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Ethics has always been one, if not the primary, concern of the medical practitioner. Every physician is familiar with the ancient Hippocratic Oath and aware of the current "code of ethics" promulgated by the American Medical Association. Indeed, among the professions, physicians have continuously been ranked among the leaders in public trust with, unfortunately, politicians, businessmen and clergy ranking far below. Recent developments in biomedical research and medical therapeutics have begun to raise new and vitally serious questions regarding the appropriate use of medical information and therapy, and of adequate controls for biotechnical experimentation.

Achievements in medicine and science in the past forty years have given man new power over acute and chronic disease, physical and mental debilitations, and the mechanical support of deteriorating bodily functions. With the discovery of anesthesia, antiobiotics, and insulin; the techniques of surgical excision, and chemotherapy; and the technologies of life-support systems, have come new and difficult responsibilities. In an important way, medical science has been too successful too rapidly. Technologies have increased our capacity to overcome many human problems of disease and debilitation. But success has come before we have adequately explored the potential abuses of the technology and before we have defined its appropriate and inappropriate uses.

"Euthanasia" is both an ancient and modern controversy. It is one

of those morally loaded words which provokes both outrage and sympathy; it conjures up images of diabolical practices as well as feelings of mercy for the release from painful dying.

The moral justifications for the arguments pro and con euthanasia were largely developed before modern technological therapeutics were discovered. The rapid development of medical technologies is now forcing a new ethical re-thinking on every aspect of life, especially the processes of birth and death. What is all too apparent today is that many ethicists, moralists, philosophers and theologians, are continuing the debate with the stale ammunition of pre-technologic notions. This is not to infer that these ideas are totally inappropriate but, rather, that serious re-thinking must be done to intensify the present debate.

The term "euthanasia" combines two Greek words, meaning "good," and "death." The term does not mean that death is good. All it refers to is the condition under which a person passes from life into death. It is sometimes called a "merciful death" meaning that the person did not suffer long and hard before death occurred.[1]

Discussion of euthanasia is usually classified according to the methods used to hasten or induce death and whether or not death is a self-chosen end. The terms most employed are: active or passive and voluntary or involuntary. Active euthanasia would refer to the direct administration of something for the express purpose of terminating a suffering and terminally ill patient's life. Examples would be a megadose of morphine or a bubble of air in a strategic vein. Passive euthanasia refers to two different types of actions: first, the failure to employ various medical therapies because it is believed that they would not serve to prolong life as much as they would serve to prolong death. Examples would be to withhold antibiotics in a terminally ill person with pneumonia; not connecting a person to a needed respirator; deciding not to institute dialysis despite renal failure; or deciding not to give calories along with IV fluids for a comatose patient. The second type would be the withdrawal of a patient from life-sustaining medical technologies even though death is anticipated. An example of this second type of passive euthanasia would be to turn off a respirator.

Voluntary euthanasia would refer to either active or passive measures performed at the behest of the patient. Involuntary euthanasia would refer to active or passive measures performed on a patient who cannot make his or her wishes known because of incompetency. An example would be someone in a "persistent vegetable state" (e.g., Karen Ann Quinlan).

We must note that in each of these there are tremendously complicated ethical issues. They become further compounded as we combine possibilities, such as active-involuntary euthanasia.

The physician today is placed in a true moral dilemma. His mandate as a physician includes at least three major responsibilities: to protect, preserve, and promote life; to do no harm; and to alleviate suffering.

The dilemma presents itself when not all three can be achieved at the same time with the same patient. For example: does his mandate to preserve and protect life exist above all else? Does this mean that all life should be preserved as long as technically possible? If his patient is in intractable pain, does his mandate to alleviate suffering mean that he can administer increasing dosages of narcotics even though vital functions will be so depressed that they will eventually become life-threatening? What is the content of his mandate to do no harm, *primum non nocere*? What is harm? Is it forcing a person to endure excruciating pain or is it to succumb to an earlier demise? Deciding for one alternative means the subjugation of the others.

Selection of Certain Values

Medicine is not now, nor has it ever been, a value-free enterprise. The practice of medicine is the selection of certain values of health as being normative for the society and the labeling of other non-normative values as deviancy or illness.[2] Advances in medical technology are forcing us to re-think our basic moral positions. Are there circumstances which make life not worth living, in spite of the fact that biologically we can be mechanically sustained? Are there circumstances in which life should be terminated? Should patients who are suffering and dying be allowed to "die with dignity" by withdrawing or failing to employ life-sustaining procedures? Should their lives be taken by death-dealing narcotics? Should such steps be taken only at the request of the patient, or in consultation with his family and his doctor?[3] The dilemma involves the prioritizing of specific values, such as the sanctity of life; the principle of least suffering; the concepts of human dignity, personal autonomy, and justice; the right to live; and the quality of the life that might be salvaged.

In Western culture, Christianity once defined the meaning and order of these ethical principles. "With the secularization of our society, however, ethical values have become autonomous."[4] There is no longer a common commitment to these basic values. And with no general commitment to values, we have no general expectation with regard to how medicine or society should answer this medical dilemma. There exists today "a great deal of conceptual confusion associated with our feelings about life and death."[5]

I am going to suggest that euthanasia need not be the demon first supposed and that it even has a morally acceptable place in our contemporary understanding of patient care for the terminally ill. But I want to make it explicitly clear at the outset that I have what I believe to be reasonable and acceptable limits to the development of a policy of euthanasia. In the line-drawing will be the parameters for my "soft" paradigm.

Our purpose is twofold: first, to encourage a new and healthy

debate on all aspects of the euthanasia issue without loading the "moral gun" before the debate begins, thus I will purposefully not use the term "killing" in my description because of its pejorative moral content;[6] and, second, to set forth a process understanding of life and death that might more adequately inform today's pastoral concerns.

Technology has brought us to the threshhold of a new era in medical care. The old arguments for and against euthanasia cannot simply be transferred to the new debate without a serious re-examination of their moral presuppositions. Just as our understanding of when death occurs has been radically restudied and redefined in recent years,[7] so also our understanding of the "process" of dying must be re-examined. Hopefully, this paper will be a start in that re-examination.

A. The Ethical Argument: The Opposite Extremes

1. The conservative, called the formalist or deontological, position places absolute value on all forms of human life no matter how debilitated. Therefore, no person has the authority to terminate any human life. In opposition to any policy of euthanasia, this position stresses the sanctity of life *per se*, and claims that life always has value regardless of its quality.[8] This has traditionally been the position of the Roman Catholic Church which has claimed that we hold life as a gift from God in trust, and, therefore, only God can take life.[9] And this is the position enshrined in the Catholic Hospital Association guideline which states that "Euthanasia in all its forms is prohibited."[10]

This was also the position of Albert Schweitzer as put forth in his famous "Reverence for Life" essay. He defended the position by saying:

> "Objection is made to this ethic that it sets too high a value on natural life. . . . The ethic of reverence for life is found particularly strange because it enables no dividing line between higher and lower, between more valuable and less valuable life. For this omission it had its reasons. To undertake to lay down universally valid distinctions of value between differing kinds of life will end in judging them by the greater or lesser distance at which they seem to stand from us as human beings — as we ourselves judge. But that is a purely subjective criterion. Who among us knows what significance any other kind of life has in itself, and as part of the universe."[11]

2. The liberal, called the utilitarian, position uses certain qualitative measures to determine the relative value of sustaining a life when seen against the backdrop of competing values. This position holds that biological life is not an end in itself, but only a means to other ends, namely productive human activities. One of the most extreme examples would be a statement by ethicist David H. Smith in which he said that he does not consider every product of the human womb a person.[12] Another example would be the so-called "indicators of humanhood" of Joseph Fletcher. He lists twenty criteria for establishing human personhood. Among these are self-awareness, self-control, a

sense of time (past and future), the capability to relate to others, curiosity, and minimal intelligence. With regard to minimal intelligence he writes, "... any individual ... who falls below the I.Q. 40-Mark ... is questionably a person; below the 20-Mark, not a person."[13] Mongoloids, mental defectives, irretrievably comatose patients, all would fail his qualitative measurements and thus be fit candidates for euthanasia.[14]

B. Ethical Presuppositions

1. The conservative position is based upon three major ethical considerations: the principle of the sanctity of life; a theory of natural law, which includes natural, or *prima facie*, obligations; and the "wedge" argument.

a. The sanctity of life principle is claimed to be inherent in the human experience. All people are aware of, at least, the value of their own lives. Theologically understood, life is a gift of a loving God. It is simply given with no prior considerations as to management potential or worthiness. It is given to man as a sacred trust to be protected and revered. It is, in the Judeo-Christian tradition, created in the image of God. This gives man a "right to life" which is grounded in his divine origin. This right to life is claimed to be "the basis of all other human rights and is the foundation of civilized society."[15] This primary valuation of life is also reflected in the second principle:

b. The theory of natural law is said to be revealed in the natural process, and intuitively known to all men through the powers of human rationality.[16] Natural law theory asserts that man universally has a *prima facie* obligation to do good (positive natural law) and to avoid evil (negative natural law). Positive natural law prescribes that certain moral acts be done because they are intrinsically good. Man has a primary obligation to do good. Negative natural law, on the other hand, proscribes certain actions which are intrinsically evil and actions which are evil because of the attending circumstances.[19] Therefore, man has the primary duty to avoid evil — and there are no exceptions.[18]

A problem often occurs when natural law theory is applied to disjunctive ends and means. Normally we would insist that means be commensurate with the ends in view; that is to say, moral ends cannot be achieved through immoral means. Here natural law theory introduces an appropriate corrective to what might become too rigid a canon of action, the principle of proportionality. For example, normally providing medical support services for life is considered morally good. But when those support services are only sustaining a terminally ill life, wracked by pain and in which there is no hope for recovery, then there are morally appropriate proportional limits on how much support we must provide. We must note here that it is within this prin-

ciple of proportionality that the Roman Catholic Church has discussed the difference between ordinary and extraordinary[19] medical therapy,[20] and also put forth the principle of double effect.[21]

These two presuppositions of the conservative position, namely the sanctity of life principle and the natural law theory, as far as they have been explicated here, this author can fully support. The third presupposition, however, remains problematic.

c. The wedge argument can be stated in two ways. First, using the Kantian principle of universality, (i.e., in order for an act to be good, the principle of that act must be universally good for all. For example, truth telling, being a universally good principle, is morally acceptable, while lying, which can never be universally good, is morally unacceptable), this says that what is wrong for a society is wrong for an individual.[22] Or, second, using the description of Norman St. John Stevas: "Once a concession about the disposability of innocent life is made in one sphere it will inevitably spread to others."[23] The horrors of this fear are vividly described by Yale Kamisar:

> "Miss Voluntary Euthanasia is not likely to be going it alone for very long. Many of her admirers . . . would be neither surprised nor distressed to see her joined by Miss Euthanitize the Congenital Idiots and Miss Euthanitize the Permanently Insane and Miss Euthanatize the Senile Dementia. And these lasses — whether or not they themselves constitute a 'parade of horrors' — certainly make excellent majorettes for such a parade."[24]

The argument is the familiar "domino theory" that warns that once you admit one, it is only a matter of time before others are included. Or, "give an inch and they'll take a mile." Or, once the "edge of the wedge" finds its way in, the whole wedge follows. The argument is also called "the slippery slope," i.e., once you begin to slide, you will eventually end up at the moral bottom.

We must note here that the "wedge argument" has been the most powerful deterrent argument against any policy of euthanasia.[25] But it is problematic because of its own inner assumptions, which are:

a. To make an exception to a rule would destroy the rule. To recognize euthanasia as morally acceptable in one case would make arbitrary any attempt to prohibit it for other cases.

b. The assumption that the worst must happen. To recognize euthanasia as morally acceptable in one case would naturally lead to outrageous abuses, terminating the lives of anyone, and perhaps everyone, who did not meet the minimum criteria for humanhood.

c. That humans are incapable of discriminating between cases that might be considered for euthanasia because of all of the uncertainties involved.

All of these underlying assumptions for the "wedge argument" are problematic, indeed. First, it is not at all clear that exceptions to rules destroy the rules. Second, there is no rational basis for asserting that

the worst must happen. And, finally, to suggest that human beings cannot discriminate between cases raises a serious and, I believe, unfounded attack upon man's conceptual powers.

2. The liberal position, on the other hand, is based upon certain assumptions about what meaningful human life is and, at least according to Joseph Fletcher, a "situational" understanding of how love can best be served, given a situation in which all the alternatives may be less than desirable.[26] This position too has problems. Indeed, the fears of abuse are much clearer here. The guidelines of this position are supplied by Fletcher himself in his presuppositions of "Situation Ethics." They are,

a. Against the "sanctity of life principle" he places pragmatism, which admits no absolutes of any kind, and relativizes every human value to its utility, its workability, and satisfactory consequences. Accordingly, human life is definable by qualitative measurements. Criteria can be established to determine the relative value of life so that life with little or no relative value is expendable.[27]

b. Against the natural law theory, Fletcher places personalism, which "rejects the vitalism and naturalistic determinism of natural law and replaces these values with personal values of human dignity, self-possession and freedom of choice."[28] Theoretically, then, individuals who cannot appropriately appreciate and express these meaningful human values do not qualify as persons, and therefore, have little or no claim to the right to life.[29]

c. In contrast to the "wedge argument" Fletcher believes that relativism can help identify how love can best be served; i.e., all moral norms are subject to the requirements of love. If love permits, or better, requires euthanasia, so be it.[30]

In fairness, we must add that Fletcher believes he is developing a truly moral approach toward a policy of euthanasia. He calls for moral responsibility in making these heavy decisions. But he believes that "even the most revered principles can be thrown aside if they conflict in any concrete case with love."[31]

Pragmatism, personalism and relativism add up to a totally subjective ethic without any necessary guarantee that any of our medical, or even pastoral, decisions will be consistent and rationally understood. Here the temptations to abuse become legitimated in the fuzziness of our moral criteria. The "parade of horrors" that Kamisar envisioned, might too easily become a reality.

C. A Synthetic Possibility For A Soft Paradigm

As an ethicist with a particular theological heritage, my own position with regard to the development of a policy of euthanasia is centered within what I accept as the foundational assumptions of pastoral care. Let me just briefly list these:

1. That we have an underlying sense of Christian values;
2. That we are dedicated persons in our professions; dedicated to the care of souls as well as the care of bodies;
3. That we have a sense of ministry and mission in our work;
4. That we are competent in our work; that we are concerned about continuously examining our own lives, our own values and how we do or do not communicate these values to others;
5. That we are essentially fulfilled persons; that we enjoy the challenges that life provides and are not always chafing at the bit;
6. That we are growth oriented; that we have a thirst for knowledge, both in our medical or pastoral specialities as well as in our quest for greater humanistic insights into life.

There is often a false fear among many people that says somehow that when we get into the thicket of decision-making in difficult cases, we are not going to be able to decide what is the best course of action to suggest or take. Even those who profess a sound religious faith, are often dismayed at their inability to reach decisions regarding care for terminally ill persons, whether they be children, adults, or the elderly. I am certainly not going to suggest that such decision-making can be simple or easy. The more difficult the case, the more difficult the decision. What I am going to suggest, however, is that our difficulty might be due to a false separation of human values regarding life and death. Indeed, I would suppose that if we examine ourselves, we would find that most of us only have values of life and have not thought very much about values of death, whether it be our own death or someone else's.

As medical and para-medical professionals, we have a unique relationship to people in need. We have an opportunity to reach out to them in their need with all of the power of both our medicines and our own personal commitments. Euthanasia may very well be a difficult testing ground for our sense of values. But, if our values are important, then they should stand up to the most difficult of challenges. To ignore or deny the challenge is not to arrive at a satisfactory answer.

I am going to insist that under no circumstance ought euthanasia be considered as an alternative to care. We have no moral ground on which to stand whatever, if we euthanize to avoid care. The mandate of the medical profession is to provide care.[32] All other values rank below this primary obligation. The mandates to promote life and relieve suffering can only be properly understood within the context of human care. To prolong life or to alleviate pain outside this context becomes an abuse of the medical privilege.

Likewise, under this rubric of care, specific therapies become meaningful activities. And under the rubric of care these medical therapies may have limited ranges of effectiveness. It is under this rubric of care that we can morally discontinue life-sustaining therapies because they are non-restorative and inefficacious.

What I am suggesting here is that the continuation of biological life is not the ultimate end value. We must not sacrifice life as long as there is reasonable hope and we certainly must not sacrifice hope when there is reasonable life. But both hope and life have reasonable limits which the rubric of care recognizes. Now, some specifics.

1. My conservative nature requires that I cling fast to the sanctity of life principle;[33] that life is a sacred gift, given to us in trust by a loving God. But, I must also recognize that this gift, and the sacredness which accompanies it, also have limits; i.e., there comes a point in time when the gift is withdrawn and with that action the sacredness diminishes.

If we regard life as a gift from God, we must recognize that He gives it to us in trust that we will use it appropriately to our understanding of His love. In recognizing that life and its sacredness have limits, we are recognizing the trustfulness with which the gift of life is given. This, of course, has biblical precedence. In the Scriptures, both persons and places can have sacredness. And this special status can be lost, not only because of sin and defilement, but also because of the presence of God being withdrawn.

For me, this biblical distinction applies to life and death. The Spirit of God is given to create life; it is also withdrawn as life loses its vitality, its entelechy, as manifested in irreversible coma, a flat (or essentially flat) electroencephalogram, or being in a "persistent vegetative state." Charles Curran makes a distinction between the "process of living" and the "process of dying." The point at which the "process of dying" overtakes the "process of living" is when life-preserving therapies can be discontinued because they are inefficacious.[34] For me, this is the withdrawal of that God-given sacredness which the gift possesses. My conservative nature requires me, therefore, to reject the need to prolong life as long as technically possible providing that certain base line criteria are established, e.g., the Harvard "brain death"[35] or irreversible coma.

2. My more moderate nature forces me to recognize that under the rubric of care excruciating and intractable pain is also destructive to the sanctity of life. Here pain moves beyond the therapeutic bounds of "purifying the soul" and is diminutive to the sacredness of that life. Under the rubric of care our mandate is to relieve pain. If we can decrease pain, even with high dosages, without depressing any physical and conceptual powers, we must do it. But if we cannot, then our first obligation is to relieve pain.

Now, what I am suggesting might not be so different from what is, in fact, being done today in every hospital. With perhaps one exception. If this be passive euthanasia, let us recognize it as such and see it as one of our legitimate values of life within the rubric of care. We may wish to call it "terminal therapy" rather than euthanasia, but we

must recognize that it is a different kind of therapy than chemo- or excisional therapy, which aim primarily at cure or remisison. This is "terminal care therapy" and we should have no qualms about admitting it, to each other, to the family, and even to the patient, if this is still possible.

Daniel Maguire, in a 1974 essay published in the *Humanist*, recognizes that given a particular patient, we may all agree that the most merciful thing would be death, while at the same time realizing that this process of dying is not the most merciful.[36] We must somehow make it clear to both patients and the public that our purpose is to provide care, whether it be health-care to those who can be restored to health, or terminal-care to those who cannot. The reality of death must be recognized, otherwise it will continue to be the dragon of fear that it is for many people today. We must realize that people do not fear death as much as they fear the process of dying. If we can assure our patients of our commitment to care, they will be less fearful of their own dying and more capable of dealing with their other anxieties.

3. We must be very clear in our discussion of euthanasia as having a legitimate place in the medical mandate of care that we not be misunderstood. We must neither see euthanasia as an alternative to care nor suggest it for individuals who are not terminally ill, in intractable pain or irretrievably comatose.[37] Here is the limit of my "soft" paradigm. We cannot morally extend it to persons not in a life-threatening terminal conditions. A distinction supplied by Paul Ramsey is important; a distinction between exceptions to a rule and exemptions from a rule.

Life-Sustaining Therapies

The rule would be to provide life-sustaining therapies of care to all. The exception to this rule would be, as already described, persons terminally ill and irretrievably comatose or in intractable pain. Exemptions from even the consideration of euthanasia would be persons not in the terminal stages of dying, or to use the terms of Kamisar, the "congenital idiots . . . the permanently insane . . . the senile dementia." These may represent those in society who are not as pleasant to look at, or relate to, but they are not, and never ought to be, the candidates for social extermination.

It is important to note here that the present state of American case law makes this point explicitly clear. Normally law exists to protect innocent life,[38] i.e., life that cannot protect itself.[39] An example of this would be the ruling of Judge Muir at the Superior Court level in New Jersey that Karen Quinlan could not be removed from her life-sustaining respirator.[40] However, the New Jersey State Supreme Court, in reversing Judge Muir has provided an appropriate corrective to the belief that the law always protects life to the fullest extent,

regardless of how terminally debilitated that life might actually be. The court ruled that:

> "We think that the State's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest."[41]

This is an extremely important legal step in morally recognizing that life has limits beyond which it ought not to be sustained. But the limits must be reached; and we cannot arbitrarily decide those limits. They are, as the court specified, to be determined medically, not socially.

If this guideline is followed, the "wedge argument" is countered. Human beings are capable of discriminating between cases and can appropriately decide when a life is beyond hope and beyond our ability to save. Yes, of course, there will be difficult cases, and cases which are not immediately clear. In these instances we must decide in favor of sustaining life. But, when the evidence is irrefutable, we must be able to express death as a positive value of life.

4. The only remaining question I wish to explore is the question of "who" should decide. Again the recent New Jersey Supreme Court Decision in the Case of Karen Quinlan is significant. Earlier, Judge Muir, in refusing to grant permission to remove her from the respirator, ruled that the decision was purely a medical decision.[42] The family could make their request known, but the doctor must make the ultimate decision.

The Supreme Court ruling reversed Judge Muir and said that it was a decision which the family must make. This was significant in that it gave Karen back to her parents for this final decision about her care. This is not to say that the doctor couldn't have made this decision wisely, but rather that values were at stake here that clearly went beyond medicine.

Ideally, of course, it would be valuable to know Karen's wishes.[44] Indeed, the patient's own wishes must be sought, if this is possible. But when this cannot ever be acquired, the proper *locus* for the decision is the family. My own addition to this would be to require that the attending physician say "when" this would be medically appropriate, for he has much greater training and experience in recognizing when a person is in the moribund state.

REFERENCES

1. I have purposely not used the term "killing" in my definition, i.e., in the sense of an overt act to end a life and as a crime against the person. This notion was not originally part of the definition. Even euthanasia as "mercy killing" is a recent concept. Historically it has a rather benign meaning. Other ethicists have tried to point this out and have tried to overcome this morally loaded pejorative

description. Arthur Dyck has introduced the word "benemortasia" meaning "good dying"; Joseph Fletcher has used the complicated term "antidystanasia" or "anti-bad/evil death"; and Hans Rudi Weber has suggested the word "orthothanasia" or "straight death" which was to represent unassisted death. See: Arthur Dyck, "Beneficent Euthanasia and Benemortasia: Alternative Views of Mercy" in Marvin Kohl, ed., *Beneficent Euthanasia* (Buffalo, N.Y.: Prometheus Books, 1974), pp. 123ff; Joseph Fletcher, *Moral Responsibility: Situation Ethics at Work* (London: SCM Press, 1967); Hans Rudi Weber, ed., *Experiments With Man* (Geneva: World Council of Churches, 1969). My own feeling is that "euthanasia" is still a valuable word in itself and therefore I will use it. However, I will purposely not intend to use the morally loaded notion of killing — as a crime against the person. I will also bracket out any discussion of the relationship of euthanasia to suicide. Not that it is not relevant, but to decide in favor of euthanasia for one's self while in the terminal stage of disease because the painful process of dying is too horrendous is clearly different than at some other time contemplating self-destruction because life is not worth living. It is a matter of proximity to death and the level of meaning granted to life.

2. Freidson, Eliot, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (New York: Harper & Row, 1970), pp. 244ff. See also: Willard Gaylin, "Forward" to Samuel Gorovitz, ed., *Moral Problems in Medicine* (Englewood Cliffs, N.J.: Prentice-Hall, 1976), p. xxi.

3. Wilson, Jerry B., *Death by Decision: The Medical, Moral, and Legal Dilemmas of Euthanasia* (Philadelphia: The Westminster Press, 1975), p. 51.

4. *Ibid.*, p. 51-52.

5. Gaylin, *op. cit.*, p. xxi.

6. See note no. 1 above.

7. See: "A Definition of Irreversible Coma: Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death" in *The Journal of the American Medical Association*, Vol. 205, No. 6 (August 5, 1968), pp. 337-340. See also: "Refinements in Criteria for the Determination of Death: An Appraisal: A Report by the Task Force on Death and Dying of the Institute of Society, Ethics and the Life Sciences" in *The Journal of the American Medical Association*, Vol. 221, No. 1 (July 3, 1972), pp. 48-53; Hans Jonas, "Against the Stream: Comments on the Definition and Redefinition of Death" in his *Philosophical Essays: From Ancient Creed to Technological Man* (Englewood Cliffs, N.J.: Prentice-Hall, 1974), pp. 132-140.

8. More precisely, some deontologists would claim that human life can never be value-less. Therefore, human life in all its many forms and stages is to be valued because it is always human life.

9. We must note here that the Roman Catholic Church does not make a moral distinction between passive and active euthanasia. Therefore, one cannot deliberately allow a patient to die solely for the purpose of relieving his suffering. This, accordingly, "is morally equivalent to direct killing" (Wilson, *op. cit.*, p.68). Other authors tend to modify this to include the possibility of taking life but only when under a direct biblical mandate, e.g., just war and capital punishment.

10. Catholic Hospital Association, *Ethical and Religious Directives for Catholic Health Facilities* (November, 1971).

11. Schweitzer, Albert, *My Life and My Thought*, pp. 1-3, 185-192. See also: Albert Schweitzer, *The Teaching of Reverence for Life* (New York: Holt, Rinehart and Winston, Inc., 1965).

12. David H. Smith, "On Letting Some Babies Die" in Peter Steinfels and Robert M. Veatch, eds., *Death Inside Out* (New York: Harper Forum Books, 1975), pp. 129-138.

13. Fletcher, Joseph, "Indicators of Humanhood: A Tentative Profile of Man" in *The Hastings Center Report*, Vol. 2, No. 5 (November, 1972), pp. 1-4. See also:

Joseph Fletcher, "Four Indicators of Humanhood — The Enquiry Matures" in *The Hastings Center Report*, Vol. 4, No. 6 (December, 1974), pp. 4-7.

14. A similar argument is sometimes put forth to stress the presence of human "personality." When personality is missing, it is claimed, human life has lost its vitalizing spark. The problem with this is, however, that personality need not be unreal simply because scientists cannot define or measure it. See: John C. Murray, *Principles of Conduct* (1959), pp. 109-110.

15. Wood, Thomas, "Sacredness of Life" in John Macquarrie, ed., *A Dictionary of Christian Ethics* (London: SCM Press, Ltd., 1967), pp. 195-196.

16. "One of the most important medieval Christian views is found in Thomas Aquinas: 'Now among all others, the rational creature is subject to divine providence in a more excellent way, in so far as he himself partakes a share in providence, by being provident both for self and for others. Therefore, he participates in eternal reason, through which he possesses a natural inclination to a fitting act and end. Such participation on the part of a rational creature in the eternal law is called natural law' " (from *Summa Theologica*, part II, section I, q. 91, art. 2) quoted in Vernon J. Bourke, "Natural Law" in Macquarrie, *op. cit.*, p. 224.

17. See Charles J. McFadden, *Medical Ethics* (Philadelphia: F. A. Davis Co., 1961, 1966), pp. 225-226.

18. Wilson, *op. cit.*, p. 63.

19. Pius XII, Pope, "The Prolongation of Life," in *The Pope Speaks*, vol. 4, pp. 395-397 (1958).

20. Ramsey, Paul, *The Patient as Person: Explorations in Medical Ethics* (New Haven: Yale University Press, 1970), p. 118. Ramsey points out valuable distinctions in the concepts of ordinary and extraordinary medical means as they are interpreted by the physician and the moralist.

21. Wilson, *op. cit.*, p. 63.

22. For the relationship of this to medical practice see: Paul Ramsey, *Deeds and Rules in Christian Ethics* (New York: Charles Scribner's Sons, 1967), pp. 166-167. This argument was also used by Willard Sperry in the essay "The Ethical Basis of Medical Practice" (1951). See Willard Sperry, *The Ethical Basis of Medical Practice* (New York: Harper and Brothers, 1956).

23. St. John Stevas, Norman, *Life, Death, and the Law* (1961). Stevas continued: "The recognition of voluntary euthanasia by the law would at once be followed by pressure to extend its scope to deformed persons and imbeciles, and eventually to the old and any who could be shown to be burdens to society."

24. Kamisar, Yale, "Some Non-Religious Views Against Proposed 'Mercy Killing' Legislation," *Minnesota Law Review*, Vol. XXII (May, 1958), p. 1031.

25. Dyck, Arthur, "Beneficent Euthanasia and Benemortasia: Alternative Views of Mercy Killing" in Marvin Kohl, ed., *Beneficent Euthanasia* (Buffalo, N.Y.: Prometheus Books, 1974), pp. 123ff.

26. Fletcher, Joseph, *Situation Ethics: The New Morality* (Philadelphia: The Westminster Press, 1966), p. 26f.

27. *Ibid.*, pp. 40-43.

28. *Ibid.*, pp. 50-52; Wilson, *op. cit.*, p. 65.

29. Fletcher, "Indicators of Humanhood," *op. cit.*, pp. 1-4.

30. Fletcher, *Situation Ethics*, *op. cit.*, pp. 43-46.

31. *Ibid.*, p. 33.

32. I am indebted here to the thought-filled writing on "care" by Paul Ramsey, especially in his book *The Patient As Person*, *op. cit.*, Ch. 3.

33. I agree in principle with Norman L. Cantor when he states: "Sanctity of life is not just a vague theological precept. It is the foundation of a free society." See: Norman L. Cantor, "A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life" in *Rutger's Law Review* 26 (Winter, 1972), p. 244.

34. Curran, Charles E., *Politics, Medicine, and Christian Ethics: A Dialogue with Paul Ramsey* (Philadelphia: Fortress Press, 1973), pp. 161-162.

35. Harvard Medical School, Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death. "A Definition of Irreversible Coma." *The Journal of the American Medical Association*, Vol. 205 (1968), pp. 337-340.

36. Maguire, Daniel C. "A Catholic View of Mercy Killing" in *The Humanist*, (July/August, 1974), pp. 16-18. See also his: *Death by Choice* (New York: Schocken Books, 1975).

37. Ramsey, Paul, *Deeds and Rules in Christian Ethics* (New York: Charles Scribner's Sons, 1967), pp. 222-223.

38. See: Richard A. McCormick, "To Save or Let Die" in *The Journal of the American Medical Association*, Vol. 229 (1974), No. 2, July 8, 1974, pp. 172-176.

39. Cantor, *op. cit.*, p. 243.

40. Superior Court of New Jersey, Chancery Division, Morris County: "In The Matter of Karen Quinlan, An Alleged Incompetent"; Docket No: C-201-75; Decided: November 10, 1975.

41. Supreme Court of New Jersey, A-116, p. 37. Decided March 31, 1976.

42. Superior Court of New Jersey, C-201-75.

43. Supreme Court of New Jersey, A-116.

44. The Supreme Court Decision made reference to this.

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