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Euthanasia and Biathanasia: On Dying and Killing

David W. Louisell*

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 pervasive in popular usage. It has come to mean the

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Professor David W. Louisell returned to the Catholic University Law School after a 22-year absence (he taught Evidence here 1947-50 while practicing in Washington), as the 1972 Pope John XXIII guest lecturer. Professor Louisell departed from both his outstanding work on Evidence and Procedure and the usual substance of law review commentary to provide a fresh and deft handling of what he sees as, and we agree, a coming enigma with which the legal profession must come to grips. We of the Catholic University Law Review take great pleasure in publishing the 1972 Pope John XXIII Lecture, Euthanasia and Biathanasia: On Dying and Killing.

1. 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" and 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 exacerbate 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 impulses 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
deliberate, intended painless putting to death 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, *benemortasia.*

*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. Does this include such a killing only when it is sought and requested by the euthanatee or one imposed upon him without regard to his consent—the elimination of defective or hopelessly ill or senile persons, such as Hitler’s “useless eaters?” In a word, is the definition directed against 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 voluntary euthanasia, with argument pertinent only to the involuntary kind. For example, during a debate on a 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.

Looking below the surface of the voluntary-involuntary dichotomy may

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*Based on program of KNXT-TV, Los Angeles, April 23, 1972, and ensuing unpublished information. For a comparable story, see On the Occasion of a Death in Boston, N.Y. Times, Oct. 23, 1972, at 31, col. 2.

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.

render the purist more understanding of the reasons for the confusion and more tolerant of the confused; a page of history may 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 over generalize about customs of euthanasia among primitives, for many societies have actually been shown to have had elaborate codes protective of their senior members. “Instances of this are seen in hospitality customs, property rights, food taboos reserving certain choice dishes for the aged [ostensibly as harmful 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 Old Testament Hebrews forbidding the killing of the innocent and just. In classical Greece, there does not seem to have been abandonment of elderly or helpless adults. In ancient Rome, largely under the influence of the Stoics, suicide was an accepted form of death as an escape from disgrace at the hands of an enemy, as, indeed, it was until recently in Japan under the form of hara-kiri. Yet Cicero—who wrote that “The God that rules within us 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 interpreted 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 of the group now known as the Voluntary Euthanasia Society in 1935. The first bill on euthanasia was brought before the British Parliament in 1936. To be eligible for euthanasia, the patient had to be over twenty-one years of age, suffering from an incurable and fatal illness, and sign a form in the presence of two witnesses asking to be put to death.

5. Id. at 21.
bill 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.\(^7\)

In his classic, *The Sanctity of Life and the Criminal Law*,\(^8\) Professor Glanville Williams, realizing the practical necessity of countering the contention that too much formality in the sick room would destroy the doctor-patient relationship, 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.\(^9\)

This proposal formed the basis of the 1968 draft bill which, with changes, was debated in the House of 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.\(^10\) But to date 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.\(^11\)

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.\(^12\)

In any event, there is today no country in the world whose law permits euthanasia either of the voluntary or involuntary type.\(^13\)

In view of the facial restrictions of the current euthanasia movement to the voluntary type, why 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 hopelessly

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11. *Id.* at 26, 30.
12. *Id.* at 26.
13. 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. *Death Warrant* 27. Apparently the law of Texas is in accord. See R. Perkins, *Criminal Law* 67 (1957).
defective infants. Unfortunately, a legislative proposal is not assured of success merely because it is worded in a studiously moderate and restrictive form. The method of attack, by those who dislike the proposal, is to use the "thin edge of the wedge" argument . . . . There is no proposal for reform of any topic, however conciliatory and moderate, that cannot be opposed by this dialectic.\(^\text{14}\)

At least several observations are pertinent in explanation of the persisting terminological confusion. Some pertain only to subjective appraisal of the good faith of discussants, but others proceed from the reality that voluntary euthanasia is not as intrinsically severable 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 even further exceptions under the impetus of permissive abortion laws. If euthanasia is right, should it be withheld from an intelligent and knowledgeable minor, one whose judgment might 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 argue, was: "The use that 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."\(^\text{15}\) Those skeptical about the vagaries and nebulousness of judicial "discretion" should take note!\(^\text{16}\)

Second, voluntary euthanasia by definition 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 it may be with respect to the execution of a will; or commitment as potentially dangerous; or responsibility for criminal conduct—whether

\(^{14}\) THE SANCTITY OF LIFE, 333-34. Note how simply the voluntary-involuntary distinction is put in J. Dedek, HUMAN LIFE: SOME MORAL ISSUES 133 (1972).

\(^{15}\) THE SANCTITY OF LIFE 340, n.8. The proposed 1969 British bill excludes minors by providing that "qualified patient" means a patient over the age of majority. DEATH WARRANT, App., at 139.

under the M'Naghten, 17 Durham, 18 Model Penal Code, 19 or diminished responsibility test; 20 or capacity to stand trial. 21 The determination of competence in such a context might be even more emergent and difficult than its conventional determinations and the significance of error even more dire in its irreversibility. Moreover difficulties might be compounded by the inhibition on free choice inherent in subjection to pain-killing drugs. 22

Third, 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 [throes 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?’ ” 23 Would a confession made in such circumstances be admissible?

Fourth, what of the proposed euthanatee who is unable to communicate for himself? 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 24 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. 25 After all, an adult under no legal disability has no natural guardian. The 1969 British bill partially avoids this dilemma 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 expiration date shall remain in force, unless revoked, during the lifetime of the declarant. 26 Even so, the continuing effectiveness of a declaration might raise the afore-

19. § 4.01; see also United States v. Currens, 290 F.2d 751 (1961); Diamond, From M’Naghten to Currens, and Beyond, 50 CALIF. L. REV. 189 (1962).
21. For criteria of responsibility in the criminal area, see generally W. CLARK AND W. MARSHALL, CRIMES § 6.01 (7th ed. 1967); Diamond, Criminal Responsibility of the Mentally Ill, 14 STAN. L. REV. 59 (1961).
23. Id. at 987-88.
24. Such as, for example, the decision of a spouse as to when the respirator should be turned off when it has failed to resuscitate the dying spouse.
26. DEATH WARRANT, App., at 140.
suggested imponderables of a life-death decision made by one for another, during, for example, a declarant’s long coma with a spouse claiming its revocation—a psychologically traumatic context.

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. Yale Kamisar has convincingly demonstrated that the movement’s purpose and method substantially has been utilization of the “wedge” principle. This conviction is fortified by the effectiveness of the “wedge” principle as used in the movement for permissive abortion. The public protests of the proponents for abortion seeking “only a moderate statute”—as they characterize the California law, permitting abortion when the mother’s physical or mental health is threatened and in case of felonious sexual assault—have given way to their real goal: abortion on demand. A physician has drawn a meaningful parallel: “I don’t think that human consciousness 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.”

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 constantly widening, and likely a never narrowing movement. It seems pertinent to remember 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 Jews were initially excluded from the program of eugenic euthanasia in Nazi Germany on the ground that they did not deserve the benefit of such psychiatric care. Whether the distinction between voluntary and involuntary euthanasia is as meaningful and abiding as its facile verbal formulation would suggest is open to debate. This article takes the proponents at their present word and limits the discussion chiefly to so-called “voluntary” euthanasia. The definition of voluntary euthanasia that puts the affirmative case in the strongest possible terms is Professor Kamisar’s

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27. Kamisar, supra note 3, at 1014-41.
29. N.Y. PENAL LAW § 125.05 (McKinney Supp. 1972).
30. Dr. Michael Kaback, as quoted in Freeman, The “God Committee,” N.Y. Times, May 21, 1972, § 6 (Magazine), at 89. [Since this paper was delivered, Roe v. Wade, 93 S. Ct. 705 (1973) and Doe v. Bolton, 93 S. Ct. 739 (1973) have been decided.]
31. THE VANISHING RIGHT 62-63; Kamisar, supra note 3, at 1033.
32. In doing so, of course we put outside our ambit one of life’s most agonizing dilemmas, crippling infant deformities which at extremity—in terminology as in actuality—produce monsters. The current attention focuses sharply on meningomyelocele, spina bifida, spina aperta, or open spine. See E. Freeman, supra note 30, at 85.
definition, which assumes:

[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 ... .

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

More Definitional Problems:
(i) Euthanasia v. Extraordinary Means to Preserve Life;
(ii) Euthanasia v. Alleviation of Pain by Drugs.

The word "euthanasia" does not include the withholding of extraordinary means to preserve life. To call the mere withholding of extraordinary means "indirect voluntary euthanasia" is, taking into account the currently accepted meaning of "euthanasia" as deliberate killing, a confusion of terms that cannot conduce to precision of thought. 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 is central to the main thesis of this article. If the distinction between affirmative killing and letting die is only a quibble, as some have characterized it, my thesis here fails.

When studying this problem, one inured 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 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 undertakes rescue he is held to the standard of due care, 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), a physician may refuse aid to the stranger-victim of an emergency without incurring legal liability, while in voluntarily rendering

33. Kamisar, supra note 3, at 1042.
35. J. FLETCHER, EUTHANASIA AND ANTI-DYSTHANASIA IN MORAL RESPONSIBILITY (The Patient's Right to Die) 141-60 (1967).
36. "The result of all this is that the Good Samaritan who tries to help may find himself mulcted in damages, while the priest and the Levite who pass by on the other side go on their cheerful way rejoicing." PROSSER, LAW OF TORTS 339 (3rd ed. 1964). Of course, this assumes the absence of a relationship that may impose a duty, e.g., teacher-pupil, carrier-passenger, innkeeper-guest, etc.
aid he incurs the obligation of using due care.\textsuperscript{88} The important point is that the \textit{attending} physician is not a volunteer; he is bound to the standards of medical performance, including affirmative acts, under the sanction of malpractice liability,\textsuperscript{89} as well as other sanctions.\textsuperscript{40} Therefore, 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.\textsuperscript{41} But a failure to use "extraordinary" means is a different matter and, in a given context, may be legally justifiable.

Similarly, 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 if 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 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.\textsuperscript{42} There is no serious practical question of the present legality of such use of drugs\textsuperscript{43} nor any genuine problem with its ethicality.\textsuperscript{44} Daniel Maguire's recent question

\textsuperscript{38} MEDICAL MALPRACTICE \| 21.35, at 594.24.

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 elsewhere. \textit{Id.} \| 21.01, at 594.3.


\textsuperscript{40} MEDICAL MALPRACTICE, Ch. VIII.

\textsuperscript{41} MEDICAL MALPRACTICE, Ch. VIII; Kamisar, supra Note 3, at 982, n.41; D. MEYERS, THE HUMAN BODY AND THE LAW 147-48 (1970).

\textsuperscript{42} DEATH WARRANT, App., at 141.

\textsuperscript{43} It is true that good motive conventionally does not per se preclude criminality in homicide. CLARK AND MARSHALL, CRIMES 263-65 (7th ed. 1967); PERKINS, CRIMINAL LAW 721 (1957); \textit{but cf. Id.} 723. Thus it remains arguable that the good motivation of alleviating pain per se would not relieve from murder a physician who injected a heavy dose of drugs with knowledge that it certainly would cause death, any more than one would be relieved who injected with the specific purpose of killing. But the requisite proof of certain "causation," when death was in process in any event, would in the typical case seem as theoretically impossible as it would be practically unavailable. \textit{Compare} G. Fletcher, \textit{Prolonging Life}, 42 WASH. L. REV. 999 (1967). In the trial of Dr. Adams for murder in Britain in 1957, the jury was instructed: "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, supra note 41, at 146-47. \textit{See also} Recent Decisions, 48 MICH. L. REV. 1199 (1950); Recent Decisions, 34 NOTRE DAME LAWYER 460 (1959).

\textsuperscript{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 sustain the distinction between such administration and intended killing, let us put aside for
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 innuendo.

The Ethics of Voluntary Euthanasia

Had this article been written 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 Glanville Williams and his opponents, has been richly productive. Whatever the diminution of moral reprehensibility by the facts of a given case, euthanasia in principle is unethical, as well as illegal, killing; this viewpoint has already been essentially presented by Yale Kamisar, Charles E. Rice, David Daube, Norman St. John-Stevas, M.P., and others. Therefore, only a brief comment regarding the ethics of voluntary euthanasia itself—the deliberate, affirmative, intentional act of effecting a mercy death—is necessary.

In discussing the ethics of euthanasia, a warning immediately comes to mind. Except as Scripture, or extrapolations therefrom, or from received Christian tradition, formulate reasons for opposing euthanasia, in what way do "religious" reasons differ from "non-religious" ones?

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, 1957 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 mid-ground 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 for the aspirin bottle at the mere hint of a headache.

46. See note 8 supra and accompanying text.
47. See note 3 supra.
48. See THE VANISHING RIGHT, Ch. 4.
49. Daube, Sanctity of Life, 60 PROC. ROY. SOC. MED. 1235 (1967).
52. Apparently to characterize reasons as "religious" is to diminish their significance:

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
Are not the following reasons for opposing voluntary euthanasia both "religious" and "non-religious?" Ascertaining 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 inhere in illness with its pain and distraction, and are compounded by narcotics and analgesics. Anything like the legal standard for voluntariness in other contexts would be hard to achieve. Would minors of knowledgeable 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 ir-retrievable, would have the odious flavor of avoidable tragedy. Moreover, the history of science and medicine increasingly demonstrates that yesterday's incurable disease is the subject matter of today's routine treatment. Even "incurable" cancer is sometimes subject to remissions. In medicine, as in life itself, there is no absolute hopelessness.

Euthanasia would even 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 dependants? Indeed, would not his new function of active euthanator tend psychologically to undermine the physician's acclimation to the historic mandate of the Hippocratic Oath? And what would acceptance of the psychology of euthanasia do to the peace of mind of the mass of the so-called incurables?

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. They are essentially human reasons.
There Is No Obligation "Officiously to Keep Alive" the Dying.

"Thou shalt not kill, but need'st not strive Officiously to keep alive."

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 those whose lives nature would forfeit and who wish to die. Further, 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 and even from strict justice, as well as from devotion toward one's family.

But normally one is held to use only ordinary means—according to circumstances of persons, places, times, and culture—that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult. Life, health, all temporal activities are in 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.55

Although Pius XII did not use the expression "extraordinary means," it has become customary to capture his thought in the shorthand phrase wise, is of course another matter. For a contemporary analysis of teaching authority of the Church, see D. Maguire, Moral Absolutes and the Magisterium 14 (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 'mercifully'" aroused wide-spread 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, at 1 col. 4. Apparently the legitimacy of such conduct was in serious dispute 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, at 15, col. 1.
“distinction between ordinary and extraordinary means.” It is a convenient condensation but, as with short names generally, may mislead 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, and the relative hardships on a realistic basis of one course of conduct as contrasted with another. 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 certain death without further surgery or a considerable probability of saving the child's life by a second opthalmectomy. From the medical viewpoint, such surgery represents an ordinary means of saving life. I take it to be the prevailing theological view that 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.

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. It should be noted that this does include artificial means, such as surgery, but not natural things, such 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, theologians have wisely incorporated into the definitions qualifications necessitated by such cases as the three-year old's,

56. P. Ramsey, The Patient as Person 118-24; Death Warrant 82; Decisions about Life and Death, A Problem in Modern Medicine, App. 4, at 56 (Church Assembly Board for Social Responsibility, Church Information Office, Westminster, 1965).
57. Id.
58. J. Lynch, S.J., Notes on Moral Theology, 19 Theological Studies 165, 176 (1958). Hopefully the increasing faculties afforded by science and technology in substitution for eye-sight, may render this judgment obsolescent. Compare the discussion in G. Kelly, S.J., The Duty of Using Artificial Means of Preserving Life, 11 Theological Studies 203 (1950), as to whether it is obligatory for a diabetic patient on insulin who develops very painful and inoperable cancer to continue to use insulin (Id. at 208, 215), or for a cancer victim to submit to intravenous feeding (Id. at 210). Where the patient is not legally competent, e.g., a minor, there are of course the additional problems. Cf. Prince v. Massachusetts, 321 U.S. 158, 170 (1944).
as well as the common-sense requirement that, to be obligatory, an artificial means 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.\(^\text{59}\)

Of course, the physician cannot be blamed for emphasizing the purely medical considerations in his appraisal of the appropriateness of the means for staving 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 the decision as to how hard and far to push to keep life going by artificial means ultimately belongs to the patient, not to the physician. Although the patient may be morally entitled to reject it as extraordinary, the physician may be legally obligated to proffer what is customary medical practice.\(^\text{60}\) Conversely, where it is his final hope because lesser efforts afford no promise, presumably the patient is entitled to have means that the physician regards as medically unusual or extraordinary.

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.\(^\text{61}\) There is more hesitancy to turn off the resuscitator than to decide originally not to turn it on. From the moral viewpoint, this distinction is only a quibble. Indeed, might there not be more justification in ceasing after a failing effort has been made, than in not trying in the first place? The medical attitude in this regard seems more psychologicaally 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.\(^\text{62}\) It seems legally far-fetched to convert "omission" into "commission" by the mere fact that the machine is turned off

\(^{59}\) Kelly, S.J., The Duty to Preserve Life, 12 THEOLOGICAL STUDIES 550 (1951) [emphasis added].
\(^{60}\) MEDICAL MALPRACTICE, Ch. VIII.
\(^{62}\) Supra note 3, at 983 n.41.
when it fails to be effective, rather than not turned on in the first place.\textsuperscript{63} Civil liability is another matter; 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.\textsuperscript{64} Estoppel might become a relevant defense in a suit for wrongful death.

The frenetic efforts to resuscitate or just to keep going often are an affront to human dignity. Those who make such efforts do not have as their objective the prolongation of life as much as the maintenance of the process of dying. Can one doubt that Shakespeare has perceived the moral as well as psychological reality when, in 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."\textsuperscript{65}

Since the case for not stretching out longer seems so self-evident, how does one 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, there is no need to look 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 is said here, 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 frantic efforts to prolong the earthly life of the aged that nature would forfeit go hand in hand with the materialism of modern society. Hilaire Belloc observed:

\begin{quote}
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!\textsuperscript{66}
\end{quote}

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 hopefulness about death as

\textsuperscript{63} Supra note 43.
\textsuperscript{64} Supra note 25 with text.
\textsuperscript{65} W. SHAKESPEARE, KING LEAR, Act V, sc. iii.
\textsuperscript{66} Supra note 58, at 174.
of pagan acceptance of dissolution in the poet's invocation of the concept of conquering "the fever called 'Living.'"^{67}

That it is permissible to withhold extraordinary means 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 allocution of Pius XII: "[O]ne 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} 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? It certainly seems relevant that profligate expense may deprive the children of education. 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 has one 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 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 stragglings. As Gerald Kelley 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 a euthanasian mentality.^{69}

^{67}. 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! of all tortures
That torture the worst
Has abated—the terrible
Torture of thirst,
For the naphthaline river
Of Passion accurst:—
I have drank of a water
That quenches all thirst:—

^{68}. See note 56 

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, ethician, moralist, physician, and lawyer.

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. 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 fine 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 put it:

[M]oral 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 paints out, each new case is really a new

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70. Compare the fine distinctions in 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 13 supra and accompanying text.

71. Montaigne’s Essays, Vol. 2, Ch. XX, We Taste Nothing Purely 607, 608 (Florio trans., Modern Library ed.)
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-intuition is at least implicit
in every willed and chosen action.\textsuperscript{72}

Common law lawyers have admirable instruments by which to effectuate
the moralist's acknowledgment of the necessity of accommodation of principle
to fact. There are at the intellectual or formal level the institutions of equity
and on the pragmatic level trial by jury. The accommodation by a jury
may be radical indeed, as Dryden observed centuries ago:

Who laugh'd but once to see an ass,
Mumbling to make the cross grain'd thistles pass;
 Might laugh again, to see a jury chaw
The prickles of an unpalatable law.\textsuperscript{73}

\textsuperscript{72} G. VANN, O.P., MORAALS AND MAN 83 (1960).
\textsuperscript{73} Quoted in Bothein, Trial Judge 182 (1952). See Repouille v. United States,
165 F.2d 152, 153 (2d Cir. 1947) (Hand, J.). Sioux City & Pacific Railroad
Co. v. Stout, 84 U.S. (17 Wall.) 657 (1873) remains a leading case on the jury's au-
thority to fix standards in ambiguous areas. Compare HOLMES, THE COMMON LAW
123-24 (1881). One wonders how much of Stout's meaning is forgotten in the
And quaere, as to the meaning of the death penalty cases, Furman v. Georgia, 408
U.S. 238 (1972), especially the opinions of White and Stewart, JJ., in respect of the
significance our society accords jury ascertainment of its value judgments. Note the
caveat in the dissenting opinion of Burger, C.J., for himself and Blackmun, Powell,
and Rehnquist, JJ.:

The selectivity of juries in imposing the punishment of death is properly
viewed as a refinement on rather than a repudiation of the statutory authoriza-
tion for that penalty. Legislatures prescribe the categories of crimes for
which the death penalty should be available, and, acting as "the conscience of
the community," juries are entrusted to determine in individual cases that the
ultimate punishment is warranted. Juries are undoubtedly influenced in this
judgment by myriad factors. The motive or lack of motive of the perpetrator,
the degree of injury or suffering of the victim or victims and the degree of
brutality in the commission of the crime would seem to be prominent among
these factors. Given the general awareness that death is no longer a routine
punishment for the crimes for which it is made available, it is hardly sur-
prising that juries have been increasingly meticulous in their imposition of
the penalty. But to assume from the mere fact of relative infrequency that
only a random assortment of pariahs are sentenced to death, is to cast grave
doubt on the basic integrity of our jury system.

It would, of course, be unrealistic to assume that juries have been perfectly
consistent in choosing the cases where the death penalty is to be imposed,
for no human institution performs with perfect consistency. There are doubt-
less prisoners on death row who would not be there had they been tried
before a different jury or in a different State. In this sense their fate has
been controlled by a fortuitous circumstance. However, this element of for-
tuity does not stand as an indictment either of the general functioning of
juries in capital cases or of the integrity of jury decisions in individual cases.
There is no empirical basis for concluding that juries have generally
failed to discharge in good faith the responsibility described in Wither-
spoon—that of choosing between life and death in individual cases according
to the dictates of community values. 408 U.S. at 388-89.
With such means of accommodation, we do not need, I think, formal provisions of law to mitigate the potential harshness in applying homicide principles to mercy deaths. But whether we do need them, is certainly a legitimate and open question; some will argue for statutes authorizing lesser penalties in case of euthanasia, as in Norway.\textsuperscript{74} I think such a formal provision for mitigation might do more harm educationally by way of undermining the distinction between letting die and killing, than good, substantively.\textsuperscript{75} This presupposes the validity of the distinction.

Daniel Maguire in Commonweal recently concluded:

\begin{quote}
[I]t 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.\textsuperscript{76}
\end{quote}

This conclusion on burden of proof might 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 Maguire’s own terms.\textsuperscript{77} 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!

The principle of double effect has four criteria. They are:

(i) the act itself must be morally good, or at least neutral;
(ii) the purpose must be to achieve the good consequence, the bad consequence being only a side effect;
(iii) the good effect must not be achieved by way of the bad, but both must result from the same act;
(iv) the bad result must not be so serious as to outweigh the advantage of the good result.\textsuperscript{78}

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. Take, for example, the distinction between

\textsuperscript{74} See also Witherspoon v. Illinois, 391 U.S. 510 (1968); McGautha v. California, 402 U.S. 183 (1971).
\textsuperscript{75} Death Warrant 28.
\textsuperscript{77} The Freedom to Die, Commonweal, August 11, 1972, at 423.
\textsuperscript{78} P. Ramsey, The Patient as Person 118-119.
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. Conceding 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, in the physiological realities, it may always remain doubtful whether the pain itself might have been as death-producing.)

Contrast 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.

There would be adverse effects on the family if law—sometimes the great teacher of our society—were to start to teach the legitimacy of direct killing. David Daube relates 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 up to 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. The visit 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 a euthansiac regime for an act that might have been coerced by a sense of obligation.79 To the sensitive and selfless especially, what the law

79. Daube, Sanctity of Life, 60 PROC. R. SOC. MED. 1235, 1336 (1967). In his
would permit might well become the measure of obligation to family and friends.\footnote{80}

paper, supra note 2, Professor Dyck asks:

Why are these distinctions [between permitting to die and causing death] important in instances where permitting to die or causing death have the same effect—namely, that a life is shortened? In both instances there is a failure to try to prolong the life of one who is dying. It is at this point that one must see why consequential reasoning is in itself too narrow, and why it is important also not to limit the discussion of euthanasia to the immediate relationship between a single patient and a single physician.

Answering, he states in part:

... If a dying person chooses for the sake of relieving pain drugs administered in potent doses, this is not primarily an act of shortening life, although it may have that effect, but it is a choice of how the patient wishes to live while dying. Similarly, if a patient chooses to forego medical interventions that would have the effect of prolonging his or her dying without in any way promising release from death, this also is a choice as to what is the most meaningful way to spend the remainder of life, however short that may be. The choice to use drugs to relieve pain and the choice not to use medical measures that cannot promise a cure for one's dying are no different in principle from the choices we make throughout our lives as to how much we will rest, how hard we will work, how little and how much medical intervention we will seek or tolerate and the like.

80. See DEATH WARRANT 83-84; J. DEDEK, HUMAN LIFE: SOME MORAL ISSUES 121, 127 (1972). Compare the euthanasia death of Sigmund Freud as told by his physician, MAX SCHUR, FREUD: LIVING AND DYING (1972). Freud's cancer of the oral cavity was discovered in April, 1923, when he was about 67 years old. Schur became his personal physician in 1928 and served until Freud's death in 1939, both in Vienna and London. Id. at 347. When he first engaged Schur, Freud obtained the promise of euthanasia:

... Mentioning only in a rather general way "some unfortunate experiences with your predecessors," he expressed the expectation that he would always be told the truth and nothing but the truth. My response must have reassured him that I meant to keep such a promise. He then added, looking searchingly to me: "Versprechen Sie mir auch noch: Wenn es mal so weit ist, werden Sie mich nicht unnötig quälen lassen." ["Promise me one more thing: that when the time comes, you won't let me suffer unnecessarily."]

All this was said with the utmost simplicity, without a trace of pathos, but also with complete determination. We shook hands at this point.

\emph{Id.} at 408. Thus doctor and patient were under euthanasia commitment during approximately the last 11 years of Freud's life. Schur relates the final scene:

On the following day, September 21, while I was sitting at his bedside, Freud took my hand and said to me: "Leiber Schur, Sie erinnern sich wohl an unser erstes Gespräch. Sie haben mir damals versprochen mir nicht im Stiche zu lassen wenn es so weit ist. Das ist jetzt nur noch Quälerei und hat keinen Sinn mehr." [My dear Schur, you certainly remember our first talk. You promised me then not to forsake me when my time comes. Now it's nothing but torture and makes no sense any more.]

I indicated that I had not forgotten my promise.

He sighed with relief, held my hand for a moment longer, and said: "Ich danke Ihnen" ['I thank you,'] and after a moment of hesitation he added: "Sagen Sie es der Anna." ['Tell Anna about this.'] All this was said without a trace of emotionality or self-pity, and with full consciousness of reality.

I informed Anna of our conversation, as Freud had asked. When he was again in agony I gave him a hypodermic of two centigrams of morphine. He soon felt relief and fell into a peaceful sleep. The expression of pain and suffering was gone. I repeated this dose after about twelve hours. Freud
The principle mischief with such life-interfering proposals as euthanasia is their undue deprecation of the importance of the natural order in human affairs. As a principle 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.\(^8\) Certainly the freedom and integrity of the human person should not be as much ravaged and stripped as have been the forests and fields and waters of the world. As a physician puts it:

\[\text{[W]e are possessed with a technologic spirit in which power over nature is the predominant theme. We ignore the fact that there is an intrinsic despair and disparity in looking to technology for a solution. We forget that our problem is not to master nature, but to nurture nature. We also forget that technological achievements are, at best, ameliorative, and, at worst, dehumanizing.}\]

The additional dilemmas that a regime of mercy deaths would impose—such problems as ascertainment of true and abiding consent—would seem of themselves reasons for avoiding the creation of more unlighted pathes.\(^8\)

Is not the preferred choice continuing progress in the alleviation of pain, loving care of the dying among our neighbors, rather than killing? We are only mortal, and in this area a grand attempt to restructure the natural order seems more dangerous than hopeful. Nature can be harsh and cruel, but it is never corrupt. Human will can be all three.

**Conclusion**

The distinction between affirmative killing and allowing one to die according to nature’s order without extraordinary effort to “stretch him out longer” continues to be valid, viable, and meaningful.\(^8\) The line of demarcation was obviously so close to the end of his reserves that he lapsed into a coma and did not wake up again. He died at 3:00 A.M. on September 23, 1939. Freud had said in his *THOUGHTS FOR THE TIMES ON WAR AND DEATH*: Towards the actual person who has died we adopt a special attitude: something like admiration for someone who has accomplished a very difficult task.

\[\text{Id. at 529.}\]

81. *See Louisell, Biology, Law and Reason: Man as Self-Creator, 16 AM. J. JURIS. 1 (1971). During my recent visit at the University of Minnesota, Mark Graubard, 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!}\]

82. H. Ratner, M.D., Editorial, 7 *CHILD AND FAMILY* 99 (1968).

83. 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 a euthanasia 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.

84. There is disturbing language in *John F. Kennedy Memorial Hospital v. Heston*, 279 A.2d 670 (N.J. 1971). In upholding the subjection of a Jehovah’s Witness, age 22 and unmarried, who had sustained severe injuries in an automobile accident, to a
may be fine, but so are many other lines that men must draw in their fallible perception and limited wisdom. Application of the principled distinction between ordinary and extra-ordinary means of prolonging life occasions difficulties, but hardly any different in quality from various other decisions in applying a general principle to particular facts. The distinction between the use of drugs to kill and their use to alleviate pain even though death 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 educative 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. The refusal so far of legislatures to intrude into the mercy-death area has been prudent and in the interest of sound social policy.

blood transfusion necessary to save her life, the Court per Weintraub, C.J., said: "It seems correct to say there is no constitutional right to choose to die." Id. at 672. 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." Id., at 673. It acknowledges that "It is arguably different when an individual, overtaken by illness, decides to let it run a fatal course." Id. Pretermittting the question of the free exercise of religion, it seems unfortunate that the Court did not confront more directly the extent of the obligation to use artificial means to sustain life. One of the cases cited by the court, Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson, 201 A.2d 537, cert. denied, 377 U.S. 985 (1964) is distinguishable, in that there the woman involved was bearing a child. Thus another life was involved, and the court there correctly concluded that an unborn child is entitled to the law's protection when a transfusion is necessary to save its life. See Louisell, Abortion, the Practice of Medicine and the Due Process of Law, 16 U.C.L.A. L. Rev. 233, 244 (1969).