for intentionally taking life or for omitting to act and thus permitting death to occur. However, the sources of these two legal proscriptions are different. And this difference in the source of the law may provide the key for the analysis of the doctor's liability in failing to prolong life in the case discussed at the outset of this article. That a doctor may not actively kill is an application of the general principle that no man may actively kill a fellow human being. In contrast, the principle that a doctor may not omit to render aid to a patient justifiably relying upon him is a function of the special relationship that exists between doctor and patient. Thus, in analyzing the doctor's legal duty to his patient, one must take into consideration whether the question involved is an act or an omission. If it is an act, the relationship between the doctor and patient is irrelevant. If it is an omission, the relationship is all controlling.

With these points in mind, we may turn to an analysis of specific aspects of the medical decision not to prolong life. The first problem is to isolate the relevant medical activity. The recurrent pattern includes: stopping cardiac resuscitation, turning off a respirator, a pacemaker or a kidney machine, and removing the tubes and devices used with these life-sustaining machines. The initial decision of classification determines the subsequent legal analysis of the case. If turning off the respirator is an "act" under the law, then it is unequivocally forbidden: it is on a par with injecting air into the patient's veins. If, on the other hand, it is classified as an "omission," the analysis proceeds more flexibly. Whether it would be forbidden as an omission would depend on the demands imposed by the relationship between doctor and patient.

There are gaps in the law; and we are confronted with one of them. There is simply no way to focus the legal authorities to determine whether the process of turning off the respirator is an act or an omission. That turning off the respirator takes physical movement need not

be controlling. There might be "acts" without physical movement, as, for example, if one should sit motionless in the driver's seat as one's car heads toward an intended victim. Surely that would be an act causing death; it would be first-degree murder regardless of the relationship between the victim and his assassin. Similarly, there might be cases of omissions involving physical exertion, perhaps even the effort required to turn off the respirator. The problem is not whether there is or there is not physical movement; there must be another test.

That other test, I should propose, is whether on all the facts we should be inclined to speak of the activity as one that causes harm or one merely that permits harm to occur. The usage of the verbs "causing" and "permitting" corresponds to the distinction in the clear cases between acts and omissions. If a doctor injects air into the veins of a suffering patient, he causes harm. On the other hand, if the doctor fails to stop on the highway to aid a stranger injured in an automobile accident, he surely permits harm to occur, and he might be morally blameworthy for that; but as the verb "cause" is ordinarily used, his failing to stop is not the cause of the harm.[18]

As native speakers of English, we are equipped with linguistic sensitivity for the distinction between causing harm and permitting harm to occur. That sensitivity reflects a common sense perception of reality; and we should employ it in classifying the hard cases arising in discussions of the prolongation of life. Is turning off the respirator an instance of causing death or permitting death to occur? If the patient is beyond recovery and on the verge of death, one balks at saying that the activity causes death. It is far more natural to speak of the case as one of permitting death to occur. It is significant that we are inclined to refer to the respirator as a means for prolonging life; we would not speak of insulin shots for a diabetic in the same way. The use of the term "prolongation of life" builds on the same perception of reality that prompts us to say that turning off the respirator is an activity permitting death to occur, rather than causing death. And that basic perception is that using the respirator interferes artificially in the pattern of events. Of course, the perception of the natural and of the artificial is a function of time and culture. What may seem artificial today, may be a matter of course in ten years. Nonetheless, one *does* perceive many uses of the respirator today as artificial

[18] For the sake of exposition, the thesis is put simply at this stage; it receives some adjustment below. *See* text at 1013-14.

prolongations of life. And that perception of artificiality should be enough to determine the legal classification of the case. Because we are prompted to refer to the activity of turning off the respirator as activity permitting death to occur, rather than causing death, we may classify the case as an omission, rather than as an act.

To clarify our approach, we might consider this scenario. A pedestrian D notices that a nearby car, parked with apparently inadequate brakes, is about to roll down hill. P's house is parked directly in its path. D rushes to the front of the car and with effort he is able to arrest its movement for a few minutes. Though he feels able to hold back the car for several more minutes (time enough perhaps to give warning of the danger), he decides that he has had enough; and he steps to one side, knowing full well that his quarry will roll squarely into P's front yard. That is precisely what it does. What are P's rights against D? Again, the problem is whether the defendant's behavior should be treated as an act or as an omission. If it is act, he is liable for trespass against P's property. If it is an omission, the law of trespass is inapplicable; and the problem devolves into a search for a relationship between P and D that would impose on D the duty to prevent this form of damage to P's property.[19] Initially, one is inclined to regard D's behavior as an act bringing on harm. Like the physician's turning off a respirator, his stepping aside represents physical exertion. Yet as in the physician's case, we are led to the opposite result by asking whether under the circumstances D caused the harm or merely permitted it to occur. Surely, a newspaper account would employ the latter description; D let the car go, he permitted it to roll on, but he is no more a causal factor than if he had not initially intervened to halt its forward motion. We deny D's causal contribution for reasons akin to those in the physician's case. In both instances, other factors are sufficient in themselves to bring on the harmful result. As the car's brakes were inadequate to hold it on the hill, so the patient's hopeless condition brought on his death. With sufficient causal factors present, we can imagine the harm's occurring without the physician's or the pedestri-

[19] The directness of injury in Trespass obviated the need to inquire as to the relationship between plaintiff and defendant. A man owed a duty to every other man not to trespass on his property, against his person, or to carry away his goods. Nonfeasance, where one had to inquire as to duty, was consistently litigated on a writ of Trespass on the Case. *See* F. MAITLAND, THE FORMS OF ACTION AT COMMON LAW 65-68 (1936); A. KIRALFY, THE ACTION ON THE CASE 59-61 (1951). We need to know more about the connection between the malfeasance-nonfeasance distinction in the evolution of the writ of Trespass on the Case and the parallel distinction that emerged in criminal cases.

an's contribution. And thus we are inclined to think of the behavior of each as something less than a causal force.[20]

One might agree that as a matter of common sense, we can distinguish between causing harm and permitting harm to occur and yet balk at referring to the way people ordinarily describe phenomena in order to solve hard problems of legal policy. After all, what if people happen to describe things differently? Would that mean that we would have to devise different answers to the same legal problems? To vindicate a resort to common sense notions and linguistic usage as a touchstone for separating acts from omissions, we must clarify the interlacing of these three planes of the problem: (1) the distinction between acts and omissions, (2) the ordinary usage of the terms "causing" and "permitting" and (3) resorting in cases of omissions, but not in cases of acts, to the relationship between the agent and his victim in setting the scope of the agent's duties. The question uniting the second and third variables is this: Is there good reason for being guided by the relationship between the parties in cases where the agent has permitted harm to occur, but not in cases where the agent has intentionally and directly caused harm to a stranger? To answer this question, we need to turn in some detail to the function of causal judgments in analyzing liability, whereupon we may clarify the link between the first and second variables of the analysis, namely between the category of omissions and the process of permitting harm to occur.

Ascribing liability for tortious and criminal harm may be looked upon as a two-stage process. The first stage is the isolation of a candidate for liability. In virtually all dimensions of the law of crimes and torts, we rely upon the concept of causation to separate from the mass of society those individuals who might prove to be liable for the proscribed harm. Upon reducing the number of potentially liable parties to those that have caused the harm, the final stage of analysis demands an evaluation of the facts under the apt rules of liability, *e.g.*, those prescribing negligence and proximate cause as conditions for liability.

The one area of the law where one has difficulty isolating candidates for liability is the area of omissions. When others have stood by and permitted harm to occur, we either have too many candidates for

[20] This conclusion is supported by the German theory of conditions (*Bedingungstheorie*), which holds that a factor is not casual if one can imagine the same sequence of events in the absence of that factor. H. L. A. HART & A. M. HONORE, CAUSATION IN THE LAW 391-92 (1959).

liability or we have none at all. A helpless old woman succumbs to starvation. Many people knew of her condition and did nothing; the postman, her hired nurse, her daughter, the bill collector, the telephone operator—each of them allowed her to die. Could we say, on analogy to causing death, that permitting the death to occur should serve as the criterion for selecting these people as candidates for liability? If we say that all of them are candidates for liability, then the burden falls to the criteria of fault to decide which of them, if any, should be liable for wrongful death and criminal homicide. The problem is whether the criteria of fault are sufficiently sensitive to resolve the question of liability. What kinds of questions should we ask in assessing fault? Did each voluntarily omit to render aid? Did any one of them face a particular hazard in doing so? Were any of them in a particularly favorable position to avert the risk of death? If these are the questions we must ask in assessing fault and affixing liability, we are at a loss to discriminate among the candidates for liability. Each acted voluntarily with knowledge of the peril; none faced personal hazard in offering assistance; and their capacities to avert the risk were equal. Thus, we may use the concept of permitting as we do the notion of causation to narrow the field to those who should be judged on criteria of fault. But if we do, the criteria of fault are useless (at least in the type of case sketched here) for discriminating among the candidates.

One wonders why this is so. In the arena of caused harms, one may have a large number of candidates for liability. The conventional test of causing harm sweeps wide in encompassing all those but for whose contribution the harm would not have occurred. Yet the criteria of liability—reasonableness of risk, ambit of risk, proximate cause—are effective in further reducing the field to those we might fairly hold liable. The reason is that each causal agent is chargeable with a different risk that loss of the given kind would occur. The risks differ in quantum and scope. Some bear a remote relationship to the harm; others seem reasonable in light of other circumstances. These differences in the posture of each causal agent toward the risk of harm enable us to assess their individual fault with some sensitivity.

In contrast, those who permit harm to occur do not bear individualized responsibility for the risk of harm. Their status derives not from the creation of the risk, but merely from knowledge that the risk exists and from the opportunity to do something about it. One could speak of the likelihood that each could avert the harm. And in some

cases, this approach might be useful; a doctor's failing to render aid to a man lying in the street is more egregious than a layman's turning the other way. Yet in the general run of case—the starvation of the old woman discussed above, the Kitty Genovese incident[21]—the risks assignable to passive bystanders are of the same murky order: each could have done something but did not.

Even if a man might be charged with a specific risk for having failed to avert harm, it is often difficult to assess the reasonableness of his permitting that likelihood of harm. Causal agents take risks that are evaluated by reference to the agent's reasons for acting. A motorist risks the death of others by embarking on an automotive trip, yet the risk is reasonable in light of his conventionally acceptable purpose of travelling by car. One cannot so readily evaluate the risks ascribable to those who fail to avert harm. Men generally do not further their goals by letting events turn as they may.[22] Is it reasonable or unreasonable for a father to let his 16-year-old son participate in drag races on the city streets? He promotes no end of his own by failing to intervene. His reasons are those of indifference and fear of involvement—the same reasons that prompted 38 people in New York City to witness the murder of Kitty Genovese. Reasons of this kind do not lend themselves to a calculus of reasonableness: how does one weigh a man's fear of involvement against the occurrence of harm? And without a calculus of reasonableness, one may hardly expect to discern differences in the personal fault of those who permit harm to occur.

Affixing liability fairly in cases of omission requires a more sensitive filtering mechanism prior to the application of the traditional criteria of personal fault. The concept of permitting harm sweeps too wide; and the criteria of personal fault tend to be of little avail in narrowing the field. Thus one can understand the role of the relationship between the parties as a touchstone of liability. Legal systems, both common law and Continental,[23] have resorted to the relationship between the parties as a device for narrowing the field to those individuals whose liability may be left to depend on personal fault. According to the

[21] Thirty-eight people in New York City watched and listened as Kitty Genovese was murdered outside their apartment building, 198 NATION 602-04 (1964).

[22] Of course, there are some cases in which a man omits to act in order to continue pursuing another goal, *e.g.*, a doctor refuses to heed the call of patient in order to attend to someone in greater need.

[23] *See* R. MAURACH, DEUTSCHES STRAFRECHT, ALLGEMEINER TEIL 510-19 (3d ed. 1966); F. J. FELDBRUGGE, SOVIET CRIMINAL LAW 100 (Law in Eastern Europe No. 9, 1964).

conventional rules, the old woman's nurse and daughter are candidates potentially liable for permitting death to occur. Liability would rest on personal fault, primarily on the voluntariness of each in omitting to render aid. Thus the conventional rules as to when one has a duty to render aid fulfill the same function as the causal inquiry in its domain: these rules, like the predication of causation, isolate individuals whose behavior is then scrutinized for the marks of negligent and intentional wrongdoing.

By demonstrating the parallel between the causal concept in cases of acts and the relationship between the parties in cases of omissions, we have come a long way in support of our thesis. We have shown that in cases of permitting harm to occur, one is required to resort to the relationship between the parties in order fairly to select those parties whose liability should turn on criteria of personal fault. In the absence of a causal judgment, with its attendant assignment of differentiated responsibility for the risk of harm, one can proceed only by asking: Is this the kind of relationship, *e.g.*, parent-child, doctor-patient, in which one person ought to help another? And on grounds ranging from common decency to contract, one derives individual duties to render aid when needed.[24]

One step of the argument remains: the conclusion that cases of permitting harm are instances of omissions, not of acts. This is a step that turns not so much on policy and analysis, as on acceptance of the received premises of the law of homicide. One of these premises is that acting intentionally to cause death is unconditionally prohibited: the relationship between the defendant and his victim is irrelevant. One may resort to the relationship between the parties only in cases of omissions indirectly resulting in harm.[25] With these two choices and no others, the logic of classification is ineluctable. Cases of permitting harm, where one must have recourse to the relationship between the parties, cannot be classified as cases of acts: to do so would preclude excusing the harm on the ground that the

[24] The tendency toward increasing the number of situations in which one person must come to the aid of another has focused attention on the general duty to rescue provisions of several European criminal codes. *See* Feldbrugge, *Good and Bad Samaritans: A Comparative Survey of Criminal Law Provisions Concerning Failure to Rescue*, 14 AM. J. COMP. L. 630 (1966); Rudzinski, *The Duty to Rescue: A Comparative Analysis*, in THE GOOD SAMARITAN AND THE LAW 91 (Ratcliffe ed. 1966).

[25] *E.g.*, Rex v. Smith, 2 Car. & P. 448, 172 E.R. 203 (Gloucester Assizes 1826) (The analysis of criminality of D for failing to care for an idiot brother turns on whether keeping the brother locked up was an act or omission. Finding the latter, the court held that the defendant bore no duty to aid his brother and directed an acquittal). *Compare* the discussion *supra* note 19.

relationship between the parties did not require its avoidance. Thus, to permit recourse to relationship of the parties, one must treat cases of permitting harm as cases of omissions.

To complete our inquiry, we need attend to an asymmetry in the analysis of causing and permitting. As Professors Hart and Honore have shown,[26] some omissions may be the causes of harm.[27] And thus, the category of causing harm includes some cases of omitting as well as all cases of acting to bring on harm. Suppose, for example, that an epileptic regularly takes pills to avert a seizure. Yet on one occasion he omits to take the pills in the hope that he is no longer required to. He has a seizure. The cause of his seizure is clear: he omitted to take the prescribed pill. In the same way, a physician failing to give a diabetic patient a routine shot of insulin would be the cause of harm that might ensue. The taking of the pill and the giving of the shot are the expected state of affairs. They represent normality, and their omission, abnormality. Because we anticipate the opposite, the omission explains what went wrong, why our expectations were not realized. In contrast, if pills to avert epileptic seizures had just been devised, we would not say as to someone who had never taken the pills that his failure to do so had brought on his attack. In that case, our expectations would be different, the omission to take pills would not represent an abnormality, and the anticipated omission would not be a satisfying causal explanation of the attack.[28]

A doctor's failure to give his diabetic patient an insulin shot is a case warranting some attention. By contemporary standards, insulin shots, unlike mechanical respirators, do not interfere artificially in the course of nature; because the use of insulin is standard medical practice, we would not describe its effect as one of prolonging life. We

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[26] H. L. A. HART & A. M. HONORE, CAUSATION IN THE LAW 35-36 (1957).

[27] Courts frequently proceed as though there could be no criminal liability without a causal relationship. *E.g.*, State v. Lowe, 66 Minn. 296, 68 N.W. 1094 (1896) (conviction for murder in the third degree reversed *inter alia* for failure of the indictment to allege that D's neglect and omission caused the death of his victim). But this is not the universal practice of common law courts; note this passage from the leading case of The Queen v. Instan, [1893] 1 Q.B. 450 (1893) (conviction of niece for neglecting aunt with whom she was then living, affirmed): "Nor can there be any question that the failure of the prisoner to discharge her legal duty at least accelerated the death of the deceased, if it did not actually cause it." *Id.* at 454. Some writers have mistakenly assumed that causation is a condition of liability for omissions as well as for acts. Hughes, *Criminal Omissions*, 67 YALE L. J. 590, 727 (1958); J. HALL, GENERAL PRINCIPLES OF CRIMINAL LAW 195 (2d ed. 1960). Admittedly, courts use the terms "causing" and "causation" in cases of omission far more liberally than is urged in this article.

[28] The relationship between expectations and causation is developed more fully in HART & HONORE, *supra* note 26, ch. 2.

would not say that withholding the shot permits death; it is a case of an omission causing harm. With the prohibition against causing death, one should not have to refer to the doctor-patient relationship to determine the criminality of the doctor's omission. Yet in fact, common law courts would ground a conviction for omitting to give the shot on the doctor's duty to render aid to his patient—a duty derived from the doctor-patient relationship. Thus we encounter an apparent inconsistency: a case of causing in which one resorts to the relationship of the parties to determine criminality. We can reconcile the case with our thesis by noting that cases of omissions causing harm possess the criteria—regularity of performance and reliance—that give rise to duties of care. The doctor is clearly under a duty to provide his patient with an insulin shot if the situation demands it. And the duty is so clear precisely because one expects an average doctor in the 1960's to use insulin when necessary; this is the same expectation that prompts us to say that his failure to give the shot would be the cause of his patient's death.

That an omission can on occasion be the cause of harm prompts us slightly to reformulate our thesis. We cannot say that causing harm may serve as the criterion for an act as opposed to an omissions because some instances of causation are omissions. But we may claim with undiminished force that permitting harm to occur should be sufficient for classification as an omission. Upon analysis, we find that our thesis for distinguishing acts from omissions survives only in part; it works for some omissions, but not for all. Yet, so far as the stimulus of this investigation is concerned, the problem of physicians permitting death to come to their terminal patients, the thesis continues to hold: permitting a patient to die is a case in which one appropriately refers to the relationship of the parties to set the scope of the physician's legal duty to his patient; in this sense it functions as an omission in legal analysis.

III

By permitting recourse to the doctor-patient relationship in fixing the scope of the doctor's duties to his patient, we have at least fashioned the concepts of the common law to respond more sensitively to the problems of the time. We have circumvented the extravagant legal conclusion that a physician's turning off a kidney machine or a respirator is tantamount to murder. Yet one critical inquiry remains. How does

shunting the analysis into the track of legal omissions actually affect the physician's flexibility in the operating room? We say that his duties are determined by his relationship with his patient; specifically, it is the consensual aspect of the relationship that is supposed to control the leeway of the physician. Yet there is some question as to where the control actually resides.

To take a clear case, let us suppose that prior to the onset of a terminal illness, the patient demands that his physician do everything to keep him alive and breathing as long as possible. And the physician responds, "Even if you have a flat EEG reading and there is no chance of recovery?" "Yes," the patient replies. If the doctor agrees to this bizaare demand, he becomes obligated to keep the respirator going indefinitely. Happily, cases of this type do not occur in day-to-day medical practice. In the average case, the patient has not given a thought to the problem; and his physician is not likely to alert him to it. The problem then is whether there is an implicit understanding between physician and patient as to how the physician should proceed in the last stages of a terminal illness. But would there be an implicit understanding about what the physician should do if the patient is in a coma and dependent on a mechanical respirator? This is not the kind of thing as to which the average man has expectations. And if he did, they would be expectations that would be based on the customary practices of the time. If he had heard about a number of cases in which patients had been sustained for long periods of time on respirators, he might (at least prior to going into the coma) expect that he would be similarly sustained.

Thus, the analysis leads us along the following path. The doctor's duty to prolong life is a function of his relationship with his patient; and in the typical case, that relationship devolves into the patient's expectations of the treatment he will receive. Those expectations, in turn, are a function of the practices prevailing in the community at the time, and practices in the use of respirators to prolong life are no more and no less than what doctors actually do in the time and place. Thus, we have come full circle. We began the inquiry by asking: Is it legally permissible for doctors to turn off respirators used to prolong the life of doomed patients? And the answer after our tortuous journey is simply: It all depends on what doctors customarily do. The law is sometimes no more precise than that.

The conclusion of our circular journey is that doctors are in a

position to fashion their own law to deal with cases of prolongation of life. By establishing customary standards, they may determine the expectations of their patients and thus regulate the understanding and the relationship between doctor and patient. And by regulating that relationship, they may control their legal obligations to render aid to doomed patients.

Thus the medical profession confronts the challenge of developing humane and sensitive customary standards for guiding decisions to prolong the lives of terminal patients. This is not a challenge that the profession may shirk. For the doctor's legal duties to render aid derive from his relationship with the patient. That relationship, along with the expectations implicit in it, is the responsibility of the individual doctor and the individual patient. With respect to problems not commonly discussed by the doctor with his patient, particularly the problems of prolonging life, the responsibility for the patient's expectations lies with the medical profession as a whole.