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Care of the Dying: The Doctor and Euthanasia

Robert Rizzo, Ph.D., and Joseph Yonder

The quality of the doctor-patient relationship is central in this discussion of the euthanasia problem.

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Concern for the rights and dignity of the dying patient motivates a number of people to urge the adoption of voluntary euthanasia, the direct killing of the patient at his own request. For them, to omit artificial life-supports is not enough, though they regard such an omission a necessary first step. Their literature abounds with mention of personality disintegration as a result of devastating illnesses and extreme suffering and with pointed references to dehumanization and depersonalization of care because of overzealous use of technology without regard for the patient's condition and wishes. Euthanasiasts feel that moral and legal acceptance of voluntary euthanasia will protect the dignity of the patient and enhance the quality of terminal care.¹

In making this point, however, they fail to analyze thoroughly what constitutes comprehensive terminal care and what role the quality of the doctor-patient relationship plays in that care. The July-August issue of the *Humanist* carries an eloquent plea for "Beneficent Euthanasia," followed by a list of distinguished signers.² The articles in support of mercy-killing shy away from an analysis of the quality of the contemporary doctor-patient relationship and the environmental factors affecting that quality. For instance, while recognizing the potential of euthanasia for undermining the relationship, Thomas W. Furlow, Jr., M.D., asserts: "More likely, however, the bond between doctor and his patient would be uniquely enhanced, and tightened, for the trust in one's doctor would have to be absolute."³ It seems justifiable to ask from what sources the doctor draws such confidence in view of the fact that without an analysis of the contemporary scene this remains a gratuitous assumption. Witness, for example, the startling increase of malpractice suits!

If the present doctor-patient relationship is generally poor, it would be unlikely that voluntary euthanasia would improve the

quality of terminal care. Because it involves the destruction of life, it can become the artificial short cut in practice to comprehensive terminal care by way of quick disposal of the object of that care, leaving unreformed those economic, psychological, social, and cultural factors undermining the relationship. On the other hand, if we have comprehensive care which embraces psychological and spiritual counseling, comfortable surroundings, powerful sedation and an open doctor-patient relationship, then the urgent need for euthanasia would fade quickly in view of the social and legal risks in institutionalizing voluntary euthanasia. Euthanasiasts are quick to discount the risk potential or the "wedge or slippery slope argument." But as Yale Kamisar well illustrates, many supporters would neither be surprised nor distressed to see the practice eventually embracing congenital idiots, permanently insane and senile dementia.⁴ A steady progression from voluntary to involuntary forms of euthanasia could very well be expected.

The underlying themes of our article are the doctor-patient relationship and the role of the physician in terminal care. These are our reference points, to which we relate our discussion of euthanasia and the omission of morally extraordinary means of preserving life. The purpose behind our method is to point up the need to focus on the quality of the contemporary doctor-patient rela-

tionship as the key issue in terminal care. The opposing sides in the euthanasia debate must find their common ground here. With this shared point of focus, they can proceed to examine the factors affecting the relationship and work toward necessary reforms.

Suggested Models for the Doctor's Role

The call for death with dignity is rooted in the growing recognition that, as Pius XII stated, "the doctor, in fact, has no separate or independent right where the patient is concerned."⁵ On moral and legal grounds, this view has strong support. George J. Annas, Director for Law and Health Sciences, Boston University, notes a consumer movement in health care based on "a recognition that individuals have certain rights as persons and do not abdicate or lose these simply by entering a hospital for treatment, and a growing public demand for the return of decision-making power regarding one's body to the patient."⁶ Robert M. Veatch of the Hastings Center discusses various models or ways of interpreting the doctor-patient relationship. There is the engineering model where the physician's role is that of "an applied scientist," a medical technologist without concern for moral issues or ethical judgments; or the priestly model where the doctor becomes a sacred figure, clothing his judgments with a paternalistic and holy aura, thereby removing from the patient decision-making responsibilities; or the collegial

model where trust and confidence are the mainstays of the relationship between friends; or the contractual model where "two individuals or groups are interacting in a way where there are obligations and expected benefits for both."⁷ Veatch prefers the last model because unlike the "moral abdication" of the engineering and priestly models its shared responsibility grants the patient the ultimate power of decision in vital matters without "the uncontrolled and false sense of equality in the collegial model."⁸ The same conclusion is expressed by David Louisell, who sees the moralist's and physician's views on omission of artificial life-sustainers reconciled in practice by the obvious fact that it is ultimately the patient's decision to reject what the physician may be legally obligated to offer as "customary medical practice."⁹ He points out that the professional bias operative in decisions to use life-sustaining measures at all costs is due to training and available skills and is reinforced by the fear of malpractice.¹⁰

There is no justification in theory or practice to speak of two distinct, though related, imperatives residing in the person of the physician: the medical responsibility to practice energetically and skillfully the art of healing and the moral responsibility to have concern and respect for the personal needs and rights of his patient.¹¹ Such dualism magnifies the problem. The physician is a

person who practices the art of healing. As *man*, the doctor has certain basic rights and responsibilities. In becoming a physician, the person assumes further rights and responsibilities which are in harmony and continuity with those possessed as *man* and not in tension with them. These arise out of the special relationship with the person as patient. A physician, just as any other person in a contractual relationship, must respect the rights of his partner. As physician, the person has no other imperative except that given by virtue of the special relationship with the patient.

Writing on "Ethical Problems in Human Experimentation," Otto E. Guttentag expresses a concept relevant to our analysis of the doctor-patient relationship in general.

With reference to the relationship between experimenter and experimental subject, it is the concept of partnership between the two, resulting from the fact of their being fellow human beings, that reflects our basic belief and cannot be subordinated to any other.¹²

The principle of partnership, characterized by sincerity, mutual trust and open communication, underlies the various Western codes, such as Nuremberg and Declaration of Helsinki, in their emphasis on the conditions for voluntary informed consent. In our estimation, the prerequisites for such consent should be made the professional ideal, the guidelines which the physician strives to follow in the use of morally

extraordinary means. In this way, we work toward safeguarding the rights of the patient in the process of dying. However, it would be unrealistic to believe that human rights will be protected simply by restating the moral or ethical principles or norms in regard to care of the sick patient and experimental subject. Even the passage of more stringent laws cannot assure compliance unless a vigorous and wide-ranging apparatus is set up to monitor and enforce observance. This is a practical issue that needs careful but urgent consideration.¹³ In practice, there are forces and reasons that make it more convenient and sometimes more profitable to ignore compliance with basic moral and legal principles.

A Complex Relationship

On the positive side, medical advances have provided doctors with greater skills and more opportunities to help their patients. However, there are practical considerations in a technological setting which may influence some physicians to interpret their relationship with the patient in a way that raises a point of conflict between their vocation to heal and the rights of the patient. Because of increased technical skills and advanced therapies, the doctor-patient relationship has become more complex. As George Annas remarks, "the doctor is more likely to be able to help a sick patient, but . . . he is apt to be more interested in the patient's disease

than in the patient as a person with human rights."¹⁴ This is more likely to happen if the doctor is inclined to see himself primarily in his technical role. But if treatment is directed towards the *whole* person, the needs of the patient must also embrace his rights. For one great personal need of the patient is to have his rights respected. This requires open lines of communication between doctor and patient. Unfortunately, in our technological age, there often seems to be contrasts between our technical skills in communication and our lack of skills in the art of interpersonal communication. How much does medical training contribute to the development of the art? And how much do cultural taboos of death and dying affect the physician in communicating with the dying patient? These are two questions among many that could be asked about the environmental factors affecting the doctor-patient relationship.¹⁵

By virtue of the Hippocratic Oath, as commonly interpreted, the doctor is committed to avoid injuring the patient, especially by giving a lethal dose even if requested, and to treat the patient "according to my ability and judgment." The Oath, according to traditional interpretation, runs counter to what is called *euthanasia* or *mercy killing*, the direct administration of medicines and procedures to terminate life. But it certainly does not prevent the doctor from omitting or stopping

specific treatment which is failing to serve effectively the patient in his fight against death. Some call this *passive euthanasia* or *indirect euthanasia* to distinguish it from lethal procedures. In this age of words with multiple meanings, it is better to omit the term *euthanasia* altogether because of the controversy that surrounds the practice so named. This would help to avoid confusion as to the moral distinction between direct administration of a death-dealing procedure and the omission or stopping of morally extraordinary means. In the latter, the physician, exercising his judgment, as the Oath prescribes, foregoes measures which are doing nothing more than prolonging the agony and dying without significant benefit to the physical, mental and spiritual well-being of the patient. We presume that, by the Oath, the physician commits himself to treat the patient as a whole person. To disregard or overlook the patient's wishes in the matter of preserving life seems to run counter to the Oath. In our age of highly sophisticated technology, relentlessly trying to halt death that is reasonably expected from all clinical signs can result in a depersonalization of the doctor-patient relationship and the mechanization of medical care. It can lead to results never intended by the Oath, particularly in cases where the patient is inadequately informed and his wishes not respected.

The proponents of euthanasia

hit a sensitive nerve when they point out the cruelty involved in sustaining a person for weeks and months in a continuing round of depersonalized and technical treatment without allowing the person to decide against such care. This has become a theme in the writings of proponents of legalized voluntary euthanasia. Though the methods they propose are not shared by us, they have challenging insights into the consequences of artificially prolonging terminal illness.

There are moral and legal differences between euthanasia and omission of morally extraordinary means. First let us concentrate on the moral distinction, which should be a primary reason for the legal difference. In euthanasia, death is caused; in omission, death is allowed to happen according to natural forces. In the latter, there is a withdrawal of artificial life-sustainers or the decision not to use any. The withdrawal of means does not constitute a *commission* in a moral or legal sense. For the moral and legal meaning of an act cannot be determined by the physical nature of the action alone but rather must be evaluated in the light of the agent's intention, the circumstances and the physical nature and scope of the action. For example, the turning off of a respirator is certainly a physical action, but in the clinical situation it is understood as an omission of a life-sustainer, based on the decision not to con-

tinue the intervention in the natural process. In euthanasia, there is the decision to intervene further in the natural process. This is seen both from the physical nature and scope of the action and its context. It is clear, moreover, from both the nature and scope of the action and its setting that the agent intends to kill and in fact does kill the patient.

The Physical and Psychological Levels

To say that the moral meanings of euthanasia and omission of morally extraordinary means are the same is to ignore what in fact is taking place on the physical and psychological levels. On the physical level, omission allows death as the result of a natural breakdown of the organic whole we call human life. Euthanasia is an action directly causing death. The psychological impact of administering a lethal procedure cannot be readily equated with the omitting of artificial measures. In euthanasia, the proximate goal or intention of the agent is the immediate death of the patient. In omission, the proximate goal is the non-intervention in the natural process. The lethal procedure is a destructive act both in intention and in the physical order. Omission is not in itself destructive but rather an admission of the failure to help recovery or to ward off death, a recognition that artificial intervention is not serving a good purpose but rather aggravating a personal ordeal. When we enter into an act which is of

its nature destructive of life, we should be aware that the psychological consequences could be decidedly detrimental to all involved in the perpetration of the deed.

The proponents of euthanasia raise the question whether it is necessarily wrong because it is a form of killing. Joseph Fletcher, a very forthright advocate of euthanasia as well as omission of extraordinary means, observes quite pointedly that "the objection that it is murder only begs the question, since the problem is precisely whether a *felo de se* for medical cause is to be held an unlawful killing."¹⁶ In the same breath, he notes that religious opponents of euthanasia fail to realize that the decalogue forbids murder and not killing and that Jews and Christians have not been conspicuous as vegetarians, pacifists or opponents of capital punishment. Fletcher proposes the possibility that euthanasia poses much less a danger to social morals than the present military strategy of mass extermination and methods of warfare.¹⁷ He also prophesizes the day when euthanasia will be as readily justified for "therapeutic reasons of mental, emotional and social well-being," as is abortion today.¹⁸ It is quite true that killing in specific contexts has been traditionally justified by Jewish and Christian moralists. But this fact in itself does not mean that euthanasia can be readily justified at this historical moment. Fletcher's pointed reference to our le-

gitimatization of nuclear and conventional warfare and capital punishment is a challenge to those who uphold the value of human life in their case against euthanasia but are more flexible in matters of warfare, capital punishment and social injustices. However, the fact that acts of destruction have been and are being justified in other sectors of life does not warrant our ready acceptance of destruction in the care of the dying. It can be argued that we continue to avoid overt and covert destructive acts in the care of the dying, while we struggle to minimize, if not eradicate, destructive attitudes and acts in other realms of life and society.

Serious Questions: Moral, Medical and Social

Writing on "Death, Legal and Illegal," Daniel C. Maguire discerns changes in moral attitudes towards different kinds of killing. "Inasmuch as those shifts reflect a recognition that we have overestimated our moral right to kill in a military setting and underestimated it in some medical and private situations, I believe the shifts are in the right ethical direction."¹⁹ To support his contention that the law is out of step, Maguire then proceeds to examine "four classes of legal killing:" abortion, capital punishment, war and suicide. We do not understand the "logic" of his argument, which is knitted together by hidden assumptions. In Maguire's reasoning, there seems to be an assumption that we are

morally evolving on all fronts at an equal pace as evidenced by our more critical attitudes towards war and capital punishment and our more tolerant or more understanding attitude towards abortion and suicide. This is a rather huge assumption in view of the possibility that in our personal and social life we may be prone to take a step forward in one area and a step back in another. As Maguire himself would admit, it is a matter of personal interpretation whether each change is regarded a sign of moral progress or regression. In our view, the emerging critical attitude towards war and the military establishment and towards capital punishment and the penal system could carry the day and have a powerfully beneficial impact in minimizing violence within our national and international communities. But this remains a hope. As regards abortion, the recent Supreme Court ruling has opened the legal way to abortion on demand but has not signaled the end to serious moral, medical and social questions about abortion as a widespread and repeated practice. As Maguire himself admits, the experience of countries with liberal abortion laws for fifteen years or more should be carefully studied to evaluate the long-range effects of the practice as a social phenomenon. A more sympathetic attitude towards those seeking abortion and towards those attempting suicide does not logically commit us to accept morally or legally abortion or suicide as so-

cial solutions to human problems. It should impel us to find ways to alleviate the suffering and solve the problems that prompt individuals to seek a solution in abortion or suicide. Our problem may be the belief that, once we moralize or legislate on a problem, we have coped with it adequately. Unfortunately moralizing and legislating can leave untouched the roots of human problems, of which abortion and suicide are symptoms.

What is Maguire's objective in illustrating shifts in attitudes? In his recent book, *Death By Choice*, Maguire writes in reference to the case of a girl born with spina bifida with meningomyelocele of the lumbar spine:

The moral question then is whether the death should be entrusted to the imminent disease or whether it could be brought on by the administration of drugs or whether a compromise could be found whereby the drugs are used to comfort and to weaken in coordination with the meningitis. In the present state of legal and moral debate, the latter possibility would offer the advantage of protective ambiguity. There is no precise way of knowing whether a drug is accelerating death as it relieves discomfort, since the unrelieved discomfort might accelerate death too and since the degree of immunity to the drug is a variable. Still, this flight to ambiguity would represent a retreat from the question to be explored in this book, viz., can it be moral and should it be legal to take direct action to terminate life in certain circumstances?²⁰

Maguire's answer is a definite "yes." The thrust of his book as well as articles on the issue is

toward the moral and legal validation of euthanasia in some form. We would caution that, before hazarding moral and legal revision of the status of euthanasia, we should analyze the care of the dying in its total context.

Euthanasia is a destructive act, no matter how it is dressed up in "antiseptic" terminology. Omission of morally extraordinary means is not in itself destructive. It is the cessation of artificial intervention upon recognition of the unreasonableness of striving to preserve life. Euthanasia is in fact an artificial intervention to terminate life. The former does not imply that the patient is then abandoned. On the contrary, the patient continues to be cared for. An example is the emphasis on personal care rather than on technical vigilance in St. Christopher's Hospice in England. Patients are not wrapped around a schedule but are allowed to feel out their last days with the help of staff and family, cheerful surroundings, powerful painkilling drugs and without the threat of cardiopulmonary resuscitation and other artificial life-supports.²¹ In the case of ever increasing doses of powerful sedatives, death may be hastened. But this is the unavoidable side effect of the overall action to care for the patient in extreme pain. It is an effect of an act which is morally good both by reason of the agent's intention and by virtue of the immediate concrete objectives of the act as seen in its context. Killing the patient is neither the intended

means nor in fact the means to achieve the proximate goal, the relief of extreme pain. Though it may seem overly subtle to distinguish morally between administering drugs to kill and drugs to relieve pain with the concomitant effect of speeding up death, there may be some merit in holding on to the moral distinction. To say the burden of proof is on those who support the distinction and not on the euthanasiasts is (to quote a famous philosopher) to "make history walk on its head." It is the rationalistic fallacy to live in a world of ideas divorced from the realities of the internal and external environment of man. It is to propose an idea "come of age" without critically examining whether the theory can be realistically implemented in the context of psychological, cultural, legal, social and economic factors.

The 'Idea of Proportionality'

While recognizing the strength of the traditional moral distinction between omission and commission in view of psychological, legal and social considerations, Maguire weaves a skillful argument for the moral and legal acceptance of euthanasia in certain circumstances. His general method is to discover moral meaning "not just in principles but in all the concrete circumstances that constitute the reality of a person's situation" and to test again and again the validity of principles in empirical experience from which they derive.²² More specifically, his method of defending death by choice, whether it involves one's

own life or the life of another, depends "to an important degree on the idea of proportionality."²³ He attempts to discover proportionate reason for terminating life by engaging in the calculus of weighing values against one another in the concrete situation: for example, the value of biological life of an irreversibly comatose patient or the unrelenting painful life of a conscious terminal patient against other significant values that would accrue to the patient and his family from a speedy termination of life. According to this calculating existential approach, the principles prohibiting direct termination are relative as only one of the factors to be weighed in the balancing of values in the conflict situation. In certain instances, the scales tip in favor of values other than life and its continuation. At this point, the question of the moral validity of the means is reduced to the question, "what means better serves the purpose of the act, that is, the achievement of the weightier values?"

Maguire pursues his analysis of the many dimensions of euthanasia much further in *Death By Choice* than in previous articles. He considers such aspects as the method of evaluating a patient's free decision; the fallibility of prognosis; cultural, social, psychological and professional reasons why doctors should not have the right to decide termination; the legal, social and moral difficulties of terminating the life of an unconscious or mentally in-

competent patient, and the general complications arising from the legal system and insurance companies. In many respects, he offers valuable insights into the factors which make euthanasia a complicated personal decision and social question. But, in our opinion, he does not go far enough in analyzing the problems which would be created by the social acceptance of euthanasia. Because euthanasia is a destructive act, its personal and social consequences must be examined in the total context of terminal care. For instance, Maguire would take from the physician the burden of deciding for euthanasia. He locates the right of decision in the patient or in a "Committee of the Person," that is, a person or group of persons designated by the patient and appointed by the court to act in time of incompetence or to a court appointed committee having some relatives as members. The physician provides information in terms of diagnosis and prognosis, and direction by his counsel. However, in the context of terminal care, the exclusion of the attending physician from the proximate decision-making seems unrealistic. Maguire slides over the fact that it will be the physician who will have the emotionally charged task of killing the patient and that all through the illness the physician is the one who carries a large share of the burden in relating to the patient and family. To realize in practice Maguire's suggestions would demand a number of major

changes in the health care profession and system and in the law itself and perhaps the creation of a new bureaucracy to administer and control euthanasia. In the care of the dying person, the central issue is the quality of the doctor-patient relationship. Whatever affects that relationship must be subjected to a more thorough evaluation than Maguire undertakes in his defense of euthanasia. In the long run, it is the quality of that relationship which determines the quality of terminal care. Maguire's focus on the social, moral and legal acceptance of euthanasia is a misplaced emphasis which overrates the importance of euthanasia for comprehensive terminal care.

Charles Curran follows a similar pattern. He proposes a practical norm which allows "positive interference at the same moment in which treatments and procedures can be discontinued because they are useless."²⁴ While recognizing the objection that euthanasia might not be easily confined to such cases, he does not confront directly the plethora of problems which euthanasia would raise once accepted in principle and in specific instances. Ironically Paul Ramsey, who strenuously objects to euthanasia on the grounds of the God-given sanctity of human life, admits exceptions.

We may say, never abandon care of the dying except when they are irretrievably inaccessible to human care. Never hasten the dying process except when it is *entirely indifferent to the patient* whether his dying is accomplished by an in-

travenous bubble of air or by the withdrawal of useless ordinary natural remedies such as nourishment.²⁵

Two exceptional cases might be a patient in deep and irreversible coma or a patient dying in extreme pain and knowing no relief.²⁶ Proposing this, Ramsey drops the whole matter into the collective lap of physicians without elucidating the practical difficulties involved in making such decisions.

Can the Risks Equal the Gain?

The relevant question is: what can be accomplished by euthanasia that could not be by other measures, and if anything is accomplished, are the legal and social risks proportionate to the gain? It seems that the omission of artificial life-sustainers when judged morally extraordinary, if intelligently applied, can remove much personal ordeal now cited as justification for euthanasia. Omission, as noted above, would be only one facet of comprehensive care. In addition, if *clinical* death is redefined in terms of neocortical death (and not total brain death), an hypothesis we explored in a previous article,²⁷ it would allow physicians to cope with cases in which patients are deeply comatose because of neocortical death, without having to justify euthanasia as a method and social policy in the care of the dying.

There is a sound legal difference between euthanasia and omission of morally extraordinary means. According to George P.

Fletcher, professor of Law, euthanasia corresponds to an act perpetrating injury forbidden by law, while permitting falls in the legal category of *omission*. In this latter instance, legal responsibility can only be determined from the context of the relationship between doctor and patient.²⁸ If the omission on the part of the doctor offends the expectations and wishes of the patient arising justifiably out of the relationship, the physician is liable to prosecution for malpractice. The omission of intravenous or respirator would be viewed legally different from a lethal procedure if it did not contradict the wishes and expectations of the patient in the context of the relationship; therefore, the importance of open and frank communication between doctor and patient. In this, the doctor has a responsibility to avoid a conspiracy of silence or half truths that may lead to misunderstanding and false hopes. As a profession, doctors have a great role in improving the social awareness of current medical practice. They must help educate the public before it becomes the patient. There already exists a well established basis for such education. As Jonas B. Robitscher, psychiatrist and lawyer, notes, the Anglo-Saxon legal system, while protecting life against aggressive acts, recognizes the patient's right to refuse treatment.²⁹ Court rulings have offered some insight into the legal interpretation of the right without, however, re-

moving all uncertainty and ambiguity. Recent court decisions in Miami (1971) and Milwaukee (1972) have upheld the right of the terminally ill to refuse treatment. In these cases, the patients were mentally competent.

The major problem is that in many cases the terminally ill's mental processes may be immature, severely impaired or non-existent. In 1972, New York State Court Justice Gerald Culkun ruled against the wife who refused to grant permission for the implantation of a new pacemaker battery for her 79-year old husband. Despite the fact that the quality of the patient's life was greatly undermined by loss of memory and insufficient awareness of his condition, the judge appointed the hospital director as the official guardian with the right to authorize the procedure. The wisdom of the decision is open to several questions. What were the expectations and wishes of the patient before he lost mental competence? If it could be shown that he did not expect and desire such morally extraordinary steps, then the doctor or the hospital should not have pursued the issue. What is the right of the medical and judicial authorities to impose a decision on the mentally incompetent patient and the next of kin when the remedy offers little or no hope of substantial benefit for recovery or restoration to any semblance of normal or tolerable existence? These are difficult questions to answer for several

reasons. It is difficult to define precisely what is meant by recovery or normal or tolerable existence.³⁰ But, as stated above, there comes a time in the care of the very sick when all indications are that the patient's own life-support systems have so deteriorated that artificial intervention offers no hope of halting the dying process or that, if it is retarded for a time, the remaining existence will be one of very restricted activity at best, excessive inconvenience and pain. If the patient in this condition has not indicated his wishes before losing mental competence, then the physician should consult the next of kin, if the party is judged emotionally capable of coping with the situation. This is quite a delicate matter because strong emotions are at work in the relatives. These can range from intense love to hostility or indifference with an admixture of guilt over real or imagined negligence and mistreatment. The doctor's responsibility is to seek out the advice of the next of kin with prudence and delicacy. It would be ideal if he could call upon the assistance of a team of specialists in the art of counseling the dying and the next of kin.

A Shared Responsibility

There are factors which favor the presumption that the next of kin knows the patient's wishes better than the doctor and hospital authorities. As in the case of the wife who has spent years caring for a sick husband, it seems

rather presumptuous of medical authorities with the aid of the court to impose further emotional, physical and economic strain on the patient and wife by artificial intervention which offers no hope of substantial benefit. If physicians and hospital authorities offered free service in such cases and gave emotional support during and for a time after the ordeal, then their decision would appear less presumptuous. In the particularly difficult cases of critically ill infants and children, a thorough diagnosis and prognosis should be given the parents along with counseling. The decision to continue artificial life-supports or attempt life-saving procedures is ultimately theirs to make. In practice, it is a responsibility shared by the physician, who should be there to counsel and give emotional support. Without counseling and emotional support, the giving of the facts would be a brutally cold way of informing. In the absence of indication from the patient and in the face of uncertainty on the part of the relatives, the physician should take a greater role in making the decision. The criteria of judgment should include the awareness of the moral grounds for justifying cessation of artificial intervention in the best interests of the patient. Certainly a technological mentality that looks only to technical possibilities without consideration for other aspects of human existence can lead to depersonalized, though technically efficient, care. In such difficult

cases, a hospital committee, consisting of members from various professions, might be helpful in easing the attending physician's burden of decision. However, one continuing obstacle is the variance in professional attitudes toward the continuation of artificial life-sustainers in terminal care.³¹ Professional consensus will be difficult to achieve if medical education is slow to encourage budding physicians to think and dialogue on moral or ethical issues.

A step towards professional consensus was made by the adoption last year by the House of Delegates of the AMA of a report that, while condemning euthanasia, endorses the patient's and/or his immediate family's right to decide for the cessation of extraordinary means in the light of "irrefutable evidence" of the imminence of "biological death."³² The fact that the report needs to recommend explicitly communication of physician to patient and family suggests that at times there are serious breakdowns in communication. While the House of Delegates failed to endorse a legal form to protect the patient's rights, others, such as Walter Sackett, a Miami physician and state legislator, and Robert Veatch with lawyer colleagues have drafted respective proposals to give legal standing to the "living will." Veatch's model law goes beyond the present Sackett bill in not only upholding the patient's right to be informed that treatment can be refused but also in recognizing that the right to

decide belongs to the patient or, in his place, to the spouse or kin or legally appointed agent and not to the physician.³³

Without exploring all the *pros* and *cons* on the advisability of such legislation, it is our opinion that some statute would be helpful in consolidating the already valid and widely recognized rights of the patient. The law should also acknowledge the right of the spouse or next of kin or legal representative to act in behalf of the patient in the event of mental incompetence. Exercise of such a right might perhaps be subject to proper scrutiny by some impartial body. We feel that any statute which completely excludes the attending physician as agent of last resort would be overly restrictive and somewhat unrealistic. Given the large number of nuclear families and great mobility in our society, given the disparity in longevity within families and the reluctance to look ahead to death (witness the hesitation to make out wills), there may be a number of occasions when the attending physician will find himself alone with the mentally incompetent patient, facing the decision without family or legal representative to consult. There may also be instances when next of kin is not emotionally capable of making a decision.

Legislation Is Not the Total Answer

Legislation will be helpful, but it will not provide a total answer to comprehensive care. We return to the crucial factor, the quality

of the doctor-patient relationship. A more personalized relationship, characterized by frank communication, would lessen in practice a number of difficulties that are foreseen in the application of the patient's right to refuse morally extraordinary means. Today, however, there are obstacles in the path of comprehensive care. We could cite possible areas in need of analysis and reform: for example, adequacy of training in comprehensive care, cultural taboos on death and dying and their influence on the physician's manner of treating the dying patient, a shortage of physicians in general practice because of misguided social priorities. Before making a decision for euthanasia, we should make an honest evaluation of ourselves and our environment.

Conclusion

Euthanasiasts are sensitive to personal injustices suffered by the terminally ill. But they are quicker to concentrate on abandoning well established principles than on examining closely social and cultural factors contributing injustice. What would be the consequences of euthanasia as a socially accepted method in a technological society prone to violence, to social inequities, to breakdowns in interpersonal communication, to shortages in personnel and resources, to short-range planning based primarily on technical and financial rather than humanistic concerns? In the light of seven years experience at St. Joseph's, an English hospice for patients with malignant dis-

eases and prognoses of three months or less, Cicely Saunders, M.D., offers what we believe to be the better approach in our present context. Because Saunders' remarks are so relevant to our own evaluation, they are cited as summing up our thoughts and feelings.

I am in the happy position of not being able to carry out drastic life-prolonging measures because we just do not have the facilities at St. Joseph's. Other people have made the decision, at a prior stage, that this is a patient for whom such procedures are not suitable or right or kind. This makes it very much easier for us than for the staff of a busy general ward. I think that it is extremely important that the decision be made by a person who has learned all he can about the family, about the patient himself, and about the whole situation. The further we go in having special means at our disposal, the more important it is that we stop and think what we are doing. . . . I have had much correspondence with the former chairman of the Euthanasia Society in Great Britain, and I took him round St. Joseph's after I had been working there some eighteen months. He came away saying, "I didn't know you could do it. If all patients died something like this, we could disband the Society." And he added, "I'd like to come and die in your Home." I do not believe in taking a deliberate step to end a patient's life — but then, I do not get asked. If you relieve a patient's pain and if you can make him feel like a wanted person, which he is, then you are not going to be asked about euthanasia. . . . I think that euthanasia is an admission of defeat, and a totally negative approach. One should be working to see that it is not needed.³⁴

If we could make the environment fertile for the doctor-patient relationship in which open communication and personalized care are the keynotes, then perhaps the moral values and principles discussed in our analysis of the patient's and doctor's rights and responsibilities would make more sense and appear more realistic. The principles provide realistic guidelines in the fertile soil of *partnership*.

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