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# Changing Attitudes Toward Euthanasia

ALICE V. MEHLING

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## *Introduction*

Down through history, death has been feared, dreaded, accepted, or even welcomed, but—except in cases of suicide—people have had little choice in *how* they died. Today there is a growing concern about the process of dying. “Letting people go” has emerged as a new concept.

For example, Generalissimo Francisco Franco’s granddaughter cried “My God, it’s enough,” after seeing the 80-pound Spanish premier in a state of quasi-hibernation, the recipient of 58 quarts of blood and of the attentions of 32 physicians. A new word, “Franconasia”, sprang up in Europe to express negative reactions toward the extraordinary measures involved in his protracted dying process.

The death of Col. Charles A. Lindbergh, from lymphoma, provided a sharp contrast. His physician, Dr. Milton Howell, explained: “He wanted no respirator, defibrillator, or other complicated paraphernalia . . . He wished his death to be a constructive act in itself.”<sup>1</sup>

Heroic measures, the term used in medicine for extraordinary efforts to prolong life, are not for the rich and famous alone. Worldwide attention has been drawn to the legal issues of the case involving a young New Jersey woman in a coma for months, kept alive on a respirator. And a wire service story was published in newspapers coast to coast when a Californian, blind and crippled from diabetes, decided to forego further dependence on a dialysis machine and await his certain death.

More and more people are expressing views about a lingering death for the incurably ill or the comatose as the prospect of being kept alive as a “vegetable” is increasingly regarded with revulsion. In 22 states,<sup>2</sup> legislators have introduced “death with dignity” bills, propelled not by organized lobbying but by the force of social attitude, in a remarkable grass roots movement rising out of specific concern within constituencies.

There are several reasons why the issue of euthanasia has reached the present level of public consciousness and become an important concern:

1) The population includes a constantly increasing number of the elderly. The United States has an over-60 population of 20 million, and it is estimated that by the year 2,000 the "youth culture" will be displaced as middle-aged and senior citizens outnumber the young. Life expectancy in the United States has risen from age 40 in 1900 to around 70. Death from communicable disease has decreased; by the same token, improved longevity has increased the fear of chronic, degenerative disease, a frequent precursor of an extended, perhaps painful, death process.

2) Recent advances in medical technology have made it possible to maintain heart, lung, and other vital functions for months or even years. A new field of "bioethics" has emerged in which medical ethicists debate the questions of "quality of life" as opposed to "sanctity of life" and discuss the role of the physician. Should he give "care and comfort," rather than continuing to attempt to "heal and cure" when there is no hope of a positive outcome?

Dr. Joseph Fletcher, theologian and medical ethicist, has said: "The classical deathbed scene, with its loving partings and solemn last words, is practically a thing of the past. In its stead is a sedated, comatose, betubed object, manipulated and subconscious, if not sub-human."<sup>3</sup> This prolongation of the dying process was of such concern to the medical profession that the House of Delegates of the American Medical Association passed a resolution in 1973 which said: "The cessation of the use of extraordinary means to prolong life when there is irrefutable evidence that biological death is imminent is the decision of the patient and the immediate family."<sup>4</sup>

This new ability to keep people alive by heroic means, usually mechanical, has led to considerable re-thinking of the definition of death itself. Common law has held that when the heart stopped beating and a person stopped breathing, he was dead. Because both heart and lungs can now be maintained artificially, a definition of "irreversible coma" as a new criterion for death is being proposed. Ten states<sup>5</sup> have adopted laws whose definition of death includes brain function criteria (frequently alluded to as "brain death" laws), and consideration is being given to similar legislation in several other states.

3) Discussion of death and dying has become more free and open. Literature in the field has proliferated. A bibliographic search of books and articles identified 400 items in 1963, as compared with almost 3,000 a decade later;<sup>6</sup> the number has further increased over the last two years. A book on the subject (Dr. Elisabeth Kubler-Ross's "On Death and Dying") has become a best seller. The "right to die" was the leading moral and theological topic in the religious press in 1975, according to *Christian Century* and Religious News Service. In its annual year-end survey of public attitudes, NBC-TV found that 72% of the American public was opposed to the use of mechanical means to prolong life when there is no hope of recovery. Network commentators observed that the results were perhaps less significant than the very inclusion of the question in the poll.

“Death education” studies are gaining popularity in colleges and high schools. At Yale University, 275 undergraduates applied for 20 places in a seminar on “The Meanings of Death.” The Euthanasia Educational Council receives daily requests for literature from students across the country who are writing papers or debating the topic, beginning at the junior high school level. Membership in the Council has doubled within the past year and now includes 75,000 supporters nationwide.

4) More people now are dying in institutional settings than at home because of cultural changes (the urban apartment may not have room for an aging parent, plus more women have joined the labor force resulting in less inclination to administer home care), and possibly because of increased third-party coverage of institutional costs. Today 80% of all deaths occur in hospitals or other institutions. This tends to increase the individual’s fear of losing control to impersonal forces, coupled with apprehension of the exorbitant financial costs of a terminal illness.

### *The Concept of Euthanasia*

Attitudes toward euthanasia begin with confusion over the definition of the word itself. Statutes that have been introduced are called “Death with Dignity Acts” or “Acts Relating to Medical Treatment”, but in only four states is the word “euthanasia” used in the proposed statutes,<sup>7</sup> and frequently legislators are apprehensive that the word will become associated with their bills. The legislative arm of the movement, the Euthanasia Society of America, changed its name to the “Society for the Right to Die” to help overcome this semantic stumbling block.

“Euthanasia” derives from the Greek: *eu*, meaning “good” and *thanatos*, “death”—hence, a “good death”. The word was not used in antiquity, but first appeared early in the 17th century, according to the *Oxford English Dictionary*, which defines it as “a quiet and easy death”. The word received a new interpretation in the 19th century when it was referred to as the *act* of inducing easy death.

Since dual interpretation of the word raises the question of human initiative, qualifying adjectives are appended: “active” or “passive”, “voluntary” or “involuntary”, sometimes “direct” or “indirect” and “negative” or “positive”. The Euthanasia Educational Council takes the position that “life supportive measures should not be used to prolong dying in cases of terminal illness with intractable pain or irreversible brain damage,” and that “medication should be given to the dying in sufficient quantity to eliminate pain even if tending to shorten life.” This is defined as *voluntary, passive* euthanasia.

Administering a lethal dose to an individual who requests it, when his condition is terminal, is defined as *voluntary, active* euthanasia.

Dr. Alfred Jaretzki, of the College of Physicians and Surgeons of Columbia University, in an address to the Seventh Annual Conference of the Euthanasia Educational Council, said passive euthanasia is “synonymous with death with dignity, and should have no more ominous meaning or intent than to allow a patient who is dying to die in a dignified manner, as comfortably as possible. I am not aware of any civil, religious, or governmental group that is really opposed to this concept of passive euthanasia. Indeed, it has been officially supported by many. . . In contrast to passive euthanasia, active euthanasia, as I see it, is a

deliberate act of taking a human's life, even though it be with the intention of benefitting the individual or benefitting society as a whole. Although I fully understand the humanitarian goals of those who support active euthanasia, I do not believe it is possible to develop the necessary safeguards to make it acceptable.”<sup>8</sup>

The practice of euthanasia is older than the word itself, and appears to have been surrounded with ambiguity going back to the times of the Greeks and the Romans. Athenian law did not sanction suicide even as a release from pain and illness, and yet suicide, often by means of poison provided by physicians, was a frequent occurrence.<sup>9</sup> On the island of Cos, aged people would gather annually for a banquet and quit the world in unison by drinking a lethal potion. At Massilia, a death potion was made available in a public depository for the use of any citizen who could justify before the Senate the motive which led him to desire death.

Most of Greek and Roman philosophic thought considered man the master of his own body and emphasized the quality of life. There were important exceptions, *e.g.*, the Pythagoreans, whose position was that man must not leave life without divine consent regardless of the circumstances. Hippocrates was strongly influenced by the Pythagorean philosophy, and his teachings, which became the ethical standard of Western medicine, reflect this position in the Hippocratic Oath: “I will neither give a deadly drug to anybody, if asked for, nor will I make a suggestion to this effect.” Its inclusion attests to the prevalence of suicides that were aided and abetted by the physician of the day.

Roman beliefs and values showed the strong influence of the Stoics, who believed death should be as honorable as life. Pliny the Elder said that the right to take one's life is one of the priceless gifts granted to men by the gods. Seneca believed that euthanasia was an alternative that should be available to all men. He wrote: “If I can choose between a death of torture and one that is simple and easy, why should I not select the latter? As I choose the ship in which I will sail, and the house I will inhabit, so I will choose the death by which I will leave life. . . . Why should I endure the agonies of disease . . . when I can emancipate myself from all my tortures?”

The early Christians were profoundly influenced by the Pythagorean philosophy. Saint Augustine, in the 5th century, said that one should endure suffering; avoidance, he felt, was cowardly. In the 13th century Thomas Aquinas used the Pythagorean position in support of arguments against suicide: taking one's life was a sin against God because life is a gift of God.

During the Renaissance, man's sovereignty over death as well as life was once again proclaimed as an expression of individuality. This was reflected in the writings of Francis Bacon and Montaigne, but particularly in the work of the 16th century scholar, Sir Thomas More (sometimes called “The Father of Euthanasia”), who made provision in “Utopia” for the incurably ill “full of continual pain and anguish to finish their lives willingly, either by fasting, or else they are released by opiate in their sleep without any feeling of death.”

The scientific discoveries of the Renaissance period, introducing more effective treatment of disease, brought the first recognition of the dilemma of modern medicine—that efforts to keep patients alive could cause suffering.

Euthanasia as a topic was considered sporadically in a few books and articles over the years, but a real movement did not begin until the 1930s, when a noted British physician touched a nerve in medical, theological and intellectual circles. Dr. C. Killick Millard spoke and wrote of cancer which “tends to kill by inches”, and in a presidential address before the Society of Medical Officers of Health proposed a Voluntary Euthanasia Legislative bill for Great Britain, which would legalize termination of life by physicians, if requested by a patient suffering from a painful, irreparable disease. (At that time, ending one’s life was a felony, and advocates of such a bill said there were already widespread secret attempts at euthanasia; consequently, it should be made open and lawful.)<sup>10</sup>

Such a bill was introduced in the House of Lords in 1936, supported by the Voluntary Euthanasia Society (founded the previous year, with such distinguished members as George Bernard Shaw, A. A. Milne, H. G. Wells, and Julian Huxley), but the Bill was defeated. Similar legislation has been introduced in the House of Lords three times since 1936; all three were voted down--the most recent in 1969 by a margin of 61-40.

The Euthanasia Society of America was organized in New York in 1936 by a small group of clergymen, doctors, lawyers, and intellectuals who joined together because of their profound belief in the need to legalize the right of incurable sufferers to die. They were committed to legislation. (Euthanasia bills had been introduced in the U.S. on two occasions prior to the organization of the Society--in Ohio in 1906<sup>11</sup> and Nebraska in 1937.<sup>12</sup> There was such nationwide opposition that a legislator in one state proposed that it be made a felony to suggest euthanasia verbally or through a written document.)

Between 1939 and 1952 three attempts were made to introduce euthanasia legislation in New York. They failed despite the organization of a committee of over 1,500 physicians and an impressive group of theologians. Members of the Euthanasia Society undertook speaking engagements where the reception was not always cordial, and they faced accusations of being “anti-God and un-American”. Clergymen who signed a petition to the New York legislature were said to be “disobedient to the laws of god”. A petition to the United Nations in 1952, to amend the Universal Declaration of Human Rights to include the right of incurable sufferers to euthanasia, was similarly unsuccessful.

The issue was far too contentious, and the Society members (numbering around 500) decided not to press for legislation, recognizing that further efforts would be futile until a more favorable climate of opinion had been created. This recognition of the need for public understanding and education led to the formation of the Euthanasia Educational Fund in 1967, which became the Euthanasia Educational Council (EEC) in 1972.

Not until very recently has there been a pronounced upsurge in what is commonly called “death with dignity” legislation, beginning in Florida in 1969 with the introduction of a bill by Dr. Walter Sackett, a Catholic physician who has admitted that he has “let hundreds of patients go”.<sup>13</sup> By 1975, when the Society for the Right to Die (formerly the Euthanasia Society of America) published a

Legislative Manual, “death with dignity” bills had been proposed in ten states. The manual had scarcely been published before bills were introduced in five additional states. Eleven bills were introduced, or re-introduced, in the first two months of 1976. One of the most remarkable indicators that euthanasia is an idea “whose hour has struck” is the grass roots movement for legislation in the ’70s.

As the Legislative Manual states: “The statutes evidence the fact that it is not death itself that is most feared, rather it is the process of dying, needlessly and inhumanely prolonged.” Most of the bills provide that “medical treatment designed solely to sustain the life processes be discontinued,” but in three states legislation for *active* euthanasia has been proposed recently.

The Hon. Raymond W. Ewell, an Illinois state representative, in describing his experience in introducing “death with dignity” legislation said: “Mine was a ‘bottom-rung’ bill. I took the simplest solution: a person has the right to make a decision when there is no prognosis for rehabilitation or recovery.” His bill came out of committee by a narrow margin, but “when it reached the floor the response was tremendous—all negative. In the debate, legislators were recalling Nazi atrocities and talking about how we were going to put to death the senile, the crippled, and the mentally defective.” The vote was 19 for and 115 against. Representative Ewell pointed out: “The only people who are sympathetic to this kind of legislation are those who know it and understand it, particularly those who have faced the problem of unnecessary prolongation of dying.”<sup>14</sup>

The Society for the Right to Die drafted a Model Bill and their legal counsel, Sidney D. Rosoff, commented that “If the Model Bill had been enacted in the state of New Jersey, and if Karen Ann Quinlan had executed the necessary document, and if the physician in charge of her case had determined she was suffering from a terminal illness (as that term is defined in the Bill), then the physician could turn off the respirator without fear of liability.”

Dr. George J. Annas, Director of Boston University’s Center for Law and the Health Sciences, regards the “right to die” issue as part of the entire “patients’ rights” movement, in which he sees a fundamental need to put the patient in the primary role of decisionmaker instead of taking it for granted that the physician is the one to decide. He sees the Model Bill as a restatement of rights that already exist. “Current law permits physicians to honor Living Wills if they want to. Legislation itself is not going to alter the behavior of physicians and patients unless more fundamental attitudes are changed.”<sup>15</sup>

With respect to legislation, Charles H. Montange, writing on “Informed Consent and the Dying Patient” in the *Yale Law Journal*, said: “Legislation which dispels the fear of possible criminal liability in cases of voluntary euthanasia is desirable. Lawmakers should mitigate the uncertainty and generate adequate legal measures to permit a dignified death.”<sup>16</sup>

Although there has been no success thus far in the passage of any euthanasia bills, the law itself has shown remarkable leniency in cases involving euthanasia. The legal history of euthanasia reflects a pronounced discrepancy between law in theory and law in practice. In principle, active euthanasia is a form of homicide and the law does not allow for motive as an element. And yet prosecutors, judges and juries

have sidestepped the issue. Only two doctors have ever come to trial for alleged “mercy killing”, and both were acquitted.<sup>17</sup> In some other cases of active euthanasia, the courts have fallen back on “insanity” in reaching acquittal. In the few cases where there has been a conviction, sentences have usually been suspended. (Within the past year a Michigan man pleaded guilty to helping his ailing wife to commit suicide. He was sentenced to 30 months’ probation and fined \$3,750. The judge said “I am well aware that there are those who say no charge should be made,” which appeared to be an acknowledgement of the hundreds of letters he received pleading for compassion.<sup>18</sup>) There has never been an indictment in this country for passive euthanasia.

No country has as yet legalized euthanasia, but compassionate motive has been recognized in the law as an extenuating circumstance. The penal code of Uruguay, for example, provides that though mercy killing is regarded as a crime “the judges are authorized to forego punishment of a person whose previous life has been honorable where he commits a homicide motivated by compassion, induced by repeated requests of the victim.”<sup>19</sup>

### *Medical Attitudes toward Euthanasia*

Within the medical profession, the physician is caught in a bind between helping the patient, who may need his compassion, and his own training and personal inclination, which cause him to believe that death is the enemy to be fought by—at least—every ordinary means. This is further complicated by the law, which may force him to act secretly, and society, which does not foster open discussion of euthanasia.

Dr. Samuel Klagsbrun, a psychiatrist associated with the College of Physicians and Surgeons of Columbia University, made these points at the December, 1975 EEC Conference. Participation in a patient’s death, he said, is a psychological experience far more than it is a legal or policy-making one, because death is a contradiction to a physician’s training, to the technology at his command, and to his own zeal for preserving life. Dr. Klagsbrun sees the need for some vehicle, such as a hospital committee, to foster open discussion so that “when such decisions take place he need not carry the incredible burden with him secretly as he has been forced to do.”

Cloaked by the anonymity of a poll, the physician will state his belief in “letting go”. A survey of physicians by *Medical Opinion* in 1974 showed that almost 80% agreed with a statement that people have a right to “choose how they die by making their wishes known to the physician,” and that more than 80% agreed that in the case of terminal illness they would allow passive “neglect” to take place.<sup>20</sup>

It is generally accepted that many doctors practice passive euthanasia on a wide scale, but this is difficult to document because, for obvious reasons, it occurs within the privacy of the patient-doctor-family relationship. Occasionally, a physician will make public his views, e.g., Dr. Christiaan Barnard, the South African heart surgeon, who recently said that he has practiced euthanasia “not by taking life, but by stopping treatment.”<sup>21</sup> An editorial in the *Journal of the American*



*Medical Association* states: "For some years physicians—though perhaps not all, or even as many as some would like—have been refusing to inflict artificial life-supports on irretrievably dying patients."<sup>22</sup>

Diana Crane, sociologist from the University of Pennsylvania, in a survey of physicians' attitudes toward the terminally ill, found that "one of the most difficult decisions is to turn off the respirator in cases where the patient has suffered irreversible cessation of brain function."<sup>23</sup> The Rev. John R. Connery, S.J., of the Kennedy Institute for Bioethics, writes of this contradiction in attitudes: "There may be a psychological problem, but clearly there is no moral problem. If there is no obligation to initiate extraordinary means there is no obligation to continue such means."<sup>24</sup>

Attitudes within the medical profession are changing in certain respects. A curtain of silence is lifting, and there is now a willingness to consider death, dying, and euthanasia in medical schools, medical journals, and medical societies. Stanley Joel Reiser, M.D., found that from the 19th to mid-20th century medical literature on the care of the dying was "appallingly meager", and that the subject was not examined in medical schools. "Public and professional discussion of euthanasia continued to be sparse up to 1965. Until this time, incurable disease and death meant defeat for the physician as well as the patient; both appeared to prefer the remedy of silence."<sup>25</sup>

A survey on death education shows that although "only a small percentage of nursing and medical schools . . . offer separate courses devoted specifically to death education, the inclusion of such concepts within the existing curriculum is nearly universal."<sup>26</sup> The EEC began co-sponsoring courses on death and dying in 1971 because of an awareness that the topic of death was shunned in hospital settings. From the fall of 1975 through the spring of 1976, the Council sponsored eight series of eight weeks duration each, with participants coming from every spectrum of the health care professions.

As the public becomes more sophisticated about medical technological possibilities and the problems it can create for medical care, more people wish to discuss their feelings on the subject with their physicians. It is part of a move to assert the right of self-determination and to influence *in advance* what might be done should they be disabled by disease or by an accident or confronted by a painful and lingering death.

The "Living Will" is most frequently used to open up such discussions. The Living Will, a document distributed by the EEC, states: "If the situation should arise in which there is no reasonable expectation of my recovery from physical or mental disability, I request that I be allowed to die and not be kept alive by artificial means or 'heroic measures'." Instructions included with the Living Will advise: "If you have a doctor, give him a copy for your medical file and discuss it with him to make sure he is in agreement." Instances of rejection by a physician appear to be few. (The EEC has received requests for more than a million copies of the Living Will since it was first published in 1969, and is now distributing the document at the rate of 50,000 per month—as compared to 1969, when the initial printing of 5,000 copies lasted a year.)

The Living Will is thus an indicator by the patient of how he would wish to be treated under certain circumstances. It has never been tested in a court case nor has legislation been enacted to make it legally binding. However, based on the opinion of attorney C. Dickerson Williams, an article in the *Euthanasia News* characterized the Living Will as an “assertion of the individual’s right to self-determination over his own body” Williams said that “the courts have uniformly held that it is an assault and battery upon a person to administer medical treatment that he does not want—assuming that he is mentally competent.” As protection for the patient who “can no longer take part in decisions for his own future”. Williams stated: “It is my opinion, and I believe would be the opinion of lawyers generally, that courts dealing with incompetents would follow its terms as showing the individual’s wishes. As a general principle, courts endeavor to ascertain what an incompetent’s wishes would be if he were capable of stating them, and act accordingly.”<sup>27</sup>

The Judicial Council of the American Medical Association, although not endorsing any particular form “to express an individual’s wishes which relate prospectively to his final illness”, recommended that the AMA House of Delegates “recognize that individuals have the right to express such wishes.” This was adopted in 1973.<sup>28</sup>

In the practice of the art of medicine the physician plays a key role in questions of both quantity of life and quality of life, but these two are not necessarily compatible. Should he be the one to make the choice if and when a choice must be made? There is a growing unwillingness to accept unquestionably the physician’s judgment; patients are demanding more of a voice in their own treatment—they are asking more questions and they are expecting fuller answers.

The courts have ruled that they are entitled to such answers under the doctrine of “informed consent”, which obligates physicians to advise patients of specific treatments, benefits, and risks.<sup>29</sup> Montagne suggests that euthanasia can be viewed as a continuum of situations in which the patient’s right to be the decision-maker is implemented.<sup>30</sup> The law prohibits active euthanasia, even if undertaken at a patient’s request; the patient cannot ask someone else to end his life. But an individual does have the right to refuse to permit a doctor to treat him, even if such treatment would prolong his life. If a doctor should act contrary to such wishes he would be subject to liability.

The doctrine of “informed consent” and the right to refuse treatment received public recognition with the publication of the Patients’ Bill of Rights by the American Hospital Association in 1973. But a high percentage of patients are not yet aware of these rights, and, according to Dr. Annas, “fully more than 80% of physicians do not tell terminally ill patients the true facts about their condition.”<sup>31</sup>

Some doctors are practicing “defensive medicine”, ostensibly from a fear of malpractice suits; others go as far as a New York neurologist who indicated that the circumspect way for doctors to help a suffering patient is to say “I have something for your pain. If you take too much it will be harmful.” And then in effect the patient decides.<sup>32</sup>

## *Religious Attitudes toward Euthanasia*

Euthanasia is as much a moral and ethical consideration as it is medical and legal. It has not received the same attention within the framework of Judaeo-Christian ethics as have other moral problems of medical practice (*e.g.*, abortion), but this situation is changing.

The concept of passive euthanasia is far more generally accepted by all religions than is usually believed. For example, Pope Pius XII, in a remarkable address on prolongation of life to a Congress of Anesthesiologists in 1957, said that only ordinary means need to be used to preserve life, and he defined ordinary as "means that do not involve any grave burden for oneself or another." He went one step further when he said, "The removal of pain and consciousness by means of drugs, when medical reasons suggest it, is permitted by religion and morality to both doctor and patient, even if the use of drugs will hasten death."

Directive No. 28 of the *Ethical and Religious Directives for Catholic Hospital Facilities* states: "The failure to supply ordinary means of preserving life is equivalent to euthanasia. However, neither the physician nor the patient is obliged to use extraordinary means."

Beginning in 1974, the Catholic Hospital Association has distributed a document called the "Christian Affirmation of Life" in which the signer asks to be informed of impending death, to be relieved of unbearable pain, and not to be kept alive by extraordinary means.

In the Karen Ann Quinlan case it was a Roman Catholic priest who advised Mr. and Mrs. Quinlan that removing the respirator from their daughter would not violate religious concepts. The Bishop of the diocese supported the "moral correctness" of the suits "in the light of the teaching of the Catholic Church", and the New Jersey Catholic Conference asked for permission to file an *amicus curiae* brief which would include the bishop's statement.<sup>33</sup>

A 1975 California poll by Mervin Field found that "77% of Catholics approve of a patient's right to refuse treatment (passive euthanasia)," and 49% believe that "an incurably ill patient should have the right to ask for and get medication that would painlessly end his or her life."

A prominent theologian, the Rev. Charles Curran of Catholic University, says the distinction between omission and commission often breaks down, and stated he is "theoretically willing to consider positive intervention, recognizing the practical problems of determining when the death process sets in."<sup>34</sup>

Within the Protestant religion there has been a wide range of viewpoints. Several Protestant theologians have been actively associated with the movement, including the first president of the Euthanasia Society, Dr. Charles Potter, as well as Dr. Harry Emerson Fosdick, Dr. Henry Sloan Coffin, Dr. Henry P. Van Dusen and Dr. Joseph Fletcher. Because of growing awareness and discussion of the moral dilemmas of terminal medical care, organized Protestant faiths in the last two years have come forth with position statements, such as the United Church of Christ, which issued the following in 1973: "We believe there comes a time in the course of an irreversible terminal illness when in the interests of love, mercy, and compassion those who are caring for the patient should say 'Enough'."

Increased interest in the topic of euthanasia can also be measured by the large number of requests from ministers and church groups, addressed to the Euthanasia Educational Council, asking for Living Wills, literature, speakers and films.

Jewish law has strong strictures against active euthanasia, and a special category is assigned to the terminal patient called *goses*. However, according to Rabbi Byron L. Sherwin, who has analyzed Jewish law in relation to euthanasia, "prolonging natural life is always obligatory, but artificially prolonging the life of a terminal patient is optional."<sup>35</sup>

The chairman of the Conservative Rabbinate's Committee on Law and Standards, Dr. Seymour Siegel, recently said, in connection with the Quinlan case, "While Judaism is opposed to active euthanasia, there are grounds for the legitimate withdrawal of means which prevent death from coming naturally—that is, 'pulling the plug'." He has recommended "adoption of the distinction between passive and active euthanasia. . . . The former would be licit; the latter is illicit."<sup>36</sup>

### *Conclusions*

Death is a very individual matter which does not readily lend itself to collective decision. Medical ethicists frequently conclude that to allow a person to die from malice is more reprehensible than to help a person to die from mercy. The most striking change which is taking place in consideration of the problem is recognition of the need to reinforce the patient's right to decide on the course of medical treatment.

A *New York Times* editorial of February 3, 1903 condemned the practice of active euthanasia by comparing it to "practices of savages in all parts of the world". Seventy years later the *Times* of July 3, 1973 carried an editorial which recognized compelling arguments for passive euthanasia. It stated ". . . a growing movement now asserts that there is a right to die as well as a right to live, and that the former right is violated often by officious, prolonged, excruciating and expensive medical intervention that keeps people alive who would be better off dead since they are in agony or are living vegetables without hope of recovery."

The subject of euthanasia has at last "come out of the closet", as its complexities are recognized and debated publicly. Individual concern with the dying process is widespread, although this concern has not yet been crystallized into an action oriented movement asserting a civil right. There is a strong possibility that changing attitudes toward euthanasia will soon be expressed in the passage of state legislation, but it will continue to generate polarized opinions for some time to come before a coherent public policy is achieved.

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- <sup>10</sup>A history of the euthanasia movement can be found in the following: Russell, O. Ruth, *Freedom to Die; Moral and Legal Aspects of Euthanasia*. N.Y.: Human Sciences Press, 1975; Wilson, Jerry B., *Death by Decision; The Medical, Moral and Legal Dilemmas of Euthanasia*. Philadelphia: Westminster Press, 1975 and *Euthanasia News*. Vol. I/4 (November, 1975).
- <sup>11</sup>Russell, *op cit.*, p. 60.
- <sup>12</sup>L.B. 135, 52nd Session, Nebraska Legislature (1937).
- <sup>13</sup>Sackett, Walter, M.D. "I've let hundreds of patients die, shouldn't you?" *Medical Economics* (April 2, 1973) p. 92-96.
- <sup>14</sup>From a speech delivered at the Eighth Annual Conference (December, 1975) of the EEC. Proceedings to be published September, 1976.
- <sup>15</sup>From a speech delivered at The Eighth Annual Conference. See note 14.
- <sup>16</sup>Montange, Charles H. "Informed Consent and the Dying Patient." *Yale Law Journal*, 83/8 (July, 1974) p. 1664.
- <sup>17</sup>*State v. Sander*, (N.H. 1950), 48 MICH. L. REV. 1197 (1950); *State v. Montemareno*, (N.Y. 1973), *N.Y. Times*, June 28, 1973, p. 1.
- <sup>18</sup>*N.Y. Daily News*, January 14, 1975.
- <sup>19</sup>Russell, *op cit.*, p. 252.
- <sup>20</sup>"Doctors and Dying: Is Euthanasia Now Becoming Accepted?" *Medical Opinion* (May, 1974) p. 31-34.
- <sup>21</sup>L.B. 135, 52nd Session, Nebraska Legislative (1937).
- <sup>22</sup>"The Karen Ann Quinlan Case" (Editorial). *Journal of the American Medical Association*, Vol. 234 (December 8, 1975) p. 1057
- <sup>23</sup>Crane, Diana. "Physicians' Attitudes Toward the Treatment of Critically Ill Patients" in *The Dilemmas of Euthanasia*, edited by John A. Behnke and Sissela Bok. Garden City, N.Y.: Anchor Press/Doubleday, 1975.
- <sup>24</sup>The Rev. John J. Connery, S.J. "The Moral Dilemmas of the Quinlan Case." *Hospital Progress* (December, 1975) p. 18-19.

- <sup>25</sup>Reiser, Stanley Joel. "The Dilemma of Euthanasia in Modern Medical History: the English and American Experience" in Behnke, John A. and Bok, Sissela, Eds., *op cit.*
- <sup>26</sup>Berg, David W. and Daugherty, George C. *Death Education: a Survey and Study of Colleges and Universities*. DeKalb, Ill.: Educational Perspectives Associates, 1974.
- <sup>27</sup>"Questions and Answers about the Living Will." *Euthanasia News*, Vol. I/3 (August, 1975) p. 3.
- <sup>28</sup>AMA Judicial Council, *op cit.*
- <sup>29</sup>*E.g.*, *Cobbs v. Grant*, 8 Cal. 3rd 220, 502 P. 2nd 1 (1972). For discussion of this and other cases see Montange, *op cit.* and Annas, George J., "Informed Consent to Treatment" in *The Rights of Hospital Patients*. N.Y.: Avon, 1975.
- <sup>30</sup>Montange, *op cit.*
- <sup>31</sup>From a speech delivered at the Eighth Annual Conference. See note 14.
- <sup>32</sup>*Newsweek*, November 3, 1975.
- <sup>33</sup>"Catholics Back Quinlans." Patterson, N.J.: *Morning News* (December 23, 1975).
- <sup>34</sup>"The fragile issue of 'Death Control.'" *New York Times* (October 13, 1975).
- <sup>35</sup>Sherwin, Byron L., "Jewish Views on Euthanasia." *The Humanist*, Vol. 34 (July/August 1974) p. 19-21.
- <sup>36</sup>"Letting patient die held not euthanasia if case is hopeless." *Jewish Week*, Vol. 185 (December 14-20, 1975).