Philosophical Medical Ethics

Acts and omissions, killing and letting die

RAANAN GILLON

One of the central arguments in the moral defence of Dr Arthur was that, although it was impermissible for a doctor to kill his patient, it was sometimes morally permissible to allow the patient to die and that such permissibility extended to cases of newborn infants with severe handicaps. Whether this distinction between killing and letting die is thought to be morally relevant in cases of newborn infants with Down's syndrome rejected by their parents (the case confronted by Dr Arthur), few doctors doubt its relevance to some medicomoral problems. Such cases include patients with fatal diseases who would actually prefer to be dead. Although some doctors would be prepared to espouse voluntary euthanasia and kill these patients,¹ most, like the BMA's *Handbook of Medical Ethics*,² would probably reject killing yet be prepared to withhold lifesaving treatment knowing that the omission would probably result in an earlier death than would be the case if treatment were given.³

The distinction is often referred to in the context of euthanasia by the satiric lines of Arthur Clough, now raised by many in the medical profession to near holy writ: "Thou shalt not kill but needs't not strive officiously to keep alive."⁴ What, if any, moral importance resides in the distinction between killing and letting die?

Acts and omissions doctrine

One argument is that actions that result in some undesirable consequence are in general morally worse than inactions, or failures to act, that have the same consequence—an argument that I call the acts and omissions doctrine. Intuitively, such a doctrine seems attractive, and indeed some would say obviously true. If I do not send a cheque to Oxfam someone will probably die who otherwise would not have died. Suppose I discover who that person is and send him (in addition to my cheque to Oxfam) a small personal food parcel containing a Danish pastry that I have carefully flavoured with the appropriate almond flavoured poison. Would I then have a moral defence that as there is no morally relevant difference between acts and omissions I was doing nothing worse in sending the poisoned cake than if I had not sent the cheque to Oxfam?⁵

Of course, in that example, it is worse to act to kill the person, and any moral theory that could not justify this conclusion would stand condemned by that fact alone by an argument of *reductio ad absurdum*. However, it is not the acts and omissions doctrine that explains the moral distinction.

Of the many philosophical attacks against the acts and omissions doctrine, perhaps one of the simplest is shown in the imaginary counterexample offered by Rachels.⁶ Starting from a consideration of the famous "Johns Hopkins case," in which on parental request an infant with Down's syndrome with duodenal atresia was not

operated on and died⁷—a case whose mirror image was the English case "re B," in which in similar circumstances a court ruled that the infant had to be operated on⁸—Rachels offers a "philosopher's example" to show that the bare distinction between acts and omissions is not necessarily morally important. Smith and Jones both stand to inherit fortunes if their 6 year old cousins predecease them. Smith drowns his cousin in the bath, making it seem like an accident. Jones intends to drown his cousin but on creeping into the bathroom sees the boy slip, bang his head, and slide unconscious beneath the water. Jones waits to make sure that the boy really does die and is ready to push his head back under the water if he should surface, but the boy drowns accidentally.

The two cases are almost identical except that one is a case of an act and the other of an omission. Yet, argues Rachels, no one would want to argue that there was any moral difference between the two cases; in particular, no one would argue that Jones was any less morally culpable than Smith. Rachels concludes therefore that in the absence of other morally important differences the bare distinction between acts and omissions, between killing and letting die, is not itself morally relevant.

It is, of course, no use retreating to the position that sometimes acts with a given consequence are worse than omissions with that consequence unless you can also say what it is that makes the moral difference; whatever that something is it must be different from the bare difference between acts and omissions.

Moral difference between killing and letting die

Sometimes the difference is seen as one of harming versus benefiting: whereas a doctor has a responsibility not to harm his patient, it may be claimed that he is not obliged always to help the patient. Although this may be a plausible defence for people who do not have particular obligations to help patients, being a doctor includes voluntarily undertaking an obligation to help one's patients—that, indeed, is the primary purpose of medicine. Thus it would be absurd for a doctor to try to justify an omission to provide lifesaving treatment for his patient on the grounds that he had no moral obligation to help his patient.

Can it be that the intuitive moral difference between cases of killing and letting die is really based on overall considerations of harm and benefit to the patient and that in cases in which doctors feel justified in not providing lifesaving treatment the justification is really that to do so would not benefit the patient (and probably harm him)? Undoubtedly, such assessments of harm and benefit are essential for all medical interventions, but again they are not equivalent to the acts and omissions doctrine, as an example should make clear. A patient suffering from untreatable widespread metastatic cancer has been labelled by the consultant and his ward team as "Do not resuscitate"; cardiopulmonary resuscitation would not, they think, benefit him and would probably harm him. The patient has a myocardial infarction in the presence of the consultant, who quite deliberately does not resuscitate him, and the patient dies. This is a case of an omission—a letting die—that the consultant considers justifiable as he believes that overall the patient would not have benefited from the omitted action.

Imperial College of Science and Technology, London SW7 1NA

RAANAN GILLON, MB, MRCP, director, Imperial College health service, editor, *Journal of Medical Ethics*, and associate director, Institute of Medical Ethics

Now consider the same patient except that this time the houseman and cardiac arrest team on night duty have resuscitated him after his infarction, and he is unconscious on a respirator, the heart having been restarted successfully. The consultant still believes that cardiopulmonary resuscitation would not benefit this patient; indeed, he is more certain than ever for there is some evidence that the resuscitation was not started until several minutes after the arrest and there is probably additional anoxic brain damage. The consultant turns off and disconnects the respirator, and the patient dies almost immediately. There is no doubt that the consultant has acted in the second case, as distinct from omitting to act in the first, and has caused the death of the patient (assuming he was not already brain dead).

If this causal account of the matter is still resisted the reader should ask whether the consultant who did the same thing for bad motives—for example, to get away for the weekend—would be described as causing the patient's death by disconnecting the ventilator. According to common medical interpretation of the Clough doctrine, the consultant's omission was morally correct in the first case, but his action in the second case was morally unacceptable. If, on the other hand, the moral analysis is based on an assessment of overall harms and benefits to the patient then if the omission in the first case is morally acceptable so too must be the action in the second case; in fact in the second case there will be better reason to believe that the patient would not have benefited by continuing life support. Clearly, assessment of harm and benefit to the patient is not equivalent to deciding whether it is the doctor's action or omission that has led to the patient's death—that is, deciding whether killing or letting die has occurred.

Rejection of doctrine by Roman Catholics

The acts and omissions doctrine outlined above is sometimes thought to be a Roman Catholic doctrine, but it is no such thing; as vigorous a rejection of this doctrine is offered by Roman Catholic philosophers and theologians^{9 10} as by secular philosophers,^{6 11 12} and one reason for its recent explicit rejection by Roman Catholics concerned with medical ethics is the way that doctors have used it to defend actions such as Dr Arthur's.¹³

Crucial to the Roman Catholic rejection of the simple, indeed simplistic, acts and omissions doctrine in relation to killing and letting die are several moral claims. Firstly, an omission by definition is not simply any inaction but a morally culpable inaction. Thus there must be some additional moral information given before any particular inaction can be classified as an omission, for, as Aquinas first defined it, "Omission means failing to do good, albeit not any good but only the good that one ought to do."¹⁴ On this account it is absurd to talk about omissions being morally acceptable because, by definition, all omissions are morally unacceptable.

The second moral claim made by the Roman Catholics is that not only does outcome matter when a moral judgment is made on a person's action but so too do preceding considerations, including pre-existing moral obligations and the understanding and intention with which the person acted. Few sophisticated moral philosophers would disagree with that; although simplistic utilitarians (usually non-philosophers) sometimes deny it, it would be mistaken to suppose that this represents a moral gulf separating Roman Catholic or other deontologists from utilitarians.

The philosophy of action is a complicated and contentious subject,¹⁴ but there is little doubt that both the consequences of an action and the agent's beliefs and intentions about what he is doing are relevant to its moral assessment. Here Roman Catholic theology has sought to differentiate between intended and unintended consequences of an action, notably in the principle of double effect. I shall consider some problems associated with this principle in the next article, but the claim that we can justifiably differentiate between those consequences of our actions and inactions that we intend, those that we foresee but do not intend, and those that we do not intend or foresee at all seems important though complex.

The third Roman Catholic moral claim in this context is that certain sorts of action and inaction are absolutely forbidden; in

particular, intentional killing of an innocent person, including bringing about death by omission, is absolutely forbidden. On the other hand, intentional actions and omissions not intended to bring about death but as a result of which death may be foreseen may in some circumstances be morally permissible. There are problems with such distinctions between foreseeing and intending to which I shall return, and I have already indicated the morally paralysing effect of pluralist absolutism, acceptance of which entails the logical impossibility of acting rightly in circumstances in which moral absolutes conflict. Moreover, to many of us there seem to be such intuitively obvious counterexamples: during the Falklands war a soldier was reported to have shot his trapped comrade in response to his comrade's anguished pleas that he was burning to death in a situation from which there was no possibility of saving him. Was that morally wrong?

Of course, all moral thinkers would agree that the injunction against intentionally bringing about the death of innocent subjects is of central importance to all societies and that it should be inculcated as a strong rule of moral life. To claim, however, that it is an absolute principle never to be transgressed, irrespective of the strength of other morally valid reasons favouring such transgression in a particular case, is to many of us utterly implausible in the light of real and theoretical counterexamples. Surely moral life is just more complicated than such simple absolutism suggests,¹⁵ though, of course, the opposite position is also widespread and fervently supported.¹⁶

References

- 1 Brewer C. Let our patients die. *BMA News Review* 1985;11:16.
- 2 British Medical Association. *Handbook of medical ethics*. London: British Medical Association, 1984:64-5.
- 3 Bayliss RIS. Thou shalt not strive officiously. *Br Med J* 1982;285:1373-5.
- 4 Clough AH. The latest decalogue. Cited in Glover J. *Causing death and saving lives*. Harmondsworth: Penguin, 1977:92.
- 5 Foot P. The problem of abortion and the doctrine of the double effect. Reprinted in: Steinbock B, ed. *Killing and letting die*. Englewood Cliffs: Prentice-Hall, 1980:156-65.
- 6 Rachels J. Active and passive euthanasia. *N Engl J Med* 1975;292:78-80. Reprinted in Steinbock.⁵
- 7 Gustafson JM. Mongolism, parental desires, and the right to life. *Perspect Biol Med* 1973;16:529-59.
- 8 Mason JK, McCall Smith RA. *Law and medical ethics*. London: Butterworths, 1983:84-5.
- 9 Linacre Centre. *Prolongation of life, paper 2. Is there a morally significant difference between killing and letting die?* London: Linacre Centre, 1978.
- 10 Mahoney J. *Bioethics and belief*. London: Sheed and Ward, 1984:36-51.
- 11 Glover J. *Causing death and saving lives*. Harmondsworth: Penguin, 1977:92-116.
- 12 Harris J. *The value of life*. London: Routledge and Kegan Paul, 1985:28-47.
- 13 Linacre Centre. *Euthanasia and clinical practice: trends, principles and alternatives*. London: Linacre Centre, 1984.
- 14 White AR, ed. *The philosophy of action*. Oxford: Oxford University Press, 1968. (A useful introductory collection of papers; see also Anscombe GEM. *Intention*. Oxford: Blackwell, 1957.)
- 15 Bennett J. Morality and consequences. In: McMurrin M, ed. *The Tanner lectures on human values, 1981*. Cambridge: Cambridge University Press, 1981:45-116.
- 16 Casey J. Actions and consequences. In: Casey J, ed. *Morality and moral reasoning*. London: Methuen, 1971:155-205.

Bibliography

There is a vast range of relevant papers as the subject is important in the treatment of newborn handicapped infants; intensive care; cardiopulmonary resuscitation; the application or withholding of medical and surgical resources in life threatening conditions whether for purposes of rationing or reasons of benevolence; treatment of the elderly and the senile; treatment of the terminally ill; treatment of the permanently unconscious; and the concept and management of brain stem death. A small selection follows:

- President's Commission for the Study of Ethical Problems in Medicine. *Deciding to forgo life sustaining treatment*. Washington: US Government Printing Office, 1983.
- Beauchamp TL, Childress JF. *Principles of biomedical ethics*. 2nd ed. Oxford, New York: Oxford University Press, 1983:106-47.
- Gorovitz S, Macklin R, Jameton A, O'Connor J, Sherwin S, eds. *Moral problems in medicine*. 2nd ed. Englewood Cliffs: Prentice-Hall, 1983.
- Campbell AGM, Duff RS. Deciding the care of severely malformed or dying infants. *J Med Ethics* 1979;5:65-7.
- Sherlock R. Selective non-treatment of newborns (a reply to the previous reference with a further response from A G M Campbell and R S Duff). *J Med Ethics* 1979;5:139-42.
- Harris J. Ethical problems in the management of some severely handicapped children (with commentaries by J Lorber, G E M Anscombe, and D J Cusine). *J Med Ethics* 1981;7:117-24.
- Shearer A. *Everybody's ethics: what future for handicapped babies?* London: Campaign for Mentally Handicapped People, 1984.
- Murray TH. The final, anticlimactic rule on baby Doe. *Hastings Cent Rep* 1985;15(suppl 3):5-9.
- Jennett B. Inappropriate use of intensive care. *Br Med J* 1984;289:1709-11.
- Miles SH, Cranford R, Schultz AL. The do-not-resuscitate order in a teaching hospital: considerations and a suggested policy. *Ann Intern Med* 1982;96:660-4.
- Lo B, Steinbrook RL. Deciding whether to resuscitate. *Arch Intern Med* 1983;143(suppl 8):1561-3.
- Lynn J, Childress JF. Must patients always be given food and water? *Hastings Cent Rep* 1983;13(suppl 5):17-21.
- Pallis C. Whole-brain death reconsidered—physiological facts and philosophy. *J Med Ethics* 1983;9:32-7.