

August 1989

## The Ethical Values That Civil Law Must Respect in the Field of Euthanasia

Rita L. Marker

Follow this and additional works at: <http://epublications.marquette.edu/lnq>

---

### Recommended Citation

Marker, Rita L. (1989) "The Ethical Values That Civil Law Must Respect in the Field of Euthanasia," *The Linacre Quarterly*: Vol. 56: No. 3, Article 6.

Available at: <http://epublications.marquette.edu/lnq/vol56/iss3/6>

# The Ethical Values That Civil Law Must Respect in the Field of Euthanasia

Rita L. Marker

*The author, director of the International Anti-Euthanasia Task Force, University of Steubenville, Steubenville, Ohio, prepared the following for presentation at the Second International Congress of Bioethics of The Italian Society of Bioethics held April 15, 1989 in Verona, Italy. Ms. Marker, in 1988, was appointed by Pope John Paul II to a five-year term on the Pontifical Council for the Family.*

---

## Euthanasia, Attitudes and the Law

Before entering into any discussion about euthanasia, it is crucial to clarify the term. Although the word "euthanasia" has been used to denote "good death", this is not its contemporary meaning. Today, "euthanasia" means deliberately causing the death of another person.

Some may ask, "Why isn't it possible to use the broader meaning of 'good death'?"

The answer is simple. We must be fully aware of meanings ascribed to words if we are to find a safe path through today's legislative and judicial minefields. To neglect this is to court misunderstanding which has deadly consequences.

For example, if one were asked, "Is euthanasia morally acceptable?", the response using the meaning "good death" would be totally different than if one based an answer on the alternate meaning.

For the purpose of this discussion, "euthanasia" means "an action or an omission which of itself or by intention causes death, in order that all suffering may be in this way eliminated."<sup>1</sup>

And, using this definition, it must be firmly and unequivocally stated that no authority can legitimately recommend or permit the direct killing of an innocent being. Therefore, civil law must not approve the practice of euthanasia.

## Delicate Balances

We have become very much aware, in recent years, that there is a

delicate balance in nature which must be recognized and respected. It is well known that natural disasters and industrial accidents affect not only the immediate site of the occurrence, but have far-reaching impact on the entire world. Witness, for example, the results of the Chernobyl disaster or the recent Alaskan oil spill. National boundaries do not contain the hazardous effects of such experiences.

There can be no doubt that when dealing with nature, we deal not with a mere assemblage of parts, but with a vast ecosystem. Upsetting the delicate balance in what appears to be an isolated corner of the globe has far-reaching impact.

Such environmental alterations change the way we live and likewise, the way we live can change the environment. As such changes take place, we adapt to, benefit from, or are harmed by them.

So, too, with the law.

In the legal realm, there is also a delicate balance. The attitudes and behavior of people lead to changes in the law. And likewise, changes in the law lead to changes in attitudes and behavior.

Using the United States as an example, I propose to discuss the way in which behavior and attitudes have brought about changes in the law, ways in which new laws have affected attitudes and behavior, and the way in which acceptance of euthanasia, under the guise of a "right to die," has taken on a momentum of its own.

### **Roots of the Euthanasia Movement**

A half-century ago, the Euthanasia Society of America proposed legislation to legalize "voluntary" euthanasia, but it was clearly stated that the Society hoped "eventually to legalize the putting to death of non-volunteers", since euthanasia was "needed mainly for defectives"<sup>2</sup> rather than for "normal persons who have become miserable through incurable illness".<sup>3</sup>

This blatant expression of intent was not well received by the America of the '30s and '40s and the euthanasia movement made little progress for years. In 1967, however, a significant step took place which, more than any single factor, has influenced attitudes about euthanasia in America.

At a meeting of the Euthanasia Society, a new document was proposed by Luis Kutner, chairman of the World Habeas Corpus Committee, World Peace through Law Center. The document was called the "Living Will," and publicity given it was intended "to promote discussion of euthanasia."<sup>4</sup>

Mention of the Living Will found its way into trade journals, magazines, newspapers, television, and radio. Scholarly journals began to carry articles about the document with some being quite open in recognizing its connection with euthanasia. Luis Kutner, the document's author, openly titled a 1969 law journal article, "Due Process of Euthanasia: The Living Will, a Proposal."<sup>5</sup> In his article, Kutner presented a very guarded

discussion of euthanasia but did acknowledge that the Living Will "is limited *in its initial creation* to adult patients who are capable of exercising their will." (Emphasis added.) His concluding remarks noted that "*as of now*, a doctor cannot be directed to act affirmatively to terminate a patient's life."<sup>6</sup> (Emphasis added.)

As the process of promoting the Living Will was taking place, acknowledgment of future steps was limited to conferences and publications directed at those who already agreed with the concept of euthanasia. Describing the need to "walk before we can run", the problems of "who shall speak for those who are incompetent or incapable of speaking for themselves" were to "wait until the general public accepts the fact that man has an inalienable right to die."<sup>7</sup>

Using the terminology of "rights" (in 1975 the Euthanasia Society even changed its name to the Society for the Right to Die) and capitalizing on hard cases and difficult situations, euthanasia proponents carefully crafted a widespread fear that one would be denied the "right to die" and would be subjected to every possible medical machine and instrument unless the Living Will were to be elevated to the status of a legally recognized document.

In August of 1976, nine years after the concept of the Living Will was introduced to the public, the first Living Will law (titled "The Natural Death Act") passed in the State of California.

It is worth noting that in the same month, participants at the first International Euthanasia Conference, held in Tokyo, issued a formal statement "to make a declaration of a person's wishes legally effective"<sup>8</sup> and declared that "at least for the present, we request that this Declaration, or the 'Living Will', be made legally effective, and pursuant to this, effort toward its legalization should be made."<sup>9</sup>

### Growth of the "Right to Die" Attitude

In the 10 years from August, 1976 through December, 1986, 38 states and the District of Columbia passed Living Will legislation. Among the remaining 12 states that had successfully held off such laws, one state (Minnesota) fell victim to euthanasia propaganda in early 1989. Passage of Minnesota's Living Will law was attributed, in large part, to lack of strong opposition — opposition which had dwindled as increasing numbers of other states passed such laws. As one legislator explained, "Even my own Roman Catholic Church, which has been a fortress for protecting human life, seems to have accepted this."<sup>10</sup>

Within weeks after Minnesota had broken the three year legislative log jam, its neighboring state, North Dakota, passed a Living Will law.

Often described as legislation which gives control to the patient, in reality Living Will laws do just the opposite. A Living Will signer gives up rights and control, often to an unknown physician. A typical Living Will form reads:

If I am diagnosed as having a terminal condition from which my death is imminent and if I am no longer able to make decisions regarding my medical care, I direct my attending physician to withhold or withdraw all medical treatment that is not necessary to my comfort or to alleviate my pain.<sup>11</sup>

The document appears harmless, even protective, but it is deceiving. Its words often carry a far different meaning than one might suspect.

According to most Living Will laws, a "terminal condition" can mean any illness or injury which is incurable or irreversible. Diabetes, hypertension, multiple sclerosis and other illnesses — although they can be kept under control — are incurable and irreversible and, as such can be considered "terminal".

A signer of a Living Will might think the words "death is imminent" will ensure that care is not withdrawn from a person who could live for months or even years.

Not so. The word "imminent", as used in Living Will laws, has been interpreted by the courts and hospitals to include a person who is expected to live for a year.<sup>12</sup>

Other portions of Living Will directives are equally misleading. "Attending physician" means any doctor caring for a person at a particular moment. In a large hospital a person could have as many as three "attending physicians" in one day.

"No longer able to make decisions regarding my medical treatment" could refer to a true inability to make decisions, but it also could mean mild senility, hearing impairment or temporary disorientation as a result of an accident.

Equally misunderstood are the words "medical treatment". These words can refer to treatment using mechanical or advanced technological procedures which carry great risk or burden. But they can, and often are interpreted to describe even normal medication on which a person may be dependent — such as insulin or blood pressure medication. Even more alarming is the fact that Living Will laws are now used to deny food and water from dependent persons.

Recent court proceedings have given ample evidence that the words "medical treatment" are being applied in the broadest possible way.

One physician, a neurologist appearing as an "expert witness" favoring the denial of food and fluids for a severely disabled woman, told the court that he would consider even spoon-feeding the woman to be "medical treatment",<sup>13</sup> implying that any type of assistance required in providing food and fluids could be considered "artificial feeding".<sup>14</sup>

Another physician, testifying under oath in court proceedings, explained that if he "treats a patient in a convalescent care facility, that, for that patient to even have a normal diet, it has to be prescribed and, therefore, it is always a medical treatment".<sup>15</sup>

Living Will laws have, indeed, changed the attitudes and behavior of the medical profession and have led to wide interpretation of such laws. In the United States today, such laws are used to justify the removal of basic care

from people who are not dying with courts expanding their use to include even those who have not signed Living Wills.

Current attitudes and practices of the medical profession have been summed up by one physician who stated:

*/T/he old, chronically ill, debilitated, or mentally impaired do not receive the same level of aggressive medical evaluation and treatment as do the young, acutely ill, and mentally normal. We do not discuss this reality or debate its ethics, but the fact remains that many patients are allowed to die by the withholding of "all available care." There seems; to be, however, a general denial of this reality.<sup>16</sup>*

This attitude — that there is a "right to die" and that this "right" should be extended even to those unable to exercise it — was shaped by the euthanasia movement and has become firmly entrenched in the law.

### **In the "Best Interests" of the Patient**

*If we can get people to accept the removal of all treatment and care — especially the removal of food and fluids — they will see what a painful way this is to die, and then, in the patient's best interest, they will accept the lethal injection.<sup>17</sup>*

That statement, made in 1984 by a speaker at the fifth biennial conference of the World Federation of Right to Die Societies, seemed extreme at the time. In 1984, it was universally presumed that care, including food, water, hygienic care, a warm bed and compassionate nursing was due every patient.

But today, as a result of the broad interpretations given to Living Will laws, denying food and fluids to disabled or dependent persons has become commonplace.

Cases coming to public attention do not deal with dying patients. Instead they center around patients who are seriously debilitated — the old, the dependent, the demented — who are viewed as burdens to others. So advanced is the abandonment of such patients that advocacy of starving and dehydrating them to death has come from the very places where, previously, one would have expected protection.

Witness, for example, the case of Dorothy Longeway. Mrs. Longeway is 76-years old. She has had several strokes; she is not in a coma nor has she been diagnosed as being in what is called a "persistent vegetative state"; she responds to painful stimuli and, according to medical reports, she seems to obey verbal commands. She receives her nourishment by gastrostomy tube which is causing her no reported discomfort. Yet her family has requested that her feeding be stopped.

In its request to stop Mrs. Longeway's food and fluids, her family is being assisted by a Catholic agency. In court documents submitted by a priest-attorney and drafted under the auspices of Catholic Charities Legal Services for Seniors in Illinois,<sup>18</sup> it was noted that such actions "would likely create various effects resulting from lack of nutrition and hydration leading eventually to her death."<sup>19</sup> Thus it was acknowledged that Mrs. Longeway will die of starvation and dehydration.

The document further stated that removing Mrs. Longeway's food and fluids "would be in accord with the teaching of her Church."<sup>20</sup> Mrs. Longeway is a Catholic.

In early 1989, the Illinois Catholic Conference drafted a law which, had it become law, would have made it possible for a family to request that all food and water (even that which the patient is capable of eating or drinking without assistance) be withheld from an elderly, senile, otherwise healthy nursing home patient. Such a request — which would result in the deliberate starvation and dehydration of the patient — would have been beyond any legal challenge as long as the attending physician and the nursing home administration were in agreement.<sup>21</sup>

Involvement of individuals and groups under Catholic auspices has been critical to the success of the euthanasia movement since non-opposition or outright support from the Catholic Church has served to silence others with the remark, "Even the Catholic Church approves of it."

Acceptance of starvation and dehydration as methods of "treating" those considered burdensome has formed the foundation for the next step in the euthanasia movement's process of achieving death-on-demand.

### The "Better Way"

In April, 1988, the World Federation of Right to Die Societies held its seventh international euthanasia convention in San Francisco. By that time, only 12 years after the organization's formulation in Tokyo, membership had grown to 29 euthanasia societies from 17 countries.<sup>22</sup> That convention coincided with — and was geared to — a campaign to pass the "Humane and Dignified Death Act" in the State of California.

On the evening preceding the convention, during a debate on the Death Act,<sup>23</sup> its co-author, Attorney Robert Risley of Americans Against Human Suffering, explained, "What we want to do is change the law ever so slightly." (He was referring to the Living Will law.) First, he reminded the audience that it is now acceptable to remove food and water and thus cause death by starvation or dehydration. He then stated, "There is a better way." The "better way" proposed was the lethal injection.<sup>24</sup>

The term used to describe this "better way" was "aid-in-dying", defined in the proposed legislation as "any medical procedure that will terminate the life of a qualified patient swiftly, painlessly and humanely".<sup>25</sup>

As with any proposal, the aid-in-dying idea carries with it a superficial appeal. As described by the author of the euthanasia law, aid-in-dying gives one the ability to choose, to control, to be autonomous and to celebrate the closing of a worthwhile life with a gentle death at the time and place of one's own choosing.<sup>26</sup>

The framers of euthanasia laws bolster their views by citing the practice of euthanasia in Holland. "It's been tested there . . . and it appears to be working," the current president of the World Federation of Right to Die Societies has stated.<sup>27</sup>

The dark side of the Dutch experience is conveniently ignored by those seeking to convince the public that euthanasia should be accepted in America. Never is it noted

- ... that Dutch hospitals are performing involuntary euthanasia;<sup>28</sup>
- ... that the Dutch Medical Association has endorsed euthanasia for minors without parental consent;<sup>29</sup>
- ... that euthanasia is administered to patients with such disabilities as multiple sclerosis, blindness or who merely need some type of normal care;<sup>30</sup>
- ... that questions abound as to the right of the mentally disabled to live;<sup>31</sup>
- ... and that the development of palliative care is not well developed,<sup>32</sup> (thus illustrating that, if it easy to kill a patient, it is less likely that efforts will be put into pain control and comfort measures.)

Practices, such as those noted above, are not abuses of euthanasia. As Dr. J. van de Sluis of Amsterdam has so perceptively noted, "These are not the abuses of euthanasia, but its uses."<sup>33</sup>

### **Efforts Continue to Legalize "Aid-in-Dying"**

"Aid-in-dying" did not become law in 1988 as its proponents had hoped. However, those in the forefront of the euthanasia movement are now concentrating their efforts to gain approval in at least one of three western states during the 1990 election year. As one euthanasia spokesperson has stated, "If we can break through one or two states, the rest will follow."<sup>34</sup>

The logical expansion of Living Will laws to include the lethal injection has been noted in medical and legal circles.

Writing about last year's California attempt to gain acceptance of "aid-in-dying", one medical journalist stated, "As drafted, the California initiative would have been a logical extension of existing state living will legislation."<sup>35</sup>

Perhaps the most revealing recognition of the connection between Living Will laws and the goal of death-on-demand is illustrated by a "Model Aid-in-Dying Act", drafted at the University of Iowa College of Law under the direction of Professors Sheldon Kurtz and Michael Saks.

A cover letter accompanying the draft of the model act (which could eventually be offered for passage in every state in the country) notes that it is intended to *expand on existing laws* which permit the withholding or withdrawal of medical care "with the intended effect of producing death."<sup>36</sup>

Taking note of current practices, the introductory portion of the model act states:

We have effectively stated that it is morally acceptable to turn off a life support machine and even to cease nutrition and hydration for a patient who is certain



never to recover. In such cases, the intent of the medical community and the patient's family is that the patient will die from the cessation of treatment.<sup>37</sup>

"Reliance upon passive procedures", the introduction correctly observes, "allows society to pretend that it is not doing precisely what it is doing."<sup>38</sup> That is, current practices, under the guise of removing life support, intentionally and directly cause the death of patients by removing necessary, non-burdensome care.

Building upon existing laws, the model legislation defines "aid-in-dying" as "the withdrawal or withholding of life-sustaining treatment *or the administration of a qualified drug for the purpose of inducing death.*"<sup>39</sup> (Emphasis added.)

The preamble to the model law notes that it is intended to provide "quality control in the termination of life, just as societally accepted birth control methods allow for quality control in the creation of life."<sup>40</sup>

The purpose of this control, among other things, is to provide a "principled means of managing our health care resources",<sup>41</sup> or, said another way, to legalize killing people to save money.

So broad is the proposal that it would legalize killing of:

- ... Children under the age of 6 upon request of the parent.<sup>42</sup>
- ... Children over the age of 6 who demand death for themselves if parents agree with the demand.<sup>43</sup>
- ... Persons with an "intolerable condition".<sup>44</sup> The authors explain that such a condition could include a concert pianist who has lost the use of his hands.<sup>45</sup>
- ... The incompetent or never competent (the mentally disabled and the elderly senile) if someone else requests it.<sup>46</sup>

Methods for carrying out the killing are carefully outlined in the proposed law. Provisions are included for:

- ... Suicide clinics — referred to as "health facilities" to "administer aid-in-dying."<sup>47</sup>
- ... Specially trained killers called "telostriicians".<sup>48</sup> Anyone over the age of 18 could become a licensed telostriician by fulfilling minimal standards set by the state.<sup>49</sup>
- ... Mandatory referrals. Health care professionals not wishing to be involved in administering aid-in-dying would be required to refer patients to someone who would carry out the killing.<sup>50</sup> Health care providers who do not make a death referral would be subject to a penalty.<sup>51</sup>

This proposed model law holds particular significance since it is proposed from a source previously uninvolved in advocacy of euthanasia, indicating the widening circle of acceptance for such initiatives.

The Iowa proposal seems to fulfill the prophetic words of a 1970 editorial in *California Medicine*, which noted that the “problems of birth control and birth selection” would be “extended inevitably to death selection and death control.”<sup>52</sup>

An additional observation in the same editorial is applicable today as well. The editorial, referring to the abortion debate taking place at that time, noted that the “considerable semantic gymnastics” being used to rationalize abortion “would be ludicrous if they were not often put forth under socially impeccable auspices.”<sup>53</sup>

### Socially Impeccable Auspices

Euthanasia’s advancement under seemingly “socially impeccable auspices” took another step with a report published March 30, 1989 in the *New England Journal of Medicine*. Described by one commentator as the “strongest public endorsement of doctor assisted suicide ever published in a major medical journal”,<sup>54</sup> and hiding behind the misleading title, “The Physician’s Responsibility Toward Hopelessly Ill Patients: A Second Look”, the “report” concluded that it’s morally acceptable for a doctor to give suicide instructions and a prescription for the lethal dose to a patient.<sup>55</sup>

One of the report’s 12 physician-authors, Minnesota neurologist Ronald Cranford, stated, “We broke new ground and we were very aware we were doing it. We felt it was an opportunity to make a statement that’s very controversial and stand by it.”<sup>56</sup>

He further noted that assisting suicide is the “same as killing the patient.”<sup>57</sup>

His admission captured the heart of the panel’s role: to serve as the “socially impeccable” window dressing for opinion manufactured by the Society for the Right to Die — the former Euthanasia Society of America.

Media descriptions of the panel gave the false impression that it was an academically-based panel of unbiased physicians “representing medical schools across the USA.”<sup>58</sup> However the physicians were *not* representing medical schools.<sup>59</sup> Instead, they were carefully chosen by the Society for the Right to Die with four of the 12 serving on the board of directors or advisory board of the euthanasia organization.<sup>60</sup> A fifth panelist, although not serving in an official capacity with a euthanasia group, is widely recognized as a spokesperson for the right-to-die causes. He has written that, in the future, “physician-assisted suicide may not only be permissible, but encouraged.”<sup>61</sup>

Selection of panel members began in 1980 when the Society for the Right to die approached physicians to “develop a consensus approach to death and dying.”<sup>62</sup> Expenses for panel meetings were paid by the Society for the Right to Die<sup>63</sup> and the euthanasia organization selected and provided materials used as background information.<sup>64</sup>

Even condensations and clarifications for the report were handled by

Society for the Right to Die staff and a board member.<sup>65</sup>

This was not the first such special "report" to be issued by the special interest group's panel. In another article, published five years ago, panel members suggested certain types of care be withheld from the "pleasantly senile" and advocated withholding food and fluids from the severely demented.<sup>66</sup>

Future decrees that the unthinkable has become morally acceptable — at least to the individuals making the proclamations — should be expected since the conclusion of the current report states there will be continuing debate about the "role euthanasia may have" in treating the terminally ill or the hopelessly ill.<sup>67</sup> Thus the stage has been set for euthanasia as a "treatment" for those who are not dying but who are considered "hopeless".

And so the death-on-demand lobby continues slowly but inexorably in its attempt to change public attitudes and, in doing so, to bring about changes in the law.

### Conclusion

The law is a great teacher. And, as the law, ever so slowly but ever so surely, permitted vulnerable people to be denied needed care, the public accepted this denial of care, under the guise of the "right to die", as normal and even laudatory.

The fatal flaw on the part of those whose role it was to speak out for the helpless and dependent was the incredibly naive and incredibly deceptive belief that it was possible to pick and choose which conclusions of the "right to die" premise would be accepted.

As one commentator has so astutely noted:

Adopting the premise requires us to adopt all the logical conclusions of that premise. We cannot accept euthanasia without accepting the premise on which it is based, and that premise is the right to be killed. Acceptance of euthanasia as a right must inevitably lead to euthanasia on demand. It is the only logical conclusion.<sup>68</sup>

The euthanasia movement's carefully executed strategy, by which killing first through neglect and finally through the provision of lethal agents, escaped recognition as it advanced under the cloak of the "right to die". But it is now upon us and cannot be denied.

In his classic writing on the Holocaust 40 years ago, Leo Alexander, M.D., who served on the staff of the Office of the Chief Counsel for War Crimes in Nuremberg, wrote:

Whatever proportions these crimes /the Nazi war crimes/ finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived . . . Gradually the sphere of those to be included in this category was enlarged . . . But it is important to realize that the infinitely small wedged-in lever

from which this entire trend of mind received its impetus was the attitude toward the nonrehabilitable sick.<sup>69</sup>

Some months before his death in July, 1985, reflecting on an article which described the withholding of food and fluids from a severely debilitated, but non-dying patient, Alexander offered his final observations on contemporary American medicine: "It is much like Germany in the Twenties and Thirties. The barriers against killing are coming down."<sup>70</sup>

And now, four years after his death, we can see clearly what Alexander meant. The barriers have been dismantled.

Will these barriers be carted away? Or will we, finally recognizing the implications of the euthanasia movement, reconstruct the legal barriers so necessary to prevent killing of vulnerable people?

If we do not reconstruct these barriers, we have failed to protect the most dependent among us.

In making any determination about the ethical values which civil law must respect in the field of euthanasia, we must ask ourselves, "If not the helpless, whom should the law protect?"

### References

1. *Declaration on Euthanasia*, May 5, 1980, St. Paul Editions, p.8.
  2. "'Mercy' Death Law Ready for Albany," *New York Times*, Jan. 27, 1939
  3. "'Mercy' Death Law Ready for Albany," *New York Times*, Feb. 14, 1939
  4. "History of Euthanasia in U.S.: Concept for Our Time," *Euthanasia News* (New York: Euthanasia Education Council), vol. 1, no.4 (November, 1975), p.3.
  5. Kutner, Luis, "Due Process of Euthanasia: The Living Will, a Proposal," *Indiana Law Journal*, vol.44 (1969), pp.539-553.
  6. *Ibid.*, p. 553
  7. *Dilemmas of Euthanasia: Excerpts from Papers and Discussions at the Fourth Euthanasia Conference*, New York Academy of Medicine, Dec. 4, 1971 (New York: Euthanasia Education Council, 1972) p. 42
  8. "Delegates to International Conference Join in Euthanasia Declaration," *Euthanasia News* (New York: Euthanasia Education Council), vol. 2, no. 4 (November, 1976), p. 2.
  9. *Ibid.*, p. 3.
  10. Coffman, Jack B., "Senate passes 'living will' legislation by wide margin," *St. Paul Pioneer Press Dispatch*, Feb. 7, 1989.
  11. Marker, Rita L., "Living wills: Preventing suffering or a deadly contract?" *State Government News*, (Council of State Governments), vol. 31, no. 12, December, 1988, p. 15.
  12. In 1983, the State of Wisconsin passed a living will law allowing the removal of "life-sustaining procedures" from patients who had a 30-day life expectancy. Some thought the 30 day requirement was too restrictive. In 1986 the law was changed to allow application to those whose predicted life expectancy was *greater than 30 days*. The wording "would cause death within 30 days" was changed to "death is imminent" which could be more broadly interpreted.
- In 1986 the Supreme Court of the State of Virginia refused to hear an appeal in the case of Hazelton v. Powhatan Nursing Home. The case marked the first time the word "imminent," as used in Living Will laws, was defined by the courts.
- Harriet Hazelton's doctors had agreed she could live for months but disagreed whether, with a life expectancy of approximately six months, her death could be considered

"imminent." The court decided that a death which is expected to occur in months should be considered "imminent."

In a 1987 *Stanford Law Review* article, "Equality for the Elderly: A Proposal for Dignified Death", it was explained that death is to be considered "imminent" if the patient's life expectancy is one year or less.

In a 1988 paper titled, "Prolonging Life and the 'Right to Die': Perspectives from the Catholic and Jewish Traditions," Rev. James J. McCartney, O.S.A., Ph.D. noted that St. Francis Hospital in Miami Beach, Florida (a Catholic hospital sponsored by the Allegany Franciscan Sisters) "has interpreted 'imminent' to mean that death will occur within one year" for the purposes of implementing Florida's Living Will law accord with hospital policy.

13. *Cruzan v. Harmon and Lampkins*, In the Circuit Court of Jasper County, Missouri, Probate Division at Carthage, Case No. CV384-9P, March 9-11, 1988, p. 228.

14. *Ibid.*

15. *McConnell v. Beverly Enterprises*, Superior Court of Connecticut, Judicial District of Danbury, Docket No. 0293888 S, Transcript of Proceedings, June 15, 1988, p. A-56.

16. Appelbaum, Paul S., and Klein, Joel, "And Therefore Choose Death?" *Commentary*, April, 1986, p. 28.

17. Fifth Biennial Conference of the World Federation of Right to Die Societies; Nice, France; Sept. 20-23, 1984. From "Ethics Panel: The Right to Choose Your Death — 'Ethical Aspects of Euthanasia.'" Remarks by panel member Helga Kuhse, Ph.D., lecturer in philosophy at Monash University and research fellow at the Center for Human Bioethics in Melbourne, Australia, Sept. 21, 1984.

18. *In Re the Estate & Person of Dorothy M. Longeway, a Disabled Person*, Appeal from Circuit Court of DuPage County, Eighteenth Judicial District, No. 88 P 270, In the Supreme Court of Illinois, No. 67318. Brief of Appellant filed by Rev. Eugene P. Parnisari, Catholic Charities Legal Service for Seniors, Naperville, Illinois.

19. *Ibid.*, p. 10.

20. *Ibid.*, p. 15.

21. "An Act to Regulate the Administration of Food and Fluids," Draft 2/28-3, with cover memorandum about "Legislation on Nutrition and Hydration," from Jimmy M. Lago of Illinois Catholic Conference to Cardinal Joseph Bernardin, March 1, 1989.

22. *World Right-to-Die Newsletter*, June, 1987, p. 8.

23. "'Aid-in-Dying': The Right to Die or the Right to Kill?," sponsored by the International Anti-Euthanasia Task Force, April 6, 1988, at the University of San Francisco, California. Speakers were Derek Humphry of the National Hemlock Society; Robert Risley of Americans Against Human Suffering; Dr. Joseph Stanton, an advisor to the International Anti-Euthanasia Task Force, and Rita Marker, Co-Director of the Human Life Center. Moderator was Michael Smith, professor of law at the University of California at Berkeley. Video tapes and transcripts of the debate are available through the Human Life Center, University of Steubenville, Steubenville, Ohio. Audio tapes are available from National Public Radio.

24. *Ibid.*

25. "Humane and Dignified Death Act Initiative Statute," State of California, File number SA 87 RF 0039.

26. "'Aid-in-Dying': The Right to Die or the Right to Kill?," *International Review*, vol. XII, no. 1, Spring, 1988, p. 58. (Transcript of April 6, 1988 public debate on "Aid-in-Dying.")

27. Remarks of Derek Humphry on *Face the Nation* national television program, Sept. 2, 1985.

28. "Involuntary Euthanasia in Holland," *Wall Street Journal*, Sept. 29, 1987, p. 31.

29. "Dutch Euthanasia Issue May Be a Pandora's Box," *Worcester Sunday Telegram*, July 5, 1987, p. 6A.

30. "Where Euthanasia is a Way of Death," *Medical Economics*, Nov. 23, 1987, p. 23.

31. Presentation by Dr. J. van der Sluis, Conference on "Euthanasia and the Future of Medicine," Clark University; Worcester, Massachusetts; Oct. 24, 1988. Hereafter cited as "van der Sluis."
32. *Euthanasia: Report of the Working Party to review the British Medical Association's guidance on euthanasia*, British Medical Association, May 5, 1988, p. 49, #195. Hereafter cited as "BMA Report."
33. van der Sluis.
34. Enns, Gregory, "Society Refocuses Euthanasia Effort," *Sarasota Herald Tribune*, Feb. 21, 1989.
35. Parachini, Allan, "The California Humane and Dignified Death Initiative," *Medical Tribune*, Feb. 16, 1989, p. 19.
36. Cover letter of Feb. 27, 1989 from the University of Iowa College of Law accompanying Model Aid-in-Dying Act.
37. "Model Aid-in-Dying Act: An Act Governing the Right of Patients Who are Terminally Ill, Technology Dependent, or Who Have an Intolerable Condition to Receive Aid-in-Dying," Distribution Draft of Feb. 12, 1989, p. 7.
38. *Ibid.*, p. 10.
39. *Ibid.*, p. 11, Section 1-102 (2).
40. *Ibid.*, pp. 6-7.
41. *Ibid.*, p. 8.
42. *Ibid.*, p. 45, Section 5-101 (a) (3); p. 52, Section 6-102 (a) (4).
43. *Ibid.*, p. 25, Section 2-101 (b); p. 45, Section 5-101, (a) (4); p. 52, Section 6-102 (a) (4).
44. *Ibid.*, p. 53, Section 7-101 (a).
45. *Ibid.*, p. 60.
46. *Ibid.*, p. 47, Section 5-102 (a) (1); p. 52, Section 6-102 (a) (1); p. 59, Section 9-103 (a) (2).
47. *Ibid.*, p. 13, Section 1-102 (11).
48. *Ibid.*, p. 16, Section 1-102 (27).
49. *Ibid.*, pp. 77-78, Section 15-103 (b).
50. *Ibid.*, p. 71, Section 12-101.
51. *Ibid.*, p. 75, Section 14-103.
52. "A New Ethic for Medicine and Society," *California Medicine*, Volume 113, No. 3, (September, 1970), p. 68.
53. *Ibid.*
54. "MacNeil-Lehrer Newshour," PBS Television, March 30, 1989. Hereafter cited as "MacNeil-Lehrer."
55. Wanzer, Sidney H., et al, "The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look," *New England Journal of Medicine*, Vol. 320, No. 13, March 30, 1989, p. 848. Hereafter cited as "NEJM."
56. MacNeil-Lehrer.
57. *Ibid.*
58. "Ethics of helping terminally ill to die," *USA Today*, March 30, 1989, p. 1D.
59. Telephone discussion with Ronald Cranford, M.D., March 30, 1989. Hereafter cited as "Cranford."
60. Member, Board of Directors: Christine K. Cassel, M.D.; Peter Safar, M.D.; Sidney H. Wanzer, M.D. Member, Advisory Committee: Bernard Lo, M.D. Listing of names from Society for the Right to Die letterhead and brochure.
61. "Dr. Ron Cranford Defines Distinctions Between 'Allowing to Die' ", *Concern for Dying Newsletter*, Volume 14, No. 2, Summer, 1988, p. 2. (Note: Concern for Dying was previously known as the Euthanasia Education Council.)
62. Cranford.
63. *Ibid.*
64. Telephone interview with Shirley Neitlich, public information director of the Society for the Right to Die, March 30, 1989.
65. *Ibid.*

66. Wanzer, Sidney H., et al, "The Physician's Responsibility Toward Hopelessly Ill Patients," *New England Journal of Medicine*, Vol. 310, No. 15, April 12, 1984, pp. 955-959.
  67. *NEJM*, p. 849.
  68. Chevelen, Eric M., M.D., "Changing the Laws and Us," unpublished.
  69. Alexander, Leo, M.D., "Medical Science Under a Dictatorship," *New England Journal of Medicine*, vol. 241 (July 14, 1949), p. 44.
  70. Derr, Patrick G., "The Real Brophy Issue," *The Boston Globe*, Nov. 18, 1985.
- 

### ***Are You Moving?***

If the next issue of this journal should be delivered to a different address, please advise AT ONCE. The return postage and cost of remailing this publication are becoming more and more costly. Your cooperation in keeping us up-to-date with your address will be most helpful.