1: Introduction

A. The Complexity of the Euthanasia Debate

Across the United States and throughout the English-speaking world an intense debate concerning euthanasia is underway. In many ways this debate is reminiscent of the debate over abortion. The participants are much the same, and the lines of argument advanced by each side invoke familiar basic principles and strategies. However, the issues related to euthanasia are far more numerous and complex than are the issues related to abortion.

The complexity of the euthanasia debate is obvious as soon as one considers together and attentively various facts which have been mentioned in the news at different times in recent years.

On the night of April 15, 1975, Miss Karen Ann Quinlan, a twenty-two-year-old New Jersey resident, stopped breathing for some minutes. She was taken to a hospital by friends and at first seemed completely unresponsive. But within a few weeks her condition changed. She did not regain normal consciousness, but she did show two different conditions: a sleeplike and an awakelike unresponsive state. In the awakelike state Miss Quinlan responds to light, to loud noises, to painful stimuli; she yawns, blinks, grimaces, cries out, and makes chewing motions. But she seems totally unaware of anyone or anything about her.

Miss Quinlan seemed to require the help of an artificial respirator to breathe. After many months Miss Quinlan's father, Mr. Joseph Quinlan, reached the painful decision that the respirator ought to be discontinued. He, a Catholic, believed this course to be morally correct and was assured by his spiritual advisors that it is consonant with Roman Catholic moral teaching. On March 31, 1976, nearly a year after Miss Quinlan became unconscious, the Supreme Court of New Jersey appointed Mr. Quinlan legal guardian of his daughter, an act clearing the way for him to remove her from the care of the physicians who believed that the respirator had to be continued.[1]

As it turned out, the experts were mistaken in their opinion that Miss

Quinlan could not survive without the respirator, for she was successfully weaned from it, and—as this is written in March 1978—she continues to breathe.

Yet on October 2, 1975, Mr. Quinlan's attorney made a statement, subsequently retracted, in a document setting forth "Factual and Legal Contentions of the Plaintiff," that "under the existing legal and medical definitions of death recognized by the State of New Jersey, Karen Ann Quinlan is dead."[2] And so from the outset the case of Miss Quinlan seemed to many to revolve around the question: When is a person dead? In popular discussion the issue was sometimes formulated bluntly: Why keep a vegetable alive? As we shall see, the real issues in this case are complex and difficult. It is not easy even to formulate them accurately and clearly.

Another case illustrates the question of the determination of death. On May 24, 1968, Mr. Bruce O. Tucker, a fifty-six-year-old black laborer in Richmond, Virginia, fell and seriously injured his brain. He was taken to the Medical College of Virginia Hospital. Efforts were made to care for him, but by the next day his attending physician decided that Mr. Tucker would not recover and that death was imminent. In the same hospital a heart-transplant team had a patient to whom they wished to attempt a transplant.

Mr. Tucker was examined by electroencephalogram (EEG, or brain-wave recording), and it was determined that there was no evidence of activity in his brain. He breathed with the help of a respirator. The machine was stopped for five minutes, and Mr. Tucker did not breathe spontaneously. He was declared dead, the respirator restarted, and his heart subsequently removed with the permission of a medical examiner.

Mr. William Tucker, the patient's brother, was not far away in the same city, and his name and address were in the patient's wallet. But the brother was not contacted. He subsequently concluded that the "donor," Mr. Bruce Tucker, had been wrongfully killed, and so he sued the transplant team. Dr. David M. Hume, the head of the team, welcomed the jury's decision finding in the team's favor by saying: "This simply brings the law in line with medical opinion."[3]

The issue in this case clearly was: Was Mr. Bruce Tucker dead when his heart was removed? But even this issue is not simple. What is it to be dead, and how can one tell that death has occurred? Should the law allow what the transplant team did? And if the law concerning the determination of death is to change, ought this to be done by allowing medical opinion and practice to set precedents which afterwards will be approved or limited by decisions of juries and judges?

Willard Gaylin, a psychiatrist, has proposed that death be defined by the irreversible cessation of specifically human functions, that "personhood" and "aliveness" be separated in the adult as they have been in the fetus. By

redefining death in this way, spontaneously breathing human individuals might be maintained for months or years, and these bodies used and harvested for various medical purposes of benefit to others.[4]

If it would be acceptable to remove a still-beating heart for a transplant, can Gaylin's proposal be ruled out by law? If so, what principle distinguishes the cases? If Gaylin's analogy between the fetus and the adult were accepted and the present law of abortion granted as a point of departure, one might conclude that people who cannot take care of themselves and who will never, or never again, be able to function in a specifically human way are already dead, even if still conscious and responsive in some of the ways an animal is.

B. D. Colen has reported that at the Maryland Institute of Emergency Medicine (commonly called the Shock Trauma Unit) in Baltimore, where victims of accident and violence from all over Maryland and contiguous areas are flown by helicopter for intensive care, treatment has been discontinued for patients who were not in coma. Colen states:

> In fact, officials of the unit told me in 1974 that it was their policy to turn off respirators sustaining the life of quadrapalegics, patients completely paralyzed from the base of the skull down but patients who were, none the less, able to see, hear, think, and (but for the respirator tubes protruding from their throats) speak. These doctors rationalize that such patients can never live off the respirator, can never function for themselves in any way, are devoid of such basic reflexes as that involved in swallowing, and will almost inevitably succumb to infection and die within a few months of discharge from the unit. So rather than pass the buck to the patient's family, or a nursing home, the physicians in the unit allow the patient to die there.

And Colen makes clear that treatment is discontinued without the express consent of the patient, although the patient in these cases is capable of communication.[5]

Hardly anyone who commented upon the case of Miss Quinlan argued that she should have been maintained indefinitely on the respirator. However, many people probably would object to the discontinuance of treatment in cases such as Colen describes. How are these sorts of cases to be distinguished from each other? Is the critical factor the impossibility of asking Miss Quinlan what she wants and the possibility of asking this question of the patients in the Shock Trauma Unit? Or is an individual's exercise of liberty important? When a choice would be a very hard and painful one for a patient to make, is the only important factor the avoidance of prolonging a life artificially under adverse conditions and with poor prospects for future worthwhile activities and experiences?

B. Complex Factors Generating the Issues

Not only are the issues related to euthanasia highly complex but so are the motives and causes which are making these issues so pressing. It would be disastrous to oversimplify the roots of the movement for euthanasia. There are legitimate concerns which must be dealt with. Those with good motives for seeking changes in the law must be heard sympathetically.

It is often said that medical advances themselves create many of the problems. There are several senses in which this is true.

First, the use of the respirator can create a state of affairs in which some of the traditional criteria for death are clearly met while others clearly are not met. The question then arises: Is this patient dead or not?

Second, improved forms of treatment maintain the lives of many very weak individuals who would in the past have died. For example, antibiotics prevent infections which formerly carried off many severely malformed infants and many inmates in public institutions for the retarded, the mentally ill, and the aged. Yet the prevention of death from infectious diseases does not restore such persons to full health. Society thus is faced with a larger proportion of individuals who continue to live but cannot function well.

Third, the development of any new form of treatment raises the question of whether or not it is to be used in specific sorts of cases. So long as nothing can be done, no decision has to be made. When something can be done, one must decide whether to do it or not. Thus, for example, when surgical intervention became possible to treat infants born with spina bifida cystica, a congenital defect resulting from the spinal column's two sides not unifying perfectly, physicians had a new power to treat or withhold treatment in each case. The problem of whether a new treatment is to be used in a particular case is especially difficult when the treatment is first introduced. For then physicians might have doubts about the value and side effects of the treatment; they also have little medical tradition to guide their judgments.

Besides these rather direct ways in which technical advances in medicine are creating new problems there is another, less direct, psychological way in which progress puts pressure on traditional attitudes toward death, sickness, and defectiveness. The more medicine has become an efficient technique, the more patients and physicians themselves expect of treatment. In former times medicine was expected to guide people to more healthful living, to help the body to heal itself, to help the patient to live with chronic disease and defect, and to relieve symptoms. Today, while much of a physician's work is necessarily still directed toward the traditional goals, there has been a revolution of rising expectations.

Just as one expects a mechanic to fix one's automobile or major appliance, to make it run according to specifications, so one is likely to expect one's

physician to intervene with a cure. For certain acute conditions dramatic interventions are possible. But the expectation is unrealistic for the dying, the chronically ill, the incurable, the irremediably defective. If an automobile or a major appliance cannot be restored to standard functioning, it is scrapped and replaced with an improved model. This mentality makes many people feel that the severely defective, the permanently insane, the declining aged are like abandoned vehicles, which no longer belong with the rest of us on the road of life.

Another way in which technical advances contribute to the problems related to euthanasia is that progress in medicine is one factor which continues to increase the price of medical care. Between 1950 and 1975 American health expenditures (public and private, social and personal) increased almost tenfold in dollars, from slightly over 12 billion to nearly 118.5 billion dollars. Part of this increase was due to inflation, but even as a proportion of gross national product, American health expenditures rose from 4.5 percent of GNP in 1950 to 8.2 percent of GNP in 1975.[6] Some of this increase was due to technical advances; some to other factors, including federal programs of Medicare and Medicaid.

Regardless of the cause of escalating health expenditures the fact of this escalation cannot be evaded. Even American wealth, vast as it is, remains finite. Resources are scarce and there are many legitimate demands for them. Health expenditures cannot continue indefinitely to consume a larger and larger share of the gross national product. This state of affairs is bound to lead to the question: Should not care be withheld from those who stand to benefit but little from it? If the answer is affirmative, the next question is: Should not those who are to be denied care be helped to die quickly, especially if they volunteer?

The fact that medicine has become less a personal art and more an impersonal technique, together with the increasing costs of treatment, leads in another way to demands for changes in laws related to euthanasia. In times past many patients trusted their physicians, the dying felt secure and cared for, hospitals were for acute care and not for the dying patient. Today many patients have little or no personal relationship with their physicians, do not trust them, and feel exploited when charged heavily for impersonal treatment. The dying often feel abandoned and betrayed. As more and more patients die in hospitals and other institutions,[7] dying and the conditions of dying often seem an affront to the dignity even of those who die first class. The demand to facilitate the exercise of patient autonomy is an understandable enough reaction.

Another factor which is generating pressure for euthanasia is that persons who cannot care for themselves are today a burden and are likely to be unwanted in ways in which they were not unwanted in the past.

On the one hand the nuclear family is changing. It is less stable due to rising divorce rates, more mobile due to economic demands and opportunities. The nuclear family is less likely to include an extra child who devotes a good many years to the care of other members who cannot care for themselves. The wife and mother is more likely to be working outside the household. Thus the family does not provide its own, built-in nursing service as it once often did.

On the other hand the very concept of nursing service seems to have lost much of its appeal. A normal, healthy child can be irritating enough; cleaning and feeding it every day, comforting it when it is ill, and putting up with its constant demands tax a parent's patience. But most parents still receive a good deal of satisfaction from the normal, healthy child and have high hopes for the unfolding person. Any dependent person other than a normal, healthy child makes greater demands, gives less satisfaction, and holds out less promise. Only a person who finds fulfillment in service to the bodily needs of another wants such a dependent.[8] Thus, understandably enough, whether rightly or wrongly, there is strong temptation to look for a final solution to the problem of the burdensome and unwanted person, who must otherwise be accepted as someone's charge and given someone's service.

When the family provided much of its own nursing service, the nearby community helped the family with a certain amount of charitable aid. Often this aid was not sufficient, and as the family changed and urbanization continued, voluntary charity became less and less adequate to the need for social assistance. Thus, largely due to genuine humanitarian concern, voluntary charity was more and more replaced by public welfare, and partly due to mass demands expressed in the democratic process, public welfare has more and more become the welfare state, further and further removing those who contribute from those who benefit, and separating the two sides by a vast bureaucracy. In the United States, the involvement of the federal government with the welfare of the aged and the disabled dates only from the 1930s.[9] The cost is immense.

C. The Mounting Burden of Public Welfare

The point can be seen clearly by considering escalating expenditures under public programs for social welfare, comparing 1950 with 1975. Here we exclude expenditures for veterans programs and for education; we include social insurance, public aid, health and medical programs, housing, and other social welfare.

In 1950 all levels of government in the United States spent a little less than 10 billion dollars for social welfare; this was 3.73 percent of GNP and 15.94

percent of all government outlays. In 1975 expenditures exceeded 191 billion dollars—13.3 percent of GNP and 39 percent of all government outlays.

In 1950 the United States federal government spent less than 4 billion dollars for social welfare; this was 1.52 percent of GNP and under 10 percent of federal outlays. In 1975 the United States federal government spent more than 140 billion dollars for social welfare; this was 9.75 percent of the GNP and 46.57 percent of federal outlays. (This compared with 1950 defense expenditures amounting to 4.7 percent of GNP and 29.1 percent of federal outlays, and with 1975 defense expenditures of 6 percent of GNP and 26.7 percent of federal outlays.)[10]

It is generally believed, and we shall provide some evidence for the belief, that the rising costs of welfare were a potent factor in the legalization of abortion. Killing the unborn who would otherwise become welfare recipients is one way of limiting increasing welfare costs. But the problem of welfare costs points beyond abortion to changes in the law which will expedite the death of dependent persons, especially of the aged and dying.[11]

D. A Proposal for Easing the Burden

As we shall show, defective infants already are being selected for nontreatment, sometimes for active nontreatment, which means the withdrawal of all food and fluids.[12] Many of the mentally retarded residing in institutions are afflicted with multiple handicaps.[13] Among these there surely are numerous individuals in worse condition and with poorer prospects than some of the infants who are being selected for nontreatment. The line between the mentally retarded and the mentally ill is not always a clear-cut one; the two groups often are mixed together in the same institution.[14] A large part, perhaps the majority, of aged nursing-home patients have psychiatric symptoms. In recent years many of the aged who formerly lived in mental hospitals have been moved to the cheaper nursing homes.[15] Thus, there is a practical continuum between the defective infants now being selected for nontreatment and the aged millions who are dependent upon public welfare expenditures of one sort or another.

In 1972 Walter W. Sackett, testifying before a United States Senate committee conducting hearings on "death with dignity," stated that severely retarded, nontrainable individuals in public institutions should be "allowed to die." In two institutions in Florida, he said, there were fifteen hundred such individuals, and it would cost the state 5 billion dollars to keep them alive artificially for a period of fifty years. He did not explain what was artificial about the means used to maintain these individuals. But he did extrapolate his figures to the nation as a whole, to claim that in the same period the cost would be 100 billion dollars.[16]

If Sackett were correct, it would cost 66,666 dollars to maintain each such individual per year. Actually, maintenance cost per individual in public institutions for the mentally retarded was 5,537 dollars in 1971. Even if allowance is made for the capital cost of buildings and equipment, Sackett's estimate was ten times too high.[17] Still, at the end of 1971 there were 180,963 residents in public institutions for the retarded in the United States. Some of these undoubtedly were temporary residents, but more than 75,000 such residents at the time of the 1970 census were at least twenty-five years old and had been resident for at least fifteen months.[18] Even at a reasonable estimate the cost of maintaining 75,000 persons in institutions would amount to one-half billion dollars per year.

Moreover, the 1970 census counted 393,460 persons in public mental hospitals, 277,453 resident for at least fifteen months. At the end of 1975, due to new modes of treatment, there were only 191,395 resident patients in such facilities. But the cost of their care is high—perhaps 1,000 dollars per resident per month.[19] At this rate, to maintain even 125,000 permanent residents would cost 1.5 billion dollars per year.

The maintenance of the aged is an even more costly proposition. In 1973–1974 there were nearly one million aged persons in nursing and personal care homes. The average monthly resident charge was 479 dollars. Nearly half of this was paid by Medicare and Medicaid, and another 11.4 percent by other public assistance. About two-thirds of these persons were over seventy-five years old. In fiscal year 1976 Medicaid charges alone for this purpose reached 5.3 billion dollars nationwide.[20] Clearly, the monthly charge was continuing to escalate.

To maintain dependent persons in institutions is extremely costly. And it is universally held that most institutions fail to provide minimally decent human living conditions.[21] Moreover, many dependent persons probably are maintained outside institutions only at considerable public cost and private difficulty.

For example, it is estimated that in 1970 there were 200,000 persons in the United States with Intelligence Quotients of 0 to 24, and 490,000 more with IQs of 25 to 49; more than one-half of these persons were over twenty years of age.[22] Again, among the aged it is estimated that there are twice as many bedfast and housebound persons living outside institutions as in them, and ten times as many aged persons living in poverty outside institutions as in them.[23]

If euthanasia were accepted as a solution to the problem of dependency, the public contribution to the support of all these persons could be terminated. Those without private means of support could be processed into public institutions and allowed or helped to die at minimal public cost.

It is hardly likely that the social costs of the dependent will be ignored in the political unfolding of the euthanasia movement. Every citizen would do

well to consider these costs and their relevance to the euthanasia debate, because the vast majority of today's population is potentially involved.

E. The Future Social Insecurity of the Elderly

Some may think themselves secure because they participate in private pension arrangements which seem sound and adequate. But inflation eats away at the value of annuities. Millions who built up sound and adequate funding for retirement in the 1920s and 1930s found themselves among the aged poor in the 1950s and 1960s. After World War II, retirement plans based upon equity investments (stocks) were developed; they held out great promise for a time. But in recent years the stock market has not kept pace with inflation, and many retirement funds, no matter how invested, have lost value in terms of constant dollars.[24]

To provide for one's old age in the face of inflation it would be necessary to save *more* during one's working years than one expected to spend during one's retirement, to take account of the negative effect of inflation which overbalances apparent earnings on investments. Invested money has never lost value over a long term; it seems impossible that the present situation will long continue. However, it is just possible that the very modern phenomenon of massive investment for retirement is going to falsify expectations based upon previous historical experience and seemingly sound theory.

Many people suppose that Social Security, which is now indexed, at least will provide a secure, minimum income for the elderly. United States Social Security was devised during the depression years of the mid-1930s as an attempt to prevent desperate poverty in old age, such as many then experienced. As originally devised, the plan mingled elements of insurance and of gratuitous public welfare assistance.[25]

However, the plan is altogether unlike insurance in two vital respects. First, participation for most people is not voluntary. Payments must be made, and are taken from the payroll, like other taxes. Second, there is no significant fund to balance the huge liabilities which Social Security has toward persons who will retire in the future. For all practical purposes the system is on a pay-as-we-go basis. The taxes collected each year are fully used in paying current benefits.[26] This system has worked until now because of the continuous economic and population expansion the United States has experienced from 1937 to 1977. But will workers in the future be willing to continue to pay the price?[27]

Already Social Security takes about 40 percent of *all* taxes on individuals—this figure includes the portion nominally paid by employers, since both portions ultimately are part of payroll costs from the economic point of view.[28]

In the 1930s there were 9.5 persons aged 20–64 for every older person; in 1975 the ratio had dropped to 5:1; in 2050, it is predicted, the ratio will have dropped still further to 3.5:1.[29]

Moreover, not all persons aged 20–64 are earning a taxable income. Currently there are about one hundred employed persons for each thirty retired persons, but those born during the baby boom of 1940–1965 will begin retiring in 2005. By 2030 there will be forty-five retired persons for every hundred who are working, an increase in burden of 50 percent. To finance this burden Social Security taxes will have to increase 50 percent over their present levels, perhaps to reach 20 percent of gross income. Such an increase would be especially burdensome to the middle class, whose marginal tax rate on an income (in current dollars) of 12,000 dollars would increase from 36 to 46 percent.[30]

The widespread fraud in Medicare and Medicaid, which are recently added public assistance programs of Social Security, threatens to erode public confidence in the whole program.[31]. Moreover, many people regard Social Security as radically unfair, and the public at large is likely to begin to share this view as the burden becomes greater. There are three main complaints.

First, Social Security taxes are at the same rate on the first dollar of the poorest worker's earnings as they are on the first dollar of the earnings of the wealthiest wage earner, and the total tax paid each year by the middle class worker is exactly the same as that paid by the wealthiest. Second, a retired wage earner must really retire to receive full Social Security benefits; a wealthy person can receive the full benefit together with an unlimited amount of unearned income from rents, investments, and other sources. Third, these characteristics might be justified if Social Security truly were insurance. But many charges against these funds cannot be rationalized as insurance.[32]

The facts about Social Security being what they are, no one should be confident that the program will do as much for the elderly in the coming forty years as it has in the past forty. At some point a large part of the currently employed might decide that they must look to their own future security and that they cannot count upon their children for it. This loss of confidence is likely to come about if the increasing burden of the retired leads to a reversal of the trend to improve their standards of living and health care. If wage earners project a downward trend to their own retirement years, the employed might decide to discontinue the intergenerational transfer payments of the Social Security system. The elderly, of course, would strongly oppose such a breach of faith—as it would seem to them. But they might not win.

As Robert N. Butler, director of the National Institute on Aging, has stated: "Americans suffer from a personal and institutionalized prejudice against older people."[33] In a youth-oriented society many older persons are forcibly disengaged from life and shunted aside. Burdened with increasing personal prob-

lems, they are expected not to be a burden to the young. Rather than being expected to grow and to contribute from the wisdom of their years, the elderly often are expected to be quiet, to go away, to decline and die quietly.[34]

Some point out, with a certain resentment, that elderly people, who are 10 percent of the population, receive 25 percent of expenditures on health care, while children, who are 38 percent of the population, receive only 9 percent of health care expenditures. Public programs, it is noticed, supply nearly 20 billion dollars of health care for the elderly—nearly two-thirds of their total health-care costs. The elderly receive per person about three times their proportionate share of the health-care service given the population as a whole.[35]

As one commentator has pointed out: "From the standpoint of social priorities, without regard for humaneness, the aged as beneficiaries of a public program and as recipients of public services (Medicare) represent a poor investment." He predicts that as pressures build up, side effects might include "a weakening of the taboo on the 'right to die.' " The chronically ill aged who need total care are likely to be shunted aside.[36]

Thus there are many factors which are making the issues related to euthanasia pressing. Not least among these factors is the growing burden of public welfare. But this factor is a double-edged sword. If Americans in the present generation begin to accept euthanasia as a means of lightening the welfare burden, they might just find that they have signed their own death warrant.

F. Killing as an Option No Longer Unthinkable

Killing on a massive scale has become a very common final solution to problems in the twentieth century.

World War I was fought brutally; it probably was the most destructive war in history up to its time. Under Lenin and Stalin, Soviet Socialism used mass killing as an instrument of political control and social transformation. Under Hitler, Nazi Germany adopted similar policies, adding the genocide of Jews. The Soviet Union was the first Western nation to legalize abortion; legalization has spread to much of the Western world, and is being carried to underdeveloped nations as a form of foreign aid.

World War II was fought even more brutally than World War I. Both sides used terroristic tactics, particularly strategic bombing, culminating in the American use of the atomic bomb on Japan to bring about unconditional surrender.

Guerrilla warfare and attempts to suppress it since World War II have refined terrorism, torture, and indiscriminate killing of military and civilian populations. Vietnam is only one example. Meanwhile, both the Soviet Union

and the United States have developed and maintain in readiness capabilities for thermonuclear war, which might in a few hours destroy a large proportion of the world's population. The American strategy is one of deterrence; the hope is that thermonuclear war will never be necessary. Close observers of the Soviet Union doubt that the commitment to deterrence really is mutual.[37]

Yet there is no reason to think that humankind is becoming less morally responsible. Indeed, much twentieth-century killing has been done in the name of high moral ideals. The communist nations, for example, declare that they are trying to liberate humankind from oppression and to establish a good and just society. Despite the cynical scepticism of liberal democratic commentators on the world scene, there is little ground to doubt the sincerity of many communists or their genuine dedication to the marxist ideal. The liberal democratic nations, likewise, declare that they are trying to protect individual liberty against totalitarianism; motives doubtless are mixed, yet there is genuine idealism here too.

How can high moral idealism lead to mass killing? The Indo-European religious tradition stressed the sanctity of human life. Life as such somehow participated in the divine; human life in particular was considered sacred through its close affinity with spirit, and with the ultimate principle of meaning and value in reality. This ultimate principle was taken to be timeless; humankind and human history were thought to go on within an established framework, whether or not this was understood as the providential plan of a personal God.[38]

Modern, post-Christian thought has a very different world view. An impersonal, spiritless, mindless universe of mass and energy is believed to evolve by natural necessity, void of meaning and value until life capable of cognition and desire emerges under the impetus of blind forces. Significance and purpose only emerge fully in humankind, where there is self-consciousness and the ability to undertake purposeful transformation of the universe. Hence, there is no objective realm of principles to which humankind must conform its plans and desires, no divine law to which human law must look for its principles. For post-Christian men and women the principles of human law are *human* desires and interests, needs and satisfactions, joys and hopes *alone*.

Human desire and satisfaction alike have their primary locus in consciousness. Self-consciousness is what distinguishes humankind. The body and its processes are of a piece with nature, except to the extent that the body and its functioning can be controlled, transformed, dominated, and reduced to obedience by technique. From this post-Christian perspective human bodiliness and human personhood are two very distinct realities; personhood is comprised only of what is distinctively human.

It follows that human individuals who have not had an opportunity to develop distinctive personalities—or who have lost the power to exercise

their distinctive personalities—hardly have the character of persons. The unborn, for this reason, seem to many only potential persons.

Likewise, from a marxist viewpoint the oppressed masses are so far deprived of personhood that mass killing for the sake of a future just society is not absurd; those killed now are only so many individual human bodies that can be used and destroyed so that the true men and women of the future can emerge. And from the liberal, democratic viewpoint the victims of totalitarianism are depersonalized; the people of southeast Asia, as well as the populations on which the missiles and their hydrogen bombs are targeted, are not persons because they do not have the liberty to develop significant personal lives.

Thus, for modern, post-Christian thinkers mass killing is acceptable as a final solution to human problems. Human life in itself no longer has sanctity. What is important is the quality of life, the extent to which an individual's life contributes instrumentally to the attainment and enjoyment of specifically human and personal values. Whenever some human individual's life is not of sufficient quality—whether measured from the individual's own perspective or from the perspective of society or both—that life becomes a disvalue. Such a life is unwanted because it is useless; it is evil because it is unwanted; it must be destroyed because it is evil.

To those who still believe in the sanctity of life the modern, post-Christian conception is unreal, almost incredible. It is hard to believe that a society which has committed itself so heavily to social welfare could turn about and systematically seek to limit and reduce the burden of welfare by mass killing. But the legalization of abortion is a fact. And abortion has been legalized on the basis that the unborn are not persons and can be destroyed if they are unwanted by the women who bear them and by society at large. Others who are unwanted differ but little from the unborn.

G. Public Confusion and the "Right to Die"

Thus far we have shown that the euthanasia debate is complex, far more so than the debate over abortion was. We also have shown that there are a great many social factors which make euthanasia a contemporary issue and which are likely to make it an even more intense issue in the future. Furthermore, there are aspects of the contemporary attitude toward human life which point toward the adoption of killing as a solution to social problems. In this state of affairs there is a real danger that proponents of euthanasia will reach their objectives before those inclined to seek other solutions have managed to sort out the issues, work out consistent and defensible positions on them, and advance attractive alternatives to euthanasia as a solution to problems.

In dealing with public opinion the clarification of the issues will be essential

if legalization of mercy killing is to be prevented. This can be seen from the results of two polls, one by Gallup and one by Harris, both taken in 1973.

The Gallup question was: "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it?" The response was 53 percent affirmative, an increase of 17 percent to the same question since 1950. (It is interesting to note that only 47 percent answered a 1974 Gallup poll that they favored the United States Supreme Court's ruling on abortion; the ruling was described in the question: "The U.S. Supreme Court has ruled that a woman may go to a doctor to end pregnancy at any time during the first three months of pregnancy.")

The Harris euthanasia poll asked two questions. "Do you think a patient with terminal disease ought to be able to tell his doctor to let him die rather than to extend his life when no cure is in sight, or do you think this is wrong?" To this question, 62 percent replied it ought to be allowed, 28 percent that it is wrong. Harris also asked: "Do you think the patient who is terminally ill, with no cure in sight, ought to have the right to tell his doctor to put him out of his misery, or do you think this is wrong?" To this question, Harris received only a 37 percent response that it ought to be allowed, while 53 percent said it is wrong.[39]

The different result of these two polls makes clear how a majority against active euthanasia can be converted into a majority in favor of it merely by submerging the distinction the Harris poll called to attention. One might imagine that the distinction between a patient's refusal of useless treatment, on the one hand, and, on the other, the application of deadly means by a physician at a patient's request would be clear to everyone. But this is not so. Proponents of euthanasia are making the most of such confusions.

In the United States a Euthanasia Society was founded in 1938. In 1967 it was making no progress toward its goal of legalizing at least voluntary euthanasia for adults. Members set up a new unit, the Euthanasia Educational Fund, to disseminate information. At or about the time this was done, Luis Kutner suggested the "living will"—something not as objectionable as mercy killing to the public at large, although not exactly what proponents of euthanasia had always sought.[40] The "living will" is a form letter, to be signed by adults, directing family and physician in case of terminal illness to avoid heroic measures or extraordinary means of treatment, and to give palliative care and permit natural death.

The Kutner proposal received much favorable publicity. Literature on death, dying, and euthanasia quickly began to burgeon. After the United States Supreme Court decisions on abortion early in 1973, much of the thrust behind the movement to legalize abortion seemed to pass over to the movement to legalize euthanasia.

At the beginning of 1975 the old Euthanasia Society was reactivated as the Society for the Right to Die, an action unit to press for legislation.[41] The Euthanasia Educational Fund and the Society for the Right to Die share the same office, and fifteen of the seventeen members of the officers and board of the latter organization in 1976 were among the officers, board, or committees of the former organization in 1974.[42] In 1975–1976 the Quinlan case was much in the news. This was what was needed to break the dam against legislation. The Society for the Right to Die vigorously promoted legislation for "death with dignity," advancing its own model bill.[43]

In 1976 California enacted the first such legislation, but the California law explicitly excludes mercy killing, extends only to competent adults, and asserts not a right to die, but only the right to refuse treatment so that nature can take its course.[44] However, in 1977, when more or less similar bills were introduced in the legislatures of forty-one states, seven additional states enacted legislation.

New Mexico and Arkansas were among these seven. Their laws do enact a right to die, extend the exercise of this to minors by means of proxy consent by a parent or guardian, and do not explicitly exclude (although they do not authorize) mercy killing.[45] The New Mexico statute is patterned on the model proposed by the Society for the Right to Die.[46] Even the more conservative California statute appears to be modeled upon the voluntary euthanasia bill which was debated by the British Parliament in 1969.[47] With only some simple amendments the California statute can become a law permitting and regulating killing with the consent of the one to be killed.

Many who doubt the wisdom of legalizing such killing believe that the proper course of action is to oppose the enactment of any legislation along these lines. Yet in California there was in the end little serious opposition to enactment of the statute. Most of those who opposed the legalization of abortion saw clearly what they wanted and did not want, and so they were able to react with vigor and unity, at least with respect to objectives. But now many of the same persons and groups are not sure where to draw the line with respect to euthanasia. The claim that people should have a way of controlling what is done to themselves is hard to reject as unreasonable. How can this claim be distinguished in theory and separated in practical politics from the legalization of killing with consent, and the authorization of absolute parental discretion concerning the nontreatment—and perhaps even the killing—of infants?

H. From Voluntary to Nonvoluntary Euthanasia

Even before the 1973 abortion decisions there was discussion of actual cases in which parents had refused treatment for their infants necessary to

preserve their lives, and physicians and hospitals had refrained from the treatment on the basis of the parental refusal, although the necessary treatment would otherwise have been given as a matter of course.

One such widely publicized case was at Johns Hopkins University Hospital; it occurred in 1963 but was not publicized until later. The infant was afflicted with Down's syndrome (mongolism) and needed a surgical operation, simple enough in itself, to remove an intestinal blockage. The parents refused consent; the physicians and hospital sought no court order; the baby starved to death in about two weeks.[48] A somwhat similar case occurred in a Catholic hospital in Decatur, Illinois, where a chaplain advised that there was no moral duty to undertake the extraordinary means of surgery upon an infant lacking a normal esophagus.[49]

Almost exactly nine months after the United States Supreme Court's abortion decisions two important articles appeared in which physicians at the University of Virginia Medical Center and Yale-New Haven Hospital described in some detail and defended their own practices of withholding treatment from newborn infants suffering from a variety of defects. The arguments for these practices were that the prospects for "meaningful life" were very poor or hopeless, that considerations of quality of life may in such cases prevail over what others would regard as the infant's right to life.[50]

An intense discussion, which we shall summarize in chapter nine, unfolded beginning about the same time concerning the selection for treatment and for neglect of infants born with spina bifida cystica. Untreated infants may nevertheless survive and, if they do, be in far worse condition than had they been treated intensively from the outset. For some who engaged in this discussion the implication was clear that neglect must be total: The infant selected for nontreatment must not be fed, although it was able to ingest food in a normal manner.

As early as May 1972 John M. Freeman of Johns Hopkins argued that if infants were to be neglected, their death should with better kindness be actively hastened.[51] The physicians at Yale-New Haven Hospital also subsequently argued that choices for death, also by active means, ought to be legally permitted.[52] Writing in the same prestigious medical journal in which the physicians publicized their practices of letting babies die, philosopher James Rachels argued that the distinction between active and passive euthanasia is unsound.[53] Some commentators who think the selective nontreatment of defective infants to amount to homicide by omission agree that in this case, at least, letting die is simply a method of killing.[54] On this view, nonvoluntary euthanasia is being widely practiced, admitted, and ignored by legal authorities in America and England today.[55]

Joseph Fletcher has argued that it is wrong—immoral and irresponsible—not to back up abortion with the measures required postnatally to end damage

in cases in which a child is born with Down's syndrome.[56] He published this view nearly five years before the United States Supreme Court's decisions concerning abortion. Since then more and more of those who argued vehemently that abortion was a very different matter from infanticide have proceeded from acceptance of the former to defense of the latter. The two practices do have a great deal in common.

Further, in the case of severely deformed infants maintained in custodial institutions, it has been argued that the alternative to kindly killing is banishment to a living death in a warehouse for human beings who are effectively reduced to a state of nonpersonhood by brutality and neglect.[57] Fletcher has pressed the view that individuals with an Intelligence Quotient below 20, perhaps also those with an IQ below 40, do not qualify as persons.[58] Again, as we shall see in chapter eight, others have joined him in this position.

Many who would not readily accept nonvoluntary euthanasia in other cases may be willing to accept it in the case of infants, for they are in a condition in which no adult ever again will be, and killing them—especially when the violence is concealed by the use of the method of calculated neglect—does not seem much different from abortion. Moreover, perhaps there are cases in which the omission of possible methods of treatment is morally acceptable and is, or should be, sanctioned by law. But if there are such cases, how can they be distinguished from others in which the neglect is simply a method of homicide, chosen merely because this method is not easily prosecuted as a crime?

Some who would reject nonvoluntary euthanasia even in the case of severely defective infants have a much more difficult time judging whether voluntary euthanasia might not be allowed for competent adults who give their informed consent to it. Clearly, here, a just respect for the person's right to life no more demands that euthanasia be forbidden than it demands that suicide and attempted suicide be considered criminal. For all practical purposes, suicide and attempted suicide are no longer held criminal in the English-speaking world. Why must those who choose to bring about their own deaths be required by law to do so by their own hands, when others who would willingly help could do the job more surely, more quickly, and more gently?[59]

However, if voluntary euthanasia is legalized, court decisions could extend the benefits of such kindly killing to children and other persons who are not legally competent. The argument would be that equal protection of the law forbids the limiting of the boon of being put out of one's misery to persons legally competent to give informed consent to the procedure. Substitute consent already is used to justify transplants from a noncompetent person.[60] And an important aspect of the New Jersey Supreme Court's resolution of the Quinlan case was the determination that Miss Quinlan's father could act on her behalf:

> If a putative decision by Karen to permit this non-cognitive, vegetative existence to terminate by natural forces is regarded as a valuable incident of her right of privacy, as we believe it to be, then it should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice. The only practical way to prevent destruction of the right is to permit the guardian and family of Karen to render their best judgment, subject to the qualifications hereinafter stated, as to whether she would exercise it in these circumstances.[61]

Of course, the New Jersey Supreme Court is not dealing with killing, and does not declare any right to die. Nevertheless, if the legislature were to hold voluntary euthanasia licit on the basis of a right to die, a court accepting this line of reasoning—which would be very difficult to reject—would be compelled to hold that the only practical way to prevent the destruction of the right in the case of noncompetent persons would be to permit others to render judgment on their behalf.

I. The Approach of This Book

Most discussions of euthanasia and related issues combine—or never begin to distinguish—questions about what is morally right and wrong with questions about what the laws should be if a democratic nation is to live up to its ideals of liberty and justice for all. When these two distinct kinds of questions are not mingled, the ethical issues are treated first, and recommendations concerning legislation are derived from the ethical conclusions. Also, in many cases the ethical discussion of issues is shaped by theological assumptions or by antireligious prejudices. An example of the latter is the work of Glanville Williams, who seems to think that showing a position to have had religious origins is enough to discredit it.[62]

In this book we try to distinguish and clarify the various issues related to euthanasia. We carefully examine arguments for changes in existing law. In working out what we believe to be a consistent position, we examine the demands of liberty and justice.

In the work that follows we carefully exclude theological considerations. We exclude them, not because we consider them unimportant, but rather because we intend this work to be a contribution to the common, public debate, in which no one's religious beliefs or antireligious prejudices can be legitimately taken as premisses for conclusions about the formation of public policy. Theological considerations must be presented to a distinct audience: those who share the faith which the theology articulates and defends.

Also we distinguish questions concerning what the law should be from questions of what is morally right and wrong. Most of this book is devoted to examining and arguing questions of the former kind, which we call "jurispru-

dential." And we deal with the jurisprudential questions first, in chapters two through ten. Only after having completed our treatment of these matters do we briefly examine the ethical questions concerning what is morally right and wrong. By treating jurisprudential questions first, we have forced ourselves to limit our approach to these issues by excluding much of our own ethical position.

Specifically, in chapters two through ten we do not assume the sanctity of human life as a principle. In other words, we do not try to settle any jurisprudential issue by invoking the principle that one should never kill the innocent. Rather, we argue from the common principles of liberty and justice which have not yet been repudiated by any substantial segment of any liberal democratic society.

The basis for our jurisprudential treatment of the issues is presented in chapter two. There we articulate what we believe to be the American conception of liberty and justice, and show some of its implications for legality. On this basis the issues in subsequent chapters are treated.

Chapters three through nine contain our jurisprudential treatment of the substantive questions. In chapter three we argue that the legal definition of death does need to be clarified, and suggest how this might best be accomplished. In chapter four we consider the problem of how persons who are legally competent might more effectively control the treatment they will receive. Neither in chapter four nor anywhere else do we take up a problem which does deserve serious work: How is legal competency to be demarcated? This problem is not specifically related to euthanasia; it would require a sizable study by itself. Thus we decided to leave it to others.

In chapter five we examine the law concerning suicide. Libertarian considerations argue strongly for wide scope for individuals to control their own treatment; the same considerations argue for caution in active interference with persons who of set purpose wish to commit suicide. In chapter six we proceed to one of the central issues: Should voluntary euthanasia be legalized? Here we reach a negative conclusion. The implications of liberty and justice are more complex here than has been recognized either by proponents or by opponents of euthanasia.

As we explained at the beginning of this introduction, questions regarding the definition of death, the liberty of persons to refuse medical treatment, suicide, and voluntary euthanasia often are muddled together. Our treatment sorts out these issues and addresses them with considerations proper to each. Similarly, we separate the jurisprudential issues concerning self-regarding acts, which are treated in chapters four through six, from the jurisprudential issues concerning other-regarding acts, which are treated in chapters seven through nine.

In chapter seven we examine the question: To what extent do forms of

killing traditionally held to be justifiable—for example, killing in self-defense or as capital punishment—provide a precedent for the euthanasia of those whom some consider would be better off dead? In chapter eight we directly confront the issue: Whether nonvoluntary euthanasia can be justifiably legalized? Our response is negative, for legalization of such killing would, we argue, deny to those to be killed the equal protection of the law. Finally, in chapter nine we complete our jurisprudential consideration of substantive questions by a discussion of the very difficult problem: How can the law ensure that persons who are not legally competent are not unjustly overtreated or deprived of treatment—especially not deprived of treatment to bring about nonvoluntary euthanasia by omission?

The consideration of substantive jurisprudential issues brings into the open some important defects in American constitutional law, as it presently stands after decisions of the United States Supreme Court in recent years. These matters of constitutional law are treated in chapter ten. In the first place we believe that justice requires the clear establishment, as a matter of constitutional principle, of the legal personhood and right to equal protection of the law of homicide of every individual who belongs to the species homo sapiens. In the second place we believe that liberty requires that religious and nonreligious worldviews be treated without prejudice, and that the latter not be assumed to have legitimacy as secular principles of jurisprudence denied by the First Amendment to the former.

Chapters eleven and twelve contain our examination of issues from an ethical perspective. Chapter eleven deals with ethical principles and defends the method of normative moral judgment we employ. This chapter also argues for the position that human life is an inherent, not merely instrumental, good of human persons, and so is not rightly treated as a mere means, but ought to be respected as inherently personal. Chapter twelve applies the normative ethical theory articulated in the previous chapter to the main issues discussed in the jurisprudential chapters, but now the question is what morality requires, regardless of what the law requires happens to be. This ethical consideration makes clear that legal standards and moral standards, as we see them, do not perfectly coincide.

Finally, in chapter thirteen we compare our own view of the relationship between law and morality with the view most commonly held by those who favor the legalization of euthanasia. We also attempt to show that the ethical theory we have articulated does offer a rational foundation for the jurisprudence assumed as the American proposition. If we are correct, sound ethics itself demands that public policy on euthanasia and related issues be formulated, not on the assumption of the sanctity of life, but rather on the principles of liberty and justice which Americans—as well as citizens of other liberal democratic nations—claim to uphold.

This book is addressed to all thoughtful persons who are willing to consider the jurisprudential and ethical questions related to euthanasia with open minds. We have developed our own positions, of course, but did not come to this subject matter with a set of ready-made positions. In the earlier stages of the inquiry we thought there might be considerably more room for the legalization of killing of competent persons with their consent and of restriction of treatment to noncompetent persons than we now consider defensible. Hence, throughout this work we make every effort to articulate counterpositions forcefully and fairly, and we try to deal with them straightforwardly and on the basis of principles which those whom we criticize ought also to accept if they are to remain consistent with their own professed ideals.

Because our conclusions will be found most acceptable by persons who doubt the wisdom of legalizing any killing of one person by another not now permitted by Anglo-American law, we hope our work will be especially helpful to such persons. We have tried hard to distinguish what ought to be conceded from what must be defended. If opponents of euthanasia cannot quickly come to agreement on these matters, we believe that proponents will attain their objectives much more easily and quickly than the merits of their case would otherwise permit.

J. The Task of the Movement for Life

There is a special urgency in acquiring a clear grasp on certain issues and in attempting to obtain legislative action which would protect liberty and justice while blocking the movement toward mass killing as a solution to the problem of social welfare costs. In chapter three we argue that the matter of the definition of death would be a proper subject for action by the United States Congress, using its enforcement power under the Fourteenth Amendment to define and protect the boundary of legal personhood for the dying. In chapter four we argue for legislation at the state level, in some ways much broader than recently passed "right-to-die" legislation, which would preempt the position now being occupied by proponents of euthanasia but would make no concessions to the ideology of their movement. In chapter eight we again suggest that the Congress might act to block legalization of nonvoluntary euthanasia by state legislatures. Finally, in chapter nine we urge legislation at the state level to put a stop to the present widespread and increasing practice of killing noncompetent individuals, especially defective infants, by omission of necessary treatment. Obviously, only some of the states offer a political opportunity to the legislation we think necessary at a state level. Still, whatever might be achieved will help save lives.

Although jurisprudential issues are to be argued on the basis of liberty and

justice, not on the basis of sanctity of life, many opponents of euthanasia will be more concerned with saving lives than with liberty and justice, although not insensitive to the demands of these principles. If, as we fear, the movement for euthanasia is likely to gain considerable ground in the United States and other English-speaking countries during the next few years, such opponents of euthanasia are likely to become disheartened, as many opponents of legalized abortion became disheartened after the United States Supreme Court decisions of 1973. It is important for such persons to realize that the movement for life has saved and continues to save many lives, even if many more are lost. And according to their own perspective, these friends of human life should be spurred on by what they have accomplished, for every human life is precious.

Moreover, if we are correct in thinking that the most basic principles of a good society—liberty and justice—are critically at stake in contemporary issues about life and death, then work to enact laws or to maintain laws consonant with these principles, even when such work is unsuccessful, has value in preventing the corruption of political society. As long as society includes groups who struggle to vindicate its principles, they are not wholly lost; the basis for reform still exists.

Furthermore, the movement for life has a value in the education of members of the society which is especially important when the support of the law is lost. By working for human life those who strive to resist legalization of euthanasia will keep alive some consciousness of the horror of killing. This consciousness will prevent many people from carrying out the killing which the law would permit; they would have to make a very determined choice to do so as they are forcefully reminded of the true significance of what they are about to do.

The educational value of work on behalf of human life is not least significant for members of the movement for life themselves. This is especially clear in the case of young people. A young man or woman who has worked to defend the unborn and to prevent the killing of the dependent is far less likely than another person to embrace killing as a solution to their own problems when these become pressing.

Proponents of euthanasia will say, as proponents of legalized abortion have said, that those working for human life are hypocritical if they strive only to maintain criminal sanctions against killing and do nothing to change the social conditions. This charge is sophistic, for even if those who object to killing with legal sanction do not fulfill every other social responsibility, still their position retains its intrinsic validity.

However, in euthanasia and issues related to it, for reasons we have already explained, the shirking of social responsibility toward dependent persons and the approval of killing as a solution to the problem of welfare costs

will go hand in hand. So must the defense of life and the acceptance of responsibility for the dependent. And when society at large shirks this responsibility, true friends of life must stand ready to shoulder voluntarily as much of it as they can. Thus the collapse of public programs based upon humanitarian idealism will make way for a rebirth of familial responsibility and neighborly charity.

To prepare for this eventuality, those who are friends of life ought even now to work hard to strengthen their own family ties, especially ties between generations and with close relatives beyond the nuclear family. They ought also to work to build up forms of practical cooperation and mutual assistance in the voluntary associations, such as local churches, to which they belong. Such associations were important media for charity in times past, nor did they always limit their help to their own membership. This function must be reactivated if as many dependent persons as possible are to be saved from the fate of those who are perceived as a public burden, and who are likely to be judged better off dead and publicly assisted in attaining this better condition.

It is very difficult to believe that the capability for thermonuclear war will continue to exist indefinitely in a divided world and never be put to use. It is even more difficult to believe that such a conflagration will be avoided as terrorism and extortion spread throughout the world, and as more and more centers of decision have some atomic weapons at their disposal. Under these conditions the use of such weapons even by a minor power or a private terrorist group could by error or escalation upset the all too delicately balanced equipoise of terror, which the United States, at least, wishes to maintain.

We do not doubt that those who survived a nuclear holocaust would be able to look back on our time and see clearly the intimate connection between the various ways in which liberty and justice are being violated in contemporary society and human life held cheap. If those who work for life, liberty, and justice cannot prevent disaster, they nevertheless should bear in mind that no disaster is total, and no future new beginning will be without roots in today's world. Thus men and women of today, even accepting as probable the most pessimistic prognosis for contemporary society, still are called upon to do what is now possible to lay the foundations for a future society in which life, liberty, and justice will be respected more perfectly and loved more purely than they are today.