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Judeo-Christian Teaching on Euthanasia: Definitions, Distinctions and Decisions

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The designation "Judeo-Christian teaching" in the title is chosen deliberately. While the bulk of official and scholarly documentation in this statement will be explicitly Catholic, I would like to make the initial point that the core teaching—and its continuity—here presented, is not narrowly singular, much less peculiar, to the Catholic tradition. What is here presented is, I submit, in accord with the broad spectrum of Protestant Christianity¹ and also in accord with Orthodox Judaism.²

Further, the basic definitions and distinctions here presented, are in basic accord with the stated ethics and policy statements of the "Judicial Council" of the American Medical Association as approved by its House of Delegates (in Anaheim, CA, Dec. 4, 1973)³ and as revised and published as "# 2.11 Terminal Illness" in the *Current Opinions* of the Judicial Council of the AMA. (1981).⁴

I

The first definition is also a distinction that will and has proved useful, not only in the context of death and dying, but to medical practice in general.

This is the distinction between ORDINARY and EXTRAORDINARY means. This distinction has a long history both in medicine and ethics: it is over 400 years old.⁵ And while there is almost complete agreement in the application of these terms in medicine and in morals, there can be some nuanced differences because the presuppositions of its moral use can be wider than those of its medical use.

In medicine, some narrow the acceptance of these terms in relation to science only. Thus, "ordinary means" connote means which are regarded as "customary", "standard", "orthodox", and "tested", procedures *in relation to medical science* as it now is. "Extraordinary means" would connote the "unusual", "heroic", "orthodox", "unproved" or "experimental"

procedures which are incompletely established or simply unestablished, again *in relation to medical science* as it now is. Thus, many of today's "ordinary means" were yesterday's "extraordinary means" not because morals are changing, but because science is progressing.

Morally, ORDINARY and EXTRAORDINARY means are calculated ethically—not in relation only to science as such—but *in relation to the patient's* actual conditions and factual circumstances, some of which would not be strictly medical or scientific.

Thus, in concise form, the cluster of relevant criteria can be stated: all medicines, procedures, treatments and operations which: (1) offer a reasonable hope of benefit to this patient, (2) without serious danger of death, and (3) without excessive burden, pain, hardship, even subjective repugnance.

Defining 'Ordinary' and 'Extraordinary'

If a particular procedure, treatment or operation does offer an individual patient a reasonable hope of benefit without serious danger or excessive burdens, then that treatment is for that patient an ORDINARY means in his/her circumstances.

If, on the other hand, a particular treatment offers a particular patient no reasonable hope of benefit, or does involve serious danger of death, or only a precarious and burdensome prolongation of life, then that is an EXTRAORDINARY means for that patient in his/her circumstances.

Traditionally, all are considered bound to use "ordinary means" to preserve their life, health and bodily integrity. (Failure to do so would ethically be suicidal.) Usually, one is not bound to use "extraordinary means" for same, but is free to do so if one so chooses. In short, "ordinary means" are considered *obligatory*; "extraordinary" are *optional*.

This, of course, is a statement of general principle(s) which requires refinement and concrete exemplification to clarify its extension and comprehension. While the terms are widely received in popular discourse, their timeless repetition is not always accompanied by timely understanding.

While the ordinary/extraordinary distinction is very old, much of its present precision is attributed to the formal and extensive teaching of the late Pope Pius XII, in particular his address, covering this subject, of Nov. 24, 1957.⁶ The same principles are presently encapsulated in two sentences in Directive #28 of *The Ethical and Religious Directives for Catholic Health Facilities* of the National Conference of Catholic Bishops, which reads:

Euthanasia ("mercy killing") in all its forms is forbidden. The failure to supply the ordinary means of preserving life is equivalent to euthanasia. However, neither the physician nor the patient is obliged to use extraordinary means.⁷

Further, in a recent and formal doctrinal instruction, the Vatican Congregation for the Doctrine of the Faith issued a "Declaration on

Euthanasia" on May 5, 1980, which confirms and clarifies the same teaching.⁸

While some of the above statements have the advantage of being concise, and, therefore, apparently clear, their rationale and refinement deserve some close attention if they are to serve as more than mere rhetorical points of reference.

I-a) Rationale. The rationale and basis for the ordinary/extraordinary distinction in Catholic teaching is meant to reflect the difference between a *negative* prohibition which is tightly circumscribed, and, a *positive* admonition which can't be circumscribed in general, but only in concrete particulars.

The received teaching understands the 5th Commandment, ("Thou shalt not kill! *Ex.* 20:13; *Mtt.* 19:18) in both positive and negative terms.⁹ The negative prohibition—in exceptionless form—proscribes and means never directly take the life of an innocent or helpless person. Positively, the same commandment proscribes an obligation to take care of our life, health and bodily integrity, which positive duty is to be fulfilled affirmatively within reasonable and proportionate limits. For this reason, "ordinary" means are said to be obligatory, and "extraordinary" means are optional.

I-b) Within the notion of ORDINARY means, it is now necessary to make some mention of MINIMAL means. "Minimal means" are always presumed to be "ordinary" while allowing that their mechanical delivery, in unusual circumstances might, by exception, qualify as "extraordinary" means.

"Minimal" means could be defined as basic hygiene and supportive measures, namely food, water, bed rest, room temperature and personal hygiene. We owe these measures of support to other human beings simply because they are human beings. In pediatric cases, where the patient cannot, by definition, be self-supporting, one can consider normal feeding, blood, oxygen, clearing air passages, supplying warmth as "minimal" and mandatory means. Neglect of these would, in fact, be destructive.

I-c) Some have recently and mistakenly converted this ordinary/extraordinary distinction into a proportionate/disproportionate calculus. Indeed, no less than a Presidential Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research proposes this substitution.¹⁰ Now, while it is certainly the right and privilege of a Presidential Commission to make recommendations about which distinctions are or are not any longer useful in the "formulation of public policy,"¹¹ I find it somewhat droll that the same federal commission would take it upon itself to reformulate Vatican teaching on behalf of the Vatican.¹² (I suspect that that Commission's ethical over-reach was due not to lack of interest, but to its own over-reliance on one of its acknowledged consultants—J. J. Paris, S.J.—whose somewhat confused grasp of received Catholic teaching may well have confused the Commission.)¹³

I-d) Rather than re-interpret what the 1980 "Declaration On Euthanasia" allegedly "substitutes", it would be better to see what it actually does say and propose as clarification (rather than substitution) in the ordinary/extraordinary distinction:

It will be possible to make a correct judgment as to the means by studying the *type of treatment* used, its *degree of complexity or risk*, its *cost* and the *possibilities* of using it, and *comparing* these elements with the result that can be expected, taking into account the *state* of the sick *person* and his or her *physical* and *moral* resources.¹⁴
(Emphasis added)

This statement, with others, of clarifying considerations is immediately followed by four kinds of general cases which underline the non-obligatory (thus ethically optional) nature of extraordinary means.

—Where other remedies do not suffice, it is permissible, with the patient's consent, to employ the most advanced techniques, even those which are experimental and not without certain risk.

—Likewise it is permissible to interrupt these same means where results fall short of expectations in accord with the reasonable wishes of the patient, the patient's family and the advice of physicians especially competent in the matter.

—It is also permissible to make do with the normal means medicine can offer for "one cannot impose on anyone the obligation to have recourse to an available technique which involves a real danger or is burdensome." Such a refusal is not the equivalent of suicide but should be considered an acceptance of the human condition.

—Lastly, when death is imminent, one can refuse forms of treatment which would secure only a precarious and burdensome prolongation of life, so long as the normal care due to the sick person, in similar cases, is not interrupted.¹⁵

In all of the above, the designation ordinary/extraordinary is predicated of the *means*, NOT of the *life* of the patient. Clearly, if a patient's life can be described as "extraordinary", then any and all means—even the most minimal means—could be described as extraordinary to that patient, which effectively finesses the question and the careful judgment of the factual circumstances of the individual case.

Easy to Slide into Judgments

It is all too easy today to slide or to jump into facile, even popular, "quality of life" judgments while pretending not to pass or make a judgment at all. Again, the proper judgment focuses on the extraordinariness of the *means*, not on some allegedly extraordinary *life*.

Of course, such factors as expectation of success or degree of comfort in survival do pertain to and focus on qualities of the patient's life. However, a now widespread and, in some places, a legal term such as "recovery to cognitive and sapient life" is a different kind of "quality-of-life" judgment. It serves now as a code word and deserves to be unpacked.

"Recovery" is an unspecified promise word! Recovery to what degree? To what extent? What of those persons for whom there is no recovery? Some are born with physical or mental disabilities from which there is no recovery.

"Cognitive and sapient life." These terms have been bouncing around the euthanasia movement for the past 80 years. Both are accordion words—either can mean as much or as little as one chooses to assign to it. One may judge from what I say here that I am not all that "cognitive", which might make me wonder whether this audience is all that "sapient." These are not accurate diagnostic ratings of pathologies but only scientific-sounding value judgments some people make about other people.

The same slippery and careless kind of value judgment is buried in another popular slogan—"meaningful life"! Meaningful to whom? To you? To me? To the editorial board of a favorite newspaper? Whoever makes this kind of quality-of-life kind of judgment will not be on the receiving end of such a judgment and, whatever degrees of "meaningfulness" are assigned to another person's life, we should not forget that that life is the only life that person has.

I-e) A patient may live a long time with a so-called "hopeless disease", so, a particular means may be useless in curing a disease, but useful in prolonging or supporting life. The fact that it will not cure the disease does not change the positive duty we have to use means which support or preserve life. If a means will prolong life and is not too burdensome, that is, I think, an ordinary means. One cannot simply argue that the disease is incurable and, by that fact alone, no obligation exists to preserve or support life. The presumption underlying the opposite conclusion does rest on a porous quality-of-life decision, i.e., if one's life does not or will not meet a certain standard, it is not considered worth living or preserving or supporting.

I-f) The 1980 "Declaration On Euthanasia" and prior statements as well, outline principles which refer to burden and benefit, or use. If a treatment is not burdensome and would be beneficial, it is considered "ordinary", and a duty to use it. In conventional ethics, preserving or supporting life is considered a benefit. Burden here, of course, refers to a burden suffered or carried by the patient, not whether this ordinary support is a burden on the community, or a burden on third-party payers, or a burden to visit such a patient on alternate Wednesdays.

I-g) Traditionally, the ordinary/extraordinary distinction is not limited to terminal cases. It can bear on cases of radical amputation or hemodialysis which can prolong life indefinitely. In these cases, the decisive focus may not be whether it benefits the patient—for clearly it does—but whether or how excessive a burden an individual patient can carry.

Father John Connery, S.J., is, I think, correct in preferring to keep separate the benefit/burden analysis in that they can be different issues often applying to different cases. The question of benefit looms larger in

terminal cases, burden looms larger in non-terminal cases, and while there can be reasons to separate them it is not objectionable to combine them.¹⁶

Also, there can as well be significant differences in terminal and non-terminal cases. Often when death is imminent (in moral terms "imminent" is measured in hours and days, not in captions of six months or one year to live), in a terminal case, nothing reasonable can be done whatever we choose, whereas, at life's beginnings, many reasonable things can be done but some choose not to do them.

In summary here, there is no pre-coded checklist or printout which can determine antecedently what is or is not an ordinary or extraordinary means as such, apart from the minimal and most highly experimental means. The correct determination of the extraordinariness of extraordinary means can only be made on a case by case basis in view of the factual and actual circumstances of that case.¹⁷

From this section, it will appear that I am not particularly sanguine about what the general statutes of civil law can establish or resolve, given the nature of the ordinary/extraordinary distinction. From what follows, it should also appear that I do not believe most recent and current legislative proposals are after that but are, perhaps, after something else.

II

A Clear and Present Danger

Apart from the public policy question of whether or not the ordinary/extraordinary distinction is helpful or even useful, new terminology has begun to permeate public discussion, legislative proposals; legal decisions and the death-and-dying literature. The last is definitely a growth industry.

It is common, now, to speak in terms of ACTIVE (positive) and PASSIVE (negative) euthanasia as ideas whose time has come. I submit that the time has come to examine these terms closely. I have a little personal rule (which is why I call it "Smith's Rule") that "All Social Engineering Is Preceded by Verbal Engineering!"

When a distinction such as the ordinary/extraordinary is well grounded in Western medicine, all Western religions and is, at least, compatible with our Anglo-American civil law tradition, I become at least curious about proposed changes of words, lest something else is really changing while appearing to be only a change in words. "All Social Engineering Is Preceded By Verbal Engineering."

And so, the proposal—active and passive euthanasia. The term "active" connotes "commission", doing something, e.g., delivering the deadly dose, a positive act which actively causes death. Most, but surely not all, in our society are at present opposed to this. We might note, however, that the *Exit* society in England and the *Hemlock* society in the U.S.A. are not opposed to active euthanasia. Indeed, their publications¹⁸ advocate euthanasia as a "right" and Derek Humphry's book, *Let Me Die Before I Wake* serves as a how-to manual by listing at the conclusion of several

chapters how much of which drugs of what toxicity are needed to cause death in the most efficient fashion.¹⁹ (Given the national rise in teenage suicide, this particular book does not deserve wide circulation.) This literature is euphemistically described as "self-deliverance" literature without benefit of mentioning just to what or to whom one's self will be delivered.

However, the present danger and greatest current confusion concerns so-called PASSIVE (negative) euthanasia which appears in most legislative proposals and, increasingly, in some court decisions.

At first, "passive" euthanasia seems to reflect the conventional ordinary/extraordinary distinction just mentioned, but it does not do so properly or completely.

The term "passive" connotes "omission" (a withholding, a withdrawal) of some treatment or procedure. But the term "passive-omission" is inherently ambiguous until and unless it is determined *what kind of means* is being passively omitted, withheld or withdrawn.

On the one hand, the *passive* omission of an *extraordinary means* is NOT euthanasia and should not be so called.²⁰ But, on the other hand, the *passive* omission of an *ordinary means* is euthanasia and should be so called.²¹

A clarifying definition pertinent to this is found in the 1980 "Declaration On Euthanasia" which reads:

By euthanasia is understood an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated. Euthanasia's terms of reference, therefore, are to be found in the intention of the will and in the methods used.²²

Please, this not merely quibbling over words. All sorts of legislative proposals and court decisions have proposed or decided a patient's alleged "right" to refuse or forego ALL medical means without clarifying whether that refusal refuses extraordinary means (with which no one really argues or absolutely forbids), or refuses all ordinary means—even minimal means—(with which most, except for euthanatizers, really do disagree).

For example, the celebrated Claire Conroy case in New Jersey, decided Jan. 17, 1985, declared no less than four times that a patient has the right "to decline to have *any* medical treatment" (p. 21); again, "to decline medical treatment" (p. 22, quoting *Quinlan*); "to refuse medical treatment" (p. 30); and finally "the right to decline *any* medical treatment, including artificial feeding" (p. 62). Over and over, the alleged "right" to decline or refuse ANY treatment without clarifying or specifying *what kind* of treatment is being declined or refused.²³

Another example is the sad and troubled Bouvia case in California which established the "right" to refuse ANY and ALL treatment on our Pacific coast. Having first won the legal right not to be fed, Ms. Bouvia next secured a court order to determine her morphine level.²⁴ Is this medicine? Or, is the physician now the equivalent of a maître d' who simply

presents a medical menu and takes orders regardless of what the patient (customer) orders or refuses?

It is this unqualified canonization of the passive omission of ANY and ALL treatment that presents a clear and present danger to our public policy and to the ethics of the medical profession. There is no way that this trend can be confined to the death-and-dying context where death is imminent; it has already been moved to and applied to the chronically ill—those patients who are not getting any better nor getting any worse. (It is already selectively applied in pediatric cases; e.g., Indiana's Baby Doe case.)

If minimal means—food, water, bed rest, room temperature, personal hygiene—can be passively omitted from this class of persons, that is no mere neutral omission, but a lethal omission which causes death; it kills. When a competent patient's ability to request same is compromised and this decision is delegated to a surrogate, to substituted judgment, or to committees of or for that person, the number of players may become larger, but the outcome is no more secure ethically.

Already, on March 15, 1986, meeting in New Orleans, a seven person committee of the Council on Ethical and Judicial Affairs of the American Medical Association, reported out favorably this recommendation:

. . . it is not unethical to discontinue all means of life-prolonging medical treatment . . . for a patient in irreversible coma when death is imminent; and even if death is not imminent . . .²⁵

It seems to me, that the small addition of the last clause, "even if death is not imminent", represents a small step back for man but a giant step backwards for mankind. I do not use the term "mankind" in a sexist sense, but rather I use it to emphasize that such a step is not "kind" to man nor woman, for it means we do not treat some as our kind anymore.

Allowing to die, by foregoing extraordinary means, is choosing to live even when dying. But the omission of ordinary—especially minimal—means is no mere omission, but a lethal omission. The 1980 "Declaration on Euthanasia" addresses this very point, that it is permitted:

. . . to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted.²⁶ (Emphasis added)

Pope John Paul II has tirelessly repeated this last qualification—on Oct. 21, 1985, addressing two working groups of the Pontifical Academy of Sciences,²⁷ and again, on Nov. 15, 1985, to a Conference on "Pre-Leukaemia" with an important reason stated:

The principle . . . while it discourages from employment of purely experimental or completely ineffectual operations, does not dispense from the valid therapeutic task of sustaining life nor from the administration of the normal means of vital support. Science, even when it is unable to heal, can and should care for and assist the sick.²⁸

Thus, we might offer as a principle: Even when there is no cure, there remains the obligation of human care—that care and assistance which include normal means of vital support.

To expand the “when-death-is-not-imminent” net can, in our society, be a very extensive net indeed, not only to the irreversibly comatose, but also to what one journal calls those “biologically tenacious individuals”; then to the chronically sick whose “cognitive” functions are lowered, lessened or hardly recordable. Some persons experience such things post trauma; others are born that way. If the most ordinary, even minimal, means of medical maintenance or support are passively omitted, passively withdrawn, or passively withheld from these persons, we have, I submit, not just a new development of words, but a new and transformed medical ethic.

III

Problem: Suggested Source and Suggested Cure

A legal litany of court cases is, by now, familiar: Quinlan (NJ); Saikewicz (MA); Perlmutter (FL); Fox/Storar (NY); Severns (DE); Brophy (MA); Herbert (CA); Barber (CA); Bouvia (CA). Traffic is very heavy in California, as are some heavy precedents.

Curiously, in this age of deregulation, California is the state with the most laws and regulations about death and dying. California was the first to pass a so-called “Natural Death Act” (1976); next, it added a “Durable Power of Attorney” law, and now is considering a third law on “Advanced Directives.” Yet this state with the most laws, whose presenting reasons were to “clarify”, is the state with the most court cases then and now. Perhaps this only proves that no law is litigation-proof and no law is interpretation-proof.

As suggested above, I do not think that positive statutes can resolve antecedently complicated judgments *re* ordinary/extraordinary, but poorly drafted statutes will certainly complicate matters further. There is an axiom in both logic and in law that a negative prohibition binds *semper et pro semper*, i.e., it is always in effect and covers all cases, whereas a positive law binds *semper sed non pro semper*, i.e., it too is always in effect but can't touch all cases.

Thus, for example, a negative law forbidding auto theft is simple enough; negatively, it forbids the taking (against the reasonable will of the owner) of any and every car, old or new, stretch size or sub-compacts. However a positive law—to pay just taxes—is always in place, but to spell that out positively in all possible circumstances is no small effort. Witness the recent overhaul of our federal tax code (what it applies to, what not). No informed person could possibly suggest that they would or could sum up that positive tax law in a sentence or two, a talk or two, an audit or two. Accuracy there depends on a mountain of factual, actual circumstances, along with a deep valley of possible exceptions.

So too, in the medical-moral decisions *re* ordinary/extraordinary

means. We already have a law that says physicians cannot kill those they cannot cure—part of the homicide statutes. But, on the other hand, there is no law that says a patient or physician must use ALL means on ALL patients at ALL times regardless of hardship, burden or grave inconvenience. Such a law would not only be futile but stupid; one might just as well pass a law against mortality. The fact is, people do die—and we will, too—whether or not we have accumulated the requisite amount of certified credits in a death and dying course.

The legislative difficulty is not, as I see it, in the extreme: do EVERYTHING or do NOTHING. The difficulty is the vast in-between. How can a positive statute possibly foresee antecedently all the actual medical factors and relevant health circumstances and possible complications of just the people in this audience? And it is the actual assessment of factual and personal circumstances which is crucial to the determination of the extraordinariness of extraordinary means in any given factual case.

My legal friends tell me that “hard cases make bad law”, and I suspect that “really hard cases make really bad law”. It is my personal opinion that you can’t legislate hard cases out of existence. My respect for our just civil laws is profound and sincere. Indeed, as a form of regulating human conduct in a way consistent with human dignity, just civil laws are light years ahead of whatever is in second place.

Question of Trust

But one problem which is not discussed very much in the rush to litigate and legislate is the question of trust. I suspect that you can’t legislate trust, either, just as I suspect and know that the core element in the physician-patient relationship is the basis in trust and the virtue of trust. Medicine, like any learned profession, rests on and needs a relationship of trust, which is why that profession, and others, require a professional oath and code of ethics.

My suggestion here is that this is the root problem: our society and public policy are making and changing the professional oath and ethics of the medical profession. The past decade (1976-1986) of legislative activity, so-called Living Wills, Natural Death Acts, Durable Powers of Attorney, Advance Directives, etc., have all advanced under the banner of unqualified patient autonomy to the extent that the zenith of unqualified autonomy has been reached and one of the core components of traditional medical ethics has been reversed.²⁹

If the most recent Bouvia decision becomes the societal trend then the new medical ethic turns on WHO is to CHOOSE rather than WHAT is CHOSEN. Procedural mechanisms are so designed to ensure “free choice” that they offer no coherent guidance for judging the relative goodness of that choice.

Unqualified autonomy mechanisms do not assist physicians to discharge their deepest ethical responsibility—first do no harm (*primum*

non nocere!), nor their duty to formulate individualized treatment recommendations based on a medically informed understanding of the patient's good.³⁰

In the new ethic, patient choice (autonomy) is more important than best interest (beneficence). This is the complete triumph of procedural ethics (mechanisms and modalities of consent) over substantive ethics (the oath and promise first to do no harm). The newly committed physician is reduced to a committed facilitator, committed to carrying out patient preferences regardless of the outcome of that preferential choice. Unless corrected, not simply by stepping off the case, this is a danger not only to physicians but to the medical community as an organized profession, committed by oath to a known ethic.

Consider the question of suicide. No jurisdiction in these United States penalizes suicide as a crime. If one succeeds, the case is moot; if one fails in the attempt, we consider that a cry for help needing counseling, not incarceration. Yet, in most jurisdictions, it is a crime to assist a suicide.

Consider next the concluding sections of most of the so-called Living-Will legislation. Almost all conclude with cautions and disclaimers: that this new law has no civil nor criminal liability consequences *re* suicide; no insurance consequences *re* suicide; no professional peer rebuke consequences *re* suicide. In net result, such laws and similar court decisions, especially those proclaiming a "right" to refuse ANY and ALL means, including the most minimal means, simply de-criminalize and de-fang all the possible penalties or consequences of assisting a suicide. Thus, in effect, we simply de-criminalize and detoxify the anti-assisted suicide statutes without even debating the merits or demerits of the crime of assisting a suicide.

A certain recognizable sequence emerges:

- (1) it is not unethical to remove all support;
- (2) a helpful court or legislature declares this a new "right";
- (3) it becomes unconstitutional to interfere with the exercise of this new "right";
- (4) a move on the federal treasury or Medicare to insure that poor people have the same access to this new "right" as the rich do;
- (5) then we have no more laws against assisting a suicide and physicians who decline to facilitate such choices will be branded "sectarian", "divisive" and, no doubt, guilty of trying to "impose their values" on poor sick people who are only trying to exercise their new "rights".

There are precedents for this sequence in our society.

If the suggestion is correct as to the problem—a changed and new medical ethic—then the suggested resolution and cure will be found not in legislation, but in a resolution of ethics.

The medical profession, like all professions in our society, has suffered the same reductionist pressure, i.e., reducing the oath and ethic of the profession simply to the promise not to do anything illegal! Obviously, that promise has a built-in drain. One promises to change or adjust one's

ethics with every change or adjustment in law. Compound that with the triumph of procedural ethics over substantive ethics, and the physician-patient relationship is turned pretty much inside-out.

Crucial Adherence to Oath

It is particularly the area of euthanasia where adherence to the professional oath is crucial. A scalpel can either cure or kill; as can drugs. These substances are blind as to their purpose and results, but the hand that guides cannot be blind. Historically, one motivational source for physician's practice came from the profession's solidarity regarding the high value of human life, of health and of compassionate therapeutic intervention. In the euthanasia field, we need not invent the future; we need only remember the past!

In this century, we have learned in horrifying detail what does happen when the ethics of medicine changes or collapses or fails to speak up; when the power to cure gets mixed up with the power to kill.

Just recently, Robert Jay Lifton has published a book entitled *The Nazi Doctors: Medical Killing and the Psychology of Genocide*.³¹ It is not a nice book to read, nor is it the first entry in the literature of misplaced sovereignty. Prior to it, Dr. Frederic Wertham published, *A Sign For Cain* in 1966, Chapter 6 of which is "The Geranium in the Window: The Euthanasia Murders."³²

Prior to both of these, Dr. Leo Alexander, a medical consultant at the Nuremberg Trials, published his famous essay "Medical Science Under Dictatorship."³³ All three of these scholars admit that the euthanasia movement in Germany did not begin when the first direct order for euthanasia was signed by Hitler on Sept. 1, 1939. Nor did it begin precisely at 12 noon on Jan. 30, 1933, when President Hindenburg, acting constitutionally, entrusted the chancellorship of Germany to Adolf Hitler.

No. The euthanasia movement in Germany began and got first respectability with the publication of a book, published in Leipzig in 1920, entitled *Die Freigabe der Vernichtung Lebensunwerten Leben*—(*The Release (Permission) of the Destruction of Life Unworthy of Life!*) This was published not by Nazis, but by two distinguished German professors: the jurist, Karl Binding, doctor of jurisprudence and philosophy who taught for 40 years on the law faculty of the University of Leipzig, and Dr. Alfred Hoche, professor of psychiatry at the University of Freiburg. Prof. Binding wrote the legal section; Dr. Hoche wrote the medical section. The book had some popularity because a second edition had to be printed two years later (1922).

The tiny change that changed everything is right there in the title, "*Lebensunwerten Leben*"! ("Life not worth living!") That there is such a thing as a "life devoid of value"!

Binding and Hoche wrote of "absolutely worthless human beings; those who have 'neither the will to live nor to die'; those who are 'mentally completely dead'".³⁴ Notice, with a publication date of 1920, the concept of

a "life not worth living" was not a Nazi invention, but with the collapse or withdrawal of the medical, legal and ministerial professions, the Nazis had no qualms about picking up a well-prepared and field-tested idea that fitted so well their own maniacal purposes.

For many of our contemporaries, their only view of pre-Hitler Germany, the Weimar Republic, is a splendid performance by Joel Gray in the Broadway show, *Cabaret*. The moral decadence and ethical drift were true and were not limited to nightclub performers. A "Silent Secularization" preceded National Socialism in the Weimar Germany of the 1920s and 1930s. It was a secular insistence that man-made ethics is superior and should take precedence over transcendent values and over the moral ideals of our common Judeo-Christian heritage.³⁵ The "smart money" in the medical field felt a real need to break out of the old and tired doctrines of the Hippocratic Oath.

The secular drive to first separate, then privatize all transcendent values and ethics in Weimar greatly facilitated the professional acceptance and acquiescence of that pivotal pitfall that there is such a thing as a "life-not-worth-living". Dr. Alexander traces the whole euthanasia movement back to this single change in mind and attitude; once we change our attitude toward the non-rehabilitable sick, we are prepared to change everything. The antidote is simply stated and it is ethical: when there is no cure, we still provide human care! This does not require ethically optional extraordinary care, but it does require ordinary care and certainly those minimal means which are required to sustain, support and preserve any human life.

I consider it a privilege to be a trustee of Calvary Hospital in the Bronx, an institution committed to patients with advanced cancer. While there is no cure for advanced cancer, we do provide medical and human care at that hospital. Here, at this Cardinal Cooke Health Care Center, for many, there is no cure, but medical and human care are provided. It's a simple rule, but a crucial one, and it is rooted more in ethics than anything else: where there is no cure, we do provide human care.

I do not here pretend to articulate public policy. I do not pretend to answer any and all legal questions. I do not pretend that there are not or will not be some very hard cases, but I make no pretense or apology for what is needed to approach any of those subjects.

The core problem is a matter of trust and that is a matter of ethics, committed trust to a promised oath and ethic: first, do no harm—no active harm, no passive harm. That is the core commitment of the medical profession and must be the first commitment in the actual practice of medicine.

No profession is immune to ignorance, human weakness, temptation or greed, and that most definitely includes my own. And that is why the function of a professional code and ethic is to give the professional his/her mark, the target for which he/she must aim. To miss chronically or to permit the miss to become a habit, is to institutionalize self-service and change a dedicated goal into a sophisticated cover-up—yes, even a

sophisticated legal cover-up.

I know, as you do, that some consider it clever to be cynical, and some consider it enlightened to be unbelieving, and some consider it sensible to be prudently silent. But, the cynical, unbelieving, sensible types have been all too willing to put professional success ahead of true standards and to put cleverness ahead of real character. That will not serve real patients. It will not serve the individual patient however compromised, nor serve the medical profession however litigated, nor will it serve our society however much some don't want to look at nor value those of us who don't function too well or hardly at all.

As Prof. Paul Ramsey often points out, the good that we can do will only be complemented and completed by the harm we refuse to do. Let the first principle of medical ethics be the last word: First, do no harm! Next, do no harm! Last, do no harm to any person of allegedly great value or allegedly no value. First and last, DO NO HARM!

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1. For an integral non-Catholic Christian presentation, cf. P. Ramsey's "The Indignity of Death With Dignity" in D. Horan-D. Mall (eds.) *Death, Dying and Euthanasia* (Washington, D.C.: University Publications, 1977) pp. 305-330; also, "Death's Pedagogy", *ibid.*, 331-343; also his *Ethics At The Edges of Life* (New Haven: Yale University Press, 1978) pp. 145-335.

2. Cf. Rabbi Immanuel Jakobovits, "Some Recent Jewish Views On Euthanasia," in Horan-Hall, *op. cit.*, pp. 344-347.

3. *New York Times*, (12/5/73), p. 22; the complete document distributed by the A.M.A. is "Report of the Judicial Council 'On The Physician and the Dying Patient'". (Dec., 1973) 5 pp.

4. Cf. "Current Opinions of the Judicial Council of the A.M.A.," (Chicago: A.M.A., 535 North Dearborn St., 1981) n. 2., 11, "Terminal Illness," p. 9.

5. Cf. T.J. O'Donnell, "Catholic Thought On Man's Duty to Prolong His Life: An Historical Review." *Medical-Moral Newsletter* v. 17, #2 (February 1980) pp. 5-8; J.R. Connery, "Prolonging Life: The Duty and Its Limits," *Linacre Quarterly*, v. 47, 2 (May 1980), pp. 151-165; G.M. Atkinson, (Ch. 7) "Theological History of Catholic Teaching On Prolonging Life" in McCarthy-Moraczewski (eds.) *Moral Responsibility in Prolonging Life Decisions* (St. Louis: Pope John Center, 1981) pp. 95-115. (This last study is limited to the examination of a 1958 doctoral dissertation.)

6. Pius XII, Pope, "Prolongation of Life" (11/24/57); the French original in *Acta Apostolicae Sedis* 49 (1957) 1027-1044; English translation in *The Pope Speaks* 4 (57-58) pp. 393-398.

7. NCCB, "Ethical and Religious Directives for Catholic Health Facilities," (Nov. 1971; rev. 1975) (Washington, D.C.: U.S.C.C., 1975) #28, p. 7.

8. SCDF, *Declaratio de Euthanasia*, (May 5, 1980); Latin original in *AAS* 72 (1980) pp. 542-552; English translation, *Declaration on Euthanasia* (Boston: St. Paul Editions, 1980) 14 pp.

9. Baker, K., *Fundamentals of Catholicism*, Vol. I, (San Francisco: Ignatius Press, 1982), #26-29, pp. 194-205.

10. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding To Forego Life-Sustaining Treatment* (Washington, D.C.: Government Printing Office, 1983), "Ordinary Versus Extraordinary Treatment," pp. 82-89; proposed "substitute", cf. footnote #132, pp. 88-89.

11. *Ibid.*, p. 88.

12. *Ibid.*, footnote #132, p. 89.

13. The term "proportionate" (disproportionate) is verbally similar to the term "proportionalism". The latter, however, is a whole moral methodology not acceptable to, and in part contradictory of, received Catholic moral teaching. While the SCDF "Declaration On Euthanasia" does once, in the Latin original, use the expression "proportionate and disproportionate means" ("*de mediis 'proportionatis' et 'disproportionatis'.*" in *AAS* 72 (1980) p. 550), it does not by that mention adopt "proportionalism" as a moral methodology, nor does it propose "proportionalism" as a replacement or substitute for the ordinary/extraordinary distinction. Indeed, the same text of the same declaration states that the principle of the non-obligatoriness of "extraordinary means" remains as a principle ("*quae, ut principum*") always valid ("*semper valet*"). *AAS* 72 (1980) p. 549).

The declaration then continues that where this "valid" principle is perhaps less clear today, a correct judgment will be possible by studying some or all of the criteria and principles spelled out through the rest of the document. (These are considered in text above.)

For a critique of the confusion that results from mistaking a verbal clarification ("proportionate/disproportionate") for a changed moral methodology ("proportionalism"), cf. J.R. Connery's critique of J. Paris in Connery's "The Clarence Herbert Case: Was Withdrawal of Treatment Justified?" in *Health Progress*, v. 65, (Feb., 1984) pp. 32-35; 70; esp. 35 and 70; Also cf. J. Finnis, *Fundamentals of Ethics* (Washington, D.C.: Georgetown University Press, 1983) pp. 106-107.

14. SCDF, *Declaration On Euthanasia* (5/5/80), n.IV, *op. cit.*, (Latin, *AAS* 72 (1980), p. 550; English, p. 11).

15. *Ibid.*, (Latin *AAS* 72 (1980) 550-551; English, p. 12).

16. Connery, J.R., in McCarthy-Moraczewski (eds.) *op. cit.*, p. 129.

17. This is not a singular conclusion on my part for the same position can be verified in approved Catholic textbooks of medical ethics, cf.: T.J. O'Donnell, *Medicine and Christian Morality* (New York: Alba House, 1976) pp. 41-63; C.J. McFadden, *The Dignity of Life* (Huntington, IN: *Our Sunday Visitor*, 1976) pp. 146-173; W.E. May, *Human Existence, Medicine and Ethics* (Chicago: Franciscan Herald Press, 1977) pp. 131-158; pp. 159-170; B. Ashley-K. O'Rourke, *Health Care Ethics* (2nd ed.) (St. Louis: Catholic Health Association, 1982) pp. 379-388. (The notion of "passive euthanasia" in the last source needs more careful definition, pp. 380-381.) J.R. Connery in McCarthy-Moraczewski (eds.) *op. cit.*, pp. 124-138. (This last is surely the best treatment on the subject.)

18. Humphry, D., *Let Me Die Before I Wake*, (Glendale, CA: Economy Self Publishing, 1982) 102 pp.; D. Humphry, A. Wickett, *The Right To Die* (NY: Harper & Row, 1986) 372 pp.; J. Rachels, *The End of Life* (NY: Oxford University Press, 1986) 204 pp.

19. Humphry, *op. cit.*, pp. 11, 18, 25, 33, 55; a page 59 footnote instructs "the 'natural gas' used in today's cooking ovens is *not* lethal, as was the old 'city gas.'"; p. 66; p. 74.

20. Cf., e.g., *Directives*, 28 and 29 of NCCB, "Ethical and Religious Directives," *op. cit.*, p. 7:

28. "... However, neither the physician nor the patient is obligated to use extraordinary means."

29. "It is not euthanasia to give a dying person sedatives and analgesics for the alleviation of pain, when such a measure is judged necessary, even though they may deprive the patient of the use of reason, or shorten his life."

Similarly, cf. 1980 "Declaration" n. IV, *op. cit.*, (Latin *AAS* 72 (1980) p. 550; English, p. 12):

"One cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a danger or is burdensome. Such a refusal is not the equivalent of suicide; . . ."

21. Cf., e.g., *Directive* # 28, *op. cit.*, p. 7:

28. "... the failure to supply the ordinary means of preserving life is equivalent to euthanasia."

22. SCDF, "Declaration" (5/5/80) n.II, *op. cit.*, (Latin. *AAS* 72 (1980) p. 546; English, p. 8).
23. Supreme Court of New Jersey, No. A-108 (September term, 1983) "In the Matter of Claire Conroy" (Decided—Jan. 17, 1985) (Opinion by Justice Schreiber for majority) 83 pp.
24. Chambers, M., *New York Times* (5/23/86) p. A, 18.
25. *New York Times* (3/17/86) p. B,7; *Time* 127 (3/31/86) p. 60.
26. SCDF, "Declaration" (5/5/80) n. IV, *op. cit.*, (Latin *AAS* 72 (1980) 551; English, p. 12).
27. Original address is in English in *AAS* 78 (1986), p. 315.
28. John Paul II, Pope, (Nov. 15, 1985) Original address in Italian in *AAS* 78 (1986) 361; English translation in English edition of *L'Osservatore Romano* (#51-2/917, (Dec. 23-30, 1985) p. 15).
29. This reversal has not gone unnoticed. Cf. e.g., M. Siegler, (M.D.), A.J. Weisband, J.D., "Against the Emerging Stream", *Archives of Internal Medicine*, v.145 (Jan. 1985) pp. 129-131. Even more directly on the reversal in ethics, cf. R.C. Sider, M.D., C. D. Clements, Ph.D., "The New Medical Ethics," *Archives of Internal Medicine*, v.145 (Dec., 1985), pp. 2169-2171.
30. Sider, R., Clements, C., *ibid.*, p. 2169.
31. Lifton, R.J., *The Nazi Doctors*, (New York: Basic Books, 1986), 561 pp.
32. Wertham, F., *A Sign For Cain* (New York: Warner Paperback, 1969), pp. 150-186.
33. Alexander, L., "Medical Science Under Dictatorship", *New England Journal of Medicine*, v.249 (1949), pp. 39-47.
34. Wertham, *op. cit.*, p. 157.
35. Fil: R. Shinner, "Secularization in Germany and America," in *Sh'ma: A Journal of Jewish Responsibility* v.15/290 (March 22, 1985) pp. 75-76; also, Rabbi A.J. Wolf and Rabbi S. Siegel in *Sh'ma*, v.15/287 (2/7/85) pp. 49-50.