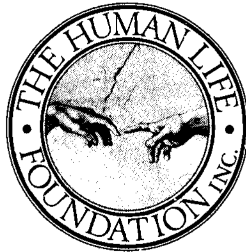
the HUMAN LIFE REVIEW



SPRING 1976

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John T. Noonan on .... Persons and the Law

M. J. Sobran on .... The Right to Die

C. Everett Koop, M.D. on .... A Doctor's View

Virgil C. Blum, S.J.
& Charles S. Sykes on ..... The Lesson of Euthanasia

Prof. Yale Kamisar on .... Mercy Killing: Some Non-Religious Views (Part I)

Bang P. Nguyen on .... An Asian View

Prof. Alfred Kotásek on .... Abortion and Its After-Effects

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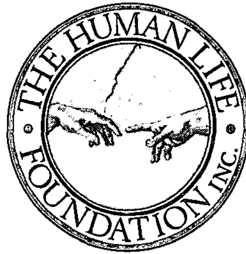

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. . . about THE HUMAN LIFE REVIEW

In this issue we continue what seems to have become our editorial "mix:" excerpts from important new books; original articles; reports from various places (as widely separated, in this instance, as Czechoslovakia and Vietnam), and a reprinting of what many consider a classic study on euthanasia (now almost 20 years old) that we have been asked repeatedly to make available to present-day readers interested in the subject. We hope (and believe) that it all makes for informative as well as interesting reading—if not something for everybody, at least something of value for anybody interested in the life issues involved here.

We still hope to institute a regular book review section in the near future, to comment, however briefly, on a great many more books that would be of interest to our readers. But this is not as easy as it sounds: it is a full-time job to cover the publishing industry's output on even a few subjects, whereas this review is concerned with a broad range of topics, to which sometimes whole books, sometimes just a chapter or two, are devoted. We would require a thorough survey of the whole field on a continuing basis. At the moment, this remains beyond our means.

We are happy to report that our new "subscription" arrangements are working out reasonably well: we now accept orders for the next four issues (one full year) at $12 (sorry, we cannot accept charge orders as yet). Please address all orders to: *The Human Life Review,* 150 E. 35 St., New York, N.Y. 10016. Previous issues are also available (see information on inside back cover of this issue).

While we cannot publish or respond to all letters received, we do thank all those (their number is rapidly becoming legion) who have taken the time to write, and assure them that their comments and suggestions are carefully considered.

Those who wish to obtain copies of Prof. Noonan's book, *Persons & Masks of the Law,* may do so from the publisher, Farrar, Strauss and Giroux, 19 Union Square West, New York City 10003, price: $10.00.

INTRODUCTION

FROM ITS INCEPTION, this review has intended to present an in-depth discussion of euthanasia (which is so obviously an important "life" issue). We assumed that it would be relatively easy to find suitable material. In fact it has been both difficult and frustrating, and has taken a great deal more time than we had imagined. There is of course no *lack* of material. However, we found that much of it lacks either objectivity, or depth, or both. At long last (this is our sixth issue) we believe we have finally assembled a number of pieces that, put together, provide a wide-screen view. In doing so we hit upon another difficulty: we cannot possibly, given limitations of space, present it all in a single issue. Therefore we will devote the major portion of both this and the following issue to euthanasia, leaving space in each for other topics as well (in relief of those who prefer variety).

Thus we begin with an article by Prof. John T. Noonan Jr. which should interest almost everyone. Dr. Noonan has appeared previously in these pages (HLR, Winter '75), writing on the abortion issue from the viewpoint of the legal scholar, and while his present essay does not so much as mention the word abortion (or euthanasia either), it does demonstrate the author's continuing concern for the treatment of the individual human person under our "impersonal" laws. We expect that many readers will want to pursue Noonan's discussion further than we are able to take it here (this is but the first chapter of his new book); if so, you will find both the title and publisher listed (see "about the HUMAN LIFE REVIEW," p. 2).

We also have, at the end of the issue, two very interesting and unusual pieces. The first is by Mr. Bang P. Nguyen, who, a year ago, managed to escape from Saigon (having been a refugee from the North 20 years previously) the day before it fell to the Communists. He provides us with an Asian view of some life issues, as well as an historical footnote: the impact of "free" abortion on Vietnamese refugees. The second, by Prof. Alfred Kotásek, is a (we think disturbing) report on the much-neglected subject of the after-effects of abortion, and how little we know about them.

Prof. Kotásek, who is generally recognized as one of the world's foremost authorities in obstetrics and gynecology, has said of the U.S.

National Academy of Sciences report (*Legalized Abortion and the Public Health*) that it is loose and superficial: "It is certainly not easy to infer the whole problem from the data as yet available, particularly in the United States, where the history of non-restrictive abortion practice is too short to provide longitudinal data . . ." Dr. Kotásek writes from the perspective of public health laws as they exist in Czechoslovakia, where abortion may be obtained on "social grounds" (i.e., more or less on demand) during the first trimester of pregnancy, and only on genuine therapeutic grounds thereafter. Dr. Kotásek's study indicates that, far from being a harmless operation, the first trimester abortions that are so common in Czechoslovakia—and in the U.S.—frequently have adverse after-effects and should be discouraged as much as possible. Some readers may well find his "conclusions" (i.e., the final two paragraphs) strangely at variance with the evidence he presents (e.g., that abortion may be used "when family planning fails," etc.); we agree, and point out that he writes not only about but *from* Czechoslovakia; he is stating, we believe *pro forma,* the "official" view on such matters. (His article came to us with a list of sources both so numerous and so largely foreign that we decided against including them here; however, should any reader want a copy, we will be glad to supply it.)

Now to euthanasia. In making our enquiries, we were frequently told about "the" study on the subject: Prof. Yale Kamisar's "Some Non-Religious Views against Proposed 'Mercy Killing' Legislation," published almost 20 years ago (1958) in the *Minnesota Law Review.* We assumed it must be outdated, but having finally acquired and read a copy (the University no longer has copies itself), we must agree with its proponents: it *is* a classic study; it is *not* outdated, and it *should* be made available to anyone interested in the euthanasia question and/or related subjects. It is not only definitive but . . . monumental as well, to the extent that we are forced to present it in two parts. It is one of those studies (rare in a field renowned for the difficult and the impenetrable) about which it should be necessary to ask only that the reader *begin* it; most will gladly read on, and come back for more (Part II will appear in the next issue). And don't miss the footnotes, which, in this instance (another rarity!) are often as informative and fascinating as the article itself.

We have prefaced Prof. Kamisar's study with several articles that are not only interesting in themselves but should also serve as a broad introduction to the current status of the euthanasia question. Mr. M. J. Sobran gives us, in his usual high style, his views on "The Right to Die," followed by Dr. C. Everett Koop with a doctor's view. Dr. Koop

has also appeared previously in this review; in fact, the present article is in tandem with his earlier one ("The Right to Live," HLR, Fall '75), and both will be published in a forthcoming book. Then we have an article coauthored by Fr. Virgil Blum and Charles Sykes, in which it is demonstrated that legalized euthanasia is hardly a new phenomenon, nor are its consequences unknown. And whatever the reader's own view, you will find a wealth of references to sources worth pursuing.

In the next issue, along with the conclusion of Prof. Kamisar's work, we will have more on euthanasia, and abortion, and (we hope) population problems. In subsequent issues we expect to delve into genetics, bio-medical ethics, and Lord knows what else: the longer we publish this review, it seems, the broader its scope. We hope so.

Letters

Reflections on Matthews

Evelyn Waugh, asked about being dive-bombed by Nazi Stukas during the retreat in Crete, said (roughly): "Impressive but, like all things German, it went on much too long." That fits Prof. Matthews' article ("Reflections on Abortion," HLR, Winter '76). I will admit that he covered the waterfront, however, bracketing everything from pornography to rock music with abortion. Prof. Matthews makes the problem seem quite impossible of solution. On the other hand, he makes it hauntingly clear that abortion is merely *one* symptom of a disintegrating society . . .
Danbury, Conn. ELIZABETH VOLZ

You are to be commended for publishing Prof. Matthews' fine article. I can't remember when a single article has "gotten it all together" like this one. I think his description of the radical change in emphasis of the women's movement is an especially important point.
Washington, D.C. EDITH PERRUSO

I have until now admitted that the abortion issue is very complicated. But Prof. Matthews makes it all *too* complicated, linking it with just about every other problem in our modern society. One at a time, gentlemen, please . . .
Dale City, Va. CARON MCCONNON

You do your cause (such as it is) a disservice to print something like [Prof. Matthews'] article. It is just too much. Few Americans are prepared to concede, however much they may agree with you on abortion, that we must stamp out the women's movement, rock, TV, movies, and what-have-you, along with it. I admit he makes the whole thing sound plausible, but I repeat, it's just too much.
Brooklyn, N.Y. R. F. JENKINS

Woman and Doctor

Very clever of you to take the notion that abortion is "a matter between a woman and her doctor" and stand it on its head [see articles by Dr. Richard Selzer and Suzanne Gordon in HLR, Winter '76]. What your articles show is that both the woman and the doctor react to abortion most *individually,* and not at all as any kind of "team," and that the real facts are, that abortion is between a woman and her family, and a doctor and his conscience.
Silver Springs, Md. MARY FENTON

In Praise of Canavan

I have been impressed by the high quality of the articles you present, but never more so than by Francis Canavan's "Law and Society's Conscience" (HLR, Winter '76), which is excellent. He goes to the heart of the matter: abortion has nothing whatever to do with the "liberalization" of our laws, but rather signals the breakdown of our moral code. A society more concerned with death than life is itself dying.
Seaford, N.Y. H. DIMOND

More Like Chesterton

M. J. Sobran's broad overviews of abortion are important and helpful—and as logical as they are readable—so I am sure it was with justly concealed wit that you printed the letter referring to Sobran's 18th Century style and mentality. With respect to the other letter, your author's style is more reminiscent of G. K. Chesterton than C. S. Lewis. Anyhow, who but a prig wants to be in touch with the modern world? Keep rebelling against the spirit of the age.
Wenham, Mass. KENNETH ZARETZKE

Un-Private Acts

The article by Dean Joseph O'Meara (HLR, Fall '75) makes a very telling point: there *is* nothing private about an abortion performed in a public hospital (or even an abortion clinic). That, it seems to me, is why the parental-consent issue is so important *re* abortion: my daughter may get pregnant in private, but she gets un-pregnant very publicly, yet I have no right even to be told about it, although it is by no means true that an abortion is a minor operation; it can have serious after-effects that—to put only the

(*Continued on p. 127*)

Persons and the Law

John T. Noonan Jr.

"THE LIFE OF THE LAW,"[1] Holmes said in his most famous epigram, "has not been logic: it has been experience." With these words, written on page one of *The Common Law,* Holmes endowed impersonal rule with existence and memory, a power of assimilation, and the capacity to develop. Like a medieval lawyer transferring from the Virgin to his craft the appellation Our Lady, like a modern dean repeating to first-year students the old saw that law is a jealous mistress, Holmes made legal knowledge into an entity—an entity which acted "by the very necessity of its nature"[2] to transmute moral standards into external or objective ones. So endowed with vitality, law was a personification.

Holmes himself supposed that "the personification of inanimate nature common to savages and children"[3] was the reason why early law made forfeit as deodands the weapons by which death was caused. Holmes even saw the primitive attraction of personification as leading to lawyers' acceptance of feminine gender for a ship, and not only of gender but of personality, so that Chief Justice Marshall could write: "The vessel acts and speaks[4] . . ." and a ship herself could be made the object of suit. Behind the "personifying language,"[5] he suggested, lay hidden grounds of policy which it was useful for the historian to bring into consciousness. Yet no less than savages or children, Holmes—all unconsciously it appears—imparted life to an inanimate concept. The law for him became a personification or, better said, an impersonation.

His mistake was double. By a form of misplaced concreteness, he attributed to an abstraction the action of living men and women. A scarecrow was given life. At the same time he overlooked the actual people in the process. The jar and motion of their experience was replaced by the imaginary adventures of the law.

Subjectively, Holmes as historian was plotting an evolutionary de-

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John T. Noonan Jr. is Professor of Law at the University of California, Berkeley. He is the author of numerous books and articles, including the definitive study *Contraception* (Harvard Univ. Press, 1956). This article is the first chapter of his new book, *Persons and Masks of the Law* (reprinted by permission of the publishers, Farrar, Strauss and Giroux, Inc., © 1976 by John T. Noonan Jr.).

velopment of particular rules. He had a thesis to demonstrate on the relation of morals to the rules of law. By his personification he concealed that the synthesis reflecting the development was effected by himself. The law—rules or prediction, a mere set of statements if Holmes' own definition was attended to—was pictured as a mighty, majestic, irresistible entity, educating and transmuting itself. Holmes gave it a fictitious life.

No person itself, the law lives in persons. Rules of law are formed by human beings to shape the attitude and conduct of human beings and applied by human beings to human beings. The human beings are persons. The rules are communications uttered, comprehended, and responded to by persons. They affect attitude and conduct as communications from persons to persons. They exist as rules—not as words on paper—in the minds of persons.

The paradigm of law is trial before a court. For almost a century the chief business of American lawyers has been elsewhere. The image of the courtroom as the center of the legal process has remained. The principal participants in the paradigmatic form are the lawyers, the judge, and the litigants. Visually examined or subjectively experienced, the form emphasizes the role of persons. The speech and action of the advocates and the judge, and the testimony elicited from the witnesses, are the principal events.

Unlike the formulae of magic and of science, legal rules do not predetermine the trial's outcome. There is one exception: when all the participants have in advance agreed to the rules to be used, interpretation and application of the rules becomes a ritual, as in the standard action for divorce. The only "clear cases," where the single rule to be applied is evident, the facts undisputed, are uncontested ones—the parking-ticket or traffic-safety violation, conceded by the motorist and typically punished without trial by a forfeiture of bail at a clerk's window: no lawyer intervenes in the process.

In contested litigation, however, the rules are invoked, interpreted, invented by the professional participants. Use of the rules depends on the ability of attorneys. The better the advocate, the less likely he is to admit a disadvantageous application of a rule. If he cannot deny the existence of a rule, or if he cannot argue against its settled interpretation, he will discover the exception, or he will show how other rules converge to a different result.

The paradigm of the trial, it may be objected, supposes that the lawyers will be equal, canceling out the importance of individual ability and making the upshot turn on the true rule. The paradigm, how-

ever, sets no standard of equality between lawyers if they meet the minimum qualification of admission to the bar; still less does the paradigm require that opposing lawyers devote equal time and care to the preparation of a case. Operationally, the paradigmatic form gives an advantage to the lawyer who by his aggressiveness or his determination, his analysis of the facts or his presentation of the rules, his sense of timing or his skill in interrogation, is a better contestant than his adversary. The advantage which goes with the better advocate is bred into the marrow of the trial. The dominant place of a lawyer in a lawsuit dramatizes what is the general case. As a process, law depends on persons.

The strongest form of the paradigm is the criminal trial where the life of the defendant is at stake. Not only is it manifest there that the process depends on persons; justice is centered on giving what is due the accused. Standing alone before the court, the prisoner is the focus of our interest and our sympathy. It is no accident that in those trials which have been celebrated in literature and in the history of our consciousness—the trial of Socrates, the trial of Thomas More, the trial of Jesus—the rules were followed and yet the human judgment has always been that injustice was done, the person condemned to death was not given his due, the paradigm of justice was violated.

The Dominance of Rules in Legal Study

Rules, not persons, are the ordinary subject matter of legal study. Legal reasoning is by analogy or example, as the classic introduction of Edward Levi describes it; and the problem addressed is, "When will it be just to treat different cases as though they were the same?" But the cases are classified by the rules they exemplify, and judicial decisions come in the form of rules stated so as to be applicable to all similar situations. What atoms are to chemistry, such units of discourse are to the study of law. Rearrangements and permutations of them are the normal way of legal development and the normal center of legal scholarship. The cataloguing work of the digest-makers, encyclopedists, and annotators consists of their analysis and arrangement. The evaluating work of treatise writers and law reviews consists of their analysis and criticism.

Little or no attention is given to the persons in whose minds and in whose interaction the rules have lived—to the persons whose difficulties have occasioned the articulation of the rule, to the lawyers who have tried the case, to the judges who have decided it. No key reporting system is keyed to counsel. No encyclopedia is arranged in terms of judges. The prime teaching tools, the casebooks, have been

composed to shed light on the life of a rule, not upon the parts of the participants in the process. Those in the classic mold, with snippets of appellate opinions arranged to display variations and contradictions of a principle, carry the indifference to the participants to the maximum.

The custom is still general, even in more modern casebooks, to give no space to the lawyers or firms who helped shape the decision. Their very names are pruned as irrelevant. Apart from Family Law, no great attention is given to the impact of the rule upon the individual lives of the litigants. Concerned with social policy, the modern casebooks reflect the play of social interests. To a very large degree, those interests are so many severed heads, detached from the persons who carried them. Such a way of study permits masks to be taken for persons.

The success of American law reviews has rested on this kind of abstract indifference. In what other learned discipline can students, one year after introduction to the methodology of the matter, evaluate successfully the work of expert practitioners? If the facts are taken as given, without respect to persons, agile minds without experience may dissect the rules by which the facts are ordered. A good law student can answer a law professor's dream of an examination question. The answer will be about *P* and *D*.

The historians of law have not provided a counterbalance to the analytical approach. They have been generally lawyers themselves, affected by professional education and outlook. Few in number, they have been isolated in schools devoted to training practitioners. They have written the life of doctrines. The best American work in legal history, that of James Willard Hurst, has been the careful investigation of the interplay between economic forces and the legal rules. Like the sociological jurisprudence of Roscoe Pound, it is by no means exclusively centered on rules: the interests of human beings are seen as affecting the results. But it is characteristic of Hurst's focus that in a book entitled *The Growth of American Law: The Law Makers,* he speaks of lawyers, legislators, and judges as "the principal agencies of law"; the individuals have become instruments. For the purpose of assessing the personal responsibility of the judges, legislators, and lawyers, this species of social history, like Pound's jurisprudence, is insufficiently attentive to persons. The classic model is still *The Common Law.*

"I shall use the history of our law," Holmes wrote on page two of his book, "so far as it is necessary to explain a conception or interpret a rule." Lawyers, litigants, and particular decision makers did not

enter into his explanation or interpretation. Like "the law" in his opening metaphor, the principles had their own existence.

No litigant who had suffered an accident and no litigant who had caused one were mentioned in Holmes's account of the development of the true principle underlying the law of negligence. Holt was noticed as a Chief Justice who had affirmed as judge a rule he had argued for as counsel. With this single exception, no relation was signaled between the enunciation of a rule and the experience of the judge who enunciated it. With this single exception, counsel in the cases of trespass and negligence were unmentioned. Half a dozen English judges were named as deciding particular cases. Nothing followed from their being named. Holmes might as easily have said "the court." Of American judges, only Lemuel Shaw, Chief Justice of Massachusetts in Holmes' youth, was recognized by name. His decision in *Brown* v. *Kendall,* Holmes wrote, was not "politic" (i.e., political), for he was "a great judge" whose strength lay in "an accurate appreciation of the requirements of the community whose officer he was." Only in this instance did Holmes acknowledge that the quality of the judge affected the judge's articulation of a rule, and he did so to dispel any notion that partisan sentiments adventitious to the emergence of the true principle had determined the result.

The metaphor of the living law had the flavor of Darwinian biology. Holmes told "a story" which afforded "an instructive example of the mode in which the law has grown, without a break, from barbarism to civilization." An evolutionary model controlled his presentation of the material. Treating of torts, he sought "to *discover* whether there is any common ground at the bottom of all liability, and if so, what the ground is." His effort would, he said, if successful, "*reveal* the general principle of civil liability at common law." The italics are mine, the emphasis on revelation through history Holmes'. His principles marched to a triumphant epiphany. This false focus on the life of doctrines has scarcely changed in a century of legal history—Milsom's *Historical Foundations of the Common Law,* published in 1969, is witness.

The Dominance of Rules in Jurisprudence

Suppose a Conference on the Study and Improvement of Railroads. The first expert, a believer in fundamentals, declares that to understand railroads is to understand how the tracks are laid out and how they lead into each other; close study of track, section by section, as it is encountered, will lead to the perfection of the science of railroading. The second expert objects to the static emphasis of the first speaker

and points out that railroading is an activity, a process. To understand it one must watch the movement of the locomotives; to master it is to be able to predict the direction and the time of arrival of the trains. A third sage interjects that railroads cannot be understood at all except in terms of their interconnections—to that extent, the first speaker was correct; but if Science is to proceed scientifically, one must imagine a hypothetical master plan in terms of which each real fragment of road may be comprehended and rationalized. A fourth expert observes that railroads will not be properly planned in today's world unless one appreciates that railroads serve important objectives of society; to plan them well one must take the stance not of a trainman but of a social engineer. A fifth, more detached speaker notes that running a railroad is essentially like playing croquet. There are a number of tunnels through which objects must be propelled at the direction of those who grasp the reciprocal relationship between the moving objects and the holes through which they move, so that it is of the highest importance to comprehend that a croquet ball without a wicket makes no more sense than a croquet wicket without a ball. So talking of tunnels and of track and of locomotives, and sometimes of social goods and intermittently of games and occasionally of engineers, the participants might greet with surprised stares a passenger who rose to ask if the persons riding on the trains are not to be considered within the province of railroading.

The cataclysms which have overtaken railroads neglectful of passengers are omens of what awaits the law after it has been studied in the terms proposed by John Austin and Oliver Wendell Holmes, Jr., and Hans Kelsen and Roscoe Pound, and Herbert L. A. Hart. The principal defect with the analogy is that persons are far more integrally part of the law than passengers are of railroads. The major writers on jurisprudence of the last hundred years, by and large—Jerome Frank and Lon Fuller are the preeminent exceptions—have not acknowledged that truth.

Their indifference, influencing and responding in turn to the indifference to persons in legal history and legal study, is most dramatically illustrated by their unconcern for a major function of Anglo-American law for three centuries, the creation and maintenance of a system in which human beings were regularly sold, bred, and distributed like beasts. Collective amnesia is the most benign description possible for this cruel neglect. The cases making these distributions of human beings as property are in the Reporters in which the fundamentals of Anglo-American common law are set out. The system in use today is continuous with that system of precedents, fictions, and

ways of argument. In *The Common Law*, for example, Holmes calmly uses an Alabama case where Lewis, a slave, chased a white girl on a country road, stopped the chase, and was indicted for attempted rape, an offense punishable by death, as a routine illustration of the rule on criminal attempts. That the case depends on the court's view of the defendant he does not acknowledge.

Herbert L. A. Hart is unusual among jurisprudents in mentioning slavery as in any way special, and he does so in a way instructive by his failure to relate the law to the institution that the lawyers created. In his inaugural lecture at Oxford in 1953, where he brought Wittgenstein's analysis of the normative use of language into specific conjunction with the use of legal concepts, he observed, "The status of a slave is not (*pace* Austin) just a collective name for his special rights and duties: there is a sense in which these are the 'consequences' of his status: it is the sense in which the obligation to leave the wicket is a consequence of being 'out.'" The comparison with cricket was enlightening in showing how legal terms acquire meaning from an institutional background: in that respect, they are like the terms employed in sports, religion, etiquette, politics, and morals. In Hart's purely formal analogy, however, no difference was made between the special duty of a slave to submit to his owner's will and the special duty of a batter to leave his wicket.

Later, in *The Concept of Law* Hart looked at the subject more substantively. He quoted from *Huckleberry Finn*, where Aunt Sally asks Huck if the explosion of a steamboat has injured anyone. Huck replies, "No'm: killed a nigger." Aunt Sally observes, "Well it's lucky because sometimes people do get hurt." For Hart the passage illustrated how "in slaveowning societies the sense that the slaves are human beings, not mere objects to be used, may be lost by the dominant group." The sense "may be lost." Hart, using a passive construction, avoided assignment of responsibility to the work of legislators, judges, lawyers in suppressing the sense of human beings, and said not a word on how the legal system made a person a non-person.

In a footnote Hart enlarged on his treatment: *Huckleberry Finn* is "a profound study of the moral dilemma created by the existence of a social morality which runs counter to the sympathies of an individual and to humanitarianism." A profound study of moral dilemma! So a law-review Note might describe Swift's *Modest Proposal*. How Mark Twain would have been amused. In his novel, Jim, around whose flight the plot turns, is a fugitive slave who is a fugitive for nothing, because unknown to him, he has been emanicipated by a will. In a denouement as sudden and ironic in its implications as the ending of

Tartuffe, he is changed from an enchained felon to a free man by disclosure of the will. Could Mark Twain have satirized the magic of legal rule more sharply? Hart missed the point because he overlooked the creation of slavery by legal rules. He did not see that it makes a difference when the rules suppress persons.

Economy is the prime intellectual justification for such rule-bound absorption. Jurisprudents have thought of themselves as dealing with the elemental constituents of the system, holding the key, as Austin expressed it, to "the science of law." The reduction of law to science, however, means the treatment of law in terms of forces which are calculable like the forces dealt with in physics. Once set on this course, it is difficult to escape the model set out in classical form by Austin—law becomes a set of commands accompanied by threats by one with authority to carry out the threats.

Constraint by the threat of force is no doubt characteristic of a legal system. But two other functions, neglected by Austin, are equally characteristic: to channel and to teach. By marking out certain types of agreement as privileged—contracts in general, marriage in particular, corporations and trusts in Anglo-American law—the legal system affords ways in which human energies and material resources may be pooled and increased. In Hart's amendment of Austin, this function is performed by "power-creating rules." But his emphasis is wrong. The human beings attracted, by the legal privileges attached, to enter a contract or form a marriage are not so much given power to have legal consequences follow their agreement as they are brought to enter cooperative relationships where almost everything will depend not on power and sanction but on reciprocal trust and good will; the legal system has not provided power so much as directions for acting in harmony—a musical script, not a set of batons.

Teaching—the main activity of appellate judges; for what else are 95 percent of their written opinions?—is even harder to accommodate within an Austinian or Hartian reduction. Teaching is, necessarily, person to person, informing and evoking. It cannot be equated with Pavlovian conditioning as an exercise in applied force. Addressing both Holmes' bad man (a real but not very typical representative of the population) and also the larger audience made up of the uncertain, the confused, the conforming, and the aspiring, the documents composed by constitution writers, legislators, and judges are educative. Their success is far more by persuasion that they are right than by coercion. To think of law as a science of power, unlocked by a key, badly obscures this function.

That the holder of the key is himself powerful is, of course, suggested

by Austin's image. Hart, with apparent relish, adapts and applies this image—his own theory is declared by him to be "the key to the science of jurisprudence." With Holmes the notion that "command of ideas" is "the most far-reaching form of power" is explicit. One is reminded of the Astronomer of *Rasselas*, who, because he could predict the movements of the stars, believed that he controlled them. But our scientists of law and jurisprudence are too rule-bound even to predict with accuracy.

Fascination with rules may mean obeisance to force or the delusion of having mastered force. It may also lead to a veritably religious veneration for the rules and their imagined author. The sovereign and his command may be deified. It is hard not to think of Tillich's Ground of Being when Kelsen speaks of the *Grundnorm*. Or what shall one say of Holmes' state of mind when he exclaims that through "the remote and more general aspects of the law, you not only become a great master in your calling but connect your subject with the universe and catch an echo of the infinite, a glimpse of its unfathomable process, a hint of the universal law"? As the believer raises his eyes, the particular persons who shaped the rule, argued the rule, applied the rule, submitted to the rule, seem to have disappeared. A type of deity remains.

Contrariwise, to regard the law as a set of rules and only as a set of rules may trivialize the subject. From Hobbes to Hart, how British philosophers have liked to treat law as a game! No doubt, games afford instructive analogies for reflection on the law. No doubt, the more rule-bound a sector of law—the old-fashioned property learning on remainders and reversions, for example—the more game-like it is. Yet to regard law only as a game is to forget that in the process human opportunities and liberties and life itself may be taken.

The Indispensability of Impersonality

That rules should be the ordinary stuff of legal analysis follows from their indispensability for social control and social construction. Those who rule are communicating to an indefinite number of persons in an indefinite number of situations. Those who rule cannot be present in each situation to respond to each situation afresh. They must in advance pick out grossly identifiable, repeatable elements of human conduct and set out what patterns should or should not be permitted or encouraged and what responses to different patterns would be appropriate.

As control, communication is most effective if the recipients do not look beyond the message. Traffic moves well if drivers stop when they see Red and start when they see Green. For a driver to pause, specu-

lating about the persons who set up the lights, would only cause congestion or an accident. The system works best if the signal received is impersonal, unambiguous, complete.

The simple situation where the users moving machinery are controlled by mechanical methods is a model for the use of rules in more complex ways. At the center of the entities by which modern society acts—the business corporation, the government agency, the university—are the rules which define responsibility and allocate power. The essential character of these organizations lies in their separation of structure from person, of office from man. The perpetuity which attends them is a derivative of their lack of human personality. They cannot be identified with any single human being. Their different human components blend into a single abstraction, "the company," "the government," "the school."

Rules mark out the process by which office is achieved. Rules identify the officeholder. Rules delineate the boundaries of the office. Rules create the roles within which the officeholder acts with authority.

Everyone has encountered not only the bad side of such creations, their anonymity, but the good side, their adherence to purposes beyond the individual. If there is conflict within them, the lawyer knows that his loyalty runs not to any person but to the institution. If there is failure or corruption, the fault is to be attributed to the individual, not to the structure he is supposed to serve. That officeholders and office are distinct makes possible the resolution of conflict, survival after failure, correction after corruption. To introduce the person as an element in law of this kind seems subversive of the system.

The paradigmatic form for law, trial in court, reinforces the necessity to exalt the role of rule. In the paradigm, the judge hears conflicting parties and decides upon the evidence which they present. The evidence is related to his decision through his selection of a rule. If the judge looks at who the parties are, he is not looking at the evidence. A judge who takes into account who the parties are will favor one or the other. A biased judge is no judge at all.

If the judge looks at the rules, he is acting in accordance with the paradigm, which requires two persons to be in controversy, and a third person, who prefers neither, to decide. The judge indicates his impartiality, he proves his good faith, by looking not at the persons but at the rule. The rule is neutral, "above" the contestants and the judge.

God Himself in Deuteronomy is this kind of judge, who "regardeth not persons nor taketh rewards." He continues as this kind of judge in Christian thought. Master and slaves, Paul reminds the Colossians,

shall be judged where there is "no acceptance of persons." The divine model is offered to human beings. The judges of Israel, Moses teaches, "shall not accept persons." You are transgressors of the law, James says, "if you show respect toward persons."

The medieval moralists teach in the same vein. The sin of "respect of persons," Thomas Aquinas declares, is a sin against justice and peculiarly the sin of a judge. In the extreme case, if the judge knows from testimony not on the record that the defendant in a capital case is innocent, and the testimony on the record makes him guilty, the judge, Thomas teaches, must act within his role, suppress his personal knowledge, and pronounce the death sentence. "Put aside favor and fear, have God alone before your eyes," Innocent III tells the judges of the Church, "and walk the royal road without respect of persons." The religious tradition, Jewish and Christian, is single in its ideal of impersonal judgment.

Invoking the rule, the judge decides fairly. Justice blindfolded in the classic representation, "God alone before his eyes" in the medieval formulation, the rule impartially applied in the modern model—the paradigm of justice forbids "acceptance of persons."

The paradigm goes beyond the court to government generally. "Relieve the judges of the rigor of text law, and the whole legal system becomes uncertain," Thomas Jefferson writes at the close of the Revolution: "Chancery is a chaos, irreducible to system, insusceptible to final rules and incapable of definition and explanation. Were this true, it would be a monster whose existence would not be suffered one moment in a free country wherein every power is dangerous which is not bound up by general rules."

The place of general rules in a constitutional democracy could not be more succinctly put. Where monsters have appeared in American government, they have appeared to issue from the sleep of rule.

The Complementarity of Rules and Persons

Indispensable but insufficient to the legal process, living only in the minds of persons and applied only in the interaction of persons, rules cannot be the sole or principal object of legal study, legal history, and legal philosophy without distortion. What is distorted is the place of persons in the process. An individual, unless he or she is expressing a whim, must articulate a rule when arguing or deciding a case. But the process consists in the interplay of the persons forming the rule with the persons applying it and the persons submitting to it.

Observing that rules alone are inadequate, Roscoe Pound in 1917, *in an article* defiantly entitled "Juristic Science and the Law" (defiantly

because he was a believer in juristic science), declared it a prime mistake to think of law "as wholly made up of rules." Above the rules were what he called "standards," such as the standard of due care, and "principles," by which rules were measured and applied. The principles were described as "the living part of the legal system" and "its most significant institution." A comparable move has been more recently made by Ronald Dworkin, Hart's successor at Oxford, amending Hart by distinguishing rules (specific directives applicable on an all or nothing basis) and principles (statements of reasons and values which are typically weighed in their application). Analogously, the brothers Kadish, philosopher Mortimer and jurisprudent Sanford, have justified discretionary departures from rules by "principles of acceptance" broader than specific, mandatory directions. In each case the expansion of rules recognizes the place of morality in the legal system: so Pound speaks of standards containing "a large moral element"; Dworkin declares his move to be a critique of positivism; the Kadishes justify departures from rules in the name of larger "ends." In no case, however, are these moves (which are so useful in the contexts in which they are made) a satisfactory substitute for the presence of persons in the system. Principles are no more "living" than rules; the personification by which they become "living" is obvious. To invoke principles instead of acknowledging that at some point persons act is to remain rule-focused.

Rules and persons may be conceived of as an antinomy—"government of law, government of men." But the principle of contradiction, that necessity of reason, makes us uncomfortable with conflicting accounts put forward as descriptions of the same process. Rules and persons may be conceived of as alternative perspectives, to be chosen depending on the view we want. This is better, but unduly encourages the attitude that the views are equally good and that either is sufficient—a slovenly and unacceptable indifferentism. The process is rightly understood only if rules and persons are seen as equally essential components, every rule depending on persons to frame, apply, and undergo it, every person using rules. Rules and persons in the analysis of law are complementary. By the same token, the paradigm of the impartial judge and the paradigm of the personally responsible judge are equally necessary.

That like cases should be treated alike, that equality of treatment excludes bribery or bias—these are axioms of justice. Yet there is no reason to suppose that justice is the only virtue required of a lawyer, legislator, or judge. If they are not to cease to be human, they must cultivate the other virtues of humanity. Justice to persons, Augustine

reminds us, may be identified with love—an active service to another who is loved.

Abandonment of the rules produces monsters; so does neglect of persons. Which monsters are the worse I will not argue. Our jurisprudence, however, has emphasized the first danger. "The intense desire," Pound observes, "to exclude the personality of the magistrate for the time being at almost any cost has left its mark on the law beyond any other factor in law making." Our history, as I shall illustrate, shows that the second danger is as great, the specific evils it has produced as enormous. Lawyers, lawmakers, judges do not act as responsible persons by mere faithful attention to rules.

In discussing Goya's masterpiece, *The Third of May, 1808,* Kenneth Clark writes that the artist

> shows one aspect of the irrational, the pre-determined brutality of men in uniform. By a stroke of genius he has contrasted the fierce, formalised repetition of the soldiers' attitudes, the steely line of their rifles, and the hard shapes of their helmets, with the crumbling irregularity of their target. As I look at the firing squad I remember that artists have been symbolising merciless conformity to this kind of inhuman repetition since the very beginning of art. One finds it in the bowmen on Egyptian reliefs, in the warriors of Asshur-nasir-pol, in the repeated shields of the giants on the Siphinian Treasury at Delphi.

Rules are formalized repetition. They enforce a conformity which may be merciless and inhuman. They embody power. "But," as Clark adds, "the victims of power are not abstract." Goya, as he might also have added, keeps the faces of the soldiers hidden by their shakos; it is the victims' faces which the artist has made visible.

In this book, in reaction to rule-oriented writers, I stress the place of persons with an emphasis redoubled because I seek to distinguish persons from masks. But it would be a travesty of what I believe to suppose that law could exist without rules. At the intersection of rules and persons, the process to be understood occurs. A chief difficulty to understanding, however, is the presence of masks, formed by rules and concealing the persons.

Masks Defined and Distinguished from Roles

By masks in this context I mean ways of classifying individual human beings so that their humanity is hidden and disavowed. I do not mean the disguises, psychological or literary, by which one may conceal the psyche. The presentation of the self in everyday life is not in my sense a mask. Humanity is not thereby put aside. By mask I mean a legal construct suppressing the humanity of a participant in the

process. Mask is the metaphor I have chosen for such constructs, because the human face is where emotion and affection are visible if not deliberately concealed.

"Property," applied to a person, is a perfect mask. No trace of human identity remains. Other legal concepts depend more obviously upon context and usage for their efficacy as masks. "Sovereign" and "court," "plaintiff" and "defendant" may, for example, function to suppress humanity. "As all who knew him are aware, the man was even greater than the judge. His passion for justice . . . appeared in his voice and words, as his love for humanity was apparent in his face," Warren Seavey writes of Cardozo—it is the unmasked face, the human voice, to which he refers.

What is the difference, then, between a mask and a role? The distinction, I believe, is both difficult and crucial. The lawmaker and the judge and the litigant are all carrying out positions assigned them by society, all are the players of roles. They have not been identified with those parts. The masked person has identified with, or been identified with, the mask.

A football team, for example, of uniformed, helmeted, numbered men is engaged in an athletic role. Their role authorizes action not normally tolerated—tackling and blocking of others, knocking them to the ground; yet obviously their role does not authorize the deliberate infliction of injuries. The equipment that accompanies a role is meant to give security and ease in its performance. It may, however, have a dehumanizing effect. So the introduction of better protection, including noseguards, has had the twin effect of making football players more aggressive, and more vulnerable to injuries where unprotected, as they are at the neck—the carapace effect, common to football players and automobile drivers. If the dehumanization were carried further and the players wore visors concealing their faces, wore jerseys which were anonymous and fungible, and took their function to be the achievement of victory although victory meant the physical destruction of their opponents, they would be masked.

The analogy suggests how a role may be turned into a mask. It suggests the importance of the carapace effect. It fails, however, to bring out sufficiently the essential contribution of roles to any community. No one can do everything and be everything. I must contribute to the community as lawyer, teacher, father, husband. In each role there is an art I must master. But as Socrates pointed out to Thrasymachus, the art is subordinated to the service of others. In his example, the role of the physician is perverted when the doctor's purpose is to make money. It may be that the role becomes a mask whenever the

purpose of serving others is forgotten; the judge who has forgotten the purpose of justice is almost surely masked.

Roles are as necessary for the display of human love as clothes for the display of human beauty. The naked individual rises to the communal expectations invested in the role—black-robed on a bench, he is different from the bureaucrat behind a desk. No more than clothes does a role obscure the human visage. But as a hat can be pulled down to cover a face, so a role, misused, becomes a mask obliterating the countenance of humanity.

Masks Subjectively and Objectively Considered

Masks of the law are of two kinds—those imposed on others and those put on oneself. "Property," applied to slaves, "sovereign," applied to lawmakers, are instances of the first kind. "The court" in the mouths of judges, "the law" in the mouths of judges and law professors are instances of the second. No doubt the extent to which these terms exclude humanity is a matter of context and degree.

Applied to oneself or accepted from another for oneself, the legal mask may be internalized—it then becomes indistinguishable at a psychological level from other disguises of the self. "The law" as a personified entity may become an invisible companion like a teddy bear or a lamb who is the alter ego of a child; the child is not responsible for Lambie's actions; he may even regret them; "however," this is what Lambie had to do. Analogously, a judge may speak and even think of the law as an invisible companion telling him what he must do.

The play of children as described by Piaget affords another analogy for the lawyers' use of masks; at what he describes as "the second stage of their development," between four and seven years of age, children take the rules of their game as fixed from above. Their own cooperative action is masked as preordained necessity. Just as this stage of development continues to exist in adults who partially outgrow it, so "the law" is often viewed as preordained necessity by adult users of the law.

To analyze the masks as mere subjective phenomena, however, would be to miss their distinctive characteristic. They are not purely private projections or creations. They are socially fashioned. They are more social even than such expressions of group hostility as "wog," "gook," or "pig," which also function to deny humanity. They have been stamped with official approval by society's official representatives of reason. They are—to repeat the tautology—a portion of the law. Examining the use of masks by George Wythe and Thomas Jefferson, Oliver Wendell Holmes, Jr., and Benjamin N. Cardozo, I do not sup-

pose that as individuals they invented the terms they used as masks. Wythe's and Jefferson's relationship with their slaves, Holmes' experience of battle, Cardozo's experience of his father's failure may have affected their choices, but they chose from what was current in the legal universe.

Mask, *persona,* itself a term that first had meaning in drama, suggests that the true character of the masks of the law may be aesthetic. In a work of literature the word of the author is objectified. He speaks through many tongues. He "do the police in many voices." He is hidden by the form he has chosen. Is not a statute or a judicial opinion also a work of literature, the author or authors objectified in the form? At the highest level, is not legal writing great literature? "Many a common law suit," Cardozo wrote of Holmes, "can be lifted from meanness to dignity if the great judge is by to see what is within . . . the sordid controversies of the litigants are the stuff out of which great and shining truths will ultimately be shaped." Judges like Holmes and Cardozo remain hidden as they transmute the tawdry materials of life into aesthetic masterpieces. To accomplish their end, it might be supposed that they had to mask themselves as "the court."

The analogy between literature and law is, however, incomplete. Besides the aesthetic objective, there is masking of a different kind. The Stendahl behind the multiple façades of *The Charterhouse of Parma* does not deny his humanity. The masked author of a judicial opinion sometimes does. The work of literature acts only upon those who respond to it. The statute or piece of legal writing, even the judicial masterpiece, may deny the humanity of those upon whom the writing bears.

In Plato's famous presentation in *The Republic* of the case against justice, Thrasymachus maintains that law always represents "the interest of the stronger": otherwise those strong enough to make the laws would not enact them. His position has great plausibility. His objection presents in its starkest shape the claim, now most strongly advanced by Marxist analysts, that law is determined by class interest. The masks of the law, it could be argued, are invented and employed by the ruling class to cover their own aggression, to cover over the faces of those they exploit. In a Marxian account, they may be regarded as reification. More generally, in any sociological analysis, the masks may be seen as devices reflecting the structure of society and the degrees of its acknowledgment of humanity in different groups.

Socrates' reply to Thrasymachus is that the interest of the strong is not self-evident. It cannot be determined without knowing the impact of the decisions upon the decision makers. The answer has a general

validity. Law is not something applied to subjects which leaves those applying it unaffected. Judge-made law, for instance, is educational—no mere umpires unaffected by the afternoon's sport, the judges are the ones most likely to be educated, and after them, the lawyers. The American legal realists emphasized the role of judges in making law. They did not sufficiently consider how making law implicated the makers. It is the law's values, perspectives, and blind spots which they shape themselves to share.

Socially employed and individually appropriated, masks are not mere instruments of power. The analogy of the visored team suggests that the masks of the law are like the accoutrements of war; and where life or liberty are taken, law seems close to war. Yet it is to suppress vital differences to treat law, even unjust law, as an act of "violence." The legal process—it is its chief justification and principal success—aims at compromise, avoidance of violence, peaceful direction of conduct. As a social reality, law is inadequately understood if it is identified with that use of force which terminates a life or makes a prisoner. Law exists in a society as a set of communications which, most of the time, are efficacious by being communicated. To treat masks as armament would be to mistake their use.

The metaphor of mask opens out to psychological or sociological investigation where the masks are analyzed as pure projections of the psyche or as pure reflections of structured power; and the metaphor invites the development of the analogies with literature, games, and war. Yet masks in the law have their own character and function which it is the work of one writing about the legal process to examine. What has been called "magic" bears closest resemblance. Soedjatmoko notes:

> Observing that words sometimes make human beings behave in accordance with the sense they convey, many people believe words to possess an inherent power which may affect situations and dead objects as well, and priests to possess the gift of handling such powerful words. We call the practice of speaking powerful words "magic" if the speaker himself believes that his words bring about the desired effect. The ancient Javanese did believe in verbal magic, as is evident from stories which we find in their literature. Considering, then, that some Javanese texts are unintelligible unless we suppose the author to have practiced magic, and that many other texts are easier to understand and fit better into a framework of facts if interpreted on the basis of that supposition, we shall have to reckon with the possibility that in Java "poetical style" and magical function were concomitant.

These observations are made of folkways on an Indonesian island. I find it difficult to distinguish the use of masks by our lawyers and judges, whose utterances show their own belief, as long as they act as lawyers or judges creating masks, in the power of their words.

Neither individual projections nor objective artifacts, neither social roles nor literary disguises, the masks of the law are magical ways by which persons are removed from the legal process. By rational criticism, by historical reconstruction, the persons may be restored.

The Removability of Masks

The users of any system—scientific, theological, legal—encounter points where their premises and their practices are inconsistent. These gaps in the system must be bridged or the system changed. To bridge the gaps, those who accept the system employ fictions. As Lon Fuller has demonstrated, fictions find as "pervasive" an application in jurisprudence as in physics: fictions are a necessity of law.

Masks are a variety of fiction. At the points of a legal system where it is too much to recognize that a human being exists, a mask is employed. The intolerable strain is relieved. It may be supposed that as fictions in general are a necessity, so the subspecies of fiction, masks, are inevitable.

The conclusion does not follow. Useful or at least harmless pretenses can be distinguished from masks—all the more necessary to make the distinction because the legal universe contains so much make-believe untested by reference to reality. In the making of masks lawyers have let their fiction-making capacity run amok. As the stories which follow suggest, masks are monsters as dangerous as those issuing from the sleep of rational rule. Masks are a type of "human self-alienation." Masks conceal persons.

To remove the masks is to distinguish between them and the persons. By the latter, I mean particular flesh and blood and consciousness. I take as a starting point that we are such beings, that we encounter such beings, and that encountering them we recognize those who are in shape and structure, in origin and destiny, like ourselves. I assume that we have the experience of responding to persons.

> Among the Bali, an individual is initially named by a unique nonsense syllable. Within the family, and in situations involving actions having effects on the family, he is called by the number designating his sibling ranking. His duties, his privileges, the principles which guide his choices, are determined by his place in a sibling-order. When he assumes offices and duties, his titles *are* his names and in that context, he *is* the bearer of that office, the actor of that role. The policies and to some extent even the memories that determine his choices as a bearer of office are entirely distinct from those that guide him as a member of his family. If he keeps the roles distinct, they need not come into conflict; but of course if he tries to conjoin them, "his" various role-policies can come into opposition.

So the anthropologist Clifford Geertz—he is quoted by Amelie Oksen-

berg Rortz, exploring the meaning of "person." The problem suggested is not only to be found among the Bali but among our own lawyers and judges. Are they identical with their function, the memories which guide them those of their office? More generally, are persons merely a collection of roles—husband, father, lawyer, etc.? I take persons to be ontological realities, perceptible through the roles, distinguishable from both roles and masks. Recognition of persons involves a conceptual scheme, but it is a conceptual scheme which is the condition of discourse. To say with Hans Kelsen, "The context of physical (natural) person means nothing but the personification of a complex of legal norms," is to put the matter backward, an inversion leading to an imaginary universe corresponding to nothing in existence. If a lawyer could not distinguish between real persons and fictional persons such as corporations or trees, he would not be capable of communication.

"Persona" once meant the disguise adopted by the actor. It came to mean an intelligent, sulf-subsisting being, "the most perfect" in the universe. In the history of the Latin term is packed the latent relation of mask and person. In the evolution of "persona" is the development I see taking place in the law, masks concealing persons and being replaced by them, the acceptance of masks being the greater sin. God, it is now seen, is not a respecter of masks.

The history of this process seems calculated to cause vicarious anger or vicarious guilt. But can any good come of it? The melancholy record of fratricidal inhumanity is the nightmare from which Stephen Dedalus shouted he was trying to awake. If Wythe and Jefferson, Holmes and Cardozo—the best lawyers of their age, our best—put on masks, who could have done differently? These are the phenomena whose terror Mircea Eliade evokes, explaining the need of redemption from time. "History!" writes Bokonon. "Read it and weep!"

Non-persons exist in contemporary American law. What need, then, of history to re-create the problem? Can the problems even be perceived in history unless one has already perceived the present posing of the issues? Is not the turning to history a withdrawal from curable ills to a past which is beyond change? The answer to each of these questions must consist in the enormous advantage that distance from an evil yields: the incentive to disguise, rationalize, or accommodate weakens or disappears. Looking intently at the past can improve our present vision.

If despair or terror or escape are not ultimate human responses, history of this kind can serve a heuristic function. It invites us not to contemplation but to inquiry—inquiry into institutions now structured

by law and served by lawyers as slavery once was. It directs us to consider the part of the active participants in these structures—the lawyers first, then the judges, lawmakers, and administrators. It leads us from inquiry to recognition of the persons who speak to us through rules and of the persons to whom the rules are spoken.

NOTES

1. Oliver Wendell Holmes, Jr., *The Common Law* (1881), 1.
2. *Ibid.*, 38.
3. *Ibid.*, 11.
4. Marshall, quoted by Story, *The Makel Adhel, 2 Howard's Report,* 210, 233, (1844), cited by Holmes, 29.
5. *Ibid.*, 30.

The Right to Die (I)

M. J. Sobran Jr.

A FEW MONTHS AGO, the World Health Organization sponsored a meeting among a group of what were called "experts" in one press report, the fruit of which meeting was a proclamation that mankind is endowed with a right that escaped the attention of Jefferson, Paine, and Robespierre: namely, "the right to sexual fulfillment." Since the general area of rights is usually regarded as part of the domain of ethics, it is tempting to ask what authorized scientific experts to issue pronouncements on the subject; but this is the kind of question that does not manage to get itself asked on matters of this sort. Proclaim a universal human "right," and you may be assured no rational challenge will revoke it: we can use all the rights we can get nowadays, and it seems so very stingy to withhold one more when they have become, by a sort of philosophical inflation, so very cheap. I remember the response of a skeptical old philosopher upon hearing of this latest right: he suggested that we could do with a master list of rights, so that we might keep track of them all. But our reservations must be uttered discreetly; to make them is to risk incurring the suspicion that we are resentful of the human happiness that is produced by this wonderful proliferation of "rights."

Lately we have been hearing of another alleged right: the right to die. At first glance one might think this a rather perverse novelty, of interest only to a people surfeited with both freedom and prosperity. Given what men have done and endured that they might live, such talk sounds somewhat ungrateful, the dialect as it were of people who have forgotten how to cherish the world, knowing neither its price nor its value. It is worlds apart, for instance, from that merciful speech of Kent in *King Lear*, who entreats his friends not to try to revive the dying Lear:

> Vex not his ghost. O let him pass! He hates him
> That would upon the rack of this tough world
> Stretch him out longer.

But waiving the question whether such talk about "the right to die"

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reflects a certain ingratitude verging on impiety, as (at least in its more casual expressions) I believe it does, let us ask what it means, and what follows from taking the expression seriously. Let us consider, first, the pure libertarian form propounded by such as Dr. Thomas Szasz, who flatly says that we should recognize the right to suicide. There is an even balder form of individualism, alluded to by Chesterton, which holds that the ideal society would include suicide machines in which a man might end his own life by putting a penny in the slot. Here one arrives at a conception of life so shallow and weightless, with choices so airily arbitrary, as almost to make one question the mental health (a phrase, by the way, Dr. Szasz is suspicious of) of its proponent.

If there is indeed a right to kill oneself, does this mean that the fireman who prevents the would-be suicide from splattering himself on the pavement should be susceptible to a tort action? Does it mean that it is even morally presumptuous to try to persuade a man not to kill himself? If he wants to jump from our office window, is it an act of benevolence to open it for him? Silly questions, perhaps, but no sillier than that view of the value of life that generates them. It is a view, in fact, that cannot distinguish values from preferences, much less discriminate primary values from lesser ones—a view of things that might be described as metaphysically flippant.

This is not to say that there can be no serious and even robust advocacy of suicide. Many societies have encouraged it in certain circumstances, not as a "right," but as a duty (or something very like a duty). Among peoples like the ancient Romans and until fairly recently the Japanese, it has been regarded as the appropriate period to life in certain circumstances: disgrace, defeat. It was held a decorous withdrawal from life, and had the character of a public act: the suicide said, in effect, Behold! His act was not concealed or hushed up.

To observe this is not to confer approval on the act, which I believe to be intrinsically wrong; but merely to recognize that suicide may have a very different significance in another cultural context from the one it has in ours. And it is just because it takes much of its meaning from such a context that we cannot simply transplant an institution, like the ritual suicide practiced among some Eskimo tribes by superannuated members, from another society into our own merely because it would apparently be convenient.

It is less the advocacy of "the right to die" than the rationale that is, in my opinion, most objectionable. Sovereignty over one's own person is indeed essential to liberty; but that sovereignty is neither

absolute and unqualified nor free from moral scrutiny. To say simply that one has a right to kill oneself, in the sense that there is nothing morally wrong in doing so, and to say this without so much as specifying that the motive must be serious rather than whimsical, is both an affront to the whole idea of social responsibility and a trivialization of life itself.

The "right" to die, like the "right" to sexual fulfillment (whatever that means), would seem to be one of those human choices it is supererogatory to announce. People do die, after all. The "right" to die may mean a number of things, but it would hardly seem necessary for a civil rights commission to step in to enforce it, since anyone who wants to commit suicide is not likely to be prevented. (In our society it is the phony suicide "attempt" rather than the genuine article that is likely to be a public act.)

What is demanded, then, is not really that we make it physically possible to die, but that we make it respectable to commit suicide. It is asked of us that we "integrate" suicide into the fabric of our lives, participate in the decision, provide ritually sanctifying means. In other words, the suicide is now forced to go it alone; "right to die" advocates would have us give him a send-off. He is to remain a member in good standing of the community he is deserting.

This may seem a harsh way of putting the matter. Does the terminal cancer victim really mean to "desert" the rest of us by ending his own misery ahead of schedule? It may not be what he means to do, I grant; but it is what he does. The Army deserter may not mean to expose his fellow soldiers to increased danger by leaving them; but he does so nonetheless. But my purpose is not to condemn the suicide. It is to investigate the meaning of his act, and whether that meaning can be assimilated into the purposes of the surviving community.

No doubt there are variations enough among individual suicides, but at least it does seem safe to say that the moral sanctions against suicide itself are so strong in the West that it seems doubtful that a man can kill himself in our society without feeling a deep sense of estrangement from those around him. It is hard to imagine those who survive him feeling proud of him: he must know that in killing himself he disgraces himself. Hence many suicide notes include apologies.

If I may be allowed a personal reminiscence, I used to know a woman who, finding widowhood intolerable, shot herself. By a horrible coincidence, another friend of mine died of cancer the same day. My reaction to her deed was, as a result, somewhat censorious: I had watched my other friend struggle against death for three years, and it struck me as ungrateful of her to throw away what he had so des-

perately clung to. I felt that only some derangement could mitigate the seriousness of her act.

The case now seems to me very different. She and her husband had been extraordinarily close to each other, and rather remote from the rest of the world. I think I lacked a proper sense of the meaning of social life at that time, and especially of the special nature of that form of social life that marriage constitutes. All her friends knew that she missed her husband—she said so constantly—but I lacked a sense of the pregnancy of the idiom. When we say we "miss" somebody, we may merely mean that we prefer his presence to his absence; but we may also mean something much stronger, that when he is absent, we feel part of ourselves to be "missing," and that we cannot, as a consequence, divert our minds from his absence and proceed with life as usual. Such a personal attachment is one of the profoundest forms of social life. Usually we think (or at least talk as if we think) that sexual love is the principal attachment of this kind; but friendship and, in some cases, kinship may be equally intense. It is evident enough that romantic love does not always attain this intensity, or sustain it for long.

My point, I am afraid, will seem labored and obvious to those who know it by experience: that when a loved one dies, part of the survivor dies too. The obverse point is that part of the loved one remains, as it were, alive within the survivor; but this fact does little to console grief. To say, with Donne, that "everyman's death diminishes me" may seem excessive; but unless one's social life is seriously impoverished, there must be someone whose death must painfully diminish, even devastate, the close survivor. The phrase "social life," in colloquial use, suggests very casual relations; but there is a sense in which it might almost be said that social life *is* life, in that most of our activities, and nearly all our values, sentiments, thoughts, joys, and so forth derive from mutual interfusions of consciousness with other people, especially those with whom we are on the most intimate terms.

And so I have come to feel that my friend's suicide was perhaps as excusable as a healthy person's suicide can ever be. But was it, in fact, excusable? I cannot say, nor see how anyone else could say either. It is one of those decisions that lie at the very margins of social life. If there are justifications for suicide, their delicate and individualized character must necessarily be such as to make them beyond the ken of public understanding; wherefore it seems to me shallow, presumptuous, and wrong-headed to attempt to foresee such justifications and to accommodate them in our institutions. Suicide will in the nature of things remain an option. But society has a duty not to encourage it—

or to put it the other way around, society has a duty to encourage its members to live.

So far I have spoken of the supposed right to die in terms of suicide generally. In practice, of course, the advocates of such a right usually refer to euthanasia, or what might be described as delegated suicide.

The first thing to note here is that to make death a matter of choice may be more a source of complication than of liberation in our lives. I have always thought that the most persuasive argument for the free market is not that it is productive, but that it is almost purely conventional: it allows matters to be settled without political intervention and the haggling and pressures that entails. No moral judgment need be made, for instance, about whether Mr. Rockefeller or Mr. Mellon deserves his great fortune, or whether he is spending it as wisely as Senator McGovern would. Similarly, letting death come when it will simplifies life. It relieves us of the huge responsibility of deciding *when*. It allows us to be, in a sense, irresponsible. It leaves the business of ending life to an "invisible hand."

Now to institutionalize suicide means not only to permit it, but also to *encourage* it. As soon as it is legitimized as an option, it becomes incumbent on the subject to explain why he has not chosen it rather than another course. In other words, to permit people to kill themselves without social obloquy is to put some pressure on them to do it. The pressure will in most cases be slight; in others, especially those of conscientious and charitable people who have become burdensome to their families, it may be intense, even irresistible. The legitimation of suicide is based on a fundamental lack of faith in the dignity of life. The lack of that dignity will be only too keenly felt by those whose life is justified only by the very fact that it *is* life, not by any advantages or satisfactions they confer on others. The consequences will be tragic.

What is more, the institutionalization of suicide necessarily implies that death is in some circumstances an objective good. That is, it implies that death may be *known* to be good not only by the subject who finds his own existence unendurable, but also by observers. Put yet another way, it means that it will be possible, and very likely socially permissible, for others to regard the subject critically and decide for themselves that he would be better off dead. All that will be lacking then for them to sentence him to die will be a decision-making apparatus. And once the attitude has taken root that we may reasonably *suggest* death for others, I cannot see why we should not proceed to *prescribe* it.

It seems obvious to me, at least, that the demand for euthanasia and other forms of suicide is part of a more general cultural phenom-

enon, an outlook that devalues life as such. I do not say this accusingly. I think it is a matter of fact concerning which there need be no dispute between me and those who applaud what I deplore. It is evidently implicit in the appeal to "quality of life" as against life itself as the criterion that should be uppermost in our minds as we approach decisions involving life and death. The value we assign to life, however, though it will remain the heart of the controversy, is only part of what must be considered; and I think that those who take opposite sides on the fundamental question can still profitably explore together the kind of considerations I have touched on here. Even those who abstractly approve of euthanasia, I would suggest, may shrink from authorizing it when they consider the kind of practical consequences it is likely to entail.

The Right to Die (II)

C. Everett Koop

IN THIS BICENTENNIAL year when we are constantly reminded of the words of Thomas Jefferson[1] concerning the inalienable rights of man to life, liberty and the pursuit of happiness, we recognize that the definition of life, the definition of liberty, and the definition of the pursuit of happiness can raise many moral and ethical dilemmas, especially as we attempt to interrelate these rights; these terms eventually defy full definition.

The process of death is a pinpoint in time for some, a short episode in life for others, and a seemingly endless transition for still others. The brevity of the first is frequently considered to be a blessing for the recipient and a tragedy for those who are left behind. The last is considered to be a tragedy for both recipient and observer. Part of this has to do with the failure of our culture to recognize death as part of the process of life which begins before birth. Death is believed by some to be a step into oblivion—the end of everything. At the other end of the scale it is a step from temporal life to eternal life. For a great host of people it is something more vague between these two possibilities. In any event for most people it represents the ultimate in the unknown and therefore for most people is frightening. Even for the Christian who looks forward to eternal life, who believes that to be absent from the body is to be present with the Lord,[2] death itself may hold no fear, but the process of dying is terrifying.

Even though our culture has not been used to speaking of dying and of death with equanimity, there is a growing tendency, in medicine particularly, but also in certain social contexts, to speak of approaching death or the possibility of dying with a new frankness. Out of the freedoms born of this frankness have come considerations of "the right to die," of "death with dignity," the discussion of a "living will," and the resurrection, for common use, of the term euthanasia, which

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formerly was the subject for discussion among a relatively small group of liberals. The definition of "right" in Webster's New World Dictionary in the sense in which it is used here is "that which a person has a just claim to; power, privilege, etc., that belongs to a person by law, nature, or tradition; as 'it was his right to say what he thought.'" The laws and the traditions of our land enunciate a right to life but not a right to death.

A "living will" is a document written by a person during his active life while in sound mind directing that at the time of approaching death he might be permitted to "die with dignity"— another term that has crept into our language with the freedom of speaking about dying and death. It appears to be a deeply-ingrained instinct of man to hang on to life. The most legally foolproof living will cannot be expected to hold water necessarily at the time of the approaching death of the would-be testator. Experience has shown that people view death differently when it approaches as compared to the way they saw it years before. There are also legal implications of what physicians might do under such "living will" instructions without trespassing upon the law. For example, if a prospective patient were to leave instructions that if he were dying of such-and-such a diagnosis and had come to such-and-such a stage in the process of dying, that his physician was to terminate his life, this would be directing a physician to commit homicide. Obviously, the physician could not commit homicide and expect, in this stage of our legal understanding, to be innocent of homicide just because he was directed to do what he did on the basis of a "living will."

The term euthanasia comes from the Greek and means painless, happy death (eu, well plus thanatos, death). Webster's dictionary goes on to define euthanasia as "an easy and painless death, or, an act or method of causing death painlessly so as to end suffering: advocated by some as a way to deal with victims of incurable disease." The Euthanasia Society of America founded in 1938 defines euthanasia as the "termination of human life by painless means for the purpose of ending severe physical suffering." Gradually the meaning of one word changed from the connotation of easy death to the actual medical deed necessary to make death easy. Finally it reached the meaning of "mercy killing." The idea that abortion is not killing is a brand new idea. However, the fact that euthanasia is not killing has really never existed because the common synonym in lay and professional vocabularies alike for euthanasia has been "mercy killing." In any discussion of euthanasia an understanding of terminology is essential. The deliberate killing of one human being by another, no matter what the motivation

might be, is murder. Some distinction is usually made between a positive decisive death-producing act as compared to permitting death to occur by withholding life-support mechanisms or life-extending procedures which in common parlance might be called heroic and in medical terminology might be called "extraordinary means."

The current discussions of the right to die are, in essence, a broad reflection on the moral and ethical problems created by an understanding of the term euthanasia. A consideration of the right to die carries with it the implication of the right of *how* to die. Does a patient have the right to expect a painless, comfortable death? Does he have the right to expect that his physician should see that it is so? Does he have the right to expect that his physician might take an active role in his dying process to shorten it for the sake of the patient's comfort or peace of mind? Does the patient have the right to expect the physician to terminate his life if the physician deems it advisable? Could this ever be an active role on the part of the physician or may he assume only a passive role? Is there a difference between an active and a passive role in this regard; is a deed of omission less reprehensible than a deed of commission legally, ethically, or morally? Does the patient have the right to participate in the decision, or better yet, to influence it?

The way one answers any of these questions will depend a good deal upon his view of life. If he is God-oriented in the sense of being either a conservative follower of Judaism or if he is a Christian and if he indeed believes that the Scriptures are the Word of God and teach that life is precious to God, he will view life as a holy thing, its end not to be decided upon by man. Yet, many physicians who truly believe that the Scriptures are the Word of God and that they give specific admonitions concerning the sanctity of life, will, in the role of physician, act passively in certain circumstances rather than carry out what the laity might call heroic measures to prolong life.

If on the other hand the individual's view of life is atheistic, agnostic, or utilitarian, his decisions about participating in the dying process actively or passively are not so much matters of conscience. In between these two views will probably lie the great majority of people who are faced with this kind of decision-making, either as a privilege or an obligation. Although they might not wish to carry the label of a situational ethicist, they would in general be making decisions on the basis of the situation. The situation would encompass for them the patient's state of health, his alertness, his understanding of what was happening to him, and his spoken desires on the matter. But all these would be in the light of the physician's understanding of that patient's disease and

that patient's ability to withstand it at all, to withstand it comfortably, or to succumb to it quickly or slowly. One can already see that several physicians might have completely different points of view in a given situation depending upon their previous knowledge of the disease in question but also tempered by their previous experience in similar situations where they had been proven right or wrong, or where their ethical decisions were affected by the morality which grows out of experience and contact with repetitive problems.

Another facet that the situational-ethicist must deal with is the situation in respect to the patient's family. In many situations, for example, there comes a time when the patient's consideration is essentially out of the picture. The patient may be unconscious, truly comatose, definitely out of pain, and waiting for an inevitable death which may be days, weeks, months, or, in rare situations, even years away. There are emotional factors to be considered in reference to the family, and there are definitely economic factors. There may be times when these economic factors may have far-reaching implications. The financial undergirding for the education of a child, for example, might disappear while an unconscious grandmother has her financial substance eaten up by medical bills. The motivation on the part of a family to see a rapid demise in a dying grandmother would understandably be varied but one can see the obvious temptation for a change in motivation as the aforementioned hypothetical example drags on and on.

Can the physician who is in the business of prolonging life and relieving the suffering of the sick and injured be asked to reverse his role and shorten life even while ministering to the needs of suffering? How much credence should he give to the pressures of the family to terminate life? How can he sort out the motivation that leads to the request? How can he balance his obligation to his patient against his compassion and his understanding for the family? If the right to live and the whole question of killing an unborn baby in the womb raises multiple dilemmas, they are as nothing compared to the dilemmas that can be enunciated in reference to the question of the right to die.

Euthanasia

Before any discussion of euthanasia for laymen, it should be medically stated that although death seems imminent to a physician and although he knows it is impossible to turn it away with the armamentarium at his disposal, death can never be exactly predicted as to time. The further away from actual death that one attempts to make this prediction the more inaccurate are the prophecies. Yet this does not mean that on the day of death it is necessarily easier to say it will

come at 2 o'clock not at 4, than to say a month in advance it will be in 21 days not 30.

Secondly, because euthanasia has been, in a sense, a subject which is taboo in our culture, and because euthanasia was a term applied by the Nazis to the elimination of those considered to be of no worth to the *Reich*, we have to separate carefully the various types of euthanasia that one might be talking about. There is a sense in which euthanasai can be construed to mean enabling the patient to die comfortable and/or quickly. It might be said: 1) that a physician could enable a patient to die without quickening his demise, 2) that he could enable a patient to die by removing any barriers to death, 3) that he could enable a patient to die while his motivation was to relieve suffering and 4) that a physician could enable a patient to die by taking a deliberate action that would shorten or terminate his life. Other terminology which would describe what I have tried to state here without putting labels in the wrong place would be *direct* or *indirect* euthanasia or *active* or *passive* euthanasia.

If euthanasia means to die happily, then enabling a patient who is going to die to do so happily might include such a thing as administering oxygen to a patient who is in respiratory distress, giving a pain-killer in moderate dosage that would not affect the duration of life, or could even be construed to mean giving emotional or spiritual support to the patient by the assurance of care for him or for his loved ones left behind.

Enabling a patient to die by permitting him to die means withholding something that would be considered by most people to prolong the dying life. An example might be to withhold a blood transfusion from a patient with sudden hemorrhage from the stomach whose death from cancer of the stomach is known to be a very short time away. To withhold a transfusion which could prolong life would be enabling the patient to die by permitting him to die from the "natural" causes that were taking place in the form of his hemorrhage. Although withholding the transfusion might be the action taken by the great majority of physicians, it is possible that in a given circumstance the physician could be held responsible for not doing what he could, for being negligent in the performance of his medical duties; to withhold the transfusion could even be considered manslaughter or possibly homicide.

Enabling a patient to die by a medical act, the motivation of which was the relief of suffering, but which had a secondary or side effect of shortening life, could be exemplified by the giving of morphine to a patient dying in great pain in spite of the fact that he would require increasingly large doses of morphine with increasing fre-

quency to render him comfortable in order to die "happily." The side effect might be a lethal dose to bring about relief from pain. It is almost unthinkable that a physician with this motivation could be accused of negligence.

Finally, enabling death by a medical act deliberately intended to shorten life, could in the minds of some be closely associated with enabling a patient to die by permitting him to die. The obvious example here is deliberate overdose of something like morphine designed to bring an end to a patient's life. Although certain physicians, in recent controversies, have, without naming patients, admitted to performing active euthanasia of this sort repeatedly, I suspect that if one were to analyze dying situations this is not a common procedure in America. If it is, I suspect that because of the fear of eventual malpractice claims or more specifically criminal charges based on manslaughter and homicide laws, physicians would not discuss this with the family perhaps even when instructed to so behave by the family. The doctor might, under certain circumstances, have a tacit agreement with his patient to act actively or passively in this regard or in other circumstances, he might, out of compassion, act this way without discussion except in his own conscience.

All of the aforementioned examples of enabling death are in general not even considered by doctors or laymen to be under the guise of euthanasia with the exception of the fourth example of enabling a patient to die by deliberately shortening his life. There would seem to be no question about the active participation of the physician here in producing death, presently considered to be a crime.

Quite different in the minds of some is actively or passively participating in the termination of a life of a newborn infant that is not considered worthy to be lived. One of the best examples of this was the report in the *New England Journal of Medicine*[3] indicating that out of 299 babies who died at the Yale New Haven Hospital in the previous two and one-half years, 43 of them had been allowed to die after the physician had discussed with the family the propriety of not letting the child live. An example: letting a baby with mongolism and intestinal obstruction starve to death rather than giving him life by operating and relieving the obstruction. Whether or not two parties (e.g. the family and the doctor) agree that active participation or passive participation in any program which will cause the death of an individual is not the issue. It does not change the fact that the motivation was to kill no matter how one explains the deed in terms of compassion and empathy. The least part either party could play in the charge of homicide is accessory before the fact. If one considers all of the

possible diagnoses that currently could fall into this category, to say nothing of what could happen if these compassion-motivated tendencies were permitted to go unbridled toward the development of a perfect or super race is a spectre difficult to contemplate. The elimination of children with such obvious diagnoses as Down's syndrome (mongolism), spina bifida (cleft spine) with neurologic changes in the lower extremities or in the sphincteric control of bladder and rectum, children with congenital medical illness (such as cystic fibrosis heralded in the newborn period occasionally by the complication of intestinal obstruction), can lead rapidly to the elimination of mentally-ill individuals who are considered to be incurable, burdensome, expensive, etc., brain-damaged after injury, senile, etc. Finally, perhaps in the not too distant future there could be termination of life that is considered unworthy not because of physical or mental incapacity but because of what might be considered to be unworthy life in the field of ethnic origin, economic capacity, political activity, productivity potential, or any other form or function currently considered to be undesirable.

In reference to what might be called passive euthanasia by some but, in a sense, really is not, it should be clearly understood that for most of my association in medicine (38 years) many physicians have elected not to use artificial life-support mechanisms on dying patients who they thought were not salvageable. Herein lies the rub: some who were thought not to be salvageable possibly were, and hence were lost. But this cannot be proven. Others who were thought to be salvageable in a short period are not: one is left with a living patient whose life is considered essentially to be subhuman (see discussion below on Karen Quinlan).

Extension of Human Life

Probably nowhere in the development of medical technological advances has our ability been greater than in the specific area of the prolongation or extension of human life almost at the will of the physician. The life support systems which are available in almost any intensive-care unit attest to this fact. It had always been far easier to exterminate life quite painlessly than to prolong it. The medical profession now has a two-edged sword; the extension of human life by artifical means and the painless termination of life by drugs. The ability of man to wield this sword has moral and ethical as well as practical considerations that are mind-boggling.

Whenever a discussion centers around dying and the shortening of life, the antithesis of this, namely, the prolongation of life, must be

considered. Technologically, medicine has advanced so quickly that older, unwritten understandings of "ordinary" and "extraordinary" care no longer seem applicable. What might have been considered "extraordinary" care a few years ago is now so commonplace as to be called "ordinary" (respirators, pacemakers, kidney dialysis machines, etc.). Furthermore what starts off in a given case to be "ordinary" care such as the application of a respirator to a patient who is unable to breathe, turns out, when the patient never can assume normal respirations on his own, to have been "extraordinary care" if one is permitted the liberty of changing the adjective after the fact. Perhaps an example would help to clarify this. If one were struck down by a car and had a serious head injury which rendered him unable to breathe and made him unable to respond, and if his bladder sphincter were in spasm so that he could not urinate, he could be placed on a respirator, he could be artifically fed intravenously or by a stomach tube, and his urinary obstruction could be taken care of by the proper placement of a catheter. If it were assumed that he would recover in a matter of a few days, all of these things would be "ordinary" care. If on the basis of superior knowledge of the neurosurgeon attending him at this time it were known that there was essentially no way he could be expected to recover, all of these things might be considered "extraordinary" care since without them his injuries would produce death.

If one had acute appendicitis and postoperatively developed a situation where his kidneys did not function, to put him on a dialysis machine (an artifical kidney) which could handle his urinary function temporarily, would be an extraordinary act and might at times be considered to be "extraordinary" care. However, in a vigorous, alert, productive individual with a normal life expectancy of several decades ahead of him, it should not be considered "extraordinary" care. On the other hand, if in a 90-year-old individual the same kidney shutdown took place and was the result of a disease process that inevitably would take this patient's life, the institution of dialysis would be an "extraordinary procedure" and would definitely be thought of, by any medically competent individual, as providing "extraordinary" care. Here the difference perhaps is less difficult to ascertain than in the aforementioned case of head injury.

To show how difficult predictions might be, *Medical World News* (May 5, 1974) reported a case of a woman with myasthenia gravis who lived "artifically" for 652 days in intensive care and then made a remarkable recovery. Said a hospital representative at the Harbor General Hospital in Terrence, California: "She made us recognize that there was no such thing as an inordinate effort. She had such a

tenacity for life we felt that everything we did, no matter how extraordinary, was appropriate to the situation."[4]

As will be shown subsequently in a discussion of the dilemma raised by the legal trial concerning Karen Quinlan, it is most difficult to judge medical action from the standpoint of what is legal justice alone. If one gets into the pure aspects of ethics, there could be concern that the use of a pain-killer in a dying individual could so cloud his conscious response that he might not in his dying moments be in a position to make decisions which in theological terms might bear upon his eternal destiny. It is essentially impossible to control pain in most instances, particularly in a debilitated or dying individual, without at the same time temporarily impairing his ability to think. From a purely ethical point of view, because clouding of judgment accompanies relief from pain produced by drugs, the situation seems to be insurmountable and therefore has become acceptable.

With the technological advances in medicine the opportunities for a physician's participation in momentous decisions concerning life and death have increased dramatically. But so have the temptations to mis-use this newfound expertise. The physician of a generation or two ago was practically powerless to extend life but on the other hand he faced fewer dilemmas.

Helmut E. Erhart[5] has outlined the history of euthanasia societies and euthanasia movements after World War I. He notes that in Germany "mentally dead children" or "monsters" and "hopelessly" insane adults were included in consideration for euthanasia. The British Euthanasia Society, on the other hand, from the beginning and without alteration in their program, has limited itself to "assistance in dying with deliberate shortening of life" in the legal sense of killing on request and has concentrated its efforts on this. In America, the original program of the Euthanasia Society also took up the problem of involuntary euthanasia by including "hopeless defective infants." However, the United States soon followed the course or pattern in England, which in the mind of Erhart was probably the correct perception that there would be much greater legal difficulties involved in sanctioning involuntary euthanasia which logically would also have to be extended to the "hopelessly handicapped," old and mentally sick.

The "mercy killing"* which took place in the Netherlands certainly was not lawful but it was obviously approved by large segments of the population. The Dutch Health Service has now proposed new guide-

*Previously described by Dr. Koop in "The Right to Live" (HLR, Fall, 1975, p. 65).

lines which have been confirmed by the Royal Society for the Promotion of Medical Science.[5] These guidelines allow in the case of the incurably ill certain measures of euthanasia "when the process of dying has begun and death is to be expected in the foreseeable time." But who really knows?

Very few legal cases against doctors come to attention because they have performed euthanasia. To my knowledge, no doctor has ever been convicted for performing euthanasia. Even when non-medical people take part in a mercy killing, the courts are usually lenient with such individuals.

Dilemmas for Doctors and Laymen Alike

The dilemmas presented by euthanasia are not dilemmas for the medical profession alone. They are dilemmas for laymen as well. The situation is somewhat akin to the remarks that are made about the malpractice crisis in American medicine today. Many people say: "The doctors certainly have a difficult problem." The fact of the matter is that it is the patient who has a difficult problem. Who do you suppose will pay for the doctor's malpractice insurance premium which has increased in cost fivefold? You, the patient, will pay that. What other dangers exist for the patient in an era where the spectre of malpractice suits hangs over the head of the responsible physician at all times? First of all, the physician will treat you not on the basis of what his experience and learned intuition dictates, but rather he will do those things which he feels would absolve him from eventual guilt were he ever sued, and he will neglect to do those things which you might need but where there is a high risk concerning a malpractice. In short, the patient's physician must practice defensive medicine and the loss is not only the physician's, it is the patient's.

So it is in the dilemmas surrounding euthanasia. Sooner or later you, the reader, may have to face some of these questions in reference to a member of your family and eventually your family may have to face these questions in reference to you. Indeed you may be party to the latter dilemma as you approach the end of your life.

Once any one category of human being is considered fair game in the arena of the right to life, where does it stop? If the mongoloid is chosen as the first category whose life is not worthy to be lived, what about the blind and the deaf? If the hopeless cripple confined to a wheelchair and considered to be a burden on society is the first category to be chosen, what about the frail, the retarded, and the senile? It does not take much fanciful imagination to extend these categories to include certain categories of disease such as cystic fibro-

sis, diabetes, and a variety of neurologic disorders. The population-control people who are concerned about food supply have been very effective in influencing society's thinking on abortion; it seems very logical that eventually one of their targets could be the obese individual who not only has eaten too much already but has to eat a lot to sustain his large body.

It is very easy to slip into moral deception in a discussion of euthanasia. One starts from the point of view of abortion and says, "I can see why you are against abortion because after all someone and preferably the law must protect the fetus because the fetus is not in a position to protect itself." But when one is talking of euthanasia, if the person is willing to undergo a "mercy killing," why should other people object? The answer is really the same as it is for abortion. Abortion on demand opens up other abuses of which euthanasia is number one. Euthanasia opens up the opportunity at this early stage of the game for almost inconceivable fraud, deception and deceit. Think of the burdensome elderly people, economically burdensome, whose rapid demise could be looked upon as an economic blessing for their family. Think of the temptation to hasten a legacy. Think of how easy, when there are ulterior motives, to emphasize the surcease from suffering and anxiety that comes with painless death.

Practical Considerations

I do not think a medical student is ever told what his mission in life is. Certainly no one told me when I was a medical student what was expected of me as a lifetime goal in assuming the role of a physician. Yet it is very clearly and indelibly imprinted upon the mind of the physician that the first obligation toward his patient is to heal him and cure him and to postpone death for as long a time as possible. The second goal is more difficult to enunciate and ever so much more difficult to practice: when cure is not possible the physician is to care for and comfort his dying patient. There is in here a gray area where the physician is not certain about the possibility of cure and yet is not ready to treat the patient as one who needs comfort in dying. The other side of that coin has to do with the behavior of the physician who, realizing that the opportunity for cure is passed, has two options: first, that of maintaining the life of a "dying" patient through the extremely difficult times of the transitions from active life to inactive life and from inactive life to death, or, secondly, to withhold certain supportive measures which would enable nature to take her course more quickly.

Let me illustrate. There is a unique tumor of childhood called the

neuroblastoma in which I have been interested for more than thirty years. Because of this I have developed a broad clinical experience with the behavior of this tumor as it affects the lives of my patients and I have perhaps had more neuroblastoma patients referred to me than would normally be the case because of my particular interest in this tumor. I present this background in order to establish the fact that with this particular tumor I have considerable expertise in understanding the clinical course and have been able to predict with relative accuracy what will happen in a given patient when certain signs and symptoms occur or when certain responses to treatment are known. In a given situation I might have as a patient a five-year-old child whose tumor was diagnosed a year ago and, who, in spite of all known treatment, has progressed to a place where although her primary tumor has been removed she now has recurrence of the tumor (metastases) in her bones. On the basis of everything I know by seeing scores of patients like her I know that her days of life are limited and that the longer she lives the more likely she is to have considerable pain. She also might become both blind and deaf because those are sequelae that might be expected when this tumor spreads in the bones of the skull.

If this five-year-old youngster is quite anemic, her ability to understand what is happening to her might be clouded. If her normal hemoglobin level should be 12 and it is now 6, I have two choices. I can let her exist with a deficient hemoglobin level knowing that it may shorten her life but also knowing that it will be beneficial in the sense that she will not be alert enough to understand all that is happening around her. On the other hand I could be a medical purist and give her blood transfusions until her hemoglobin level were up to acceptable standards. In the process of so doing she would become more alert, she would be more conscious of the things happening around her, she would feel her pain more deeply, and she might live longer to increase the problems presented by all of these things.

In the second place there are anti-cancer drugs which I know beyond any shadow of a doubt will not cure this child, but which may shrink the recurring tumor in several places of her body, postponing the inevitable death by a matter of a few days or weeks. However, it is possible that the effect of these drugs will not be very dramatic on the tumors in the skull. They may relentlessly expand, producing blindness and deafness. Would it be better to let this little girl slip into death quietly, with relatively little pain, with her parents knowing that she can both see and hear, or should we prolong her life by two or three weeks, increase the intensity and duration of the pain she

would have and possibly run the risk of the added, terrible complications for the family to witness—blindness and/or deafness? In such a circumstance I opt to withhold supportive measures that would prolong miserable life for the patient to bear and the family to see.

I well remember the occasion on which I decided that this would always be my course of action *re* this particular tumor, unless I was forced to do otherwise or there were some very extenuating circumstances. One of my patients was approaching the aforementioned condition and had been sent home because of the approach of the Christmas holidays and the desire of his family to have the child with them. In the days before his discharge I had promised him a chemistry set for Christmas and on the day before Christmas I delivered the gift in the afternoon. His family took me into their living room and there before the Christmas tree was a big mound on the floor which looked like a heaped-up beige blanket. Under it was my patient on his hands and knees slumped down into a position as though hands and knees could no longer support his weight. The story was most pitiful. Earlier he had asked to come down from his bedroom to see the electric trains under the Christmas tree and found a measure of comfort on his hands and knees before the trains. He asked not to be moved because he had found a position in which he seemed more comfortable than when lying in bed. He died the next day in that same position.

In a situation such as I have just described one gets to the very nonlegalistic moral core of the relationship of a physician with his patient. Whether the patient is a child and the relationship has to be with his parents or whether the patient is an adult and the physician's relationship must be with the patient himself and his relatives, there has to be a sense of trust and confidence that the physician will do the "right" thing whether the disease process is curable or is one which will cause death. There have been many occasions in my life when I have clearly described the thoughts that went through my mind as I outlined to parents why I planned what I did plan to do with their child. But much more often, there has been between parent and physician an understanding which exceeds the bounds of pure trust and confidence where the family seems to know, and I encourage them to think, that their child is in understanding hands as well as in competent hands, that their child will be kindly treated in this terrible process of dying to which death brings a sense of relief and release. Here the family senses that I will treat their child the way I would like someone in my position to treat my child were he in the same circumstance. Yet through all this there is the understanding that this life, waning though

it may be, is precious to the patient, is precious to the family, is precious to me, and in my particular belief the understanding that this life is also precious to God.

Therefore, it should be very clear that the decisions that are made in any circumstance are tailored to the problems at hand, the background and experience of the physician, the depth of understanding of the family, and the relationship which exists between patient and physician, and family and physician. There is no way that there can be a set of rules to govern this circumstance. Guidelines perhaps are possible, but not rules. I can think of no more tragic circumstance to come on the practice of medicine and no more tragic circumstance for a future patient to face than to have a legal decision made by someone in the field of jurisprudence who has not lived through these circumstances, and who could not in a lifetime of testimony understand what the problems are and how they should be handled. His training, his experience and his emotions have not been intimately involved with similar circumstances in the past where his decision and his decision alone is the one that must answer all the questions, no matter how inadequately.

The arrival of the era of organ transplantation adds another series of dilemmas to the practice of medicine in reference to the ethics and the morality of the prolongation of life on the one hand, or its extermination on the other. Add to all of the other questions that have been raised previously the new one of terminating one life to enable an organ transplant to another individual in order that the second individual's life may be meaningfully prolonged. Some of these decisions are relatively open and shut, as for example in brain death of an individual, perhaps young, who is kept alive by a respirator in the presence of a functioning heart. But, one can also easily imagine the pressures that develop from the family of an individual consigned to death because of the lack of a vital organ, when he could have his life significantly prolonged by the removal of that organ from another individual whose life may not be considered by him and other interested parties to be worthy of extraordinary care. These pressures are felt especially by those engaged in kidney-transplant programs.

The Case of Karen Quinlan

The name Karen Quinlan became identified in the Fall of 1975 in the minds of all who are concerned about matters of life and death with the extraordinary possibility of the termination of life becoming a legal matter. In piecing the story together, *Time* magazine wrote it this way.[6] Karen Ann Quinlan had been born of unknown parents

in Pennsylvania and was adopted by Mr. and Mrs. Joseph Quinlan when she was four weeks old. *Time* said that the Quinlans considered her to be a friendly, outgoing girl, a fine skier and swimmer, and one who sang in their church. Karen's friends in the high school from which she graduated in 1972 described her as quiet but popular with the boys. Her employer who discharged her because of a company cutback in August of 1974 remembered her as a good, hard worker.

Apparently in the last few months of her active life Karen, after losing her job, moved out of her parents' home and into employment and friendships unlike her previous life style (". . . somewhere along the line, she began experimenting with drugs. Several friends described her as an occasional marijuana user and frequent pill popper who took 'uppers' and 'downers' to suit her moods.").[7]

Time concluded that drugs were probably responsible for Karen's current condition. On April 14th, apparently depressed, she not only took some tranquilizers but then went to a bar to celebrate her friend's birthday. After drinking gin and tonic, she began to "nod out." Friends took Karen home and put her to bed, where she passed out. It was realized that she was more than drunk. Attempts were made to revive her with mouth-to-mouth resuscitation. An ambulance was called; she never regained consciousness.

It is important to recognize from the standpoint of this discussion that Karen was then presented as an emergency situation to the local community hospital where, without much knowledge of what had happened before, the immediate resuscitative measures including the use of a respirator were probably begun. To have taken the time in gaining a history that would have revealed all that is known months later, would have forfeited the one opportunity Karen's doctors had to restore her to active life. It is also worth mentioning that many people presented to the emergency room of a hospital with the same signs and symptoms are treated exactly as Karen was, and recover—most of those recovering having their full faculties.

Time reports that Karen's parents kept hoping that she would recover and were looking for a miracle. Mr. Quinlan's own parish priest feared that Mr. Quinlan was losing touch with reality in this regard.

Karen had been in a coma since the early morning of April 15, her breathing maintained by a mechanical device called a respirator. By all accounts reported in *Time*, she had shriveled into something scarcely human, weighed only sixty pounds, was unable to move a muscle, to speak, or to think. This was the picture presented to the world through the news media when in September, 1975, at Mr. Quinlan's request, the doctors caring for Karen refused to pull the electric

plug from the respirator, thereby terminating her life. Mr. Quinlan then sued for his child's right to die, putting it in his own religious terms: "In my own mind, I had already resolved this spiritually through my prayers, and I had placed Karen's body and soul into the gentle, loving hands of the Lord . . . It was resolved that we would turn the machine off."[8]

There were several facts that were not immediately made known in the media and which have never been clarified in the minds of many who have criticized the eventual decision of Superior Court Judge Robert Muir, Jr., when he finally decided on November 10th that the doctors could not disconnect the life-sustaining respirator from Karen Ann Quinlan's body and allow her to die.

The first of these facts was that Karen was alive. The fact that it was reported that she could not move a muscle was not completely true, because she did respond to pain and cried when pinched. Although her electroencephalographic tracing (electrical brain waves) was not normal, it did show electrical activity which in this gray netherland between life and death has been interpreted over and over again by medical experts to indicate that the brain is still alive, even though it may not appear to think or function. Although many of the medical experts appearing as expert witnesses at the trial agreed that Karen was like a child without a brain, nevertheless they insisted that the machine could not be turned off. The consensus was that Karen met none of the medically accepted criteria for determining death. In other words, in spite of her situation she had not had "brain death" which is the legal definition of death in the eight states that have statutes concerning this matter. (New Jersey where this trial took place is not one of them.)

The second fact was that although many medical decisions are made not to start the use of an extraordinary life support mechanism such as a respirator, once the decision *is* made to start such (I have already indicated that there was really no alternative to this decision at the time Karen was presented to her emergency room physicians) then with a living organism who has not exhibited brain death, to turn off the life support mechanism is to deliberately produce death. This act is in the minds of those interested in intricacies of both law and medicine, homicide.

Thirdly, the whole conduct of medical care these days is governed to a large extent by the shadow of malpractice suits hanging over the medical profession. There are lawyers who say there has never been a relationship between a physician and a patient in which they cannot find a cause for a medical malpractice suit. Whereas in days gone

by medical malpractice centered around not practicing medicine in conformity with the standards of the community, now medical malpractice suits are instituted because the result is less than perfect or less than the patient or his family expected in a given encounter with disease or surgery. Obviously, the spectre of malpractice litigation hung over the doctors who were requested to disconnect the respirator from the body of Karen Quinlan.

During the trial a number of things were discussed in the press not only as news reports but in analyses by people both competent and incompetent to make such analyses. It was clear that whereas it can be argued with conviction that there is a right to live legally under our Constitution, there is no "right to die" under that same Constitution. In fact many legal actions work in the opposite direction. Members of the Jehovah's Witnesses sect legally have been shown not to have the right to refuse a blood transfusion on religious grounds nor to withhold such from a minor who has not reached the age of consent. It is also legal practice for the courts to appoint guardians for children in order that they will be given adequate medical treatment that parents for multiple reasons are unwilling to provide.

Franklin Zimring, professor of law at the University of Chicago, put the matter succinctly in reference to the proper place for decisions of this kind to be made: "Some decisions are beyond the law's competence to make with any rigor or confidence in being right."[9]

There was legal eloquence with theological overtones from such competent and respected jurists as Ralph Porzio who is not new to these concerns, having written a book in recent years concerning the multitudinous problems of life and death which arise around the medical transplantation of organs from one person to the other. He asked these questions:

"Dare we defy the undisputed premise, the granite foundation of this case, that Karen Ann Quinlan is legally and medically alive?"

"Dare we defy nature's immutable command to survive?"

"Dare we defy the divine command, 'Thou shall not kill'?"[10]

Many analysts tried to condense into one newspaper column a synthesis of religious and moral teaching of the three major religions in the United States: Judaism, Catholicism, and Protestantism. All of these fell short of anything like reaching the mark because there is no monolithic theological or religious teaching about this matter in any of these religions. What may be the personal sincere conviction of the Quinlans' parish priest might not be what the Vatican thinks on the same subject. Although Orthodox Judaism has as high a regard for the sanctity of human life based upon the Old Testament Scrip-

tures as can be found in our culture, the younger generation practicing Reform Judaism does not hold to this same high opinion nor does it base its decisions on Scripture. In the Protestant religion, not only are there innumerable denominational differences, but, within the denominations, both liberal and conservative differences. If one were to ask a situational ethicist such as Joseph Fletcher he might tell you that death control is the same as birth control. On the other hand an ethicist such as Paul Ramsey who bases his decisions on the Bible which he considers to be the Word of God says it this way: "Attention paid to God's dominion means man has only stewardship over life." And, "Proper stewardship can involve deciding how to live the last days of (one's) life."[11]

I interrupt this train of thought to recall once again to the reader's mind that there is a distinct difference in the mind of the practicing physician who deals with these matters day in and day out between not starting a life support extraordinary technique because he feels it would produce a "Karen Quinlan" as compared to having made the decision to start it and then to terminate it which is a deliberate act ending the life of a patient, interpreted by many as homicide.

In mid-November, in a forty-four page ruling, Judge Robert Muir, Jr. discounted "the compassion, sympathy he felt toward the Quinlan family" and went on to say that both "judicial conscience and morality" told him that Karen's fate was being handled properly by "the treating physician." Under common law, he said, "The fact that the victim is on the threshold of death" no "humanitarian motives" can justify taking life. He dismissed "semantics" by which he referred to questions whether disconnecting Karen's body from the respirator would be an act of commision or omission; either would result in the taking of her life which the law says is homicide. Judge Muir clearly stated that "there is no constitutional right to die that can be asserted by a parent for his incompetent adult child."[12]

It is worthwhile to consider the arguments that were presented by Karen Quinlan's lawyers because they are the arguments that come into the mind of any reader of the press in circumstances that are so reported.

1. "Medical science holds no hope for Miss Quinlan's recovery."
   In fact doctors at the trial had indicated that there is always a possibility of recovery although not as a human being with cerebral function. The judge concluded that if such were possible "what level or plateau she will reach is unknown."

2. "Miss Quinlan would want the respirator turned off."

   Mr. Quinlan had stated that his daughter had made statements like this before her concomitant taking of alcohol and drugs somehow put her into the situation which produced her discerebrate condition causing coma. The judge noted that even if these had been the wishes of Miss Quinlan when she was well and happy it was not when she was "under solemn and sobering fact that death was a distinct choice."

3. "Doctors have no legal obligation to keep Miss Quinlan alive."

   The judge believed that such a duty exists when the physician believes that she should be kept alive. Judge Muir very properly stated that a patient placed in the care of a doctor expects that the doctor "will do all within his human power to favor life against death."

4. "The wishes of the parents of an incompetent patient should be paramount in a doctor's life-or-death decision."

   The judge took a contrary point of view because "there is always the dilemma of whether it is the conscious being's belief or the conscious being's welfare that governs the parental motivation."

5. "The constitutional right of privacy should allow parents or guardians to make the decision that an incompetent child's life should no longer be prolonged."

   Judge Muir believed that all previous right-to-privacy cases concerned rights to maintain a lifestyle, not rights to end life altogether.

6. "Freedom of religion should allow Miss Quinlan, a Roman Catholic, to die."

   Judge Muir felt that the previous interpretations of the right to exercise religious beliefs as enunciated by the United States Supreme Court dealt with life on earth, not life hereafter.

7. "The beauty and meaning of Karen's life was over and she should be allowed to die."

   Judge Muir indicated, again rightly so, that today the use of a respirator as an emergency measure in a patient in Karen Quinlan's condition the night she was presented to the emergency room of the local hospital was really an ordinary, rather than extraordinary, step in medical practice. He said, "Continuation of medical treatment, in whatever form, where

> its goal is sustenance of life, is not something degrading, arbitrarily inflicted, unacceptable to contemporary society, or unnecessary."*

In the days that followed Judge Muir's decision, editorial comment in general was in favor of the jurists' point of view and those who knew best about the laws of the land recognized that the laws we now have currently forbid anyone from giving permission to any other person to pull the plug on a life-sustaining machine. The judge knows when he is asked to do this that it is productive of homicide. In that sense, this entire trial was a futile exercise because somebody should have been able to say at the start that no judge could rightly tell someone else to commit a homicide. After the emotional furor associated with the trial had quieted down most agreed that the right of Karen to die was not a matter for the courts. This was all well and good, but it opened speculation in another area that could be just as bad.

Most editorial comment, after agreeing that Karen's problem was not a matter for the courts, attributed this to archaic or obsolete laws and this is wrong. If it were not even called homicide, just to pose an argument, it is impossible for a jurist or, even worse, a jury, to make a decision even when they have all of the pertinent facts such as are available in the case of Karen Quinlan. How then can legislators establish laws on the right to die when Karen Quinlan's problem is only one of literally hundreds that exist, all with different reasons, motivations, with their attendant emotional overlay?[13]

If well-meaning legislators pressured by public opinion rising out of the emotional concern around the Karen Quinlan case or others like it should push several of the United States to formulate laws concerning the right to die, Pandora's box will have been opened to expose a situation that really has no solution. We are dealing with medicine, with technology, and with law. Basic to the relationship between physician and patient is the expectation that life is worthy to be lived, that physicians will act on behalf of their patients toward this end, and that if acts of omission or commission lead to an earlier demise of a patient than might ordinarily have been expected *these decisions have to remain within the bounds of the expected, compassionate, understanding relationship between the patient and his doctor and the patient's family and the patient's doctor*. The number of examples of this decision-making is legion. It is unthinkable that the law could

*Much of the seven questions has been taken from the excellent analysis of Aaron Epstein, a staff writer of the Philadelphia *Inquirer* reported in that newspaper November 11, 1975.

direct this decision-making on the part of the physician because to do so would undermine the fundamental principles in all of the great field of health care.

In reviewing a case like that of Karen Quinlan's* the decisions are difficult enough and fraught with sufficient danger to give anyone pause even if he confines his attention to concern for the patient and consideration for the patient's family. But human beings being what they are, were it possible for the law, in its cold impersonal way, to direct decision-making on the part of a physician concerning life and death, other motives would very quickly enter the picture, and whereas it can be argued that all of the motives in the Karen Quinlan case are pure and simple, the opportunity for base, evil, calculating, conniving motives is wide open if the decision-directed death could be demanded of a physician by way of the law. Without our knowing it, it is the Judeo-Christian concept of the sanctity of human life, even respected by a religious people, that makes it possible for us to live day by day in the relative security of the obviously imperfect, poorly defined parameters of decision-making concerning death and dying in medicine. To remove the decision-making from the person primarily involved, namely the physician, and to place it in the hands of the law, would remove that security and expose each of us, first to improper and inappropriate decisions at the time of death, but with the erosion of the morality which would necessarily take place, those decisions would be moved closer and closer to vibrant life instead of being confined to the area of waning life.

Theology, Morality, and Ethics

Because the termination of unborn life precludes the living of the life for three score and ten years, and euthanasia only shortens a life that has already been lived, is no reason to regard the taking of life by euthanasia as any less serious a moral decision than the former.

Obviously the great majority of the people realize that a decision concerning abortion will never be theirs to make personally. It naturally follows that many people will be indifferent to the implications of liberalized abortion laws, not recognizing how the change in our understanding of abortion affects so many other aspects of our lives today and in the future. But when it comes to death, there is no one

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*At this writing a question has been raised concerning Karen Quinlan's condition when she was presented to the emergency room of her community hospital April 15. She had an egg-size bump on her head as well as a series of bruises on her body that had been received shortly before admission (*Time*, December 29, 1975).

who can say that a decision concerning the way his death is managed will be of no concern to him. The death rate is still one per capita.

It has always been of considerable interest to me that any discussion of human life inevitably rapidly becomes associated with theological discussions. The fact that as distingiushed a journal as *The Human Life Review* would contain technical articles on population, learned discourses on jurisprudence, and publish them side by side with the theological implications of man's regard for human life, suggests to me incontrovertibly that life and death are God's business.

As with abortion, any discussion of euthanasia by the individual leans heavily upon that individual's understanding of the sanctity or lack of sanctity of human life, an understanding of man's understanding of God, and whether or not in the synthesis of these things the individual believes that there is life not worthy to be lived. My own perspective of the dilemmas presented by euthanasia represents an understanding produced by the synthesis of where my belief in Biblical revelation crosses my experience in medicine.

Don't turn away, reader, because your own beliefs on these matters may be based on theological arguments of which you are not aware as well as on Christian spin-offs that regulate your society.

Life to one raised in Judeo-Christian moral philosophy might be considered on a much higher plane than the right considered inalienable by Thomas Jefferson; if one were to consider life as a sacred privilege, that understanding can be extended to include the view that this sacred privilege was indeed designed by God in order that a creature might relate to the creator in a personal way—in a relationship in which God is sovereign.

If man was indeed created in the image of God and he was created for a life of fellowship with God, then death is alien to anything that God in his creation of man intended before the fall of man. From a theological point of view the sanctity of life represents or rather understands man as a trinity. He is a soul, he does inhabit a body, and he has a spirit. In the trinitarian Christian view there is a sanctity of life for each of these.

The term "death with dignity" has caught on because of its alliterative catchiness rather than because it represents anything based upon Judeo-Christian moral principles.[14] The Judeo-Christian understanding of the fall of man is essential to an appreciation of this point of view. Man was created in the image of God and would have lived in fellowship with Him had it not been for the disobedience of the progenitor of our race, Adam. Anything that exists within man's nature to enable him to have fellowship with God must be regarded

as a gift from God and in a sense the worthiness of this life has meaning only insofar as it has this relationship to God.

In a sense the whole problem of the right to live and the right to die which centers around one's understanding of abortion and euthanasia has a significant analogy to the behavior of Lucifer. We do not know whence his temptation came but we do know that he sought to be "like the most high."[15] Our society, having lost its understanding of the sanctity of human life, is pushing the medical profession into assuming one of God's prerogatives, namely, deciding what life shall be born and when life should end.

A great deal of our Western civilization with its concomitant culture is based upon Christian principles, Christian ethics, Christian morality. Even though many refer to this era as the post-Christian era, there are a remarkable number of spin-offs that we accept as everyday rights and privileges which would never have been part of Western society had Christian influence not been brought to bear upon that society.

If one were to superimpose maps of the Western world, one showing those places where the Christian Gospel has been preached, where Christian morality and influence has had its greatest impact, and another map showing those parts of the Western world where what used to be called social reforms were most prevalent—literacy, education, hospitals, orphanages, homes for the aged, institutions for the retarded and the insane available to all regardless of creed—these maps would be almost identical.

Without theological insights that help to form the basis of one's understanding of matters relating to the life and death of patients, I would find it impossible to make judgments in these matters. I suspect that theological principles, some of which may be vague implantations from early religious training, are probably at work in the minds of the great majority of physicians as they face some of these decisions.

If there is not to be a Judeo-Christian ethic in the preservation of life in matters pertaining to euthanasia, what does the future hold? To assume the role of prophet, I can almost hear the arguments that will be given by the proponents of euthanasia, outlining the safeguards that the state can build into euthanasia laws to prevent euthanasia from becoming perverted as it once did in the days of the Nazis in Germany. It comes down to the question as it does in reference to any matter of life: "Is there life not worthy to be lived?" The day may come when my life objectively is not considered to be worth much by the death selection committee. On the other hand, the subjective worth of my life in my eyes and those in my family who love me might

be quite different. Many cases will be open and shut but the number of cases in the gray area will exceed those where physicians have clarity of thought and relative unanimity of opinion. Certainly the rights of individuals will disappear, depersonalization and dehumanization will reign. If our human-value concepts are to be preserved, no one should take the life of another human being passively without the deepest concern and consideration of all the implications thereto. Once the human value-ethic becomes weakened or tarnished, it doesn't take long for inhuman human experimentation to take place. Auschwitz could be in the offing.

Where Do We Go From Here?

The decision of the Supreme Court in favor of abortion on demand literally hands over the decision of the survival of one person's life to another person. All of the economic, social, emotional, and compassionate arguments that are used in favor of abortion very suddenly become the same arguments in euthanasia.

It does not take long to move rapidly to a new set of standards once we have learned to live for a short time with an abrogation of a former principle. Take the medical profession, for example. For four centuries longer than the Christian era, doctors have taken the Hippocratic oath. To be sure, there are many things that are outdated because of the difference in culture between the time of Hippocrates and this modern era. To be sure, there are changes in our understanding of modern medicine which alter or render obsolete certain areas of the Hippocratic oath. But the one thing that the public could rely on was that a medical profession functioning on the traditional oath of Hippocrates was in the business of being on the side of life. Life was to be preserved just as suffering was to be alleviated. But nowhere were the skills of the physician to be used as intervention to lower the health standards of the patient or to shorten his life. If the medical profession abandons the life-principle embodied in the Hippocratic oath, and sees its privilege to extend to the interruption of unborn life in the womb and to painlessly exterminate a waning life much as the veterinarian would put an ailing dog to sleep, it will have changed its *raison d'etre*. The patient can no longer look at his physician as his advocate for the extension of life because when in the mind of that physician that patient's life is waning, the sick person has no guarantee that the physician will approach him in the role of life-preserver; he may be coming as executioner. The medical profession has been disappointingly silent as they have heard the intellectual arguments, Supreme Court rulings, and population-concern

pressures that have begun to alter the fundamental basis which has for so long set them apart as the proponents of the healing art.

Before the century is out, it is quite possible that the elderly will exceed in numbers those who are saddled with their support, whether as family or under some legal technicality such as the Social Security Act. If the question of euthanasia presents a dilemma now on moral and ethical grounds, think of what it will present in days to come when, in addition to moral and ethical considerations, there is the overpowering question of economics. Unless we get our ethics and our morals straightened out now, the death selection committee that decides for you may be motivated more by money than by ecological concerns.

Most of the dilemmas that present themselves in reference to the dying patient have been described. If the reader feels at this juncture that he does not have a good grasp of how the author would act in a given circumstance then the reader has grasped the situation rather well. It is almost impossible to present in capsule form how one feels on this subject, so extenuating are the circumstances in different situations. Perhaps no more difficult question is ever asked of me by an intern or a resident than to summarize in a few sentences my feelings on this subject. When asked to do so, I put it somewhat like this: "As a basic principle keep as many men at as many guns for as long a time as possible, that's how you win the war. I am in the life-saving business and that comes first but I recognize also that I am in the business of alleviating suffering. I never take a deliberate action with the motive of terminating a patient's life. It is possible that a patient's life might be shortened by some therapeutic measure I employ with the intent of relieving suffering. In some circumstances where I believe that I have sufficient experience and expertise with the life history of a given diagnosis and my patient's response to his disease as well as his therapy I would withhold treatment that might be considered extraordinary or heroic in the given circumstance in reference to the quality of life that might be salvaged for a short period of time. Even as I write these words I recognize full well the chance for errors in judgment. Because of that I try to err only on the side of life."

Perhaps the most frightening thing to me in all of the controversy concerning the right to live and the right to die is the manner in which infanticide is actually being practiced today. The report in the *New England Journal of Medicine* concerning the New Haven experience is of discretionary infanticide.[15] It matters little whether you let a baby starve to death, shut off his oxygen, or kill him. See how easy it was to step from killing the unborn baby in the womb to killing the born baby outside the womb. Although it has not yet been enunciated

it would seem that there is some kind of a "right" for a parent to deprive his new born child of life if he does not conform to his presumption of expected perfection. As I write these words there is almost no controversy about this subject. I think it is because those who practice infanticide recognize that at the moment they are committing homicide and that our society as yet does not condone it. It is easier to look the other way. How is it that in the same hospitals where we have programs for child abuse that try to seek out of the community those children who are being emotionally or physically abused by their parents, we also permit children to die because they are not wanted in their state of defectiveness by their parents? We are indeed a schizophrenic society.

NOTES

1. Declaration of Independence.
2. 2 Cor. 5:8.
3. Duff, R.S., and Campbell, A.G.M. "Moral and Ethical Dilemmas in the Special Care Nursery," *New England Journal of Medicine* 289:890, 1973.
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The Lesson of Euthanasia

Virgil C. Blum and Charles J. Sykes

As THE EUTHANASIA and abortion movements in the United States continue to grow in scope and intensity it becomes of the utmost importance to remind ourselves of the history of so-called "mercy-killing." We must not ignore the striking and disquieting parallels between the arguments and logic used by contemporary proponents and those used in Germany even before the Nazi period. We need not indulge in fantasizing or "divining" the future to see the ramifications of such programs. Too often predictions of the ultimate progression of abortion to euthanasia to the wide-spread killing of the aged and infirm are dismissed as extremist and alarmist. We must recognize, however, the progression that has *already* taken place. The relevance of the German experience, hazy and indefinite in the minds of most, is still widely misrepresented and misunderstood. But the parallels between the German experience and our own are impressive. The warnings are clear, if we will only heed them.

Despite what some people would like to think, the mass euthanasia program cannot be written off as a Nazi aberration or as an alien element thrust upon civilization by fanaticism. The movement was not one of storm-troopers or of demented sadists, but was rather the culmination of an intellectual movement which can be traced back to 1920 with the publication of *The Release of the Destruction of Life Devoid of Value,* by the psychiatrist Alfred Hoche and the jurist Karl Binding. They developed the idea of "absolutely worthless human beings" and advocated the "killing of those who cannot be rescued and whose death is urgently necessary."[1] They stress the economic burden of keeping these patients alive and conversely the advantages of killing them. Probably neither Hoche nor Binding had ever heard of Adolf Hitler, and it is not likely that Hitler ever read their book. But it is extremely significant that just as the Fuehrer's career was beginning, the concept of "life devoid of value" was being advanced

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in the intellectual community. Frederic Wertham, in his book *A Sign for Cain,* writes, "This little book influenced, or at least crystallized, the thinking of a whole generation."[2] Dr. Paul Marx in his booklet on mercy-killing also commenting on this book wrote that, "the German atrocities began as the voluntary deeds of eminent scientists not as the reluctant response to a mad despot's commands."[3]

The German program got off to a rather modest beginning. In 1933 the Law for the Prevention of Hereditary Diseases provided for compulsory sterilization to prevent the propagation of "serious Hereditary diseases," such as hereditary imbecility, insanity, epilepsy, deafness, blindness, and alcoholism. One of the architects of the program, Dr. Arthur Guett, head of the National Hygiene Department, offered the comforting reassurance as late as 1938 that "stringent regulations have been issued to prevent any misuse."[4] But by the outbreak of the Second World War in 1939, 375,000 persons, including workers who had lost limbs in industrial accidents, had been sterilized.[5] As Wertham points out, "The compulsory sterilization law was the forerunner of the mass killing of psychiatric patients."[6]

The German professionals were heavily influenced by a utilitarian medical ethic in which the consequences alone determined whether an act was right or wrong. Michael LaChat in his article "Utilitarian Reasoning in Nazi Medical Policy," writes that such reasoning "often rests upon a rejection of any concept of a natural order imposing absolute values, an acceptance of the doctrine that the control of life is a proper function of society rightly influenced by factors such as the population explosion and an emphasis on the needs of the community."[7]

The Germans regarded national and racial purity as a biological imperative, subordinating the individual person to the eugenic ideal of the perfect Aryan man. Humanistic, Western ideals were rejected in this new biological order. Thinkers like Ernst Haeckl made repeated assaults on the traditional values of the Judeo-Christian ethic. Haeckl argued that infanticide should not be regarded as murder, but rather as "a practice of advantage both to the infants destroyed and to the community."[8] He advocated the establishment of a commission which would determine questions of life or death; careful cost-benefit analyses were made to justify such new measures.

Supporting the evolving program of mercy-killing were many of the top medical minds of Germany. Germain Grisez in his book *Abortion: The Myths, The Realities, and the Arguments* declares that "This murderous project was not initiated by Nazi officials but by the medical profession itself; in fact no law ever gave it formal sanction . . . The

vast majority of the participants in the affair were no less sane and no less upright than the members of any modern nation's medical profession."[9]

Several physicians openly refused to participate and were never punished, belying the claim that the doctors who did participate acted under compulsion.[10] Wertham writes: "From its very inception the euthanasia program was guided in all important matters, including concrete details, by psychiatrists . . . No mental patients were ever killed without psychiatrists being involved."[11] The remarkable part of the story and the most important for the future of violence, and I believe of mankind, Wertham says, was the identity of the killers: "They were not non-entities or outsiders. Most of them had all the hallmarks of civic and scientific respectability. They were not Nazi puppets but had made their careers and reputations as psychiatrists long before Hitler came to power . . . Most of the names read like a roster of prominent psychiatrists . . . They are still quoted in international psychiatric literature."[12]

It was the ideas of these men, filtering down through their profession and through the public at large, that sparked the holocaust directed not at the Jews or Slavs, but at Aryan Germans who happened to be blind, or insane, or retarded.

The application of this utilitarian medical philosophy was grim. Two hundred and fifty thousand (250,000)[13] innocent men, women, and children were killed in what was described in the aseptic, conscience-dulling euphemisms of the medical community, "mercy-deaths," "mercy-killings," "help for the dying," or "destruction of life devoid of value." In 1939 Germany had 300,000 mental patients; in 1946 only 40,000 could be accounted for.[14] Children were killed in pediatric hospitals and psychiatric institutions. In the beginning only severely retarded or deformed children were killed, but later children with "badly modeled ears," "bed wetters" and those who were simply "difficult to train" were killed.[15] Many infants were killed by the injection of iodine which caused them to die in convulsions; others were simply allowed to starve to death. Many patients were killed who were merely aged and infirm. Wertham tells of psychiatrists and nurses watching as mental patients are gassed to death, gasping for breath, their faces contorted with fear.[16] Relatives were routinely informed of death by natural causes. Inexorably the list of those deemed "useless" grew.

The government had tried actively to prepare the public for the acceptance of euthanasia. Ironically, the Nazis offered the idea of sterilization and euthanasia as acts of kindness and mercy. Dr. Guett

refers to a "mistaken sense of charity" which leads people to "commit acts of ruthless cruelty" against those "being racially inferior or suffering from an incurable disease" by not killing them.[17] The propaganda movie "I Accuse" coincided with the secret implementation of the mercy killing program. It depicts a woman suffering from sclerosis who is killed by her husband who then repeats all the arguments for euthanasia at his trial. But occasionally these attempts backfired. A Nazi intelligence report notes one viewer's prophetic comments that: "In this film, the same thing happens as in the asylums where they are finishing off all the lunatics right now. What guarantee have we got that no abuses creep in?"[18]

The Bishop of Limburg wrote a moving account of the hospital at Hadamar where thousands of patients were killed. The incoming vans were well known to the inhabitants of the town, as was the smoke rising from the chimneys. In a 1941 letter the Bishop describes the scene: "You hear old folks say, 'Don't send me to a state hospital!' After the feeble-minded have been finished off, the next useless eaters whose turn will come are the old people."[19] Instinctively these people recognized the pattern of enlargement, the ever growing circle of those classified under the fatal rubric, "worthless."

Dr. Braune, a German Protestant minister, called for the immediate cessation of the program which, he said, "strikes sharply at the moral fiber of the nation as a whole. The inviolability of human life is a pillar of every social order."[20] In August, 1941, Catholic Bishop Clemens Von Galen bitterly denounced the killing of these "innocents."[21] The resulting public outcry forced the program to go underground at least for a while.

One of the great myths about the "mercy-killings" is that they were commanded by Hitler. But the only relevant Hitler document merely gave restricted authority after "a most critical diagnosis" for patients to "be accorded a mercy death."[22] This authority was far from a direct order for mass killing. The wide-spread nature of these killings must be attributed to the initiative of the doctors themselves.

Once the utilitarian ethic was established and the Judeo-Christian ethic of respect for the sanctity of human life was subverted, there could be no limit. As Grisez writes, "this same medical profession itself organized and pushed ahead the euthanasia program of the late 1930's which merged into the genocide program of 1941-1945."[23] Wertham writes: "Technical experience first gained with killing psychiatric patients was utilized later for the destruction of millions. The psychiatric murders came first."[24]

Dr. Leo Alexander, Chief Counsel at the Nuremburg trials sums up the basic course of the German experience:

> Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted, and finally all non-Germans. But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the nonrehabilitable sick.[25]

What emerges as the horrifying reality is the ready acceptance and routineness of the procedures. Our preconceptions are rudely shattered. We were prepared to encounter the iron fist of authoritarian Fascism, but not the calculating, deliberate consensus of the German medical community. Our confident assertion, "It can't happen here; after all, *we* aren't Nazis," crumbles when we see how little fanaticism there was, and how respectable, how familiar the participants and the causes were. It is always terrifying to encounter the devil and to find in his face a vague but definite resemblance to your own. As Michael LaChat has written, "No one has to believe in a Nazi racist revival or resort to mud-slinging 'ad hominem' arguments to demonstrate parallels with modern utilitarian thought."[26]

Already, thirty years after the fall of Nazi Germany, new definitions of what constitutes humanity and the right-to-life have been presented with the natural, simultaneous recurrence of the idea of lives "devoid of value." Joseph Fletcher, an Episcopalian clergyman and a leading exponent of "situation ethics," has drawn up a list of criteria by which "humanhood" ought to be judged. To be human, or rather to be regarded as such by Fletcher, one must have a "self-awareness, self-control, a sense of time, of futurity and of the past, concern for others, control of existence, curiosity, changeability, and creativity, a balance of rationality and feeling, distinctiveness . . ." In short, Fletcher declares that "mere biological life . . . is without personal status."[27] Even the euthanasia advocate Daniel Maguire sees the ominous implications in Fletcher's position since "it implies too strongly that fetuses and comatose persons, lacking humanhood in Fletcher's sense of the term, lack a claim to life or are reduced to merely animal or object status."[28]

This arbitrary circumscription of the human family is accompanied

by an even more serious and profound development quite similar to what happened in Germany in the 1920's and 1930's. The traditional Western ethic of the sanctity and inviolability of human life is rapidly yielding before a new ethic of medicine in the areas of abortion and euthanasia. Fletcher rejects the restrictions on killing in the Hippocratic Oath saying, "There is no reason to take that unknown moralist's understanding of right and wrong, or good and evil as permanent models of conscience for all times."[29] Fletcher's brand of situation ethics rejects the absolute prohibition against killing the innocent because, "what is right or good does not transcend changing circumstances, it arises out of them."[30]

Avoiding any of the popular attempts at obfuscating the issue, *California Medicine, the Journal of the California Medical Association,*[31] clearly outlines this attack on the traditional ethic. In the September, 1970, issue it reviews the Western ethic which "has always placed great emphasis on the intrinsic and equal value of every human life regardless of its stage or condition." But noting the "human population explosion which tends to proceed uncontrolled" and the burden this puts upon our resources, *California Medicine* declares that the "quality of life" must supersede the older sanctity of life. Following the utilitarian logic of its position, the journal observes that in order to preserve this "quality of life" attainable with our new technology, "hard choices will have to be made." The journal says bluntly: "This will of necessity violate and ultimately destroy the traditional Western ethic with all that this portends." Relative values must replace absolute values "on such things as human life." It concedes that "this is quite distinctly at variance with the Judeo-Christian ethic and carries serious philosophical, social, economic, and political implications for world society." It acknowledges that already the acceptance of abortion has taken place in "defiance of the long held Western ethic."

Just how vague and ominous these relative values are, *California Medicine* makes clear: "The criteria upon which these relative values are to be based will depend upon whatever concept of the quality of life or living is developed." This argument becomes almost indistinguishable from the German argument: "This may be expected to reflect the extent that quality of life is considered to be a function of personal fulfillment; of individual responsibility for the common welfare, the preservation of the environment, the betterment of the species . . ." Having stated this blatantly utilitarian, eugenic doctrine, it proceeds, "and whether or not, or to what extent, these responsibilities are to be exercised on a compulsory or voluntary basis." Already, in this country we have a respected medical journal writing seriously of

the possibility of *compulsory* eugenic measures (including abortion and euthanasia) taken "for the betterment of the species."

Drawing the inevitable link, *California Medicine* sees the further development of birth control and birth selection to death control and death selection, "whether by the individual or by society." The article ends with an admonition to "examine this new ethic, recognizing it for what it is, and will mean for human society, and prepare to apply it in a rational development for the fulfillment and betterment of mankind in what is almost certain to be a biologically-oriented world society."

The fundamental question remains what new ethic will arise out of the ruins of the destroyed ethical consensus which has held us together for centuries?

The criteria for humanity, originally propounded with regard to fetuses and comatose persons, has been logically extended to exclude new-born infants. Millard S. Everett in his book *Ideals of Life* envisions a time when "no child shall be admitted into this society who would have any social handicap, for example, any physical or mental defect that would prevent marriage or would make others tolerate his company only from a sense of mercy . . . Only normal life shall be accepted."[32] The British jurist Glanville Williams explicitly advocates infanticide. As Grisez says, "On utilitarian grounds, he . . . proposes a tolerant and permissive view of the killing of defective infants."[33] He observes that Williams "does not see any basis for an indispensable legal principle protecting the right of life of those who cannot protect themselves—of those not useful to society."[34]

Joining with Fletcher in restricting those who qualify as human is sociologist Ashley Montagu. He denies the humanity of the unborn child, claims that the unborn "do not really become functionally human until humanized in the human socializing process."[35] Clearly, this criterion of personality leads to infanticide as well as abortion. It further opens the door to justifying the elimination of any group not regarded by the decision makers as "functionally human." Under Montagu's criteria, according to Grisez, Helen Keller "surely ought to have been exterminated."[36]

The slogan "no unwanted child" rapidly becomes "no unwanted person." If one can commit medical homicide at the beginning of life (abortion), Fletcher suggests rhetorically, why not also at the end (euthanasia)?[37]

Employing the economic cost-benefit perspective, Fletcher further supports killing a patient when factors such as cost "combine to outweigh the benefits of keeping him alive."[38] Echoing the German anal-

ysis, Fletcher says: "Sooner or later we shall be forced back on 'statistical morality,'" and stresses grimly the necessity of keeping hospital beds vacant and available.[39] He also proposes the establishment of "death boards" to deal with the question of life and death[40] (a proposal that prompted one physician to remark, when asked about mercy-killing, "Not unless I am on the committee.").

Fletcher has nothing but contempt for fears of a "Nazi-type misuse of euthanasia" which he regards as the "reactionary fear of innovation and enhanced powers of control because they can be used for evil as well as for good."[41] He would have ridiculed the fears of the elderly Germans who watched the smoke rise from the death factory of Hadamar and, indeed, every fear of granting absolute power over life and death to an unaccountable authority. How can we help but fear when men like Fletcher dispense with the notion of intrinsic right and wrong? Where will they draw the line when they deny the existence of any firm line? It must be borne in mind, moreover, that a mistake with regard to a "mercy action" is by its very nature never reversible, never correctable.

What has already happened is frightening enough. The United States Supreme Court, in legalizing abortion in the first nine months of pregnancy, adopted the "quality of life" criterion with its concept of "meaningful life." As Dr. Marx points out, the decision is of critical importance in that the court's "vague and open-ended definition" of what constitutes a person, "supplies the constitutional precedent for dehumanizing other segments of humanity by defining their lives as meaningless or incomplete."[42]

Many qualified observers see the same signposts in the United States in the 1970's as were present in Nazi Germany forty years ago. And well they might. Nobel prize winner Dr. James D. Watson has proposed that legal status be withheld from infants until three days after birth in order to allow for killing deformed or retarded children.[43] Presumably defects which take longer to diagnose would receive a further extension, some perhaps indefinitely. For Dr. Robert H. Williams this presents no problem, at least during the first year of a child's existence. He writes, "Only near the end of the first year of age does a child demonstrate intellectual development, speaking ability, and other attributes that differentiate him significantly from other species."[44]

In 1971, the nation was shocked when it became known that a mongoloid baby at Johns Hopkins Hospital was deliberately allowed to starve to death, taking fifteen days to die.[45] More recently, in Mesa, Arizona, the parents of an infant with meningitis allowed it to starve for nine days before it died.[46] No legal action was taken in either case.

Such chilling events led Patrick Cardinal O'Boyle of Washington to predict: "Infanticide will be proposed first for hard cases, but eventually any case will be accepted as hard enough."[47]

Even more gruesome are accounts of modern, refined techniques of experimentations on living fetuses. A new chemical, Prostin F2 Alpha, induces abortions which leave the baby alive and intact following the procedure, and thus has made experiments possible that were not even imagined by the Nazis. While the fetus's heart is still beating doctors dissect the infant, removing the brain, lungs, liver, and other organs suitable for further experimentation.[48] Babies that are still moving are packed in ice for shipment to experimental laboratories. Scientists use children destined to be killed by abortion to test the effects of potentially harmful drugs.[49]

These new scientific methods merely put a more efficient and sophisticated facade on the experimentation that took place in German psychiatric hospitals (which were, incidentally, extensively involved in experimenting on human brains extracted from their victims) and the concentration camps.[50] The Vice-President and General Manager of the Upjohn Corporation, which produces such new drugs as F2 Alpha, recently said with a somewhat weak historical perspective and a somewhat startling degree of cold-bloodedness: "For the first time, the medical profession is involved in the inhibition of life, and here we look to the most effective and convenient means . . ."[51] The wheel it seems, at least with regard to human experimentation, has come full circle.

In 1969 a bill was introduced in the Florida legislature stipulating that "life shall not be prolonged beyond the point of meaningful existence," however "meaningful existence" might be defined. Under the terms of the bill, relatives could authorize the killing of a patient, or in the case of a patient without relatives three doctors could sign the death warrant. The author of the bill, Dr. Walter Sackett, has gone so far as to propose that 90% of the patients in Florida hospitals for the mentally retarded be allowed to die. Again he uses the utilitarian economic argument that "five billion dollars could be saved in the next half century if the state's mongoloids" were permitted to die.[52]

Echoing the German eugenic position, a scientist of the eminence of Dr. Philips Handler, president of the U.S. National Academy of Science, expresses concern over "the dreadful prospect of serious damage to the human gene pool."[53] Another, like Dr. Y. Edward Hsia, a Yale geneticist, favors compulsory abortion for unborn babies ascertained to be deformed.[54] Dr. H. Tristram Engelhardt, of the University of Texas, has even developed the idea of "wrongful life" in which a per-

son may be legally liable for committing a tort or injury against another by *not* killing them, by keeping them alive.[55] This is a concept which, if it is accepted, will exert great pressure on all of us to become "mercy-killers."

In addition, the killing of the aged could be expedited by the adoption of a proposal made in New Zealand that up to $3,750 be paid by the government to dependents of anyone who dies before the age of 65.[56]

These are the experts, the doctors. But, as Dr. Rene Dubos observed in *Reason Awake:* "A society that blindly accepts the decision of experts is a sick society on its way to death."[57]

Bernard Haring, author of the book *Medical Ethics,* asks perceptively if the "discussion on positive euthanasia unmasks the horrifying situation of a humanity that has lost its understanding of life and death?" He declares that the doctors "are unquestionably marked by that attitude which led Hitler to distinguish between 'fit' and 'unfit' life."[58]

The implications of situation ethics and utilitarianism for the sanctity of human life are of the utmost importance. Its chief proponents refuse to acknowledge the inherent danger in any system which rejects the notion of intrinsically right or wrong actions, and in which right and wrong are determined only by the situation or the consequences. In their view, temporal, material happiness constitutes the highest good; pain and suffering the worst evils, to be avoided at any cost. A principle is established in which the individual good is subordinated to the good of society. Thus, all human rights are seen to be granted not by nature but conditionally by the community, as expressed through the State. And, of course, any right which the State gives, including the right to life, it can also take away. No value, not even that of human life can be of much weight when the ultimate good is seen to be the "greatest good for the greatest number," however that might be defined in the utilitarian philosophy. What the ramifications of such a philosophy would be can only be darkly surmised. The logical progression of the present attack on the intrinsic value of human life has not yet reached its conclusion in this country. But if we will only learn from history, we have a very good idea where it will go.

It is hardly forgiveable naiveté to assume that we can limit the scope of the so-called "mercy-killers" by means of our normal sensibilities and instinctive humaneness when the very basis of just that morality has been shattered, when the demands of Christian mercy and the right to life are replaced by a new and, as yet, hazily defined ethic.

As Bishop Cahal Daly has said, "The end is contained in the begin-

ning."[59] We must recognize that the first time we knowingly kill an innocent person for reasons of expediency (including that catch-all, "the public good") we are beginning a process whose pattern we have already established, but whose end we cannot control. Unless we recognize where we are going, and unless we heed the warnings of the German experience, it will be only a matter of time before the Western ethic, with its respect for the value and equality of human life, ceases to be a living reality and is consigned to the archaic curiosities of history. And then, in W. B. Yeats' words:

> What rough beast, its hour come round at last,
> Slouches towards Bethlehem to be born?

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Some Non-Religious Views against Proposed "Mercy-Killing" Legislation

Yale Kamisar

Part I

At the Crystal Palace Aquarium not long ago I saw a crab euthanatising a sickly fish, doubtless from the highest motives.[1]

A recent book, Glanville Williams' *The Sanctity of Life and the Criminal Law,*[2] once again brings to the fore the controversial topic of euthanasia,[3] more popularly known as "mercy killing." In keeping with the trend of the euthanasia movement over the past generation, Williams concentrates his efforts for reform on the *voluntary* type of euthanasia, for example, the cancer victim begging for death; as opposed to the *involuntary variety,* that is, the case of the congenital idiot, the permanently insane or the senile.

When a legal scholar of Williams' stature[4] joins the ranks of such formidable criminal law thinkers as America's Herbert Wechsler and the late Jerome Michael,[5] and England's Hermann Mannheim[6] in approving voluntary euthanasia, at least under certain circumstances, a major exploration of the bases for the euthanasia prohibition seems in order.[7] This need is underscored by the fact that Williams' book arrives on the scene so soon after the stir caused by a brilliant Anglican clergyman's plea for voluntary euthanasia.[8]

The Law On The Books condemns all "mercy killings."[9] That this has a substantial deterrent effect, even its harshest critics admit.[10] Of course, it does not stamp out all "mercy killings," just as murder and rape provisions do not stamp out all murder and rape, but presumably it does impose a substantially greater responsibility on physicians and relatives in a euthanasia situation and turns them away from significantly more doubtful cases than would otherwise be the practice under any proposed euthanasia legislation to date. When a "mercy killing" occurs, however, The Law In Action is as malleable as The Law On The Books is uncompromising. The high incidence of failures

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to indict,[11] acquittals,[12] suspended sentences[13] and reprieves[14] lend considerable support to the view that

> If the circumstances are so compelling that the defendant ought to violate the law, then they are compelling enough for the jury to violate their oaths. The law does well to declare these homicides unlawful. It does equally well to put no more than the sanction of an oath in the way of an acquittal.[15]

The complaint has been registered that "the prospect of a sentimental acquittal cannot be reckoned as a certainty."[16] Of course not. The defendant is not always *entitled* to a sentimental acquittal. The few American convictions cited for the proposition that the present state of affairs breeds "inequality" in application may be cited as well for the proposition that it is characterized by elasticity and flexibility.[17] In any event, if inequality of application suffices to damn a particular provision of the criminal law, we might as well tear up all our codes—beginning with the section on chicken-stealing.[18]

The criticism is also made that

> . . . public confidence in the administration of criminal justice is hardly strengthened when moral issues are shifted instead of being solved, or when the law relegates to juries the function of correcting its inequities.[19]

But there are many, many occasions on which the jury wrestles with moral issues, and there is certainly substantial support for this practice.[20]

The existing law on euthanasia is hardly perfect. But if it is not too good, neither, as I have suggested, is it much worse than the rest of the criminal law. At any rate, the imperfections of the existing law are not cured by Williams' proposal. Indeed, I believe adoption of his views would add more difficulties than it would remove.

Williams strongly suggests that "euthanasia can be condemned only according to a religious opinion."[21] He tends to view the opposing camps as Roman Catholics versus Liberals. Although this has a certain initial appeal to me, a non-Catholic and a self-styled liberal, I deny that this is the only way the battle lines can, or should, be drawn. I leave the religious arguments to the theologians. I share the view that "those who hold the faith may follow its precepts without requiring those who do not hold it to act as if they did."[22] But I do find substantial utilitarian obstacles on the high road to euthanasia.[23]

As an ultimate philosophical proposition, the case for voluntary euthanasia is strong. Whatever may be said for and against suicide generally,[24] the appeal of death is immeasurably greater when it is sought not for a poor reason or just any reason, but for "good cause," so to

speak; when it is invoked not on behalf of a "socially useful" person, but on behalf of, for example, the pain-racked "hopelessly incurable" cancer victim. *If* a person is *in fact* (1) presently incurable, (2) beyond the aid of any respite which may come along in his life expectancy, suffering (3) intolerable and (4) unmitigable pain and of a (5) fixed and (6) rational desire to die, I would hate to have to argue that the hand of death should be stayed. But abstract propositions and carefully formed hypotheticals are one thing; specific proposals designed to cover everyday situations are something else again.

In essence, Williams' specific proposal is that death be authorized for a person in the above situation "by giving the medical practitioner a wide discretion and trusting to his good sense."[25] This, I submit, raises too great a risk of abuse and mistake to warrant a change in the existing law. That a proposal entails risk of mistake is hardly a conclusive reason against it. But neither is it irrelevant. Under any euthanasia program the consequences of mistake, of course, are always fatal. As I shall endeavor to show, the incidence of mistake of one kind or another is likely to be quite appreciable. If this indeed be the case, unless the need for the authorized conduct is compelling enough to override it, I take it the risk of mistake *is* a conclusive reason against such authorization. I submit, too, that the possible radiations from the proposed legislation, *e.g.*, involuntary euthanasia of idiots and imbeciles (the typical "mercy killings" reported by the press) and the emergence of the legal precedent that there are lives not "worth living," give additional cause to pause.

I see the issue, then, as the need for voluntary euthanasia versus (1) the incidence of mistake and abuse; and (2) the danger that legal machinery initially designed to kill those who are a nuisance to themselves may someday engulf those who are a nuisance to others.[26]

The "freedom to choose a merciful death by euthanasia" may well be regarded, as does Professor Harry Kalven in a carefully measured review of another recent book urging a similar proposal,[27] as "a special area of civil liberties far removed from the familiar concerns with criminal procedures, race discrimination and freedom of speech and religion."[28] The civil liberties angle is definitely a part of Professor Williams' approach:

> If the law were to remove its ban on euthanasia, the effect would merely be to leave this subject to the individual conscience. This proposal would . . . be easy to defend, as restoring personal liberty in a field in which men differ on the question of conscience. . . .
>
> On a question like this there is surely everything to be said for the liberty of the individual.[29]

I am perfectly willing to accept civil liberties as the battlefield, but issues of "liberty" and "freedom" mean little until we begin to pin down *whose* "liberty" and "freedom" and for *what* need and at *what* price. This paper is concerned largely with such questions.

> It is true also of journeys in the law that the place you reach depends on the direction you are taking. And so, where one comes out on a case depends on where one goes in.[30]

So it is with the question at hand. Williams champions the "personal liberty" of the dying to die painlessly. I am more concerned about the life and liberty of those who would needlessly be killed in the process or who would irrationally choose to partake of the process. Williams' price on behalf of those who are *in fact* "hopeless incurables" and *in fact* of a fixed and rational desire to die is the sacrifice of (1) some few, who, though they know it not, because their physicians know it not, need not and should not die; (2) others, probably not so few, who, though they go through the motions of "volunteering," are casualties of strain, pain or narcotics to such an extent that they really know not what they do. My price on behalf of those who, despite appearances to the contrary, have some relatively normal and reasonably useful life left in them, or who are incapable of making the choice, is the lingering on for awhile of those who, if you will, *in fact* have no desire and no reason to linger on.

A Close-Up View of Voluntary Euthanasia

A. The Euthanasiast's Dilemma and Williams' Proposed Solution

As if the general principle they advocate did not raise enough difficulties in itself, euthanasiasts have learned only too bitterly that specific plans of enforcement are often much less palatable than the abstract notions they are designed to effectuate. In the case of voluntary euthanasia, the means of implementation vary from (1) the simple proposal that "mercy killings" by anyone, typically relatives, be immunized from the criminal law; to (2) the elaborate legal machinery contained in the bills of the Voluntary Euthanasia Legalisation Society (England) and the Euthanasia Society of America for carrying out euthanasia.

The English Society would require the eligible patient, *i.e.*, one over twenty-one and "suffering from a disease involving severe pain and of an incurable and fatal character,"[31] to forward a specially prescribed application—along with two medical certificates, one signed by the attending physician, and the other by a specially qualified physician—

to a specially appointed Euthanasia Referee "who shall satisfy himself by means of a personal interview with the patient and otherwise that the said conditions shall have been fulfilled and that the patient fully understands the nature and purpose of the application"; and, if so satisfied, shall then send a euthanasia permit to the patient; which permit shall, seven days after receipt, become "operative" in the presence of an official witness; unless the nearest relative manages to cancel the permit by persuading a court of appropriate jurisdiction that the requisite conditions have not been met.

The American Society would have the eligible patient, *i.e.,* one over twenty-one "suffering from severe physical pain caused by a disease for which no remedy affording lasting relief or recovery is at the time known to medical science,"[32] petition for euthanasia in the presence of two witnesses and file same, along with the certificate of an attending physician, in a court of appropriate jurisdiction; said court to then appoint a committee of three, of whom at least two must be physicians, "who shall forthwith examine the patient and such other persons as they deem advisable or as the court may direct and within five days after their appointment, shall report to the court whether or not the patient understands the nature and purpose of the petition and comes within the [act's] provisions"; whereupon, if the report is in the affirmative, the court shall—"unless there is some reason to believe that the report is erroneous or untrue"—grant the petition; in which event euthanasia is to be administered in the presence of the committee, or any two members thereof.

As will be seen, and as might be expected, the simple negative proposal to remove "mercy killings" from the ban of the criminal law is strenuously resisted on the ground that it offers the patient far too little protection from not-so-necessary or not-so-merciful killings. On the other hand, the elaborate affirmative proposals of the euthanasia societies meet much pronounced eye-blinking, not a few guffaws,[33] and sharp criticism that the legal machinery is so drawn-out, so complex, so formal and so tedious as to offer the patient far too little solace.

The naked suggestion that "mercy killing" be made a good defense against a charge of criminal homicide appears to have no prospect of success in the foreseeable future. Only recently, the Royal Commission on Capital Punishment "reluctantly" concluded that such homicides could not feasibly be taken out of the category of murder, let alone completely immunized:

> [Witnesses] thought it would be most dangerous to provide that 'mercy killings' should not be murder, because it would be impossible to define a category which could not be seriously abused. Such a definition could only

> be in terms of the motive of the offender . . . which is notoriously difficult to establish and cannot, like intent, be inferred from a person's overt actions. Moreover it was agreed by almost all witnesses, including those who thought that there would be no real difficulty in discriminating between genuine and spurious suicide pacts, that, even if such a definition could be devised, it would in practice often prove extremely difficult to distinguish killings where the motive was merciful from those where it was not. How, for example, were the jury to decide whether a daughter had killed her invalid father from compassion, from a desire for material gain, from a natural wish to bring to an end a trying period of her life, or from a combination of motives?[34]

While the appeal in simply taking "mercy killings" off the books is dulled by the likelihood of abuse, the force of the idea is likewise substantially diminished by the encumbering protective features proposed by the American and English Societies. Thus, Lord Dawson, an eminent medical member of the House of Lords and one of the great leaders of the English medical profession, protested that the English Bill "would turn the sick room into a bureau," that he was revolted by "the very idea of the sick chamber being visited by officials and the patient, who is struggling with this dire malady, being treated as if it was a case of insanity."[35] Dr. A. Leslie Banks, then Principal Medical Officer of the Ministry of Health, reflected that the proposed machinery would "produce an atmosphere quite foreign to all accepted notions of dying in peace."[36] Dr. I. Phillips Frohman has similarly objected to the American Bill as one whose

> . . . whole procedure is so lengthy that it does not seem consonant either with the 'mercy' motive on which presumably it is based, or with the 'bearableness' of the pain.[37]

The extensive procedural concern of the euthanasia bills have repelled many, but perhaps the best evidence of its psychological misconception is that it has distressed sympathizers of the movement as well. The very year the English Society was organized and a proposed bill drafted, Dr. Harry Roberts observed:

> We all realize the intensified horror attached to the death-penalty by its accompanying formalities—from the phraseology of the judge's sentence, and his black cap, to the weight-gauging visit of the hangman to the cell, and the correct attendance at the final scene of the surpliced chaplain, the doctor, and the prison governor. This is not irrelevant to the problem of legalized euthanasia. . . .[38]

After discussing the many procedural steps of the English Bill Dr. Roberts observed: "I can almost hear the cheerful announcement: 'please, ma'am, the euthanizer's come.' "

At a meeting of the Medico-Legal Society, Dr. Kenneth McFadyean, after reminding the group that

> . . . some time ago he stated from a public platform that he had practiced euthanasia for twenty years and he did not believe he was running risks because he had helped a hopeless sufferer out of this life,

commented on the English Bill:

> There was not comparison between being in a position to make a will and making a patient choose his own death at any stated moment. The patient had to discuss it—not once with his own doctor, but two, three, or even four times with strangers, which was not solace or comfort to people suffering intolerable pain.[39]

Nothing rouses Professor Williams' ire more than the fact that opponents of the euthanasia movement argue that euthanasia proposals offer either inadequate protection or overelaborate safeguards. Williams appears to meet this dilemma with the insinuation that because arguments are made in the antithesis *they must each be invalid, each be obstructionist, and each be made in bad faith.*[40]

It just may be, however, that each alternative argument is quite valid, that the trouble lies with the euthanasiasts themselves in seeking a goal which is *inherently inconsistent*: a procedure for death which *both* (1) provides ample safeguards against abuse and mistake; and (2) is "quick" and "easy" in operation. Professor Williams meets the problem with more than bitter comments about the tactics of the opposition. He makes a brave try to break through the dilemma:

> [T]he reformers might be well advised, in their next proposal, to abandon all their cumbrous safeguards and to do as their opponents wish, giving the medical practitioner a wide discretion and trusting to his good sense.
>
> [T]he essence of the bill would then be simple. It would provide that no medical practitioner should be guilty of an offense in respect of an act done intentionally to accelerate the death of a patient who is seriously ill, unless it is proved that the act was not done in good faith with the consent of the patient and for the purpose of saving him from severe pain in an illness believed to be of an incurable and fatal character. Under this formula it would be for the physician, if charged, to show that the patient was seriously ill, but for the prosecution to prove that the physician acted from some motive other than the humanitarian one allowed to him by law.[41]

Evidently, the presumption is that the general practitioner is a sufficient buffer between the patient and the restless spouse or overwrought or overreaching relative, as well as a depository of enough general scientific know-how and enough information about current research developments and trends, to assure a minimum of error in diagnosis and anticipation of new measures of relief. Whether or not

the general practitioner will accept the responsibility Williams would confer on him is itself a problem of major proportions.[42] Putting that question aside, the soundness of the underlying premises of Williams' "legislative suggestion" will be examined in the course of the discussion of various aspects of the euthanasia problem.

B. "The Choice"

Under current proposals to establish legal machinery, elaborate or otherwise, for the administration of a quick and easy death, it is not enough that those authorized to pass on the question decide that the patient, in effect, is "better off dead." The patient must concur in this opinion. Much of the appeal in the current proposal lies in this so-called "voluntary" attribute.

But is the adult patient[43] really in a position to concur? Is he truly able to make euthanasia a "voluntary" act? There is a good deal to be said, is there not, for Dr. Frohman's pithy comment that the "voluntary" plan is supposed to be carried out "only if the victim is both sane and crazed by pain."[44]

By hypothesis, voluntary euthanasia is not to be resorted to until narcotics have long since been administered and the patient has developed a tolerance to them. *When,* then, does the patient make the choice? While heavily drugged?[45] Or is narcotic relief to be withdrawn for the time of decision? But if heavy dosage no longer deadens pain, indeed, no longer makes it bearable, how overwhelming is it when whatever relief narcotics offer is taken away, too?

"Hypersensitivity to pain after analgesia has worn off is nearly always noted."[46] Moreover,

> . . . the mental side-effects of narcotics, unfortunately for anyone wishing to suspend them temporarily without unduly tormenting the patient, appear to outlast the analgesic effect [and] by many hours.[47]

The situation is further complicated by the fact that

> . . . a person in terminal stages of cancer who had been given morphine steadily for a matter of weeks would certainly be dependent upon it physically and would probably be addicted to it and react with the addict's response.[48]

The narcotics problem aside, Dr. Benjamin Miller, who probably has personally experienced more pain than any other commentator on the euthanasia scene,[49] observes:

> Anyone who has been severely ill knows how distorted his judgment became during the worst moments of the illness. Pain and the toxic effect of

> disease, or the violent reaction to certain surgical procedures may change our capacity for rational and courageous thought.[50]

If, say, a man in this plight were a criminal defendant and he were to decline the assistance of counsel would the courts hold that he had "intelligently and understandingly waived the benefit of counsel?"[51]

Undoubtedly, some euthanasia candidates will have their lucid moments. How they are to be distinguished from fellowsufferers who do not, or how these instances are to be distinguished from others when the patient is exercising an irrational judgment is not an easy matter. Particularly is this so under Williams' proposal, where no specially qualified persons, psychiatrically trained or otherwise, are to assist in the process.

Assuming, for purposes of argument, that the occasion when a euthanasia candidate possesses a sufficiently clear mind can be ascertained and that a request for euthanasia is then made, there remain other problems. The mind of the painracked may occasionally be clear, but is it not also likely to be uncertain and variable? This point was pressed hard by the great physician, Lord Horder, in the House of Lords debates:

> During the morning depression he [the patient] will be found to favour the application under this Bill, later in the day he will think quite differently, or will have forgotten all about it. The mental clarity with which noble Lords who present this Bill are able to think and to speak must not be thought to have any counterpart in the alternating moods and confused judgments of the sick man.[52]

The concept of "voluntary" in voluntary euthanasia would have a great deal more substance to it if, as is the case with voluntary admission statutes for the mentally ill,[53] the patient retained the right to reverse the process within a specified number of days after he gives written notice of his desire to do so—but unfortunately this cannot be. The choice here, of course, is an irrevocable one.

The likelihood of confusion, distortion or vacillation would appear to be serious drawbacks to any voluntary plan. Moreover, Williams' proposal is particularly vulnerable in this regard, since, as he admits, by eliminating the fairly elaborate procedure of the American and English Societies' plans, he also eliminates a time period which would furnish substantial evidence of the patient's settled intention to avail himself of euthanasia.[54] But if Williams does not always choose to slug it out, he can box neatly and parry gingerly:

> [T]he problem can be exaggerated. Every law has to face difficulties in application, and these difficulties are not a conclusive argument against a

> law if it has a beneficial operation. The measure here proposed is designed to meet the situation where the patient's consent to euthanasia is clear and incontrovertible. The physician, conscious of the need to protect himself against malicious accusations, can devise his own safeguards appropriate to the circumstances: he would normally be well advised to get the patient's consent in writing, just as is now the practice before operations. Sometimes the patient's consent will be particularly clear because he will have expressed a desire for ultimate euthanasia while he is still clear-headed and before he comes to be racked by pain; if the expression of desire is never revoked, but rather is reaffirmed under the pain, there is the best possible proof of full consent. If, on the other hand, there is no such settled frame of mind, and if the physician chooses to administer euthanasia when the patient's mind is in a variable state, he will be walking in the margin of the law and may find himself unprotected.[55]

If consent is given at a time when the patient's condition has so degenerated that he has become a fit candidate for euthanasia, when, if ever, will it be "clear and incontrovertible?" Is the suggested alternative of consent in advance a satisfactory solution? Can such a consent be deemed an informed one? Is this much different from holding a man to a prior statement of intent that if such and such an employment opportunity would present itself he would accept it, or if such and such a young woman were to come along he would marry her? Need one marshal authority for the proposition that many an "iffy" inclination is disregarded when the actual facts are at hand?[56]

Professor Williams states that where a pre-pain desire for "ultimate euthanasia" is "reaffirmed" under pain, "there is the best possible proof of full consent." Perhaps. But what if it is alternately renounced and reaffirmed under pain? What if it is neither affirmed or renounced? What if it is only renounced? Will a physician be free to go ahead on the ground that the prior desire was "rational," but the present desire "irrational"? Under Williams' plan, will not the physician frequently "be walking in the margin of the law"—just as he is now? Do we really accomplish much more under this proposal than to put the euthanasia principle on the books?

Even if the patient's choice could be said to be "clear and incontrovertible," do not other difficulties remain? Is this the kind of choice, assuming that it can be made in a fixed and rational manner, that we want to offer a gravely ill person? Will we not sweep up, in the process, some who are not really tired of life, but think others are tired of them; some who do not really want to die, but who feel they should not live on, because to do so when there looms the legal alternative of euthanasia is to do a selfish or a cowardly act? Will not some feel an obligation to have themselves "eliminated" in order that funds allocated

for their terminal care might be better used by their families or, financial worries aside, in order to relieve their families of the emotional strain involved?

It would not be surprising for the gravely ill person to seek to inquire of those close to him whether he should avail himself of the legal alternative of euthanasia. Certainly, he is likely to wonder about their attitude in the matter. It is quite possible, is it not, that he will not exactly be gratified by any inclination on their part—however noble their motives may be in fact—that he resort to the new procedure? At this stage, the patient-family relationship may well be a good deal less than it ought to be:

> Illness, pain and fear of death tend to activate the dependent longings [for the family unit]. Conflict can easily arise, since it may be very difficult for the individual to satisfy his need for these passive dependent needs and his previous concept of the necessity for a competitive, constructive individuality. Our culture provides few defenses for this type of stress beyond a suppression of the need. If the individual's defenses break down, he may feel angry toward himself and toward the members of his family.[57]

And what of the relatives? If their views will not always influence the patient, will they not at least influence the attending physician? Will a physician assume the risks to his reputation, if not his pocketbook, by administering the *coup de grace* over the objection—however irrational—of a close relative?[58] Do not the relatives, then, also have a "choice"? Is not the decision on their part to do nothing and say nothing *itself* a "choice"?[59] In many families there will be some, will there not, who will consider a stand against euthanasia the only proof of love, devotion and gratitude for past events? What of the stress and strife if close relatives differ—as they did in the famous *Sander* case[60] —over the desirability of euthanatizing the patient?

At such a time, as the well-known *Paight* case clearly demonstrates,[61] members of the family are not likely to be in the best state of mind, either, to make this kind of decision. Financial stress and conscious or unconscious competition for the family's estate aside:

> The chronic illness and persistent pain in terminal carcinoma may place strong and excessive stresses upon the family's emotional ties with the patient. The family members who have strong emotional attachment to start with are most likely to take the patient's fears, pains and fate personally. Panic often strikes them. Whatever guilt feelings they may have toward the patient emerge to plague them.
>
> If the patient is maintained at home, many frustrations and physical demands may be imposed on the family by the advanced illness. There may develop extreme weakness, incontinence and bad odors. The pressure of caring for the individual under these circumstances is likely to arouse a re-

> sentment and, in turn, guilt feelings on the part of those who have to do the nursing.[62]

Nor should it be overlooked that while Professor Williams would remove the various procedural steps and the various personnel contemplated in the American and English Bills and bank his all on the "good sense" of the general practitioner, no man is immune to the fear, anxieties and frustrations engendered by the apparently helpless, hopeless patient. Not even the general practitioner:

> Working with a patient suffering from a malignancy causes special problems for the physician. First of all, the patient with a malignancy is most likely to engender anxiety concerning death, even in the doctor. And at the same time, this type of patient constitutes a serious threat or frustration to medical ambition. As a result, a doctor may react more emotionally and less objectively than in any other area of medical practice. . . . His deep concern may make him more pessimistic than is necessary. As a result of the feeling of frustration in his wish to help, the doctor may have moments of annoyance with the patient. He may even feel almost inclined to want to avoid this type of patient.[63]

The only Anglo-American prosecution involving an alleged "mercy killing" physician seems to be the case of Dr. Herman Sander. The state's testimony was to the effect that, as Sander had admitted on various occasions, he finally yielded to the persistent pleas of his patient's husband and pumped air into her veins "in a weak moment."[64] Sander's version was that he finally "snapped" under the strain of caring for the cancer victim,[65] bungled simple tasks,[66] and became "obsessed" with the need to "do something" for her—if only to inject air into her *already* dead body.[67] Whichever side one believes—and the jury evidently believed Dr. Sander[68]—the case well demonstrates that at the moment of decision the tired practitioner's "good sense" may not be as good as it might be.

Putting aside the problem of whether the good sense of the general practitioner warrants dispensing with other personnel, there still remains the problems posed by any voluntary euthanasia program: the aforementioned considerable pressures on the patient and his family. Are these the kinds of pressures we want to inflict on any person, let alone a very sick person? Are these the kinds of pressures we want to impose on any family, let alone an emotionally-shattered family? And if so, why are they not also proper considerations for the crippled, the paralyzed, the quadruple amputee, the iron lung occupant and their families?

Might it not be said of the existing ban on euthanasia, as Professor Herbert Wechsler has said of the criminal law in another connection:

> It also operates, and perhaps more significantly, at anterior stages in the patterns of conduct, the dark shadow of organized disapproval eliminating from the ambit of consideration alternatives that might otherwise present themselves in the final competition of choice.[69]

C. The "Hopelessly Incurable" Patient and The Fallible Doctor

Professor Williams notes as "standard argument" the plea that

> . . . no sufferer from an apparently fatal illness should be deprived of his life because there is always the possibility that the diagnosis is wrong, or else that some remarkable cure will be discovered in time.[70]

But he does not reach the issue until he has already dismissed it with this prefatory remark:

> It has been noticed before in this work that writers who object to a practice for theological reasons frequently try to support their condemnation on medical grounds. With euthanasia this is difficult, but the effort is made.[71]

Does not Williams, while he pleads that euthanasia not be theologically prejudged, at the same time invite the inference that nontheological objections to euthanasia are simply camouflage?

It is no doubt true that many theological opponents employ medical arguments as well, but it is also true that the doctor who has probably most forcefully advanced medical objections to euthanasia of the so-called incurables, Cornell University's world-renowned Foster Kennedy, a former president of the Euthanasia Society of America, *advocates* euthanasia in other areas where error in diagnosis and prospect of new relief or cures are much reduced, *i.e.,* the "congenitally unfit."[72] In large part for the same reasons, Great Britain's Dr. A. Leslie Banks, then Principal Medical Officer of the Ministry of Health, maintained that a better case could be made for the destruction of congenital idiots and those in the final stages of dementia, particularly senile dementia, than could be made for the doing away of the pain-stricken incurable.[73] Surely, such opponents of voluntary euthanasia cannot be accused of wrapping theological objections in medical dressing!

Until the euthanasia societies of England and America had been organized and a party decision reached, shall we say, to advocate euthanasia only for incurables on their request, Dr. Abraham L. Wolbarst, one of the most ardent supporters of the movement, was less troubled about putting away "insane or defective people [who] have suffered mental incapacity and tortures of the mind for many years" than he was about the "incurables."[74] He recognized the "difficulty involved in the decision as to incurability" as one of the "doubtful aspects of euthanasia."

> Doctors are only human beings, with few if any supermen among them. They make honest mistakes, like other men, because of the limitations of human mind.[75]

He noted further that

> . . . it goes without saying that, in recently developed cases with a possibility of cure, euthanasia should not even be considered, [that] the law might establish a limit of, say, ten years in which there is a chance of the patient's recovery.[76]

Dr. Benjamin Miller is another who is unlikely to harbor an ulterior theological motive. His interest is more personal. He himself was left to die the death of a "hopeless" tuberculosis victim only to discover that he was suffering from a rare malady which affects the lungs in much the same manner but seldom kills. Five years and sixteen hospitalizations later, Dr. Miller dramatized his point by recalling the last diagnostic clinic of the brilliant Richard Cabot, on the occasion of his official retirement:

> He was given the case records [complete medical histories and results of careful examinations] of two patients and asked to diagnose their illnesses. . . . The patients had died and only the hospital pathologist knew the exact diagnosis beyond doubt, for he had seen the descriptions of the postmortem findings. Dr. Cabot, usually very accurate in his diagnosis, that day missed both.
>
> The chief pathologist who had selected the cases was a wise person. He had purposely chosen two of the most deceptive to remind the medical students and young physicians that even at the end of a long and rich experience one of the greatest diagnosticians of our time was still not infallible.[77]

Richard Cabot was the John W. Davis, the John Lord O'Brian, of his profession. When one reads the account of his last clinic, one cannot help but think of how fallible the *average* general practitioner must be, how fallible the *young doctor just starting practice* must be—and this, of course, is all that some small communities have in the way of medical care—how fallible the *worst* practitioner, young or old, must be. If the range of skill and judgment among licensed physicians approaches the wide gap between the very best and the very worst members of the bar—and I have no reason to think it does not—then the minimally competent physician is hardly the man to be given the responsibility for ending another's life.[78] Yet, under Williams' proposal at least, the marginal physician, as well as his more distinguished brethren, would have legal authorization to make just such decisions. Under Williams' proposal, euthanatizing a patient or two would all be part of the routine day's work.[79]

Perhaps it is not amiss to add as a final note, that no less a euthanasiast than Dr. C. Killick Millard[80] had such little faith in the average general practitioner that as regards the *mere administering* of the *coup de grace*, he observed:

> In order to prevent any likelihood of bungling, it would be very necessary that only medical practitioners who had been specially licensed to euthanise (after acquiring special knowledge and skill) should be allowed to administer euthanasia. Quite possibly, the work would largely be left in the hands of the official euthanisors, who would have to be appointed specially for each area.[81]

True, the percentage of correct diagnosis is particularly high in cancer.[82] The short answer, however, is that euthanasiasts most emphatically do not propose to restrict "mercy killing" to cancer cases. Dr. Millard has maintained that

> . . . there are very many diseases besides cancer which tend to kill 'by inches,' and where death, when it does at last come to the rescue, is brought about by pain and exhaustion.[83]

Furthermore, even if "mercy killings" were to be limited to cancer, however relatively accurate the diagnosis in these cases, here, too,

> . . . incurability of a disease is never more than an estimate based upon experience, and how fallacious experience may be in medicine only those who have had a great deal of experience fully realize.[84]

Dr. Daniel Laszlo, Chief of Division of Neoplastic Diseases, Montefiore Hospital, New York City, and three other physicians have observed:

> The mass crowding of a group of patients labeled 'terminal' in institutions designated for that kind of care carries a grave danger. The experience gathered from this group makes it seem reasonable to conclude that a fresh evaluation of any large group in mental institutions, in institutions for chronic care, or in homes for the incurably sick, would unearth a rewarding number of salvageable patients who can be returned to their normal place in society. . . . For purposes of this study we were especially interested in those with a diagnosis of advanced cancer. In a number of these patients, major errors in diagnosis or management were encountered.[85]

The authors then discuss in considerable detail the case histories of eleven patients admitted or transferred to Montefiore Hospital alone with the diagnosis of *"advanced cancer in its terminal stage,"* none of whom had cancer at all. In three cases the organ suspected to be the primary site of malignancy was unaffected; in the other eight cases it was the site of some nonmalignant disease. The impact of these find-

ings may be gleaned from a subsequent comment by Doctors Laszlo and Spencer:

> Such cases [of mistaken diagnosis of advanced cancer] are encountered even in large medical centers and probably many more could be found in areas poorly provided with medical facilities.[86]

Only recently, Dr. R. Ger, citing case histories of false cancer diagnoses to buttress his point, had occasion to warn his colleagues:

> Students are often told, and one is exhorted repeatedly in textbooks to do so, to regard signs and symptoms appearing over the age of 40 years as due to carcinoma [malignant epithelial tumor] until proved otherwise. While it is true that carcinoma should take first place on grounds of commonness, it must not be forgotten that there are other conditions which may mimic carcinoma clinically, radiologically and at operation, and which are essentially benign. There is danger, moreover, when presented with a case simulating carcinoma to assume it to be carcinoma without proving or disproving the diagnosis. This may give rise to unnecessary fatalities by either denying treatment because of a hopeless prognosis or carrying out unnecessary procedures.[87]

Even more recently, Doctors De Vet and Walder scored the "extremely dangerous" tendency on the part of general practitioners and specialists alike

> . . . when a neoplasm becomes manifest in a patient previously operated on for a malignant tumour . . . to presume that the new growth is a metastasis [a transfer of the malignant disease].[88]

Their studies demonstrated that it is "by no means a rare occurrence" for patients to develop "another, benign tumour after having been operated upon for a malignant one."[89] De Vet and Walder also stress the "remarkable similarity" in symptoms, including "violent pain" in both cases, between metastases and benign processes of the spinal column and the spinal cord.[90]

Faulty diagnosis is only one ground for error. Even if the diagnosis is correct, a second ground for error lies in the possibility that some measure of relief, if not a full cure may come to the fore within the life expectancy of the patient. Since Glanville Williams does not deign this objection to euthanasia worth more than a passing reference,[91] it is necessary to turn elsewhere to ascertain how it has been met.

One answer is:

> It must be little comfort to a man slowly coming apart from multiple sclerosis to think that, fifteen years from now, death might not be his only hope.[92]

To state the problem this way is, of course, to avoid it entirely. How do we know that fifteen *days* or fifteen *hours* from now, "death might not be [the incurable's] only hope"?

A second answer is:

> [N]o cure for cancer which might be found 'tomorrow' would be of any value to a man or woman 'so far advanced in cancerous toxemia as to be an applicant for euthanasia.'[93]

As I shall endeavor to show, this approach is a good deal easier to formulate than it is to apply. For one thing, it presumes that we know today *what* cures will be found tomorrow. For another, it overlooks that if such cases can be said to exist, the patient is likely to be *so far* advanced in cancerous toxemia as to be no longer capable of understanding the step he is taking and hence *beyond* the stage when euthanasia ought to be administered.[94]

A generation ago, Dr. Haven Emerson, then President of the American Public Health Association, made the point that

> . . . no one can say today what will be incurable tomorrow. No one can predict what disease will be fatal or permanently incurable until medicine becomes stationary and sterile.

Dr. Emerson went so far as to say that "to be at all accurate we must drop altogether the term 'incurables' and substitute for it some such term as 'chronic illness.' "[95]

That was a generation ago. Dr. Emerson did not have to go back more than a decade to document his contention. Before Banting and Best's insulin discovery, many a diabetic had been doomed. Before the Whipple-Minot-Murphy liver treatment made it a relatively minor malady, many a pernicious anemia sufferer had been branded "hopeless." Before the uses of sulfanilimide were disclosed, a patient with widespread streptococcal blood poisoning was a condemned man.[96]

Today, we may take even that most resolute disease, cancer, and we need look back no further than the last decade of research in this field to document the same contention.[97]

Three years ago, Dr. William D. McCarthy presented the results, to date, of an effort begun in 1950 to open a new approach in cancer palliation,[98] a report whose findings of "remarkable improvement" in nearly a third of the cases invoked strong editorial comment in the *New England Journal of Medicine*.[99] At the time of Dr. McCarthy's report, 100 "hopeless" patients with a wide variety of neoplasms had been treated with a combination of nitrogen mustard and ACTH or cortisone.

> All patients in the series were in advanced or terminal phases of disease, and were accepted for treatment only after the disease was determined to be progressive after adequate surgery or radiation therapy.[100]

Dr. McCarthy summarizes the results:

> In several of these cases there was associated tumor regression or arrest, with definite prolongation of life in increased comfort. This group constituted 15 percent of the series. Reserved for the classification as excellent response were 16 additional patients (16 percent) whose subjective and objective remissions were striking, often accompanied with tumor regression or arrest, and whose improvement persisted for six months or longer. These patients represent the true temporary remissions of the series. They are, however, temporary remissions and not permanent remissions or so-called 'cures.' Nevertheless, as a group originally considered hopeless, each has been afforded longer life, acceptable health and freedom from pain. Fortunately, prolongation of life appeared to occur only in patients who received good palliation. . . .
>
> Unusual temporary remissions for intervals as long as three years were obtained. . . .[101]

Needless to say, a number of those who received substantial benefits from this particular therapy were suffering from great pain and appeared to be leading candidates for voluntary euthanasia. In 1950, the year the new combination therapy investigation was initiated, a swift death appeared to be their only hope. Instead they resumed full and useful lives for a considerable period of time.[102]

Since February, 1951, in a new effort to inhibit certain cancer growth,[103] a number of advanced cancer patients at the Memorial Center for Cancer and Allied Disease have had their adrenal glands removed.[104] Of a total of ten patients with cancer of the prostate adrenalectomized at the time of the 1952 report, three died in the immediate postoperative period of various causes, leaving seven effective cases for evaluation:

> The most striking beneficial response to adrenalectomy was relief of pain. Three of the patients were confined to bed with pain prior to surgery and were taking narcotics frequently. . . . All three had striking relief of pain postoperatively and became ambulatory. One (J.W.) was in a stuporous condition preoperatively, confined to bed, and unable to feed himself. Following adrenalectomy his general condition improved remarkably. He became ambulatory and was able to return home to live a relatively normal life. This improvement has been maintained until the present, 218 days after surgery. . . .
>
> Summarizing the prostatic cancer cases, all seven effective cases had striking subjective improvement. Only two cases showed objective improvement. Improvement was temporary in all cases.[105]

From all indications "J.W." was a most attractive target for the euthanasiasts. He was suffering from

> . . . severe pain requiring frequent injections of narcotics for relief . . . was extremely lethargic and relatively unresponsive . . . had to be fed by the nursing staff.[106]

If he, to use Dr. Wolbarst's words, was not "so far advanced in cancerous toxemia as to be an applicant for euthanasia," when will anybody be? I am not at all sure that at this point J.W. was still *capable* of consenting to his death. If he were, he certainly had reached the very brink. As it turned out, however, to have put J.W. out of his misery at the time would have been to deprive him of over seven months of a "relatively normal life."[107] Adequate quantities of cortisone and other active corticoids had just become available. The postoperative problem of adrenal insufficiency had just been solved.

Breast cancer, the most common cancer in woman,[108] has also yielded substantially to adrenalectomy. A recent five-year evaluation of 52 consecutive patients with metastatic mammary cancer who underwent adrenalectomy disclosed that significant objective remissions of varying lengths of time occurred in 20 patients.[109] Prolonged survival—from three years to 68 months—occurred in seven of these patients, all of whom had been suffering from advanced stages of the disease, had failed to respond to various other types of therapy and were incapacitated. After treatment, "all of them were able to resume their normal physical activities."[110] One of the seven had had such extensive metastases that she "appeared to be moribund," but she survived, with great regression of the neoplasm, more than five years after adrenalectomy.[111]

The pituitary gland, as well as the adrenal glands, has had an increasing apparent role in the control of breast cancer. Since 1951, the availability of ACTH and cortisone has allowed an intensive investigation of the effects of hypophysectomy, *i.e.*, surgical removal of the pituitary body. The results have been most gratifying. A recent report, for example, discloses that of twenty-eight patients with advanced breast cancer who underwent total hypophysectomy, "eighteen . . . have demonstrated striking objective clinical regressions" up to 20 months while an additional four who showed no objective evidence of regression experienced "striking relief of pain."[112]

The dynamic state of current cancer research would appear to be amply demonstrated by the indication, already, that in the treatment of advanced breast cancer adrenalectomy, itself still in the infant stages, may yield to hypophysectomy.[113]

True, many types of cancer still run their course virtually unhampered by man's arduous efforts to inhibit them. But the number of cancers coming under some control is ever increasing. With medicine attacking on so many fronts with so many weapons who would bet a man's life on when and how the next type of cancer will yield, if only just a bit?[114]

True, we are not betting much of a life. For even in those areas where gains have been registered, the life is not "saved," death is only postponed. Of course, in a sense this is the case with every "cure" for every ailment. But it may be urged that after all there is a great deal of difference between the typical "cure" which achieves an indefinite postponement, more or less, and the cancer respite which results in only a brief intermission, so to speak, of rarely more than six months or a year. Is this really long enough to warrant all the bother?

Well, how long *is* long enough? In many recent cases of cancer respite, the patient, though experiencing only temporary relief, underwent sufficient improvement to retake his place in society.[115] Six or twelve or eighteen months is long enough to do most of the things which socially justify our existence, is it not? Long enough for a nurse to care for more patients, a teacher to impart learning to more classes, a judge to write a great opinion, a novelist to write a stimulating book, a scientist to make an important discovery and, after all, for a factory hand to put the wheels on another year's Cadillac.

D. "Mistakes Are Always Possible"

Under Professor Williams' "legislative suggestion" a doctor could "refrain from taking steps to prolong the patient's life by medical means" solely on his own authority. Only when disposition by affirmative "mercy killing" is a considered alternative need he do so much as, and only so much as, consult another general practitioner.[116] There are no other safeguards. No "euthanasia referee," no requirement that death be administered in the presence of an official witness, as in the English society's bill. No court to petition, no committee to investigate and report back to the court, as in the American society's bill. Professor Williams' view is:

> 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.[117]

That mistakes are always possible, that mistakes are always made, does not, it is true, deter society from pursuing a particular line of

conduct—if the line of conduct is *compelled* by needs which override the risk of mistake. A thousand *Convicting the Innocent's*[118] or *Not Guilty's*[119] may stir us, may spur us to improve the administration of the criminal law, but they cannot and should not bring the business of deterring and incapacitating dangerous criminals or would-be dangerous criminals to an abrupt and complete halt.

Professor Williams points to capital punishment, as proponents of euthanasia are fond of doing,[120] but defenders of this practice do not—as, of course, they cannot—rest on the negative argument that "mistakes are always possible." Rightly or wrongly, they contend that the deterrent value of the death penalty so exceeds that of life-imprisonment or long-term imprisonment that it is required for the protection of society, that it results in the net gain of a substantial number of human lives.[121] This is generally regarded as the "central" or "fundamental" question in considering whether the death penalty should be abolished or retained.[122] This, as Viscount St. Davids said of a House of Lords debate on capital punishment which saw him advocate abolition, "was what the whole debate was about."[123]

Presumably, when and if it can be established to the satisfaction of all reasonable men that the deterrent value of capital punishment as against imprisonment is nil or *de minimus,* mistakes will no longer be tolerated and the abolitionists will have prevailed over the few remaining retentionists who would still defend capital punishment on other grounds.[124] In any event, it is not exactly a show of strength for euthanasiasts to rely on so battered and shaky a practice as capital punishment.[125]

A relevant question, then, is what is the need for euthanasia which leads us to tolerate the mistakes, the very fatal mistakes, which will inevitably occur? What is the compelling force which requires us to tinker with deeply entrenched and almost universal[126] precepts of criminal law?

Let us first examine the qualitative need for euthanasia:

Proponents of euthanasia like to present for consideration the case of the surgical operation, particularly a highly dangerous one: risk of death is substantial, perhaps even more probable than not; in addition, there is always the risk that the doctors have misjudged the situation and that no operation was needed at all. Yet it is not unlawful to perform the operation.[127]

The short answer is the witticism that whatever the incidence of death in connection with different types of operations "no doubt, it is in all cases below 100 percent, which is the incidence rate for euthanasia."[128] But this may not be the full answer. There are occasions

where the law permits action involving about a 100 percent incidence of death, for example, self-defense. There may well be other instances where the law should condone such action, for example, the "necessity" cases illustrated by the overcrowded lifeboat,[129] the starving survivors of a shipwreck,[130] and—perhaps best of all—by Professor Lon Fuller's penetrating and fascinating tale of the trapped cave explorers.[131]

In all these situations, death for some may well be excused, if not justified, yet the prospect that some deaths will be unnecessary is a real one. He who kills in self-defense may have misjudged the facts. They who throw passengers overboard to lighten the load may no sooner do so than see "masts and sails of rescue . . . emerge out of the fog."[132] But no human being will ever find himself in a situation where he knows for an absolute certainty that one or several must die that he or others may live. "Modern legal systems . . . do not require divine knowledge of human beings."[133]

Reasonable mistakes, then, may be tolerated if as in the above circumstances and as in the case of the surgical operation, these mistakes are the inevitable by-products of efforts to save one or more human lives.[134]

The need the euthanasiast advances, however, is a good deal less compelling. It is only to ease pain.

Let us next examine the quantitative need for euthanasia:

No figures are available, so far as I can determine, as to the number of say, cancer victims, who undergo intolerable or overwhelming pain. That an appreciable number do suffer such pain, I have no doubt. But that anything approaching this number, whatever it is, need suffer such pain, I have—viewing the many sundry palliative measures now available[135]—considerable doubt. The whole field of severe pain and its management in the terminal stage of cancer is, according to an eminent physician "a subject neglected far too much by the medical profession."[136] Other well-qualified commentators have recently noted the "obvious lack of interest in the literature about the problem of cancer pain"[137] and have scored "the deplorable attitude of defeatism and therapeutic inactivity found in some quarters."[138]

The picture of the advanced cancer victim beyond the relief of morphine and like drugs is a poignant one, but apparently no small number of these situations may have been brought about by premature or excessive application of these drugs.[139] Psychotherapy "unfortunately . . . has barely been explored"[140] in this area, although a survey conducted on approximately 300 patients with advanced cancer disclosed that "over 50 percent of patients who had received analgesics for long periods of time could be adequately controlled by placebo medica-

tion."[141] Nor should it be overlooked that nowadays drugs are only one of many ways—and by no means always the most effective way—of attacking the pain problem. Radiation, roentgen and X-ray therapy; the administration of various endocrine substances; intrathecal alcohol injections and other types of nerve blocking; and various neurosurgical operations such as spinothalmic chordotomy and spinothalmic tractomy, have all furnished striking relief in many cases.[142] These various formidable non-narcotic measures, it should be added, are conspicuously absent from the prolific writings of the euthanasiasts.

That of those who do suffer and must necessarily suffer the requisite pain, many *really* desire death, I have considerable doubt.[143] Further, that of those who may desire death at a given moment, many have a fixed and rational desire for death, I likewise have considerable doubt.[144] Finally, taking those who may have such a desire, again I must register a strong note of skepticism that many cannot do the job themselves.[145] It is not that I condone suicide. It is simply that for reasons discussed in subsequent sections of this paper I find it easier to prefer a *laissez-faire* approach in such matters over an approach aided and sanctioned by the state.

The need is only one variable. The incidence of mistake is another. Can it not be said that although the need is not very great it is great enough to outweigh the few mistakes which are likely to occur? I think not. The incidence of error may be small in euthanasia, but as I have endeavored to show, and as Professor Williams has not taken pains to deny, under our present state of knowledge appreciable error is inevitable. *Some,* no matter how severe the pain, no matter how strikingly similar the symptoms, will not be cancer victims or other qualified candidates for euthanasia. Furthermore, among those who are in fact so inflicted, there are bound to be *some* who no matter how "hopeless" their plight at the moment, would be able to benefit from some treatment. That is, they would have been able to lead relatively normal, reasonably useful lives for, say, six months or a year, if death had not come until it came in its own way in its own time.

How many are *"some"*? I do not know, but I think they are a good deal more than *de minimus.* The business of predicting what cures or temporary checks or measures of relief from pain are around the corner is obviously an inexact science. And as for error in diagnosis, doctors, as a rule, do not contribute to *True Confessions.*[146] But I venture to say that the percentage and the absolute figures would not be as small, certainly not any smaller, than the grants of federal *habeas corpus* petitions to set aside state convictions. Federal *habeas corpus* so operates that only a handful of petitions are granted and only a small

fraction of these cases are ultimately discharged.[147] Yet its continued existence has been ably defended as but another example of the recurrent theme that it is better that many guilty go free than one innocent be convicted.[148] So long as this is the vogue, I do not hesitate—although Williams evidently thinks it is "no contest"—to pit the two or three or four who might be saved against the hundred who cannot be.

Even if the need for voluntary euthanasia could be said to outweigh the risk of mistake, this is not the end of the matter. That "all that can be expected of any moral agent is that he should do his best on the facts as they appear to him"[149] may be true as far as it goes, but it would seem that where the consequence of error is so irreparable it is not too much to expect of society that there be *a good deal more than one moral agent* "to do his best on the facts as they appear to him." It is not too much to expect for example, that something approaching the protection thrown around one who appears to have perpetrated a serious crime be extended to one who appears to have an incurable disease. Williams' proposal falls far short of this mark.

(To be Continued.)

NOTES

1. Anonymous letter to the editor, *The Spectator,* 46:241, 1873.
2. 1957. (This book is hereinafter referred to as "Williams.")

   The book is an expanded and revised version of the James S. Carpentier lectures delivered by Professor Williams at Columbia University and at the Association of the Bar of the City of New York in the Spring of 1956. "The connecting thread," observes the author, "is the extent to which human life, actual or potential, is or ought to be protected under the criminal law of the English-speaking peoples," Preface, p. vii. The product of his dexterous needlework, one might add, is a coat of many colors: philosophical, medical, ethical, religious, social, as well as legal. *The Un-Sanctity of Life* would seem to be a more descriptive title, however, since the author presents cogent reasons for decriminalizing infanticide and abortion at one end of a man's span, and "unselfish abetment of suicide and the unselfish homicide upon request," *id.* p. 310, at the other.

   The book was recently lauded by Bertrand Russell, *Stan. L. Rev.,* 10:382, 1958. For more restrained receptions *see* the interesting and incisive reviews by Professor William J. Curran, *Harv. L. Rev.,* 71:585, 1958 and Professor Richard C. Donnelly, *Yale L. J.,* 67:753, 1958.
3. Euthanasia has a Greek origin: *eu* (easy, happy, painless), *thanatos* (death). The term apparently first appeared in the English language in the early seventeenth century in its original meaning—a gentle, easy death. The term then came to mean the *doctrine* or *theory* that in certain circumstances a person should be painlessly killed, and, more recently has come to mean the *act* or *practice* of bringing about a gentle and easy death. In its broad sense, euthanasia embraces a variety of situations, some where the patient is capable of consenting to his death, others where he obviously is not. Thus, two generations ago, H. J. Rose defined the euthanasia circumstances as "when owing to disease, senility, or the like, a person's life has ceased to be either agreeable or useful." In Hastings (Ed.) *Encyclopedia of Religion and Ethics.* 1912, Vol. 7, p. 598. In the 1930's there sprung up organizations in both England and America which dramatized the plight of the patient in "unnecessary" pain and urged euthanasia for the incurable and suffering patient who wanted to die. Consequently, a current popular meaning of the term is painless death "releasing"

the patient from severe physical suffering. An advocate of euthanasia has been called a "euthanasiast"; to subject to euthanasia has been called to "euthanatize." These terms will be so used throughout this paper. *See* generally Fletcher. *Morals and Medicine.* 1954, pp. 172-3; Sullivan. *The Morality of Mercy Killing.* 1950, pp. 1-3 (originally a dissertation entitled "Catholic Teaching on the Morality of Euthanasia"); Banks, Euthanasia. *Practitioner,* 161:101, 1948.

4. Williams' admirable treatise, *Criminal Law: The General Part,* 1953, stamps him as one of the giants in the field.
5. Wechsler and Michael. A Rationale of the Law of Homicide: I. *Colum. L. Rev.,* 37:701, 739-40, 1937. Since the article was written before the Nazi euthanasia venture, it is conceivable that Prof. Wechsler, who had ample opportunity to study the Nazi experience as Technical Adviser to American Judges, International Military Tribunal, would come out somewhat differently today.
6. Mannheim. *Criminal Justice and Social Reconstruction.* 1946, pp. 7-13.
7. Since the proposals for reform which have commanded the greatest attention have urged complete immunization of voluntary euthanasia, this paper is concerned with whether or not such killings should be legalized, not whether or not they should be regarded as murder, which is now the case, *see infra* 9, or some lesser degree of criminal homicide. One way to achieve mitigation would be to give recognition to "good motive" generally; another would be to make a specific statutory reduction of penalty for voluntary euthanasia alone. For a discussion of these alternatives, *see* Kalven. A Special Corner of Civil Liberties: A Legal View I. *N.Y.U.L. Rev.,* 31:1223, 1235-6, 1956; Silving, Euthanasia: A Study In Comparative Criminal Law. *U. of Pa. L. Rev.,* 103:350, 386-9, 1954. The Royal Commission on Capital Punishment (1949-53) took the position that "mercy killings" could not feasibly be reduced in penalty. *See* text at ref. 34 and 34, *infra.*
8. Fletcher, *supra* 3, pp. 172-210. The book is quite similar to Williams in that it deals with the moral and legal issues raised by contraception, artificial insemination, sterilization and right of the patient to know the truth. It is the subject of an interesting and stimulating symposium review, *N.Y.U.L. Rev.,* 31:1160-1245, 1956, by two lawyers, Prof. Harry Kalven and Judge Morris Ploscowe; two theologians, Emanuel Rackman and Paul Ramsey; two philosophers, Horace M. Kallen and Joseph D. Hasset; and a physician, I. Phillips Frohman.
9. In Anglo-American jurisprudence a "mercy killing" is murder. In theory, neither good motive nor consent of the victim is relevant. *See, e.g.,* Burdick. *Law of Crimes.* §§422, 447, 1946, Vol. 2; Miller. *Criminal Law.* 1934, pp. 55, 172; Perkins. *Criminal Law.* 1957, p. 721; Wharton. In Anderson (Ed.) *Criminal Law and Procedure.* §194, 1957, Vol. I; Orth. Legal Aspects Relating to Euthanasia. *Md. Med. J.,* 2:120, 1953 (symposium on euthanasia); *Mich. L. Rev.,* 48:1199, 1950; Anno., *Amer. L. Rev.,* 25:1007, 1923.

   In a number of countries, *e.g.,* Germany, Norway, Switzerland, a compassionate motive and/or "homicide upon request" operate to reduce the penalty. *See* generally Helen Silving's valuable comparative study, *supra* 7. However, apparently only Uruguayan law completely immunizes a homicide characterized by both of the above factors. *Id.* p. 369 and n. 74. The Silving article only contains an interesting and fairly extensive comparative study of assisted suicide and the degree to which it is treated differently from a direct "mercy killing." In this regard *see also* Friedman, Suicide, Euthanasia and the Law, *Med. Times.* 85:681, 1957.
10. *See* Williams, p. 342.
11. *See, e.g.,* the case of Harry C. Johnson, who asphyxiated his cancer-stricken wife, apparently at her urging. *N.Y. Times,* Oct. 2, 1938, p. 1, col. 3; Oct. 3, 1938, p. 34, col. 3. Various psychiatrists reported that Johnson was "temporarily insane" at the time of the killing, but was "now sane," *N.Y. Times,* Oct. 12, 1938, p. 30, col. 4. A week later, a Nassau County grand jury refused to indict him. *N.Y. Times,* Oct. 19, 1938, p. 46, col. 1.
12. *See, e.g.,* the *Sander, Paight* and *Braunsdorf* cases discussed at 172-6, 183, *infra.*
13. *See, e.g.,* the *Repouille* case discussed at 181, *infra.*

14. *See, e.g.,* the *Brownhill* and *Long* cases discussed at 178-9, *infra.*
15. Curtis. *It's Your Law.* 1954, p. 95.
16. Williams, p. 328.
17. Both Williams, p. 328, and Prof. Harry Kalven, *supra* 7, p. 1235, cite a single authority for the proposition that the prevailing system does not afford equality of treatment of mercy killers. That single authority is Helen Silving's study, *supra* 7. Silving in turn relies on a single case, that of Harold Mohr, who was convicted of voluntary manslaughter and sentenced to from three to six years in prison, for the slaying of his blind, cancer-stricken brother. Unlike other "mercy killing" cases which resulted in acquittals, Mohr's victim had apparently made urgent and repeated requests for death. *Id.* p. 354 and n. 15. Silving fails to note, however, that Mohr's defense that he "blacked out" just before the shooting was likely to be received with something less than maximum sympathy in light of the fact, pressed hard by the prosecution, that immediately prior to shooting his brother he made a round of taprooms and clubs for *seven* hours and consumed *ten* to *twelve* beers in the process. *N.Y. Times,* Apr. 8, 1950, p. 26, col. 1. Nor was the jury likely to consider it insignificant that two other brothers of Mohr testified on behalf of the state. *Ibid.* So far as I know, this is the only "mercy killing" case where relatives testified against the defendant.

    In *Repouille* v. *United States,* 165 F. 2d 152, 153 (2d cir. 1947) (denying citizenship to alien on ground that chloroforming of idiot son impaired "good moral character"), Judge Learned Hand noted that while Repouille had received a suspended sentence, a "similar offender in Massachusetts" had been imprisoned for life. This, evidently, is a reference to the case of John F. Noxon, who, less than two years after Repouille's "mercy killing," was sentenced to death for electrocuting his idiot son. The sentence was then commuted to life. *See infra* 182. But Noxon banked all on the defense that the electrocution had been just an accident, a gamble entailing the risk that the jury would be quite unsympathetic to him if it disbelieved his story. Certainly, a full presentation of the appalling "mercy killing" circumstances would be more difficult under the theory Noxon adopted than under the typical "temporary insanity" defense. That different legal tactics lead to "inequality of treatment" on similar facts is obvious.

    Furthermore, the jury might well have been revolted by the manner in which the act was perpetrated: electrocuting the infant by wrapping wire around him, dressing him in wet diapers, and placing him on a silver serving tray. Then, too, whereas Repouille's son was a thirteen year old with the mentality of a two year old and Greenfield's son, to draw upon another leading case of this type, *see infra* 180, was a seventeen year old with the mentality of a two year old, Noxon's son was only a six month infant who apparently *would never develop* the mentality of an adult—a situation the jury might well view as less pathetic, at least less provoking. Finally, it should be noted that even in the *Noxon* case, the Law In Action was not without effect. His death sentence was commuted to life and, a year after Judge Hand's apparent reference to him, further commuted to six years. He was paroled less than five years after his conviction of first degree murder. *See infra* 182.

    In any event, the legislation urged by Williams, Fletcher and the English and American euthanasia societies would in no way relieve the plight of a "mercy killer" such as Noxon, for his was an act of *involuntary* euthanasia and hence beyond the scope of present proposals.
18. "Not a great many years ago, upon the Norfolk circuit, a larceny was committed by two men in a poultry yard, but only one of them was apprehended; the other having escaped into a distant part of the country, had eluded all pursuit. At the next assizes the apprehended thief was tried and convicted; but Lord Loughborough, before whom he was tried, thinking the offense a very slight one, sentenced him only to a few months imprisonment. The news of this sentence having reached the accomplice in his retreat, he immediately returned, and surrendered himself to take his trial at the next assizes. The next assizes came; but, unfortunately for the prisoner, it was a different judge who presided; and still

more unfortunately, Mr. Justice Gould, who happened to be the judge, though of a very mild and indulgent disposition, had observed, or thought he had observed, that men who set out with stealing fowls, generally end by committing the most atrocious crimes; and building a sort of system upon this observation, had made it a rule to punish this offense with very great severity, and he accordingly, to the great astonishment of this unhappy man, sentenced him to be transported. While one was taking his departure for Botany Bay, the term of the other's imprisonment had expired; and what must have been the notions which that little public, who witnessed and compared these two examples, formed of our system of criminal jurisprudence?"

Romilly. *Observations on the Criminal Law of England.* 1810, pp. 18-9. The observations constitute a somewhat revised and expanded version of a famous speech delivered in the House of Commons in support of bills to repeal legislation making it a capital offense to commit certain petty thefts. A substantial portion of the speech, including the extract above, is reprinted in Michael and Wechsler. *Criminal Law and its Administration.* 1940, pp. 252-5. For recent instances of disparities and erraticism in sentencing, *see* Glueck, The Sentencing Problem. *Fed. Prob.*, Dec. 1956, p. 15.

19. Silving, *supra* 7, p. 354.
20. For example, in the famous case of *Durham* v. *United States,* 214 F. 2d 862 (D.C. Cir. 1954) regarded by many as a triumph over the forces of darkness in the much-agitated area of mental responsibility, the Court concluded (214 F. 2d at 876): "Finally, in leaving the determination of the ultimate question of fact to the jury, we permit it to perform its traditional function which . . . is to apply 'our inherited ideas of moral responsibility to individuals prosecuted for crime. . . .' Juries will continue to make moral judgments, still operating under the fundamental precept that 'our collective conscience does not allow punishment where it cannot impose blame.'"

    To take another example, the difficult area of criminal law dealing with causal relationship between conduct and result, "as has often been said, the question usually presented is not whether there is cause in fact, but rather whether there should be liability for results in fact caused." Wechsler and Michael, *supra* 5, p. 724. Herbert Wechsler, the Chief Reporter of the Model Penal Code, favors the "culpability" rather than "causality" approach, *ALI Proceedings,* 32:162-3, 1955, and this view may very well be ultimately adopted. *See* section 2.03 (2) (b) of the Model Penal Code (Tent. Draft No. 4, 1955) and the appropriate comment to this section, *id.* p. 135, for a discussion of the advantages and disadvantages "of putting the issue squarely to the jury's sense of justice." To take still another example, the elusive distinction between first and second degree murder has well been described as "merely a privilege offered to the jury to find the lesser degree when the suddenness of the intent, the vehemence of the passion, seems to call irresistibly for the exercise of mercy." Cardozo. What Medicine Can Do For Law. In *Law and Literature.* 1931, p. 100. This view is buttressed by the subsequent disclosure that of some 700 cases, every homicide case contained in the New York reports at that time, "only *three* cases have been found where on a murder charge, the indictment was for second degree murder." New York Revision Commission. *Communication and Study Relating to Homicide.* 1937, p. 82, n. 202. Cardozo pointed out that he had "no objection to giving them [the jury] this dispensing power, but it should be given to them directly and not in a mystifying cloud of words." From the frequency with which the dispensing power is exercised, and the manner in which it is viewed by the press and public generally, it seem fairly clear that nobody is mystified very much in the "mercy killing" cases.
21. Williams, p. 312. This seems to be the position taken by Bertrand Russell in his review of Williams' book *supra* 2, p. 382: "The central theme of the book is the conflict in the criminal law between the two divergent systems of ethics which may be called respectively utilitarian and taboo morality. . . . Utilitarian morality in the wide sense in which I am using the word, judges actions by their effects. . . . In taboo morality . . . forbidden actions are sin, and they do not cease to be so when their consequences are such as we should all welcome." I trust Russell would agree, if he should read this paper, that the issue is

not quite so simple. At any rate, I trust he would agree that I stay within the system of utilitarian ethics.

22. Wechsler and Michael, *supra* 5, p. 740. *But see* Denning. The Influence of Religion. In *The Changing Law*. 1953, p. 99 (". . . without religion there can be no morality; and without morality there can be no law.") Lord Justice Denning's assertion is the motif of Fitch, Harding, Katz and Quillian. *Religion, Morality and Law*, 1956.

23. I am aware that the arguments I set forth, however "reasonable" or "logical" some of them may be, were not the reasons which first led to the prohibition against "mercy killings." I realize, too, that those who are inexorably opposed to any form of euthanasia on religious grounds do not always limit their arguments to religious ones. *See, e.g.*, Martin, Euthanasia and Modern Morality, *The Jurist*, 10:437, 1950 which views the issue as a conflict between Christianity and paganism, and, in addition raises many non-religious objections. I risk, therefore, the charge that I am but another example of "the tendency of the human mind to graft upon an actual course of conduct a justification or even a duty to observe this same course in the future." Stone. *The Province and Function of Law*. 1946, pp. 673-4. I would meet this charge with the observation that "ordinary experience seems to indicate quite clearly that the reasons people give for their religious, political, economic and legal policies do influence the development of these policies, and that the 'good reasons' professed by our fathers yesterday are among the real reasons of the life of today." Cohen, M. R. *The Faith of a Liberal*. 1946, p. 70.

    After all, that the criminal law itself arose to fill the need to regulate and obviate self-help and private vengeance, *see, e.g.*, Holdsworth. *History of English Law*. 1936, Vol. 2, pp. 43-7. Fourth edition.; Holmes, *The Common Law*. 1881, pp. 2-3, 40; Main. In Pollack (Ed.) *Ancient Law*. 1930, pp. 391-401; to say nothing of a possible point of origin in "a religious institution of sacrificing an impious wrongdoer to an offending god who might else inflict his wrath upon the whole community." Pound, *Criminal Justice in America*, 1930, p. 54, renders deterrence, incapacitation and rehabilitation no less the "real reasons" of today and no less the real bases for drafting new codes or amending old ones.

    It would meet the charge, too, by pointing out that I am not enamored of the *status quo* on "mercy killing." But while I am not prepared to defend it against all comers, I am prepared to defend it against the proposals for change which have come forth to date.

24. Unlike Professor Williams, even many proponents of voluntary euthanasia appear to shrink from suicide as a general proposition. Consider, for example, the following statements made by vice-presidents of England's Voluntary Euthanasia Legalisation Society: The act of the suicide is wrong because he takes his own life solely on his own judgment. It may be that he does so in a mood of despair or remorse and thus evades the responsibility of doing what he can to repair the wrong or improve the situation. He flings away his life when there is still the possibility of service and when there are still duties to be done. The proposals for Voluntary Euthanasia have nothing in common with suicide. They take the decision out of the hands of the individual. The case is submitted to the objective judgment of doctors and specially appointed officials whose duty it would be to enquire whether the conditions which constitute the sinfulness of suicide are present or not. Matthews. Voluntary Euthanasia: The Ethical Aspects. pp. 4-5. (Address by the Very Rev. W. R. Matthews, Dean of St. Paul's Voluntary Euthanasia Legalisation Society Annual Meeting, May 2, 1950) (distributed by the American and English Societies). "[I]n respect of each of its citizens, the State has made an investment of a substantial amount, and as a mere matter of business it is entitled to demand an adequate return. If a useful citizen, by taking his life, diminishes that return, he does an anti-social act to the detriment of the community as a whole. We cannot carry the doctrine of isolation to the extent of saying that we live unto ourselves. Hence it appears on purely rationalistic grounds that the State is entitled to discountenance suicide." Earengey. Voluntary Euthanasia. *Medico-Legal & Crim. Rev.*, 8:91, 92, 1940.

25. Williams, p. 339.

26. *Cf.* Chesterton, G. K. Euthanasia and Murder. *Amer. Rev.*, 8:486, 490, 1937.
27. *See* Fletcher, *supra* 8.
28. Kalven, *supra* 7. I would qualify this statement only by the suggestion that to some extent this freedom may be viewed as an aspect of the freedom of religion of the non-Believer. For a consideration of the problems raised by organizations which claim to be "religious" but do not require their adherents to believe in a Supreme Being, *see Washington Ethical Soc'y* v. *District of Columbia,* 249 F. 2d 127 (D.C. Cir. 1957); *Fellowship of Humanity* v. *County of Alameda,* 315 P. 2d 394 (Cal. App. 1957), *Colum. L. Rev.*, 58:417, 1958.

    Undoubtedly the most extreme expression of this view is the bitter comment of Viscount Esher, upon concluding from the run of the speeches that he and his allies would be overwhelmed in the House of Lords debate on the question (169 H.L. Deb. [5th ser.] 551, 574-76, 1950): Voluntary euthanasia "is certainly an evolutionary extension of liberty of great importance, giving to the individual new rights to which, up till now, he has not had access. . . . What we propose this afternoon is, in point of fact, a new freedom, and undoubtedly it will antagonize the embattled forces of the official world. . . . I believe that posterity will look back on this refusal you are going to make this afternoon . . . as people look now on the burning of witches—as a barbarous survival of mediaeval ideas, an example of that high-minded cruelty from the entanglement of which it has taken mankind so many centuries to emerge. In that day we few, we five or six shall, I believe, be remembered." At the end, the euthanasiasts avoided a vote by withdrawing the question, *id.* p. 598. In an earlier House of Lords debate, proposed voluntary euthanasia legislation was defeated by a 35-14 vote. 103 H.L. Deb. (5th ser.) 466, 506, 1936.
29. Williams, pp. 341, 346.
30. Frankfurter, J., dissenting in *United States* v. *Rabinowitz,* 338 U.S. 56, 69 (1950).

    Perhaps as good an example as any may be taken from Glanville Williams' own text, *Criminal Law: The General Part* §180, 1953. With a deep concern for the parents' "freedom not to conform" as his starting point, Williams makes a strong policy argument for immunizing from criminal law sanctions those "peculiar people" who for sincere religious reasons fail to summon medical aid to their sick children. One who takes the health and welfare of *children* as his starting point might well reach a somewhat different conclusion.
31. Section 2 (1) of the English Bill. The full text is set forth in Roberts, *Euthanasia and Other Aspects of Life and Death,* 1936, pp. 21-6.
32. Section 301 of the American Bill. The full text is set forth in Sullivan, *supra* 3, pp. 25-8. Fletcher, *supra* 3, p. 187, regards this bill as "perhaps the model legislation." Such bills have been unsuccessfully introduced in the legislatures of Nebraska, *N.Y. Times,* Feb. 3, 1937, p. 7, col. 1; Feb. 14, 1937, p. 17, col. 1; and, some ten years later, New York, Fletcher pp. 184-5.
33. I venture to say there are few men indeed who will not so much as smile at the portion of the American Society's Bill, Sullivan *supra* 3, p. 28, which provides that if the petition for euthanasia shall be denied by a Justice of the Supreme Court, "an appeal may be taken to the appellate division of the Supreme Court, and/or to the Court of Appeals."
34. Royal Commission on Capital Punishment, Report, Cmd. No. 8932, para. 179, 1953. *Cf.* Bentham. In Ogden (Ed.) *The Theory of Legislation.* 1931, p. 256. "Let us recollect that there is no room for considering the motive except when it is manifest and palpable. It would often be very difficult to discover the true or dominant motive, when the action might be equally produced by different motives, or where motives of several sorts might have cooperated in its production. In the interpretation of these doubtful cases it is necessary to distrust the malignity of the human heart, and that general disposition to exhibit a brilliant sagacity at the expense of good nature. We involuntarily deceive even ourselves as to what puts us into action. In relation even to our own motives we are wilfully blind, and are always ready to break into a passion against the oculist who

desires to remove the cataract of ignorance and prejudice." *Cf.* Roberts, *supra* 31, pp. 10-1: "Self-deception as to one's motives, what the psychologists call 'rationalization,' is one of the most powerful of man's self-protective mechanisms. It is an old observation of criminal psychologists that the day-dreamers and the rationalizers account for a very large proportion of the criminal population; whilst, in murderers, this habit of self-deception is often carried to incredible lengths."

It should be noted, however, that the likelihood of faked "mercy killings" would seem to be substantially reduced when such acts are not completely immunized but only categorized as a lesser degree of criminal homicide. If "mercy killings" were simply taken out of the category of murder, a second line of defense might well be the appearance of a "mercy killing" but in planned murders generally the primary concern of the murderer must surely be to escape all punishment whatever, not to give a serious, but not the most serious, appearance to his act, not to substitute a long period of imprisonment for execution. *Cf.* the discussion of faked suicide pacts in Royal Commission, *supra,* Minutes of Evidence, paras. 804-7. As was stated at the outset, however, *see supra* 7, this paper deals with proposals to completely legalize "mercy killings," not with the advisability of taking it out of the category of murder.

35. 103 H.L. Deb. (5th ser.) 484-5, 1936.
36. Banks, *supra* 3, pp. 101, 104.
37. Frohman. Vexing Problems in Forensic Medicine: A Physician's View. *N.Y.U. L. Rev.,* 31:1215, 1222, 1956.
38. Roberts, *supra* 31, pp. 14-5.
39. Earengey, *supra* 24, pp. 91, 106 (discussion following the reading of Judge Earengey's paper).
40. Williams, p. 334: "The promoters of the bill hoped that they might be able to mollify the opposition by providing stringent safeguards. Now, they were right in thinking that if they had put in no safeguards—if they had merely said that a doctor could kill his patient whenever he thought it right—they would have been passionately opposed on this ground. So they put in the safeguards.

* * *

Did the opposition like these elaborate safeguards? On the contrary, they made them a matter of complaint. The safeguards would, it was said, bring too much formality into the sick-room, and destroy the relationship between doctor and patient. So the safeguards were wrong, but not one of the opposition speakers said that he would have voted for the bill without the safeguards."
41. *Id.* pp. 339-40. The desire to give doctors a free hand is expressed numerous times: "[T]here should be no formalities and . . . everything should be left to the discretion of the doctor (p. 340), . . . the bill would merely leave this question to the discretion and conscience of the individual medical practitioner . . . (p. 341). It would be the purpose of the proposed legislation to set doctors free from the fear of the law so that they can think only of the relief of their patients . . . (p. 342). It would bring the whole subject within ordinary medical practice." (*Ibid.*) Williams suggests that the pertinent provisions might be worded as follows (p. 345):

"1. For the avoidance of doubt, it is hereby declared that it shall be lawful for a physician whose patient is seriously ill—

* * *

b. to refrain from taking steps to prolong the patient's life by medical means;
—unless it is proved that . . . the omission was not made in good faith for the purpose of saving the patient from severe pain in an illness believed to be of an incurable and fatal character.

2. It shall be lawful for a physician, after consultation with another physician, to accelerate by any merciful means the death of a patient who is seriously ill, unless it is proved that the act was not done in good faith with the consent of the patient and for the purpose of saving him from severe pain in an illness believed to be of an incurable and fatal character."

The completely unrestricted authorization to kill by omission may well be based on Williams' belief. p. 326, that under existing law "'mercy killing' by omission to prolong life is probably lawul" since the physician is "probably exempted" from the duty to use reasonable care to conserve his patient's life "if life has become a burden." And he adds—as if this settles the legal question—that "the morality of an omission in these circumstances is conceded even by Catholics." *Ibid.*

If Williams means, as he seems to, *that once a doctor has undertaken treatment and the patient is entrusted solely to his care* he may sit by the bedside of the patient whose life has "become a burden" and let him die, *e.g.*, by not replacing the oxygen bottle, I submit that he is quite mistaken.

The outer limits of criminal liability for inaction are hardly free from doubt, but it seems fairly clear under existing law that the special and traditional relationship of physician and patient imposes a "legal duty to act," particularly where the patient is helpless and completely dependent on the physician, and that the physician who withholds life-preserving medical means of the type described above commits criminal homicide by omission. In this regard, *see* Burdick, *supra* 9, §466c; Hall. *Principles of Criminal Law*. 1947, pp. 272-8; Kenny. In Turner (Ed.) *Outlines of Criminal Law*. 1952, pp. 14-5, 107-9. Sixteenth edition.; Perkins. *Criminal Law*, 1957, pp. 513-27; Russell. In Turner (Ed.) *Crime*, 1950, Vol. 1, pp. 449-66. Tenth edition.; Hughes, Criminal Omissions. *Yale L. J.*, 67:590, 599-600, 621-6, 630 n. 142, 1958; Kirchheimer. Criminal Omissions. *Harv. L. Rev.*, 55:615, 625-8, 1942; Wechsler and Michael, *supra* 5, pp. 742-5.

Nor am I at all certain that the Catholics do "concede" this point. Williams' reference is to Sullivan, *supra* 3, p. 64. But Sullivan considers therein what might be viewed as relatively remote and indirect omissions, *e.g.*, whether to call in a very expensive specialist, whether to undergo a very painful or very drastic operation.

The Catholic approach raises nice questions and draws fine lines. *E.g.*, how many limbs must be amputated before an operation is to be regarded as non-obligatory "extraordinary," as opposed to "ordinary" means, but they will not be dwelt upon herein. Suffice to say that apparently there has never been an indictment, let alone a conviction, for a "mercy killing" by omission, not even one which directly and immediately produces death.

This, of course, is not to say that no such negative "mercy killings" have ever occurred. There is reason to think that not too infrequently this is the fate of the defective newborn infant. Williams, p. 22, simply asserts that the "beneficient tendency of nature [in that "monsters" usually die quickly after birth] is assisted, in Britain at any rate, by the practice of doctors and nurses, who, when an infant is born seriously malformed, do not 'strive officiously to keep alive.'" Fletcher, *supra* 3, p. 207, n. 54, makes a similar and likewise undocumented observation that "it has always been a quite common practice of midwives and, in modern times, doctors simply to fail to respirate monstrous babies at birth." A supposition to the same effect was made twenty years earlier in Gregg, The Right to Kill, *No. Amer. Rev.*, 237:239, 242, 1934. A noted obstetrician and gynecologist, Dr. Frederic Loomis, has told of occasions where expectant fathers have, in effect, asked him to destroy the child, if born abnormal. Loomis. *Consultation Room*. 1946, p. 53. For an eloquent presentation of the problem raised by the defective infant *see id.* pp. 53-64.

It is difficult to discuss the consultation feature of Williams' proposal for affirmative "mercy killing" because Williams himself never discusses it. This fact, plus the fact that Williams' recurrent theme is to give the general practitioner a free hand indicates that he himself does not regard consultation as a significant feature of his plan. The attending physician need only consult another general practitioner and there is no requirement that there be any concurrence in his diagnosis. There is no requirement of a written report. There is no indication as to what point in time there need be consultation. Probably there need be consultation only as to diagnosis of the disease and from that point on the extent and mitigatory nature of the pain, and the firmness and rationality of the

desire to die is to be judged solely by the attending physician. For the view that even under rather elaborate consultation requirements, in many thinly staffed communities the consulted doctor would merely reflect the view of the attending physician *see* Life and Death, *Time,* Mar. 13, 1950, p. 50. After reviewing eleven case histories of patients wrongly diagnosed as having advanced cancer, diagnoses that stood uncorrected over long periods of time and after several admissions at leading hospitals. Doctors Laszlo, Colmer, Silver and Standard conclude: "[I]t became increasingly clear that the original error was one easily made, but that the continuation of that error was due to an acceptance of the original data without exploring their verity and completeness." (Errors in Diagnosis and Management of Cancer. *Ann. Int. Med.,* 33:670, 1950.)

42. In taking the Hippocratic Oath, the oldest code of professional ethics, the physician promises, of course, to "give no deadly medicine to any one if asked, nor suggest any such counsel." Many doctors have indicated they would not accept the role in which legalized euthanasia would cast them. *See, e.g.,* Frohman, *supra* 37, p. 1221 ("I could never deliberately choose the time of another's dying. The preservation of human life is not only the primary but the all-encompassing general law underlying the code of the physician. . . . Do not ask life's guardian to be also its executioner."); Gumpert, A False Mercy, *The Nation,* 170-80, 1950. ("As a physician, I feel I would have to reject the power and responsibility of the ultimate decision"); Lord Haden-Guests, 169 H.L. Deb. (5th ser.) 551, 586, 1950 ("You are asking the medical profession to do it. Ask somebody else."); Kennedy, Euthanasia: To Be or Not To Be. *Colliers,* May 20, 1939, pp. 15, 57, reprinted in *Colliers,* Apr. 22, 1950, pp. 13, 50 ("Who is going to carry out the sentence of death? I am sure not I . . . too grisly a notion for the profession of medicine to stomach."). In 1950, a banner year for "mercy killing" trials (*see* the *Mohr* case, *supra* 17, and the *Sander, Paight* and *Braunsdorf* cases at 172-6, 183, *infra* and accompanying text) the General Assembly of the World Medical Association approved a resolution recommending to all national associations that they "condemn the practice of euthanasia under any circumstances." *N.Y. Times,* Oct. 18, 1950, p. 22, col. 4. Earlier that year, the Medical Society of the State of New York, went on record as being "unalterably opposed to euthanasia and to any legislation which will legalize euthanasia." *N.Y. Times,* May 10, 1950, p. 29, col. 1.

On the other hand, euthanasiasts claim their movement finds great support in the medical profession. The most impressive and most frequently cited piece of evidence is the formation, in 1946, of a committee of 1,776 physicians for the legalization of voluntary euthanasia in New York. *See* Williams p. 331; Fletcher, *supra* 3, p. 187. Williams states that of 3,272 physicians who replied to a questionnaire in New York state in 1946, 80 percent approved voluntary euthanasia and the Committee of 1,776 came from among this favorable group. I have been unable to find any authority for the 80 percent figure, and Williams cites none. Some years ago, Gertrude Anne Edwards, then editor of the Euthanasia Society *Bulletin,* claimed 3,272 physicians—apparently *all* who replied—favored legalizing voluntary euthanasia. Edwards. Mercy Death For Incurables Should Be Made Legal. *The Daily Compass,* Aug. 24, 1949, p. 8, col. 1 (issue of the day). Presumably, as in the case of the recent New Jersey questionnaire discussed below, *every* physician in New York was sent a questionnaire. If so, then the figures cited, whether Williams or Edwards, would mean a great deal more (and support the euthanasiasts a great deal less) if it were added that 88 or 89 percent of the physicians in the state did not reply at all. In 1940, there were over 26,000 physicians in the State of New York. U.S. Department of Commerce, Bureau of the Census. *The Labor Force,* Part 4, p. 366: in 1950 there were over 30,000, U.S. Department of Commerce, Bureau of the Census. *Characteristics of the Population,* Part 32, p. 260.

The most recent petition of physicians for legalized euthanasia was that signed by 166 New Jersey physicians early in 1957 urging in effect the adoption of the American Society's Bill. *See* Anderson. Who Signed for Euthanasia? *America,* 96:573,1957. According to this article, the American Society had sent a letter to *all* the doctors in the

state asking them to sign such a petition. The doctors were asked to check either of two places, one indicating that their name could be used, the other that it could not. The 1950 census records over 7,000 physicians in New Jersey. *Characteristics of the Population,* Part 30, p. 203. Thus, about 98 percent of the state medical profession *declined* to sign such a petition. The Medical Society of New Jersey immediately issued a statement that "euthanasia has been and continues to be in conflict with accepted principles of morality and sound medical practice." *See* Anderson, *supra.* When their names were published in a state newspaper, many of the 166 claimed they had not signed the petition or that they had misunderstood its purpose or that, unknown to them, some secretary had handled the matter in a routine manner.

Cf. para. 27 of the Memorandum submitted by the Council of the British Medical Association (Royal Commission, Minutes of Evidence p. 318): *See* Anderson, *supra.*

"In the opinion of the Association, no medical practitioner should be asked to take part in bringing about the death of a convicted murderer. The Association would be most strongly opposed to any proposal to introduce, in place of judicial hanging, a method of execution which would require the services of a medical practitioner, either in carrying out the actual process of killing or in instructing others in the technique of the process."

Examination of medical witnesses disclosed that they opposed execution by intravenous injection as "a matter of professional ethics" since "under oath we are bound to promote life . . . whereas any action which has as its object the termination of life, even directly, we feel is undesirable." *Id.* para. 4041 (Feb. 3, 1950). *See also* para. 4 of the Memorandum of the Association of Anaesthetists to the effect that if intravenous injection is adopted as an alternative method of execution "the executioner should have no connection or association with the medical profession." *Id.* p. 678A. For a general discussion of the problem and the views of the medical profession on the matter, *see* Royal Commission Report paras. 737-48. Apparently the American medical profession has the same reluctance to participate in execution by intravenous injection. *See* Weihofen. *The Urge to Punish.* 1956, p. 168.

43. It should be noted that under what might be termed the "family plan" feature of Williams' proposal, minors may be euthanatized, too. Their fate is to be "left to the good sense of the doctor, taking into account, as he always does, the wishes of the parents as well as those of the child." Williams, p. 340, n. 8. The dubious quality of the "voluntariness" of euthanasia in these circumstances need not be labored.
44. Frohman. Vexing Problems in Forensic Medicine: A Physician's View. *N.Y.U.L. Rev.,* 31:1215, 1222, 1956.
45. The disturbing mental effects of morphine, "the classic opiate for the relief of severe pain," Schiffrin and Gross, Systematic Analgetics, In Schiffrin (Ed.) *Management of Pain In Cancer,* 1956, p. 22, and "still the most commonly used potent narcotic analgesic in treatment of cancer pain." Bonica, The Management of Cancer Pain, *GP,* Nov. 1954, pp. 35, 39, have been described in considerable detail by Drs. Wolff, Hardy and Goodell in Studies on Pain: Measurement of the Effect of Morphine, Codeine, and other Opiates on the Pain Threshold and an Analysis of their Relation to the Pain Experience, *J. Clin. Investig.,* 19:659, 664, 1940. It is not easy to generalize about the psychological effects of drugs for there is good reason to believe that the type of drug reaction is correlated with "differential personality dynamics, primarily in terms of the balance of mature, socially oriented controls over impulsive, egocentric emotionality," von Felsinger, Lasagna and Beecher, Drug-Induced Mood Changes in Man, *JAMA,* 157:1113, 1119, 1955, that for example, persons with atypical reactions to drugs are likely to be those with preexisting immaturity, anxiety and hostility, *id.* p. 1116. *See also* Lindemann and Clark. Modifications In Ego Structure and Personality Reactions Under the Influence of the Effects of Drugs. *Amer. J. Psychiat.,* 108:561, 1952. It would seem, however, that the severely ill person would be likely to experience substantially more pronounced effects than those described by Wolff, Hardy and Goodell, *supra,* because in that instance the "subjects" studied were the authors themselves, representing both sexes and different body

types, experiencing various degrees of pain by exposing portions of their skin surfaces to thermal radiation, but in the case of an illness due to a malignancy or suspected malignancy, we *start* with a situation where "all kinds of irrational attitudes come to the fore." Zarling. Psychological Aspects of Pain in Terminal Malignancies. In Schiffrin (Ed.) *supra* p. 205.

The increasing use of ACTH or cortisone therapy in cancer palliation, *see* 98-101, *infra* and accompanying text, presents further problems. Such therapy "frequently" leads to a "severe degree of disturbance in capacity for rational, sequential thought. Lindemann and Clark, *supra,* p. 566. Clark, *et al.,* Preliminary Observations On Mental Disturbance Occurring in Patients under Therapy with Cortisone and ACTH, *N. Engl. J. Med.,* 246:205, 215, 1952 describe six case histories of "major disturbances" where "delusions of depressive, paranoid and grandiose types occurred" and "affective disturbances, also invariably present, varied from depression to hypomania and from apathy to panic; they included ill-defined states that might be described as bewilderment or turmoil." In a subsequent paper, the authors conclude, Clark, *et al.,* Further Observations on Mental Disturbances Associated with Cortisone and ACTH Therapy. *N. Engl. J. Med.,* 249:178, 182, 1953 that the clinical course of psychoses associated with ACTH and cortisone is "more remarkable for its variability and unpredictability than any other feature," that, for example, mental disturbances may be separated by "intervals of relative lucidity," that "patients may have tolerated previous courses of ACTH or cortisone without complications and yet become psychotic during a subsequent course of treatment with comparable or even smaller doses."

For an extensive review of the many hypotheses purporting to explain mental disturbances associated with ACTH and cortisone *see* Quarton, *et al.,* Mental Disturbances Associated with ACTH and Cortisone: A Review of Explanatory Hypotheses, *Med.,* 34:13, 1955. The authors emphasize the inadequacy of present knowledge of mental disturbances associated with this therapy, but believe, "because of the clinical and experimental studies which suggest it," that "it is useful to assume" cortisone and ACTH produce a ['probably reversible'] specific pattern of modified nervous system function which is invariably present when a gross mental disturbance occurs. . . ." *Id.,* p. 41.

46. Goodman and Gilman. *The Pharmacological Basis of Therapeutics.* 1955, p. 235. Second edition. To the same effect is Seevers and Pfeiffer, A Study of the Analgesia, Subjective Depression, and Euphoria Produced by Morphine, Heroin, Dilaudid and Codeine in the Normal Human Subject. *J. Pharm. & Exper. Therap.,* 56:166, 182, 187, 1936.
47. Sharpe, Medication as a Threat to Testamentary Capacity, *N.C.L. Rev.,* 35:380, 382, 1957 and medical authorities cited therein.

    In the case of cortisone or ACTH therapy, the situation is complicated by the fact that "a frequent pattern of recovery" from psychoses induced by such therapy is "by the occurrence of lucid intervals of increasing frequency and duration, punctuated by relapses into psychotic behavior." Clark, *et al., supra* 45, 1953, pp. 178, 183.
48. Sharpe, *supra* 47, p. 384. Goodman and Gilman, *supra* 46, p. 234, observe that while "different individuals require varying periods of time before the repeated administration of morphine results in tolerance . . . as a rule . . . after about two to three weeks of continued use of the same dose of alkaloid the usual depressant effects fail to appear" whereupon "phenomenally large doses may be taken." For a discussion of "the nature of addiction," *see* Maurer and Vogel, *Narcotics and Narcotic Addiction.* 1954, pp. 20-31.
49. *See infra* 77, and accompanying text.
50. Miller. Why I Oppose Mercy Killings. *Women's Home Companion,* June, 1950, pp. 38, 103.
51. *Moore* v. *Michigan,* 335 U.S. 155, 161 (1957).
52. 103 H.L. Deb. (5th ser.) 466, 492-3, 1936. To the same effect is Lord Horder's speech in the 1950 debates, 169 H.L. Deb. (5th ser.) 551, 569, 1950. *See also* Gumpert, *supra* 42: "Even the incapacitated, agonized patient in despair most of the time, may still get some joy from existence. His mood will change between longing for death and fear of

death. Who would want to decide what should be done on such unsafe ground?"

For a recent layman's account of the self-pity and fluctuating desires for life and death of a seriously ill person, *see* the reflections of the famous sports broadcaster Ted Husing in My Friends Wouldn't Let Me Die, *Look*, Feb. 4, 1958, p. 64.

53. *See* Guttmacher and Weihofen. *Psychiatry and the Law*. 1952, p. 307.
54. Williams, pp. 343-4.
55. *Id.*, p. 344.
56. Dr. James J. Walsh in Life Is Sacred, *The Forum*, 94:333-4, recalls the following Aesop's fable: "It was a bitter-cold day in the wintertime, and an old man was gathering broken branches in the forest to make a fire at home. The branches were covered with ice, many of them were frozen and had to be pulled apart, and his discomfort was intense. Finally the poor old fellow became so thoroughly wrought up by his suffering that he called loudly upon death to come. To his surprise, Death came at once and asked what he wanted. Very hastily the old man replied, 'Oh, nothing: nothing except to help me carry this bundle of sticks home so that I may make a fire.' "
57. Zarling, *supra* 45, p. 215.
58. The medical profession is apparently already quite sensitive about the "sue consciousness" on the part of the public. *See* Caswell. A Surgeon's Thoughts on Malpractice. *Temple L. Q.*, 30:391, 1957. (Symposium) There is good reason to think that "the greater incidence of suits and claims against physicians alleging medical malpractice and a greater financial success in prosecuting these" has led to "insecurity" on the part of many physicians, and "the insecure physician is going to play it safe." Wachowski and Stronach. The Radiologist and Professional Medical Liability. *Temple L. Q.*, 30:398, 1957. Apparently, in some fields fear of claims and litigation has already set "the psychological stage for undertreatment." *Id.*, p. 399.
59. *Cf.* the examination of Sir Harold Scott, Commissioner of Police of the Metropolis by the Royal Commission on Capital Punishment, Minutes of Evidence, Oct. 7, 1949, p. 151: "1599. Nobody at present, except the law, has to decide that a particular person should be sentenced to death, no individual?—No individual at present, except the Home Secretary, has to decide that a particular person sentenced to death must hang.

    1600. The Home Secretary is in a different position is he not? He does not primarily prescribe the death penalty; the law does that. The Home Secretary says whether or not he deems it right to interfere with the course of the law?—Yes, that is the legal position. It is a different position, technically, but it seems to me that morally there really is no difference. The responsibility upon the Home Secretary is really to decide whether this man shall die or not die. The machinery may be by interference or non-interference with the law, but the responsibility to me seems the same."
60. *See infra* 172. *See also* the *Mohr* case; *supra* 17, where two brothers testified against a third who had euthanatized a fourth.
61. *See infra* 176.
62. Zarling, *supra* 45, pp. 211-2.
63. *Id.*, pp. 213-4. *See also* Dr. Benjamin Miller to the effect that cancer "can be a 'horrible experience' for the doctor too" and that "a long difficult illness may emotionally exhaust the relatives and physician even more than the patient." Miller, *supra* 50, p. 103; and Stephen, Murder from the Best of Motives, *L. Q. Rev.*, 5:188, 1889, commenting on the disclosure by a Dr. Thwing that he had practiced euthanasia: "The boldness of this avowal is made particularly conspicuous by Dr. Thwing's express admission that the only person for whom the lady's death, if she had been allowed to die naturally, would have been in any degree painful was not the lady herself, but Dr. Thwing."
64. *N.Y. Times*, Feb. 24, 1950, p. 1, col. 6.
65. "As I looked at her face and all of the thoughts of the past went through my mind, something snapped in me, and I felt impelled or possessed to do something, and why I did it, I can't tell. It doesn't make sense." *N.Y. Times*, Mar. 7, 1950, p. 19, col. 1.
66. "I didn't use a tourniquet, which is also rather a ridiculous thing, because ordinarily in

a normal patient we put on a tourniquet to bring up the vein so that we can see it. Her veins were collapsed anyhow and I couldn't have been thinking the way I ordinarily do at the time. Otherwise I wouldn't have acted this way." *Ibid.*

67. "[J]ust the appearance of her face and the combination of all the though'- of her long suffering and of her husband's suffering also—this expression on her fa_ might have just touched me off and made me feel obsessed that I had to do something and what I did does not make sense." *Ibid.*
68. *See infra* 172, and accompanying text.
69. Wechsler. The Issues of the Nuremberg Trial. *Pol. Sci. Q.*, 62:11, 16, 1947. *Cf.* Cardozo, *supra* 20, pp. 88-9: "Punishment is necessary, indeed, not only to deter the man who is a criminal at heart, who has felt the criminal impulse, who is on the brink of indecision, but also to deter others who in our existing social organization have never felt the criminal impulse and shrink from crime in horror. Most of us have such a scorn and loathing of robbery or forgery that the temptation to rob or forge is never within the range of choice; it is never a real alternative. There can be little doubt, however, that some of this repugnance is due to the ignominy that has been attached to these and like offenses through the sanctions of the criminal law. If the ignominy were withdrawn, the horror might be dimmed."
70. Williams, p. 318.
71. *Id.* pp. 317-8.
72. "What to do with the hopelessly unfit? I had thought at a younger time of my life that the legalizing of euthanasia—a soft gentle-sounding word—was a thing to be encouraged; but as I pondered, and as my experience in medicine grew, I became less sure. Now my face is set against the legalization of euthanasia for any person, who, having been well, has at last become ill, for however ill they be, many get well and help the world for years after. But I *am* in favor of euthanasia for those hopeless ones who should never have been born—Nature's mistakes. In this category it is, with care and knowledge, impossible to be mistaken in either diagnosis or prognosis." Kennedy. The Problem of Social Control of the Congenital Defective. *Amer. J. Psychiat.*, 99:13, 14, 1942.

    "We doctors do not always know when a disease in a previously healthy person has become entirely incurable. But there are thousands and tens of thousands of the congenitally unfit, about whom no diagnostic error would be possible . . . with nature's mistakes . . . there can be, after five years . . . of life, no error in diagnosis, nor any hope of betterment." Kennedy, *supra* 42, 1939, pp. 15, 58 (1950, pp. 13, 51).

    At the February, 1939, meeting of the Society of Medical Jurisprudence, Charles E. Nixdorff, treasurer and board chairman of the Euthanasia Society of America stated that the case of a 19 year old girl in Bellevue, with a broken back and paralyzed legs, who "prayed for death every night" was sufficient reason for the Euthanasia Society "to carry on the fight." "Dr. [Foster] Kennedy [then President of the Euthanasia Society], in conversation, said later he did not think that was a particularly good example. He said he had known many such cases where the patients 'got around' and only recently he had 'danced with one.'" *N.Y. Times*, Feb. 14, 1939, p. 2, col. 6.
73. Banks, *supra* 3, pp. 101, 106. According to him, neither "pain" nor "incurability" "is capable of precise and final definition, and indeed if each case had to be argued in open court there would be conflict of medical opinion in practically every instance." *Id.* p. 104.
74. Wolbarst. Legalize Euthanasia! *The Forum*, 94:330, 332, 1935. (*But see* Wolbarst. The Doctor Looks at Euthanasia. *Medical Record*, 149:354, 1939).
75. *Id.* pp. 330, 331.
76. *Id.* p. 332.
77. *Supra* 49, p. 39.
78. As to how bad the bad physician can be, *see* generally, even with a grain of salt, Belli, *Modern Trials*, 1954, §§327-53, Vol. 3. *See also* Regan, *Doctor and Patient and the Law*, 1956, pp. 17-40. Third edition.
79. *See supra* 41, and accompanying text.

80. As Williams points out, p. 330, Dr. Millard introduced the topic of euthanasia into public debate in 1932 when he advocated that "mercy killing" should be legalized in his presidential address to the Society of Medical Officers of Health. In moving the second reading of the voluntary euthanasia bill, Lord Ponsonby stated that "the movement in favour of drafting a Bill" had "originated" with Dr. Millard. 103 H. L. Deb. 466-7, 1936.
81. Millard. The Case For Euthanasia. *Fortnightly Rev.*, 136:701, 717, 1931. Under his proposed safeguards (two independent doctors, followed by a "medical referee") Dr. Millard viewed error in diagnosis as a non-deterrable "remote possibility."
82. Euthanasia opponents readily admit this. *See e.g., supra* 49, p. 38.
83. *Supra* 81, p. 702.
84. *Supra* 37, pp. 1215, 1216. Dr. Frohman added: "we practice our art with the tools and information yielded by laboratory and research scientists, but an ill patient is not subject to experimental control, nor are his reactions always predictable. A good physician employs his scientific tools whenever they are useful, but many are the times when intuition, chance, and faith are his most successful techniques.
85. Laszlo, *et al., supra* 41.
86. Laszlo and Spencer. Medical Problems in the Mangement of Cancer. *Med. Clin. No. Amer.*, 37:869, 873, 1953.
87. Ger. Diagnosis and Misdiagnosis of Carcinoma. *So. Afr. Med. J.*, 28:670, 1954.
88. De Vet and Walder. Pseudo-Metastases. *Archivium Chirurgicum Neerlandicum,* 7:78, 1955.
89. *Id.* p. 83.
90. *Id.* p. 82. Consider also the following: At the 1951 annual meeting of the American Cancer Society, devoted to cytologic diagnosis of cancer, Dr. Henry M. Lemon noted: *Proceedings, Symposium on Exfoliative Cytology,* Oct. 23-24, 1951, p. 106: "The problem of false positive diagnoses has always been a difficult one. About 5 percent of the 541 non-cancer patients in whom cancer secretions have been studied in the past had false positive diagnosis made, and in our experience, gastritis has been a common cause of false positive diagnosis." At the same meeting, Dr. William A. Cooper told of "fifteen misses" in X-ray gastric cancer diagnosis out of one hundred cases (*Id.* p. 102): "Four of the twenty-five cases of cancer were said to have benign lesions, while eleven of the seventy-five benign lesions were said to have cancer."
91. *See* Williams, p. 318.
92. Pro & Con: Shall We Legalize "Mercy Killing?" *Readers Digest,* 33:94, 96, Nov. 1938.
93. James. Euthanasia—Right or Wrong? *Survey Graphic,* May, 1948, pp. 241, 243; Wolbarst, *supra* 74, 1939, pp. 354, 355.
94. Thus, Doctor Millard, in his leading article, *supra* 81, p. 710, states: "A patient who is too ill to understand the significance of the step he is taking has got beyond the stage when euthanasia ought to be administered. In any case his sufferings are probably nearly over." Glanville Williams similarly observes, pp. 342-4: "Under the bill as I have proposed to word it, the consent of the patient would be required, whereas it seems that some doctors are now accustomed to give fatal doses without consulting the patient. I take it to be clear that no legislative sanction can be accorded to this practice, in so far as the course of the disease is deliberately anticipated. The essence of the measures proposed by the two societies is that euthanasia should be voluntarily accepted by the patient.

    . . . The measure here proposed is designed to meet the situation where the patient's consent to euthanasis is clear and incontrovertible."
95. Emerson. Who Is Incurable? A Query and Reply. *N.Y. Times,* Oct. 22, 1933, Sec. 8, p. 5, col. 1.
96. *Ibid.; supra* 49, p. 39.
97. This is not to say that progress in the treatment of cancer cases has been limited to the last decade. Over twenty years ago, Lord Horder, 103 H.L. Deb. 466, 492, 1936, opposing the euthanasia bill in the House of Lords debates, observed: "[A]lthough it is common knowledge that the essential causative factors of cancer still elude us, there are patients

today suffering from this disease, not only living but free from pain, who would not have been living ten years ago, and this as the result of advances made in treatment."

98. McCarthy. The Palliation and Remission of Cancer With Combined Corticosteroid and Nitrogen Mustard Therapy. *N. Engl. J. Med.*, 252:467, 1955.
99. Treatment of Advanced Cancer. *N. Engl. J. Med.* 252:502, 1955.
100. *Supra* 98, p. 468.
101. Id. pp. 470, 475. Some of the results were little short of spectacular. *See, e.g.*, Case 1, p. 470, the case of a woman whose reticulum-cell sarcoma "was considered too disseminated for radiation therapy" who responded so well to therapy that she returned to employment as a nurse for three years; Case 3, *Ibid.* that of a man taken to the hospital "in a terminal state" with "a massive lymphosarcoma of the pelvis" which had received X-ray therapy and which was increasing rapidly in size, who returned to his occupation and but for a short interval when he underwent a second course of therapy "continued working up to the time of his death . . . eighteen months after the first course of combination therapy"; Case 11, p. 472-3, that of a stomach-cancer victim "in a terminal condition, unable to retain solids or fluids" who, after three months of the therapy, regained her normal weight, returned to her occupation and enjoyed excellent health for a full year.

    On the other hand, some 40 percent of the group were considered failures (those who died within a month and those who survived longer but received little benefit); 29 percent were classed as fair in response (moderate but brief palliation), p. 470.
102. *See also* Ravich, Euthanasia and Pain in Cancer, *Unio Internationalis Contra Cancrum,* 9:397, 1953, a report of the promising experimental chemotherapeutic measures (*n*-Butanol, glycerine and sodium thirosulfate) of Dr. Emanuel Revici and the staff of the Institute of Applied Biology. A number of patients whose cancers "had advanced beyond the point where any help was to be anticipated from surgery, X-ray or radium, according to the opinions of the attending physicians," p. 398, returned to their normal occupations after the onset of treatment and remained on the job for several years.
103. Drs. Huggins and Scott had reported the first total bilateral adrenalectomies in patients with prostatic carcinoma in 1945, but since cortisone was not then available all patients died in adrenal insufficiency. The authors therefore concluded at that time that the operation was not practical and temporarily abandoned this approach. *See* Huggins and Scott. Bilateral Adrenalectomy in Prostatic Cancer: Clinical Features and Urinary Excretion of 17 Ketosteroids and Estrogen. *Ann. Surg.*, 122:1031, 1945.
104. West, *et al.* The Effect of Bilateral Adrenalectomy Upon Neoplastic Disease in Man. *Cancer,* 5:1009, 1952.
105. *Id.* pp. 1012-3. Dr. M. P. Reiser of the University of Minnesota Medical School and his colleagues have planted radon-filled seeds of gold into the prostate area in an effort to save patients with "inoperable" cancer of the prostate gland. As a result, thirteen of twenty-five patients have lived at least a year; six have lived from three to seven years. Radon is the gas of radium. *See* Cohn. 'U' Reports Victories over Cancer. *Minneapolis Morning Trib.*, Apr. 4, 1958, p. 13, col. 4.
106. *Supra* 104, p. 1010.
107. An addendum to the report discloses that J. W.'s postoperative "subjective improvement" lasted 220 days and that he survived for 294 days, *id.* pp. 1016-7. What pain J. W. suffered in his last days is not revealed, but in general discussion the authors state that ". . . [I]n the majority of the cases, the pain never did return to its preoperative intensity even though the patient later died of cancer." *Id.* p. 1015.
108. American Cancer Society. *1958 Cancer Facts and Figures,* p. 17.
109. Dao and Huggins. Metastatic Cancer of the Breast Treated by Adrenalectomy. *JAMA,* 165:1793, 1957.

    Furthermore, an additional nine patients who underwent no demonstrable regression experienced marked objective improvement in relief of bone pain, disappearance of respiratory symptoms and return of a sense of well-being. An earlier report on adrenal-

ectomy disclosed that of five "effective" breast carcinoma cases, a sixth having died of other causes a short time after undergoing the operation, "all had severe pain preoperatively, and all had either partial or complete relief of pain following adrenalectomy." *Supra* 104, p. 1014.

110. *Id.* p. 1796.

111. *Ibid.*

112. Kennedy, French and Peyton. Hypophysectomy in Advanced Breast Cancer. *N. Engl. J. Med.*, 255:1165, 1171, 1956. *See also* Kennedy. The Present Status of Hormone Therapy in Advanced Breast Cancer. *Radiology*, 69:330, 333-4, 1957.

For earlier reports, *see* Luft and Olivercrona. Hypophysectomy in Man: Experiences in Metastatic Cancer of the Breast. *Cancer*, 8:261, 1955. (13 of 37 patients showed subjective or objective improvement for from three to 27 months); Pearson, *et al.*, Hypophysectomy in Treatment of Advanced Cancer, *JAMA*, 161:17, 21, 1956 (over half of 41 patients who could be evaluated underwent objective remissions).

113. "In view of the favorable responses after hypophysectomy, the concomitant adrenal atrophy and the ease in managing the patient, it appears that hypophysectomy is to be preferred over adrenalectomy in the treatment of advanced breast cancer." Kennedy, French and Peyton, *supra* 112, p. 1171.

114. In addition to the various approaches to the cancer problem discussed above, consider, *e.g.*, the following items which have appeared in the daily newspapers the past few months:

(1) In April of 1958, scientists uncovered a new chemical compound—fluorine combined with a body compound used by cancer cells for growth—which inhibits the growth of cancer cells. The discovery was hailed as a major step in the search for a medical "magic bullet" which can kill cancer cells outright. *N.Y. Times*, Apr. 4, 1958, p. 23, col. 7; *Minneapolis Morning Trib.*, Apr. 4, 1958, p. 14, col. 5.

(2) Neutron radiation on brain cancer patients has led to "significant" increases in length of life, according to Dr. William H. Sweet of the Harvard Medical School. This September, Dr. Sweet will use an atomic reactor in an unprecedented effort to remove all remnants of brain cancer from a patient. Cohn. Brain Cancer Surgeons Will Use Atomic Reactor. *Minneapolis Morning Trib.*, Mar. 30, 1958, p. 1, col. 1.

(3) There is reason to think that neurosonic surgery, sound waves focussed on precise spots inside the brain, may prove valuable in treating brain cancers—with a dosage devised to kill only cancer cells. Palsy victims for as long as 35 years have been relieved by such treatment. *N.Y. Times*, Apr. 2, 1958, p. 33, col. 8; *Minneapolis Morning Trib.*, Apr. 2, 1958, p. 8, col. 5.

(4) Dr. Roy Hertz, an expert of the National Cancer Institute, has disclosed that a drug called methotrexate has suppressed all evidence of a type of cancer occurring in woman during pregnancy, but the "full value of the treatment remains to be determined." *N.Y. Times*, Feb. 29, 1958, p. 62, col. 4.

(5) Dr. L. M. Tocantins of Jefferson Medical College has been conducting experiments to combat leukemia with whole-body X-ray doses calculated to kill the sick bone marrow cells that are producing the illness. Good marrow, taken from the bones of volunteers, is then injected into the patients. Such a technique has reversed leukemia's course in mice and given some of them normal life spans. Cohn. They Give Ribs to Fight Leukemia. *Minneapolis Morning Trib.*, Mar. 26, 1958, p. 1, col. 4.

115. *See supra* 101, 102, 109, 109.

116. For a discussion of the legal significance of "mercy killing" by omission and Williams' consultation feature for affirmative "mercy killing," *see supra* 41.

117. Williams, p. 318.

118. Borchard. *Convicting the Innocent.* 1932.

119. Frank and Frank. *Not Guilty.* 1957.

120. *See, e.g.*, Fletcher, *supra* 3, pp. 181, 195-6; Millard, *supra* 81; Potter. The Case for Euthanasia. *Reader's Scope*, May 1947, pp. 111, 113.

121. *See* generally Royal Commission on Capital Punishment, Report, Cmd. No. 8932, 1949-53, paras. 55-68; Michael and Wechsler, *supra* 18, pp. 235-62.
122. Hart, H.L.A. Murder and the Principle of Punishment: England and the United States. *N.W.U.L. Rev.*, 52:433, 446, 455, 1957. *See also, e.g.*, Bye. *Capital Punishment in the United States*. 1919, p. 31; Gardiner. *Capital Punishment as a Deterrent: And the Alternative*. 1956, pp. 17, 22; Caldwell. Why Is the Death Penalty Retained? *Ann. Amer. Acad. Pol. & Soc. Sci.*, 284:45, 50, 1952.
123. "I believed that the figures showed that if you abolish capital punishment you do not, in fact, lose more human lives. Other noble Lords took the opposite view: they believed that if capital punishment were abolished we should lose more lives. Both sides, however, believed that there is an ultimate value in human life. That was what the whole debate was about." 169 H.L. Deb. (5th ser.) 551, 591, 1950.
124. The remaining pockets of resistance would be manned by those who would utilize the death penalty as an instrument of vengeance, as a device for placing a special stigma on certain crimes, and as a means of furnishing the criminal with an extraordinary opportunity to repent before execution. *See* the discussion in the Royal Commission Report, *supra* 121, paras. 52-4.
125. Books attacking the utilization of the death penalty include Bye, *supra* 122; Calvert. *Capital Punishment in the Twentieth Century*. 1930. Fourth edition; *Supra* 119, p. 248; Gardiner, *supra* 122; Koestler, *Reflections on Hanging*. 1956; Lawes. *Twenty Thousand Years in Sing Sing*. 1932, pp. 291-337; Weihofen, *supra* 42, pp. 146-70.

    In February, 1956, the House of Commons on a free vote of 292 to 246 passed a resolution calling for the abolition or suspension of the death penalty which stated in part that "the death penalty for murder no longer accords with the needs or true interests of a civilized society" 548 H.C. Deb. (5th ser.) 2556, 2652, 2655, 1956. The House of Lords, however, rejected the legislation passed in the spirit of this resolution. *See* Hart, *supra* 122, p. 434. Bertrand Russell recently commented, *supra* 2, p. 385: "I have not the relevant statistics, but I think if a poll had been taken [of the House of Lords in 1936] it would have been found that most of those who objected to euthanasia favoured capital punishment, the dominant consideration in each case being faithfulness to tradition." Perhaps, but I would speculate further that if such a poll had been taken, it may well have been found that most of those who *favoured* euthanasia *objected* to capital punishment. And on such grounds as the irrevocability of the death sentence and the inevitable incident of error in the selection of its victims, the insufficient showing that such a drastic method is needed, and, perhaps, the sanctity of life.
126. *See* Silving, *supra* 7.
127. *See, e.g.*, Fletcher, *supra* 3, p. 198; Euthanasia Society of America, Merciful Release, art. 7; Millard, *supra* 81, p. 717.
128. Rudd. Euthanasia, *J. Clin. & Exper. Psychopath.*, 14:1, 4, 1953.
129. *See United States* v. *Holmes,* 26 Fed. Cas. No. 15, 383 (C.C.E.D. Pa. 1842).
130. *See Regina* v. *Dudley & Stephens,* 14 Q.B.D. 273, 1884.
131. Fuller. The Case of the Speluncean Explorers. *Harv. L. Rev.*, 62:616, 1949.
132. Cardozo, *supra* 20, p. 113.
133. Hall. *General Principles of Criminal Law*. 1947, p. 399. Cardozo, on the other hand, seems to say that absent such certainty it is wrong for those in a "necessity" situation to escape their plight by sacrificing any life. Cardozo, *supra* 20, p. 113. On this point, as on the whole question of "necessity," his reasoning, it is submitted, is paled by the careful and intensive analyses found in Hall, *supra,* pp. 377-426, and Williams, *supra* 4, pp. 577-86.

    See also Cohn. *The Moral Decision*. 1955. Although he takes the position that in the Holmes' situation, "if none sacrifice themselves of free will to spare the others—they must all wait and die together," Cohn rejects Cardozo's view as one which "seems to deny that we can ever reach enough certainty as to our factual beliefs to be morally justified in the action we take." Pp. 70-1.

Some time after this paper was in galley, Section 3.02 of the Model Penal Code (Tent. Draft No. 8, 1958) made its appearance. This section provides (unless the legislature has otherwise spoken) that certain "necessity" killings shall be deemed justifiable so long as the actor was not "reckless or negligent in bringing about the situation requiring a choice of evils or in appraising the necessity for his conduct." The section only applies to a situation where "the evil sought to be avoided by such conduct is greater than that sought to be prevented by the law," *e.g.*, killing one that several may live. The defense would not be available, *e.g.*, "to one who acted to save himself at the expense of another as by seizing a raft when men are shipwrecked." *Comment* to Section 3.02, *id.* p. 8. For "in all ordinary circumstances lives in being must be assumed . . . to be of equal value, equally deserving the protection of the law." *Ibid.*

134. *Cf.* Macauley. Notes on the Indian Penal Code, Note B, 1851, p. 131, reprinted in *The Miscellaneous Works of Lord Macauley*. Vol. 7, p. 252. Bibliophile edition. "It is often the wisest thing that a man can do to expose his life to great hazard. It is often the greatest service that can be rendered to him to do what may very probably cause his death. He may labor under a cruel and wasting malady which is certain to shorten his life, and which renders his life, while it lasts, useless to others and a torment to himself. Suppose that under these circumstances he, undeceived, gives his free and intelligent consent to take the risk of an operation which in a large proportion of cases has proved fatal, but which is the only method by which his disease can possibly be cured, and which, if it succeeds, will restore him to health and vigor. We do not conceive that it would be expedient to punish the surgeon who should perform the operation, though by performing it he might cause death, not intending to cause death, but knowing himself to be likely to cause it."

135. The management of intractable pain in cancer may be grouped under two main categories: (1) measures which check, decrease or eliminate the growth itself, (2) symptomatic treatment, *i.e.*, control of the pain without affecting the growth. In the first category are palliative operations for cancers no longer curable; radiation, roentgen and X-ray therapy; administration of endocrine substances, steroids, nitrogen mustards, and radioactive iodine and iron. *See* text at refs. 98-113, *supra.* In the second category are nonnarcotic analgesics such as cobra venom, hypnotics and sedatives; narcotic analgesics, such as morphine, codeine, methadone and, recently, chlorpromazine; neurosurgical operations, such as rhizotomy, the technique of choice in the mangement of cancer pain of the head and neck, spinothalmic tractotomy and chordotomy, for relief of pain at or below the nipple line; and prefrontal lobotomy.

The various measures sketched above are discussed at considerable length in Bonica and Backup, Control of Cancer Pain, *Nw. Med.*, 54:22, 1955; Bonica, *supra* 45, p. 35; and more extensively by Doctors Schiffrin and Gross (Systematic Analgetics), Sadove and Balogot (Nerve Blocks For Pain In Malignancy), Sugar (Neurosurgical Aspects of Pain Management), Taylor and Schiffrin (Humoral and Chemical Palliation of Malignancy), Schwarz (Surgical Procedures In Control of Pain In Advanced Cancer) and Carpender (Radiation Therapy In The Relief of Pain In Malignant Disease). In Schiffrin (Ed.) *The Management of Pain In Cancer.* 1956.

Relief of pain by nerve blocking "has a great deal more to offer than prolonged narcotic therapy. Effective blocks produce adequate relief of pain and enable these sufferers to receive more intensive radiation therapy and other forms of medical treatment which otherwise could not be tolerated." Bonica and Backup, *supra*, p. 27; Bonica, *supra*, p. 43. "A recent analysis of cases reported in the literature revealed that of the many patients treated by alcohol nerve blocking, 63 percent obtained complete relief, 23.5 percent obtained partial relief, and only 13.5 percent received no benefits from the blocks." Bonica, *supra*, p. 43.

"Chordotomy is perhaps the most useful and most effective neurosurgical operation for the relief of cancer pain. When skillfully carried out in properly selected patients, it produces complete relief in about 65 percent of the patients, partial relief in another

25 percent, and no relief in approximately 10 percent." Bonica and Backup, *supra*, p. 25.

Prefrontal lobotomy is a radical procedure which many regard as a last resort. Bilateral prefrontal lobotomy almost always produces striking changes in the patient's personality, frequently impairing judgment and causing apathy; the mental changes produced by unilateral lobotomy are much less marked, but pain is likely to recur if the patient survives more than several months. *See* Sugar, *supra*, pp. 101-4; Bonica, *supra*, pp. 41-2.

136. Foreword by Dr. Warren H. Cole. In Schriffrin (Ed.), *supra* 135.
137. Bonica and Backup, *supra* 135, p. 22; Bonica, *supra* 135, p. 35.
138. *Ibid.*
139. "The efficacy of *narcotics analgesics*, particularly opiates, in managing pain of terminal malignancy, is too well-known to warrant discussion. . . . Unfortunately their effectiveness, low cost, and ease of administration—very desirable qualities in any drug—are conducive to improper use by the busy practitioner. He may have neither time nor the interest to study and consider each case individually so that the pharmacologic properties of the various narcotic drugs are fully exploited to the advantage of the patient. The attitude and practice of some physicians to 'snow the patient under because the end is inevitable' denotes lack of understanding of the problem. Because it is very difficult to estimate the length of life in each individual case, such sense of mistaken humanitarianism may be productive of an unnecessarily premature addiction with consequent stupefication, respiratory depression, headache, anorexia, nausea, vomiting, and will bring on a state of cachexia more rapidly. Moreover, because tolerance develops rapidly, the patient may not obtain adequate relief in the latter stages of the disease, when comfort is so essential, even with massive doses, and he may also develop withdrawal symptoms when the amount administered is no longer effective."

    Bonica and Backup, *supra* 135, pp. 24-5; to the same effect is Bonica, *supra* 135, p. 38. *See also* Schiffrin and Gross, *supra* 135, p. 17:

    "Factors facilitating the development of tolerance include the administration of the drug at frequent, regular intervals and the use of successively larger doses. The appearance of clinically significant tolerance can be delayed by using the minimal effective dose as infrequently as possible and by limiting the use of addicting drugs to their primary characteristic, analgesia, and not to secondary properties such as sedation. The writing of such an order as '¼ gr. morphine q. 4 h.' is to be deplored. Addicting analgetics are to be ordered on the basis of pain, not according to the clock or nursing habits."
140. "The opinion appears to prevail in the medical profession that severe pain requiring potent analgesics and narcotics frequently occurs in advanced cancer. Fortunately, this does not appear to be the case. Fear and anxiety, the patient's need for more attention from the family or from the physician, are frequently mistaken for expressions of pain. Reassurance and an unhesitating approach in presenting a plan of management to the patient are well-known patient 'remedies,' and probably the clue to success of many medical quackeries. Since superficial psychotherapy as practiced by physicians without psychiatric training is often helpful, actual psychiatric treatment is expected to be of more value. Unfortunately, the potential therapeutic usefulness of this tool has barely been explored." Laszlo and Spencer, *supra* 86, pp. 869, 875.
141. *Ibid.* "Placebo" medication is medication having no pharmacologic effect given for the purpose of pleasing or humoring the patient. The survey was conducted on patients in Montefiore Hospital, N.Y.C. One clear implication is that "analgesics should be prescribed only after an adequate trial of placebos."
142. *See supra* 135.
143. The one thing agreed upon by the eminent physicians Abraham L. Wolbarst, later an officer of the Euthanasia Society of America, and James J. Walsh in their debate on "The Right To Die" was that very, very few people ever really want to die.

Dr. Walsh reported that in all the time he worked at Mother Alphonsa's Home for Incurable Cancer he never heard one patient express the wish that he "would be better off dead" and "I know, too, that Mother Alphonsa had very rarely heard it." "On the other hand," adds Walsh, "I have often heard neurotic patients wish that they might be taken out of existence because they could no longer bear up under the pain they were suffering. . . . They were overcome mainly by self-pity. Above all, they were sympathy seekers . . . of physical pain there was almost no trace, but they were hysterically ready, so they claimed to welcome death. . . . *Supra* 56, p. 333. Walsh's opponent, Dr. Wolbarst, conceded at the outset that "very few incurables have or express the wish to die. However great their physical suffering may be, the will to live, the desire for life, is such an overwhelming force that pain and suffering become bearable and they prefer to live." Wolbarst, *supra* 74, 1935, p. 330.

The first "lesson" the noted British physician, A. Leslie Banks, learned as Resident Officer to cancer wards at the Middlesex Hospital was that "the patients, however ill they were and however much they suffered, never asked for death." Banks. Euthanasia. *Bull. N.Y. Acad. Med.*, 26:297, 301, 1950.

144. *See* text at 49 and 52, *supra.*

145. Selwyn James, *supra* 93, p. 241, makes considerable hay of the Euthanasia Society of America's claim that numerous cancer patients phone the society and beg for a doctor who will give them euthanasia. If a person retains sufficient physical and mental ability to look up a number, get to a phone and dial, does he really have to ask *others* to deal him death? That is, if it is death he really desires, and not, say, attention or pity.

146. *See, e.g., Proceedings, Symposium on Exfoliative Cytology, supra* 90, p. 58, "Dr. Mortimer Benioff: Dr. [Peter] Herbert is to be congratulated on showing you particularly some of the cases which were operated on and did not have cancer. Most of the time we have a tendency in our enthusiasm not to talk about things like that. . . ."

147. During the nine years from 1946 through 1954, only 79 or 1.6 percent of 4,849 federal habeas corpus applications were granted. In 1954, the percentage was down to 1.3; in 1955 it had fallen below 1 percent: 5 out of 688 cases. *See* Baker. Federal Judicial Control of State Criminal Justice. *Mo. L. Rev.*, 22:109, 140, 1957; Pollak. Proposals to Curtail Federal Habeas Corpus for State Prisoners; Collateral Attack on the Great Writ. *Yale L. J.*, 66:50, 53, 1956; Ribble. A Look at the Policy Making Powers of the United States Supreme Court and the Position of the Individual. *Wash. & Lee L. Rev.*, 14:167, 178-9, 1957; Schaefer. Federalism and State Criminal Procedure. *Harv. L. Rev.*, 70:1, 19, 1956. Of course, these figures do not necessarily reflect the actual proportion of meritorious cases. Professor Pollak suggests that the very low measure of success is due in no small degree to the difficulties of proof involved in reconstructing trials of the distant past and the ineptness of prisoners handling their own past-conviction litigation, *Yale L. J.*, 66:54, while Professor Baker takes the contrary position that "if even the federal courts themselves must admit that the state tribunals have been correct at least 98.6 [98.4?] percent of the time when their convictions have been challenged, it is not completely amiss to surmise that the state courts may have been right in those few cases where the writs were granted and the prisoners discharged," *Mo. L. Rev.*, 22:140. I, for one, find Pollak's reasoning more persuasive, but I think it fair to say that most defenders of the writ are willing to take the figures as they find them.

Yet, of the handful whose petitions were granted, how many actually get relief? In 1953, Mr. Justice Frankfurter noted that "during the last four years five state prisoners, all told, were discharged by federal district courts," *Brown* v. *Allen*, 344 U.S. 443, 510 (1953) (dissenting opinion), "the miniscule figure of 15 percent," as one of the writ's staunchest friends has put it. Pollak, *supra*, p. 53.

148. It is not surprising that the cry has gone out that federal habeas corpus is not worth *it*, that "one swallow does not make a summer," Baker, *supra* 147, p. 1042, and that "he who must search a haystack for a needle is likely to end up with the attitude that

the needle is not worth the search." Jackson, J., concurring in *Brown* v. *Allen,* 344 U.S. 443, 537 (1953). But these views have not prevailed. As Illinois Supreme Court Justice Walter Schaefer recently observed in his Holmes lecture: "Even with the narrowest focus it is not a needle we are looking for in these stacks of paper, but the rights of a human being. And if the perspective is broadened, even the significance of that single human being diminishes, and we begin to catch a glimpse of the full picture. The aim which justifies the existence of *habeas corpus* is not fundamentally different from that which informs our criminal law in general, that it is better that a guilty man go free than that an innocent one be punished. To the extent that the small numbers of meritorious petitions show that the standards of due process are being honored in criminal trials we should be gratified; but the continuing availability of the federal remedy is in large part responsible for that result. What is involved, however, is not just the enforcement of defined standards. It is also the creative process of writing specific content into the highest of our ideals. So viewed, the burdensome test of shifting the meritorious from the worthless appears less futile. . . ." Schaefer, *supra* 147, pp. 25-6.

I think Justice Schaefer would agree that his thought is more often articulated in terms of "it is better to let a *hundred* guilty men go free than to convict one innocent." *See* Kadish. Methodology and Criteria in Due Process Adjudication—A Survey and Criticism. *Yale L. J.*, 66:319, 346, 1957.

149. Williams, p. 318.

A Vietnamese View

Vietnamese Pro-Life Traditions

by Bang Phi Nguyen

Destroying life under any form, especially human life, goes deeply against Vietnamese cultural and religious traditions. The Vietnamese word *hieu sinh,* which literally means pro-life, represents by coincidence a foundation cornerstone common to Buddhism and Confucianism. And the Buddhist doctrine and the teaching of Confucius have been for some two millennia of Vietnam's recorded history the ethical basis of Vietnamese society.

Gioi Sat (Do not kill) is one of the five commandments in Buddha's teaching and the Buddhist dogma of reincarnation brings the respect for life to the transcendental level which requires that the *gioi sat* apply not only to human beings but also to all forms of animal life and at every stage of life—born and unborn. In its popularized form the Buddhist doctrine teaches followers not to kill any living creature that has eyes. It also forbids monks to use anything of animal origin which results from or involves directly or indirectly the destruction of animal life. Thus Buddhist monks in the orthodox tradition may not wear sandals or shoes made of leather and a strictly vegetarian diet is the hallmark common to all Buddhist sects no matter how divergent they are on other dogmatic matters.

In its deepest meaning however the Buddhist reincarnation doctrine makes it unmistakably clear that life should be respected at every stage because the essence of life itself is an uninterrupted process of resurrection and renewal which allows man to purify his *Dharma* and attain absolute happiness (*Nirvana*). In this continuous process the indestructible essence of life is reincarnated the moment the act of being physically conceived is accomplished. There is therefore no controversial debate among Buddhist thinkers in regard to the status of life which they believe to exist at every stage in the physical development of the conceived. The notion of *Dharma* (or *Nghiep* in Vietnamese) has no equivalent translation in the language of western philosophy. It deserves some elaboration in this context however as it is closely related to the pro-life teaching of Buddhism. Essentially it means the combination between the destiny of man and his intrinsic power to control it through the self-purification process of reincarnation. That power is built on the belief in the *Nhan Qua* (seed and fruit or cause and effect) Law. Under this law the course of a man's life in the present and the degree to which he can enjoy internal happiness is the result pre-determined by what he did in his past, pre-incarnated life, and at the same time sows the seed for his future, reincarnated one. Man is taught to continuously seek to improve himself in order to shorten this vicious circle of the *Dharma* and reach early attainment to absolute happiness (*Nirvana*). Thus the Buddhist belief that life as the way to the *Nirvana* is every man's unalienable right is at the root of Buddhism's pro-life attitude.

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In Vietnam for many centuries that attitude has been greatly strengthened by the Confucianist concept of "charity" which prescribes the respect for old age and human procreation. The humanistic nature of Confucius' teaching emphasizes kindly feeling in the relationship among all men to begin with that between father and son. Thus the quasi-religious cult of ancestors which is an age-old and typically Vietnamese tradition is based at least in part on the Confucianist concept of filial piety. The Vietnamese believe that human procreation is a duty towards their ancestors and Vietnamese law throughout history encourages and upholds respect for life at every stage. One popular saying dating back from time immemorial cites three crimes a man should not commit against his parents and ancestors, the most serious one being to have no children.

The usually large size of Vietnamese families therefore cannot be explained by the materialistic notion that human labor is the only resource known to a backward, rural economy. Quite the contrary, the Vietnamese peasants, as many of their popular sayings go, are quite aware of the fact that large families require more sacrifice of personal well-being and more hard work. They have always considered manpower only as the third-ranking factor, after Heaven's will and nature, which determines the success or failure of their constant effort to survive in an environment once regarded as poorly endowed, often afflicted with acts of God and threatened by a powerful neighbor to the north.

To what extent does the contemporary Vietnamese society still respect these age-old pro-life traditions? There is no precise picture of population trends in Vietnam where the latest demographic survey was made during World War II. The first attempt to regulate population growth, in both North and South Vietnam, was introduced less than ten years ago (in or around 1967). In the South the so-called "mother's health care units" where birth-control facilities (including, in many cases, abortion) were provided free of charge, started being established in public hospitals and dispensaries in 1968. The number of these units, according to official reports, had proliferated from about half a dozen that year to about 100 by 1974. Regarding the situation in North Vietnam not much is known by the outside world on this sensitive subject apart from the "two delays" slogan which often appears in the official newspaper. This slogan exhorts the younger generations to delay getting married and once married, delay having children. In the South there were no precise statistics on birth control, but it was commonly recognized among officials concerned with the matter that even in the cities, only the relatively sophisticated people, and a very small portion of them, practiced or were conscious of birth control in recent years. Birth control pills were freely imported and sold in drug stores almost openly to anyone without the need of a doctor's prescription. The law in South Vietnam however, part of it dating back over two hundred years, provided for severe penalties to both parties involved in an abortion and prohibits the sale and distribution of artificial birth-control devices. There is no solid ground to speculate on the thinking of the average peasant in North Vietnam's paddy field on this subject. But in South Vietnam, up until last year at least, the age-old pro-life traditions were still very much alive. The idea of terminating a pregnancy is still abhorrent to the general public and in early 1974 when it became known that abortion had been administered by the largest public hospital in Saigon there was an outraged reaction from the press of every political shade. In this context it can be recalled without any political connotation that, quite unsuspectedly, one of the little-noticed but decisive factors which

greatly contributed to the decline of former President Thieu in the last year of his regime was directly related to the issue of birth control and abortion. In early 1974 Thieu's (majority) Democracy Party spearheaded an effort to introduce (and have the National Assembly pass) a bill making birth control and abortion legal. The effort was thwarted as it encountered strong reaction from a large cross section of the public, especially religious groups, both Buddhist and Catholic. It was the first time a legislative move by the Democracy Party failed to become law and in many ways this unhappy episode served as an impetus to the opposition movement which erupted later that year in which religious groups of various denominations played a dominant role.

The extended family institution so common among the Vietnamese refugees now living in this country actually is the result of what is still a strong belief that the ability for three or four generations to live under one roof is a heavenly blessing. These refugees mostly come from a traditional, conservative Vietnamese background. It is therefore rather unfortunate that in their first encounter with the U.S. they were given the impression that birth control and abortion were common practice in American society. According to testimony before the House Committee on Immigration, Citizenry and International Law (on January 12 this year), in four months, from May to September 1975, no less than 79 abortions were carried out on refugee women in the four refugee camps, including 19 at Fort Indiantown Gap, and 57 at Camp Pendleton. Extrapolation of official refugee population statistics concerning that period of time shows that there was one abortion to about every 50 refugee women of child-bearing age. There was of course no physical coercion. But given the special circumstances and the tremendous psychological stress suffered by these women during and after their escape from Vietnam, it is questionable whether they agreed to abort their unborn children through an act of lucid judgement. Many of these women at that time did not know the whereabouts of their husbands, who may have been stranded in Vietnam. It is also quite possible that the traditionally submissive Vietnamese woman under such circumstances could misunderstand the family planning counselor by assuming that abortion is not only an authorized but even desirable alternative.

Report From Czechoslovakia

Medical Consequences of Induced Abortion and Its Effect on Subsequent Pregnancy

Alfred Kotásek

A liberalization of the legally accepted indications for artificial termination of pregnancy is apparent internationally; the number of countries with more liberal abortion laws increases from year to year, not only in Europe and in the United States, but in many countries of Asia and Africa and in Australia, too. In many countries with tough anti-abortion laws—France, Italy, *et al.*—a nationwide move to liberalize abortion laws has been started with the support of many doctors, deputies and institutions.[1]

One aim of the more liberal abortion laws has been to get rid of illegal abortions with all their bad consequences. The backstreet element has been greatly decreased, but many of the bad consequences remain. Legal abortion has undoubtedly diminished the number of maternal deaths and reduced some serious complications, but a great sum of serious morbidity following legal artificial termination of pregnancy has been noticed and described in many reports.

Evaluating the consequences of artificial pregnancy terminations, we find that the prevalence of morbidity reported by many writers from different countries depends upon *how long* the women concerned are kept under surveillance after the operation. The longer the surveillance the higher the morbidity reported (Wynn, 1972). Most clinics lose sight of their patients very soon after the operation and never see them again; morbidity details registered during this short period are of very limited value. Only long-term studies, including the subsequent period of pregnancy, will add to our knowledge. No wonder that early complications are found in about 5-10% whereas permanent or "longer-term" complications are recorded in 15, 30, 50, or even 70% of all women who undergo abortions.

In our opinion there are three groups of women that warrant separate consideration from many medical, social and legal angles:

1. women who may or will have children subsequently;
2. women who do not wish to have additional children;
3. teenage/adolescent patients.

There is good evidence that abortions late in pregnancy are associated with higher morbidity and greater patient stress than are those performed earlier (Mallory, 1972), and that the consequences are definitely higher in *primigravidae* than in *multigravidae*. According to our law (in Czechoslovakia) artificial termination of pregnancy on social grounds (i.e., non-medical) is not permitted if the period of gestation exceeds twelve weeks: our experience concerns close to two million legal first-trimester abortions over a period of 17 years. In contrast, the complications of mid-trimester abortions are reported primarily from foreign sources and summarized separately. The morbidity of legal abortions seems to be directly related to the type of procedure undertaken.

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Morbidity and mortality following legal abortion.

A. *First trimester abortions.*

1. Immediate complications
   - –death following induced abortion
   - –excessive blood loss
   - –injuries to the cervix
   - –perforation of the uterus
2. Early complications
   - –fever
   - –bleeding
   - –retained products of conception
   - –infection of endometrium and myometrium
   - –"the postabortal pain syndrome"
3. "Long-term" complications
   - –chronic inflammatory conditions of the genital organs/latent inflammatory conditions of the genital organs
   - –menstrual disorders
   - –psychological and psychiatric complications
   - –disorders of sexual life and behavior
   - –sterility
4. Latent morbidity becoming apparent during a subsequent pregnancy
   - –extra-uterine pregnancy
   - –iso-immunization (Rh, ABO)
   - –spontaneous abortions; mid-trimester abortions (cervical incompetence)
   - –increase in perinatal mortality (stillbirths)
   - –increase in premature births
   - –greater frequency of hemorrhage during pregnancy
   - –longer average duration of labor
   - –retained and adherent placentae
   - –severe hemorrhage at parturition

Early complications

The *mortality* from legally induced abortion was about 16 per 100,000 in England and Wales in 1970; six out of fourteen deaths followed induced abortion at less than twelve weeks gestation (M. Wynn, 1970). Mortality is largely confined to abortion with sterilization, and to second-trimester abortion, while that attributed to first-trimester aspiration or dilatation and curettage, without sterilization, is about 3 per 100,000 abortions, according to a document entitled "Legal abortion in Britain," published in November 1972 (TPPF Medical Bulletin, 7.7, 1973-February), fully consistent with the more extensive Eastern European data. In Czechoslovakia there have been 20 maternal deaths in connection with artificial termination of pregnancy in a period of ten years, including about 1,000,000 induced abortions, one-half of them due to the primary maternal disease. Recent data are more favorable. At the same time 116 women died in connection with an illegal abortion, the ratio being about 1:6. Nowadays complicated illegal abortions are rarely seen in this country.

Excessive blood losses are recorded mostly in mid-trimester abortions and will be discussed in the following section. In first-trimester abortions by means of

vacuum aspiration the amount of the blood lost per operation has been estimated in thirty-five cases (Holmberg, *et al.*, 1972); the total blood loss during the aspiration was calculated at 175 ml. There was a significantly higher hemoglobin loss at an aspiration in the eleventh week of gestation than in the tenth week. In contrast, excessive bleeding in 21% of cases and transfusion in 18% have been registered in a detailed study in an Australian state; vacuum aspiration (77%) or hysterotomy (20%) were the usual procedures employed (Miller, 1973). According to our experience blood loss during the operation necessitating blood transfusions is exceptional.

Injuries of the cervix are of three kinds:
a) lesions from forcible dilatation;
b) injuries caused mainly by infection;
c) cervical incompetence.

From results in different papers it can be inferred that the damage to the cervix is far from a rare event. It has been found in 0.5% among 10,000 induced abortions till week twelve (Žák, 1970), and in 0.36% among 6,500 artificial terminations of pregnancy (Nesit, 1970). X-ray examination 22 to 81 months after the injury during operation revealed an abnormal shape of cervical canal and a defect in the location of the scar (Nesit, 1970).

The most significant morbidity of early uterine evacuation is *uterine perforation*. Their number differs according to method employed, experience, length of gestation, etc., from 0.12% (Nesit, 1970), about 0.2% (Kronus, 1970, Mehlan, 1970, etc.), 0.35% (Žák, 1971), to 0.81% (Miller, 1973). Conservative and operative treatment is successful in most cases, but sometimes hysterectomy is needed and even death can occur.

Late hemorrhage after unrecognized ruptures of the uterus in interruption of pregnancy may be fatal owing to blood loss and infection (Andrýs *et al.*, 1970).

Fever (*pyrexia*) appears sometimes soon after the operation (19%, Žák, 1970), and is of short duration, but sometimes lasts for several days (15%, Žák, 1970). Pyrexia is described as one of significant complications occurring after vacuum aspiration in 15% (Miller, 1973). The incidence of fever attributable to laminaria tents used as the primary means of cervical dilatation in 500 patients having abortion by suction curettage was 2.2%, but antibiotics were used in another 5.2% of patients for "fever of unknown origin" (Newton, 1972).

Uterine bleeding necessitating readmission has been noticed in 1.3% of 750 induced abortions (Houdek *et al.*, 1970), and in 3.5% of the patients from 10,000 artificial terminations of pregnancy (Žák, 1970).

Retained products of conception were found by repeated curettage in 4% of 10,000 induced abortions (Žák, 1970). Some authors found that vacuum aspiration did not remove fetal bones reliably after ten or eleven weeks of gestation (Stamm, 1972, *et al.*). Sometimes heterotopic tissue in the uterus is discovered without logical explanation; however, the instrumental implantation of fetal tissues during cervical dilatation and endometrial curettage associated with an abortion does provide such an explanation for the presence of these heterotopic tissues (Newton, *et al.*, 1972). In 37 women having had induced first-trimester abortion the endometrium has been microscopically examined following first menstruation; no clinical symptoms have been noticed. In nearly 1% of the samples examined small retained particles of fetal tissues have been recognized. It

appears that without any clinical symptoms latent morbidity from retained small products of conception may exist (Benešová, *et al.*, 1970).

Infection of endometrium and myometrium develops very soon after the operation, mostly in three to four days (Diviš, *et al.*, 1970); inflammation of other pelvic organs may become apparent later. Immediate acute inflammatory complications occur in about 5 to 10% of cases; at least 2 to 5% of patients require readmission (Diviš, 1970; Sokolík, 1970; Houdek, *et al.*, 1970).

A syndrome of abdominal pain and tenderness several hours post first trimester procedures in an ambulatory abortion clinic (60,000 terminations of first trimester pregnancies), closely resembling the picture of uterine perforation, has been identified and is called "the postabortal pain syndrome." It is promptly relieved by resuctioning the patient. It is suggested that a significant coagulopathy resembling that previously described in second trimester abortion may be operative here (Nathanson, 1973).

"Long-term" complications"

Chronic and latent inflammatory conditions of the genital organs are subdivided into endometritus, endomyometritis, adnexitis, parametritis, describing inflammation, infection or damage to pelvic organs that are sometimes apparent soon after operation, but more often much later (A. Wynn, 1972). The late inflammatory conditions cannot be recorded in percentage, as a part of them is treated in hospitals (about 2 to 3%), another part of patients undergoes medical treatment in policlinics; a part of chronic inflammatory conditions is discovered by chance when the patient is examined for sterility or for another reason; in 30 women examined by X-rays several months after artifical termination of pregnancy the hystero-salpingographic picture revealed in six of them (20%) severe damage to pelvic organs (Láska *et al.*, 1970).

Disorders of the menstrual cycle after artificial interruption of pregnancy need to be followed up for a long period to add substantially to our understanding. When based upon only a short surveillance, the results can be misleading. In Czechoslovak papers disorders of the menstrual cycle were recorded in from 8.5% of patients after induced abortion (Macků *et al.*, 1970), to 70% (Dlhoš *et al.*, 1970). It is of special interest that these disorders have been observed especially in young women (under 20), who were in their first pregnancy.

Psychological and psychiatric complications. During the past decade, psychiatrists have undergone a gradual change of opinion regarding the psychiatric complications of induced abortions. Most normal women were found to react to abortions with mild feeling of depression without serious aftereffects.

The psychosomatic and psychological reactions of 75 women applying for a therapeutic abortion were compared to those of 33 women in the same state of pregnancy but not requesting an abortion. The applicants reported considerably more negative psychological reactions than the control subjects (Meikle, 1973). Another paper has attempted to place in perspective several possible psychiatric consequences of abortion. It concluded that psychiatric illness may range from neuroses to psychoses with depressive reactions and schizophrenia most frequent in occurrence. The epidemiological consequences of abortion may therefore become statistically relevant in the not too distant future with far-reaching public health significance (Gullattee, 1972).

This part we can conclude with the logical words of the Wynns:

> "There are no grounds for assuming that there are no long-term psychiatric sequelae of abortion particularly in those cases where there are physical sequelae or a latent morbidity becomes apparent in a subsequent pregnancy."

Quite a bit of attention has been devoted to *functional sexual disorders* following artificial termination of pregnancy. Among 200 women psychologically examined in connection with interruption of pregnancy more than 30% admitted lower or negative attitudes towards sexuality. More severely emotionally disturbed patients did not improve as much as those with lesser psychologic disturbances (Kolářová, 1970). Among 60 women examined by another author after induced abortion, 13% of patients previously normal announced mild or serious signs of frigidity, 5% of women even more serious disturbances (Kohoutek, *et al.,* 1970). Among 570 women examined following induced abortion 62% admitted no changes in sexual life, whereas 32% noticed a deterioration (Dlhoš *et al.,* 1970).

Sterility following induced abortions is a problem which can hardly be expressed in figures; women who do not wish to have further children would not attend a doctor to cure their potential sterility; some women are unlikely to have children at all. In different papers 2 to 5% of sterility following artificial termination of pregnancy is quoted (Rep. of Sweden Government Commission 1971); in Czechoslovak papers 1.3 to 7.4% of the induced sterility observed is connected with previous artificial abortion (Kohoutek, 1970).

Latent morbidity becoming apparent during a subsequent pregnancy.

A 100 to 150% increase in *extrauterine pregnancies* has been noticed in papers from different countries (Hall, 1970; Kotásek, 1971); liability to an ectopic pregnancy is another form of latent morbidity following an artificial termination of pregnancy. In a Czechoslovak clinic the number of ectopic pregnancies following induced abortion rose 2.3 times in comparison with previous years before the Abortion Law (Macku *et al.,* 1970). There is no predisposition in chronic inflammatory conditions, but in previous abortions (Cernoch, 1971).

The threat of *Rh-immunization and ABO incompatibility* from induced abortion is not negligible. Studies indicate that 5 to 10% of unprotected patients undergoing induced abortion become immunized to Rh. The risk increases quite steeply with the number of pregnancies, and depends also on the method of abortion used. When we compare the risk of feto-maternal transfusion and isoimmunization following abortion by curettage to that consequent on vacuum aspiration, a lower risk using vacuum aspiration has been found (Asztalos, *et al.,* 1972). In 300 Rh-negative pregnant women not already immunized in whom termination of pregnancy was undertaken in the eighth to twelfth week of pregnancy, in 18% of cases studied a feto-maternal transfusion of more than 0.25 ml has been found, which could effect sensitization of the mother (Bajtai, *et al.,* 1972). In another study Rh-immunization has been noticed in about 4% of Rh-negative women after early and late induced abortion (Goldman, *et al.,* 1973).

Feto-maternal transfusion was found to be significantly more common in ectopic pregnancy than in normal pregnancy of corresponding duration. Ectopic pregnancy, but never normal pregnancy in the first trimester, was sometimes as-

sociated with sufficient feto-maternal transfusion to cause Rh-immunization (Liedholm, 1971).

Patients requiring an induced abortion should be tested serologically prior to the procedure and prophylactic administration of anti-Rh immunoglobulin is indicated in all Rh-negative women undergoing induced abortion (Goldman, 1973). Also in ectopic pregnancy in an Rh-negative, non-immunized woman administration of prophylactic anti-D gamma globulin as early as possible after the operation is indicated (Liedholm, 1971).

A high incidence of *spontaneous abortions* results from interruption of pregnancy. In a detailed study from Prague it has been concluded that only 57% of pregnancies following an induced abortion terminated in a term delivery: the abortion rate was 2.2 times higher than "normal" (Fuchs *et al.,* 1970). In another Czech paper the abortion rate following induced terminations of pregnancy is estimated as high as 18.3%, infertility 20% (Lane, *et al.,* 1970). Especially striking is a high incidence of *cervical incompetence* resulting from interruption of pregnancy. Incompetence of the internal cervical os as a prominent etiologic factor in late abortions and premature deliveries has been well established. A tenfold increase in second trimester abortions in pregnancies that followed an induced abortion has been explained by cervical incompetence (Wright, 1972). There are many papers from eastern and western countries associating cervical incompetence and induced abortion (Barter, 1967; Naver, 1968; Fuchs, 1969, 1970; Dráč, 1970; Wright, 1972; Palmer, 1972; Yosowitz, 1972, etc.). It has been demonstrated that incompetence of the cervix was a rare cause of a group of second trimester abortions and premature deliveries before the year 1958 in Czechoslovakia, when the law concerning artificial termination of pregnancy was passed, but ten years later a high incidence of mid-trimester abortions has been noticed (Fuchs, 1969); mid-trimester abortion was two to five times more often than in the group without induced abortion (Fuchs, 1970; Dráč, 1970). In the last two years nearly all women with mid-trimester abortions admitted an artificial termination of pregnancy at week eleven or twelve, when asked repeatedly (Fuchs, unpublished).

A very high standard of ante-natal care from the end of the first trimester for all women who have had a previous artificial termination of pregnancy is advisable with digital examinations of the cervix; after a previous mid-trimester abortion digital assessment of the cervix is essential every week or at least every two weeks. The cerclage method as advocated by Shirodkar (1955) and modified by others (McDonald, 1957; Barter, 1958; Ritter, 1961, etc.) is quite simple and the results of the treatment are good regardless of the method used (Naver, 1968); 60 to 85% good results, with improvement of fetal salvage of from 15 to 80% have been reported (Raphael, 1966). But the rate of premature deliveries is higher in the sample with operations than in the control group and thus perinatal mortality is increased (Man, 1972). Besides, when following the pregnancies after cerclage method by diamino-oxidase titres (Weingold, 1968), or by HCG titres (Fuchs, *et al.,* 1969) it has been demonstrated that in many instances the enzyme titres and the hormone titres dipped after the operation; this suggests that the incompetent os syndrome may be associated with a biochemical alternation in the fetoplacental unit (Weingold, 1968). Preliminary data on a series of sixty-three subjects with the incompetent os syndrome indicates that approximately 30% of the surviving infants born of these pregnancies had abnormal neurologic

findings at one year of age (Fourth World Congress FIGO, 1966, cited by Weingold).

The higher *prevalence of prematurity* in subsequent pregnancies following induced abortion has been reported by many authors (Klinger, 1970; Stallworthy *et al.,* 1971; Kotásek, 1971; Łembrych, 1972). In Czechoslovakia, Dráč *et al.* (1970) reported a 40% increase in premature births in women after one artificially terminated pregnancy and 70% increase after more than one induced abortion. In Hungary the prematurity rate rose from 14.4% following one induced abortion to 20.5% following three or more interruptions of pregnancy (Horský, 1971). Different handicaps such as cerebral palsy, epilepsy, mental deficiency and behavior disorders are very often associated with complications of pregnancy, particularly prematurity (M. Wynn, 1972). It is of interest that during the six years following the liberalization of abortion in Japan the infant death rate from congential malformations increased by 43% (cited by M. Wynn, 1972). In Czechoslovakia, where about 2,000,000 artificial terminations of pregnancy have been performed, no increase of congenital malformations has been noticed.

The percentage of stillbirths and premature births among the women with previous abortions was double that of the control group—total of both groups, 8,312 women (Pantelakis, *et al.,* 1973). In another study among 5,000 babies the incidence of prematurity was more than twofold in women with one or more induced abortions (Papaevangelou *et al.,* 1973).

Specific damage to the endometrium in induced abortion may result in *defective implantation* and in consequence in *faulty development of the placenta.* This may be connected not only with troubles at confinement, but with placental insufficiency and with various complications such as retained and adherent placentae, or severe hemorrhage at parturition. A significant increase in the duration of the third stage of labor in pregnancies preceded by a previous abortion has been recorded in several papers (Hofmann, 1968; Laně, 1970). Retained and adherent placentae were found in Czechoslovak papers in 1.5 to 1.7% of deliveries (Koutský, Hodr, *et al.*). After deliveries preceded by a previous abortion there was a higher percentage of adherent placentae: 3.8% (Slunský, 1964). In the period before the abortion law this complication was noticed in 1.2% of deliveries; in the years following the abortion law an increase up to nearly 2% has been recorded (Brutar, Fuchs, 1970). Severe hemorrhage was more often in the third stage of labor following induced abortion (Heczko, *et al.,* 1970, Łembrych, 1972).

Mid-trimester abortion

The findings of the Joint Program for the Study of Abortion (U.S.A.) have confirmed and quantified the differential risk of early complications between abortions in the second and first trimester, late abortion being about three to four times more risky than early abortion (Tietze, 1972). There are now many techniques for the induction of abortion and the operator must choose the one which is appropriate for his patient after considering all the relevant facts (Gillespie, 1973). For the mid-trimester pregnancy the use of hypertonic solutions injected intra-amniotically requires extreme caution to be safe for the patient. The intra-amniotic injection of hypertonic saline (20% sodium chloride solution) is now a well-known technique for inducing abortion (Aburel, 1938; Bengtsson, 1962; *et al.*); in Eastern Europe hypertonic glucose (Kovacz, 1948) or Rivanol with

Albucid (Manstein, 1951) is preferred (Vido, *et al.*, 1970; Chalupa, 1970).

Some of the hypertonic saline may be injected into the maternal circulation rather than into the amniotic fluid and this can prove fatal (Wagatsuma, 1965; Cameron, 1966). The potential dangers of a rise in serum volume and sodium content after injection of intra-amniotic hypertonic saline in the patient with poor cardiac or renal function and in toxemia have been pointed out (Turnbull, Anderson, 1966), and convulsions, coma and cerebral damage have been described.

Postabortion complications included: retained placentae, fever, hemorrhage with blood transfusion (Stim, 1973—612 saline abortions). Extensive experience with 3,564 saline abortions resulted in an initial complication rate of 7%, and 2.7% of the patients returned with late complications (Bellard, 1972). Among 911 women who underwent saline abortions fever developed in forty-four (4.9%) and one woman died of staphylococcal septicemia ten days after having a saline abortion performed in a hospital (Berger, 1973). The incidence of febrile complications was found to be 18.5% (Steinberg, *et al.*, 1972).

The mean injection abortion interval is about 33 ± 13 hours (Ballard, 1972; Stimm, 1973); excessive bleeding was almost three times as common, and retained placenta was more than four times as common, when instillation abortion time was longer than 22 hours (Bracken, 1972).

Many publications report on *changes in maternal coagulation factors* following the intra-amniotic injection of hypertonic saline. Evidence of transient disseminated intravascular coagulation was presented in the four cases studied (Stander), and cases of DIC with severe bleeding were reported (Sedaghat, 1972; Schwartz, *et al.*, 1972; Spivak, *et al.*, 1972; Badraoni, *et al.*, 1973). In another paper defibrination syndrome after intra-amniotic infusion of hypertonic saline has been studied and highly significant decreases in platelets, fibrinogen and factors VIII and V were observed; it would appear that a generally mild and self-limited form of diffuse intravascular coagulation develops after intra-amniotic infusion of hypertonic saline; in some patients, this defibrination process may result in a clinically significant bleeding diathesis (Weiss, *et al.*, 1972; Schwartz, *et al.*, 1972).

In one woman of a group of 23, extensive *myometrial necrosis* leading to hysterectomy occurred after the injection of hypertonic saline to terminate pregnancy after prostaglandin F2 alpha had failed to induce abortion. Myometrial necrosis was produced in pregnant rhesus monkeys by the injection of hypertonic saline (Wentz, King, 1972).

A number of instances of abortion occurring through a *posterior uterovaginal fistula,* bypassing an undilated cervix, after the intra-amniotic injection of hypertonic saline in the second trimester of pregnancy has been described (Berk, *et al.*, 1971), and severe damage to the cervix after intra-amniotic injection of 80g urea dissolved in 100 ml of normal saline into the amniotic cavity has been reported (Bradley-Watson, *et al.*, 1973). Cervical fistulas, which apparently resulted from mid-trimester abortions have been described (Goodlin, *et al.*, 1972).

Artifical abortions have been successfully performed in midterm patients by inducing mechanical stimulation of the uterus by placement of laminaria tents in the cervical canal and a metreurynter into the lower uterine cavity to give a mechanical stretch (Manabe, Nakajima, Griggs, 1973).

The prostaglandins (especially the newer analogues) show great promise as a one-shot technique (Gillespie, 1973). After extra-amniotic injection of hypertonic

saline prostaglandin F2 alpha is released into the amniotic fluid (Gustavii, Green, 1972).

The 15 methyl analogues of PGE_2 and PGF_2 are resistant to degradation by the enzyme 15-hydroxy-dehydrogenase and they display increased potency, prolonged duration of action, fewer side effects and greater safety (Amy, Karim, *et al.,* 1973).

The incidence of fever, vomiting and diarrhea is dependent on the route of administration and on the dosage (Wentz, *et al.,* 1973). Moderately severe bronchoconstriction was noted clinically during infusion of PGF_2 to a patient with history of bronchial asthma (Fishburne, 1972).

Conclusions

It can be concluded that artificial termination of pregnancy increases subsequent spontaneous abortions, especially midterm abortions by latent cervical incompetence, the proportion of premature births, ectopic pregnancies and produces a number of complications affecting subsequent pregnancies. In addition, abortion frequently reduces a woman's future reproductive capability, and affects her emotional and sexual life. Abortion cannot be regarded as a safe and simple contraceptive method, but as a back-up to be used when family planning fails.

Late abortion being about three to four times more risky than early abortion, it should be recommended to terminate the pregnancies on social grounds before week thirteen. When there is a substantial risk that continuation of the pregnancy would gravely impair the health and life of the mother, abortion should be induced as soon as possible. Abortion must never be allowed to replace adequate preventive care, such as sex education in schools and education for planned and conscientious parenthood, and contraceptive measures.

NOTES

1. For the French development, cf. Harold O. J. Brown, "Abortion on Demand in France?" in *Human Life Review,* Vol. II, No. 1 (Winter, 1976), pp. 64-73.

Letters (*cont.*)

most materialistic case against it—may end up costing me a great deal of money if she is still legally my responsibility. I think you should go deeper into this whole parental-consent area, because I am sure that the general public is wholly unaware of the many ramifications.

Pelham, N.Y. JAMES W. O'BRYAN

Not So Simple Opinions

A deeply negative reaction to an abortion by women who either take the operation for granted as a legal right, as is common now, or who considered it a blow for the cause of women's liberation a few years ago while it was still risky or difficult to arrange, is probably universal, even though not often publicly-expressed for obvious reasons. Suzanne Gordon isn't just an isolated example of a too-sensitive women, who perhaps just hasn't been liberated *enough.* In the early 70's in Cambridge, I talked to several women who had had abortions. The atmosphere of "women's caucuses" which often met to discuss ways of propagandizing the "right to our bodies," also encouraged emotional, open discussion between participants; that was the sisterhood part. I don't think anyone ever really thought of an abortion as a "positive experience," even those who advocated it most agressively. In private, when the ideological act sort of faded out, I remember one or two particularly who felt themselves to have been deeply scarred, and had struggled, in one instance for months, with a tragic sense of sadness. Last summer, my roommate confided that she had had an abortion—expecting the kind of blasé, abstracted response that is usual in conversation. We had never discussed the issue, and since by then I had come to think of the abortion movement as totally wrong and destructive, my unpremeditated reaction was a sort of sympathetic wince. The rapport between us for a moment was absolute—that it was a profound grief in her life, and a terrible reality for her still.

New York City NAME WITHHELD

Re Fetal Experimentation

In his article "Medical Ethics" (HLR, Winter '76) my friend Paul Ramsey may have given the impression that I am unopposed to indiscriminate fetal research procedures prior to abortion. I trust my views on the subject are by now well enough known to obviate any such impression. It is simply my view that it is somewhat quaint to see all sorts of people who have no qualms about decapitating a fetus with a curette on grounds of convenience express all sorts of doubts about giving it a drug beforehand. As for myself, I could do neither, even before a spontaneous miscarriage. As I have stated in print many times, I do not believe one's impending death, whether spontaneous or induced, is sufficient warranty for being experimented upon.

Georgetown University

ANDRÉ E. HELLEGERS, M.D.

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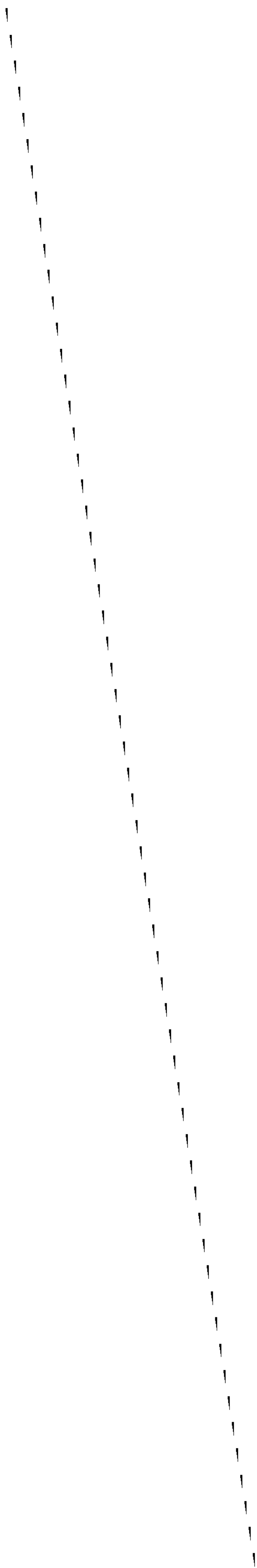

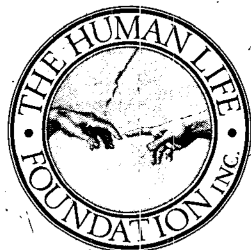
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