Euthanasia and Biathanasia: On Dying and Killing

David W. Louisell
Euthanasia and Biathanasia: On Dying and Killing

David W. Louisell

Introduction: The Nature of the Dilemma

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

At the beginning the announcer had said: "Because of the sensitive nature of this program (the sponsor) has relinquished all commercial messages." But its generous im-

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

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

The Definitional Problem: Voluntary and Involuntary Euthanasia

Taking "euthanasia", in accordance with modern usage, to mean deliberate, intentional painless killing is only the beginning of the definitional problem. Do we mean to include such a killing only when it is sought and requested by the euthanatee, or also one imposed upon him without regard to his consent — the elimination of defective or hopelessly ill or senile persons, for example, Hitler's "useless eaters"? In a word, do we mean only voluntary, or also involuntary, euthanasia?
On the surface, the dichotomy would appear clean-cut. If so, the precise thinker would have cause to resent the countering of argument for or against voluntary euthanasia, with argument pertinent only to the involuntary kind. For example, during the debate on the 1936 bill in Parliament for voluntary euthanasia, one of the prominent proponents invoked two dramatic and appealing cases, one where a man had drowned his four year old daughter who had contracted tuberculosis and had developed gangrene on the face, the other where a woman had killed her mother who was suffering from general paralysis of the insane. Obviously these were instances of compulsory, or involuntary, euthanasia, yet, although the proponent acknowledged that the cases were not covered by the proposed bill for voluntary euthanasia, they were the only specific cases he described.

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

Among some primitive people the abandonment or killing of the aged or helpless apparently was an accepted practice. The Hottentots carried their elderly parents into the bush to die. The Lapp who became too infirm to trek over the mountains with their families were left behind to die unattended, their frozen corpses to be buried on the family’s return. But it is easy to overly generalize about customs of euthanasia among primitive or many societies have actually been shown to have had elaborate rules protective of their senior members. "Instances of this are seen in hospitality customs, property rights, taboos reserving certain choice dishes for the aged (ostensibly as harm to the young) and other usages."

Doubtless the settled agricultural communities showed the highest level of solicitude for the elderly, as witness the laws of the Hebrews in the Old Testament forbidding the killing of the innocent and aged. In classical Greece there does not seem to have been abandonment of elderly or helpless adults. Of course in ancient Rome, largely unde the influence of the Stoics, suicide was an accepted form of death as was escape from disgrace at the hands of an enemy, as indeed it was until recently at least in Japan under the form of hara-kiri. Yet Cicero who had written: "The God that rules us within forbids us to depart hence unbidden" abided his conviction and declined to play the "Roman fool" when pursued to death by the revenge of Antony. Jewish, Christian and Islamic teachings alike have always maintained that deliberate killing in case of abnormality or incurable illness is wrong. The apparent exception in St. Thomas More's Utopia is often over-read to imply his personal endorsement. The modern interest in euthanasia is usually dated from the 1870's but the formal movement did not begin in Britain until the 1930's with the organization in 1935 of the group now known as the Voluntary Euthanasia Society. The first bill on euthanasia was brought before the United Kingdom Parliament in 1936. It required for eligibility for euthanasia that the patient be over twenty-one years of age, be suffering from an incurable and fatal illness, and sign a form in the presence of two witnesses asking to be put to death. It embraced relatively complicated legal proceedings including investigation by a euthanasia referee and a hearing before a special court. In 1950 there was further debate in the House of Lords on a motion in favor of voluntary euthanasia. The distinguished legal scholar and specialist in criminal law, Professor Glanville Williams, realizing the practical necessity of countering the contention that too much formality in the sick room would destroy the doctor-patient relation, in his classic The Sanctity of Life and the Criminal Law proposed a simple formula quite different from the 1936 attempt. He suggested the uncomplicated provision that no medical practitioner should be guilty of an offense in respect of an act done intentionally to accelerate the death of a patient who is seriously ill, unless it is proved that the act was not done in good faith and for the purpose of saving him from severe pain in an illness believed to be of an incurable and fatal character. This was the basis of the 1968 draft bill which, with changes, was debated in the Lords in 1969. The most recent parliamentary euthanasia debate was in the House of Commons in April, 1970, on a motion for leave to introduce a bill. No statute has been enacted.

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

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

The [English Society's] bill [debated in Lords in 1936 and 1950] excluded any question of compulsory euthanasia, even for hopeless or infantile. Unfortunately, a legislative
At least several observations are pertinent in explanation of the persisting terminological confusion. Some perhaps pertain only to subjective appraisal of the good faith of discussants, but others seem to proceed from the reality that, intrinsically, voluntary euthanasia is not as separable from the involuntary as the clean-cut verbal distinction suggests.

First, the problem of the rights of minors always lurks to compound the difficulties of human forays into life-death decisions unless application to minors is explicitly precluded. Normally decisions respecting serious medical procedures on minors must await parental or guardian approval, although historically there have been exceptions for emergencies and now further exceptions under the impetus of permissive abortion laws. If euthanasia is right, should it be withheld from an intelligent and knowledgeable minor, say one of an age whose judgment would be highly pertinent to judicial decision respecting child custody in divorce cases? And if the minor and parent differ on acceleration of the former's death, whose judgment controls? Confronted with this dilemma, apparently the best that Glanville Williams could do in The Sanctity of Life and the

Criminal Law, was: "The use of an act which may be made of my proposed measure (euthanasia) in respect of patients who are minors is best left to the good sense of the doctor, taking into account, as he always does, the wishes of the parents as well as those of the child." Those skeptical about the vagaries and inscrutability of judicial "discretion" will take note.

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

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

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

Lastly, Glanville Williams' resentment of the "thin edge of the wedge" opposition to euthanasia, however justified in the abstract, loses cogency in the actual context of the movement's strategy and tactics. I submit that Yale Kamisar has convincingly demonstrated that the movement's purpose and method substantially has been utilization of the "wedge" principle. My conviction in this regard has been fortified by my personal observations of how effectively the "wedge" principle has been used in the movement to permissive abortion. I have heard the public protests of the proponents "All we want is this moderate statute" (as they characterized the California one, permitting abortion when the mother's physical or mental health is threatened and in cases of felonious sexual assault) "give us this and we will ask no more." But I heard them simultaneously boasting privately: "Just wait till the door is opened, and our foot is in it!" The boast was not an idle one. A physician has drawn a meaningful parallel: "I don't think that human con-
sciousness and psychology as it exists in our society today could tolerate euthanasia. Yet 20 years ago our society wouldn’t have tolerated extensive abortion. Our mores change.39

The “thin edge of the wedge” danger is real; the camel’s nose does get under the tent; once opened, the movement of the door to death by human choice may be a constantly widening, and likely never narrowing, movement. It seems pertinent to remember that the Hitlerian eugenic euthanasia, the elimination of “useless eaters,” which preceded his wholesale racial genocide, was supported by “humanitarian” petitions to him by parents of malformed children requesting authority for “mercy deaths.” It is perhaps the supreme irony that at first Jews were apparently excluded from the program on the ground that they did not deserve the benefit of psychiatric euthanasia.38

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

A person... in fact (1) presently incurable, (2) beyond the aid of any respite which may come along in his life expectancy, suffering (3) intolerable and (4) unmitigatable pain and of a (5) fixed and (6) rational desire to die... 30

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

More Definition Problems

(i) Euthanasia v. Extraordinary Means to Preserve Life.

(ii) Euthanasia v. Alleviation of Pain by Drugs.

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

The student of this problem, especially one insured to common-law thinking, must be careful lest he assimilate the “extraordinary” — “ordinary” means distinction to our law’s classic differentiation between “action” and “inaction.” The common law’s notion that despite the relative ease of rescue a stranger may safely ignore a person in dire predicament — a drowning child, for example — whereas if he acts St. Luke’s Good Samaritan role and undertakes rescue he is held to the standard of due care,36 does not govern in the typical application of the “extraordinary” — “ordinary” means distinction. Under the common law rule (which by no means is universally accepted)37 a physician may refuse aid to the stranger-victim of an emergency without incurring legal liability, however morally reprehensible his abstenance may be, while in voluntarily rendering aid he incurs the obligation of using due care.38 The way this caused Good Samaritan statutes, exculpating the physician who follows his conscience rather than his convenience, to sweep the country like prairie fire, is a story I have tried to tell elsewhere39 and need not detain us here.

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

Similarly, I maintain that the use of drugs to alleviate pain, even though that use in fact may hasten death, is not “euthanasia” in the modern meaning of direct, deliberate killing, because even in both cases death may be “willed” in the sense of desired, there is a difference in means of abiding significance in the realities of the human condition. Thus I think a provision in the British euthanasia bill of 1969 works a disservice to clarity of analysis when it couples a provision authorizing true euthanasia with one declaring that a patient suffering from an irremediable condition reasonably thought in his case to be terminal shall be entitled to the administration of whatever quantity of drugs may be required to keep him free from pain.41 I submit there is no serious practical question of the present legality of such use of drugs42 nor any genuine problem with its ethicality.43 Daniel Maguire’s recent question equating “positive action” and “calculated benign neglect” has a similar defect. Although in his instance there is at least the justification of an ensuing explicit confrontation with the question’s inuenudo.44

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

Linacre Quarterly

November, 1973
sustain the distinction, let us put aside for the moment. But I should candidly note here that I am not among those inclined to emphasize the moral value of pain. Sometimes the writers, particularly some of the more ancient theologians, seem almost to be arguing that it is, after all, human suffering that makes this the best of all possible worlds! Amidst such mock heroics it is refreshing to turn to the common sense of Pius XII who in his February, 1937 address to the Italian anesthesiologists, after pointing out that the growth in the love of God does not come from suffering itself but from the intention of the will, candidly concluded that instead of assisting toward expiation and merit, suffering can also furnish occasion for new faults. Surely there must be a midground between the exaltation of human suffering as glorious, and the attitude often lived by today that it is the ultimate evil, reflected in the automatic gulp from the aspirin bottle at the mere hint of a headache.

The Ethics of Voluntary Euthanasia

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

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

A warning comes to mind:

It is a great mistake to let people know that moral issues involve religion. If you talk about religion you might just as well talk about politics. Everyone agrees that politics and religion are a matter of opinion. You can take your pick. Let this be clear. When we talk about moral problems we are not talking about religious beliefs — which we can take or leave. Stealing, lying, killing, fornicating would be wrong even if no church condemned them. Hijacking aircraft, tossing bombs into crowded shopping centers and selling drugs to your children are not sins mentioned in the Bible. Nor is euthanasia. So keep religion out of this... I perhaps believe the wisdom implicit in the foregoing when I reveal that the writer is the Archbishop of Westminster, John Cardinal Hennan.

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

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

Lastly, how long would we have voluntary euthanasia without surrendering to pressures for the involuntary? Would not the pressures be truly inexorable? Merely to ask such questions and state these points seems to belie a dichotomy.
between "religious" and "non-religious" reasons for opposing voluntary euthanasia. I see essentially human reasons.72

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

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

Though shalt not kill, but need'st not strive Officially to keep alive.69

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

Natural reason and Christian morals say that man and whoever is entrusted with the task of taking care of his fellowman has the right and the duty in case of serious illness to take the necessary treatment for the preservation of life and health. This duty that one has toward himself, toward God, toward the human community, and in most cases toward certain determined persons, derives from well ordered charity, from submission to the Creator, from social justice even from strict justice, as well as from devotion toward one's family. But normally one is held to only ordinary means — according to the circumstances of persons, places, times, and culture — that is to means that do not involve any great burden for oneself or another. A moral obligation would be too burden some for most men and would require the attainment of the higher, more important good too difficult. In health, all temporal activities are fact subordinated to spiritual ends. On the other hand, one is not forbidden to take more than the strictly necessary steps to preserve life and health, as long as he does not fail in some more serious duty.68

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

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

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

Ordinary means are all medicines, treatments, and operations, which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconvenience.

Extraordinary means are all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit.60

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

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

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

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

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

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

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

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

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

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

November, 1973

247
happiest claim — its historic bulldogged defense of human life. For in result, even when not in motivation, there is more than professional pride and human ego in the physician's struggles. As Gerald Kelley, S.J. put it: "By working on even the smallest hope doctors often produce wonderful results, whereas a defeatist attitude would in a certain sense 'turn back the clock' of medical progress. Also, this professional ideal is a sure preventive of an euthanasian mentality."

Our last, and hardest question, essentially becomes: Is the distinction between letting die, and killing, sound enough to preclude the euthanasian mentality? The Distinction between Killing, and Letting Die, Continues to be Viable, Valid and Meaningful

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

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

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

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

Moral action presupposes science but is itself an art, the art of living. Moral science concerns itself first of all with general principles, as indeed being a science it must; but the subject of morality is not human action in general, but this or that human action, in this or that set of circumstances, and emanating from this or that personality. Hence the fact, remarked upon by Aristotle, that ethics cannot be an exact science.

There is no set of ready-made rules to be applied to each individual case; the principles have to be applied, but this is the function of the virtue of prudence, and with prudence as with art, as Maritain points out, each new case is really a new and unique case, each action is a unique action. What constitutes the goodness of an action is the relation of the mind not to moral principles in the abstract but to this individual moral action. Hence an essential element of quasi-inuition is at least implicit in every willed and chosen action.

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

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

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

Daniel Maquiere in Commonweal recently concluded: "It can be said that in certain cases, direct positive intervention to bring on death may be morally permissible... The absolutist stance opposed to this conclusion must assume the burden of proof — an impossible burden, I believe." This conclusion on burden of proof will I think astound the proceduralist, certainly one of historical orientation, as much as the moralist. For centuries medical ethics has drawn sharp and firm distinction between "positive action" and "calculated benign neglect," to use Maquire's own terms.

The theologian's principle of double effect is an ancient one. In the face of the historical realities, why, suddenly, this reversal of the burden of proof? Hardly because today's logic is sharper; the principle of double effect has been reexamined and criticized by able minds for generations. Do the new psychological insights justify such reversal of the field? Quite the contrary, I submit.

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

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

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

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

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

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

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

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

REFERENCES:
2. Saltonstall Professor of Population at Harvard, in a remarkable paper, Religion: Aid or Obstacle to Life and Death Decisions in Modern Medicine?, furnished me in manuscript form by the Joseph P. Kennedy, Jr. Foundation, Washington, D.C.
8. The sick room under a euthanasia regime has been likened to the goulash-singing scene, in which the executioner we go to the condemned cell, ascertain his weight, his stature, the stringiness of his neck, etc. All of this is ensued upon the judge's doing a black mask behind which he pronounced sentence.
12. Ibid. at 26. 30.
13. Ibid. at 26.
14. Ibid. See also C. Rice, note 10 supra at 81-63; J. Dedek, Human Life: Some Moral Issues 121 (1972); Kamisar, note 3 supra at 1032 n. 213, 1034.

Note how simply the voluntary-involuntary distinction is put in J. Dedek, note 14 supra at 133.
17. Ibid. at 340. The proposed 1969 British bill excludes minors by providing that "qualified patient" means a patient over the age of majority, Death Warrant, App. p. 139.
18. On other occasions I have attempted to show the folly in contending that moral value judgments in the biological area are exclusively for physicians just because they have the technical medical competence, for example, Louiseill, "Abortion, the Practice of Medicine, and the Due Process of Law," 16 C.C.L.A. L. Rev. 233, 245-246, (1969).

Homicides in the manner of the law, fortunately for the legal system, unfortunately may thereby be hastened, is like­

Lina cre Quarterly
November, 1973
pure G. Fletcher, "Prolonging Life." 42 Wash. L. Rev. 999 (1967). In the trial of Dr. Adams for murder in Britain in 1957, the jury considered that "If the first purpose of medicine, the restoration of health, can no longer be achieved there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten human life." Meyers, note 40 supra at 146-47. See also "Recent Decisions," 48 Mich. L. Rev. 1199 (1950); 34 Notre Dame Law. 460 (1959).

43. See note 45 infra.


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

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

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

Now growth in the love of God and in abandonment to His will does not come from the sufferings which are accepted, but from a voluntary intention supported by grace. This intention in many of the dying can be strengthened and become more active if their sufferings are eased, for these sufferings aggravate the state of weakness and physical exhaustion, check the order of soul, and sap the moral powers instead of sustaining them. On the other hand, the suppression of pain removes physical and mental tension, makes prayer easier, and makes possible a more generous gift of self.

If some dying persons accept their suffering as a means of expiation and a source of merits, in order to progress in love of God and abandonment to His will, do not force anyone upon them. They should not be aided to follow their own way.

Where suffering is not so accepted it would be advisable to suggest to dying persons the ascetical considerations set out above. It is to be remembered that instead of assisting toward expiation and merit, suffering can also furnish occasion for faults. (p. 46)

He then pointed out the value and desirability, from a moral and family viewpoint, of retaining full consciousness when dying, if possible, and that the use of narcotics with the sole purpose of depriving a person of consciousness at the end "would not be a notable advance in modern teaching, but a truly regrettable practice." (p. 47)

He also said a dying person should not be rendered unconscious before he has completed his moral obligations. (p. 47) This Address to the Italian Society of Anaesthesiology of February 24, 1957, sometimes in the literature is confused with, or at least not distinguished from, his Address of November 24, 1947 to the International Congress of Anaesthesiologists on "The Prolongation of Life. See Note 9 infra and accompanying text. See also T. D'onnell, S., "Moral Principles of Anaesthesia: A Re-Evaluation," 21 Theological Studies 928 (1960).

46. See note 9 supra and accompanying text.

47. Note 3 supra.

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


50. Note 6 supra.

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

52. Note 3 supra at 974.

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


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

56. Deuteronomy 30:19.

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


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


63. Louiss & Williams, note 26 supra Ch. 8.

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

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

66. See note 42 supra.

67. See note 26 supra and accompanying text.

68. Act v. Se iii.


70. Quoted in Maguire, note 44 supra.

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

Thank Heaven! the crisis-

The danger is past.

And the lingering illness
Is over at last-

And the fever called "Living"

Is conquered at last.

And oh! all the tortures

That torture the worst,

Has abated--the terrible

Torture of thirst.

For the naphthaline river

Of Passion assure:--

I have drank of a water

That quenches all thirst:--

72. Note 59 supra and accompanying text.

Death Warrant. 69.

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

74. Compare the fine distinctions in the French and Swiss law whereby a physician may provide, but may not administer, poison at the request of a dying patient. This is because suicide is not a crime, and therefore to be an accessory to it cannot be criminal; but directly to kill another even from humane motives is still murder. Death Warrant 27-28. In 1961 the illegality of attempted suicide was abolished in English law, but it remains a serious crime for a person to incite or assist another to commit suicide. See note 15 supra and accompanying text.
It would, of course, be unreasonable to assume that juries have been perfectly consistent in choosing the cases where the death penalty is to be imposed or that human institutions perform with perfect consistency. There are double pri-
soners on death row who would be be before there had been tried before differ-
cence jury or in a different state. In this
sense their fate has been qualified by a
fortuitous circumstance. However,
this element of fortuity does not stand
as an indictment either of the gen-
eral functioning of juries in capital cases or
the integrity of jury decisions in
dividual cases. There is no empirical
basis for concluding that juries have
generally failed to discharge their
responsibility described in
Witherspoon—that of choosing between
death and individual cases accord-
ing to the dictates of community values.
difficult task. (p. 529)
86. See Ehrenzweig, Psychoanalytic Jurisprudence §5, passim. (1971).
87. Louissell, note 69 supra. During my recent visit at the University of Minnesota, Mark Wraubard, professor of the history of science (now emeritus), indicated a possible incursion into the areas suggested in this paragraph of the text. I hope it is forthcoming!
89. While I have often thought that permissive abortion is more morally reprehensible than voluntary euthanasia for the aged in that the former cuts off life before it has had its chance, it must be conceded that the self-centered fears and anxieties an euthanasic regime might engender among the elderly (or those in the process of becoming elderly — as we all are) have no exact counterpart in the case of abortion.
90. There is disturbing language in J. F. Kennedy Memorial Hospital v. Boston, 58 N.J. 576, 270 A2d 670 (1971). In upholding the subjection of an adult Jehovah’s Witness, who had sustained severe injuries in an automobile accident, to a blood transfusion necessary to save her life, the Court per Weintrub, Ch. J., said: “It seems correct to say there is no constitutional right to choose to die.” Replying to the patient’s contention that there is a difference between passively submitting to death and actively seeking it, the Court said: “If the State may interrupt one mode of self-destruction (suicide) it may with equal authority interfere with the other.” It acknowledges that “it is arguably different when an individual, overtaken by illness, decides to let it run a fatal course.” Pretreating the question of the free exercise of religion, it seems unfortunate that the Court apparently did not confront more directly the extent of the obligation to use artificial means to sustain life.

Marriage Counseling and The Physician

James T. McHugh

Monsignor James T. McHugh is Director of the Family Life Division of the United States Catholic Conference. He writes a weekly syndicated column for the National Catholic News Feature Service and has written books and articles relating to marriage and the family.

During the past three to five years, there has been a continual effort to revise and update the marriage laws throughout the United States. In too many cases this has become simply an effort to replace current divorce laws with the so-called no-fault statute, and in many other states, the more important aspects of domestic relations law receive less attention because of the debate about no-fault divorce. No-fault divorce laws will receive increasing public attention for the next few years, principally because some type of no-fault legislation has been introduced in several states and has already been adopted in some. Thus it is worth considering this specific legal proposal and the anticipated effects it will have in terms of marriage counseling and the physician’s role.

A model no-fault divorce statute has been developed by the National Conference of Commissioners on Uniform State Laws. The model statute was referred by the American Bar Association to its Family Law Section in 1971. After careful study, the Family Law Section recommended that the ABA withhold endorsement of the model law pending more extensive study, and as of the February, 1972, meeting of the ABA, no endorsement was given.

No-fault divorce is looked upon as a radical departure from the past system. There are no grounds for divorce other than the irretrievable breakdown of the marriage. There is no necessity to determine who is guilty for the breakdown of the marriage, but simply the necessity to verify that it has irretrievably broken down. Most often, this is ascertained from the affirmation by the couple.

The basic difficulties of the breakdown theory are:

1. Establishing objective criteria that can be applied to indicate the breakdown of marriage.
2. Establishing some manageable...