# EUTHANASIA

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Thanks to the progress in modern medicine we live longer and we are healthier. Diseases that once took the lives of infants and children, including smallpox, scarlet fever, measles, whooping cough and so on have been virtually eliminated. Tuberculosis and infantile paralysis, each of which became national and international health issues, are almost unheard of today. Of course, new health problems continue to develop and at the present time national and international concerns are expressed concerning cancer and AIDS (acquired immune deficiency syndrome), with the hope that these diseases will also come under control. Modern pharmaceutical research has produced "wonder drugs" that, together with medical engineering (pacemakers, for example), provide control over ailing parts of the body or less-than-effective body organs. Consequently,the life expectancy patterns have undergone dramatic changes since the turn of the century, so that the child born today has a life-potential of approximately 75 years as opposed to 47 years in 1900.

However, living longer and healthier lives does not guarantee a better or more acceptable death. Indeed, there are those who would argue that modern medical technology provides the means for extending the process of dying, which can be both painful and meaningless for patients, and torturous and financially burdensome for their families. In November, 1975, Max Ferber a Los Angeles businessman wrote an article concerning the death of his wife Irma. It was an angry statement. When he wrote of his tears, he stated that they were shed, not over the fact of her death but for "the ignominious way of her going, the degradation of the spirit that was once her, the flagellation of her body, the torture inflicted by medical ethics and by a society that values the flesh over the spirit." He wrote, "At any hospital, the dedication is heedlessly to prolong life. No, not just to prolong life but to do so by using ingenious devices that not only measure the semblance of life but also confirm that the machinery itself is functioning." He saw this woman with whom he had shared most of his life now entubated and sustained by machinery. His essay was truly a heart-cry. *(The Los Angeles Times,* November 26, 1975; *Reader's Digest,* April 1976.) His plea for a humane and dignified death is only one of thousands which have given rise to euthanasia societies in some 47 countries throughout the world.

The term "euthanasia" is derived from two Greek words: *eu,* meaning "good" and *thanatos,* meaning "death;" therefore euthanasia means "a good death" or an "appropriate" or, perhaps, an "acceptable" death. The concept of an appropriate death is not new, although the notion of just what might be considered to be a good death might vary from time to time and place to place. For example, when the Hebrew monarch Abimelech was injured during an attack on the city of Thebes, he was killed at his own request by a sword thrust delivered by his armor-bearer. He had been

fatally wounded by a millstone dropped from the city wall by a woman. Such a death at the hands of a woman was not acceptable or honorable for a warrior-king. (Judges 9:50-54.) When King Saul was wounded and in danger of being captured and tortured to death by his Philistine enemies, he too requested his armor-bearer to kill him. When the soldier failed to obey, the king fell on his own sword and died. Death by the hand of his fellow-soldier or by his own hand was preferable to death by the enemy (I Sam. 31.) **In** both instances the monarchs sought what they considered to be a good death or a suitable or honorable death.

Generally speaking, there are two kinds of euthanasia: passive and active. Passive euthanasia means that the patient is permitted to die as peacefully as possible without the employment of so-called "heroic" means to sustain or continue life. This "passivity" may refer to the refusal to use mechanical life-support systems on a terminally ill patient - machinery which would keep the patient alive by artificial means. Or it may involve the removal of life-support systems that have been employed to maintain life.

Active euthanasia refers to bringing about the death of a terminally ill patient by active means such as injections of lethal drugs. Active euthanasia is sometimes labeled "mercy killing," but this term is avoided by proponents because of its association with the barbaric acts performed by the Nazis in World War II to eliminate populations that they decided were useless or not worthy of life, including Gypsies, Jews, the old and feeble, etc.

Passive or active euthanasia, performed at the request of the terminally ill patient is sub-labeled voluntary euthanasia. **In** one way or another, the patient, who is assumed to be rational at the moment of requesting euthanasia, has voluntarily assented to the act. Involuntary euthanasia refers to acts performed to terminate a terminally ill patient's life, without that person's consent. **In** such instances, the removal of life-support equipment as in passive euthanasia, usually requires a court order in response to requests by next-of-kin. Of course, involuntary active euthanasia, if performed without court approval, is treated as murder when the act is discovered - as is voluntary active euthanasia. Both passive and active euthanasia are to be distinguished from suicide because the patient does not kill himself or herself. **In** those instances where medication is provided for a patient to commit suicide, the provider may be prosecuted for assisting suicide.

Robert G. Twycross of St. Michael Sobell House, The Churchill Hospital in Headington, Oxford, wrestled with the medical-ethical issues in euthanasia. He stated that:

> "Euthanasia" literally means death without suffering but is now generally defined as bringing about the death of a human being on purpose as part of the medical care being given him. **In** relation to the terminally ill, a more precise functional definition is

> helpful - the administration of a drug (or drugs) deliberately and specifically to precipitate or accelerate death in order to terminate suffering. ("Debate: Euthanasia a physician's viewpoint." *Journal of Medical Ethics,* 1982,8. pp. 86-95.)

He faulted the term "passive euthanasia." Every doctor knows that eventually a patient will die and that there may come a time when the doctor, in treating the patient, may do nothing to prolong the dying process, but focus on comfort care. The term passive euthanasia fails "to distinguish between the aims of acute medicine and those of terminal care. Priorities change when a patient is expected to die within a few weeks or months; the primary aim is then not to preserve life but to make the life that remains as comfortable and as meaningful as possible." He rejected the use of extreme measures on the terminally ill as "inappropriate" and consequently as "bad medicine."

**THE DEFINITION OF DEATH**

There was a time when issues pertaining to life and death appear to have been much simpler than they are today. One was conceived, one was born, one lived one's life, then one died and was buried. Not all lives were easy or happy. Some individuals were born healthy and well-formed; others were sickly from birth or malformed. For some, life was bounteous; for others existence was bound in "shallows and in miseries." For some death came easily during sleep or with suddenness; for others the dying process was marked by prolonged pain and suffering. But when the heart ceased its beating, and breathing stopped, the person was pronounced "dead" and was prepared for burial.

True, there were misdiagnoses. Medical personnel followed the accepted practices of the day: they listened for heartbeat or they placed a feather on the upper lip to see if the faintest breath might cause it to quiver. They assumed that the inability to hear heartbeat or the evidence of lack of breathing signified death. However, as exhumations were to demonstrate, some persons were buried alive. They had not been dead but were in a deep coma. They awakened in their tombs as the cloth and wooden linings of the coffins, shredded and scarred by clawing, were to demonstrate. One can appreciate those who provided for sepulchral alarm systems, so that should they waken in the grave they might pull a cord to ring a bell and summon aid.

Modern medicine has moved far beyond those dark days. Electrical monitors can register the faintest of heartbeats and a failing heart can be reactivated. Breathing can be made to begin again. Cardio-pulminary treatment, mechanical heart and lung machinery, drug stimulants can re-energize the body and keep it functioning resulting in miraculous revivals of life. For example, in January 1977, in Boston, Joseph Rue was thought to be dead. He had been found in a hallway of a downtown building where he had attempted to sleep off his alcoholic overdose. Ambulance attendants could discern no pulse. At the Boston City

Hospital, the electrocardiagraph registered no heartbeat. There were no reflexes, the eyes did not respond to light. Rue had suffered hypothermia and had a body temperature of 80 degrees. The medical staff inserted tubes into his lungs to help Rue breathe. Warm fluids were pumped into his body. He was wrapped in an electric blanket and external heart massage was initiated. Rue's temperature began to rise and his heart started to beat. Further testing indicated normal reflexes and, apparently because the low body temperature had slowed his metabolism there was no brain damage. The rescue operations took 2 1/2 hours (Associated Press report in *The Los Angeles Times,* Jan. 21, 1977.) **In** an earlier age, Rue would have been registered as "dead" and might have been one of those unfortunate persons who was buried alive.

One of the most serious problems confronting modern medicine is an appropriate and an adequate definition of "death." The simple notion of "not living" can no longer serve, because persons who apparently have "died" have been revived; and there are those whose bodies can carryon normal functions, but who have suffered brain injury and are permanently unaware of the external world. Were the revived persons truly dead? Are those who are in permanent coma alive?

It is not surprising to discover that a variety of death terms have been developed including: clinical death, biological death, psychological death, spiritual death, cerebral death, brain death, neocortical death, cardiac death and so on, each seeking to define precisely some dimension of the death process. Cardiac death may explain how the death came about-through cardiac arrest - but neocortical death indicates that only part of the brain is not functioning.

Perhaps the best known case of partial brain death is that of Karen Ann Quinlan, a 21-year-old woman, who lapsed into a coma on April 14, 1975. She had been on a crash diet and without having eaten all day attended a party where she drank a few gin-and-tonics and later took aspirin and a therapeutic dose of tranquilizer. Shortly afterward she lapsed into a coma, the true cause of which was never determined inasmuch as the drugs and alcohol were deemed insufficient causes. Within a month, her body had shrunk to a mere 70 pounds and was contorted into a gross simulation of the fetal position. Her life was sustained by machines that pumped air into her lungs and tubes that fed her and delivered antibiotics into her system. Neurologists determined that she had entered into a rigid, irreversible vegetative state and that her cognitive brain functions had ceased. Only the parts of the brain controlling her breathing, facial movement, blood pressure and heart rate, and to some degree her body temperature were still functioning. It was clear that Karen would never recover the use of her brain and that her twisted limbs would never untwine. She was, medically speaking, "brain dead", she would never be cognitively aware.

On July 31, her parents requested that the respirator be removed and that Karen be permitted to die. The hospital authorities and the doctor, although sympathetic, refused inasmuch as Karen was of age. And since her parents were not her guardians, they could not authorize the removal

of the respirator - only Karen could do that and she was in coma. The lower courts upheld the decision, but on March 31, 1976, the Supreme Court of New Jersey reversed the decision and established the first right-to-die ruling in legal history. Despite the Supreme Court ruling the hospital and physician in charge did not drastically alter their treatment - indeed, in May, a temperature control device was added as a technological support. On May 17th, all support machines were removed, but Karen continued to live, breathing on her own. Her life and death were now under the control of her own body, augmented of course by hospital care and feeding. She died in 1985.

The Quinlan case produced a veritable flood of newspaper and magazine articles, scholarly and professional commentaries, letters to editors, case history reports, and raised a number of legal, ethical and moral issues. An individual's right to die with dignity became a subject for study in medical circles. In December, 1973, two years before the Quinlan case, the House of Delegates of the American Medical Association adopted the following statement:

> "The intentional terminationoflife of one human being by another - mercy killing - is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association. The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/ or his immediate family. The advice and judgment of the physician should be freely available to the patient and/ or his immediate family."

For some doctors, the decision to stop treatment and remove life-sustaining equipment comes hard. They view their medical task as concerned with health and healing and with the prolongation of life, not with the taking of life. Some are eager to employ almost any technological or medical knowledge to sustain life. Death is the enemy, and when a patient dies, the enemy wins.

There is also concern in the medical community about possible legal issues, and these concerns are not without foundation in fact. For example, in 1979 Brother Joseph Fox, an 83-year-old Marianist Brother suffered cardiorespiratory arrest after a routine hernia operation and the administration of 10 mg. of valium. Heart massage restored the beat, but during the arrest, insufficient oxygen reached the brain and Bother Fox suffered massive brain cell destruction which reduced him to a chronic vegetative state. He was not able to speak, hear, move, think or recognize anyone, and was able to perform only the most primitive digestive processes. Brother Fox had previously made known his repugnance toward life in this state and the Marianist Brothers requested that the life support equipment be removed and that Brother Fox be permitted to die naturally. The Nassau Hospital officials refused the request, and the

County District Attorney, pressured by right-to-life groups warned that whoever disconnected the life support apparatus would face prosecution for homicide.

The Marianist Brothers petitioned the court and the trial ended with support for their position. However, the District Attorney appealed to the Appellate Court which upheld the early decision. Again the attorney appealed - this time to the New York Court of Appeals, the highest court in the state. Before the case was heard, Brother Fox died. But the message was clearly given to the medical profession: there was jeopardy in passive euthanasia.

To add to the dilemma, the courts have not always been consistent in their rulings. In December, 1975, Duval County Circuit Judge John S. Cox in Jacksonville, Florida, ordered that Mrs. Cecilia Cain's respirator be disconnected for 45 minutes so that Mrs. Cain might be permitted to die as her husband had requested. If the woman continued to show signs of life after that time, the machine was to be reconnected. There were no such signs and Mrs. Cain died *(Los Angeles Times*, Dec. 5, 1975.) Just one month earlier, Circuit Court Judge William Corrigan in St. Louis County, Missouri, ruled that doctors could not shut off the life support systems as requested by Gary Debro, husband of Judith Ann Debro who had been in a coma for three months following an automobile accident *(Los Angeles Times,* Nov. 28, 1975).

To help alleviate the possibility of litigations, a directive to physicians called "The Living Will" came into being. This document makes it possible for an individual to express his/ her wishes for removal of life support systems in instances where the support system would prolong artificially the moment of death and to ask that pain relieving drugs be employed to give relief from pain. The opinions of two physicians are required for action. Copies of the will are presented to the family physician to determine the doctor's willingness to comply, and other copies are given to family members and perhaps also to the family lawyer to ensure enactment. In 1976, the Governor of California signed into law a highly controversial law permitting terminally ill patients to order an end to life-sustaining efforts after they had been initiated. Similar laws have been passed in other states.

A second important document known as A Durable Power of Attorney for Health Care adapts an idea from commerce and industry to the self-regulation of dying. The power of representation, whereby another acts for a person in the event of incompetence or in the event that an individual is unable to make decisions, permits the assigned person to make health-care treatment choices. Both the Living Will and the Durable of Attorney for Health Care documents are designed to render the physician safe from prosecution while at the same time providing a potential patient with the feeling of having some control over life-death decisions.

There are those who, for personal religious, moral or ethical concerns refuse to have anything to do with passive euthanasia, despite the

widespread support for the idea. Some suggest that the practice might be abused and that unwanted persons, undesirables, rich relatives whose continued existence deprives heirs of anticipated inheritances, and so on, might wrongfully be consigned to death. Supporters argue that any such violation of the principles involved would be tantamount to murder and would be subject to prosecution. Some object on the basis of the so called "slippery slope" argument, suggesting that although the concept may sound perfectly acceptable in its present form there is always a possibility that the regulations could be made to include any person or group deemed undesirable and the prime example is, of course, the extermination policies of Nazi Germany. Proponents claim that this is a specious argument and that proper safeguards can protect against such broadened interpretations. Most religious groups support the idea of passive euthanasia, and indeed, when Karen Ann Quinlan's family struggled with this issue, at every step they had the support of their Roman Catholic clergy.

Some protests have centered in the argument that medicine has its limits and that it is possible that a person might recover and not die no matter what one or two or more doctors might think. And there have been such cases. For instance, Carol Dusold Rogman of Union, Illinois, was injured in a motor accident in 1966 when she was 19-years-old. Her brain stem was severely bruised and her left arm broken. For four months she was in a coma and was fed intravenously. This woman, who had been high school homecoming queen, now wasted away to 65 pounds and her body was twisted grotesquely. Today she is married and is the mother of a child. Apart from a mild speech impediment and a permanently twisted left hand, she functions normally. Her recovery came despite the fact that she had been diagnosed as being in an irreversible coma. Through patient care by a devout family and work with therapists she was taught to sit, stand, walk and speak again. There are just enough of such cases to give physicians pause.

Perhaps the most significant issue to arise from the employment of modern medical skill and knowledge is the determination of death. Just when is a person to be classified as "dead"? **In** the August 5, 1968 *Journal of the American Medical Association* (Vol. 205, pp. 337-340) the report of Ad Hoc Committee of the Harvard Medical School to examine the definition of brain death was published. The purpose was "to define irreversible coma as a new criterion for death." The research was prompted by the fact that improved "resuscitative and supportive measures" for patients severely injured sometimes produced only partial success resulting in the restoration of heartbeat in an individual "whose brain is irreversibly damaged." As a result, immense burdens were placed on the patient, the families, the over-worked hospital staff and facilities. What was of equal importance, was the need to be able to give assurance that the patient was dead before organs were removed for transplanting. The committee focussed on "only those comotose individuals who have no discernible central nervous system activity."

The criteria proposed were as follows:

I. Unreceptivity and unresponsivity, which implies total unawareness of external, even the most painful, stimuli, which evoke no vocal (not even a groan) or other response including quickening of respiration or limb withdrawal.

2. No movement or breathing after the respirator has been turned off for a three minute period and no effort to breath spontaneously.

3. No reflexes such as non-pupil response to bright light, no evidence of swallowing, yawning, vocalization, etc.

4. A flat (isoelectric) electroencephalogram.

These procedures, conducted by a physician should be repeated and record no change within a 24 hour period. If all criteria are met, the patient is, for all practical purposes, presumed to be, medically speaking, dead.

The Harvard criteria, which has been widely accepted with, perhaps, some minor adjustments, provides the family and the medical staff with needed criteria for making decisions. The other side of the issue involves patient's rights. For example, have all reasonable treatments been employed and is there any possible hope that the condition might be reversed? What are the expressed wishes of the patient - and in this instance, the signing of a Living Will or the designation of some one having the Durable Power of Attorney is significant. Another significant patient "right" includes the right to honest, complete and accurate information. Without such data the patient is unable to make clear. judgments about his/ her future, nor can the patient have a proper or adequate understanding of medical staff expectations. If patient rights have been observed and if the Harvard criteria is used to determine death, the potential for successful organ transplantation is greatly increased. If a "donor card" has been signed, many body parts can be utilized to rescue others. For example skin may be grafted onto burn victims or onto open wounds. Although skin must be "harvested" quickly through a freezing process it can be stored successfully for up to six months. Fresh bone marrow, though limited in use by the need for complete identity (rather than mere compatability) and potential host rejection has important uses. Corneas, hearts, lungs, kidneys, and livers are all transplantable and m~dical science is at the edge of successful transplantation of endocrines, spleens and intestines. The determination of death is important, not only for the patient, the patient's family, the hospital and its staff, but also for the potential saving of lives of others through the transplanting of body parts.

SOME MEDICAL/MORAL ISSlIES.

Professor C. K. Drinkwater of the Department of Family and Community Medicine, University of Newcastle-Upon Tyne, in 1977, in discussing a case where the patient was suffering terminal presenile dementia (which today would probably be labeled Alzheimer's disease) and who subsequently suffered congestive cardiac failure, suggested that the case could be seen to

demonstrate a clash between two moral beliefs. On the one hand, everything possible should be done to prolong the man's life, and on the other the quality of the man's life could sometimes be considered more important than life itself. ("Case Conference" *Journal of Medical Ethics,* 1977,3,189-193.) He could envisage three legal codes that might be applied to such a case "by three different societies or by the same society at different stages in time." They were:

> I. Everything possible should be done to prolong life.
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> 2. Given certain safeguards an individual should, in certain circumstances, have the right to choose whether or not to die.
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> 3. The individual may be sacrificed for the sake of the group.

He pointed out that at present the first position is favored by law. This means, that anyone who directly or indirectly, or by any means causes the death of a person commits homicide. However, he notes that the second position, which provides for individual autonomy, is gaining favor. The California Natural Death Act which has been enacted in other states is clear evidence of this change in mood. The fact that in many countries, including the United States, suicide is no longer a crime (although assisting in suicide is) is further evidence. The third position is in effect in those nomadic groups that abandon the elderly or infirm when they cannot keep pace with tribal migrations (as in certain parts of Iran). Our own society, whenever it chooses not to expend funds on expensive life-prolonging machinery, actually sacrifices individuals for the sake of the group. Positions one and two deny the individual autonomy, either by insisting upon keeping the patient alive despite his/ her wishes, and so does the third by deciding who to save and who to to let die - a choice that is to be made by experts - the physicians or some decision making group.

The moral dimensions may assume different proportions when the issue of terminal illness moves from the theoretical to the personal and when intractable pain is involved. A letter from Dr. Frederick Stenn was published in *The New England Journal of Medicine,* Vol. 303, No. 15, October 9, 1980, p. 891. The title given was "A Plea was Voluntary Euthanasia" and the plea was moving and personal. Dr. Stenn wrote:

> "As one who has had a long,full, rich life of practice, service and fulfillment, whose days are limited by a rapidly growing, highly malignant sarcoma of the peritoneum, whose hours, days and nights are racked by intractable pain, discomfort, and insomnia, whose mind is often beclouded and disoriented by soporific drugs, and whose body is assaulted by needles and tubes that have little effect on the prognosis, I urge medical, legal, religious and social support for a program of voluntary euthanasia with dignity.

> "Prolonging the life of such a patient is cruelty. It indicates a lack of sensitivity to the needs of a dying patient and is an admission of refusal to focus on a subject that the healthy cannot face. Attention from the first breath of life through the last breath is the doctor's work; the last breath is no less important than the first.
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> "Consent by the patient with a clear understanding of this act, by the patient's immediate family, by the family physician, lawyer, minister or friend should violate no rules of social conduct. There is no reason for the erratic, painful course of the final events of life to be left to blind nature. Man chooses how to live; let him choose how to die. Let man choose when to depart, where, and under what circumstances the harsh winds that blow over the terminus of life must be subdued. "

There is no room for debate in this letter. The call is for response to human suffering and human need. The core issues involved include the freedom to make choices while recognizing the legal, religious and ethical debates that can rage within the medical community concerning what is good and what is bad medicine.

For some doctors, one phrase in the Hippocratic oath stands out: "I will give no deadly medicine to anyone if asked nor suggest any such counseL." For others, this oath which was formulated somewhere between the 6th and 1st centuries Before the Common Era, reflects the medical situation of a different time and place, and cannot be used as anything but a nostalgic reminiscence of medical principles. Modern medicine must deal with present day realities.

Religio-moral principles are also invoked against euthanasia. For example the commandment against homicide (5th in Jewish-Protestant codes, 6th in Roman Catholic reckoning) which is generally translated "Thou shalt not kill" underscores the sacredness of life and supports the notion that because "God gave life" only God should be able to take life. **In** those societies where the "law of karma" is accepted, it can be argued that terminal suffering is not only part of the patient's fate based on acts in a past life.and preparation for a future life, but that interfering with that karma can affect not only the patient's future existence but also the next-life existence of the doctor or those who interfere. Those who would prefer the term "nature" to God, can justify intrusion into the cycle of suffering. Those who do not accept the karmic cycle beliefs can and do dismiss them as irrelevant.

As Daniel C. Maguire, Professor of Theology at Marquette University, Milwaukee, Wisconsin has pointed out:

> "Medicine cannot distinguish between good death and bad death. As medicine has developed, it is geared to promoting life under all circumstances. Death is the natural enemy of the healing sciences:'

Death, however, can at times be a welcome deliverence from a situation that has ceased to be bearable. Pneumonia has been referred to as "an old man's friend" since it often served, in days of simpler science, to shorten the old man's final agony. Actually it was death that was the friend, pneumonia merely gave access to it. Now course, pneumonia usually can be contained and the old man lingers on in agony. *(Nursing Digest,* October 1974, p.38)

He notes that there is "a big difference between not treating pneumonia, and overdosing a patient to accelerate the death process." Although there is a difference between acts of commission and omission with, perhaps, "a potential for radically different moral meanings, they have a suggestive similarity in that in both cases, someone is dead who would have been alive if a different decision (to act or not to act) had been made."

**QUALITY OF LIFE / QUALITY OF DEATH**

Sometime during the 2nd century of the Common Era, the Stoic philosopher Marcus Aurelius wrote:

> "Do not despise death,but be well content with it,since this too is one of those things which nature wills. For such as it is to be young and to grow old, and to increase and reach maturity, and to have teeth and beard and grey hairs and to beget, and to be pregnant and to bring forth, and all the other natural operations which the seasons of thy life bring, such also is dissolution." *(Meditations,* Book IX, Section 3)

His concepts appear cool and removed from terminal suffering or the agony of intractable pain. He is thinking of a quiet and peaceful death, which all of us crave. He does not, as Dylan Thomas urged his father, suggest that one should "Rage, rage against the dying of the light." He does remind his readers of the obvious fact that death is part of the life cycle.

By what standards does one determine the value of life? What is it that gives meaning to existence? What are the basic principles that determine the quality of life? According to what might be termed "perfectionist" standards, one might list the minimal qualities, and to whatever degree these minima are exceeded to that degree life becomes more valuable. For example, Plato proposed the balance of reason, desire and spirit. Aristotle emphasized reason. Modern psychologists speak of self-actualization while Kant looked to reason and autonomy. More popular standards include such things as self-awareness (as opposed to coma state), memory (as opposed to dementia), the ability to give and receive love, the potential

for communication and conceptual thinking. Some would add physical mobility and perhaps, also, happiness, however defined.

If one prefers a utilitarian standard, then pertinent issues would include fulfillment (as opposed to non-fulfillment); creativity (as opposed to non-creativity); a socially contributory life (as opposed to a non-contributory existence), a life marked by pleasure (as opposed to one characterized by pain, unless that pain could be envisioned as contributory). Insofar as the good and pleasant and contributory exceed the evil and unpleasant and non-contributory that life can be envisioned as worthwhile.

Some would look to religious interpretations for determining the values of life and death. In biblical times, disease was considered to be an act of God, and indeed, in some insurance policies, natural disasters are still labeled in this way. The plague or personal illness came as a punishment for some imagined disobedience to divine will. Personal illness could be interpreted as testing by the deity as in the case of Job. But all of this was before the time of Pasteur and the discovery of microbes, and the subsequent understanding of natural causes of disease. But much modern religion is burdened by the reasoning and interpretations of the ancient past, hence opposition to euthanasia may rest, in part, on outmoded notions concerning illness and disease.

Some would hold to the idea that life is a gift of God and that the proper time to die is "when God summons the person home." Should that summons entail agony and suffering, church teachings can accept pain medication and the abandonment of "heroic" means to sustain life but refuse any possibility of active euthanasia. Indeed, even the suffering can be given a theological interpretation. For example, in the Vatican's Declaration on Euthanasia, publicized in 1980, it was stated that ..... suffering during the last moments of life, has a special place in God's saving plan; it is in fact a sharing in Christ's Passion and a union with the redeeming sacrifice which he offered in obedience to the Father's will. Therefore one must not be surprised if some Christians prefer to moderate their use of painkillers, in order to accept voluntarily, at least, a part oftheir sufferings and thus associate themselves in a conscious way with the sufferings of Christ crucified." The edict does not forbid the use of palliatives nor does it disparage passive euthanasia. What it does do is place a premium on voluntary suffering, suggesting that there is some spiritual merit to be gained.

Some, in keeping with karmic theology, believe that terminal suffering is part of the individual's fate and is related to that which transpired in a past existence with potential influence extending into the next incarnation. Indeed, not only is the patient's suffering to be endured without interference, but should anyone dare to interrupt the fated pattern, that person's karma would also be affected. Not everyone finds solace in these theories, not only because there is no way of validating what is proclaimed as divine will nor in proving reincarnation and karma. Indeed so-called spiritual identification or submission to fate do little to ease the reality of pain and suffering. Few find nobility in personally writhing in pain and agony or in watching a loved one suffer. Modern medicine employs pain

relievers which may be helpful in making death more dignified, but even these drugs can fail or can keep the patient in a stupor. What particular quality is to be found in dying in a drugged or coma state with senses numbed and communication with loved ones and the outside world nullified?

The crucial question concerning the criteria for quality-of-life decisions has been raised by many, for on that determination some would be swayed toward continuation or discontinuation of life-supporting therapy. Dr. Anne J. Davis, a nurse-ethicist in commenting on a controversial case noted:

> "... the quality of life is a more recent ethical principle that has emerged as technical capabilities have developed. This principle considers qualities of life a particular patient now has, actually or potentially, versus the qualities he deems to be normative and desirable. The quality-of-life criteria, ideally, should center on benefits to the patient. In some instances, to initiate treatment to prolong dying or postpone death is nonbeneficial to the patient. It can be ethically argued that, in some instances, to preserve life could be a dishonoring of the sanctity of life itself.
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> "But who is to make this decision and on what ethical principle? The family and doctor, in this case, may hold that the sanctity of life is a higher principle than the quality of life. The nurse seems to lean toward the quality-of-life principle. The particular situation is complicated further by the fact that the patient's mental status is unclear.
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> "Only if the patient is competent to make decisions can he act autonomously as a moral agent and make his own ethical decisions. If the patient is not competent to make his own decision, then the questions are who can act in his best interest and what is his best interest- the sanctity or quality of life?"("To Make Liveor Let Die", *American Journal of Nursing*, March 1981, p.582)

Of course, for patients under age, parents and guardians may act in their behalf, although decisions to withhold or withdraw treatment may be rejected by hospitals and physicians and may ultimately be decided by courts of law. Those cases in which the patient is competent may also be controversial.

The last question raised by Dr. Davis has been answered recently by the legal acceptance in some states of the document known as "The Durable Power of Attorney".

**LEGALIZATION OF EIITHANSIA**

Despite the protection afforded by Living Wills and Durable Power of Attorney statements, there are physicians and hospitals that balk at terminating treatment for terminally ill patients. Euthanasia societies urge potential patients to be sure before hospitalization what the medical policies of physicians and hospitals are lest their wishes to be permitted to die be ignored. At the same time, efforts are underway to legalize euthanasia in Holland where euthanasia is commonly permitted by the courts; in California where a ballot-referendum is being sought to permit physician assisted suicide, and in England and Australia.

The concept of physician assisted suicide is troubling to some physicians. Others admit to giving huge overdoses of morphine "to alleviate pain" knowing full well that the dosage, while cause-slowing of respiration and other vital functions, will ultimately cause death - as would any other massive narcotic overdose. In other words, some physicians actually practice active euthanasia, but disguise the act or re-Iabel the act as pain medication. The disguised act may cover both the fact of killing a patient and the doctor's uneasiness, but the denial continues to leave the issue of euthanasia in limbo. There can be no question that the efforts to legalize euthanasia will be met with stiff opposition on the grounds that taking the life of another, even with that person's permission or because that person is in intractable pain and requests aid-in-dying, is murder and murder is murder no matter how compassionate the crime may be.

There is also deep concern about the potential expansion of legalized killing so that it might extend beyond dealing with the voluntary death of the terminally ill in intractable pain. Despite the protestations of supporters of active euthanasia that properly articulated laws and careful observance of the laws can protect against such potentialities, there are sociological issues to be reckoned with. For example, studies concerned with the graying of the world's population, estimate that by the year 2025 the number of persons 100 or more years of age will increase in the United States alone from the present 25,000 to 400,000. Even today we are increasingly aware of the problems associated with coping with the medical needs of the debilitations associated with old age. The costs could become staggering. Even today we face difficulties in meeting the medical needs of our total population and of the aged; in the future, if the burden increases, some selective processes may well be set in motion. Mentally defective newborns might be at risk.Severely disturbed mental patients might also come under judgment. As population continues to expand, the fears of extension of euthanasia patterns could be considered - hence the fears of those who warn againt present law becoming "the thin edge of the wedge" or "the slippery slope" must be heeded.

But the present is upon us and there continue to be those who are in irreversible coma or in intractable pain and whose illness is terminal. Their pain and their unhappy situation affects their families and their caretakers. From time to time, loving, devoted, caring family members take steps to stop the pain or terminate the coma state by killing their loved ones.

Much of the time the act is done in secret; occasionally the distraught loved one acts impulsively and kills by some easily detectable act. When the killing is overt the courts may punish severely or with compassion. Some doctors give massive narcotic overdoses to relieve pain and to kill the patient, and again the act, no matter how compassionate, is murder and must be accomplished covertly. The present may affect the future but it should not control it. At present there is desperate need for assistance in dying for some patients in irreversible coma or in intractable pain in terminal illness. It should be possible to design legislation that will maximize human freedom so that an individual might have some control over his/ her death and to design that legislation to protect the lives of those who might become victims to greed, or anger or some other human weakness. These same laws can offer guidance and protection for future situations which can only be imagined at present while permitting the future to develop its own criteria and responses to human life-death problems.

## HUMANISM AND EUTHANASIA

In a recent study of the attitude of various religious groups to euthanasia, only one supported the notion of active voluntary euthanasia - the Humanists (see Gerald A. Larue, *Euthanasia and Religion,* Los Angeles: The Hemlock Society, 1985). In 1973 the American Humanist Society published its position in Manifesto II:

> "To enhance freedom and dignity the individual must experience a full range of civil liberties in all societies. This includes freedom of speech and the press, political democracy, the legal right of opposition to governmental policies, fair judicial process, religious liberty, freedom of association, and artistic, scientific, cultural freedom. It also includes a recognition of an individual's right to die with dignity, euthanasia and the right to suicide.

In the July/ August, 1974 issue of *The Humanist* m~gazine "A Plea for Beneficent Euthanasia" was signed by distinguished humanists.

Indeed, as early as March 3, 1963, Algernon D. Black, a Leader in the Americal Ethi~al Union addressed the New York Ethical Culture Society in a Platform address and called for "spiritual freedom" which embraced "the right of an individual to decide how he will live and how he will die." Other Leaders in the organization have supported this position. As Black noted, humanists "do not look back 3,000 or 2,000 years for answers on contemporary problems or specific questions of ethics." It is the present orientation of the movement that is its strength that makes it possible to confront problems of death and suffering without theological preconceptions.

The idea of active voluntary euthanasia is attracting followers. In the United States only the Hemlock Society of the three euthanasia

organizations openly supports the concept. Hemlock has even gone so far as to produce a book, edited by Derek Humphry titled *Let Me Die Before I Wake* (1982) in which case histories are given together with the proper dosages of lethal medications necessary to kill. No other American society has gone so far. At a recent World Congress of Right-to-Die Societies, it became clear that support for active voluntary euthanasia was gaining ground. Humanists are in the forefront of this progressive development.

## THE AFTERMATH

How do those who have helped loved ones die by acquiring the necessary medication or administering the lethal injection feel after it is over? It is satisfying to note that none with whom 1 have talked have any regrets. They may be sorry that they cannot talk openly about what they have done because of possible legal problems, but they feel happy that they were able to help someone they cared about find release from agonized dying.

Perhaps an example will clarify the issue. Several years ago 1 received a phone call from a university professor in Canada. Her mother was dying of cancer and was in agony that could only partially be resolved by palliatives that left her groggy and semi-comotose. The woman asked: "What can I do?" How could I advise someone whom I had never met and who lived thousands of miles away? I said "Talk to your doctor."

The next few days were troublesome ones for me. Finally I phoned the hospital room (I had all the necessary telephone numbers) and the professor answered. She said, "I am so glad you phoned. I have just given my mother the lethal injection." I asked what was happening. "She is completely relaxed, her breathing is getting shallower and she has that wonderful little smile on her face."

She related what had occured. After 1talked with her she spoke to her doctor. "This morning he came down the hall and put a syringe in my hand and said that he never wanted to talk to me about this again." The professor had time to talk with her mother, to achieve a warm and loving closure, and to assure her mother that she was about to fill her mother's often repeated request to be let die, to be released from pain. About 15 months later she was in California attending a conference and we met. She was radiant. She had expressed her love in a positive caring way. She had shortened the time of suffering. She had no regrets, no guilt, only peace and joy in the knowledge that this act of death was an act of love.

On the other hand I have met those who failed to provide release for loved ones and I have been moved by the guilt and the pain they carry within themselves. At a Right-to-Die Congress at Oxford, England, a great rugged Norwegian told of the anguish he had carried for years and was still carrying because he had failed to help someone very close and very dear to him die, but instead let that person writhe in pain until merciful death released him. In Arizona, a man who had not helped his wife die when she was terminally ill and in unremitting pain said over and over again, "She screamed. She screamed during the day. She screamed at night. She died

screaming. And I did not help her." In my limited experience, I have found that those who have assisted a loved one through euthanasia are far healthier and more content than those who feel they have failed to respond to pleas for aid in dying.

Finally, the medical doctors with whom I have talked, who have in one way or another practiced active euthanasia at the request of their patients are convinced that they have acted in accord with the noblest ideals of their medical therapeutic commission. They carry no guilt because they have responded in terminal crises by providing the best treatment for their suffering, terminal patients.