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EUTHANASIA AND THE RIGHT TO DIE—MORAL, ETHICAL AND LEGAL PERSPECTIVES

BRUCE VODIGA*

QUESTIONS REGARDING DEATH and dying have recently become popular topics for discussion by lawyers, physicians, theologians, philosophers and the public. Is euthanasia murder? Should steps be taken toward legalization? Is private regulation an effective method for con trol? These questions and numerous others are being asked with increasing frequency. These are urgent questions that require careful and thorough analysis and comprehensive answers.

This article examines these questions and some of the answers that have been developed.[1] Hopefully, it will provide the reader not only with some basic reference material for more thorough evaluation of the now "controversial" concept of human death, but also with a frame of reference, a rational, logical and persuasive perspective from which to consider death and dying. This, then, will not be a detailed legal analysis, that would make it unnecessarily redundant; this will not be a lengthy exposition, that would make it counterproductively boring; this will merely be a brief intrusion into the mystically evasive and deeply personal realm that death occupies in the human mind.

We are about to examine a subject that has invited intellectual indulgence since man acquired a perception of the inevitability of death. Of late, it is receiving attention of monumental proportions from members of the public and the legal, theological, philophical,

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1. Before proceeding with this article, the writer must emphatically make a disclaimer. This article is *not* an exposition of AMA beliefs or policies. As a result of my affiliation I have had occasion to observe the formulation of AMA policy regarding the present topic, and some of the views expressed in this paper parallel AMA views. However, this paper is neither an official nor unofficial expression of any AMA position.

journalistic and medical communities. Much of the discourse devoted to death, however, is of dubious value because it does not seek to make death less palatable, frightening, terrible or impounderable. Rather, it advocates a cold, mechanistic approach to death.[2]

This observation is really my point of departure for this paper. With all due respect for those who have considered "death" before me, whose immense intellectual capacities far exceed mine, with awe at the care and diligence in their work, and with deference to their integrity and honorable intentions, I submit that it is to life *not* death that we must turn our attention. By developing and improving life—our concept of it, our respect for it, and our concern with improving the quality of it—we can construct the foundations for a moral, ethical and legal environment in which death may then be perceived, dealt with and allowed to occur as a natural terminating function of life.

SEMANTICS—WHICH "TYPE" OF "EUTHANASIA" SHALL WE CONSIDER?

One of my favorite law professors liked to tell a story about a lawyer who in the course of oral argument before the United States Supreme Court answered one of the justices' questions with the casual observation that "It's only a matter of semantics, your Honor." The professor was then serving as clerk to Mr. Justice Frankfurter, who was not often motivated to stir during oral argument. Upon this occasion, however, the esteemed justice rumbled, rose and roared, "Young man, the law *is* semantics!"

To avoid the obvious pitfalls in taking the semantics of this discussion for granted, perhaps a brief look at the terminology involved will be helpful. The definitions that follow are those of the writer, and are submitted only for purposes of this discussion. If they be deemed erroneous, so it may well be; but since there has been very little agreement among scholars in this regard, they are likely to be as accurate as any.

Throughout this paper it is hoped the reader will keep in mind that its subject is a matter of "bio-ethics" and not one of "medical ethics." The former term is generally used to denote the moral considerations and principles concerned with life and living things, a broad and wide-ranging topic which is not confined to the perspectives of

2. This mechanistic approach is especially evident in proposals to legislatively define death and the circumstances in which it may be permitted to occur. Both of these theories will be surveyed later in this paper.

any single profession or field of endeavor.[3] Bio-ethics is inter-disciplinary. The latter term, on the other hand, denotes a set of professional standards applicable only to the practice of medicine,[4] a far narrower concept. Viewing questions about death from the standpoint of medical ethics would, therefore, necessarily exclude legal, theological and other implications which are indispensable to a comprehensive treatment of them. Thus, we are concerned here with a subject that is properly within the scope of bio-ethics, not simply medical ethics.

Beyond agreement that "euthanasia" literally means "happy death,"[5] there is no consensus as to its precise colloquial meaning. The word generally connotes the taking of human life for other than malicious purpose. It implies that some sort of humane or compassionate motivation is the prime-mover in the taking. But definitional problems arise in defining the character of the manner in which the taking of life is accomplished.

Terminology such as "negative," "voluntary," or "passive-" euthanasia, and its inverse corollary, *e.g.* "positive-," "involuntary-," or "active-" euthanasia has proliferated.[6] While the prefixes vary the distinction is generally accepted that the former group describes the taking of human life by the omission of some act essential to the preservation of life[7] and the latter indicates the performance of some affirmative conduct which directly results in the taking of life.[8]

Regardless of the specific term used or its precise definition, a common thread ties them together; euthanasia is the *taking* of human life, regardless of its motivation, or of whether it is an act or omission. Euthanasia is *not* permitting death to occur or allowing the inevitable to come about. To be sure, it could be defined to include these things, but this would destroy any value the word might have.

3. *See*, Clouser, *Some Things Medical Ethics Is Not*, 223 J.A.M.A. 787 (1973); Editorial, *Bioscience - Bioethics*, 220 J.A.M.A. 272 (1972).

4. L. LUKE, MEDICAL ETHICS 31-46 (1957); C. LEAKE, PERCIVAL'S MEDICAL ETHICS 1, 5 (1927).

5. *See* notes 18-72, *infra*.

6. These exemplary terms are cited without authority at this point because each writer assigns his own definition to whichever of them he selects for use. This will become apparent as this article progresses. This writer prefers to not add to the confusion already caused by lack of uniform definition with his own specific offering. Rather, very broad descriptions of this terminology are offered. *See* notes 7 & 8 and accompanying text, *infra*.

7. The former group also usually includes instances wherein the person, or immediate family of the person whose life is in balance, give consent to fatal omission.

8. The latter group usually includes that taking of life without consent or even against the will of the person whose life is in question.

By rejecting a definition of "euthanasia" that includes allowing death to occur, a potentially valuable analytical perspective can be gained. Making a distinction between "euthanasia" and "allowing death" permits discussion of their respective implications without incurring the substantial semantic difficulties that have consumed much attention in prior discussions.

Perhaps the only other words in need of definition at this point are three that represent the essence of the law, theology and philosophy in this country: morality, ethics and law.[9] Specifically, it is the interrelationship and interdependence of the concepts inplicit in these words that should be defined to help clarify the discussion about to be presented. The following definitions are offered. "Morality" is the recognition of qualities, such as correct or incorrect, and the application of values, such as good or bad, to those qualities in order to achieve a frame of reference within which to conduct the affairs of life.[10] There are a multiplicity of sources from which the morality of our society has been drawn, but probably the most influencial of these has been theology.[11] "Ethics" is the systemization of a morality in which standards of conduct are established.[12] The efficacy of any such system depends upon its voluntary adoption by the group of people to which it applies.[13] Religion exemplifies this. The mandatory nature of "law" is the feature of that system of standardizing morality which distinguishes it from ethics. Thus, while both ethics and law erect standards of conduct for the persons to which they apply, they differ with respect to the methods of enforcement they use.[14]

There is a common theme in morality, ethics and law: they all involve making value judgments regarding the conduct of some person

9. The writer is aware that in discussing these concepts he invades the province of some of the greatest thinkers of all time. He does not profess possession of adequate qualification for this venture and accepts whatever criticisms may result from his lack of expertise or naiveté.

10. *Cf.* Clouser, *supra* note 2, at 788; Moffat, *The Indispensable Role of Independent Ethical Judgment*, 21 FLA. L. REV. 477 (1969); Barton, *Sources of Medical Morals*, 193 J.A.M.A. 127 (1965); Allred, *Legal Aspects of Euthanasia*, 14 LINACRE Q. 1, 2-3 (1947). The writer suggests that this definition not as expression of a particular moral philosophy, *e.g.* natural, pragmatic, etc., but only as a description of the elements of any morality. Any suggestion that one morality is to be preferred to another is purely unintentional.

11. While the words "theology" and "religion" are often used interchangeably, the word "theology" is intentionally used here to indicate the influence of all religions upon morality in our country.

12. *Cf.* notes 3 and 10, *supra.*

13. *See* notes 172-7 and accompanying text, *infra.*

14. *Cf.* Clouser, note 2 *supra*, at 788; Moffat, note 10 *supra.*

or group of people. Each, with increasing degrees of particularity as these value judgments progress from morality to ethics to law, defines the idea of the quality of life; and each, with increasing force, influences and regulates that quality. Theoretically, at least, if one of the voluntary value judgment procedures is working effectively, then the next successive one should not be required. For example, if an ethical principle is generally adherred to by those to whom it applies and is otherwise acceptable and desirable, then a law erecting a standard for the same conduct should not be required.[15]

Although it may seem unexpected, no definition of death will be presented at this point. It is sufficient for the moment to state that death is the cessation of life. In addition, no specification of a particular class of persons, e.g. the terminally ill, is offered at this point to identify the targets of the practices being discussed. Defining either of these concepts now would be premature in the context of the organization of this paper.[16]

CREATION AND CONSTRUCTION OF A CONTROVERSY—SURVEY

This section contains descriptions of some of the thoughts and arguments of selected commentators on euthanasia. Selections were made to provide a sample of the opinions that abound in the spheres of legal, theological, medical and general literature.[17]

For ease of consumption, the following survey is categorized by area of endeavor: law, theology and medicine. No inference that this

15. This concept is similar to a pyramid: the foundation and broadest part of a society's values are its morality; the next successive level upward, but narrower in scope, are the ethics of groups within the society; and, the uppermost and least broad level is the law. The law is "least broad" because, while it addresses virtually every form of endeavor, it has real bearing upon only a few specific types of conduct. Each successive level of the pyramid is subject to control by the one above it.

16. One of the purposes of this article is to illustrate the confused semantics which all too often have prevented the concepts of "death" and "euthanasia" from being rationally discussed. It is hoped that by sifting through some of the most misused and misunderstood terminology a more clear idea of the essential elements in a well reasoned analysis will become apparent.

17. Many of the authorities cited herein provide detailed and comprehensive reference lists, either in the form of bibliographies or footnotes. Some of these will be alluded to in subsequent notes.

The writer has often been admonished by one mentor that the answer one gets is determined by the question he asks. Other authorities agree. *See* Kamisar, note 23 *infra*, at 977 and n.30. And, so it is conceded that the result attempted to be achieved by this article was determined well in advance of its actual composition. Realizing this, an unconscious attempt was probably made to select source material so as to support the desired result. In retrospect, however, the writer believes that even a perfectly random selection would have yielded the same outcome.

method of presentation is indicative of significance to be attached to any subdivision is intended.

Legal Scholars

1. *Helen Silving*[18]

Ms. Silving, as a Research Associate at the Harvard Law School, made her contribution to the euthanasia controversy ostensibly as more of an academic exercise than as an expression of viewpoint.[19] As such, it purports to be an exploration of the criminality of euthanasia in various systems of law. Ms. Silving draws a distinction between several unnamed types of euthanasia and thereby makes a case for the need to reform the criminal law in this country to accommodate motives that lack the desire to do harm, as well as the desires of the person whose life is in the balance.[20] (She avoids recommending that some measurement of the value of the life in question be included in the law reform she advocates). Though she considers legalizing euthanasia, she appears to favor lessening criminal penalties for mercy-motivated murder.[21]

Her conclusion is that euthanasia is murder within the context of contemporary criminal law in this country because it includes the elements constituting that criminal offense, regardless of what it might be called.[22] This argument for criminal law reform has interested sub-

18. Silving, *Euthanasia: A Study in Comparative Criminal Law*, 103 U. PA. L. REV. 350 (1954). Helen Silving was a Research Associate in Law at the Harvard Law School when this article was published.

19. *Id.* at 350, 386.

20. Id. at 360-9, 386-7. Ms. Silving is one of the few writers who does not assign names to types of euthanasia. She says, simply, "The most diverse acts have been referred to under the common term 'euthanasia' ", describes some of them, and proceeds with her discussion. *Id.* at 351-2 and n.5.

21. *Id.* at 387-8. She states her reasons for this preference as follows:

> In trying to find the proper solution, consideration should be given to the prevailing mores of American society (footnote omitted). State controlled euthanasia is predicated upon ethical approval of the act . . . . There is no evidence that the majority of the American people approve of euthanasia, but it is reasonable to assume that most people consider a killing motivated by mercy less reprehensible than killing for a base motive. *Id.* at 388.

22. Although Silving observes that many of the diverse acts often referred to as euthanasia "are perfectly lawful under all systems of criminal law . . . ." *Id.* at 351, and thereby recognizes that not all of those acts are in fact euthanasia, most other legal scholars would disagree. For example, George Fletcher predicates his entire article on the assumption that if conduct is *called* "euthanasia", it must be criminal. *See* Fletcher, *Prolonging Life*, 42 WASH. L. REV. 999 (1967) (discussed in notes 38-45 and accompanying text, *infra*). *See also*, Sanders, *Euthanasia: None Dare Call It Murder*. 60 J. CRIM. L. 351 (1969); Kutner, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 IND. L.J. 539, 539-40 (1969); Morris, *Voluntary Euthanasia*, 45 WASH.

sequent legal scholars far less than proposals for legislation legalizing some "form" of euthanasia. Nevertheless, Ms. Silving's recommendation that reform is warranted to bring the criminal law into harmony with the manner in which it is frequently administered in euthanasia cases is well presented and reasoned.

2. *Yale Kamisar*[23] and *Glanville Williams*[24]

In 1958, and in response to noted legal scholar Glanville Williams, Professor Yale Kamisar of the University of Minnesota Law School rebutted Williams' proposal to statutorily legalize "voluntary" euthanasia. In Kamisar's article, "voluntary" euthanasia was defined by example: "the cancer victim begging for death."[25]

Because he considers his views to be those of a non-religious utilitarian ethician, Professor Kamisar challenges the ideas upon which proposals for legislation to legalize euthanasia are most often predicated. He orients his argument to Williams' views, but aims it at all those who would support them.

Although it is impossible to capsulize Kamisar's detailed exposition, the following is a summary of the highlights of his article. To Williams' contention that legislative action is necessitated by inequal application of the criminal law in cases where euthanasia is apparently involved,[26] Kamisar observes that "if inequality of application suffices to damn a particular provision of the criminal law, we might as well tear up all our codes . . . ."[27] Kamisar then argues that it is properly within the purview of a jury to consider moral issues in its deliberations and states that Williams' proposal would not cure the ills in existing

L. REV. 239 (1970): Note, *"Voluntary" Euthanasia*, 36 ALBANY L. REV. 674 675-8 (1973).

In her discussion of some "euthanasia" cases Ms. Silving points out that juries will often aquit defendants who appear to have been motivated by mercy or compassion. Silving, note 18 *supra*, at 352-4. This, she reasons, indicates a need for criminal law reform. *Id.*

23. Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969 (1958).

24. G. WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW (1957) (hereinafter cited as "WILLIAMS"). Williams' book will be discussed concurrent with Kamisar's rebuttal to it. Williams himself replied to Kamisar in, *"Mercy-Killing" Legislation—A Rejoinder*, 43 MINN. L. REV. 1 (1958). *See also* Williams, *Euthanasia and Abortion*, 38 U. COLO. L. REV. 178 (1966).

25. Kamisar, note 23, *supra*, at 969-70 and nn. 3 & 7.

26. Kamisar, note 23 *supra*, at 971 (quoting WILLIAMS at 328); *see id.* at 971-2 and nn. 11-17.

27. *Id.* at 972.

law, but would compound them.[28]

To Williams' argument that decisions regarding euthanasia should be left to the discretion and common sense of physicians,[29] Kamisar raises the central arguments in his rebuttal—the possibility of mistake and abuse, and the likelihood that "voluntary" euthanasia legislation might someday be extended to include "involuntary" euthanasia.[30] Kamisar agrees with Williams that the battlefiled is civil liberties but questions whether the premature and unnatural death of but one individual by mistake is worth relieving the pain and suffering of any number of others.[31]

Mistakes and abuses can be prevented, or at least minimized, only by erecting elaborate legal machinery or by somehow assuring the infallibility of all physicians' medical judgment and moral scruples.[32] The former alternative would preclude any possibility of expeditious administration, and the latter would impose a burden upon medical technology that it is incapable of assuming and that its practitioners are unwilling to accept.[33] Additional mistakes can be introduced into whatever procedure might be established by difficulties in assessing whether the person who purportedly requests death is in fact capable of making such request freely and voluntarily, and by the possibility—however slight—that an advance or breakthrough in medical technology could save and preserve, if not fully restore, the life in question.[34]

28. *Id.* at 973-4.

29. WILLIAMS at 339-42.

30. Kamisar, note 23 *supra*, at 976. In anticipatory rebuttal to the first objection to his proposal, regarding mistakes, Williams says:

> It may be allowed that mistakes are always possible, but this is so in any of the affairs of life. And it is just as possible to make a mistake by doing nothing as by acting. All that can be expected of any moral agent is that he should do his best on the facts as they appear to him. Williams at 318.

Kamisar's surrebuttal is that "reasonable mistakes, then, may be tolerated if . . . these are the inevitable by-products of efforts to save one or more human lives." Kamisar, note 23 *supra* at 1008.

31. *Id.* at 976-7. It is in passages such as this that Kamisar betrays the moral underpinnings of his analysis. His assurance that he leaves "the religious arguments to the theologians" in the final analysis becomes unconvincing. The obvious morality underlying it does not differ substantially from that which one might reasonably expect of a theologian. *Id.* at 976-7, 974 and n.23.

32. *Id.* at 981, 984. Williams proposal to circumvent problems with logubrious legal machinery is, of course, to elevate the role of the physician by giving them a free hand to exercise singular discretion. WILLIAMS at 339-40. Kamisar cannot accept imposing such responsibility upon physicians, and raises the possibilities of criminal prosecution and violation of moral principles to support his position. Kamisar, note 23 *supra* at 982 n.41.

33. *Id.* at 984, 993-1005.

34. *Id.* at 985-93. "[I]s the adult patient (footnote omitted) really in a position

Williams himself acknowledged the possibility and, inferentially, predicted the future acceptability of putting to death aged senile persons, defective infants and others whose mental or physical deficiencies make their lives somehow worth less than others when measured on some abstract scale of quality of human life.[35] Williams' reasons for anticipating this form of euthanasia are that someday these "defective" people will cause problems in our society sufficiently serious to warrant a change in present public opinion. Kamisar dismisses Williams' reasons for even raising the possibility of extending legislation to "defective persons" with a kind of moral pragmatism and the statement that since he finds the proposal itself undesirable, the extension of it would be even more so. He then applies his legal version of the political "domino" theory and in asking "Where do we, how do we, draw the line?" finds the killing of "defectives" utterly unacceptable.[36]

One of the least emphasized but perhaps most persuasive arguments by Kamisar is that since virtually all of the cases on the books deal with "involuntary" euthanasia, the proffered need for legislation regulating "voluntary" euthanasia (grounded upon disapproval of the rationale or results in those cases) is at best imagined and is at worst the crass commercialization and exploitation of a topic to which the public is sensitive. In spite of this, many scholars have persistesd to disregard their self-imposed definitional distinction between "voluntary" and "involuntary" euthanasia, and have used inconsistencies in the law regarding the latter to justify acting upon the former. When ever such reasoning is relied upon as as the basic premise for an argument favoring legislation regulating "voluntary" euthanasia, it is hope lessly illogical and therefore cannot be accepted without serious reservation.[37]

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to concur? Is he truly able to make euthanasia a 'voluntary' act? There is a good deal to be said, is there not, for [the] pithy comment that the "voluntary' plan is supposed to be carried out 'only if the victim is both sane and crazed by pain (footnote omitted).' . . . *When*, then, does the patient make the choice? While heavily drugged (footnote omitted)?" *Id.* at 985-6 (Emphasis added).

Here is an example of the question-asked-determines-the-answer-obtained reasoning. Rather than ask, "Should the patient be kept alive to await a new treatment that may not be forthcoming?" Kamisar would ask, "Should the patient be put to death when there is a possibility of some new treatment?" *Id.* at 993-1005.

35. WILLIAMS at 333-4, 348-50.

36. Kamisar, note 23 *supra*, at 1026, 1030-41. Kamisar calls this the "parade of horrors" or "wedge" principle.

37. This observation is purely personal. In purusing the authorities, I am often overcome with the impression that many of them write less out of true concern for the subject and more for reasons related to sensationalism and notoriety.

3. *George Fletcher*[38]

After Professor Kamisar's article and Williams' rejoinder to it,[39] there was a lull in the attention given the issue of euthanasia. However, when the first heart transplant operation came into the public eye in 1967,[40] death again became a popular subject for discussion and debate. There was an urgent need to establish criteria for the circumstances in which removal of vital organs for transplantation purposes would be proper. Accompanying discourse on the need for new definition of death was a renewed interest in "euthanasia."

George Fletcher, Assistant Professor of Law at the University of Washington, directed his attention to the criminality of euthanasia. His article seems to be an attempt to return to the question of the criminal liability involved in administering euthanasia. After enumerating the common law elements of murder,[41] his analysis focuses on one of them, "an act resulting in death," and the criminality of an omission in the context of that element.[42] He proposes that the desired test should be "whether on all the facts we should be inclined to speak of the activity as one that causes harm or one merely that permits harm to occur."[43] He thus makes a distinction between acts and omissions. It turns upon the difference between "causation" and "permission."

Professor Fletcher then turns to the physician-patient relationship to examine whether its scope includes the implied consent by a patient to the omission of some medical treatment by his physician.[44] He finds that "what doctors customarily do" determines the existence of that implied consent. He thereby infers that if what doctors customarily do includes the giving of implied consent by their patients, then an omission by a physician that permits harm to occur is not criminal conduct.[45]

38. Fletcher, *Prolonging Life*, 42 WASH. L. REV. 999 (1967), reprinted 203 J.A.M.A. 65 (1968). This writer is a law professor, George P. Fletcher, who is to be distinguished from theologian Dr. Joseph Fletcher, whose position is discussed in notes 59-71 and accompanying text, *infra*.

39. *Supra* notes 23-25.

40. *See* 202 J.A.M.A. 23 (1967).

41. Fletcher, note 38 *supra*, at 1002:
(1) an act resulting in death.
(2) an intent to inflict death.
(3) malice aforethought.
(4) absence of defenses.

42. *Id.* at 1004.

43. *Id.* at 1007. Only once during the course of his discussion does Fletcher speak simply of "death" without referring concurrently to "harm."

44. *Id.* at 1009-14.

45. *Id.* at 1015.

4. *Luis Kutner*

In a recent article, the Chairman of the World Habeas Corpus Committee of the World Peace Through Law Center proposes an approach to "euthanasia" that is one of the most creative suggestions thus far, the "living will." Without describing the first part of Mr. Kutner's article, which follows what appears to have become a standard format for legal writers,[46] let us turn immediately to Mr. Kutner's proposal. It is summarized as follows:[47]

(a) The document would be referred to as a "living will," "testament permitting death," "declaration for ending treatment," or the like.

(b) The purpose of the document would be to allow a person to "indicate to what extent he would consent to treatment" while "fully in control of his faculties and his ability to express himself."

(c) "The document would provide that if the individual's bodily state becomes completely vegetative and it is certain that he cannot regain his mental and physical capacities, medical treatment shall cease."

(d) The document would be acted upon only with the approval of a hospital committee or similar board which would "consider the circumstances under which the document was made in determining the patient's intent . . . and whether the condition of the patient has indeed reached the point where he would no longer want any treatment."

To these provisions Mr. Kutner attaches several qualifications. One of them specifies that the wills could not be executed by incompetents incapable of consenting to medical treatment.[48] Another provides that the document could not authorize the commission of euthanasia.[49]

Mr. Kutner's proposal has been adopted by several organizations

46. Kutner, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 IND. L.J. 539 (1969).

47. *Id.* at 551. Although he does not seem to care which or what label is attached to the document he proposes, Kutner prefers "living will".

48. *Id.* at 552-3. Like Kamisar, the writer feels that most of us really do not want to die, and can conceive of few instances if any in which a human being "would no longer want" *any* treatment. *See* Kamisar, note 23 *supra*, at 1011. Paul Ramsey agrees. *See* note 73-74 and accompanying text, *infra*.

49. *Id.* at 553. Kutner apparently believes that by any name, euthanasia is criminal.

and actively advocated by them.[50] Standard form "living wills" are now available to the public and are used by a growing number of persons. There are, however, several problems inherent in the use of "living wills" which must be solved before their use may become well-advised. The foremost of these are:[51] (1) such documents are without any legal effect; (2) the limited consent to treatment expressed in them is not an expression of present intent or consent as such documents are only prospective in nature; and, (3) the suggestesd forms are necessarily broad but therefore fatally vague and there is no rational way to expect laymen or even lawyers to correct these defects and still achieve the desired result. In spite of these criticisms, the "living will" may still be one of the best methods yet proposed to deal with human death and terminal illness humanely and efficaciously.[52]

5. *Other Legal Scholars*

The list of legal scholars devoting attention to the concept of death is continually growing. As this survey is not intended to present summaries of all the material available, brief reference has been made to a representative sample and the remainder will be left to the curiousity of the reader. A few more, however, are deserving of mention without extensive comment.[53]

Joseph Sanders' position is that since the "present system of criminal law, as fictitious as it sometimes is, has not yet worked a great injustice on anyone committing euthanasia" and since "trial by jury permits justice to be done without causing any tear in the conceptual fabric of the law," a compelling case for changing the present situation is difficult to prove.[54] On the other hand, Howard Brill notes that as the present law can be circumvented by a variety of techniques, it is definitely in need of legislative change to legalize "voluntary" eu-

50. It would be entirely too presumptuous to credit Kutner with the idea for the document he advocates, as such forms have been included in most of the legislative proposals thus far advanced. *E.g.*, *see* N. ST. JOHN-STEVAS, LIFE, DEATH AND THE LAW 267-8, App. XIV (1964).

51. Who can be certain today that tomorrow he will desire anything, much less death? *See* Kamisar, note 23, *supra*, 1011.

52. The idea in and of itself has merit. It is in the implementing legislation and the intricate mechanisms that inevitably must accompany it that such documents will become difficult, if not impossible, to administer. *See* Kamisar, note 23, *supra*, at 978-82.

53. Two bibliographies worthy of comment, but not mentioned in the text, are available from the National Library of Medicine, Bethesda, Maryland, and The Institute of Society, Ethics and the Life Science, Hastings-on-Hudson, New York.

54. Sanders, *Euthanasia: None Dare Call It Murder*, 60 J. CRIM. L. 351, 357 (1969).

thanasia.[55] In an article that may seem to present rather appealing arguments favoring "voluntary" euthanasia, but which upon careful analysis fails to support those arguments with a substantial quantity of supportive facts or any quality of persuasive reasoning, Professor Arval Morris of the University of Washington law school adds yet another article to those already mentioned.[56]

A team of three law students recently compiled a most comprehensive survey of the legal ramifications of euthanasia.[57] It touches upon every conceiveable aspect of the subject within the reach of the inquisitive mind, sometimes with less than thorough analysis. The survey does, however, provide valuable background and the footnotes comprise an invaluable bibliography for the prospective investigator.

Theologians[58]

1. *Joseph Fletcher*

Recently, Dr. Fletcher left the modern-day euthanasia "controversy" he started in 1954,[59] still debating the merits of "voluntary" euthanasia, and forged ahead into the area of "involuntary" euthanasia. Where once this noted Professor of Medical Ethics supported the idea of permitting patients to obtain a court order under conditions prescribed by statute for the administration of "voluntary" euthanasia to such patients, he now advocates the approval of "involuntary" euthanasia.[60]

Starting with the premise that the issue of whether to permit "passive" or "negative" euthanasia (or "whether we may 'let the patient go') is as dead as Queen Anne," Dr. Fletcher reasons that "it is

55. Note, *Death With Dignity: A Recommendation For Statutory Change*, 22 U. FLA L. REV. 368 (1970).

56. Morris, *Voluntary Euthanasia*, 45 WASH. L. REV. 239 (1970).

57. Survey, 48 NOTRE D. LAWYER 1202 (1973). The footnotes to this survey provide any interested investigator with an excellent reference list. Perhaps the only problem with such a survey is its necessary brevity. This one, however, suffers from an additional failing: it does not fully consider the positions of some of the authorities relied upon. This writer is disappointed at the willingness of the students to accept Professor Morris's position that religious grounds against proposed legislation are "constitutionally irrelevant" without performing any analysis of it or interposing any challenge to it. *Id.* at 1259-60.

58. It is particularly difficult to provide the reader with a representative sample of theological opinion. There is far too much material available to present other than a general outline of some representative ideas.

59. *See* J. FLETCHER, MORALS AND MEDICINE 172-210 (1954).

60. *See* Fletcher, *Ethics and Euthanasia*, 73 AM. J. NURSING 670 (1973). *See also* Weber, Ethics a*nd Euthanasia - Another View*, 73 AM. J. NURSING. 1228 (1973), for an initial rebuttal.

harder morally to justify letting somebody die a slow and ugly death, dehumanized, than it is to justify helping him to escape from such misery."[61] His justification for this view is, that adjustments to traditional ethics, which are mandated by recent technological advances, enable euthanasia to be justified as a reasonable means to achieve the termination of life that is or has become useless. His "new ethics" is one which emphasizes the quality of life, and the essence of his argument is that the end of putting useless life to death, justifies the means euthanasia, because the positive value of the end, that of terminating useless life, outweighs the negative value of the means.[62]

Dr. Fletcher's new thesis necessarily raises several questions. Who will determine when a life has become valueless? How will the value of that life be determined? These questions cause him little difficulty. He readily admits that scientific change has enabled us to "play God," and argues that the "real question is: Which or whose God are we playing?"[63] Thus, because we are playing God, we can morally justify evaluating the quality of life exhibited by other human beings and, if we find it useless, we can therefore justify ending it.[64]

The position espoused by Dr. Fletcher is an extension of his former position favoring "involuntary" euthanasia. Where once he believed that "consent is a common ethical consideration in all medicine . . . [and] while it should never be perfunctory it will always have to be substantial rather than perfect,"[65] he would now de-emphasize the importance of consent in determining who should die. Whereas he once said that "we might choose death for ourselves more rightly than we can choose it for others,"[66] he would now have it chosen for all who are "useless" or "defective."

Fletcher closes his disclosure on "involuntary" euthanasia with the prediction that

> The day will come when people will . . . be able to carry a card, notarized and legally executed, which explains that they do not want to be kept alive beyond the *humanum* point, and authorizing the ending of their biological processes by any of the methods of euthanasia which seems appropriate.[67]

61. Fletcher, note 60 *supra,* at 670.
62. *Id.* at 674.
63. Fletcher, note 59 *supra,* at 674.
64. *See* Fletcher, *Indicators of Humanhood: A Tenative Profile of Man,* 2 HASTINGS REP. 1 (1972).
65. Fletcher, *Our Shameful Waste of Human Tissue,* essay in UPDATING LIFE AND DEATH at 1, 16-7 (1969).
66. *Id.* at 26-7.
67. Fletcher, note 59 *supra,* at 675.

Thus he still recognizes the precept that consent is important in any euthanasia question. But this does not lessen the impact of his current position advocating "involuntary" euthanasia and the obvious moral questions raised by it.

2. *Immanuel Jakobovits*

In what is otherwise a dearth of written material available to the lay public dealing with "death," Rabbi Jakobovits' book, *Jewish Medical Ethics,*[68] stands out as an indication of the relationship of Jewish moral and religious principles to that subject. Three conclusions regarding death and euthanasia are stated by the respected authority on Jewish history, culture and religion. First, "the doctor is obliged '*ex precepto charitatis*' personally to inform the patient of the hopelessness of his condition . . . . Any failure to do so involves the doctor in grave sin, since he allows spiritual or material damage to occur which he could have prevented."[69] Second, even when death is imminent and inevitable the patient must be treated as though he were living by affording his normal comfort and attention. Although death may not be hastened, impediments to it may be removed and its agony should not be lengthened.[70] Third, even when it is certain that death is near, euthanasia is strictly prohibited. "In fact, it is condemned as plain murder . . . . At the same time, Jewish law sanctions, and perhaps even demands, the withdrawal of any factor . . . which may artificially delay [the patient's] demise in the final phase."[71]

3. *Paul Ramsey*

As one of the leading Christian ethicists of our time, Professor Ramsey has had occasion to consider "death" in great depth and in many contexts. In order to provide the reader with a succinct synopsis of his views, this survey is limited to Professor Ramsey's opinions that relate most closely to the arguments advanced in favor of the adoption of "voluntary" euthanasia legislation.

In orienting most of his discussions to patients for whom death is both inevitable and imminent, Ramsey believes that "Fletcher's case for voluntary euthanasia is *morally* complete so far as the *patient* alone

68. (1959) [hereinafter cited as "Jakobovits"]. Another Jewish opinion is expressed by Rackman, *Morality in Medico-Legal Problems,* 31 N.Y.U.L. REV. 1205 (1956).
69. *Id.* at 121-3.
70. *Id.* at 123-4.
71. *Id.* at 124.

is concerned."[72] Ramsey questions, however, whether the roles of other parties in relation to the one whose life is in balance raise moral issues not covered by Dr. Fletcher. He suggests that Dr. Fletcher's justification for "inducing death" by equating it with "permitting death to occur" may not be entirely justifiable on moral grounds.

> [D]oing something and omitting something in order to do something else are different sorts of acts. To do or not to do something may, then, be subject to different moral evaluations. One may be wrong and the other may be right, even if these decisions and actions are followed by the same end result, namely, the death of a patient.
>
> What Fletcher has gained by an improper characterization of actions that allow a patient to die while caring for him—by calling them indirect voluntary euthanasia—is that, without abandoning the case he and many other moralists have made for only caring for the dying, he can the more readily succeed in apparently reducing the warrants for omitting medical interventions to the moral equivalent of the alleged warrants for acts of direct euthanasia.
>
> But to respond in this way would exhibit a considerable misunderstanding of the positive quality and proper purpose intended in only caring for the dying. . . . These actions are fulfillments of the *categorical* imperative: Never abandon care! . . . [T]hey effectuate or hasten the coming of no end at all. Upon ceasing to try to rescue the perishing, one then is free to care for the dying.[73]

Professor Ramsey's thesis is as simple as this: care for the dying. He argues that it is necessary to establish the "moral limits properly surrounding efforts to save life" so that medical treatment will cease when appropriate, and caring for the dying will begin.[74] He emphasizes a patient-oriented approach that centers on the life, not the death of the dying patient. He takes a middle ground, adopting neither the stand that there is never a reason to stop using life-sustaining medical procedures, nor one that advocates killing terminal patients. Rather, he prefers to leave the awesome decision regarding determination of when cure has become impossible and when the process of dying commences in a particular case to the physician and the patient together. "The patient has entered a covenant with the physician for his complete *care*, not for continuing useless efforts to *cure*."[75]

72. Ramsey, *Freedom and Responsibility in Medical and Sex Ethics: A Protestant View*, 31 N.Y.U.L. Rev. 1189, 1200 (1956).
73. P. Ramsey, The Patient as Person 151-3 (1970).
74. *Id.* at 144-57.
75. *Id.* at 134.

4. *Pope Pius XII*

In an address to an international congress of anesthesiologists, Pope Pius XII stated the position of the Roman Catholic Church regarding the prolongation of life with eloquent simplicity. It is hoped that the following abstract does that address justice.

> Does [the doctor] have the right, or is he bound, in all cases of deep unconsciousness, even in those that are considered to be completely hopeless . . . , to use modern artificial respiration apparatus . . . ?
>
> [N]ormally 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 . . . . 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 . . . .
>
> The rights and duties of the doctor are correlative to those of the patient. The doctor, in fact, has no separate or independent right where the patient is concerned. In general he can take action only if the patient explicitly or implicitly, directly or indirectly, gives him permission. The technique of resuscitation which concerns us here does not contain anything immoral in itself. Therefore the patient, if he were capable of making a personal decision, could lawfully use it and, consequently, give the doctor permission to use it. On the other hand, since these forms of treatment go beyond the ordinary means to which one is bound, it cannot be held that there is an obligation to use them or, consequently, that one is bound to give the doctor permission to use them.[76]

5. *Other Theological Views*

Several churches have adopted positions regarding death and euthanasia.[77] Summaries of the views of those churches that have issued formal statements follow.

76. Pius XII, *The Prolongation of Life*, 4 POPE SPEAKS 393, 397-8 (1958).

77. For other theological and philosophical opinion not referred to here the reader may wish to consult: Reeves, *When Is It Time to Die? Prolegomenon To Voluntary Euthanasia*, 8 NEW ENGL. L. REV. 183 (1973) (includes excellent bibliography); Symposium, *Contemporary Themes*, BRIT. MED. J., Jan. 6, 1973, at 29; Veatch, *Choosing Not To Prolong Dying*, MED. DIMENSIONS, Dec., 1972; D. HENDIN, DEATH AS A FACT OF LIFE (1972) (a collection of essays with an excellent bibliography); K. MANN, DEADLINE FOR SURVIVAL 92-106 (1970) (this book was prepared as a result of a study conducted for the Episcopal Church); Reid, *Prolongation of Life or Prolonging the Act of Dying?* 202 J.A.M.A. 181 (1967); Whitlow, *Extreme Measures to Prolong Life*, 202 J.A.M.A. 226 (1967).

The American Lutheran Church[78]

> While life is precious, there comes for every person that time when his earthly existence must end. The Lutheran hospital . . . believes that he is entitled to die with dignity . . . The Lutheran hospital stands firm in its opposition to compulsory euthanasia . . . . It does not lend its facilities to any active intervention that arbitrarily and ruthlessly brings about the death of any person who comes to it for care and treatment.

United Church of Christ[79]

> We believe it is ethically and theologically proper for a person to wish to avoid artificial and/or painful prolongation of a terminal illness and for him or her to execute a living will or similar document, at times, may workk to the harm of the patients . . . . We believe that there comes a time in the course of an irreversible terminal illness when, in the interest of love, mercy and compassion, those who are caring for the patient should say: 'Enough.' We do not believe simply the continuance of mere physical existence is either morally defensible or socially desirable or is God's will.

United Methodist Church[80]

> We assert the right of every person to die in dignity, with loving personal care and without efforts to prolong terminal illness merely because the technology is available to do so.

Physicians

1. *Walter Sackett, Jr.*

Probably the most outspoken, if not the most widely publicized physician to address the subject of death is Walter Sackett. This is because he is not only a physician who professes to have allowed countless of his patients to die,[81] but is a Florida state representative as well. In his latter capacity he has on several occasions since 1969, introduced a bill into the Florida legislature to amend the state constiution's Declaration of Rights to include the right to be permitted to "die with dignity."[82] In support of his proposal, Dr. Sackett assumes

78. Pamphlet, *Ethical and Policy Guidelines for a Lutheran Hospital* Lutheran Hospital Association, 1966.

79. Statement, *The Rights and Responsibilities of Christians Regarding Human Death*, Council for Christian Social Action, United Church of Christ, June 25, 1973.

80. *Report of the Social Principle Study Commission*, United Methodist Church, April, 1973.

81. Sackett, *I've Let Hundreds of Patients Die, Shouldn't You?* MED. ECON. Apr. 2, 1973, at 92, 97; Sackett, *Death With Dignity: A Recommendation for Statutory Change*, 59 J. FLA. MED. ASSN 82 (1972).

82. Note, *Death With Dignity: A Recommendation for Statutory Change*, 22 U. FLA. L. REV. 368 (1970).

his role as a physician and advances two arguments: a multitude of his patients want to be allowed to die with dignity, and the medical profession should be protected from legal vulnerability.[83]

Dr. Sackett places several conditions on the exercise of the right he would constitutionally enunciate. Among them are that the patient's condition must be irreversibly terminal, his condition must be incurable within the definition of the then current state of medical technology and the patient, his family or a medical review board must request or concur in any decision to permit the patient to die.[84]

2. *Sackett's Opponents*

The physicians who oppose Dr. Sackett's proposal readily concede that "no doctor would advocate useless treatment when life is irretrievable."[85] This opposition is grounded on the argument that the bill, if adopted, would not accomplish any useful or helpful purpose, much less change or introduce anything that cannot presently be done without such a measure. It is not properly within the purview of a medical practitioner to do anything except help his patient.[86]

This argument against Dr. Sackett's position is founded on the view that he would have the physician become an executioner, acting so as to accomodate death, whereas he should never act with respect to anything but life.[87] Mistakes in diagnosis and treatment can be and are made. New cures can be and are developed. Heroic measures to save life can and do produce hope and comfort for the dying patient. Pain and suffering can be controlled. "Loneliness and de-personalization cause the terminally ill more suffering than the pain does."[88]

Whereas Dr. Sackett views the problem as one of "death," his opponents view it as one of "life." In neither view is it denied that mistakes are possible, heroic measures can be of value, and pain and suffering should be minimized. It is perhaps fear of "judicious neglect" that compels Sackett opponents to speak out.[89]

The other aspect of the argument against Sackett that his bill "is

83. *Id.*
84. *See* note 82 *supra.*
85. *See* Epstein, *No, It's Our Duty to Keep Patients Alive,* MED. ECON., Apr. 2, 1973, at 97; Evans, *Is This Legislation Really Necessary?,* 59 J. FLA. MED. ASSN. 51 (1972).
86. *See* Epstein, note 85 *supra,* at 108-9.
87. *Id.* at 102-3.
88. *Id.* at 103.
89. Evans, note 85 *supra,* at 53.

useless, meaningless and superfluous [and] is founded on the opinion that there is no legal or medical justification for it."[90] In addition, there is no apparent indication of any rational and well-informed public demand for it.[91] Such legislation would unnecessarily confine the judgment and conduct of the physician to its terms alone. Whereas he can now handle death and communicate with his patient and the immediate family simply and quietly, the proposed bill would entangle the situation with legal requirements and could even promote malpractice litigation. "It would serve the people and their physicians best to desist from pushing legislation which has no useful or helpful purpose and which would accomplish nothing more than can be done without it."[92]

3. *Survey of Physicians*

In 1958, 418 physicians at two Seattle hospitals were sent a questionnaire intended to acquire their views of death and euthanasia, *inter alia.*[93] Without commenting upon the adequacy of the statistical basis used, some of the results of that survey are included in this article for purposes of clarity and comprehension.

Most of the physicians at both hospitals favored omitting procedures and medications which would probably extend life if such omission is at the request of the patients or, where necessary, their immediate families. A greater majority of physicians who were in practice at community hospitals held this view than their colleagues at the university ("teaching") hospitals. The surveyors attempted to explain this difference by proposing four possible theories. First, doctors in community hospitals see more patients and hence more death than those at teaching hospitals. Second, the house staff, *i.e.* interns and residents, at teaching hospitals has less occasion to counsel its patients. Third, "the teaching how to preserve life in the university setting is often so powerful that it may overwhelm any thoughts of euthanasia." Lastly, the nature of the illnesses treated at university hospitals may be "biased toward those (patients) who do not want to die."[94]

90. *Id.* at 53.

91. *Id.*

92. *Id.* Other individual physicians in addition to Epstein and Evans do not hold with Sackett's view that legislation is required. *See* Elkington, *The Dying Patient, The Doctor, and The Law*, 13 VILLA. L. REV. 740 (1968): Frohman, *Vexing Problems in Forensic Medicine: A Physician's View*, 31 N.Y.U.L. REV. 1215 (1956).

93. Brown *et al, The Preservation of Life*, 211 J.A.M.A. 76-8 (1970).

94. *Id.* It should be noted that there are those who would advance the opposite hypothesis, arguing that the lesser patient load enables teaching hospital staffs to have more time for patients.

Forty percent of the doctors polled approved of signed statements, "living wills", permitting the withdrawal of necessary life-support equipment or medication. However, a clear majority indicated that they would practice "negative" euthanasia in the absence of signed authorization.[95]

Thirty-one percent of the respondents "favored change in social attitudes which would allow positive euthanasia to be carried out in selected patients." Nearly that percentage indicated they would practice "positive" eithanasia, social attitudes permitting.[96] About half of the physicians favored establishment of panels or review boards for consultation in cases presenting difficult philosophical or moral questions. These were essentially the same doctors who favored utilizing authorization statements and who, therefore, would be less likely to encounter such problems.[97]

4. *Medical Organizations*

In April of 1973, the House of Delegates (policy making body) of the Connecticut State Medical Society approved a statement regarding "a patient's right to die in dignity." The statement approved a standard form "living will" for use by persons wishing to express their wishes in the event they could no longer do so orally and to provide a means for permitting their deaths to occur.[98] This is the only medical professional organization that has adopted or approved the use of a *pro forma* "living will".

Several other organizations of physicians have expressed their policies regarding death in the context of the practice of medicine without resort to signed statements. Although this would appear to be contradictory to the attitudes apparent in the doctors responding to the survey discussed above, three state medical associations have done so and more are considering similar action.[99] What they appear to

95. *Id.* at 79.
96. *Id.*
97. *Id.* at 80.
98. Resolution, *Dignity In Life and In Death*, House of Delegates, Connecticut State Medical Society, April, 1973.
99. *E.g.*, Resolution, House of Delegates, Medical Society of the State of New York, February, 1973:

> The use of euthanasia is not in the province of the physician. The right to die with dignity, or the cessation of the employment of extraordinary means to prolong life of the body when there is irrefutable evidence that biological death is inevitable, is the decision of the patient and/or the immediate family with the approval of the family physician. *Id.*

The State Medical Society of Wisconsin said simply, "[T]he act of killing individuals that are hopelessly sick or injured for reasons of mercy [is opposed]." Resolution, House of Delegates, State Medical Society of Wisconsin, March, 1973.

enunciate are the views of their members without confining them and patients alike to fixed forms. The recent statement of the House of Delegates of the American Medical Association is exemplary:[100]

> The intentional termination of the life of one human being by another—mercy killing—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.

With this statement the AMA seeks not only to encourage its members to practice good medicine, including both the technological and human aspects of it, but also to recognize that death and dying are exclusively within the province of the individual. It is not within the province of the physician to judge who should die. His task is to determine when, and in some instances, how, that death occurs. His mercy and compassion should be directed toward the patient in the form of the medical care he provides, including full discussion of the medical circumstances involved in the patient's condition. Given this, the patient must then confront death and dying in the comfort and intimacy of his privacy.[101]

CONTROVERSIAL CONSENSUS

The foregoing section of this discussion was primarily intended to provide the reader with a general view of some opinions regarding euthanasia. Its principal purpose was to illustrate and thereby circumstantially underscore the notion that the controversy over euthanasia is due more to unsettled and confused semantics than to disagreement

100. Report, *The Physician and the Dying Patient*, Judicial Council Report B, American Medical Association, adopted Dec. 5, 1973. This report was adopted after over six months of intensive study the AMA Judicial Council (its committee on ethics). After AMA President-Elect Dr. Malcolm C. Todd called for the appointment of a national commission to study whether "euthanasia" has a place in the practice of medicine, *see* The Washington Post, June 29, 1973, at p. A14, the Judicial Council consulted with a panel of leading authorities (including some of the authorities cited herein) and polled AMA members and over fifty professional groups. Thus, the report reproduced in the text is the result of gathering many diverse opinions, considering them in relation to medical ethical principles and achieving a rational result.

101. The AMA rendered no stated opinion as to the desirability of legislation legalizing "voluntary" euthanasia or its possible ramifications regarding the "involuntary" type.

over basic substantive issues. With the exception of Joseph Fletcher and possibly Glanville Williams, who appear to use approval and rationalization to justification for "involuntary" or "active" type, euthanasia most authorities either condemn the taking of human life without the consent or against the will of the person whose life is in question, or they avoid the subject altogether. They agree that pain and suffering should not be prolonged in instances where death is imminent and inevitable, and when the patient requests termination of life-supporting medical treatment.

The crux of the semantic problem arises in attempting to differentiate between "allowing death to occur" and what the writers persist in calling "voluntary" or "passive" euthanasia. Those who would prefer to some type of euthanasia even though they qualify their name for it and emphasize that it is undertaken with the consent or approval of the patient and with the most merciful and compassionate of motivations—are still nevertheless speaking of the *taking* of a human life. To make this taking more palatable, they further qualify their chosen terms so that it is limited to only terminally ill *patients* (not "persons") who are doomed to die in a matter of days anyway. By the time they are finished adding qualifiers to their definitions (of whatever terminology they select), they are, in essence and in fact, talking about "permitting death to occur."

Sometimes terms such as "extraordinary treatments," "artificial means" and "heroic measures" are used to describe medical efforts aimed at attempting to preserve the lives of dying patients.[102] They can contribute to the confusion surrounding euthanasia. But here again, even though they may fail to recognize it, there is essential agreement among the authorities.[103] For example, suppose that a physician has obtained, either from the patient or his immediate family, an authorization in the nature of a "living will". Assume further that the patient in question is unconscious and suffering from a terminal disease which involves great pain and discomfort, for which there is no presently known cure and which will, so far as medical technology is concerned, inevitably lead to his death within a short time. Upon these assumptions, precisely what conduct on the part of the physician constitutes "voluntary" or "indirect" euthanasia, and what constitutes "allowing death to occur"?

102. Most of the authorities utilize such language. For an enlightened discussion of some of these terms, *see* Ramsey, note 72 *supra*, at 118-24.
103. *See* authorities cited notes 18-72, *supra*.

Suppose a new medication which might cure the patient's affliction has just been authorized for experimentation on human subjects. Is it an "extraordinary treatment"? If so and it is not administered, when the patient dies is this euthanasia, or simply death? If the new drug is used and the patient lives for two days, was it an "artificial means" that kept him alive? What if he lives for two years? Suppose the patient is being treated with a respirator. Is the device an "artificial means?" If so and it is unplugged, when the patient dies, is this euthanasia or death?

In pursuing these questions perhaps the reader is inclined to desire more information to formulate his answers. Just what ailment does the patient have? Who gave the authorization? Why? How old is the patient? How long has he suffered? The questions could become an imponderably involved inquisition.

Perhaps a committee or board should be appointed or designated to look into this matter with all the care and discretion it deserves. It could construe the authorization, assess all of the facts, interpret the possible medical alternatives and reach a decision upon which some type of conduct might then be appropriate. But, in the meanwhile, what of the patient? What should his doctor do *now*?

Without implying that the definitions of terms such as "extraordinary treatments" are irrelevant in a given case, it is submitted that their uses and meanings are not proper reasons for maintaining any controvesy. Their definitions are a matter of circumstance, a function of too many necessary component viariables for them to be used in a conceptual discussion.[104]

Thus we return to the subject at hand, euthanasia, to find that there really is no controversy. The "type" of euthanasia that the authorities support is really "permitting death to occur".

The only visible purpose that can be served by referring to a "type" of euthanasia is to trade upon the connotations that the word euthanasia carries with it. If those who refer to "voluntary" euthanasia would not further qualify their definitions with provisions that their terminology is specifically aimed at patients for whom death is imminent and inevitable (using whatever language they chooses to attach to this additional qualification), then a controversy might indeed exist. If, for example, one would speak of denying or removing the insulin of a diabetic his request and out of compassion because he has con-

104. *See* Ramsey, note 72 *supra*, at 118-24.

tracted terminal cancer,[105] then one might be speaking of "passive" or "voluntary" euthanasia, and there might be some controversy.

Opinion is uniform regarding the propriety of euthanasia.[106] It is condemned. It is criminal. It should not be permitted. Perhaps the penalties for it should be mitigated according to the motivation behind it, but nevertheless there should be a penalty for it.[107]

Opinion is also uniform regarding the propriety of allowing death to occur. It is condoned. It is not criminal. It is morally acceptable.[108]

The only real question that remains is whether it is either necessary or desirable to legislate any aspect of the natural termination of life.[109]

MORALITY, ETHICS AND LAW

This portion of the discussion is devoted to whether legislation regarding "death" and "dying" is warranted. In considering this question a three part approach will be offered. This will define the three levels of value judgments the writer assigns to the processes of conduct appraisal utilized in our society, and to assist the reader in selecting one of them for his or her approach to the question.

Morality

Many of the authorities cited above refer to the concept of death as one which grips human interest. It concerns all of us. At one time or another, like it or not, we all ponder death, realizing it is inevitable. We tend to think about death as an abstract occurence in the lives of others rather than as something that will occur in our lives. However we may approach it, we all hold opinions about death. Even

105. This example was propounded by Ramsey in his discussion. *Id.* at 129-30. Perhaps by this time the reader who is familiar with Ramsey's philosophy has noticed that the viewpoint and the views expressed in this article are essentially parallel derogations of those advanced by Professor Ramsey. For one interested in reading philosophical exposition of the subject at hand with the eloquence of a master reference to Ramsey is mandatory.

106. As used here, the word "euthanasia" is as defined by the writer. *See* notes 3-7 and accompanying text, *supra.*

107. The writer takes no stand regarding this possibility.

108. This observation is made with the hope that Fletcher and Williams's advocacy of euthanasia as morally proper does not express the views of any significant number of people in our society, much less any number of the intellectuals who engage in these discussions.

109. This phraseology is used only to signify that the semantics have now been resolved and the discussion now turns to substantive issues.

those who say they do not think about it at all are thereby expressing an opinion about it. Regardless of what our various opinions may be, we share the characteristic of assigning a value judgment to death.

The most elementary mechanism for making our value judgments is what might be called morality—the recognition of qualities and the application of values to those qualities to achieve a frame of reference within which to conduct our lives.[110] It is impossible to know how much of our morality is instinctive and how much is learned. From birth we are imparted with instinctive perceptions and bombarded with environmental influences. As we grow we begin thinking in terms of good and bad, correct and incorrect, right and wrong. We organize things into groups and systems, and we characterize them as good and bad, correct and incorrect, right and wrong. We think about other people, and we also characterize them. Life becomes a way—a philosophy, if you will—of looking at things and others. It becomes a series of value judgments made according to that philosophy. Thus, we acquire a morality and govern our own lives by that morality.

As a result of our morality we assign a value to life itself; we make a value judgment about life. This value judgment has nothing whatever to do with anything but our personal morality. Each of us assigns his own value to his own life and the lives of others about him. To the extent that we agree that human life has value, we share common morality; to the extent that we disagree about the measure of that value, we must adopt a common frame of reference to accomodate our respective moralities.[111]

Joseph Fletcher attempts to construct that frame of reference for us in his proposal favoring euthanasia. In so doing he gets entrapped in form, forsaking substance. His system would impose values rather than accomodate them; it would quantify qualities rather than identify

110. Here, I return to the definitions submitted at notes 9-16 and accompanying text, *supra*.

111. I must again reiterate that it is not my intention to be labelled a pragmatist, utilitarian, naturalist or whatever. Thus, I do not advance any explanation for how one might acquire the notion that human life has value, I simply observe that in anyone's morality human life is an inextracable element. *See* Moffat, *The Indispensable Role of Independent Ethical Judgment*, 21 U. FLA. L. REV. 477, 480-2 (1969); Nichols, *Profiles of Ethics: A Tribute to Lewis Miller Stevens*, 363 ANNALS 1 (1966); Barton, *Sources of Medical Ethics*, 193 J.A.M.A. 127, 134-6 (1965).

> Nations, or in fact any form of society, local communities, cities and states, have reputations and present images to mankind based upon their conduct . . . . These behavior patterns are often described in terms involving value judgments: they are deemed either good or bad. . . . (T)he description of a community profile of ethics may be difficult to capture and record, for its elements may be complex and blurred. Nichols at 1.

them. In Dr. Fletcher's system, philosophical perspectives and moral approaches must all be categorized and named.[112] Euthanasia must be dissected into four parts.[113] Life must be measured on a scale. Death must be statutorily defined. Subjected to all of this categorization, naming, dissection, measurement and definition his argument looses the quality of persuasiveness.

Similarly, subjected to these things the quality of life also suffers a loss. By categorizing people they loose the ability to change. By naming ideas they become less conceptual. By dissecting life into childhood and adulthood the continuum of growth becomes obscured. By measuring success life looses capacity for happiness. By legislating conduct life looses the fullness of natural freedom. With a realization that it is sometimes necessary to perform these quantifications to preserve and protect our common morality, and that restricted life qualities can be better than none at all, perhaps Dr. Flethcer goes too far. The quantification he advocates for determining the quality of life and those persons qualified to retain it, in a very real sense, dehumanize us all. To say that *any* life is so utterly useless and without value that it should be extinguished is to deny that there is a nameless quality in all of us which is distinctly, uniquely and lovingly human.

By acknowleding the value of life we recognize death. Regardless of how we conceive of it, death is that inevitable mysterious quality in life that gives our values a sense of reality. It imparts to us and our morality an urgency that makes time important. It is no less a quality than love, and no less an integral part of our morality.

Ethics

One of the frames of reference for morality is ethics—the systemization of morality into standards of conduct for a defined group of people.[114] Each such system depends upon voluntary adherence

112. *See* Fletcher, note 60 *supra*, at 674-5. Fletcher categorizes euthanasia as: 1. voluntary and direct, 2. voluntary but indirect, 3. direct but involuntary, or 4. both indirect and involuntary. *Id.* at 673.

113. *See* Fletcher, note 64 *supra*. (Fletcher proposes, for example, that I.Q. could be used to measure the value of a given life).

See also Fletcher, note 60 *supra*, at 675. Of all the verbal exercises in which Fletcher seems to engage, Ramsey says, "Fletcher's is a *persuasive* use of language, not a convincing one. Writing primarily as a proponent of euthanasia (current usage), he subscribes along the way to an ethics of only caring for the dying. By calling the latter 'indirect euthanasia' his words, at least, gain the force of suggesting that this point of view is not quite as honest or forthright as 'direct' euthanasia." Ramsey, note 72 *supra*, at 150-1.

114. *See* authorities cited note 111, *supra*.

to it by the members of a specified group in specified circumstances. Each member accepts the morality of the system and follows the indicated standards of conduct. This does not mean that he betrays his personal morality as a member of society. Rather, it admits that in addition to being a member of society, he is also a member of a smaller, more specifically defined group. Thus, a church prescribes religious ethics for its membership, the practice of medicine includes standards of professional conduct known as medical ethics, and so forth.

Because of its interdisciplinary nature, bio-ethics is more difficult to define and comprehend than other ethics.[115] Because many members of many groups are concerned with bio-ethics, it surpasses the realm of the ethics of any one of these groups. Bio-ethics is in reality a systemization of the morality of our entire society. Its applicability to biologicial life necessarily includes all mankind, and its inclusion of the specific discipline of theology, medicine and law sets up various sub-systems within the major system. The bio-ethics involved in permitting human death to occur will illustrate this.

When a human being for whom death is imminent and inevitable is allowed to expire, the major system of bio-ethics as well as many of its sub-systems are involved. Basic human morality operates to make possible value judgments regarding pain and suffering. It also enables the laymen involved in the process to judge that the end of a life is near. Religious ethics may apply similarly to the laymen, and they would of course be particularly appropriate in guiding the involvement of a clergyman in the counselling and comforting of the other participants.[116] Medical ethics is apposite to the attending physician in designating his professional responsibilities.[117] In this situation, no single ethics predominates. Rather, each sub-system contributes to the whole and in concert they operate as bio-ethics to enable the making of a value judgment upon the entire situation. Accordingly, a conclusion is achieved and conduct recommended.

The most difficult problem of ethics is enforcement. This is a problem common to all systems of ethics, regardless of the group to

115. For the definition of bio-ethics offered here, the writer has relied primarily on the teachings of Edwin J. Holman, whose comprehension and understanding of the topic have been applied here to derive the ideas presented.

116. *See* Williamson, *Life or Death - Whose Decision?* 197 J.A.M.A. 139, 141 (1966); *see, generally,* Ramsey, note 72 *supra.*

117. *See id.*; *see also, Principles of Medical Ethics,* American Medical Association (1967).

which they apply.[118] In theory, at least, ethical principles are not the pontifical pronouncements of a small, elite superstructure imposed upon the foundation group in order to arbitraily specify unrealistically lofty standards of conduct. They are the common sense consensus of the group, intended to translate morality into useful guidelines for the conduct of the affairs which form the basis of the group. As such they are understandable and acceptable to the members of the group. The common welfare is promoted by adherence to them because they serve as realistic goals for the group members and enable presentation of a single image to persons outside the group. Thus, enforcement of ethical principles should not be difficult. Even if enforcement is not a major problem for a given group, the few cases of disobedience that do arise can be hard to handle because the group has little punitive power. Voluntary standards do not lend themselves well to involuntary punishment.

Perhaps the most cohesive force in any ethics is one which is very subtle, and yet is also the one which enables enforcement to be effective. It is impossible to assign a name to that cohesive force. It is that intangible factor that explains why one likes to go to a particular church, why doctors all seem to act like doctors, and why lawyers seem *enjoined* to act like lawyers. Perhaps it is something in their training and education; perhaps it is something they share in getting together at the end of a busy day or week. Whatever it might be called — fraternalism, brotherhood, professionalism—it is the core of the group, the rallying point, the reason why eligible persons desire membership and correspondingly why they voluntarily adhere to the group standards and accept group discipline.[119]

Given a group wherein its ethics are accepted and followed, and wherein its discipline is effective, there is no need for any other control or regulation of its group-related activities. So long as internal control works, any additional, external regulation is superflous. It is only when the group looses the ability to govern itself that the force of law should come to bear upon the group members.

Law

The law is the ethics of government, the standards which the gov-

118. *See generally,* Carroll, *The Ethics of Transplantation,* 56 A.B.A.J. 137 (1970); Blake, *Should the Code of Ethics in Public Life Be Absolute or Relative?* 363 ANNALS 4 (1966).

119. Here, again, I rely upon the ideas of a friend. I am in agreement with them and grateful for his sharing them.

ernment imposes upon its constituency. In this country the law should be those standards which the people impose upon themselves. And, as the people each possess a morality, their law should be a reflection of their common morality. To say that law is without morality is to deny that it has any purpose whatever.

In regulating our lives by defining our freedom and limiting our conduct, our law recognizes that indivual qualities and values must be preserved by circumscribing the extent to which any among us can impose his values upon or interfere with those of others. Laws, like ethical systems, establish standards of conduct.[120] But, unlike ethics, laws also set up the means of mandatory enforcement. They contain mechanisms for ensuring that they are carried out and for punishing those who disobey.[121]

Thus, law is the uppermost trier of morality.[122] It is the standard that supersedes the others when those others become ineffectual, unmanageable or incapable of coexisting with each other. It should be resorted to only when there is evidence that moral vales are threatened or violated. How much and what kind of evidence should require the intercession of law is a matter for resolution by government. For the sake of this discussion, however, the arguments favoring adoption of legislation regarding euthanasia are next examined to see if they appear to contain persuasive evidence in support of their positions.

1. *Definitions of Death*

The type of legislation most often promoted by the authorities cited in this discussion would regulate conditions for permitting death to occur. Those proposals will be discussed shortly. Before doing so, however, another type of legislation which has received some attention will be briefly examined. These are the statutes that would simply define "death".

In the law, the determination of death is often a critical element in ascertaining the rights of the living. Ownership of property changes, control of business, wealth and political organizations are altered by death. In the law, then, it is often necessary to know that the life of one person has in fact ended in order to know how the lives of others will continue.

120. *See*, Reid, note 77 *supra*, at 181 (quoting Holman); Allred, *Legal Aspects of Euthanasia*, 14 LINACRE Q. 1, 2 (1947).

121. *Id.*

122. This, of course, is the writer's "pyramid" concept. *See* note 16 *supra*; *see also*, Allred, note 120 *supra*, at 2.

The need to know when the law will declare that death has occurred is usually satisfied by a simple criterion: the cessation of life.[123] For years, this simple, straight-forward standard has been applied in the law with little embellishment or statutory authority. It has been widely accepted without the neccesity of legislative mandate.

Recently, however, some have concluded that this legal definition of death as the cessation of life must be made more precise and specific. They argue that death has become too complex to be defined so simply; and they urge that statutes must be enacted to provide the desired precision and specificity.

One of the overriding concerns of those who advocate statutory definitions of death is the protection of potential donors in organ transplantation procedures. After the first heart transplant in 1967,[124] the problem of protecting heart donors came into sharp focus. The questions were posed—and properly so: *When* is a potential donor dead? *How* should the proper time to remove a donor's heart be determined? *Who* should make the determination of death? Thus, we ask: Is legislation necessary to ensure that the answers to these questions are specified and enforced?

At once, after the first heart transplant, these questions became the issues in a worldwide debate. There was a fear that donors' hearts might be prematurely removed for transplantation, thereby removing all hope of recovery or survival for the donors.[125]

The intellectual community set to work at once to prevent this awful fate for those whose hearts might be removed for transplantation. Mighty discourse ensued. All were resolved to prevent the possibility that someone might be killed to obtain his heart for use by someone else. Definitions of death were formulated, guidelines were issued for cardiac surgeons and the cry went up that "there oughta be a law!"

Although most of the reports that were issued were oriented to heart transplantation problems, they are also relevant to matters which concern us more directly. While few of us may ever be involved in an organ transplantation, all of us will probably be involved with the deaths of other human beings. Some of the deaths we perceive may

123. BLACK'S LAW DICTIONARY 488 (4th ed. 1957).
124. *See* note 40 and accompanying text, *supra*.
125. *See* Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, *A Definition of Irreversible Coma*, 205 J.A.M.A. 337 (1968) [hereinafter cited as Committee].

lead us to ask the same questions which the transplant committees asked—when, how, and who determines the moment of death?

First among the committees was the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death It published its report in the *Journal of the American Medical Association* in the summer of 1968.[126] Specific medical criteria for the determination of a permanently nonfunctioning brain were advanced by the Committee. These were: 1. Unreceptivity and unresponsivity; 2. No movements or breathing; 3. No reflexes; and, 4. Flat electroencephalogram.[127] Other determinents of the absence of cerebral function would also be acceptable, the Committee said.

The report also contained comment upon the legal definition of death. The Harvard Committee recognized that the law treats the question of death as one of fact to be determined in each particular case. It also said:[128]

> In this report, however, we suggest that responsible medical opinion is ready to adopt new criteria for pronouncing death to have occurred in an individual sustaining irreversible coma as a result of permanent brain damage. If this position is adopted by the medical community, it can form the basis for change in the current legal concept of death. No statutory change in the law should be necessary since the law treats this question essentially as one of fact to be determined by physicians. The only circumstance in which it would be necessary that legislation be offered in the various states to define "death" by law would be in the event that great controversy were engendered surrounding the subject and physicians were unable to agree on the new medical criteria.
>
> It is recommended as a part of these procedures that judgment of the existence of these criteria is solely a medical criteria.

Shortly after the Harvard Committee published its report, the American Medical Association adopted "Guidelines for Organ Transplantation".[129] These Guidelines are intended to provide ethical standards to physicians connected with transplant procedures. Among the standards contained in the AMA Guidelines are the following:[130]

> 1. In all professional relationships between a physician and his patient, the physician's primary concern must be the health of his patient. He owes the patient his primary allegiance. This

126. *Id.*
127. *Id.*
128. *Id.* at 339.
129. Id.; Judicial Council of the AMA, *Ethical Guidelines for Organ Transplantation*, 205 J.A.M.A. 89 (1968) [hereinafter cited as Council].
130. *Id.* at 90.

concern and allegiance must be preserved in all medical procedures, including those which involve the transplantation of an organ from one person to another where both donor and recipient are patients. Care must, therefore, be taken to protect the rights of both the donor and the recipient, and no physician may assume a responsibility in organ transplantation unless the rights of both donor and recipient are equally protected.

2. A prospective organ transplant offers no justification for a relaxation of the usual standard of medical care. The physician should provide his patient, who may be a prospective organ donor, with that care usually given others being treated for a similar injury or disease.

3. When a vital, single organ is to be transplanted, the death of the donor shall have been determined by at least one physician other than the recipient's physician. Death shall be determined by the clinical judgment of the physician. In making this determination, the ethical physician will use all available, currently accepted scientific tests.

The Harvard Committee Report and the AMA Guidelines were among the first authoritative statements issued regarding human organ transplantation and death. While both reports recognize the sensitive and urgent nature of their subject matter, neither of them advocated the adoption of statutory definitions of death. The Harvard Committee Report specifically states that "no statutory change in the law should be necessary."[131] The AMA Guidelines state that the determination of death should be made using scientific tests.[132] Nevertheless, others have argued that legal tests are necessary.

In 1970, Kansas became the first state to adopt a statutory definition of death. The enactment of this legislation came in response to the social and political pressures which were generated by heart transplantation. The Kansas statute specifies alternative definitions of death; one is associated with absence of the classical vital signs and the other relates to absence of spontaneous brain functions. Either definition may be used by the attending physician in Kansas as the statute does not indicate a preference or order of application. The Kansas act defines death as follows:[133]

A person will be considered medically and legally dead if, in the opinion of a physician, based on ordinary standards of medical practice, there is the absence of spontaneous respiratory and cardiac function and, because of the disease or condition which caused, directly or indirectly, these functions to cease, attempts at

131. Committee, note 125 *supra*, at 339.
132. Council, note 129 *supra*, at 90.
133. KAN. STAT. ANN. § 117-202 (supp. 1971).

resuscitations are considered hopeless; and, in this event, death will have occurred at the time these functions ceased; or

A person will be considered medically and legally dead if, in the opinion of a physician, based on ordinary standards of medical practice, there is the absence of spontaneous brain function; and if based on ordinary standards of medical practice, during reasonable attempts to either maintain or restore spontaneous circulatory or respiratory function in the absence of aforesaid brain function, it appears that further attempts at resuscitation or supportive maintenance will not succeed, death will have occurred at the time when these conditions first coincide. Death is to be pronounced before artificial means of supporting respiratory and circulatory function are terminated and before any vital organ is removed for purposes of transplantation.

These alternative definitions of death are to be utilized for all purposes in this state, including the trials of civil and criminal cases, and laws to the contrary notwithstanding.

As the first enactement of its kind, the Kansas statute has been subjected to a great deal of analysis and criticism. Four of the most frequent criticisms are:

1. It is incorrect, medically, to say that death is two different conditions. Death is, after all, only one condition that may be characterized in more than one manner.[134]

2. The Kansas statute is too specific. It does not permit physicians to exercise medical judgment according to their scientific opinion of a particular case. It is so inflexible as to be repressive.[135]

3. It is obviously oriented to facilitating transplantation procedures, whereas it should have as its primary purpose the protection of all dying patients, whether they are potential organ donors or not.[136]

4. The Kansas law does not address itself to the attending physician or physicians. It does not require that more than one physician make a determination of death in difficult or questionable cases; it does not ensure that determination of death will be made by at least a physician other than one involved in caring for an organ recipient.[137]

In spite of these and other criticisms, the fact remains that the

134. Address by M. Murphy, *Medico-Legal Aspects of Death,* Fourth National Congress in Medical Ethics (AMA), April 26-28, 1973.

135. *See* Capron and Kass, *A Statutory Definition of the Standards for Determining Human Death: An Appraisal and a Proposal,* 121 U. PA. L. REV. 87 (1972); Note, *The Criteria for Determining Death in Vital Organ Transplants - A Medico-Legal Dilemma,* 38 MO. L. REV. 220 (1973).

136. Committee, note 125 *supra,* at 339; Council note 129 *supra,* at 90.

137. *Id.*

Kansas statute sought to quiet the voices that so loudly cried, "There oughta be a law!". (Parenthetically, only one other state legislature—Maryland—has been similarly motivated).[138] Even now, the cries for statutory definitions of death persist. Have they found ways to correct the faults of the Kansas statute? Let us first consider the arguments made in favor of the statutory definitions of death and then look at a recent proposal.

The movement for statutory definitions of death persists because its advocates feel that it is vital for the public to be involved in defining death.[139] To be sure, death is a partly religious and philosophical phenomenon; it is inextricably associated with living and the quality of life. Death is certainly not only a medical or scientific phenomenon. As a matter of extra-medical concern, death is a matter of public concern and sometimes confusion. Thus, it is reasoned, as a matter of public concern, death is a proper matter for public expression. And, it is urged, the proper forum for public expression concerning death is a state legislature, and the proper manner in which to voice public expression is a statute.[140]

While it is clear that the subject of death is one in which the public has a valid interest, it does not seem so clear that legislative definitions of death are of much practical value or that they answer the particular public need. Certainly the definition of death is a matter of public concern and ought to be discussed; but, will a statute lessen concern or expedite discussion? The mere passage of a statute does not, in and of itself, alleviate concern regarding the matter regulated by the law. The passage of a statute also might not promote free discussion of its subject matter. A statute might tend to inhibit expression by becoming the object of discussion rather than a vehicle for it.

Other reasons advanced in support of statutory definitions of death are that they would help achieve uniformity in the law and also might reduce malpractice litigation.[141] It is indeed doubtful that statutory definitions of death will help the law of the several states become more uniform unless every state legislature adopts precisely the same statute. No uniformity can be achieved by adoption of a slightly different statute in each state. It is true that courts have disagreed in

138. *See* ANN. CODE OF MD., ART. 43 § 54F (1972).
139. *See* Capron and Kass, note 135 *supra*, at 100-1.
140. *Id.*
141. *Id.* at 97-9.

particular cases regarding definitions of death. But it is difficult to imagine how legislative disagreement could be better than judicial disagreement. It is also difficult to accept that legislative uniformity might be achieved more easily than judicial uniformity. Perhaps the present legal system, wherein the question of death is decided according to all of the facts and circumstances of each case, is better than being bound by fixed legislative standards. Perhaps the best thing about the present law is its flexibility to meet the exigencies of each case it confronts.

The argument that statutory definitions of death would reduce malpractice litigation is the last one discussed here. The law of malpractice is, to a large extent, involved with the concept of negligence. Medical malpractice is concerned with negligence by physicians' treating patients. Regardless of whether a statutory or medical standard is used to determine the arrival of death, the standard of care with which a physician must treat his patients does not change. It is impossible for any mere definition of death to either lessen or increase the responsibility of the physician to care for his patients.

Suffice it to say that there are those who would disagree with this appraisal of the need for statutory definitions of death. They believe it is necessary and urgent for every state to enact such legislation.

Two of the most vigorous proponents of definition of death legislation have developed a legislative proposal they feel meets the objections to the Kansas statute.[142] They are Alexander M. Capron, a member of the law faculty of the University of Pennsylvania, and Leon R. Kass, a physician and doctor of philosophy and Executive Secretary of the Committee on the Life Sciences and Social Policy of the National Research Council of the National Academy of Sciences.[143] Both of these gentlemen were members of the Task Force on Death and Dying of the Institute of Society, Ethics and the Life Sciences (Purely as an aside, one might note that the Task Force concluded that no statutory change in the law will be necessary if the medical profession itself adopts the Harvard brain death criteria.[144]

The Capron-Kass proposal reads as follows:

> A person will be considered dead if in the announced opinion of a physician, based on ordinary standards of medical practice,

142. *Id.*
143. *Id.* at 87.
144. Report of the Task Force on Death and Dying of the Institute of Society, Ethics and the Life Sciences, *Refinements in Criteria for the Determination of Death*, 221 J.A.M.A. 85, 87 (1968).

> he has experienced an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions have ceased, a person will be considered dead if in the announced opinion of a physicians, based on ordinary standards of medical practice, he has experienced an irreversible cessation of spontaneous brain functions. Death will have occurred at the time when the relevant functions ceased.[145]

Although Capron and Kass obviously feel that this language meets the criticisms aimed at the Kansas statute, it is possible that it is too vague to be a significant or substantial variance from current law. It may not be any improvement at all over what we have now.

While such arguments as these discussed may persuade some that statutory definitions of death are desirable, they do not include any evidence that such legislation is necessary. There is no evidence that physicians are unable to determine whether death has overcome a given patient, there is no evidence that physicians have killed any given patient-donor to remove his heart, and there is no evidence that ethical principles are being violated. How would a statute relieve a doctor's responsibility? He must still minister to his patient, he must still be the one who first perceives that it is appropriate to raise the question of whether death has occurred. When should the doctor ask the question? Would it be preferable to have the physician attending his patient ask, "What can and should I do next *for* my patient?" or "Are the statutory criteria now applicable *to* my patient?" What is the difference between a defendant-physician in a malpractice case showing that he adhered to the normal standards of medical practice in his community and his showing that he applied the statute? Wouldn't he still be liable for a negligent failure to do either? Lastly, where is the public outcry demanding a more active role in death decision-making? Even if there were such demands, would it then be plausible to expect the public to then disregard *medical* determinations by physicians? Would dying patients really desire their plight to become a subject of public concern?

Is there, then, sufficient evidence to indicate that a law defining death is required? Since the beginnings of medical practice doctors have been treating men's ailments to ward off death. They have been dealing with it and determining when it has occurred. They have investigated it and developed ever better methods of staying and perceiving it. They will continue to do so. Is this or any other the proper

145. Capron and Kass, note 135 *supra,* at 111.

moment in the state of the medical art to remove death from the sphere of medicine? Can or will we accept the responsibility of changing today's law to accomodate tomorrow's medical advance in sufficient time to achieve any useful result? There is no reason to suppose that an affirmative answer to this question is reasonable.[146]

2. *"Dying Patient" Statutes*[147]

We now return to the statutes establishing procedure for allowing of death to occur, and find yet another problem with definition of death legislation. Given the definition of death legislation and the request of a patient that he be permitted to die, hopeless confusion results. Certainly there is a way to resolve the obvious problems, but this would no doubt take the form of additional legislation attempting to include all of the variations possible. Perhaps the problems could be resolved, and if not the courts could intercede to decide. We return to minutia, nothing has been resolved, morality prevails.

As for the "dying patient" statutes, what would be accomplished? By persisting in referring to euthanasia, the necessary inference accompanies the reference that because we speak of euthanasia it is something to be condemned unless it is controlled by law. Therefore, we need the proffered legislation. However we have such condemnatory legislation. It is the universally adopted law that penalizes murder.

But, it is argued, there is a need to go beyond the criminal law and statutorily regulate the circumstances in which the dying patient should be permitted to expire. Perhaps if we do not adopt such legislation those poor, suffering people for whom death is a certainty would not otherwise die. Simply because the proposed legislation speaks only to the situation in which death is imminent and inevitable it is patently ridiculous. What is sought to be controlled by law is nothing more than the natural termination of life. This is not only an incredibly unbelieveable posture for a statute to assume, it is arro-

146. Thus, we return to a definition of death that is simply the termination of or departure from life. Halley and Harvey, *Medical vs. Legal Definitions of Death*, 204 J.A.M.A. 103, 104 (1968). For authorities opposing proposed definition of death statutes, *see* Murphy, note 134 *supra*; Bergen, *Death, Definition and Diagnosis*, 209 J.A.M.A. 1759 (1969): Kennedy, *The Kansas Statute on Death - An Appraisal*, 285 N. ENGL. J. MED. 946 (1971). The AMA recently adopted a position opposing such statutes, and requesting members to make this view known. Report, *Death*, Judicial Council Report A, American Medical Association, adopted Dec. 5, 1973.

147. This, of course, is the subject most often discussed. *See* notes 18-101 and accompanying text, *supra*.

gant and unnecessary. Possibly the next item on the legislative agenda should be legal recognition of the right to wake up at the termination of sleep.

The right to life includes the right to experience its natural termination. This is a part of life that occurs around us every day. It is being handled and recognized by all of us, each in his own manner. Must we now invade that most private and mysterious fate that awaits us with a law that would deny us the intimacy and urgency of life's last moments? Such law would change nothing but the dignity of meeting the end surrounded by the values it has taken us that lifetime to develop.

3. *The Right to Refuse Life-Supporting Medical Treatment*

It is said that from the moment of birth we begin the process of dying. Throughout this discussion I have attempted to use the words "imminent and inevitable" in referring to the matter at hand. This terminology helped confine this discussion to one class of dying persons, a class which all too often has been called simply "dying patient".

At any time during our lives when we become afflicated with an ailment that could cause death and when we receive the attention of a physician because of that ailment, we are "dying patients". Death might even be "imminent" for some of us, and it might be "inevitable" for others. And, when it becomes both imminent and inevitable we acquire the right to experience it. But what of the patient for whom it is only imminent? Does he have any correlary right to die?

The law has addressed itself to this question and the commentators are urged that there is such a right.[148] They also observe that it is a right which is subject to legal restriction. Since death is these cases is not inevitable, the necessary condition imposed on the right to die is that the patient should be compelled to live if his death would produce undesirable effects upon society.[149] Thus, for example,

148. There is absolutely nothing wrong with allowing morality to determine the conduct of our society so long as that conduct is well-founded and universal. The fact of the matter is that oftentimes a law is just not required. *See* Holman, *The Time Lag between Medicine and Law*, 9 LEX ET SCIENTIA 102, 106-8 (1972) (citing cases in which the courts expressed substantially the same view).

149. *See* Sullivan, *The Dying Person - His Plight and His Right*, 8 N. ENGL. L. REV. 197 (1973); Note, *Compulsory Medical Treatment and Constitutional Guarantees: A Conflict?* 33 PITT. L. REV. 628 (1972); Note, *The Right To Die*, 7 HOUST. L. REV. 654 (1970); Note, *The Dying Patient: A Qualified Right to Refuse Medical Treatment*, 7 J. FAM. L. 644 (1968).

where the dying patient would seek to refuse life-saving medications but whose death would work an unreasonable hardship upon his family, the government has a valid interest in denying the right to die.[150]

Let us not confuse such cases with the plight of the dying patient for whom death is both imminent and inevitable. Let us not use them as support for legislation regarding something else. Let us consider the question of statutory regulation of death according to the precise nature of the proper subject matter, and let the law intercede only where morality and ethics will not suffice.

CONCLUSION

The "euthanasia controversy" is more one of semantics than of substance. As it is now constituted, the controversy does not exist. But, there is a substantial problem looming on the horizon, one which must be addressed, considered and, if necessary, acted upon.

In continuing to look at death as an entity unto itself, the question of who should die can arise. By asking this question we begin to consider the possibilities—the strong and healthy should live, and the weak and timid should die; the intelligent should live, and the unintelligent should die. Thus we fall into the trap that those who would have us extinguish the "defective" would set for us. This cannot be permitted to happen.

Rather than viewing death as a separate function, we must include it in our total concept of life. The issue must be whether we can do anything about improving life, not whether we can facilitate death. Our attention must be focused on life, and our efforts must be toward improving it. Our compassion and human understanding should guide our steps toward the goal of life with dignity not death with dignity for each individual. The morality of mankind would not have it otherwise.

150. *See id.*