The Linacre Quarterly

Volume 40 | Number 4 Article 4

November 1973

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Recommended Citation
Louisell, David W. (1973) "Euthanasia and Biathanasia: On Dying and Killing," *The Linacre Quarterly*: Vol. 40 : No. 4 , Article 4.
Available at: http://epublications.marquette.edu/lnq/vol40/iss4/4

Euthanasia and Biathanasia: On Dying and Killing

David W. Louisell

Introduction: The Nature of the Dilemma

Not long ago one of the country's great financial houses sponsored a television show called "The Very Personal Death of Elizabeth Schell Holt-Hartford." It starkly dramatized one of the saddest phases of the human condition, perhaps especially cruel quantitatively and qualitatively in our generation: the loneliness, sense of uselessness and abandonment, and bitterness of many old people. The subject of the story was a lady living alone, who had been divorced and [illegible] died at the age of 82, leaving no known survivors. She often spoke of her dire need for, but lack of, human companionship. The sense of her unhappiness can almost be touched from her own words — "It's such a grim life; the only thing you can do is to bear it until someone shoots you." Her physician tells her, "You do not know what is on the other side" and she answers "What I know is on this side and I don't want any more of it." That she remains rational and indeed intellectual even after she broke her hip and was immobilized — pointing out for example that she knows she is lucky compared to the aged poverty-stricken of India — seems only to exacerbate the tragedy by emphasizing the felt pain.

Professor Louisell, a member of the Linacre Editorial advisory board, is the Elizabeth Josselyn Boalt Professor of Law at the University of California Law School in Berkeley. His article was originally delivered as the 1972 Pope John XXIII lecture at the Catholic University of America. At his request, we publish this article as delivered with all of the nuances arising out of the delicate ethical distinctions drawn.

At the beginning the announcer had said: "Because of the sensitive nature of this program (the sponsor) has relinquished all commercial messages." But its generous impulses had little counterpart in the public's reaction, which evidenced a bitterness not unlike that of Mrs. Holt-Hartford's own declining years. In a word, the sponsor was charged with advocating euthanasia. The reactions ranged from the frenetic to the thoughtful, one writer pointing out that what was reprehensible about the program was (according to his interpretation) that the only solution to the problem of old age that was suggested was euthanasia. One who did not view the program will withhold appraisal of the accuracy of this essentially artistic judgment of the theme. The interesting thing for our purposes was the universal use of the word "euthanasia" to characterize that theme. You have advocated euthanasia, and euthanasia is murder!

Had I been privy to the reactions to "The Very Personal Death of Elizabeth Schell Holt-Hartford" when the faculty invited me to deliver the Pope John XXIII lecture this year, I wonder whether I would have had the fortitude to persevere with a title using "Euthanasia." Yet, in its precise meaning, "euthaneasia" is the desideratum of religion as well as of any morally or ethically based social policy that has to do with death. Coming from the Greek words meaning "good" and "death", it specifies the kind of a death that must be as much the ideal of the moral theologian as it is of the philosopher and secular humanist — a happy death. Yet its corruption seems as pervasive in popular usage generally as apparently it was among the reactors to "The Very Personal Death of Elizabeth Schell Holt-Hartford." It has come to mean the deliberate, intended putting to death painlessly of one human person by another, the willed termination of human life, which is a euphemism for murder as defined by our law. It would have been better to adhere to the original meaning of "euthanasia" and use another word, perhaps "biathanasia" for deliberate, affirmative killing in the mercy-death context. But so pervasive and universal is the terminological corruption that scholars, too, seem to have relinquished any notion of restoring original usage and have accepted the modern meaning of euthanasia. Thus Professor Arthur J. Dyck, in using "euthanasia" in the modern sense, would adopt as a synonym for its original meaning the Latin expression, *benemortasia.*[2]

The Definitional Problem: Voluntary and Involuntary Euthanasia

Taking "euthanasia", in accordance with modern usage, to mean deliberate, intentional painless killing is only the beginning of the definitional problem. Do we mean to include such a killing only when it is sought and requested by the euthanatee, or also one imposed upon him without regard to his consent — the elimination of defective or hopelessly ill or senile persons, for example, Hitler's "useless eaters"? In a word, do we mean only voluntary, or also involuntary, euthanasia?

On the surface, the dichotomy would appear clean-cut. If so, the precise thinker would have cause to resent the countering of argument for or against voluntary euthanasia, with argument pertinent only to the involuntary kind. For example, during the debate on the 1936 bill in Parliament for voluntary euthanasia, one of the prominent proponents invoked two dramatic and appealing cases, one where a man had drowned his four year old daughter who had contracted tuberculosis and had develobed gangrene on the face, the other where a woman had killed her mother who was suffering from general paralysis of the insane. Obviously these were instances of compulsory, or involuntary, euthanasia, yet, although the proponent acknowledged that the cases were not covered by the proposed bill for voluntary euthanasia, they were the only specific cases he described.[3]

Digging a bit below the surface of the voluntary-involuntary dichotomy may render the purist more understanding of the reasons for the confusion and more tolerant of the confused. A page of history may again be worth a chapter of linguistic analysis.

Among some primitive people the abandonment or killing of the aged or helpless apparently was an accepted practice. The Hottentots carried their elderly parents into the bush to die. The Lapp who became too infirm to trek over the mountains with their families were left behind to die unattended, their frozen corpses to be buried on the family's return. But it is easy to overly generalize about customs of euthanasia among primitives for many societies have actually been shown to have had elaborate rules protective of their senior members.

> "Instances of this are seen in hospitality customs, property rights, food taboos reserving certain choice dishes for the aged (ostensibly as harmful to the young) and other usages."[4]

Doubtless the settled agricultural communities showed the highest level of solicitude for the elderly, as witness the laws of the Hebrews in the Old Testament forbidding the killing of the innocent and just. In classical Greece there does not seem to have been abandonment of elderly or helpless adults. Of course in ancient Rome, largely under the influence of the Stoics, suicide was an accepted form of death as an escape from disgrace at the hands of an enemy, as indeed it was until recently at least in Japan under the form of hara-kiri. Yet Cicero who had written: "The God that rules within us forbids us to depart hence unbidden" abided his conviction and declined to play the "Roman fool" when pursued to death by the revenge of Antony.[5] Jewish, Christian and Islamic teachings alike have always maintained that deliberate killing in case of abnormality or incurable illness is wrong. The apparent exception in St. Thomas Moore's *Utopia* is often over-read to imply his personal endorsement.[6]

The modern interest in euthanasia is usually dated from the 1870's but the formal movement did not begin in Britain until the 1930's with the organization in 1935 of the group now known as the Voluntary Euthanasia Society. The first bill

on euthanasia was brought before the United Kingdom Parliament in 1936. It required for eligibility for euthanasia that the patient be over twenty-one years of age, be suffering from an incurable and fatal illness, and sign a form in the presence of two witnesses asking to be put to death. It embraced relatively complicated legal proceedings including investigation by a euthanasia referee and a hearing before a special court. In 1950 there was further debate in the House of Lords on a motion in favor of voluntary euthanasia.[7]

The distinguished legal scholar and specialist in criminal law, Professor Glanville Williams, realizing the practical necessity of countering the contention that too much formality in the sick room would destroy the doctor-patient relation,[8] in his classic *The Sanctity of Life and the Criminal Law*[9] proposed a simple formula quite different from the 1936 attempt. He suggested the uncomplicated provision that no medical practitioner should be guilty of an offense in respect of an act done intentionally to accelerate the death of a patient who is seriously ill, unless it is proved that the act was not done in good faith and for the purpose of saving him from severe pain in an illness believed to be of an incurable and fatal character.[10] This was the basis of the 1968 draft bill which, with changes, was debated in the Lords in 1969. The most recent parlimentary euthanasia debate was in the House of Commons in April, 1970, on a motion for leave to introduce a bill.[11] No statute has been enacted.

The Euthanasia Society of America was constituted in 1938 and a bill, following the 1936 British model, was introduced that year in the Nebraska Assembly but lost. A similar attempt failed in the New York Assembly.[12] "The Euthanasia Society of America had at first proposed to advocate the compulsory 'euthanasia' of monstrosities and imbeciles, but as a result of replies to a questionnaire addressed to physicians in the State of New York in 1941, it decided to limit itself to propaganda for voluntary euthanasia."[13] To what extent the purported restriction of recent euthanasia efforts to the voluntary kind, is a function of the euthanasia of Nazi Germany and revelations of the Nuremberg trials, is a matter for speculation.[14] In any event, there is today no country in the world whose law permits euthanasia either of the voluntary or involuntary type. French and Swiss permissiveness whereby a physician may provide, but may not administer, poison at the request of a dying patient, is to be distinguished.[15]

Some Difficulties

In view of the facial restriction of the current euthanasia movement to the voluntary type, why in the argument over it does confusion persist as to what precisely is being proposed. Why has Glanville Williams protested:

> The [English Society's] bill [debated in Lords in 1936 and 1950] excluded any question of compulsory euthanasia, even for hopelessly defective infants. Unfortunately, a legislative

proposal is not assured of success merely because it is worded in a studiously moderate and restrictive form. The method of attack, by those who dislike the proposal, is to use the "thin edge of the wedge" argument ... There is no proposal for reform of any topic, however conciliatory and moderate, that cannot be opposed by this dialectic.[16]

At least several observations are pertinent in explanation of the persisting terminological confusion. Some perhaps pertain only to subjective appraisal of the good faith of discussants, but others seem to proceed from the reality that, intrinsically, voluntary euthanasia is not as severable from the involuntary as the clean-cut verbal distinction suggests.

First, the problem of the rights of minors always lurks to compound the difficulties of human forays into life-death decisions unless application to minors is explicitly precluded. Normally decisions respecting serious medical procedures on minors must await parental or guardian approval, although historically there have been exceptions for emergencies and now further exceptions under the impetus of permissive abortion laws. If euthanasia is right, should it be withheld from an intelligent and knowledgeable minor, say one of an age whose judgment would be highly pertinent to judicial decision respecting child custody in divorce cases? And if the minor and parent differ on acceleration of the former's death, whose judgment controls? Confronted with this dilemna, apparently the best that Glanville Williams could do in *The Sanctity of Life and the Criminal Law*, was: "The use that may be made of my proposed measure (euthanasia) in respect of patients who are minors is best left to the good sense of the doctor, taking into account, as he always does, the wishes of the parents as well as those of the child."[17] Those skeptical about the vagaries and nebulosity of judicial "discretion" will take note![18]

Secondly, by definition voluntary euthanasia would be available only to those who freely, intelligently and knowingly request it. This presupposes mental competence. Might the test of competence be as intangible and uncertain as, in a given case, it may be in respect of execution of a will; or commitment as potentially dangerous; or responsibility for criminal conduct — whether under the M'Naghten,[19] Durham,[20] Model Penal Code,[21] or diminished responsibility test;[22] or capacity to stand trial.[23] The determination of competence might be in a context even more emergent and difficult than that which exists for conventional determinations, and the significance of error even more dire, that is, irreversible. Moreover difficulties might and perhaps typically would be, compounded by the inhibition on free choice inherent in subjection to pain-killing drugs.[24]

Thirdly, quite independently of the effect of narcotics on consciousness, pain itself, the toxic effects of disease, and the repercussions of surgical procedures may substantially undermine the capacity for rational and independent thought. As Professor Yale Kamisar asks: "If ... a man in this plight (throes of serious pain or disease) were a criminal defendant and he were to decline the assistance of counsel would the courts hold that he had 'intelligently and understandingly waived the benefit of counsel'?"[25] Would a confession made in such circumstances be admissible?

Fourthly, what of the proposed euthanatee who is unable to communicate for himself, for example the victim of lasting coma? Would another, possibly a spouse or next of kin, be presumed to be a competent speaker for him? Those who have inquired into the authority of one to bear for another the decisional burden in the more conventional medical dilemmas (such for example where the doctrine of informed consent may require that information about a dangerous procedure be given the patient which he is psychologically unable to bear, and the physician instead speaks with the spouse) know how difficult it is to construct an adequate juridical basis for placement of the patient's burden of decision on another, even a loving spouse.[26] After all, an adult under no legal disability has no natural guardian. The 1969 British bill perhaps avoids this dilemna at least in part by providing that a declaration for euthanasia shall come into force 30 days after being made, shall remain in force, unless revoked, for three years, and a declaration re-executed within the 12 months preceding its expiry date shall remain in force, unless revoked, during the lifetime of the declarant.[27] Even so, the problem of the continuing effectiveness of a declaration, during for example the declarant's long coma with for instance a spouse claiming its revocation might raise — but in an even more psychologically traumatic context — the afore-suggested imponderables of a life-death decision made by one for another.

Lastly, Glanville Williams' resentment of the "thin edge of the wedge" opposition to euthanasia, however justified in the abstract, loses cogency in the actual context of the movement's strategy and tactics. I submit that Yale Kamisar has convincingly demonstrated that the movement's purpose and method substantially has been utilization of the "wedge" principle.[28] My conviction in this regard has been fortified by my personal observations of how effectively the "wedge" principle has been used in the movement to permissive abortion. I have heard the public protests of the proponents "All we want is this moderate statute" (as they characterized the California one, permitting abortion when the mother's physical or mental health is threatened and in case of felonious sexual assault)[29] "give us this and we will ask no more." But I heard them simultaneously boasting privately: "Just wait till the door is opened, and our foot is in it!" The boast was not an idle one. A physician has drawn a meaningful parallel: "I don't think that human con-

sciousness and psychology as it exists in our society today could tolerate euthanasia. Yet 20 years ago our society wouldn't have tolerated extensive abortion. Our mores change."[30]

The "thin edge of the wedge" danger is real; the camel's nose does get under the tent; once opened, the movement of the door to death by human choice may be a constantly widening, and likely a never narrowing, movement. It seems pertinent to remember that the Hitlerian eugenic euthanasia, the elimination of "useless eaters," which preceded his wholesale racial genocide, was supported by "humanitarian" petitions to him by parents of malformed children requesting authority for "mercy deaths." It is perhaps the supreme irony that at first Jews were apparently excluded from the program on the ground that they did not deserve the benefit of psychiatric euthanasia![31]

Is the distinction between voluntary and involuntary euthanasia as meaningful and abiding as its facile verbal formulation would suggest? But let us take the proponents at their present word, and limit out discussion chiefly to so-called "voluntary" euthanasia.[32] And let us work with a definition of voluntary euthanasia that puts the affirmative case in the strongest possible terms, as I believe Professor Kamisar's definition does in assuming:

> A person ... *in fact* (1) presently incurable, (2) beyond the aid of any respite which may come along in his life expectancy, suffering (3) intolerable and (4) unmitigatable pain and of a (5) fixed and (6) rational desire to die ...[33]

But before applying that definition to our problem, a few more preliminary delineations are in order.

More Definitional Problems
(i) Euthanasia v. Extraordinary Means to Preserve Life;
(ii) Euthanasia v. Alleviation of Pain by Drugs

In the word "euthanasia" I do not include — and I submit that one who struggles for precise communication should not include — the withholding of extraordinary means to preserve life. To call the mere withholding of extraordinary means "indirect voluntary euthanasia" is I submit, taking into account the currently accepted meaning of "euthanasia" as deliberate killing, a confusion of terms that cannot conduce to precision of thought.[34] Putting aside for the moment the difficulties in adequately articulating the difference between "extraordinary" and "ordinary" means of preserving life, the soundness of the distinction in principle becomes a part of my main thesis today. If the distinction between affirmative killing and letting die is only a quibble, as some have characterized it,[35] my thesis fails.

The student of this problem, especially one innured to common-law thinking, must be careful lest he assimilate the "extraordinary" — "ordinary" means distinction to our law's classic differentiation between "action" and "inaction". The common law's notion that despite the relative ease of rescue a stranger may safely ignore a person in dire predicament — a drowning child, for example — whereas if he acts St. Luke's Good Samaritan role and undertakes rescue he is held to the standard of due care,[36] does not govern in the typical application of the "extraordinary" — "ordinary" means distinction. Under the common law rule (which by no means is universally accepted)[37] a physician may refuse aid to the stranger-victim of an emergency without incurring legal liability, however morally reprehensible his abstenance may be, while in voluntarily rendering aid he incurs the obligation of using due care.[38] The way this caused Good Samaritan statutes, exculpating the physician who follows his conscience rather than his convenience, to sweep the country like prairie fire, is a story I have tried to tell elsewhere[39] and need not detain us here.

The important point for present purposes is that the *attending* physician is of course not a volunteer; he is bound to the standards of medical performance, including affirmative acts, under the sanction of malpractice liability, besides other sanctions. Thus an attending physician's attempted justification for failure to fulfill the standards of medical practice, on the sole ground that his failure was "inaction" rather than "affirmative action" would be preposterous.[40] But I shall attempt to show that a failure to use "extraordinary" or "heroic" means is a different matter and, in a given context, may be both legally and morally justifiable, or, indeed, perhaps even morally obligatory.

Similarly, I maintain that the use of drugs to alleviate pain, even though that use in fact may hasten death, is not "euthanasia" in the modern meaning of direct, deliberate killing, because even if in both cases death may be "willed" in the sense of desired, there is a difference in means of abiding significance in the realities of the human condition. Thus I think a provision in the British euthanasia bill of 1969 works a disservice to clarity of analysis when it couples a provision authorizing true euthanasia with one declaring that a patient suffering from an irremediable condition reasonably thought in his case to be terminal shall be entitled to the administration of whatever quantity of drugs may be required to keep him free from pain.[41] I submit there is no serious practical question of the present legality of such use of drugs[42] nor any genuine problem with its ethicality.[43] Daniel Maguire's recent question equating "positive action" and "calculated benign neglect" has a similar defect, although in his instance there is at least the justification of an ensuing explicit confrontation with the question's innuendo.[44]

Whether my conclusion that it is ethical for the physician to administer drugs to alleviate pain even to an extent that may shorten life is any more viable than the principle of double effect, or whether indeed that principle is enough to

sustain the distinction, let us put aside for the moment. But I should candidly note here that I am not among those inclined to emphasize the moral value of pain. Sometimes the writers, particularly some of the more ancient theologians, seem almost to be arguing that it is, after all, human suffering that makes this the best of all possible worlds! Amidst such mock heroics it is refreshing to turn to the common sense of Pius XII who in his February, 1957 address to the Italian anesthesiologists, after pointing out that the growth in the love of God does not come from suffering itself but from the intention of the will, candidly concluded that instead of assisting toward expiation and merit, suffering can also furnish occasion for new faults.[45] Surely there must be a midground between the exaltation of human suffering as glorious, and the attitude often lived by today that it is the ultimate evil, reflected in the automatic gulp from the aspirin bottle at the mere hint of a headache.

The Ethics of Voluntary Euthanasia

Had this paper been presented fifteen years ago, its gist almost necessarily would have been an inquiry into the ethics of euthanasia. But in the meantime such inquiry, acutely engendered at one stage by the running debate between Glanville Williams[46] and his opponents, has been richly productive. My viewpoint — that whatever the diminution of moral reprehensibility by the facts of a given case, euthanasia in principle is unethical as well as illegal killing — has already been essentially presented by my law professor colleagues Yale Kamisar,[47] Charles E. Rice,[48] and David Daube,[49] and by Norman St. John Stevas, M.P.,[50] and others. Therefore, I tarry only briefly with the ethics of voluntary euthanasia itself, that is, the deliberate, affirmative, intentional act of effecting a mercy death.

My only serious issue with Professor Kamisar concerns his essay: "Some Non-Religious Views Against Proposed 'Mercy-Killing' Legislation". Supporting the distinction, he says: "I leave the religious arguments (for opposing euthanasia) to the theologians."[52] True, the injunction of *Exodus*[53] "The innocent and just man thou shalt not put to death" arguably is a religious, or perhaps more precisely, a theological reason, for opposing euthanasia. He who is Lord of Life is also ultimately Lord of the time of Death. But except as Scripture or extrapolations therefrom, or from received Christian tradition, formulate religious reasons for opposing euthanasia, in what way do the "religious" reasons differ from the "non-religious" or utilitarian ones? A warning comes to mind:

> It is a great mistake to let poeple know that moral issues involve religion. If you talk about religion you might just as well talk about politics. Everyone agrees that politics and religion are a matter of opinion. You can take your pick . . .
>
> Let this be clear. When we talk about moral problems we are not talking about religious beliefs — which we can take or leave. Stealing, lying, killing, fornicating would be wrong even if no church condemned them. Hijacking aircraft, tossing bombs into crowded shopping centers and selling drugs to your children are not sins mentioned in the bible. Nor is euthanasia. So keep religion out of this . . .[54]

I perhaps belie the wisdom implicit in the foregoing when I reveal that the writer is the Archbishop of Westminister, John Cardinal Heenan.

Are not the following reasons for opposing voluntary euthanasia both "religious" and "non-religious"? Ascertainment of a sick person's abiding desire for death and persistent and true intention affirmatively to seek it, is intrinsically difficult and often impossible. The difficulties inhere in illness with its pain and distraction, and are compounded by narcotics and analgesics. Anything like the legal standard for voluntariness in other contexts, for example for criminal confessions, would be hard to achieve. Would minors of knowledgeable age and discretion be allowed to elect it, and with or without parental consent? A decision made before illness to elect euthanasia conditionally, would have morbid aspects and would leave lingering doubts as to the continuity of intention, especially with intervening coma. Euthanasia, if legally formalized by procedural restrictions, would threaten to convert the sick room into an adjudicative tribunal. The consequences of required decisions and procedures might be harsher for the family, especially young children, than for the dying person. If left essentially to the discretion of the physician, administration of euthanasia would be as variable as the tremendous variation in medical competence. But not even the best physician is infallible and mistakes, necessarily irretrievable, would have the odious flavor of avoidable tragedy. Moreover, the history of science and medicine increasingly demonstrates that yesterday's incurable disease is subject matter of today's routine treatment. Even "incurable" cancer is sometimes subject to remissions.[55] In medicine, as in life itself, there is no true hopelessness.

Euthanasia would threaten the patient-physician relationship; confidence might give way to suspicion. Would a patient who had intended to revoke his declaration for euthanasia have faith that his second word would be heeded? Can the physician, historic battler for life, become an affirmative agent of death without jeopardizing the trust of his dependents? Indeed, would not his new function of active euthanator tend psychologically to undermine the physician's acclimation to the historic mandate, "I place before you life and death. Therefore, choose life."?[56] And what would acceptance of the psychology of euthanasia do to the peace of mind of the mass of the so-called incurables.

Lastly, how long would we have voluntary euthanasia without surrendering to pressures for the involuntary? Would not the pressures be truly inexorable? Merely to ask such questions and state these points seems to belie a dichotomy

between "religious" and "non-religious" reasons for opposing voluntary euthanasia. I see essentially human reasons.[57]

There is no Obligation "Officiously to Keep Alive" the Dying

If humor may be brought to consideration even of these grim problems — and perhaps the more serious the problem, the more helpful the light touch — I may be pardoned for commencing this part with the words of Arthur Hugh Clough who apparently wrote in light vein:

> Though shalt not kill, but need'st not strive Officiously to keep alive.[58]

I submit that it is about as clear as human answers can be in such matters that there is no moral obligation to keep alive by artificial means the Elizabeth Schell Holt-Hartfords of the world whose lives nature would forfeit and who, in nature's terms, wish to die, or in Christian terms, wish to pass over to the promised land. I submit further that the law in no manner seeks to set at nought this moral truth. The moral idea was put this way by Pius XII when in November 1957 he answered questions for the International Congress of Anesthesiologists:

> Natural reason and Christian morals say that man (and whoever is entrusted with the task of taking care of his fellowman) has the right and the duty in case of serious illness to take the necessary treatment for the preservation of life and health. This duty that one has toward himself, toward God, toward the human community, and in most cases toward certain determined persons, derives from well ordered charity, from submission to the Creator, from social justice and even from strict justice, as well as from devotion toward one's family.
>
> But normally one is held to use only ordinary means — according to circumstances of persons, places, times, and culture — that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult. Life, health, all temporal activities are in fact subordinated to spiritual ends. On the other hand, one is not forbidden to take more than the strictly necessary steps to preserve life and health, as long as he does not fail in some more serious duty.[59]

Although Pius XII did not, I believe, use the expression "extraordinary means" it has become customary to capture his thought in the shorthand phrase "distinction between ordinary and extraordinary means." It is a convenient condensation but, as with short names generally, may mislead unless clarified. For one thing, there seems to be considerable difference between the significance typically given the "ordinary and extraordinary means" distinction by physicians on the one hand, and moral theologians, on the other. Physicians seem to take the distinction as equivalent to that between *customary* and *unusual* means as a matter of medical practice. Theologians pour into the distinction all factors relevant to appropriate moral decision however non-medical they may be: the patient's philosophic preference, the conditions of the family including the economic facts, the relative hardships on a realistic basis of one course of conduct as contrasted with another.[60] Even means that are "ordinary" from the viewpoint of medical practice, may be "extraordinary" in the totality of life's dilemmas.

Take the case of a three-year old child, one of whose eyes had already been removed surgically because of malignant tumor. The other eye later became infected in the same way, and medical prognosis offered only the dilemma of either certain death without further surgery or a considerable probability of saving the child's life by a second ophthalmectomy. From the medical viewpoint, doubtless such surgery represents an ordinary means of saving life. I take it to be the prevailing theological view that (putting aside the additional problem of one acting for another — the father for the three-year old) one is not obliged to save his life when that entails a lifetime of total blindness. In other words, under the circumstances the surgery would be an extraordinary, and morally not required, way of saving life.[61]

Thus an artificial means, however ordinary in medical practice, may be morally extraordinary and not obligatory. Also, it may be non-obligatory, even though ordinary, because it is likely to be useless. (I speak now of *artificial* means, such as surgery, and not of natural things as furnishing of food, drink and the means of rest). To save the convenient distinction between ordinary and extraordinary means, while at the same time promoting its accuracy, the theologians have wisely incorporated into the definitions qualifications necessitated by such cases as the three-year old's, as well as the common-sense requirement that an artificial means to be obligatory must be of potential usefulness. Thus:

> *Ordinary* means are all medicines, treatments, and operations, which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconvenience.
>
> *Extraordinary means* are all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit.[62]

Of course the physician cannot be blamed for emphasizing the purely medical considerations in his appraisal of the appropriateness of the means for staving off death. Necessarily this is the trend of his training and competence, perhaps sometimes fortified by the potentiality of malpractice liability. On a practical level the reconciliation of the physician's and moralist's views on extraordinary means is in the reality that, after all, the decision as to how hard and far to push to keep life going by artificial means, is ultimately the patient's, not the physician's. That is, the physician may be legally obligated to proffer what is customary medical practice although the patient may be morally entitled to reject it as extraordinary.[63] Conversely, presumably the patient is entitled to have, in situations where that is his final hope because lesser efforts afford no promise, means that the

physician regards as medically unusual or extraordinary — although I should like to qualify this a moment later from the moral viewpoint.

While discussing physicians' participation in the life-death decisional process, it is pertinent to note an apparent tendency among them to regard as more significant, and more hazardous, the stopping of extraordinary means compared to failure to start them in the first place.[64] Thus, there is more hesitancy to turn off the resuscitator than to decide originally not to turn it on. This distinction is I think from the oral viewpoint, only a quibble. Indeed, might there not be more justification in ceasing after a failing effort has been made, then in not trying in the first place? The medical attitude in this regard seems more psychologically than rationally based. Perhaps the physician has been excessively influenced by the common law's historic distinction between "action" and "inaction." From the legal viewpoint it is worth noting that Professor Kamisar's careful research failed to reveal by 1958 a single case where there had been an indictment, let alone a conviction, for a "mercy-killing" by omission;[65] and I know of none since. It seems legally far-fetched to convert "omission" into "commission" by the mere fact that the machine is turned off when it fails to be effective, rather than not turned on in the first place.[66] Civil liability of course is something else; but is there really much danger of malpractice because a physician ceases to continue to use an apparently hopeless medical technique, just because he has tried it out? Certainly not so where the patient declines further use; and when he is beyond personal decision, because for example unconscious, clearance from a spouse or family member seems to help, although as previously noted it is hard to find a juridical basis for letting one adult decide for another.[67] Estoppel might become a relevant defense in a suit for wrongful death.

Can one wander through the wards of the aged dying, observing the Elizabeth Schell Holt-Hartfords, hearing the murmured prayers "Let me pass over," without realizing that often the frenetic efforts to resuscitate or just to keep going are an affront to human dignity? In all truth their objective is not as much the prolongation of life as of the process of dying. Can one doubt that the Master Observer of the human condition has perceived the moral as well as psychological reality when in his King Lear he put it:

> Vex not his ghost: O, let him pass! he hates him That would upon the rack of this tough world Stretch him out longer.[68]

Needless to say, I now put aside the additional and relatively new problem, not without moral implications of its own, of keeping a body pronounced dead functioning in part essentially as an organ bank for transplantation purposes.[69]

Since the case for not stretching out longer seems so self-evident, how explain the countervailing motives and practices of so many physicians and families? In the case of the former, is it sometimes sheer professional pride, human ego, the thrill of the game, perhaps akin to the lawyer's will to win? As to the families, maybe one typically need look no further than to the traumatic shock of threatened death of a beloved. But is a sense of guilt over past neglect, rather than love, sometimes at least a partial explanation? In such an area one should not speak abstractly; each threatened death is unique and very personal. Who, however much in agreement with what I have just said, would not applaud the most persistent and heroic efforts imaginable to succor the youthful victim of a casualty such as an automobile accident? Who would deny that in such a case every intendment of the presumption of the will to live should be indulged by the physicians and all concerned?

Perhaps these frenetic efforts to keep going the earthly life of the aged that nature would forfeit go hand in hand with the materialism of modern society. The witty Hilaire Belloc observed:

> Of old when men lay sick and sorely tried,
> The doctors gave them physic and they died.
> But here's a happier age, for now we know
> Both how to make men sick and keep them so![70]

The willingness to let pass those who are ready and wish to pass seems as much an act of Christian faith as of reconciliation with nature's way. In this sense perhaps there is as much of Christian hopefulness about death as of pagan acceptance of dissolution in the poet's invocation of the concept of *conquering* "the fever called 'Living.'"[71]

That it is permissible to withhold extraordinary means to me seems so clear that future discussion is likely to focus instead on whether and under what circumstances there is a duty to do so. Recall the ending of the quoted allocution of Pius XII: "One is not forbidden to take more than the strictly necessary steps to preserve life and health, as long as he does not fail in some more serious duty."[72] Doubtless that is the starting point of the relevant analysis and doubtless, too, the decision typically is for the patient, not the physician. But what are the more serious duties that should preponderate for example in the mind of the head of the family, over extravagant efforts to preserve his own life? That profligate expense may deprive the children of education, certainly seems relevant. Hardly less so is the mental torture that may be imposed on the family by indefinite prolongation of the physical dissolution of its head. And possibly, if medical facilities and services increasingly become of lesser availability in relation to the demand, society's needs may some day be held to supersede the personal requests for extraordinary means even by those financially able to pay.

No sooner as one has thus spoken of the right, even possibly the duty, of withholding extraordinary means than he wonders if his message tends to undermine the medical professional's proudest boast and

happiest claim — its historic bulldogged defense of human life. For in result, even when not in motivation, there is more than professional pride and human ego in the physician's strugglings. As Gerald Kelley, S.J. put it: "By working on even the smallest hope doctors often produce wonderful results, whereas a defeatist attitude would in a certain sense 'turn back the clock' of medical progress. Also, this professional ideal is a sure preventive of an euthanasian mentality."[73]

Our last, and hardest question, essentially becomes: Is the distinction between letting die, and killing, sound enough to preclude the euthanasian mentality?

The Distinction between Killing, and Letting Die, Continues to be Viable, Valid and Meaningful

If it is permissible to let die a patient direly afflicted and sorely suffering, why is it wrong affirmatively to help him die with loving purpose and kindly means? The question poses stark challenge to philosopher, theologian, ethician, moralist, physician, lawyer and all persons of good will whether or not religiously oriented.

Let us put onto the scales our conclusions to the moment, on the one side the permissible things, on the other those forbidden. Note that on each side there is a negative and an affirmative thing. It is permissible to withhold extraordinary means, and also to give drugs to relieve pain even to the point of causing death. It is not permissible to withhold ordinary means, or affirmatively and intentionally to cause death.

All of us, specifically lawyers, are under injunction to avoid the hypocrisy that inflicts on man and unnecessary burdens. One cannot daily face in law school classes the youth of the country without perceiving that whatever may have happened to parts of the Decalogue, hypocrisy remains an acknowledged and detested sin. Will our distinctions withstand indictment as deception or sham? Can we insist upon them without being hypocrites?

Certainly the fact that our distinctions are fine does not of itself condemn them. Biology, psychology and morality, like life itself, are filled with close questions, narrow definitions, and fine distinctions.[74] The margin between pain and pleasure may be as imprecise as that between love and hate.[75] Nor is universal certainty and equality of application of principle to the facts of cases necessarily a test of the principle's validity. Appellate judges are wont to say that much must be left to the discretion of trial judges, and moralists must concur that much must be left to the judgment of those who apply principle to hard facts. As Gerald Vann, O.P. put it:

> Moral action presupposes science but is itself an art, the art of living. Moral science concerns itself first of all with general principles, as indeed being a science it must; but the subject of morality is not human action in general, but this or that human action, in this or that set of circumstances, and emanating from this or that personality. Hence the fact, remarked upon by Aristotle, that ethics cannot be an exact science. There is no set of ready-made rules to be applied to each individual case; the principles have to be applied, but this is the function of the virtue of prudence, and with prudence as with art, as Maritain points out, each new case is really a new and unique case, each action is a unique action. What constitutes the goodness of an action is the relation of the mind not to moral principles in the abstract but to this individual moral action. Hence an essential element of quasi-intuition is at least implicit in every willed and chosen action.[76]

Incidentally, we common law lawyers have admirable instruments by which to effectuate the moralist's acknowledgment of the necessity of accommodation of principle to fact. We have at the intellectual or formal level the institutions of Equity and on the pragmatic level trial by jury. True, the accommodation by a jury may be radical indeed, as Dryden observed centuries ago:

> Who laughs but once to see an ass
> Mumbling to make the course-grained thistles pass,
> Would laugh again to see a jury chaw
> The thistles of an unpalatable law.[77]

My only point in passing is that with such means of accommodation, I doubt that we need formal provisions of law to mitigate the potential harshness in applying homicide principles to mercy deaths. Whether or not we do, is certainly a legitimate and open question; some will argue for statutes authorizing lesser penalties in case of euthanasia, as in Norway.[78] Personally, I fear that formal provision for mitigation might do more harm educationally by way of undermining the distinction between letting die and killing, than good substantively.[79] This of course presupposes the validity of the distinction, to which we now turn.

Daniel Maquire in *Commonweal* recently concluded: "It can be said that in certain cases, direct positive intervention to bring on death may be morally permissible . . . The absolutist stance opposed to this conclusion must assume the burden of proof — an impossible burden, I believe."[80] This conclusion on burden of proof will I think astound the proceduralist, certainly one of historical orientation, as much as the moralist. For centuries medical ethics has drawn sharp and firm distinction between "positive action" and "calculated benign neglect," to use Maquire's own terms.[81] The theologian's principle of double effect is an ancient one. In the face of the historical realities, why, suddenly, this reversal of the burden of proof? Hardly because today's logic is sharper; the principle of double effect has been reexamined and criticized by able minds for generations. Do the new psychological insights justify such reversal of the field? Quite the contrary, I submit.

The principle of double effect has four criteria. Let us apply them to the distinction perhaps the hardest of all to sustain, that between the administration of drugs to kill, on the one hand, and the administration to relieve pain even though death may be hastened, on the other. The criteria are:

> (i) the act itself must be morally good, or at least neutral;

(ii) the purpose must be to achieve the good consequence, the bad consequence being only a side effect;

(iii) the good effect must not be achieved by way of the bad, but both must result from the same act;

(iv) the bad result must not be so serious as to outweigh the advantage of the good result.[82]

Admittedly application of these criteria may produce nuances so delicate that the decision of one able and conscientious mind may be at odds with another equally able and conscientious. Conceding *arguendo* that a principle of such ambivalent potential may have logical deficiencies, is not the ultimate question of its justification not one of dry logic but of its psychological validity? Let us suppose a physician, faced with his patient's intolerable pain unmitigable by lesser doses and his urgent plea for relief, decides on a dose of analgesic likely to cause death. (You may substitute "certainly to cause death" if you wish, but I would remind that in the physiological realities, it may always remain doubtful whether the pain itself might have been as death-producing.)

Contrast the attitude and manner which the motive of relieving pain engenders, with those likely consequent upon a grim determination to kill. If the purpose explicitly were to kill, would there not be profound difference in the very way one would grasp the syringe, the look in the eye, the words that might be spoken or withheld, those subtle admixtures of fear and hope that haunt the death-bed scene? And would not the consequences of the difference be compounded almost geometrically at least for the physician as he killed one such patient after another? And what of the repercussions of the difference on the nurses and hospital attendants?[83] How long would the quality and attitude of mercy survive death-intending conduct? The line between the civilized and savage in men is fine enough without jeopardizing it by euthanasia. History teaches the line is maintainable under the principle of double effect; it might well not be under a regime of direct intentional killing.

Moreover, I fear the effects on the family if law, sometimes the great teacher of our society, were to start to teach the legitimacy of direct killing. I am indebted to my colleague David Daube for a telling illustration of the validity of this concern. There was at Oxford one of the great historians of the century who was totally paralyzed up to the shoulders, with all that implies by way of dependence and suffering. A loving wife and family nurtured and sustained him, at no mean cost, of course. The visits of this profound scholar and scintilating conversationalist to All Souls College were a weekly delight to all who could share the coffee hour with him, even as he sipped with a tube from the cup. Immobile in his wheel chair, he nevertheless gave a final memorable lecture. Under a regime of euthanasia's legitimacy, would not cultivated, sensitive, and selfless spirits such as this feel an obligation to spare their families the burden? Certainly in this case, as Professor Daube concludes, scholarship, family life and All Souls College might have paid a heavy price in an euthanasiac regime for an act that might have been coerced by a sense of obligation.[84] To the sensitive and selfless especially, what the law would permit might well become the measure of obligation to family and friends.[85]

There is no time to wend our way back to the great natural law philosophers such as Heraclitus and Cicero. In any event I claim no special competence to lead the trek, as has recently my colleague Ehrenzweig in his usually profound and comprehensive way, albeit in unconventional context.[86] I cannot help wonder, though, whether the principal mischief with such life-interfering proposals as euthanasia is their undue deprecation of the importance of the natural order in human affairs. As a principal heresy of the 19th Century was that progress lay in human domination of the environment, perhaps the heresy of this century will prove to be that biological evolution must be dominated by human will.[87] Certainly we must hope that the freedom and integrity of the human person will not be as much ravaged and stripped as have been the forests and fields and waters of the world. As a physician puts it:

> We are possessed with a technologic spirit in which power over nature is the predominant theme. We ignore the fact that there is an intrinsic despair and disparity in looking to technology for a solution. We forget that our problem is not to master nature, but to nurture nature. We also forget that technological achievements are, at best, ameliorative, and, at worst, dehumanizing.[88]

The additional dilemmas that a regime of mercy deaths would impose — such problems as ascertainment of true and abiding consent — would seem of themselves reasons for avoiding the creation of more unlighted paths.[89] Is not the preferred choice continuing progress in the alleviation of pain and loving care of the Elizabeth Schell Holt-Hartfords among our neighbors, rather than killing? We are only mortal, and in this area a grand attempt to restructure the natural order seems more dangerous than hopeful. Nature can be harsh and cruel, but it is never corrupt. Human will can be all three.

Perhaps after all I have discovered rapport with at least one song the young folks sing, "Que sera, sera." There are some things that would be that we'd better let be.

Conclusion

The distinction between affirmative killing, and allowing one to die according to nature's order without extraordinary effort to "stretch him out longer," continues to be a valid, viable and meaningful distinction.[90] The line of demarcation may be fine, but so are many other lines that men must draw in their fallible perception and limited wisdom. Application of the principled distinction between ordinary and extraordinary means of prolonging life occasions difficulties, but hardly any different in quality from various other decisions in applying a general principle to particular facts. The distinction between the use of drugs to kill, and their use to alleviate pain even though death

may thereby be hastened, is likewise valid.

When the question becomes one for the legal system, fortunately our law has time-tested devices for accommodating principle and facts, notably the jury. It seems hardly necessary or wise for us to attempt articulation of formal legal standards of lesser liability in cases of euthanasia than for other criminal homicides in the manner of Norwegian law. The harm of the educative effects of formalization of lesser penalties for euthanasia, probably would outweigh the values thereby gained by way of certainty of legal consequence and surer guarantee of equal protection of the law.

Our era is one that seeks, and often for good reason, a constant expansion of a juridical order in human affairs. But not every human relationship stands to profit from complete juridicalization, as witness parent-child relations. Besides the force of law, there is also the kingdom of love. Perhaps the best we can do is to work for the right of our Elizabeth Schell Holt-Hartfords peacefully to die when their time comes in the embrace of their neighbors and fellow members of that kingdom.

REFERENCES:

1. Based on program of KNXT-TV, Los Angeles, April 23, 1972, and ensuing unpublished information. A comparable story is told by Sweeney, "On the Occasion of a Death in Boston," *New York Times*, Oct. 23, 1972, p. 31.

2. Saltonstall Professor of Population at Harvard, in a remarkable paper, *Religion: Aid or Obstacle to Life and Death Decisions in Modern Medicine?*, furnished me in manuscript form by the Joseph P. Kenn[illegible] Jr. Foundation, Washington, D.C.

3. Kamisar, "Some Non-Religious [illegible]ews Against Proposed Mercy-Killing [illegible]slation," 42 *Minn. L. Rev.* 969, 1016, [illegible]58).

4. *Your Death Warrant?* (Gould an[illegible] [illegible]aigmyle, eds. 1971). This book, frequent[illegible] [illegible]ted, is the product of a Study Group on [illegible]thanasia set up as a joint venture by the [illegible]holic Union of Great Britain and the G[illegible] [illegible] of Catholic Doctors. The members of the [illegible]oup were Cicely Clarke, Lord Craigmyle, C[illegible]rles Dent, J. G. Frost, J. E. McA. Glanc[illegible] [illegible]MD, Jonathan Gould, F. J. Herbert, [illegible]eph Molony, QC, G. E. Moriarty, R. [illegible] G. O'Brien, F. F. M. Pole, Hugh Rossi, M[illegible] [illegible]S. Tweedy and William T. Wells, QC. [illegible]ereafter the book will be cited simply as [illegible]*ath Warrant*.

5. *Death Warrant*, 21.

6. *Death Warrant*, 22; N. St. John-[illegible]vas, *Life, Death and The Law*, 270, (1961[illegible]

7. *Death Warrant*, 23-26.

8. The sick room under a eutha[illegible]siac regime has been likened to the goulish [illegible]nging scene, in which the executioner wo[illegible] [illegible]l go to the condemned's cell, ascertain his w[illegible]ght, his stature, the sturdiness of his nec[illegible] etc. All of this ensued upon the judge's d[illegible]ning a black mask behind which he prono[illegible]ced sentence.

9. Chapter VIII, (1957). See also Wi[illegible]ams, "Mercy Killing Legislation — a Rejoin[illegible]er," 43 *Minn. L. Rev.* 1, (1958); Williams, "[illegible]thanasia and Abortion," 38 U. *Colo. L. Rev.* 178, (1966).

10. Williams, *The Sanctity of Life an[illegible] the Criminal Law*, n. 9, *supra* at 340. See also C. Rice, *The Vanishing Right to Li[illegible]* 54, (1969).

11. The story of the Parliamentary proposals and debates from 1936 through 1970 is told in *Death Warrant*, 24-67.

12. *Ibid.* at 26, 30.

13. *Ibid.* at 26.

14. *Ibid.* See also C. Rice, note 10 *supra* at 61-63; J. Dedek, *Human Life: Some Moral Issues* 121 (1972); Kamisar, note 3 *supra* at 1032 n. 213, 1034.

15. *Death Warrant*, 27. Apparently the Law of Texas is in accord, Perkins, *Criminal Law*, 67, (1957).

16. Williams, notes 9-10 *supra* at 333-334. Note how simply the voluntary-involuntary distinction is put in J. Dedek, note 14, *supra* at 133.

17. *Ibid.* at 340. The proposed 1969 British bill excludes minors by providing that "qualified patient" means a patient over the age of majority. *Death Warrant*, App. p. 139.

18. On other occasions I have attempted to show the folly in contending that moral value judgments in the biological area are exclusively for physicians just because they have the technical medical competence, for example, Louisell, "Abortion, the Practice of Medicine, and the Due Process of Law," 16 *U.C.L.A. L. Rev.* 233, 245-246, (1969); Louisell and Noonan, "Constitutional Balance," in *The Morality of Abortion* 220, 256-257, (Noonan ed., 1970). See Jakobovits, "Jewish View on Abortion," in *Abortion and the Law*, 124, 125-126 (1967); Hellegers, "Law and the Common Good," *Commonweal*, June 30, 1967, at 418.

19. M'Naghten's Case, 10 Clark & F. 200, 8 Eng. Rep. 718, (1843).

20. Durham v. United States, 214 F. 2d 862 (D.C. Cir. 1954).

21. §4.01; see also United States v. Currens, 290 F.2d 751, (1961); Diamond, "From M'Naghten to Currens, and Beyond," 50 *Calif. L. Rev.* 189, (1962).

22. People v. Wells, 33 Cal. 2d 330, 202 P.2d 53, (1949); People v. Gorshen, 51 Cal.2d 716, 336 P.2d 492, (1959); see Louisell & Hazard, "Insanity as a Defense: The Bifurcated Trial," 49 *Calif. L. Rev.* 805, 816, (1961). For brief summary of St. Thomas Aquinas' prescription of criteria relevant to responsibility for acts, see Louisell & Diamond, "Law and Psychiatry: Detente, Entente, or Concomitance?" 50 *Corn. L. Q.* 217, 218 n. 8, (1965).

23. For criteria of responsibility in the criminal area, see generally Clark and Marshall, *Crimes* §6.01 (7th ed., 1967); Diamond, "Criminal Responsibility of the Mentally Ill," 14 *Stan. L. Rev.* 59, (1961).

24. Kamisar, note 3 *supra* at 986-87.

25. *Ibid.* at 987-88.

26. Louisell & Williams, *Medical Malpractice* §22.09 (Rev. ed., 1971).

27. *Death Warrant*, App. p. 140.

28. Kamisar, note 3 *supra* at 1014-41.

29. Calif. Health & Welfare Code §§25951-25952, (1967).

30. Dr. Michael Kaback, as quoted in Freeman, "The God Committee," *The New York Times Magazine*, May 21, 1972, p. 86.

31. C. Rice, note 10 *supra* at 62-63; Kamisar, note 3 *supra* at 1033.

32. In doing so, of course we put outside our ambit one of life's most agonizing dilemmas, crippling infant deformities which at extremity — in terminology as in actuality — produce monsters. The current attention focuses sharply on meningomyelocele, *spina bifida, spina aperta*, or open spine. See Freeman, "The God Committee," *The New York Times Magazine*, May 21, 1972, p. 85.

33. Kamisar, note 3 *supra* at 975.

34. P. Ramsey, *The Patient as Person*, 152-53, (1970); C. Rice, note 10 *supra* at 68-69.

35. J. Fletcher, "Euthanasia and Anti-Dysthanasia (The Patient's Right to Die)" in *Moral Responsibility*, 141-160, (1967).

36. "The result of all this is that the Good Samaritan who tries to help may find himself mulcted in damages, while the priest and the Levite who pass by on the other side go on their cheerful way rejoicing." Prosser, *Law of Torts*, 339 (3rd ed., 1964); Of course this assumes the absence of a relationship that may impose a duty, e.g. teacher-pupil, carrier-passenger, inn keeper-guest, etc.

37. German Criminal Code §330c; French Penal Code Art. 63. See Louisell and Williams, note 26 *supra* ¶21.42.

38. *Ibid.* at ¶21.35.

39. *Ibid.* Ch. XXI.

40. *Ibid.* Ch. VIII; Kamisar, note 3 *supra* at 982 n. 41; Meyers, *The Human Body and the Law*, 147-48, (1970).

41. *Death Warrant*, App. p. 141.

42. It is true that good motive conventionally does not *per se* preclude criminality in homicide. Clark and Marshall, *Crimes*, 263-65 (7th ed., 1967); Perkins, Criminal Law, 721, (1957); but cf. *id.* 723. Thus it remains arguable that the good motivation of alleviating pain *per se* would not relieve from murder a physician who injected a heavy dose of drugs with knowledge that it certainly would cause death, any more than one would be relieved who injected with the specific purpose of killing. But the requisite proof of certain "causation," when death was in process in any event, would in the typical case seem as theoretically impossible as it would be practically unavailable. Com-

pare G. Fletcher, "Prolonging Life," 42 *Wash. L. Rev.* 999, (1967). In the trial of Dr. Adams for murder in Britain in 1957, the jury was instructed: "If the first purpose of medicine, the restoration of health, can no longer be achieved there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten human life." Meyers, note 40 *supra* at 146-47. See also "Recent Decisions," 48 *Mich. L. Rev.* 1199, (1950); 34 Notre Dame Law. 460, (1959).

43. See note 45, *infra*.

44. "The Freedom to Die," *Commonweal* August 11, 1972 p. 423, 424.

45. "Anaesthesia: Three Moral Questions," 4 *The Pope Speaks* 33, (Summer 1957). After discussion of the suppression of all sense perception in general anaesthesia, the more or less marked deadening of the sensibility to pain in partial anaesthesia and analgesia (p. 41), and the general moral obligation to endure physical pain, he addressed three specific questions (p. 33). The third was:

> 3. Is it lawful for the dying or the sick who are in danger of death to make use of narcotics when there are medical reasons for their use? Can narcotics be used even if the lessening of pain will probably be accompanied by a shortening of life? (p. 33)

In answering this question "Yes," he said in part:

> Now growth in the love of God and in abandonment to His will does not come from the sufferings which are accepted, but from a voluntary intention supported by grace. This intention in many of the dying can be strengthened and become more active if their sufferings are eased, for these sufferings aggravate the state of weakness and physical exhaustion, check the ordor of soul, and sap the moral powers instead of sustaining them. On the other hand, the suppression of pain removes physical and mental tension, makes prayer easier, and makes possible a more generous gift of self.
>
> If some dying persons accept their suffering as a means of expiation and a source of merits, in order to pro gress in love of God and abando ment to His will, do not force ane thesia on them. They should rath be aided to follow their own wa
>
> Where suffering is not so accepte it would be inadvisable to suggest t dying persons the ascetical consider tions set out above. It is to be r membered that instead of assistin toward expiation and merit, sufferin can also furnish occasion for ne faults. (p. 46)

He then pointed out the value and desirability, from a moral and family viewpoint, of retaining full consciousness when dying if possible, and that the use of narcotics with the sole purpose of depriving the sick person of consciousness at the end "would not be a notable advance in modern healing, but a truly regrettable practice." (p. 47) He also said a dying person should not be rendered unconscious before he has completed his moral obligations. (p. 47) This Address to the Italian Society of Anaesthesiology of February 24, 1957, sometimes in the literature is confused with, or at least not distinguished from, his Address of November 24, 1947 to the International Congress of Anaesthesiologists on *The Prolongation of Life*. See Note 59 *infra* and accompanying text. See also T. O'Donnell, S. J., "Moral Principles of Anaesthesia: A Re-Evaluation," 21 *Theological Studies* 626 (1960).

46. See note 9 *supra* and accompanying text.

47. Note 3 *supra*.

48. Note 10 *supra*, Ch. 4, *Euthanasia*.

49. "Sanctity of Life," in *Symposium on The Coast of Life*, 60 Proc. R. Soc. Med. 1235, (1967).

50. Note 6 *supra*.

51. E.g., *Death Warrant;* P. Ramsey, note 34 *supra* Ch. 3 *On (Only) Caring for the Dying;* compare D. Meyers, note 40 *supra* Ch. 6. *Euthanasia*. A. Dyck, note 2, *supra*.

52. Note 3 *supra* at 974.

53. 23:7; see also Daniel 13:53.

54. *Death Warrant*, Preface 13 (1971).

55. See Kamisar, note 3 *supra* at 996-1005.

56. Deuteronomy 30:19.

57. See notes 47-51, *supra*. The problem of additional moral sanctions behind reasons formally taught by a religion according to its principles of revelation, or otherwise, is of course another matter. For a contemporary analysis of teaching authority of the Church, see D. Maguire, *Moral Absolutes and the Magisterium* 14 et seq. (Corpus Papers, 1970).

58. Louisell, "Transplantation: Existing Legal Constraints," in *Ethics in Medical Progress* 78, 93 (G. Wolstenholme & M. O'Connor, ed. 1966).

59. 4 *The Pope Speaks* 393, 395-96 (Spring, 1958). Compare the condemnation of euthanasia by Pius XII, both compulsory, in his encyclical *Mystici Corporis*, A.A.S. 35:239 (1943), and voluntary, Address of May 25, 1948, to Italian Congress of Medical Men, *L'Osservatore Romano*, May 23, 1948. See St. John-Stevas, note 10 *supra* at 270-71; III B. Haring, *The Law of Christ* 239-41 (1966); note 45, *supra*.

In March, 1972 a physician's withdrawal of food from a new-born infant with a seriously defective brain because "the best thing to do was to let him die 'mercifully'" aroused wide-spread interest. The withdrawal of food was countermanded by another physician in the hospital before the baby died. H. Nelson, "Life or Death for Brain-damaged Infant?" *Los Angeles Times*, March 17, 1972, p. 1. Apparently the legitimacy of such conduct was in serious dispute among physicians at the August, 1972 hearings before the special U.S. Senate Committee on Aging, although the distinction between withholding extraordinary means, and affirmative euthanasia, seems not always to have been acknowledged, or even perceived. *The New York Times*, August 8, 1972.

60. P. Ramsey, note 34 *supra* at 118-124; *Death Warrant* 82; *Decisions about Life and Death, A Problem in Modern Medicine*, App. 4 p. 56 (Church Assembly Board for Social Responsibility, Church Information Office, Westminster 1965).

61. J. Lynch, S. J., "Notes on Moral Theology," 19 *Theological Studies* 165, 176 (1958). Compare the discussion in G. Kelly, S.J., "The Duty of Using Artificial Means of Preserving Life," 11 *Theological Studies* 203 (1950), as to whether it is obligatory for a diabetic patient on insulin who develops very painful and inoperable cancer to continue to use insulin (pp. 208, 215), or for a cancer victim to submit to intravenous feeding, (p. 210). Where the patient is not legally competent, e.g., a minor, there are of course the additional problems. Cf. Prince v. Commonwealth, 321 U.S. 158, 170 (1944).

62. G. Kelly, S.J., "The Duty to Preserve Life," 12 *Theological Studies* 550 (1951).

63. Louisell & Williams, note 26, *supra* Ch. 8.

64. P. Ramsey, note 34 *supra* at 121-22; G. Fletcher, note 42 *supra* at 1005 et seq.

65. Note 3 *supra* at 983, n. 41.

66. See note 42 *supra*.

67. See note 26 *supra* and accompanying text.

68. Act v, Sc iii.

69. Louisell, "Biology, Law and Reason; Man as Self-Creator," 16 *The American Journal of Jurisprudence* 1, 10 n. 33 and accompanying text (1971).

70. Quoted in Maguire, note 44 *supra*.

71. Edgar Allan Poe, *For Annie*, first and sixth verses:

> Thank Heaven! the crisis—
> The danger is past,
> And the lingering illness
> Is over at last—
> And the fever called "Living"
> Is conquered at last.
>
> . . .
>
> And oh! of all tortures
> *That* torture the worst
> Has abated—the terrible
> Torture of thirst,
> For the naphthaline river
> Of Passion accurst:—
> I have drank of a water
> That quenches all thirst:—

72. Note 59 *supra* and accompanying text. *Death Warrant*, 69.

73. G. Kelly, note 61 *supra* at 216-17.

74. Compare the fine distinctions in French and Swiss law whereby a physician may provide, but may not administer, poison at the request of a dying patient. This is because suicide is not a crime, and therefore to be an accessory to it cannot be criminal; but directly to kill another even from humane motives is still murder. *Death Warrant*, 27-28. In 1961 the illegality of attempted suicide was abolished in English law, but it remains a serious crime for a person to incite or assist another to commit suicide. See note 15 *supra* and accompanying text.

75. Montaigne's *Essays*, Ch. XX, *We Taste Nothing Purely* 607, 608 (Florio trans. Modern Library ed.)

76. *Morals and Man*, 83 (1960).

77. Quoted in Botein, *Trial Judge*, 182 (1952). See Repouille v. United States, 165 F.2d 152, 153 (2d Cir. 1947) (per L. Hand, J.). Sioux City & Pacific Railroad Co. v. Stout, 17 Wall. (U.S.) 657 (1873) remains a leading case on the jury's authority to fix standards in ambiguous areas. Compare Holmes, *The Common Law* 123-24 (1881). One wonders how much of Stout's meaning is forgotten in the movement to the smaller jury, Williams v. Florida, 399 U.S. 78, 90 S. Ct. 1893, 26 L. Ed.2d 466 (1970); see also Apodaca v. Oregon, U.S., 92 S. Ct., 32 L.Ed.2d 184 (1972). And *quaere*, as to the meaning of the death penalty cases, Furman v. Georgia, U.S., 92 S. Ct., f3 L. Ed.2d 346 (1972), especially the opinions of White and Stewart, JJ., in respect of the significance our society accords jury ascertainment of its value judgments. Note the *caveat* in the dissenting opinion of Burger, C.J. for himself and Blackmun, Powell and Rehnquist, JJ.:

> The selectivity of juries in imposing the punishment of death is properly viewed as a refinement on rather than a repudiation of the statutory authorization for that penalty. Legislatures prescribe the categories of crimes for which the death penalty should be available, and, acting as "the conscience of the community," juries are entrusted to determine in individual cases that the ultimate punishment is warranted. Juries are undoubtedly influenced in this judgment by myriad factors. The motive or lack of motive of the perpetrator, the degree of injury or suffering of the victim or victims and the degree of brutality in the commission of the crime would seem to be prominent among these factors. Given the general awareness that death is no longer a routine punishment for the crimes for which it is made available, it is hardly surprising that juries have been increasingly meticulous in their imposition of the penalty. But to assume from the mere fact of relative infrequency that only a random assortment of pariahs sentenced to death, is to cast grave doubt on the basic integrity of our jury system.
>
> It would, of course, be unrealistic to assume that juries have been perfectly consistent in choosing the cases where the death penalty is to be imposed, for no human institution performs with perfect consistency. There are doubtless prisoners on death row who would not be there had they been tried before a different jury or in a different State. In this sense their fate has been controlled by a fortuitous circumstance. However, this element of fortuity does not stand as an indictment either of the general functioning of juries in capital cases or of the integrity of jury decisions in individual cases. There is no empirical basis for concluding that juries have generally failed to discharge in good faith the responsibility described in Witherspoon—that of choosing between life and death in individual cases according to the dictates of community values. (33 L.Ed.2d at 435-46)

See also Witherspoon v. Illinois, 391 U.S. 510, 88 S.Ct. 1770, 20 L.Ed.2d 776 (1968); McGautha v. California, 402 U.S. 183, 91 S. Ct. 1454, 28 L.Ed.2d 711 (1971).

78. *Death Warrant*, 28.

79. Compare Silving, "Euthanasia: A Study in Comparative Criminal Law," 103 *U. Pa. L. Rev.* 350, 352-54 (1954); "Recent Decisions," 34 *Notre Dame Law.* 460, 464 (1959). See note 77, *supra*.

80. Note 44 *supra*, 426.

81. P. Ramsey, note 34 *supra*, 118-19.

82. *Death Warrant*, 80. For a contemporary discussion of the principle of double effect, see C. Curran, *Medicine and Morals*, 5-7 (Corpus Papers 1970).

83. It seems perhaps ironical that, with permissive abortion, it may be not so much logical analyses as the aesthetic sense—e.g. nurses' and hospital attendants' revulsion at viewing the Monday morning aftermath of the week-end's abortions—that shocks us into realization of what is going on. See Louisell, note 69 *supra* at 21 n. 69; Doube, "Legal Problems in Medical Advance," 6 *Israeli L. Rev.* 1, 2 (1971).

84. Daube, note 49 *supra*, 1336. Professor Dyck in his paper, note 2 *supra* asks:

> Why are these distinctions (between permitting to die and causing death) important in instances where permitting to die or causing death have the same effect—namely, that a life is shortened? In both instances there is a failure to try to prolong the life of one who is dying. It is at this point that one must see why consequential reasoning is in itself too narrow, and why it is important also not to limit the discussion of euthanasia to the immediate relationship between a single patient and a single physician.

Answering, he states in part:

> ... If a dying person chooses for the sake of relieving pain drugs administered in potent dose, this is not primarily an act of shortening life, although it may have that effect, but it is a choice of how the patient wishes to live while dying. Similarly, if a patient chooses to forego medical interventions that would have the effect of prolonging his or her dying without in any way promising release from death, this also is a choice as to what is the most meaningful way to spend the remainder of life, however short that may be. The choice to use drugs to relieve pain and the choice not to use medical measures that cannot promise a cure for one's dying are no different in principle from the choices we make throughout our lives as to how much we will rest, how hard we will work, how little and how much medical intervention we will seek or tolerate and the like.

85. See *Death Warrant*, 83-84; J. Dedek, note 14 *supra*, 137. Compare the euthanasiac death of Sigmund Freud as told by his physician, Max Schur, *Freud: Living and Dying*, (1972). Freud's cancer of the oral cavity was discovered in April, 1923, when he was about 67 years old. Schur became his personal physician in 1928 and served until Freud's death in 1939, both in Vienna and London. (p. 347) When he first engaged Schur, Freud obtained the promise of euthanasia:

> ... Mentioning only in a rather general way "some unfortunate experiences with your predecessors," he expressed the expectation that he would always be told the truth and nothing but the truth. My response must have reassured him that I meant to keep such a promise. He than added, looking searchingly at me: "Versprechen Sie mir auch noch: Wenn es mal so weit ist, werden Sie mich nicht unnotig qualen lassen." ("Promise me one more thing: that when the time comes, you won't let me suffer unnecessarily.") All this was said with the utmost simplicity, without a trace of pathos, but also with complete determination. We shook hands at this point. (p. 408.)

Thus doctor and patient were under euthanasiac commitment during approximately the last 11 years of Freud's life. Schur relates the final scene:

> On the following day, September 21, while I was sitting at his beside, Freud took my hand and said to me: "Leiber Schur, Sie erinnern sich wohl an unser erstes Gesprach. Sie haben mir damals versprochen mich nicht im Stiche zu lassen wenn es so weit ist. Das ist jetzt nur noch Qualerei und hat keinen Sinn mehr." (My dear Schur, you certainly remember our first talk. You promised me then not to forsake me when my time comes. Now it's nothing but torture and makes no sense any more.")
>
> I indicated that I had not forgotten my promise. He sighed with relief, held my hand for a moment longer, and said: "Ich danke Ihnen" ("I thank you"), and after a moment of hesitation he added: "Sagen Sie es der Anna" ("Tell Anna about this"). All this was said without a trace of emotionality or self-pity, and with full consciousness of reality.
>
> I informed Anna of our conversation, as Freud had asked. When he was again in agony, I gave him a hypodermic of two centigrams of morphine. He soon felt relief and fell into a peaceful sleep. The expression of pain and suffering was gone. I repeated this dose after about twelve hours. Freud was obviously so close to the end of his reserves that he lapsed into a coma and did not wake up again. He died at 3:00 A.M. on September 23, 1939.

Freud had said in his "Thoughts for the Times on War and Death":

> Towards the actual person who has died we adopt a special attitude: something like admiration for someone who has accomplished a very

difficult task. (p. 529)

86. See Ehrenzweig, *Psychoanalytic Jurisprudence* §5, *passim*, (1971).

87. Louisell, note 69 *supra*. During my recent visit at the University of Minnesota, Mark Wraubard, professor of the history of science (now emeritus), indicated a possible incursion into the areas suggested in this paragraph of the text. I hope it is forthcoming!

88. H. Ratner, M.D., Editorial, 7 *Child and Family* 99 (1968).

89. While I have often thought that permissive abortion is more morally reprehensible than voluntary euthanasia for the aged in that the former cuts off life before it has had its chance, it must be conceded that the self-centered fears and anxieties an euthanasiac regime might engender among the elderly (or those in the process of becoming elderly — as we all are) have no exact counterpart in the case of abortion.

90. There is disturbing language in J. F. Kennedy Memorial Hospital v. Heston, 58 N.J. 576, 279 A2d 670 (1971). In upholding the subjection of an adult Jehovah's Witness, who had sustained severe injuries in an automobile accident, to a blood transfusion necessary to save her life, the Court per Weintraub, Ch. J. said: "It seems correct to say there is no constitutional right to choose to die." Replying to the patient's contention that there is a difference between passively submitting to death and actively seeking it, the Court said: "If the State may interrupt one mode of self-destruction (suicide) it may with equal authority interfere with the other." It acknowledges that "It is arguably different when an individual, overtaken by illness, decides to let it run a fatal course." Pretermitting the question of the free exercise of religion, it seems unfortunate that the Court apparently did not confront more directly the extent of the obligation to use artificial means to sustain life.