

ACTMISSIONS

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ABSTRACT

Most observers agree that it is morally worse to cause harm by engaging in an act than to contribute to producing the same harm by an

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omission. As a result, American criminal law punishes harmful omissions less than similarly harmful acts, unless there are exceptional circumstances that warrant punishing them equally. Yet there are many cases in which actors cause harm by engaging in conduct that can be reasonably described as either an act or an omission. Think of a doctor who flips a switch that discontinues life support to a patient. If the patient dies as a result, did the doctor kill the patient (an act) or did he let the patient die (an omission)? The majority of legal scholars and philosophers believe that disconnecting life support is an omission, even if flipping a switch amounts to a willed bodily movement that is most obviously described as an act. Others have argued that these cases demonstrate that the act/omission distinction collapses in borderline cases. In contrast, this Article argues that these cases are best described as “actmissions” that are less blameworthy than actions yet more blameworthy than omissions. The person who causes the death of another by pressing a button that discontinues life support engages in conduct that shares certain important features of actions (willed bodily movement) and omissions (failure to continue to provide medical treatment). The same is true of the person who begins rescue (throws a rope to a fellow climber) and then engages in an act that terminates rescue (cuts the rope). The full import of such conduct cannot be grasped until the simultaneous omissive and active nature of such fact patterns is acknowledged. This, in turn, helps explain why both the passive euthanasia cases and the duty to rescue tort cases remain controversial despite the fact that courts have framed them as cases of mere omissions to continue life saving measures.

I. INTRODUCTION

The act requirement is a bedrock principle of criminal law.¹ Despite its importance, it is also widely acknowledged that there are exceptions to the act requirement. While it is true that criminal liability typically requires an act, punishment is often imposed for failures to act (omissions).² While there is much disagreement as to when punishing omissions is warranted, most scholars agree that deviating from the act requirement requires special justification.³ They also agree that special justification is needed when deviating from the act requirement because—all things being equal—it is morally worse to help bring about harm by engaging in an act than to contribute to produce the same harm

¹ See, e.g., PAUL ROBINSON, *FUNDAMENTALS OF CRIMINAL LAW* 117 (1988); see also *State v. Eaton*, 229 P.3d 704, 707 (Wash. 2010) (en banc); OLIVER WENDELL HOLMES, *THE COMMON LAW* 46 (1881).

² Punishment is also imposed for possession of certain items. It is unclear whether possession is an act, an omission or a state of affairs that is neither an act nor an omission. See Douglas Husak, *Rethinking the Act Requirement*, 28 *CARDOZO L. REV.* 2437, 2438–46 (2007).

³ *Id.* at 2438.

by an omission.⁴ As a result, American criminal law punishes harmful omissions less than similarly harmful acts, unless there are exceptional circumstances that warrant punishing them equally.⁵ But how much should we punish actors who cause harm by engaging in conduct that can be reasonably described as either an act or an omission?

Consider the following examples. A doctor flips a switch that disconnects life support to a patient. The patient dies as a result. Did the doctor kill the patient (an act) or did he let the patient die (an omission)? A mountain climber and his friend are hiking when the friend loses his grip. The friend is grabbed by the climber before he falls into the abyss. After several minutes, the climber lets go of his friend's hand. The friend falls and dies. Did the climber kill his friend (an act) or did he let him die (an omission)? A tired surfer waits for the next set of waves. Suddenly he feels someone grabbing his board. It turns out to be a drowning swimmer who is desperately attempting to stay afloat. The surfer spots the wave of a lifetime and decides to catch the wave, knowing that doing so will cause the swimmer to lose grip of the board and drown. The surfer catches the wave. The swimmer is dislodged from the board and drowns. Did the surfer kill the swimmer (an act) or did he let him die (an omission)?

Determining whether the actors in these cases kill or let die is no easy task. On the one hand, in all three cases something is done to the victim. There is a willed bodily movement (action) that causally contributes to the killing. A switch is flipped, a hand is opened, and a surfboard is moved. On the other hand, there is also a sense in which the actors in these cases merely let the victims die. The doctor fails to continue treating his patient. The climber fails to rescue his friend. The surfer lets the swimmer drown. Given the ambiguity presented by these cases, should the actors be punished as if they had killed their victims or as if they had let them die?

This Article offers a novel theory that explains how cases such as these (and others) should be treated both in law and morality. It does so by creating a new category of human conduct that it calls "actmissions." An actmission is conduct that is both active and omissive in morally relevant ways. Actmissions

⁴ Warren S. Quinn, *Actions, Intentions and Consequences: The Doctrine of Doing and Allowing*, 98 PHIL. REV. 287, 289 (1989).

⁵ In most American jurisdictions, there is no general duty to assist those who are in need of aid. Therefore, harmful omissions do not typically give rise to criminal liability. WAYNE R. LAFAYE, *SUBSTANTIVE CRIMINAL LAW* § 6.2(f) (4th ed. 2011). Further, even in the few jurisdictions that impose a general duty to rescue, much less punishment is imposed for omitting rescue than for actively causing harm. *See, e.g.*, VT. STAT. ANN. tit. 12, § 519 (2013). The punishment in Vermont for omitting rescue when the victim is at risk of suffering grave physical harm is a \$100 fine, whereas the punishment for actively causing grave physical harm in Vermont can be up to 15 years of imprisonment and a \$10,000 fine. VT. STAT. ANN. tit. 13, § 1024 (2013). The special circumstances that warrant punishing acts and omissions equally are the existence of special duties to act that trigger heightened liability for omissions. Special duties to act may arise out of family relationships and contracts, amongst others.

are active because they include a willed bodily movement that contributes significantly to causing harm, yet omissive because they entail a failure to do something that would prevent harm from materializing.

According to this Article, actively causing harm is blameworthy because it leaves the victim worse off than she was before the harm causing event took place. The victim who is stabbed is worse off after the stabbing than she was before. In contrast, a failure to prevent harm is blameworthy because it fails to leave the victim better off than she was before the failure to act took place. The person choking on a fishbone who is not saved by someone who fails to perform the Heimlich maneuver is not made worse off than she was before the failure to rescue took place. Nevertheless, the choking victim would have been better off had someone tried to save her.

This Article suggests that, like actions, actmissions leave the victim worse off than she was immediately prior to the willed bodily movement that caused the harm. The patient is worse off when life support is disconnected than right before the doctor decided to disconnect life support. The falling climber is worse off when his friend lets go of his hand than when the friend decided to hang on to him. The swimmer is worse off when the surfer dislodges him from the board than when he first grabbed a hold of the board. However, actmissions, like failures to act, do not leave the victim worse off than she was before she first interacted with the actor. The patient is in no worse condition after life support is disconnected than she was before the doctor decided to provide life support. The climber is no worse off after his friend lets go than he was before his friend lent him a helping hand. The swimmer is no worse off after the surfer dislodges him from the board than he was before he grabbed on to it.

This Article has three major goals. First, it intends to show that it is best to view some courses of conduct as actmissions that combine features of both acts and omissions. This intermediate category of actmissions better captures the nature of several problematic cases that seem to blur the line between acts and omissions. Contrary to what some have argued, these cases do not demonstrate that the act/omission distinction collapses in borderline cases. Rather, they show the need for an intermediate category of conduct that lies somewhere between acts and omissions. The law all too often adopts all-or-nothing rules that do not accurately depict the complexity of the moral universe it intends to replicate. This is another one of those instances.

The second goal of this Article is to explain why actmissions are less blameworthy than actions yet more blameworthy than omissions. Unlike actions, actmissions do not leave the victim worse off than she was before she first interacted with the actor. At the end of the day, the victim is no better and no worse than before the actor engaged with her. Since actions make the victim worse off than she was before the actor approached her, actmissions are less blameworthy than actions. On the other hand, unlike omissions, actmissions leave the victim worse off than she was after the actor first approaches her.

Given that omissions do not make the victim worse off than she was prior to or after the actor approaches her, actmissions are more blameworthy than omissions.

The third goal of the Article is to identify instances in which current law treats some actmissions as worse than omissions but not as blameworthy as actions. The most prominent example involves doctors who contribute to causing the death of their patients. Current law bars doctors from actively killing their patients. However, the law grants doctors the discretion to refuse to provide medical treatment even if doing so would hasten the death of the patient. Finally, the law allows doctors to discontinue life support, but only if the patient or the patient's family consent to do so. Why require consent in such cases? This Article argues that such cases present the signature structure of an actmission. Discontinuing life support (an act) is worse than not providing life support at all (an omission), which the doctor is authorized to do without the consent of the patient or her family. As a result, the law requires that doctors obtain consent before engaging in such a course of action. However, discontinuing life support is less blameworthy than actively killing the patient. Therefore, the law allows the former while it disallows the latter. Without calling the doctor's decision to discontinue life support an actmission, the law is actually treating it as such, for it recognizes that this conduct is worse than letting the patient die but less blameworthy than killing her.

This Article is comprised of two parts. Part II defines actmissions and discusses how actmissions are already part of American criminal law even though courts and scholars have failed to expressly identify them as such. Part III assesses some objections that can be leveled against the theory of actmissions and proposes responses to the objections.

II. EXAMPLES OF ACTMISSIONS IN AMERICAN LAW

Contrary to what may appear at first glance, cases involving actmissions are relatively common. Further, there are some instances in which the law already treats cases involving actmissions in a different way than cases involving acts or omissions. To be sure, courts and lawyers do not expressly acknowledge that these cases present the structure of what this Article calls actmissions. Nevertheless, there appear to be pockets of cases in which courts and scholars argue that the consequences of causing harm by way of what this Article would call an actmission should be different than the consequences of causing the same harm by way of an act or an omission. This Part of this Article explores three such cases. First, it analyzes euthanasia cases in which a doctor orders life support to be discontinued. Second, it examines certain lesser evils cases in which a person appears to justifiably save her life by killing an innocent person. Finally, it discusses tort liability cases in which a person begins rescue of a stranger but later abandons the rescue.

A. *Actmissions and Euthanasia*

This Article argues that the conduct of a doctor who contributes to causing the death of a patient by disconnecting life support is best described as an actmission. At first glance, this might seem to fly in the face of the way in which courts and commentators describe these courses of conduct. The conventional understanding is that most courts and scholars believe that disconnecting life support is an omission.⁶ Such omissions are contrasted with what is generally believed to be the act of assisting in suicide. This distinction matters, for it is legally permissible to let a patient die, but it is not legal to assist in a person's suicide. Much less is it lawful to affirmatively kill a patient.

This Section argues that this conventional understanding is incomplete. While there is an important difference between discontinuing life support and affirmatively killing a patient by, say, injecting him with a poisonous substance, terminating life support is not purely omissive conduct, at least not when life support is terminated by engaging in an act, such as flipping a switch that turns a respirator off. Further, this Section contends that, upon closer inspection, the law does not really treat such cases of discontinuing life support as purely omissive either. The law requires more of a doctor who wants to discontinue life support than of a doctor who refuses to provide life support in the first place.⁷ This, in turn, reveals that the law treats discontinuing life support as something that is more blameworthy than merely failing to provide life support even if it is less worthy of blame than killing the patient. Without expressly saying so, the law reveals, then, that discontinuing life support is neither an act nor an omission. It is, in other words, an actmission.

In order to better understand the way in which the law treats cases of discontinuing life support, it is necessary to first explain how the law treats cases of assisting in the suicide of patients and instances of refusing to provide life-saving treatment in the first place.

1. *Assisting in Suicide, Killing Patients and Other Harm Causing Acts*

The law has consistently distinguished between cases in which doctors merely let their patients die and instances in which doctors kill their patients.⁸ Additionally, the law may differentiate between assisting a patient in committing suicide and actually killing the patient.⁹ The difference has significant practical implications. Doctors who let their patients die are generally not liable for their patient's death as long as they follow certain

⁶ See, e.g., *Barber v. Superior Court*, 195 Cal. Rptr. 484, 490 (Ct. App. 1983).

⁷ See discussion *infra* Part II.A.3.

⁸ See *Vacco v. Quill*, 521 U.S. 793, 801–08 (1996).

⁹ See, e.g., *Woods v. Commonwealth*, 142 S.W.3d 24 (Ky. 2004).

procedures.¹⁰ In contrast, doctors who either kill their patients or assist them in committing suicide are usually held criminally liable, although assisting in suicide is typically punished less severely than affirmatively killing the patient.¹¹

Some people faced with a terminal disease seek doctors who will help them kill themselves in order to put an end to their suffering. Doctors who help such patients kill themselves are assisting in the patient's suicide. Other people who suffer from similar diseases may wish to end their lives but are either unwilling or unable to kill themselves. Such patients sometimes ask doctors to kill them rather than to merely assist them in suicide.¹²

The paradigmatic example of a doctor who affirmatively killed his patient is that of Jack Kevorkian's administration of a lethal injection to Thomas Youk in 1998.¹³ Before this case, Kevorkian was well known for building so-called death machines that allowed the patient to either push a button or open a valve that allowed the device to administer a substance that would cause the patient's death.¹⁴ As a result of the cases involving the use of these machines, Kevorkian was tried on several occasions and acquitted for assisting in suicide.¹⁵ The Youk case was different, however, as Kevorkian administered the lethal substance rather than the patient.¹⁶ The difference proved determinative in Kevorkian's trial for Youk's death, as he was eventually found guilty of second-degree murder and was sentenced to 10 to 25 years of imprisonment.¹⁷

In cases such as these, the doctor clearly kills the patient by engaging in an affirmative act that directly causes death. Kevorkian, for example, killed Youk by injecting him with a poisonous substance that would surely cause his death. As a result, such cases give rise to liability for homicide. Further, in most jurisdictions, these cases trigger liability for murder, which is considered the most serious kind of homicide.

¹⁰ See *id.* at 47–51.

¹¹ See, e.g., ARK. CODE ANN. § 5-10-106 (2012) (making physician assisted suicide a Class C felony).

¹² The paradigmatic examples of this are the patients who sought Dr. Jack Kevorkian's assistance in their suicide. Several of the Kevorkian cases—and the legal rules that were applied in the cases—are discussed in the materials that follow.

¹³ See Pam Belluck, *Dr. Kevorkian is a Murderer, The Jury Finds*, N.Y. TIMES (Mar. 27, 1999), <http://www.nytimes.com/1999/03/27/us/dr-kevorkian-is-a-murderer-the-jury-finds.html>.

¹⁴ Kevorkian called this contraption the “Thanatron,” which is Greek for “death machine.” *The Thanatron*, FRONTLINE, <http://www.pbs.org/wgbh/pages/frontline/kevorkian/aboutk/thanatronblurb.html> (last visited Oct. 10, 2013).

¹⁵ Belluck, *supra* note 13.

¹⁶ *Id.*

¹⁷ See Dirk Johnson, *Kevorkian Sentenced to 10 to 25 Years in Prison*, N.Y. TIMES (Apr. 14, 1999), <http://www.nytimes.com/1999/04/14/us/kevorkian-sentenced-to-10-to-25-years-in-prison.html>.

Kevorkian's killing of Youk ought to be distinguished from cases in which a doctor assists a patient in committing suicide. Sometimes doctors who assist a patient to commit suicide are prosecuted for homicide or murder.¹⁸ The problem with such prosecutions is that in order to find a defendant liable for homicide, the state must prove that the defendant's conduct was both the actual¹⁹ and proximate cause²⁰ of the victim's death. Doctors who assist in a patient's suicide are often acquitted of homicide because it is found that the patient's voluntary decision to terminate his own life coupled with the patient's act of administering the lethal treatment herself are typically considered intervening causes that break the causal link between the doctor's conduct and the patient's death. As a result, although the doctor's assistance is considered a but-for cause of the patient's death, it is typically not considered the proximate cause of the death. The distinction between a doctor affirmatively killing a patient and a doctor assisting in the patient's suicide is of significant import as far as the punishment of these acts is concerned. As a general matter, it appears that the typical punishment for intentional homicide is at least double the typical punishment that is imposed for assisting in suicide.²¹

In spite of the differences between killing a patient and assisting in the patient's suicide, both of these courses of conduct share an important feature. Whether a doctor contributes to the death of a patient by directly administering a lethal injection or by providing the patient with the lethal injection so that the patient can administer it herself, both types of conduct are best described as harm-causing actions. In both scenarios, doctors engage in a willed bodily movement that significantly contributes to bringing about the death of the patient. Therefore, doctors who engage in this conduct receive significant punishment, as their conduct is perceived as making their patients worse off than they were before.²²

¹⁸ See generally *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994).

¹⁹ A defendant's act is a "but-for" or "actual" cause of a result if the result would not have taken place but for the defendant's act.

²⁰ The victim's voluntary decision to harm herself usually precludes finding that the defendant's conduct is the proximate cause of victim's self-inflicted harm. This is especially true in assisted suicide cases. See, e.g., *People v. Campbell*, 335 N.W.2d 27, 29 (Mich. Ct. App. 1983) (reasoning that providing a gun to an intoxicated person with the hope that that person would kill themselves is not enough for the provider of the weapon to stand trial for murder).

²¹ In Michigan, for example, assisting in suicide is punished with a term of imprisonment that should not exceed five years. MICH. COMP. LAWS ANN. § 750.329a (West 2013). In contrast, manslaughter is punished with a term of imprisonment that may not exceed fifteen years. *Id.* § 750.321. Intentional killings in Michigan are thus punished at least three times as severely as assisting in suicide.

²² This Article does not address the thorny issue of whether there is or should be a right to die. It is assumed—without endorsing the assumption—that there has been a societal determination that being dead is worse than being alive.

2. Refusing to Provide Treatment and Harm Causing Omissions

Most jurisdictions distinguish between doctors who engage in actions that contribute to causing the death of their patients and doctors who causally contribute to causing the death of their patients by failing to provide life-saving medical treatment. Whereas the former is unlawful in the vast majority of jurisdictions, the latter is typically lawful. A further distinction is warranted. The failures to act that are discussed here are not those in which a doctor provides life-saving treatment and later engages in an act that terminates such treatment (such as flipping a switch, for example).²³ Instead, this subsection focuses on cases in which the doctor fails to provide life-saving treatment either by not providing it in the first place or by omitting to continue treatment. Such failures may, and often do, contribute to causing a patient's death. Interestingly, however, doctors who refuse to provide such are not typically subject to legal sanctions.

The paradigmatic scenario is that of a physician who stops providing CPR or other resuscitation once she decides that continuing to do so would be useless. Such a refusal to continue treatment is generally lawful as long as the doctor's decision is reasonable. Further, and perhaps more importantly, a doctor may terminate such treatment even if she believes that the patient would have liked him to keep trying or if the family asks him to do more. Thus, it is the general opinion of "medical ethicists and EMS experts . . . that physicians may withhold futile interventions deemed unlikely to benefit patients even when requested by patients or families."²⁴ It is generally acknowledged that a physician may terminate CPR after providing it for a certain period of time. The period of time may vary depending on the patient's age.²⁵ The decision to terminate such treatment lies ultimately within the province of the physician's discretion. The patient's presumed wishes or the desires of the patient's family are not determinative of the decision.

It might be tempting to conclude that doctors may discontinue treatment in such scenarios because at that point in time the patient is already dead. Technically speaking, however, this is not the case. Doctors may stop providing treatment if the probability of survival is sufficiently low. While most patients who stop receiving treatment will die, a small fraction of them might very well survive if they were to receive additional treatment. Nevertheless, a doctor who refuses to continue to provide life-saving treatment

²³ See *supra* Part II.A.3.

²⁴ U.S. COAST GUARD, CARDIOPULMONARY RESUSCITATION PROTOCOL, available at http://www.uscg.mil/health/docs/pdf/SAR_CPR_protocols.pdf (last visited Oct. 8, 2013).

²⁵ For certain newly born infants, CPR may be terminated after 15 minutes; for adults, it may take up to 30 minutes. AM. HEART ASS'N, *Part 2: Ethical Aspects of CPR and ECC*, 102 CIRCULATION I-12 (Supp. I 2000), available at http://circ.ahajournals.org/content/102/suppl_1/I-12.full.

will be shielded from liability as long as it was reasonable for him to conclude that providing such additional treatment would have been futile, *even if it turns out that—as a matter of fact—providing such treatment would have saved the patient’s life*. Therefore, a doctor who reasonably refuses to provide additional medical treatment is not criminally liable for the patient’s death regardless of whether his omission contributed to causing the death of the patient.

This is even more obvious in cases involving newly born infants born with certain congenital anomalies. The guidelines issued in the Advanced Cardiac Life Support Manual authorize withholding CPR and other heroic lifesaving treatment for newborns in the delivery room that suffer from confirmed Trisomy 13.²⁶ Although such omissions can clearly lead to the child’s death, physicians are authorized to refuse treatment in these cases and no criminal or civil liability would attach if they do so. Further, whether the child’s parents agree to this or not is irrelevant to assessing the doctor’s liability for omitting treatment. In contrast, a physician would not be entitled to actively kill a newly born infant with Trisomy 13 regardless of whether she thinks that doing so would be in the best interests of the child and regardless of whether the parents agree to do so.

In sum, physicians in these cases are allowed to refuse to provide further treatment because by doing so they are merely letting the patient die rather than killing him. When this is the case, the doctor’s professional judgment as to whether to provide treatment is determinative regardless of the wishes of the patient or the patient’s family.

3. Discontinuing Life Support and Harm Causing Actmissions

a. *Discontinuing Life Support: Killing or Letting Die?*

In certain cases, physicians contribute to causing a person’s death by engaging in an act that terminates lifesaving treatment. The typical case is that of the doctor who discontinues life support by flipping a switch that turns off a respirator. These cases were the source of deep controversy in the 1970’s. Perhaps the most famous case was that of Karen Quinlan.²⁷ Ms. Quinlan became unconscious and was taken to the hospital after she had stopped breathing twice for more than fifteen minutes.²⁸ While at the hospital, Ms. Quinlan unfortunately fell into a permanent vegetative state. She was subsequently kept alive by a ventilator.²⁹ Several months later, her parents asked the hospital to remove the ventilator and allow their daughter to die. When local authorities threatened to charge the doctors with homicide if they

²⁶ *Id.*

²⁷ *In re Quinlan*, 355 A.2d 647, 653–54 (N.J. 1976).

²⁸ *Id.*

²⁹ *Id.*

removed Ms. Quinlan from mechanical ventilation, the physicians and the parents sought a court order authorizing the removal of ventilator.³⁰ Eventually the New Jersey Supreme Court authorized discontinuing life support.³¹

In *Quinlan*, as in many other similar cases, the Court suggested that turning off the ventilator would amount to a “refusal to treat” the patient.³² The payoff of describing the physician’s conduct in this manner is obvious. By characterizing the act of turning off the respirator as a “refusal to continue treatment,” the Court is suggesting that the doctor’s conduct is merely an omission. This is an important rhetorical move, for—as was discussed in the previous subsection—doctors may lawfully withhold medical treatment even if doing so contributes to causing the death of the patient, whereas—as the *Kevorkian* case illustrates—physicians may not lawfully engage in affirmative acts that cause the death of the patient. Doctors, in sum, are allowed to engage in conduct that merely lets a patient die. They may not, however, engage in acts that kill a patient. Since removing the ventilator merely allows Ms. Quinlan to die, the New Jersey Supreme Court concluded that the doctors could engage in such conduct without incurring criminal or civil liability.

The distinction between killing and letting die in this context is so significant that it has a constitutional dimension. According to the Supreme Court, a patient has a constitutional right to refuse medical treatment even if doing so contributes to causing her death.³³ Nevertheless, a patient does not have a constitutional right to be assisted in suicide.³⁴ The *Quinlan* case is an illustration of the former, whereas *Kevorkian* type cases illustrate the latter.

*b. The Conventionally Accepted Legal Answer:
Discontinuing Life Support as an Omission*

At a more basic level, the distinction between killing and letting die in this context reflects the act/omission dichotomy in criminal law. While we all have a duty to abstain from contributing to someone else’s death by engaging in conduct that is constitutive of an act, we are not under a similar duty to abstain from contributing to the death of another by omission. Courts have therefore gone out of their way to describe discontinuing life support in these cases as mere “omissions.” This was the tack famously taken by the California

³⁰ *Id.* at 657.

³¹ *Id.* But see *Matter of Conroy*, 486 A.2d 1209 (N.J. 1985). Interestingly, and contrary to predictions, Ms. Quinlan did not die when life support was discontinued. She died nine years later from pneumonia. *History of Karen Ann Quinlan and the Memorial Foundation*, KAREN ANN QUINLAN MEMORIAL FOUND., <http://www.karenannquinlanhospice.org/history/> (last visited Oct. 18, 2013).

³² *Matter of Quinlan*, 355 A.2d at 667.

³³ *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261 (1990).

³⁴ *Washington v. Glucksberg*, 521 U.S. 702, 723 (1997).

Supreme Court in *Barber v. Superior Court*.³⁵ The physicians in *Barber*—like those in the *Quinlan* case—were asked by the comatose patient’s family to remove the patient from artificial life support.³⁶ The doctors honored the family’s request.³⁷ They were subsequently charged by state authorities with murdering the patient.³⁸ The Court of Appeals of California rejected the state’s contention that disconnecting the mechanical devices that kept the patient alive would amount to murder.³⁹ In doing so, the Court emphasized that the “the cessation of ‘heroic’ life support measures is not an affirmative act but rather a withdrawal or omission of further treatment”.⁴⁰ Furthermore, the court stated that:

Even though these life support devices are, to a degree, “self-propelled,” each pulsation of the respirator or each drop of fluid introduced into the patient’s body by intravenous feeding devices is comparable to a manually administered injection or item of medication. Hence “disconnecting” of the mechanical devices is comparable to withholding the manually administered injection or medication.⁴¹

c. Discontinuing Life Support: Why it Is Also an Act

The problem, of course, is that the physicians who turned off the respirator in the *Barber* and *Quinlan* cases did not merely refuse to provide additional treatment. They flipped a switch. Flipping a switch is an act, not an omission. That the effect of this act is to stop providing life support to Ms. Quinlan or to the patient in *Barber* does not change the nature of the conduct. In its most generic form, an act is a willed bodily movement.⁴² And this is exactly what flipping a switch amounts to.

Suppose, for example, that a stranger surreptitiously entered Ms. Quinlan’s room and flipped the switch that gave power to the respirator. Would we say that this person engaged in an “act” that contributed to causing the death of Ms. Quinlan or would we say that the person merely “omitted” to provide Ms. Quinlan with further medical treatment? The answer seems obvious. The stranger’s flipping of the switch is an act. Besides the oddness of describing the stranger’s flipping of the switch as an omission, describing it as a failure to act

³⁵ 195 Cal. Rptr. 484 (Ct. App. 1983).

³⁶ *Id.* at 486.

³⁷ *Id.*

³⁸ *See id.*

³⁹ *Id.* at 493.

⁴⁰ *Id.* at 490.

⁴¹ *Id.*

⁴² MICHAEL MOORE, ACT AND CRIME 39 (1993).

would generate absurd legal consequences. Given that the stranger has, by definition, no connection with the patient, he would not owe the patient a special legal duty to take care of her.⁴³ Further, the stranger cannot be faulted for “failing to take care of the patient” in the absence of a legal duty to do so. Therefore, if the stranger merely omits to take care of the patient when he turns off the respirator, he would not be subject to any criminal or civil liability for his conduct.

This provides us with a normative argument against considering that the stranger’s conduct is an omission, for describing it in that manner would generate a counterintuitive and unjust legal outcome. As a result, we have powerful descriptive and normative reasons to consider the stranger’s conduct of turning off the respirator as an act rather than an omission. Now, if flipping the switch is an act when done by a stranger, it must also be an act when done by a doctor. There is no difference as far as the physical act performed is concerned. There is, of course, great difference in the reasons that motivate the acts in each of the two cases. These motives, however, do not change the nature of the act. They may justify flipping the switch in one case and not the other, but the conduct in both cases remains identical.

d. Discontinuing Life Support as an Actmission

This is not to say that it is irrelevant that the acts in these cases contribute to causing death by discontinuing life support. While it is true that turning off the respirator is an act, it is equally true that the effect of turning off life support is to withhold further medical treatment. This is what makes these cases so difficult. Depending on how you look at it, the case is either about a harm causing act (flipping the switch) or about a harm causing omission (withholding medical treatment). The problem with the conventional legal approach to these cases is not that it describes the conduct at issue as an omission, but rather that it ignores that the course of conduct also involves an affirmative act. This is *Barber’s* omission. It is also the problem with *Quinlan*. It is helpful to analogize the flipping of the switch to a withholding of future medical treatment. However, it is disingenuous to believe that this is all that is going on in these cases. In order to fully grasp the moral issues raised by these cases, it is imperative to take into account *both* that disconnecting life support amounts to a withdrawal of medical treatment *and* that this is achieved by engaging in conduct that is constitutive of an act. Only when both features of the conduct are taken into account does the full import of the conduct come into view.

Because these cases share important features of acts and omissions, I believe that it is best to think of them as hybrid courses of conduct that present

⁴³ As was pointed out previously, there is typically no general duty to take care of strangers. See *supra* Part II.A.2.

the structure of both active and omissive wrongdoing. The cases reveal, in sum, that the actor has caused harm by engaging in what this Article calls an “actmission.” But what follows from describing discontinuing life support in this manner? The answer is twofold. First, the doctor’s conduct ought to be viewed as more blameworthy than purely omissive conduct. Second, the doctor’s conduct should be considered less blameworthy than purely active conduct. Expressed in more general terms, harmful actmissions are more blameworthy than harmful omissions, but less blameworthy than harmful actions.

While intuitions may suggest that actmissions (discontinuing life support) are more blameworthy than omissions (refusing to provide life support in the first place) but less blameworthy than actions (assisting in suicide), are these intuitions justified? They probably are. Acts are blameworthy because they create a risk of harm to the victim that did not exist before the act was performed. Injecting a poisonous substance into the body of a patient creates an imminent risk of death that did not exist prior to the doctor’s conduct. In contrast, the blameworthiness of omissions is not explained by the fact that they create a risk that did not exist prior to the actor’s conduct. The doctor’s refusal to provide medical treatment does not create a risk of harm for the patient that did not exist prior to the doctor’s omission. In such cases, the patient’s wellbeing is jeopardized by his ailment, rather than by the doctor’s omission. Why, then, may a doctor’s omission to provide treatment be blameworthy? Such conduct is blameworthy because by omitting medical treatment, the doctor fails to neutralize the risk that is endangering the patient’s wellbeing. While not as blameworthy as creating a risk of harm, failing to neutralize an existing risk, when doing so can be done at little to no cost, is still worthy of blame.

But are actmissions blameworthy because—like omissions—they fail to neutralize an existing risk, or because—like actions—they create a new risk of harm? The answer is that actmissions do a little of both depending on how you look at it. Actmissions—like actions—create a risk that did not exist immediately prior to the relevant harm causing willed bodily movement. The patient whose life support is discontinued now faces a risk of death that did not exist right before life support was terminated. Nevertheless, actmissions—like failures to act—do not create a risk that is different from the risk that jeopardized the victim’s wellbeing in the first place. That is, discontinuing life support merely subjects the victim to the same risk that she was subjected to prior to receiving medical treatment. In this sense, actmissions do not create a new risk, for they do not set in motion the course of events that is likely to cause harm to the victim. In the context of the life support cases, one could say that the patient’s life is jeopardized by his ailment, not by the withholding of further treatment. This is what makes actmissions different from actions. Actions set in motion a course of events that will likely result in harm to the victim. The doctor who injects a poisonous substance into the patient’s body

sets in motion a course of conduct that will likely lead to the patient's death. Actmissions, in contrast, do not set in motion a harm causing course of events. They merely allow those harm causing events to finally run their course. In the medical context, removing life support does not set in motion the course of events that is likely to cause the patient's death. Those events happened prior to the doctor entering the picture (cancer, car accident, etc.). By removing life support, the doctor is thus allowing that original harm causing event to run its natural course rather than creating a risk that did not exist prior to his conduct.

Given that actmissions do not create the risk that is likely to harm the victim, what makes actmissions more blameworthy than omissions? After all, omissions also do not create the risk that leads to harming the victim. Omissions merely let the harm materialize. Actmissions are different from omissions in one of two ways. Some actmissions are more blameworthy than omissions because they accelerate the culmination of a harmful course of events that was already in motion when the actmission takes place. This sometimes happens when life support is terminated. Some patients are likely going to die regardless of whether life support is terminated or not. Nevertheless, the termination of life support does something more than merely letting events run their course. It *accelerates* the occurrence of the harm that was likely to take place anyway. And this is more blameworthy than merely letting the harm happen in due course.

While some actmissions are blameworthy because they hasten the occurrence of harm that would likely materialize anyway, other actmissions are blameworthy because they return the victim to a zone of danger that she was shielded against by the very actor who now places her in the same danger again. This is what happened in the *Quinlan* case. Note that the termination of life support did not appear to accelerate Karen Quinlan's death, for she lived several years after she was removed from the ventilator. By discontinuing life support, however, the doctor returned Karen Quinlan to the same dangerous condition that she was before the decision to begin life support was made. This kind of actmission presents a course of conduct that can thus be described as an abandoned rescue. The victim is temporarily safer because she is protected by the actor, who then decides to do something that results in an abandoned rescue. In doing so, the actor once again places the victim at risk of suffering the kind of harm that it seemed that the actor was protecting her against.

To summarize, some actmissions accelerate the occurrence of harm that was likely to take place anyway. Other actmissions return the victim to a situation in which she will have to face a risk that she had been shielded against. Both types of actmissions do not change the nature of the risk that endangered the victim prior to her interaction with the actor. Thus, the patient's risk after life support is disconnected is the same risk that endangered her when the doctor ordered life support to be supplied.

In light of the reasons that explain the relative blameworthiness of actmissions, it is submitted that a course of conduct counts as an actmission if

five requirements are met. First, a harm causing event must be set in motion by someone or something other than the actor. Second, the actor must find himself in a position in which he can do something to prevent the event from transpiring and causing harm to the victim. Third, the actor fails to do something to prevent harm to the actor. Fourth, the actor's failure to do something to prevent harm to the actor must consist of a willed bodily movement. Fifth, the willed bodily movement either accelerates the occurrence of a harm that would have likely taken place anyway or returns the victim to a zone of danger that the actor had shielded her against.

Cases that involve discontinuing life support by turning off equipment such as a ventilator present the five features that characterize actmissions. First, the event or condition that jeopardizes the life of the patient in these cases was put in motion by someone or something other than the physician. In *Quinlan*, for example, the patient's life was jeopardized by the mix of alcohol and tranquilizers that she took before passing out. Second, the physicians find themselves in a position in which they can do something to avert or postpone the harm from taking place. In these cases, the physicians can avert the patient's death by continuing to provide life support. Third, the physician fails to do something that would prevent the harm from materializing. Physicians in these cases fail to prevent the patient's death when they discontinue life support. Fourth—and most importantly—the physician's failure to do something that prevents the harm from taking place consists in a willed bodily movement. This is certainly the case in these instances, as the physician discontinues treatment by engaging in the willed bodily movement of flipping a switch. Finally, the physician's willed bodily movement either accelerates the death of the patient or returns the victim to a zone of danger that the actor had shielded her against. In most of these cases, the doctor accelerates the death of the patient by flipping the switch that discontinues life support. In others—such as the *Quinlan* case—the doctor does not accelerate death, but does return the patient to the zone of danger in which she was before life support was commenced.

Treating these cases as instances of actmissions makes sense from a normative perspective. On the one hand, flipping a switch that terminates life support seems less intrusive than affirmatively giving the patient a substance that kills him. On the other hand, discontinuing life support by flipping a switch seems more intrusive than merely refusing to continue CPR or refusing to provide CPR in the first place. When compared to giving the patient a substance that kills him, flipping a switch that discontinues life support is less intrusive because discontinuing life support does not make the patient worse off than he was before life support was commenced. It merely returns the patient to the same position or danger that she was in before. In contrast, giving the patient a substance that kills him makes him worse off than he was before the

doctor first intervened.⁴⁴ Rather than returning the patient to the same position or danger that he was in before, it significantly increases the likelihood that he might die. Nevertheless, flipping a switch that discontinues life support is more intrusive than refusing to provide CPR or stopping CPR because actively discontinuing life support makes the patient worse off than she was while she was receiving life support. In other words, without continued life support, the patient is likely to die soon. However, with continued life support the patient would likely avert death for an indefinite amount of time. In contrast, the patient who does not receive CPR or who stops receiving CPR is not made worse off by the failure to receive CPR than he was before she was placed in the physician's care. At most, the physician who omits CPR fails to make the patient better off than she would have been without medical intervention.⁴⁵

e. The Law Already Treats Discontinuing Life Support as Conduct that Is Less Intrusive than Failing to Provide Treatment but More Intrusive than Affirmatively Causing a Patient's Death

While American criminal law does not expressly recognize actmissions as an autonomous form of human conduct, it does treat certain harms that are caused by what is described here as an actmission as harms that are more

⁴⁴ The patient is considered "worse off" in this context if she is closer to death. The patient is "better off" if she averts death. For the purposes of this discussion, it is assumed that there exists a societal determination in America that being alive is better than being dead. This societal determination explains why active euthanasia is a crime in all but a couple of state jurisdictions.

⁴⁵ Michael Moore recently argued that flipping a switch that discontinues life support is easier to justify than actively killing the patient (by injecting him with morphine, for example). According to Moore, while flipping a switch that discontinues life support is an act, it does not cause the death of the patient. Properly understood, the death of the patient is caused by the underlying disease, not by the discontinuance of life support. In metaphysical terms, Moore argues that discontinuing life support amounts to a "double prevention," for by flipping the switch the doctor *prevents* the machine from *preventing* death. According to Moore's view of causation, double preventions—like omissions—are not causes. Consequently, it is easier for the doctor to justify discontinuing life support than actively injecting morphine into the patient's veins, given that turning off life saving devices does not truly cause death, whereas injecting a deadly substance into the patient's body does cause death. See MICHAEL MOORE, CAUSATION AND RESPONSIBILITY 460–65 (Oxford ed. 2009).

In my opinion, the distinction between double prevention and causation does not appear to be as morally relevant as Moore claims it to be. See generally, e.g., Gideon Rosen, *Causation, Counterfactual Dependence and Culpability: Moral Philosophy in Michael Moore's Causation and Responsibility*, 42 RUTGERS L.J. 405, 415 (2011). What makes the cases described here as actmissions of intermediate gravity when compared to actions and omissions is not the metaphysical difference between double preventions and causation, but rather the difference between creating a new threat to the victim's wellbeing (action), failing to defuse an already existing threat (omission) and accelerating the harm that will be caused by an already existing threat (actmission) or returning the actor to a zone in which she is once again threatened by a previously existing threat (actmission).

serious than identical harms brought about by omissions but less serious than identical harms that are the result of an affirmative act. As a result, even though the law does not recognize actmissions as a *de jure* legal category, it seems to *de facto* treat it as such, at least in some cases.

Cases of discontinuing life support are paradigmatic examples. The law treats discontinuing life support as a course of conduct that is more serious than merely stopping CPR but less serious than affirmatively giving something to the patient that will likely kill him. Thus, it is a crime in most American jurisdictions to affirmatively give something to the patient that is likely to kill him. Any physician who does so is subject to criminal sanctions and it is no defense that the patient consented to the physician's conduct. At the other side of the spectrum, a physician may stop providing CPR or (in some cases) refuse to provide CPR without incurring in civil or criminal liability, even if doing so contributes to causing the death of the patient. Further, the physician may stop such treatment as long as he has reasonable grounds to do so and regardless of whether doing so would be contrary to the express wishes of the patient's family and the (inferred) desires of the patient.

Discontinuing life support lies between these two extremes. While doctors may engage in an affirmative act that discontinues life support without being held liable for their conduct, they can only do so if the patient or her family consents to doing so. Thus, the legal rules governing cases of discontinuing life support are more strict than those governing the refusal to continue CPR but less stringent than the legal regime that typically applies to cases in which doctors give something to patients that is likely to kill them. More specifically, unlike cases in which the doctor assists the patient in suicide, the patient's consent to discontinuing life support shields the physician from liability if the patient dies as a result of the doctor's conduct. However, unlike cases in which the doctor merely refuses to provide CPR, the doctor who discontinues life support may only do so if he first obtains consent from either the patient or the patient's family.

From the way in which the law treats these three cases, it may reasonably be inferred that there is something special about discontinuing life support that makes these cases subject to more stringent regulation than the pure omission cases but less stringent regulation than the assisting in suicide cases. Alas, the law currently lacks the conceptual framework that allows it to coherently explain what is special about these cases. The most obvious explanation for this is that only acts and omissions are recognized as legally relevant forms of commission of criminal offenses. This, in turn, leads to harm causing conduct being classified as either an act that triggers substantial liability or as an omission that generates substantially less—if any—liability.

The problem is that although the act/omission distinction is tidy in theory, it breaks down in borderline cases. Some cases—like the ones that concern discontinuing life support—can be described in morally relevant ways as involving both acts and omissions. When this happens, it would be improper

to treat such cases as involving merely acts or merely omissions. It would be equally improper to subject these cases to the same rules that apply in cases of pure acts or pure omissions.

This is what makes the discontinuing life support cases so interesting. Although courts feel compelled to treat them as cases in which the conduct performed by the physician amounts to a pure omission, the legal rules that courts flesh out to deal with these cases are not the same as the rules that apply in cases involving true omissions. That is, while courts conclude that the physician who discontinues life support engages in an omission, they go on to subject the physician to more stringent standards than the ones that apply when the physician engages in a pure omission like refusing to continue performing CPR. Courts nevertheless subject the physician to less stringent standards than the ones that govern cases of physicians who give something to the patient that is likely to cause the death of the patient.

These concessions give the game away, for they reveal that there are features of the conduct of discontinuing life support that warrant treating these cases differently from merely omitting to provide medical treatment and from assisting the patient's suicide. They reveal, in sum, that discontinuing life support is not truly an act or an omission. It is, even if courts have not thought about it in these terms, an *actmission* that is more serious than a pure refusal to continue treatment and less serious than an affirmative act of helping a patient to commit suicide.

B. Actmissions, Cutting the Rope and Lesser Evils

In 1985, mountaineers Joe Simpson and Simon Yates successfully made the first ascent of the west face of the Siula Grande in the Peruvian Andes. During the descent, Simpson broke his leg. Given that Simpson could not walk, Yates decided to lower him down the steep slope on a rope. Unfortunately, at one point Yates unwittingly lowered Simpson over a crevasse, leaving Simpson suspended in midair. The weight of Simpson was wearing down Yates and after hanging on for close to an hour in the bitter cold, Yates finally decided to cut the rope knowing that doing so would likely lead to Simpson's death. After cutting the rope, Yates returned to camp. Astonishingly, Simpson survived the fall and made it back to camp.⁴⁶

Some in the climbing community chided Yates for cutting the rope. Simpson came to his defense, however, stating that he would have done the same thing had the roles been reversed. Charging Yates with a crime was never seriously considered, probably because Simpson survived the fall. Nevertheless, it is worth asking whether Yates would have been liable for

⁴⁶ The events are recounted in Simpson's book *Touching the Void*. See JOE SIMPSON TOUCHING THE VOID: THE TRUE STORY OF ONE MAN'S MIRACULOUS SURVIVAL (Perennial 2004). They are also the subject of Kevin McDonald's docudrama *Touching the Void*. See TOUCHING THE VOID (FilmFour 2003).

homicide had Simpson perished as a result of the rope being cut. Many, if not most, scholars and philosophers who have pondered this question seem to believe that Yates did the right thing when he cut the rope and that the analysis would not change had Simpson died as a result of cutting the rope.⁴⁷ In other words, most believe that cutting the rope was justified even if doing so precipitated Simpson's death.⁴⁸

According to Professor Heidi Hurd, the underlying intuition that explains why cutting the rope is justified is that while it may be wrong to save one's life by killing a person who is not in danger, it is justified to save one's life by accelerating the death of someone who is about to die.⁴⁹ She claims that in such cases there is a sense in which the victim is "already dead" and that it is less blameworthy to kill someone who is "already dead" than to kill someone who is not about to die.⁵⁰ More specifically, Hurd claims that by cutting the rope, one is not really causing the person's death. Since the person is going to die regardless of whether the rope is cut, cutting the rope merely accelerates the time of death.⁵¹

While Hurd's argument raises various contentious issues, she makes several points that are probably not controversial. First, most people share the intuition that cutting the rope is justified even if it leads to Simpson's death. Second, it is easier to justify killing a person who was previously at risk of dying than justifying the killing of a person who was not previously in danger of dying. Third, it is less blameworthy to accelerate the death of someone who is soon going to die anyway than to cause the death of someone who would otherwise live indefinitely. This is not to say that it is not wrong or blameworthy to engage in conduct that accelerates death. It surely is. However, it is intuitively plausible to argue that it is more blameworthy to cause the death of someone who is not going to die than to accelerate the death of someone who is in a sense "already dead".

The problem with Hurd's account is that it proves too much. The reason why it was justified for Yates to save himself by cutting the rope cannot be solely because by doing so he was contributing to the death of someone who was going to die anyway. If it were, the case would barely be distinguishable from the killing of the cabin boy in the celebrated *Dudley and Stephens*⁵² case. The defendants in *Dudley and Stephens* killed and cannibalized the cabin boy in order to stave off starvation and maximize their chances of being rescued.⁵³

⁴⁷ See Heidi M. Hurd, *What in the World is Wrong?*, 5 J. CONTEMP. LEGAL ISSUES 157, 206 (1994).

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² Queen. v. Dudley & Stephens, [1884] 14 Q.B.D. 273 (Eng.).

⁵³ *Id.*

One of the arguments they advanced in support of their conduct was that the cabin boy was likely to die anyway. The House of Lords rejected the argument, contending, among other things, that a person ought to sacrifice himself before killing an innocent human being.⁵⁴ It did not matter whether the person killed was going to die anyway.

More recently, the International Criminal Tribunal for the Former Yugoslavia (ICTY) ruled in *Prosecutor v. Erdemovic* that a soldier who was threatened with death if he refused to kill innocent civilians could not justify the killing of such civilians on the basis that they were surely going to die anyway at the hands of other soldiers who were willing and able to kill them.⁵⁵ The ICTY refused to justify the killing on such grounds by pointing out that life is of significant value regardless of how much time the victims have to live.⁵⁶ A similar argument was advanced by the German Constitutional Court when it refused to authorize legislation that would allow government officials to shoot down commercial jetliners headed towards heavily populated buildings.⁵⁷ The German government argued that shooting down the planes in such scenarios was justified at least in part because the innocent passengers inside the plane were going to die anyway, for they would die when the plane collides with its target. The German Constitutional Court rejected the argument partially on the grounds that each second and minute of human life has significant value and that they did not feel comfortable holding that the lives of the passengers were less deserving of legal protection merely because they had less time to live than the people who inhabit the plane's target.⁵⁸

These cases do not, of course, demonstrate that Hurd's argument is flawed. Perhaps what is flawed is the reasoning underlying the cases. Nevertheless, it is telling that domestic and international courts in both civil and common law jurisdictions have consistently rejected the argument that one may save oneself by killing someone who is going to die anyway. While the issue is complicated, accepting the aforementioned proposition leads to unpalatable outcomes. Imagine, for example, that a patient in a hospital is dying of a terminal disease. Physicians believe that she will likely die within the next several hours. Can a person who is in need of organs justifiably kill the dying patient in order to harvest her organs? Such a killing strikes most as obviously unjustified. But why? If Hurd is right that one may save oneself by killing someone who is "already dead", why can't the organ needing patient kill the patient who is about to die in order to harvest her organs? The standard

⁵⁴ *Id.*

⁵⁵ *Prosecutor v. Erdemovic*, Case No. IT-96-22, Sentencing Judgment, ¶ 10 (Int'l Crim. Trib. for the Former Yugoslavia Nov. 29, 1996).

⁵⁶ *Id.*

⁵⁷ Bundesverwaltungsgericht [BVerfG] [Federal Constitutional Court] Feb. 15, 2006, NEUE JURISTISCHE WOCHENSCHRIFT [NJW] 751 (Ger.).

⁵⁸ *Id.*

answer given by courts when they reject this argument partially explains the intuition. It is difficult to quantify the value of a second, an hour or a day of life. As Keynes famously said—"in the long run we are all dead"—so it is in a sense true that whenever someone is killed, the person killed was in a sense already dead. Granted, Hurd meant to limit her argument to killing people who were about to die. Nevertheless, it is a very thorny matter to calculate the value of human life and it is an even thornier matter to discount the value of human life on the basis of the amount of time that the person will remain alive.

Engaging in such a difficult calculus can be avoided by shifting the focus from whether the person was going to die anyway to the nature of the conduct that precipitates the victim's death. Although she does not expressly say so, Hurd must be assuming that cutting the rope that kept Simpson alive amounted to an act. If cutting the rope amounted to an omission, the case would lose most of its controversial nature, for it is generally accepted that mountaineers do not have a duty to risk their lives in order to rescue fellow mountaineers.⁵⁹ As a result, if the cutting of the rope is considered a failure to come to the aid of Simpson, then Yates would obviously not be held liable for homicide. Yates would not have killed Simpson, but rather would have merely let him die. In contrast, if cutting the rope is considered an act, then doing so amounts to killing Simpson, which is far more troubling than merely letting him die.

But must the cutting of the rope be considered an act? Not necessarily. There is a sense in which cutting the rope amounts to an omission. When Yates cut the rope that kept Simpson from falling into the crevasse, he was deciding to stop providing help to his partner. By attaching the rope to Simpson and lowering him down, Yates was attempting to rescue the injured Simpson. Focusing on Yates's conduct as an attempted rescue puts the nature of the conduct of cutting the rope into better view. Once the course of conduct is viewed as a rescue attempt, the cutting of the rope appears as the termination of the rescue. Yates's cutting of the rope is thus similar to the physicians' flipping of the switch in euthanasia cases. By cutting the rope Yates is effectively terminating the rescue effort of his climbing partner. Similarly, by flipping the switch and turning off the respirator, the physician is effectively terminating his medical treatment of the patient. Note that in both cases the termination of life saving efforts takes place as a result of a willed bodily movement. The doctor flips a switch. The climber cuts a rope. Both of these courses of conduct are conventionally viewed as acts. However, the consequence of both of these acts is to terminate life-saving efforts. If the focus is shifted from the willed bodily movement to the effect of the act, then the course of conduct starts to look like an omission. After all, the refusal to continue to engage in conduct that would prevent the death of another sounds more like an omission than an action.

⁵⁹ See generally SCHMID ET AL., *CLIMBING: PHILOSOPHY FOR EVERYONE* (Wiley 2010).

Recall that the *Barber* court analogized self-propelled respirators and intravenous feeding devices with manually administering injection or items of medication.⁶⁰ As a result, the court concluded that disconnecting the respirator was the functional equivalent of withholding manually administered medication.⁶¹ In a similar vein, a climber's holding on to the rope is analogous to a climber manually grabbing his partner and pulling him up (or down) a difficult and steep section of a hill. Cutting the rope would then be considered the functional equivalent of refusing to continue to grab the partner and help him up or down the hill.

Looking at the cutting of the rope as an omission highlights an important feature of the conduct. Regardless of the fact that cutting a rope is a willed bodily movement and thus technically an act, the consequence of engaging in such conduct is to terminate life-saving efforts. This has important normative implications. Once the cutting of the rope is viewed as a refusal to continue life-saving efforts, it can be argued that the reason why such conduct is blameworthy is because it failed to make the climbing partner better off as opposed to making him worse off. This is what makes omissions generally less blameworthy than actions. Omitting rescue fails to make the victim better off than she would have been had rescue been successfully carried out. Nevertheless, the victim is not made worse off by the omission than she was before. In contrast, actively killing or harming the victim makes her worse off than she was before the harmful conduct took place. Applied to the case of cutting the rope, if the best way of describing the course of conduct is as the climber's failure to continue rescue efforts that would prevent harm to his partner, then cutting the rope merely fails to make his partner better off. This is less blameworthy than making him worse off by, for example, killing him in order to cannibalize him.

While something is gained by describing the climber's cutting of the rope as an omission, this tells only part of the story. There is something more to cutting the rope than merely omitting to provide further rescue. The most obvious feature that distinguishes this fact pattern from the standard omission case is that cutting the rope amounts to what is conventionally understood as an act, given that it is accomplished by engaging in a voluntary physical movement.

In addition to this—and more importantly—by cutting the rope the climber is not merely allowing his partner to die. He is also hastening his partner's death, for the partner would surely have lived longer had the climber abstained from cutting the rope. This feature of the conduct is incompatible with our standard understanding of omissions. As a general rule, a person who omits rescue does not do something that accelerates the victim's death. To be sure, effecting rescue would prolong the person's life. However, failing to

⁶⁰ *Barber v. Superior Court*, 195 Cal. Rptr. 484, 490 (Ct. App. 1983).

⁶¹ *Id.*

rescue would not hasten death. It would merely allow death to take place as it would have taken place had no one been in a position to rescue in the first place. Nevertheless, the act of killing is legally and morally relevant—at least in part—because it precipitates the victim’s death. Insofar as cutting the rope accelerates death rather than merely letting it take place as it would have had no rescue efforts taken place to begin with, the conduct should not be viewed as purely omissive in nature.

As the previous discussion illustrates, contributing to causing the death of a climbing partner by cutting the rope that keeps him from falling into an abyss shares features of both active and omissive conduct. There is a relevant sense in which the conduct amounts to a failure to continue life-saving rescue. There is also a sense in which the conduct amounts to accelerating death. And this is more compatible with the structure of harm causing acts. Cutting the rope in such cases thus reflects the signature structure of an actmission. First, the event that endangered the life of climber was a product of natural forces and can thus not be attributed to the climber who cut the rope. Second, the climber was in an ideal position to prevent further harm to his partner by rescuing him, which he attempted to do. Thirdly, the climber terminates life-saving efforts. Fourth, the climber’s failure to continue life-saving efforts stems from a willed bodily movement (cutting the rope). Finally, the climber’s willed bodily movement accelerates the death of the partner.

Viewing the climber’s cutting of the rope as an actmission makes sense from a normative perspective. Recall that actmissions are more blameworthy than pure omissions but less worthy of condemnation than full-fledged affirmative actions. Interestingly, the law appears to treat cases of cutting the rope as courses of conduct of intermediate gravity that are less serious than cases of affirmatively killing a climbing partner and more serious than instances of merely failing to rescue the partner. Note that the law generally frowns upon affirmatively killing someone in emergency situations even if doing so is necessary to stave off death. This is the lesson to be learned from the *Dudley & Stephens* case. Killing an innocent human being is unlawful regardless of whether the individual killed is dying and of whether doing so is necessary to save even more lives.⁶² In contrast, failing to rescue a person is generally lawful even if it would have been easy to effectuate rescue and even if rescuing the person would prevent her death.⁶³ As a result, it continues to be the general rule that climbers are not liable for failing to initiate rescue of other climbers even if the endangered climber will surely die if rescue is not attempted.⁶⁴

As far as the law is concerned, cutting a rope that keeps a climbing partner from falling to his death seems to lie somewhere in between actively

⁶² Queen. v. Dudley & Stephens, [1884] 14 Q.B.D. 273 (Eng.).

⁶³ RESTATEMENT (THIRD) OF TORTS § 37 (2012).

⁶⁴ SCHMID ET AL., *supra* note 59.

killing your partner and merely failing to rescue him. Most commentators suggest that the climber should be allowed to cut the rope in order to save his life, even if doing so precipitates his partner's death. It is assumed that this is the correct legal solution to the problem, even though there is no precedent directly on point. If so, cutting the rope would be treated differently than affirmatively killing an innocent person in order to save your life. The latter is prohibited pursuant to the *Dudley and Stephens* rule. Nevertheless, the law would likely not treat cutting the rope in the same manner as it would treat a pure failure to rescue. In a pure failure to rescue case, there is simply no legal duty to effectuate rescue. Thus, the climber will escape liability regardless of how unreasonable his decision to refuse to rescue may be. Contrarily, it seems that a climber who cuts the rope will only evade punishment if cutting the rope is necessary to save his life. If so, contributing to the death of a climbing partner by cutting a rope is considered more serious than merely failing to rescue him, but less serious than affirmatively killing him. It is, in sum, treated as an actmission, even if the law does not actually refer to it in that manner.

C. *Actmissions and Duty to Rescue in Tort Law*

There is a common thread uniting the cases discussed in this section. In both the euthanasia cases and the "cutting the rope" cases the conduct that gives rise to death may be described as a way of discontinuing life-saving efforts. The liability arising as a result of discontinuing aid is not only of interest in the criminal law context. Such cases have also pushed the boundaries of traditional tort doctrines. More specifically, courts and commentators have long debated whether voluntary undertakings to rescue should generate liability for harms suffered by the victim when rescue is attempted but later abandoned. The problem was deemed to be of such importance, that it was expressly addressed in the Restatement (Second) of Torts. According to the Restatement, the "duty of one who takes charge of another who is helpless" is the following:

One who, being under no duty to do so, takes charge of another who is helpless adequately to aid or protect himself is subject to liability to the other for any bodily harm caused to him by . . . (b) the actor's discontinuing his aid or protection, if by so doing he leaves the other in a worse position than when the actor took charge of him.⁶⁵

The Restatement recommends imposing liability only when discontinuing aid leaves the actor in a worse position than he was before rescue was initiated. The actor is left in a worse position if after the rescue attempt she is "exposed to increased risks or harms" that were not present before rescue

⁶⁵ RESTATEMENT (SECOND) OF TORTS § 324 (1965).

was attempted.⁶⁶ The actor is also made worse off than before rescue is initiated if “her new position reduces her likelihood of getting assistance from others.”⁶⁷

The Restatement does not recommend imposing liability if discontinuing aid does not make the victim worse off.⁶⁸ Interestingly, however, the Restatement does not recommend against imposing liability in such cases either. Instead, the Restatement approaches these cases by taking what Professor Epstein has called “a studied pass.”⁶⁹ Thus, the Restatement makes it clear that:

The Institute expresses no opinion as to whether there may not be situations in which an actor who has taken charge of a helpless person may be subject to liability for harm resulting from his discontinuance of the aid or protection, where by doing so he leaves the other in no worse position than when the actor took charge of him.⁷⁰

The issue is one that has generated considerable controversy. According to what some have called the “traditional view,” once rescue is initiated, the rescuer “must not leave the victim in a worse position.” If the victim is left worse off, liability would follow.⁷¹ Nevertheless, if the victim is not made worse off, liability would be inappropriate even if the rescue is discontinued.⁷² According to the “more modern view,” however, the “rescuer is obligated to act reasonably once she has begun to act.”⁷³ Liability would thus follow even if the victim cannot claim to have been made worse off than she was before rescue was initiated.⁷⁴

The different approaches have been illustrated in a widely used torts hornbook by use of the following example.⁷⁵ An expert swimmer is sunbathing in a deserted beach. She spots a person drowning and decides to swim out to him. After she reaches the halfway point, she decides to abandon the rescue and returns to shore. The victim drowns. Is the expert swimmer liable in tort?⁷⁶ According to the so-called traditional view, the swimmer would not be liable because she did not leave the drowning person worse off than she was before

⁶⁶ RICHARD A. EPSTEIN, TORTS 293 (1999).

⁶⁷ *Id.*

⁶⁸ RESTATEMENT (SECOND) OF TORTS § 324, caveat (1965).

⁶⁹ EPSTEIN, *supra* note 66, at 293.

⁷⁰ RESTATEMENT (SECOND) OF TORTS § 324, caveat (1965).

⁷¹ JOHN L. DIAMOND ET AL., UNDERSTANDING TORTS 112 (3d ed. 2008).

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ See DIAMOND, *supra* note 71.

⁷⁶ *Id.*

rescue was initiated.⁷⁷ Given that the beach was deserted, the victim cannot claim that the swimmer's abandoned rescue attempt made it less likely that others would come to his aid. And since the victim was drowning before the rescue was initiated, the abandonment of the rescue effort did nothing to alter the position of the victim. In contrast, under the more modern view, the swimmer would likely be liable because it seems unreasonable to abandon rescue in these circumstances.⁷⁸

While the appropriate solution to his case is unclear, a slight alteration of the hypothetical makes it easier to draw additional important distinctions. Suppose that the expert swimmer decides to swim out to rescue the drowning person. But this time the expert swimmer actually grabs the drowning person and starts swimming with him back to shore. After reaching the halfway point, the expert swimmer decides to let the drowning person go for no apparent reason. The expert swimmer swims back to shore and the drowning person eventually drowns. Is the expert swimmer liable? Once again, the result depends on whether the issue is approached under the "traditional" or "modern" view. Given that the expert swimmer did not leave the drowning person worse off than she was before rescue was initiated, the traditional view would lead to a finding of no liability. In contrast, given that abandoning rescue in such circumstances seems unreasonable, there would likely be liability under the modern view. So conceived, the modified example appears identical to the original hypothetical in terms of the liability that ought to be imposed.

What the modified hypothetical does, however, is highlight the role that expectations and reliance play in deciding whether liability should be imposed in these types of cases. Once more, the drowning person cannot reasonably expect that she is going to be rescued before a rescue attempt is launched. Nevertheless, once the expert swimmer initiates rescue, expectations change. This becomes even more evident when the expert swimmer grabs the drowning person and starts pulling her closer to shore. Once the expert swimmer has a hold of the drowning person, the drowning person can reasonably expect that rescue will be completed. At that point, it does not seem to matter much whether abandoning rescue would make the victim worse off than she was before the rescue attempt began. Note that it appears likely that the victim would not be made worse off than she was before rescue began if rescue is abandoned. She was likely going to drown had no rescue been initiated, and she will likely drown if rescue is abandoned. Yet, there is also a relevant sense in which the victim is made worse off by the abandoned rescue. The victim is made worse off *vis a vis* the position she was *after* rescue was initiated but before it was abandoned. More specifically, when the expert swimmer grabbed the drowning person and started pulling her closer to shore, the situation of the drowning person evolved from one of likely death to one of

⁷⁷ *Id.*

⁷⁸ *Id.*

likely survival. By letting her go and abandoning rescue, the expert swimmer leaves the victim worse off than she was when rescue was being performed.

The subtle change in the facts highlights an important feature of American tort law. There is no debate as to the liability of someone who makes another worse off by abandoning rescue. If it is concluded that the abandoned rescue makes the person worse off, imposing liability is uncontroversial.⁷⁹ In contrast, there is much debate as to whether it is appropriate to impose liability when the abandoned rescue is unreasonable but it does not make the victim worse off than she was before. Note that the only argument in favor of imposing liability in the original hypothetical is that the decision to abandon rescue was unreasonable. In that case no argument can be made that the swimmer was made worse off by the failed rescue.

In contrast, it is plausible to argue that in the modified hypothetical the victim is made worse off by the actor's decision to abandon rescue by letting go of the victim. While in this case the victim is not made worse off than she was before rescue was initiated, she is made worse off than she was after the actor grabbed a hold of her and started pulling her back to shore. The distinction is one of legal significance. Thus, according to the Restatement comments:

If the actor has succeeded in removing the other from a position of danger to one of safety, he cannot change his position for the worse by unreasonably putting him back into the same peril, or into a new one. Thus, while A, who has taken B from a trench filled with poisonous gas, does not thereby obligate himself to pay for B's treatment in a hospital, he cannot throw B back into the same trench⁸⁰

Application of this rule to the modified swimmer hypothetical is straightforward. The expert swimmer who removes the drowning person from a position of danger by grabbing him and pulling him towards the shore incurs a tort liability if he abandons rescue by letting go of the drowning person and returning him to the same peril.

Tort law thus distinguishes between two different types of abandoned rescues. On the one hand, there are cases in which the rescuer abandons rescue before he manages to remove the victim from the position of danger that threatened her wellbeing. This case is illustrated by the original expert swimmer hypothetical. It is controversial whether liability is appropriate in these cases and the Restatement expressly considered the issue and declined to take a position. On the other hand, there are cases in which the rescuer abandons rescue *after* he removed the victim from the peril that jeopardized her wellbeing. These cases are illustrated by the modified expert swimmer

⁷⁹ Assuming, of course, that the plaintiff proves that defendant's termination of rescue efforts was negligent. There can be no liability for a tort of negligence without proof of negligence.

⁸⁰ RESTATEMENT (SECOND) OF TORTS § 324 cmt. g (1965).

example. In such cases, the imposition of liability is uncontroversial, as illustrated by the Restatement comments.

What justifies this disparate treatment? The chief difference is that when rescue is abandoned prior to removing the victim from peril, the actor's conduct amounts to a pure omission. The abandoned rescue amounts to a failure to rescue. However, when rescue is abandoned after the victim is removed from peril, the actor's conduct can no longer be considered a pure omission. When the actor removes the victim from peril she typically engages in a willed bodily movement. Thus, the expert swimmer removes the drowning person from danger by grabbing her. Similarly, the person who removes another from a trench filled with poisonous gas does so by, for example, grabbing the person and pulling her up or throwing a rope to the person. Subsequently, rescue is typically terminated when the actor engages in a willed bodily movement that returns the victim to the peril that she was exposed to before rescue was initiated. The expert swimmer, for example, lets go of the victim. The person who removed another from the trench by grabbing on to her lets go of the victim. If the person was removed from the trench by a rope, the rescuer may cut the rope to terminate rescue.

Given that in all of these cases rescue is terminated by way of an act, there is a sense in which the termination of rescue amounts to both an act and an omission. It shares the structure of action because rescue is terminated by way of a willed bodily movement (i.e., an act). In contrast, it shares the feature of omissive behavior because the effect of the willed bodily movement is to terminate rescue and the termination of rescue can be described as a failure or an omission to aid. Since such cases share important features of both actions and omissions, it is sensible to describe them as actmissions that are more blameworthy than harm causing omissions but less worthy of condemnation than harm causing actions. Current tort law appears to treat these cases in this manner. Pure omission cases are reflective of such little blame that they either generate no liability whatsoever (standard failure to rescue cases) or it is unclear whether they generate liability (abandoned rescue cases in which no act is performed that removes the victim from danger and subsequently returns her to danger). In contrast, cases in which harm is caused by way of an affirmative act generate full liability for the harm caused. But lying somewhere in between these two extremes is the actmission of abandoning rescue by engaging in an act that returns the victim to the situation of peril. Doing so appears to generate tort liability. Therefore, the law treats these cases as more serious wrongs than cases in which rescue is never attempted or it is attempted but abandoned without ever removing the victim from the situation of danger. Nevertheless, it treats them as less egregious wrongs than cases in which the wrongdoer harms the victim by engaging in an affirmative act.

III. A PHILOSOPHICAL AND LEGAL OBJECTION TO THE THEORY OF ACTMISSIONS AND REPLIES TO THE OBJECTIONS

A. *Philosophical Objection—Acts Are Not More Blameworthy than Omissions*

As defined in this article, harm causing actmissions are less blameworthy than harm causing actions but more worthy of condemnation than harm producing omissions. This assumes that actions are, as a general rule, more blameworthy than omissions. If it turns out, however, that harms that result as a consequence of an omission are as blameworthy as harms that are the product of an act, then creating an intermediate category of actmissions makes little sense. The whole point of this exercise is to argue that the act/omission distinction does not adequately capture the full import of the blameworthiness of certain courses of conduct. Nevertheless, if killing (action) and letting die (omission) are equally blameworthy, it would not make much moral or legal difference to conclude that there are some cases that share features of killings and failures prevent death (actmissions).

As a result, an obvious objection to the thesis advanced in this article is that actions are not really more blameworthy than omissions. This thesis finds some support in the philosophical literature. Professor Michael Tooley, for example, has famously argued that, *ceteris paribus*, there is no moral difference between performing an act that causes a particular harm and failing to engage in an act that would prevent that harm from materializing. In the context of homicide, Tooley's thesis implies that:

[O]ther things being equal, it is just as wrong intentionally to refrain from administering an antidote to someone who is dying of poisoning as it is to administer the poison, provided that the same motive is operative in both cases.⁸¹

For Tooley, what ultimately determines the blameworthiness of a given course of conduct are the actor's intentions and motives rather than whether the harm was brought about by action or inaction.⁸² While Tooley admits that it is often the case that actors who cause harm by acting usually have worse motives than those who cause harm by failing to act, he argues that there is nothing about the act/omission distinction that makes this necessarily the case. One can surely imagine cases in which the actor who affirmatively causes harm and the one who refrains from preventing harm engage in their respective courses of conduct for exactly the same reasons. According to Tooley, in such cases there

⁸¹ Michael Tooley, *An Irrelevant Consideration: Killing vs. Letting Die*, in *KILLING AND LETTING DIE* 103, 104 (Alastair Norcross & Bonnie Steinbock eds., Fordham Univ. Press 2d ed.1994).

⁸² *Id.*

is no intrinsic moral difference between actively causing harm and failing to prevent it. Tooley uses the following example to illustrate his argument:

Imagine a machine containing two children, John and Mary. If one pushes a button, John will be killed, but Mary will emerge unharmed. If one does not push the button, John will emerge unharmed, but Mary will be killed. In the first case one kills John, while in the second case one merely lets Mary die.⁸³

Faced with this predicament, Tooley asks if “one really wish[es] to say that the action of intentionally refraining from pushing the button is morally preferable to the action of pushing it”.⁸⁴ He then goes on to argue that “[t]he best action, . . . would be to flip a coin to decide which action to perform, thus giving each person an equal chance of surviving.”⁸⁵ If that is not possible, however, Tooley contends that it is a “matter of indifference whether one pushes the button or not.”⁸⁶

The most obvious argument that can be leveled against Tooley’s thesis is that most people believe that contributing to harm by way of an act is more blameworthy than contributing to harm by failing to act. The distinction between action and inaction is so deeply ingrained in the human psyche that many of the decisions we make in our lives are consciously or unconsciously influenced by this dichotomy. The most obvious example is that of charity. Most people consider that giving time or resources to help others is supererogatory. Therefore, while helping those in need of help is praiseworthy, it is not, as a general matter, morally or legally required. Further, even in the few instances in which it may be morally required to help those in need of aid, failing to do so is generally not as blameworthy as actively causing harm.

As a result, most of us often fail to help those who are in need of aid. Perhaps most of us give money to charity or volunteer at the local YMCA. However, few of us give all our financial resources or free time to charity. Many of us are willing to devote considerable amounts of money and time to relatively trivial things like going to a football game or having an expensive dinner at a fancy restaurant. Deep inside, we know that spending that time or money helping people in need of help is more worthy of praise. Many of us are intellectually aware that we would save dozens if not hundreds of lives if we gave all the money we spend on things we do not truly need to people who need food and medicine to survive. Nevertheless, we do not usually consider ourselves responsible for the harms suffered by those that we fail to help. While some might go as far as considering that their failure to devote all their time and money to helping those in need of help is a moral failure, few would

⁸³ *Id.* at 108.

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ *Id.*

believe that the failure to help the needy is tantamount to actively harming them. As a result of this generalized intuition, most people believe that the duty to abstain from causing harm to others is more stringent than the duty to aid those who are in need of help. Consequently, most people go out of their way to act in a way that does no harm. In contrast, considerably fewer people go out of their way to help others. This behavior is morally coherent only if it is generally worse to affirmatively cause harm than to fail to prevent it.

As appealing as these intuitions are, they do not alone disprove Tooley's thesis. It can turn out—as is often the case—that people's intuitions are wrong. The issue then becomes whether these widespread intuitions can be defended by appealing to a coherent moral distinction. Fortunately, there is a coherent moral argument that explains why acts are generally worse than omissions. As was already pointed out in the Introduction, the act/omission distinction is morally relevant because it is generally worse to engage in conduct that makes someone worse off than to engage in conduct that merely fails to make someone better off. Acts and omissions are important to this distinction because, as a general rule, the actor who affirmatively causes harm makes the victim worse off than she was before she interacted with the actor, whereas the person that fails to prevent harm merely fails to make the victim better off than she was before the omission took place.

According to Professor Warren Quinn, the distinction between making a person worse off and failing to make her better off is of significant moral import because it implicates different kinds of rights.⁸⁷ A person that is made worse off by another's conduct may appropriately claim that such conduct impinged on one of her negative rights.⁸⁸ In contrast, a person that is not made better off by another's conduct cannot claim that such conduct impinges on her negative rights.⁸⁹ At most, such conduct interferes with her positive rights. Negative rights are rights against others interfering with your conduct.⁹⁰ If, for example, John has a negative right to life, then others are barred from interfering with John's life. In contrast, positive rights are rights requiring others to provide you with something that is of value to you.⁹¹ As a result, if María has a positive right to life, then others are required to come to María's aid if her life is in danger.

These rights, in turn, impose different duties. If one has a negative right to life, then others have a duty to abstain from engaging in acts that might cause one's death. In contrast, if we have a positive right to life, then others have a duty to rescue us if our lives are in jeopardy. The duties imposed by positive rights are thus far more demanding than those imposed by negative rights. In

⁸⁷ See Quinn, *supra* note 4, at 289.

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *Id.*

order for us to respect the negative rights of others we only need to abstain from engaging in harm causing actions. In contrast, in order for us to respect the positive rights of others we need to engage in all sorts of acts that accrue to the benefit of others. The latter is a much more stringent duty than the former. Further, negative rights are more basic than positive rights. Societal life would not be possible if people continuously interfered with each other's lives. In contrast, societal life would surely be possible even if people failed to come to each other's help. While such a society might not be particularly attractive, it would be more tolerable than a society in which others continuously interfere with your affairs.

Once the distinction between positive and negative rights is grasped, it is easy to see why harms brought about by acts are worse than harms brought about by omissions. Harm causing acts make people worse off than they were before. As a result, harm causing acts interfere with the negative rights of the victim. In contrast, harm causing omissions fail to make the victim better off than she was before. Such omissions interfere with the positive rights of the victim, as they fail to provide her with something that she values. Given that negative rights are more fundamental than positive rights and that harm causing acts interfere with negative rights whereas harm causing omissions interfere with positive rights, acts are generally more blameworthy than omissions.

B. Legal Objection—Actmissions Are Really Omissions in Which There Is a Duty to Act

Viewed from a legal perspective, it is worth asking if it is better to treat actmissions as instances of omission in which there is a special duty to act. The termination of life support cases could be viewed in this way. Maybe the whole story in such cases is that the doctor owes a duty to provide life support to the patient and that the doctor may only disconnect life support if the patient consents to doing so or if the duty to continue treatment wanes because there is no real chance of survival. In the former case, one might say that the duty to continue treatment disappears because the patient waives her right to receive treatment. In the latter case, it might be argued that the duty evaporates because continuing treatment would be futile. This account of the termination of life support cases is so pervasive that it is commonly invoked by courts and commentators as the best way of describing the considerations that are at stake in these cases.

The problem with describing actmissions as omission cases in which there is a special duty to act is twofold. First, there are many instances of actmissions in which it is unclear whether there is a duty to act. Second, even if there is a duty to act and the obligation that is imposed is to rescue the victim, actmissions deserve less punishment than the punishment that is traditionally imposed when harm is caused as a result of a breach of a special duty to act.

Regarding the first problem, it is not obvious that in all actmission cases there is a duty to act. The case of the climber who cuts the rope is a good

example. Many have argued that in such circumstances there is no duty to continue rescue. It is often argued that climbers in high risk situations simply do not owe each other a reciprocal obligation to rescue. Such endeavors are so risky that the conventional understanding seems to be that each climber proceeds at his own peril. It would thus seem odd to describe the case as one in which the climber breaches a duty. The morally relevant feature in the case is that cutting the rope is a willed bodily movement. As a result, the case is more disturbing than a standard case of a mere failure to rescue. This feature of the case is simply unaccounted for if one describes the course of conduct as one that solely entails an omission.

Secondly, even in the cases of actmissions in which there is a duty to rescue, there is something untoward about terminating rescue or abandoning rescue by engaging in a willed bodily movement. The cutting the rope fact pattern is once again a case in point. Even if for the sake of argument one assumes that the climber has a duty to rescue his partner, there is something particularly disconcerting about breaching that duty by actively cutting the rope as opposed to by merely omitting aid. Similarly, in the discontinuing life support cases, there is something special about flipping the switch that terminates life support that is simply not implicated when a doctor refuses to provide life-saving treatment in the first place. This is also illustrated by the tort cases. While it is generally the case that failing to rescue those who are in need of help generates no tort liability, undertaking rescue and subsequently terminating rescue may—and often does—generate tort liability.

At the end of the day, there is something about all of these cases that cannot be explained by merely pointing out that there has been a breach of a duty. The fact that in all of these instances the so-called breach of the duty results as a consequence of engaging in a willed bodily movement (cutting the rope, flipping the switch, or returning the victim to the trench filled with poisonous gas) is an essential feature of these cases that cannot be ignored. As a result, describing these actmission cases as mere failures to act that result in a breach of a duty does not do justice to the subtle moral features that makes these cases worthy of close scrutiny.

IV. CONCLUSION

This article argued that there is a category of human conduct that lies somewhere between acts and omissions and that when such conduct contributes to bringing about a harmful consequence it should usually be deemed more wrongful than causing that result by way of an omission but less wrongful than causing the same result by way of an action. This article called these courses of conduct “actmissions.” The article further argued that the best way of understanding several important and controversial cases, including, but not limited to, euthanasia cases and certain duty to rescue tort cases is by describing them as actmissions. The person who causes the death of another by pressing a button that discontinues life support engages in conduct that shares

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certain important features of actions (willed bodily movement) and omissions (failure to continue to provide medical treatment). The same is true of the person who begins rescue (throws a rope to a fellow climber) and then engages in an act that terminates rescue (cuts the rope). The full import of such conduct cannot be grasped until the simultaneous omissive and active nature of such fact patterns is acknowledged. This, in turn, helps explain why both the passive euthanasia cases and the duty to rescue tort cases remain controversial despite the fact that courts have framed them as cases of mere omissions to continue life saving measures.