The original documents are located in Box 37, folder "Definition of Death (2)" of the American Citizens Concerned for Life, Inc., Records at the Gerald R. Ford Presidential Library.

The Right to a Natural Death

James F. Csank

ONE OF THE inevitable results of the modern beliefs in judicial activism and judicial supremacy is the phenomenon of "taking to court" almost any aspect of contemporary life in these United States with which a person feels uncomfortable or by which he feels oppressed. Does someone object to the way in which the electoral districts of his state legislature are drawn? Take the "equal protection of the laws" clause of the Fourteenth Amendment to the United States Constitution, add a catchy slogan like "one man, one vote," and run to the courthouse. Does a pregnant woman in Texas want an abortion? Take a catchy slogan like "the right of privacy," add some rhetoric about "the penumbras of the Bill of Rights," and you have your lawsuit.

Theoretically, the court system exists to provide a forum for the resolution of the disputes which unavoidably arise between members or groups in society, and for the invocation of the organized power of the state with which to enforce the terms of the judicial resolution. Courts are necessary if we are to maintain at least a modicum of sociability, if we are to reduce to a minimum our resort to self-help. What we see around us today, however, is a *reductio ad absurdum* of this reliance on and faith in the judicial process. Conflicts are created, fashioned into lawsuits, and presented to various courts for decision. Often, the litigants are too impatient to turn to the political processes; in many cases, they are too unsure of obtaining their desired end by any method other than the judicial.

Many courts are only too eager to respond. Hypnotized by their power, which in the final analysis rests upon the seemingly endless capacity of the American people to accept any judicial decision as the right decision, and by their self-proclaimed wisdom, courts in general are willing to hear and decide any controversy submitted to them, no matter how nebulous, no matter how contrived, no matter whether the issues presented are within the competence of the judiciary to solve.

This increasing dependence upon judges for the settlement of conflicts would be neither dangerous nor frightening if the courts were merely undertaking to exercise more often their traditional role in their traditional areas. We might in such case only smile at the

James F. Csank is a practising attorney, and a frequent contributor to this review.

litigiousness of Americans, a phenomenon noted by Tocqueville. But we deal here with a difference in kind, not just in degree. The new litigation is not the type of dispute the courts are used to seeing; the new breed of lawsuit is a different kind of animal. When some segment of society, some widely-accepted attitude, some existing power structure frustrates the attainment of a desired end, a conflict exists for which new theories are developed. And this new breed of lawsuit requires the court to fashion new legal principles of jurisprudence. That the courts have become adept at disguising the nature and extent of the new principles upon which they rely, by using the language of existing, well-settled principles, should not blind us to what is actually happening.

What is dangerous and frightening about it all is the source of these new principles. Given our history and the make-up of our people, it is perhaps unavoidable that these principles are sought in the philosophy of secular humanism. And given the fact that the new breed of lawsuit arises within a society which is secularly oriented, and is fashioned by people who are, for the most part, secularly educated, it is unavoidable that the cases will demand resolution according to secularistic principles. This is not to say that all of the parties in whose names these cases are brought, all of the attorneys creating and arguing the new legal theories, and all of the judges considering these cases, are secular humanists. It is to say: 1) the society in which the suits arise has educated and conditioned the litigants, attorneys, and judges (which is obvious enough); 2) society has adopted and constantly presents to its members, through its most vocal and articulate members, the philosophy of secular humanism (which is not quite so obvious); and 3) many of the new breed of lawsuits embody principles which, on their face, are not openly or avowedly secularistic, but which, if they are carried to their logical end, and if their hidden premises and unstated conclusions are made explicit, reveal their true nature (which is the least obvious of all).

Secular humanism, no doubt, means different things to different people. Each of us, in communicating, is entitled to use whatever term he feels is proper, as long as two conditions are met: that he give fair warning of the meaning which he attaches to the term, and that he is consistent in that use. Without claiming that the following definition is exhaustive, then, by secular humanism I shall refer to that philosophy which sees the end of Man to be Man; which acknowledges nothing beyond this world and Man, and the perfection of both; which considers that God is dead because man no longer needs Him; which accepts Feuerbach's aphorism that "God is merely the projected essence of Man"; or, since that statement leaves

something to be desired if we are in the market for a slogan, Feuerbach's other aphorism: "man's God is Man."

An excellent example of the new breed of lawsuit was the aforementioned case brought in the early 1970's by a pregnant Texas woman who wished to be accorded the freedom to abort her unborn child, a freedom which Texas withheld from her. The United States Supreme Court decision is an excellent example of the adoption of principles of secular humanism by an activist court majority; that decision not only granted the litigant the right to abort her child, but declared such a right to be constitutionally mandated and protected, applicable nation-wide. Why? Because the unborn child is only a "potential life," with no rights of its own, and completely subject to the caprice of his or her mother.

Not all of the new breed litigants are open secular humanists, who see in the activist courts their best opportunity and greatest chance for success in replacing the principles of Judeo-Christian morality with their own ethical principles; some of them would be quite surprised if told that their legal theories — indeed, even the cases they fashion for the courts — are based on secularism.

In the successful litigation of a new-breed lawsuit, the strategy is to give the Court every opportunity to be judicially active by 1) framing the issues presented in as abstract a manner, with as broad a potential application as possible, while remaining within the context of the facts of the case; 2) requesting the Court to enter upon areas in which its competence is at least open to doubt; and 3) stretching accepted legal principles and phrases to cover the new situation.

Early in 1976, the Supreme Court of New Jersey was presented with *In the Matter of Karen Quinlan* (70 N.J.10., 355 A.2nd 647), a lawsuit pregnant with possibilities for the fashioning of new legal principles, for the assertion of judicial competence and authority over questions in the field of medicine and medical ethics. All of the strategies mentioned above were utilized in Karen's case. An activist court would not have been able to resist the temptation to discover a new "right to die"; an activist court would have been eager to lay down broad guidelines for determining when and under what circumstances the life of a patient had become meaningless because the hope of recovery was minimal, and an activist court would not have hesitated to impose its own solution to the complex medical problems and delicate moral dilemmas posed by the tragedy of Karen Ann Quinlan.

The New Jersey Supreme Court rejected the activist approach, in a display of judicial restraint rarely seen in the United States today. The Court's opinion, written by Chief Justice Richard Hughes for

a unanimous bench, is a remarkable document, not only for what it says and how it says it, but for what it does not say.

The Facts and the Issues Presented

Little time and space need be devoted to the circumstances involved in this litigation, for they are widely known. For reasons still unknown, Karen Ann Quinlan stopped breathing on the night of April 15, 1975; after being taken to a hospital, she was placed on a respirator and diagnosis was undertaken. She lapsed into a state of coma, from which she has never emerged. Physical deterioration, including brain damage, ensued, although Karen was still alive in the sense that her body continued to perform various functions, albeit with the aid of the respirator, catheters, feeding tubes, and twenty-four-hour care. Neither did Karen's condition amount to brain death, which, according to the testimony at the trial, results only when both the sapient and the vegetative functions of the brain are absent. (The vegetative functions of the brain refer to those functions of the body which are controlled by areas of the brain, such functions as breathing, blood pressure, swallowing, and heart beat.)

After some months, Karen's parents reluctantly came to the conclusion that the use of these extraordinary medical techniques (which we will hereafter, on our own, refer to as EMT's) gave no hope for eventual recovery. They asked that Karen be removed from the equipment, and that she be allowed to return to a more natural state. The attending physicians, as well as the hospital administrators, refused, claiming that to do so would not be in accordance with medical standards, practice, or ethics.

Mr. Quinlan brought suit, asking that he be appointed guardian for his daughter. The following is a list of the parties eventually involved in the litigation, with a brief statement of the relief requested or issues presented by each:

1) Mr. Quinlan asked that, if he were appointed guardian, he be granted "an express power . . . as guardian to authorize the discontinuance of all extraordinary medical procedures"; he also asked that Karen's attending physicians be restrained by court order from interfering with his removal of Karen from the EMT's if so authorized, and that the prosecuting attorney be enjoined from such interference prior to the removal and from initiating any criminal prosecution against any member of the family after such removal.

2) The Attorney General of New Jersey, asserting the state's interest in the preservation of life and defending the right of an attending physician to treat a patient according to the physicians' best judgment, opposed the granting to Mr. Quinlan of the relief he requested.

3) The County Prosecutor asked the court to state what effect the granting of relief to Mr. Quinlan would have on the enforcement of the state criminal homicide laws.

> 4) The hospital at which Karen was being treated requested that the Court declare whether a physician's reliance on the "brain death" criteria in his determination of a patient's death would be "in accordance with ordinary and standard medical practice."

The presentation of such a wide spectrum of issues is in the best tradition of judicial activism. For example, the criteria of "brain death" was based upon a 1968 report of the Ad Hoc Committee of the Harvard Medical School. At the time that the Court was considering this case, that report was less than eight years old; yet here was a hospital asking a *Court* to declare that the use of this criteria would or would not be "in accordance with ordinary and standard *medical* practice."

Nor did Mr. Quinlan's attorneys fail to avail themselves of the "stretching" tactic. One of the theories which they presented in support of their client's right to relief was that a denial of such relief would be tantamount to subjecting Karen Ann Quinlan to "cruel and unusual punishment," in violation of the Eighth Amendment to the Federal Constitution. The New Jersey Court, recognizing the ploy for what it was, spent only three short paragraphs dismissing the theory as "inapplicable" and "irrelevant."[1]

The Decision

The Court held that Karen had the right to order that the use of EMT's on her person be discontinued. Because such a decision affected only herself, the state of New Jersey had "no external compelling interest (which would require) Karen to endure the unendurable."[2] The State could interfere neither through the criminal law nor through injunctive proceedings. And since Karen was incapable of making such a decision, the Court would recognize the right and power in her guardian to make the decision for her.

Next, the Court held that the evidence indicated that Mr. Quinlan was a "very sincere, moral, ethical, and religious" person, and was therefore best-suited to be his daughter's guardian.[3] As such, he was to have "full power to make decisions with regard to the identity of (her) treating physicians."[4]

Resisting the temptation to speak *ex cathedra* on other complex questions set before the Court in the pleadings and briefs, the Court confined itself to the following issue, as they formulated it in the opening paragraph of the opinion:

> The litigation has to do, in final analysis, with (Karen's) life — its continuance or cessation — and the *responsibilities, rights, and duties,* with regard to any fateful decision concerning it, of her family, her guardian, her doctors, the hospital, the State through its law enforcement authorities, and finally the Courts of justice.[5] (Emphasis added)

Discussion

By refusing to remove Karen from the life-sustaining EMT's, her attending physicians had in effect assumed the right, the duty, and the responsibility of making the final decision as to her fate. That they had done so under their conception of prevailing medical standards and ethics, the Court was ready to accept and acknowledge. But the question, as the Justices saw it, was whether those standards, as they were employed in determining Karen's present status, her chances of recovery, and the procedures to be used, were of such binding quality, were "of such internal consistency and rationality" as to require the Court to deny Mr. Quinlan any authority to intervene or as to require the Court to adopt a hands-off policy toward the entire case. The Court answered in the negative. Its reasoning on this question included a recognition of the possibility that the doctors, perhaps unconsciously, reached their determination in part because of a fear of the imposition of criminal sanctions or of an exposure to malpractice claims should they decide to remove Karen from the EMT's. The physicians may have been acting on motivations personal to themselves; i.e., they may have lost some of the impartiality, some of the detachment from personal involvement, so necessary and desirable in the practice of medicine. The decision as to whether or not a person already relying upon life-sustaining equipment should be removed therefrom is a decision which should not rest with the doctors or with the administrators of the hospital alone. The Court suggests, but does not mandate, the establishment of a review board, before which all relevant facts could be presented, and expresses the "hope that this decision might be serviceable to some degree in ameliorating the professional problems under discussion."[6]

Since the decision to continue or suspend the use of EMT's is one personal to the patient, or to the patient's court-appointed guardian, the State has no power to interfere, either before or after the decision is carried out. And if, in the circumstances of this case, death ensues after the machines are disconnected, it will be due to existing natural causes within the patient, not to the infliction of harm by another.

It is important to note that the Court does not lay down broad rules in general language, rules which would only serve to confuse and mislead others, and which would lead to an increase in litigation attempting to resolve the unavoidable ambiguities. The Justices were careful to confine themselves to the narrow circumstances of Karen's case in every area in which they did award or deny relief, and to avoid discussing areas irrelevant to those circumstances.

The Relief

It will be recalled that Mr. Quinlan requested, if letters of guardianship were granted, that they include "an express power to him as guardian to authorize the discontinuance of all extraordinary medical procedures." The opinion of the Court characterized such authorization as itself "extraordinary,"[7] and it refused to grant it. The Court thus declined to appropriate to itself the right, the duty, or the responsibility for ordering such discontinuance; for if the Court had done so, the removal of Karen from the EMT's would have been the act of the Court, or in the abstract, of the Law, and not the act of Mr. Quinlan. It was as if the Court had addressed itself to Mr. Quinlan in the following words:

> We recognize that, as a loving parent and a moral and responsible person, your motivation arises from your love for your daughter and a sincere desire to do that which is best for her and for other members of your family. We also know that you have given deep consideration to the moral and religious factors involved. We agree that you are the person best suited to act in place of Karen. But we will not allow you to impose upon this Court, nor upon any other Court of this State which in the future must follow our guidelines, the responsibility for removing Karen from the machines which are, or appear to be at present, helping to sustain her life. Nor will we even go so far as to say that such a decision is yours alone, or that of your family alone; for we assume that you, like the members of this Court, lack the required medical knowledge and expertise. Neither do we grant you the authority to order the discontinuance of her present treatment against the advice or with the disapproval of the attending physicians, for no decision of this magnitude should be made without expert advice; and since this is a decision of life and death, with which you must live for the rest of your life, the moral weight of making it should not rest on your shoulders alone. What we do grant is that it is within your authority as Karen's guardian to choose who will be her doctors. If you choose to dismiss those who are at present so acting and retain others; and if these others conclude that there is no reasonable possibility of Karen's recovery; and if you and those doctors then consult with the Ethics Committee of the hospital; and if that body agrees with your determination; *then* the life-support systems presently in use may be withdrawn. They may be withdrawn without fear on your part or on the doctors' part of the imposition of criminal sanctions; they may be withdrawn without fear on the doctors' part that the doctors may be open to malpractice liability; for you, Mr. Quinlan, shall have taken such part in the process of decision, and shall bear such part of the responsibility therefor, as shall preclude you from calling that decision into question.

The Significance

Ask the next person you meet to characterize the "Karen Ann Quinlan" case, and chances are he will repeat what he has read in the papers and heard on television: "Oh yeah, that's the right to die case." Yet the New Jersey Supreme Court does not discover, and never even

discusses, a "right to die." The closest it comes to connecting the concept of "right" with the process of dying is when it cites, from one of the legal briefs, a statement issued by a Catholic bishop which used the phrase "the right to a natural death." Though some may argue that we are mincing words, and that what the Court in effect did was to recognize a "right to die," we must insist that there is a difference between the two concepts; the latter is susceptible to being stretched to rationalize euthanasia, while "the right to a natural death," by its very terms, cannot be so stretched.

The Court is careful not to rest its decision upon the tenets of the Roman Catholic religion, the religion of Karen and her family. It discusses the Church's attitude toward the moral dilemma with which the family is faced, but emphasizes that it does so only to judge the fitness of Joseph Quinlan for the guardianship of his daughter; i.e., it takes into account the Church's teaching only in order to determine whether Mr. Quinlan is acting with a formed conscience. And the Court goes out of its way to say that it would have done the same thing if Mr. Quinlan were a Buddhist, an agnostic, or an atheist. We are, after all, a nation which has agreed to subordinate the religious question in our discussion of other issues properly belonging to the public realm; a nation which, on the question of whether there is one God or twenty gods, has agreed to disagree; and this, to the extent that, if the Court *had* based its decision upon the principles of Roman Catholicism, we would have been shocked.

Yet it is also true that, as a nation, we belong to Western Civilization; we are part of the Judeo-Christian heritage, including its respect for human life, and its teaching of awe and humility in the face of death's mystery. To recognize that heritage, and to seek to preserve it in the face of the onslaught by secular humanism, is the great war through which we are living today.

The greatest victory to date in that war has been won by the secular humanists and is embodied in the 1973 abortion decision; because of that victory, untold millions of unborn children have been sacrificed to the comfort and convenience of others. The legal battle over the fate of Karen Ann Quinlan could have resulted in another such victory; establishing in the rhetoric of a "right to die" the rationalization for the "humane" disposition of those whose lives have become a burden to others. I have no doubt that such a result was never contemplated or desired by Karen's family; it may be that it was not contemplated or desired by anyone who had anything to do with the case. Yet if the Court had been persuaded to adopt principles of secular humanism; if it had discovered a "right to die"; if it had *judicially* determined that Karen had no hope of recovery;

if the Court itself had ordered the discontinuance of the EMT's, the danger is real that others, in the not too distant future, would have been eager to stretch those new principles to allow euthanasia, or infanticide of the deformed, or other "humane" practices.

But the Court did none of the foregoing. The decision it reached, the way in which it reached that decision, the things it refused to decide, are compatible with, indeed recognize and preserve, the Judeo-Christian heritage. The Court does not emphasize it, but it is there:

> We glean from the record here that physicians distinguish between curing the ill and comforting and easing the dying; that they refuse to treat the curable as if they were dying or ought to die, and that they have sometimes refused to treat the hopeless and dying as if they were curable . . . We think these attitudes represent a balance implementation of a profoundly realistic perspective on the meaning of life and death and that they respect the whole Judeo-Christian tradition of regard for human life.[8]

In one view, it would appear that judicial activism was alive and well in the decision of the Supreme Court of New Jersey. Using the tactic of "stretching accepted legal principles and phrases to cover the new situation," the Court based its decision on the theory of a right of privacy, a theory which first appeared in constitutional law in *Griswold v. Connecticut*.[9]

In the latter, the Supreme Court held that a Connecticut statute which prohibited the sale and use of contraceptives to married persons unlawfully infringed on the right to privacy, i.e., on the right of married persons to be free from governmental intrusion into the most intimate expressions of their love. Since then, the right of privacy has been extended to protect the availability of contraceptives to unmarried persons,[10] and to teen-agers.[11] It has protected the possession of pornography by a private person in his home,[12] and is the basis for the right to abort the unborn.[13] Indeed, this extension of the principle of the "right of privacy" from a case involving the sacred and most fundamental relationship underlying Judeo-Christian civilization to cases involving ethical beliefs of secular humanism which tend to destroy that basic relationship is an example *par excellence* of the technique of judicial activism and secularization with which this essay began.

The "right of privacy" cases have been used by the Courts to protect certain types of behavior from the imposition of criminal sanctions, but this is not to say that it cannot be used for other purposes or grounded on other beliefs. The New Jersey Court extended the right of privacy, but articulated a foundation for it significantly different from that previously posited.

The Court used the right of privacy 1) to prevent the imposition of criminal sanctions on *Mr. Quinlan,* if he decided to remove Karen from the respirator and she consequently died; and 2) to establish and protect *Karen's* right to decide to permit her "vegetative existence to terminate by natural forces."[14] There is a world of difference between these uses, as what follows will indicate.

The right to refuse medical treatment, or the right to terminate treatment already undertaken, is a right that belongs to Karen. She was held to have this right because 1) the invasion of her body was substantial, and 2) her chances of recovery were slight.[15] It is important to understand clearly what interests the state sought to protect by attempting to interfere in that question; as set out by the Court,[16] those interests were "the preservation and sanctity of human life," and "defense of the right of the *physician* to administer medical treatment according to *his* best judgment" (emphasis added). The Court in effect denied to the *state* the right or power to require a patient to accept medical treatment, and denied to a *physician* the right or power to impose such treatment regardless of the patient's wishes. Thus, the Court's "right of privacy" had nothing to do with the prevention of the state from prosecuting Karen; its concept of *Karen's* right is quite close to the "personal dignity. . . . (including) a right of bodily integrity and intangibility" cited by Professors Grisez and Boyle as the proper basis of a right to natural death.[17]

The right of privacy was also used to shelter Mr. Quinlan from criminal liability. The Court emphasized that Mr. Quinlan, as Karen's guardian, would be exercising *her* right to privacy, and that he had no separate, parental right of privacy of his own.[18] *Somebody* must exercise Karen's right of privacy, because, to reiterate, 1) the degree of invasion of her person was great, and 2) there was little hope of recovery; "her prognosis," said the Court, "is extremely poor."[19] (The fact that Karen still lives, that she did not die upon termination of the BMT's, is a fact clear only with the perfect vision of hindsight.)

The tone of the Court's opinion is learned, yet humble; dispassionate yet sensitive; frank yet subtle. The decision leaves this delicate question where it belongs: with the family of the stricken Karen, to be made after consultation with the medical experts, after consultation each with his own heart. The Court extends the right of privacy, true; but it extends it in such a way that the meaning of life, the sorrow of suffering, and the mystery of death are surrounded by a protective shell. The members of the family, with their shared faith and mutual love, are protected from all those who would in-

trude but who do not belong: the doctors, the hospital, the State, and, yes, the Courts of justice.

NOTES

1. *In the Matter of Karen Quinlan*, 355 A2 647, at 662 (N.J., 1976).
2. *Ibid.*, at 663.
3. *Ibid.*, at 671.
4. *Ibid.*
5. *Ibid.*, at 651.
6. *Ibid.* at 668.
7. *Ibid.*, at 651.
8. *Ibid.*, at 667.
9. 381 U.S. 479, 85 S. Ct. 1678 (1965).
10. *Eisenstadt v. Baird*, 405 U.S. 438, 92 S. Ct. 1029 (1972).
11. *Carey v. Population Services Int'l*, 97 S. Ct. 2010 (1977).
12. *Stanley v. Georgia*, 394 U.S. 557, 89 S. Ct. 1243 (1969).
13. *Roe v. Wade*, 410 U.S. 113, 93 S. Ct. 705 (1973).
14. *In the Matter of Karen Quinlan*, supra, at 664.
15. *Ibid.*
16. *Ibid.*, at p. 663.
17. See "An Alternative to 'Death with Dignity,'" in this issue.
18. *In the Matter of Karen Quinlan*, supra, at 664.
19. *Ibid.*

An Alternative to "Death with Dignity"

Germain Grisez and Joseph M. Boyle, Jr.

THE EUTHANASIA DEBATE has begun. Opinion polls across the United States reveal increasing public acceptance of euthanasia. In 1976, California enacted the first "death-with-dignity" legislation.[1] In 1977, more or less similar bills were introduced in the legislatures of at least forty-one states. In seven of these states (Texas, Oregon, Idaho, Nevada, North Carolina, New Mexico, and Arkansas[2]) bills were enacted into law by mid-1977. Some of the 1977 statutes are objectionable in certain respects in which the California Natural Death Act is not. The Idaho, Nevada, and North Carolina laws are looser in their definitions of key terms. The New Mexico and Arkansas laws enact a "right to die" and extend the exercise of this right to minors by means of proxy consent. The Idaho statute uses "right to die" in its title. The California statute contains a section explicitly excluding mercy-killing; its avowed purpose is only to recognize the right of a competent adult to direct a physician to withhold or withdraw life-sustaining procedures in the event of a terminal illness so that nature can take its course.[3] The Idaho, New Mexico, and Arkansas laws do not authorize mercy-killing, but neither do they explicitly exclude it.

The "death-with-dignity" legislation has been widely criticized, mainly for intruding into the already delicate physician-family-dying-patient situation unnecessary legalisms which do little to facilitate exercise of the patient's rights. In fact, the new laws may have the effect of infringing on the patient's rights by reinforcing the already very great authority of the physician and by implying that patients who do not meet the formalities of the statute must be kept alive by all available means — must be treated to death.[4]

We see two things wrong with the "death-with-dignity" legislation which we consider even more serious. First, it opens up possibilities of homicide by omission. Second, it is paving the way for active euthanasia.

As to the first point: if these statutes authorize physicians to withhold or withdraw treatment in any case in which they would not be allowed to limit treatment without the new laws, then in some instances of that type of case mistakes will be made, treatment

Germain Grisez is Professor of Philosophy at the University of Regina in Canada; **Joseph M. Boyle, Jr.** is Assistant Professor of Philosophy at the College of St. Thomas in Minnesota.

limited, and the death of patients hastened against their will. Moreover, some of the statutes are seriously weak both in their definitions and in their formal requirements for making and certifying a directive. Such statutes — notably those of New Mexico and Arkansas once more — lend themselves to abuse by one forger and two cooperative physicians, who can dispose of any noncompetent adult (who needs medical treatment to survive) simply by not administering that treatment. A case which, without the statute, obviously would have involved gross negligence thus becomes a case of "death with dignity." If there is an investigation, there is a natural cause of death and prosecution for negligence is excluded.

As to the second point: the old Euthanasia Society, founded in 1938, was going nowhere in 1967. Members organized a new unit, the Euthanasia Educational Fund, to disseminate information. At or about the time this was done, Dr. Luis Kutner suggested the "living will" — not what someone committed to euthanasia really wants but something in the neighborhood which has acceptability that mercy-killing lacks.[5] As anyone doing research on euthanasia and related topics discovers very rapidly, the literature on death and euthanasia-related questions quickly began to burgeon; since 1973 the rate of growth has been exponential not only in the popular media but also in medical, legal, and other journals. At the beginning of 1975, the old Euthanasia Society was reactivated as the Society for the Right to Die, an action-union to press for legislation.[6] The Euthanasia Educational Fund and the Society for the Right to Die have 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.[7] In 1975-1976 the Karen Quinlan case was very much in the news. This was the event the pro-euthanasia movement needed to break the dam against legislation. The Society for the Right to Die vigorously promoted "death-with-dignity" legislation, advancing its own model bill.[8] The New Mexico statute is adapted from it.

But all the "death-with-dignity" legislation is full of euthanasia concepts and language, including the concepts that death is natural and good — not something to be prolonged by "artificial" means — and the language of "unnecessary pain" and "dignity." More important, the more tightly drawn bills, the California statute and those modeled on it, contain safeguards: the requirement that one's terminal condition be certified by two physicians for one to become a *qualified patient,* the prescription of a legal form for the *directive to physicians,* a fourteen-day *waiting period* after one is qualified before the directive becomes fully effective, and a *penalty for*

homicide specified for anyone forging a directive or concealing its revocation. Such safeguards are admirable from one point of view, but they also constitute exactly the sort of machinery required for active euthanasia. The Voluntary Euthanasia bill considered by the British Parliament in 1969 included precisely such safeguards; a comparison of this bill with the California statute makes clear that the latter was modeled on the former.[9]

What is going on has not altogether escaped the attention of persons and groups who are concerned about the right to life. The same mentality and interests which succeeded in bringing it about that unwanted babies, especially ones who would be costly in public welfare money, are much less often born alive, are fast moving toward success in bringing it about that unwanted defective children and unwanted inmates of public institutions will much less often be kept alive by undignified and unnatural means — in fact, that they soon will be spared the pain and suffering of lingering to an undignified, natural death which a little human art can easily forestall.[10]

But if those who are concerned about the right to life can see what is beginning with the "death-with-dignity" legislation, they have not yet developed a strategy to permanently block the passage of such legislation. We think it urgently necessary that legislative alternatives to the euthanasia-oriented bills be developed. Such alternatives can be promoted as substitutes or sources of right-to-life amendments for statutes already on the books, as right-to-life contenders against right-to-die bills when the latter are likely to pass, and even as potential legislation which would have its own inherent value. There is an old saying in politics: You can't beat somebody with nobody. Up to now, those concerned about the right to life have proposed no positive alternative to "death-with-dignity" bills.

The advocates of euthanasia are winning the initial battles. There are many reasons why this is so, among them a large carry-over of sympathy and opinion, techniques and forces, from the right-to-abort campaign into the right-to-die campaign. But there is another factor which should not be ignored. "Death-with-dignity" legislation has a great deal of public appeal. Many people are afraid of dying a prolonged and painful death. The "living will" and the new legislation appeals to this strong self-interest, just as the argument for abortion appealed to concern for the well-being of pregnant women "forced" to obtain illegal abortions.

Moreover, it is hard to argue with the avowed, initial purpose of the new legislation. It is based upon the right to refuse medical treatment. Even if critics of the new laws are correct in saying that they do nothing to facilitate the patient's rights, the right to refuse treat-

ment is a real and valuable one which many people might wish to exercise effectively. And people *think* that the new legislation will help them satisfy this legitimate wish.

It follows that an alternative to pro-euthanasia "death-with-dignity" bills must be a serious proposal, compatible with the right-to-life philosophy, for effectively articulating, protecting, and facilitating the liberty to give and to refuse consent to medical treatment.

Anglo-American law has long recognized the liberty of every person to refuse medical treatment. One need not have any good reason for refusing. In our present law, this liberty of the patient if conscious and adult is nearly absolute, although many persons do not realize this fact. What is the basis of this liberty? Certainly not any right to die, and not the new right of privacy by which the United States Supreme Court legalized abortion. The basis of the liberty to refuse treatment goes back much further, to common law which was rooted in Christian morality and Christian conceptions of personal dignity. Every person has a right to bodily integrity and intangibility. To cut a person, even to touch a person, is a personal offense unless the person cut or touched consents. Each person is regarded by law as the best judge of what contacts with his or her own body will be permissible, and personal choice in this matter is given the force of law. Hence, if medical treatment is imposed upon someone without consent, even without malice and with good results for the patient, the wrong of assault is committed. Therefore, with few exceptions any competent adult is at liberty to refuse medical treatment and no physician administers treatment without some sort of consent, although the consent usually is implicit in the fact that one goes to the doctor rather than the other way round.[11]

The liberty to refuse medical treatment is not absolute. Sometimes the public health demands that people receive unwanted treatment. On the reasonable assumption that they are not themselves, people attempting suicide and self-mutilation are treated despite their protests. In a few cases, courts have ordered treatment, especially treatment necessary to preserve life, to be administered to adults refusing it. Many of these cases involve Jehovah's Witnesses refusing blood transfusions. In several but not all the cases in which refused treatment has been ordered by a court, part of the ground for overriding the individual's liberty and religious convictions has been that without the treatment the patient would become incapable, by death or otherwise, of fulfilling responsibilities to dependent children.[12]

But there is another common and very familiar situation in which

an adult is given medical treatment without his or her own consent: in an emergency situation in which the person is unable either to give or to refuse consent. When the patient is unconscious or otherwise incompetent, the law presumes consent and the physician incurs no liability provided that he proceeds to do what is appropriate and meets the usual standard of good medical practice. The basis for assuming consent is obvious and reasonable: most people would want needed treatment and would consent if they could. In such cases, a family member often is asked to sign a form, but this is more a matter of protecting the physician and making sure someone will pay the bill than it is a requirement based on the patient's own right of bodily integrity and intangibility.[13]

The three crucial factors in an emergency situation — the presumption of consent by the patient, the essential irrelevance of the wishes of the family, and the legal obligation of the physician to meet the usual standard of good medical practice — can combine to create a situation in which treatment that most people would consider futile and unnecessary is continued upon a non-competent adult without any discussion with the family once the initial consent is given, and sometimes is continued even despite the family's protests. The Karen Quinlan case is an instance in point.[14]

While it is undoubtedly true that informal procedures, especially more discussion among physicians, could clarify the limits to which treatment ought to be carried, many people are concerned that they or members of their families will be over-treated. This concern has led to a great many proposals, only one of which the "death-with-dignity" legislation follows up, for clarifying and protecting the patient's liberty to refuse consent to medical treatment and for providing every competent adult with a way whose legal effectiveness is certain to make personal wishes about his or her own future treatment prevail despite noncompetence at the time to consent or refuse treatment. One appealing method of accomplishing the latter purpose is to provide by statute that anyone who wishes may designate a family member or trusted friend (or a group or ordered series of such persons) who will have legal authority to make necessary decisions if one becomes noncompetent. But a broader statute which would allow individuals the freedom to make their choices effective in whatever way they wish would in our opinion be even better.

Critics of "death-with-dignity" legislation may deny the need for any such statute, but they will have a hard time convincing Jehovah's Witnesses who have received unwanted blood transfusions, they will have a hard time convincing people who are afraid of being treated

to death by a physician more concerned about avoiding a malpractice suit than about the interests of a dying patient, and they will have a hard time convincing Mr. Quinlan.

We believe a good statute should do five things. First, it should make clear precisely what right is being protected and why: not the right to die or the new right of privacy, but the right of bodily intangibility and the liberty to decide for oneself which incursions upon oneself are acceptable. Second, it should facilitate the liberty to refuse treatment for the future to the whole extent to which a competent adult has it at present. Third, it should protect physicians and hospitals who do their best within the limits set by patients. Fourth, it should guarantee that patients who want treatment are not denied it by mistake or by malice. Fifth, it should provide a simple, flexible, and workable framework for individuals to act in.

We can think of no solution to the problem except to give legal authority, with only a few necessary limitations, to the choice of any competent adult to refuse consent to any unwanted medical treatment, whether at present or in the future. People must be allowed to express their wishes, which will differ a great deal, in any way they please, provided that they make clear exactly *what* they want and *that* they really do want it. As we have suggested, one simple way of doing this would be to make unmistakably clear that a certain person will have authority if one becomes noncompetent — for example, a young adult might name a parent, a married person a spouse, an older person a mature child, or anyone a trusted friend, a lawyer, or a pastor. If an individual personally made such a designation in writing, complying with the formalities required for a valid will, and personally left copies with a number of persons — physician, lawyer, clergyman, family members, and so on — then there would be no reasonable doubt as to who would have authority during a subsequent time of noncompetence. One could do this even without legislation, but there is no assurance that a court would abide by one's wishes or that one's wishes would solve the physician's problem of liability.

Even with a document such as we are describing, however, it would be unsafe to authorize physicians to withhold treatment they considered medically indicated on the strength of a person's agent's refusal without providing that the document be tested by a court and determined to be valid and effective. There are problems about revocation and codicils which inevitably come up, and physicians cannot be expected to adjudicate such problems. Moreover, if we are right in thinking that everyone should not be forced into making their wishes about future treatment effective by one and the same

method, then a Jehovah's Witness's refusal of blood transfusions and a proponent of natural death's refusal of anything which has to be plugged in also must be facilitated, and putting their desires into effect may involve problems of interpreting as well as testing evidence beyond the competence of anything but a probate court procedure and judge. The result of requiring each case to be given its hour in court may be some additional litigation, but this cost is light compared with the danger to everyone's life which could result from a loose procedure. Moreover, every will is probated, even no-fault divorces get some sort of hearing, and an argument over a small amount of money can be taken to court. And, of course, if people are satisfied with the way things are now, they need do nothing, and a well-drawn bill will leave the present situation unchanged so far as they are concerned.

We think a well-drawn bill would begin with an extensive statement of legislative findings, in order to provide a legislative history and context in which, hopefully, courts would interpret and apply the act. Such findings might well begin with a statement of the nature and true foundation of the right which is to be protected:

> The legislature finds that the liberty of competent adults to give and to refuse consent to medical treatment upon themselves has been recognized at common law from time immemorial and has in general been protected by the law of this State. This liberty is an aspect of the right of every person to bodily integrity and intangibility, a right closely related to the right to life. The administration to any person of medical treatment without informed consent is an assault upon that person. Such an assault is justified neither by the beneficent intentions of the one who commits it nor by any good result which might follow from it.
>
> The legislature also finds that the liberty of competent adults to give and to refuse consent to medical treatment upon themselves may be regarded as a right reserved to the people by the Ninth Amendment and as a liberty or immunity protected by the Fourteenth Amendment of the Constitution of the United States, as well as by _____ of the Constitution of this State.
>
> The legislature also finds that this liberty neither presupposes nor implies that any person has a right to die. Since every act which causes death or hastens it is a crime, no person can have a duty to do such an act, and so no person can have a right to die which would correspond to such a duty. There can be no right to die with dignity, although there certainly is a right to the protection of one's dignity from the very beginning of one's life until its end, including those times when one is sick, injured, and dying.
>
> Moreover, if anyone attempts to commit suicide, then his or her liberty to refuse treatment may be lawfully ignored.
>
> The legislature also finds that the liberty to give and to refuse consent to medical treatment is not an aspect of the right of personal privacy, which protects certain forms of behavior from criminal sanction. No criminal

sanction ever has been attached to the exercise of this liberty. Moreover, this liberty was recognized in our law long before the right of privacy was extended to the protection of abortion and other behavior previously held criminal by our law.

Having clarified the nature and true foundation of the right to be protected, the legislative finding might continue with a statement of the need and purpose for legislation. This might be phrased along the following lines:

> The legislature further finds that although the liberty to give and to refuse consent to medical treatment is well established in our law, certain problems require that this liberty be clarified and further protected by statute. Judicial decisions in some jurisdictions have imposed medical treatment upon persons despite their refusal of it, even when the refusal has been on religious grounds. Also, some doubt exists about the liability of physicians and health-care facilities when persons refuse consent to treatment, yet do not altogether withdraw themselves from care. Moreover, there is a reasonable public demand that the liberty to refuse consent be facilitated, so that the personal decisions of individuals will continue to control treatment of them when they become noncompetent.
>
> The legislature also finds that some people choose to refuse all or certain forms of medical treatment on religious and other deeply held conscientious grounds; that others choose to refuse or to limit treatment on grounds of cost, painfulness, or mutilating effect; that others choose to refuse treatment which might preserve life but which they consider to be futile; and that others choose to refuse treatment for other reasons.
>
> The legislature finds that there are certain conditions under which the liberty of a competent person to give and to refuse consent to medical treatment may be justly overridden. Such conditions exist if the administration of treatment to a nonconsenting person is required by the public health, welfare, or safety; if it is required for self-inflicted injury, when the person must be considered temporarily unstable; and if refusal of treatment is likely to lead to incapacity to fulfill lawful responsibilities of a grave kind toward dependent children or others.
>
> Apart from such exceptions, the legislature finds that all choices to refuse medical treatment upon oneself are lawful. The legislature considers itself bound as a matter of justice to protect and facilitate all lawful choices in a way which will afford equal protection of the law to all persons in this State. The legislature recognizes that some persons may abuse their liberty to refuse treatment by making foolish or immoral choices; nevertheless, the legislature finds that justice requires that this liberty be protected even if it is abused.

Having stated the purpose and need for legislation, a legislature might well make clear why the legislation it adopts is so different from that widely proposed and adopted by some other States:

> The legislature also finds that no statute which would afford the equal protection of the law to all persons lawfully choosing to refuse medical treatment can limit itself to facilitating the wishes of those patients who happen to be terminally ill or who happen to especially dislike certain forms of treat-

> ment. Likewise, the legislature finds that it would be unjust to demand that people refusing treatment do so with certain intentions, since the intentions of persons exercising a liberty can be of no legitimate interest to the government. The legislature finds that proposals including such restrictions are unacceptable because they arbitrarily limit rather than protect and facilitate the liberty which citizens have enjoyed until now.

Although the statute will apply to the refusal by competent adults of treatment at the time it is proposed, the new and more important aspect will be its provision for effectively determining one's treatment during a future time when one may be noncompetent. This aspect may be explained in the legislative findings:

> The legislature further finds that in the absence of evidence to the contrary most noncompetent persons must be assumed to consent to treatment, provided that it is appropriate and rendered in accord with the usual standard of good medical practice for a condition of disease or injury from which they are suffering. Moreover, physicians and health-care facilities are required by law to proceed on this assumption.
>
> The legislature therefore finds that if persons wish to refuse treatment which might be administered to them in accord with this assumption, then it is their responsibility both to provide evidence which will express and prove their choice beyond a reasonable doubt and to make sure that this evidence will come to the attention of physicians and health-care facilities which might provide unwanted treatment. The legislature finds and this act permits that persons might provide evidence of various chosen determinations about treatment in the event they become noncompetent: that regardless of their condition they refuse all or certain forms of treatment, that in certain circumstances they refuse all but palliative treatment, that they consent only to the treatment approved at the time of need by a certain designated person or persons, or that they limit the usual assumption of consent in some other lawful way. The legislature finds that it is the responsibility of persons who wish to make their choices legally effective under the provisions of this act to express their wishes in a sufficiently clear and definite form that there will be no doubt what their wishes are, and in a sufficiently certain and binding form that there will be no doubt that these are their wishes.
>
> The legislature further finds that it would be unjust to ask physicians and the administrators of health-care facilities to assume a judicial role in cases in which a patient provides evidence that consent is refused to treatment otherwise necessary to meet the usual standard of good medical practice. The legislature also finds that it is not in the public interest to lessen the responsibility of physicians and health-care facilities to provide standard care on the untested evidence that the ordinary assumption of consent does not correspond to the desires of a particular patient.
>
> Accordingly, the legislature finds that if there is evidence that a noncompetent adult patient may not consent to treatment otherwise medically indicated, and if there is any doubt about the legal duty of a physician or health-care facility toward such a patient, then the duty is to administer the treatment immediately and urgently required, and to seek promptly a judicial

> determination of the doubt. Only such a determination will settle whether medical treatment is to proceed on the usual assumption or is to be limited in accord with the proved limits of the noncompetent person's consent.

So much for legislative findings. We realize that so lengthy a rationale for a statute would be unusual, but it also could be very useful, for the statute might be badly misinterpreted without this rationale, which embodies many concepts which have not been given much publicity in the last few years.

The statute itself will require a number of definitions, which must be supplied in accord with the existing law of each State. For example, "medical treatment" must be defined as treatment provided by certain classes of persons and institutions acting professionally. One of the more important definitions will be that of "the usual standard of medical practice." A definition along the following lines would be appropriate:

> Treatment according to the usual standard of medical practice in this act means medical treatment appropriate for an existing condition of disease or injury carried out in all respects in the manner in which a person practicing with the average professional skill and carefulness would carry it out in any case in which all of the relevant circumstances were the same or similar. Any limitation imposed upon a practitioner or health-care facility by refusal of consent to treatment which otherwise would be medically indicated shall be considered a relevant circumstance.

By this definition, refusal of consent *changes* the usual standard of practice but does not release anyone from liability for failing to meet the standard. Physicians thus will be required to take the patient's decisions as determinative in deciding how to proceed, but will be held for doing well whatever process of treatment is undertaken.

The statute also must make clear that it applies only to persons of an age judged to be the appropriate age for competency in consenting to medical treatment. We are not going to discuss the large problem of the proper age of competency for this purpose, but it is worth noting that for many particular purposes the age of competency has been reduced in recent years. Perhaps it would be reasonable to consider young people able to make decisions regarding health-care in general at an age younger, maybe even much younger, than eighteen. Whatever the proper age for competency is judged to be, a clause along the following lines will be needed:

> The existing law of this State with respect to all the conditions for lawful medical treatment of persons under _____ years of age and persons who have been declared legally noncompetent is in no way modified by any provision of this act, except insofar as a person declared legally noncompetent has made known his or her wishes concerning medical treatment during some prior period of competency.

This phrasing also takes care of the problem of persons who have been committed; their situation is a special problem which requires other legislation if it needs to be altered from the way it stands at present.

The statute also should contain a section excluding several likely misconstructions. These include misconstructions of its purpose and of its intended effect upon the existing situation. Something along the following lines might do:

> Nothing in this act is to be construed
>
> (a) as introducing or recognizing any right to die; or
>
> (b) as authorizing any person to do or to refrain from doing anything in order to bring about the death of any person; or
>
> (c) as creating any new obligation that a physician administer treatment above and beyond that required by the usual standard of medical care; or
>
> (d) as causing any treatment to be required by the usual standard of medical care if such treatment prior to the enactment of this statute was commonly considered futile and useless by competent and careful physicians; or
>
> (e) as impairing or superceding any legal right or responsibility which any person would have prior to the enactment of this statute to bring about the withholding or withdrawal of medical treatment in any lawful manner; or
>
> (f) as requiring physicians or health-care facilities to seek judicial determination of their duties in cases in which there would have been no doubt as to their liability if they failed to respect a patient's wishes had such cases occurred prior to the enactment of this statute.

Our intention in proposing this phrasing is to keep the present situation as much as possible just as it is for people who are satisfied with it. The statute also must contain provisions regarding insurance. We doubt that the law can justly require that persons who limit or refuse consent be treated in all respects the same for insurance purposes as those who do not. This would unfairly impose voluntary risks on those who do not choose them. But the statute definitely must include a provision excluding as unlawful any attempt to make a person refuse or limit care as a condition for granting an application for health or disability insurance, and the like.

The statute also should contain severe penalties for forging or tampering with evidence as to any person's wishes in regard to his or her own medical care. In particular, the misrepresentation that a person refuses treatment on which life might depend should be classed as attempted first degree murder, and as first degree murder if the misrepresentation causes or hastens death.

The four main sections of a statute would be embedded in the middle of it, but for convenience we number them here as sections one to four. The first affirmatively states the liberty to refuse treatment and gives it all possible legal clarity:

Section one. It is a violation of the bodily integrity and intangibility of a person, subject to criminal and civil liability established in existing law of this State, to administer to any person without his or her personal, informed consent any medical treatment, except in the cases specified in section two of this act, unless such person be a minor or noncompetent person excluded by section _____ from the provisions of this act.

Whenever a physician-patient or other medical treatment relationship is initiated and whenever explicit consent to medical treatment is sought, the person initiating the relationship with or seeking consent of the patient must if the patient be competent clearly and explicitly state that the patient is at liberty to give or to refuse consent to treatment. Evidence of the failure to inform the patient of the right to refuse consent shall be evidence of negligence which if willful and deliberate shall also be criminal.

The liberty is not only affirmed in its whole breadth, but also defined and enforced by the requirement that patients be informed of it. The second section states and limits exceptions to the liberty to refuse treatment:

Section two. Notwithstanding the liberty of every competent person ___ years of age or older to give and to refuse consent to medical treatment, no physician and no health-care facility shall be deemed to have administered medical treatment without consent if one or more of the following conditions is fulfilled:

(a) the treatment is authorized by statute to be administered without the consent of the person treated for the protection of the public health or safety; or

(b) the treatment is appropriate to remedy a condition of bodily injury or harm which the person treated has brought upon himself or herself in attempting suicide or self-mutilation; or

(c) the treatment either is ordered to be given by a court of law or is consented to be a guardian appointed and authorized by a court to act in the matter; or

(d) the treatment is administered to a person from whom consent cannot be obtained because of his or her inability either to give or to refuse consent to treatment, and the following three conditions are met: (i) the treatment is an appropriate remedy for an existing condition of disease or injury; and (ii) the treatment is carried out in accord with the usual standard of medical practice; and (iii) there is no evidence known to persons administering the treatment or to administrators of any health-care facility in which it is carried out which a reasonable person would take to be sufficient to call into question the ordinary assumption that the noncompetent patient would consent to treatment which is medically indicated; or

(e) the treatment is administered to a person from whom consent cannot be obtained because of his or her inability either to give or to refuse consent to treatment, and the following two conditions also are met: (i) the treatment provided is urgently and immediately required to preserve the life or protect the health of the patient pending judicial determination of the case; and (ii) judicial determination is pending or is promptly sought.

Having limited the conditions in which consent can be overridden

and created a situation in which any evidence putting in question the usual assumption of the consent of the noncompetent person to indicated treatment will provide a strong incentive for taking the case to court for determination, the statute must go on to direct interested parties to a suitable court and to indicate to courts what is required of them:

> Section three. Upon a petition by a patient under medical care or by a representative of such a patient, by a relative of such a patient, by a physician or health-care facility responsible for such a patient, or by any other interested party, any court of _____ of this State shall promptly schedule a hearing and give notice of it to all interested parties. At the hearing the court shall receive and examine all evidence produced by any party concerning the nonconsent of the patient to proposed treatment or to treatment already in progress.
>
> Evidence considered may include but need not be limited to expert testimony concerning the probable utility and benefit of the treatment; anything which might show that the patient rejects all or certain kinds of medical treatment on the basis of religious or other deeply held conscientious convictions, that under specified conditions the patient refuses all but palliative care, or that the patient desires decisions to be made on his or her behalf by some designated person or persons.
>
> In assessing the evidence, the court shall consider the presumption of consent to be in possession and shall not alter this presumption unless a different conclusion is established by the evidence beyond reasonable doubt. The refusal by any person of consent to medical treatment shall not itself be considered evidence of the noncompetence of such person.
>
> If the court determines that one or both of the following conditions is met, then it shall direct that medical treatment be administered in accord with the usual standard of medical practice unrestricted by lack of consent:
>
> (a) if treatment of the patient is required by the compelling state interest of the public health, welfare, or safety; or
>
> (b) if the usual assumption that a noncompetent person does consent to treatment to which a reasonable and competent person usually would consent should stand in the present case, either because the eivdence presented does not establish beyond reasonable doubt that the patient when competent exercised the liberty to limit or refuse consent, or because the evidence presented does not sufficiently show what limitation, modification, or termination of treatment would give effect to the patient's wishes.
>
> In finding that treatment of a nonconsenting patient is required by the compelling state interest, the court must find that lack of treatment would be likely to result in substantial harm other than harm to the patient's own life or health. Such harm might include but is not limited to the probable resulting incapacity through death or otherwise of the patient to fulfill responsibilities to dependent children. If the patient's refusal of treatment is based on religious or other deeply held conscientious convictions, then the prospect of harm which grounds the state interest must be such as to constitute a clear and present danger.

> If the court finds that neither condition (a) nor condition (b) is met, then the court shall cause treatment of the patient to be limited, modified, or terminated in accord with the proved will of the patient. In giving effect to the will of the patient, the court may act by its own order or by appointing and authorizing a guardian to act on behalf of the patient or by both of these modes.

The court's assignment is to examine evidence about the patient's consent. This keeps the focus where it ought to be. Nevertheless, the usual assumption is that the patient consents to treatment in accord with the usual standard of medical practice, and such treatment is limited to that which is somehow of use and benefit to the patient. Hence, the court could consider expert testimony which would show that the treatment was not of use and benefit, and on this basis rule that nonconsent must be presumed. This is in fact what the Supreme Court of New Jersey did in the Quinlan case, although the Court's confusion about what it was doing tended to conceal this fact.[15]

The final section of the statute, as we have projected it, would be the one indispensable section — the limitation of liability:

> Section four. Whenever medical treatment is restricted and delayed in conformity with section 2(e) or is limited, modified, or terminated in accord with a judicial decision under section 3, the provisions of this act and what is done in accord with it shall be a material and relevant circumstance in determining the usual standard of medical practice. Neither physicians nor health-care facilities shall incur any civil or criminal liability for acting in accord with the usual standard of medical practice as determined with this circumstance taken into account.
>
> If a physician proposes a medical treatment which would be in accord with the usual standard of medical practice if the patient consented to it, and if the physician is prevented from proceeding with such treatment because of refusal of consent in accord with the provisions of this statute, then the physician shall not be deemed to have abandoned the patient if the physician withdraws from the case, provided that sufficient notice is given to the patient or to others concerned with the patient's interests to permit the obtaining of the services of another physician.

By this provision, nothing in the way of protection of the patient's rights is given up, yet the physician and the hospital are given the assurance they need to do the best they can for a patient within the limits set by the patient. If a physician, because of reasons of conscience or other concerns, objects to working under such limitations, the statute provides a way out.

As philosophers, we do not pretend to be legislative draftsmen. We have articulated our proposed alternative to "death-with-dignity" legislation in a formal mode, to give definite embodiment to our basic idea: an alternative to the statutes now being enacted is essential.

Many objections are likely to be made against any proposal along the lines we are suggesting. We conclude by considering some of them.

Some might object that no new strategy is needed at this time to deal with the euthanasia movement. Even legislation such as we are proposing will be open to amendment in the direction of facilitating voluntary euthanasia. The answer to this objection is that the euthanasia movement has been gaining momentum consistently; it has not suffered a serious setback since 1967. Opponents of abortion were able to appeal to a residue of decent sentiment in the battles up to 1973. Opponents of euthanasia will be able to appeal only to self-interest. A picture of a normal, unborn twenty-week baby has emotional impact; so, unfortunately, does a picture of a defective child, a psychotic, a senile person. Identification with such persons is more difficult for most of us than is identification with the infant. Self-interest can be served by limiting nonvoluntary euthanasia to the noncompetent in institutions. Therefore, some new strategy is needed. We believe that legislation along the lines we are proposing will be less open to revision to facilitate euthanasia than will the common-law situation which still exists in most states, and will be a substantial obstacle to euthanasia in comparison with the "death-with-dignity" legislation which provides both an ideological framework and the legal safeguards necessary for euthanasia.

Some might object that the legislation we propose will encourage people to make decisions about future treatment, when people are considering death abstractly and at a distance, but those decisions might well be different when the consequences of refusing treatment are imminent. The answer is that under the legislation we are proposing people could leave the future decisions to be made as they are now or could assign responsibility to someone they trust to make them at the time. Moreover, there is nothing in the proposed bill to prevent people from changing their minds. Besides, we see no reason to suppose that a person's desires or hypothetical desires at the time treatment is needed are more likely to express his or her true self than the same person's free and deliberate choice made at some earlier and calmer moment.

Some might object that it is unwise to give people so broad a right to refuse treatment. The answer is that legislation along the lines we are proposing is not giving anyone a right; it is only recognizing and facilitating a right people already have. The new statute would help people to make their wishes in respect to their own future more effective than is now possible. However, we can see no justification for limiting people's liberty with respect to the future which would

not equally justify limiting it with respect to the present. While the law does have a duty to protect children and the permanently non-competent from themselves and from the irresponsibility of others, it is of the essence of liberty that competent persons be able to make decisions about their personal lives and to have these decisions respected not only at the time they are made but also during the whole time to which they are meant to apply. Liberty may be exercised foolishly and even immorally, yet it must be respected. The alternative is a paternalism which might be benevolent but which cannot be just and is bound to be odious.

Some might object that if the liberty to refuse treatment is protected to the extent we propose, some people will abuse this liberty even to the point of using it to commit suicide, and that in consequence there will be further lessening of respect for human life. The answer is that nothing in our proposal lends color of lawfulness to suicide. On the contrary, we suggest provisions to make clear that suicide is against public policy. Still, someone might commit suicide by refusing treatment — understanding "suicide" in a moral sense. But this possibility already exists. The statute we are proposing only extends this possibility as an unwanted side-effect of extending the just protection of a genuine liberty. The grounds of this liberty are not in any supposed right to die, but rather in the right of persons to bodily integrity and intangibility, which is closely related to the right to life itself.

Those who favor euthanasia are attempting to impose a morality of beneficent killing, a quality-of-life ethic, upon the whole society. This ethic is based upon the utilitarian principle of the greatest happiness of the greatest number. As beneficent killing, this principle means that everyone would be better off if some people were dead. If any substantive moral view is going to be imposed upon American society today, it will be this view. Opponents of euthanasia can make their most compelling case against the imposition of the quality-of-life ethic not by appealing to the substantive good of life, but by appealing to liberty and by defending the right of defective children and other nonwilling beneficiaries of the "right to die" to protection of the laws equal to that afforded the rest of us. In short, in a society as anti-life as ours, anyone seriously dedicated to protecting the right to life also must be dedicated to protecting liberty.

Having taken a libertarian position, opponents of euthanasia will be able to appeal consistently to the same principle at every stage of the euthanasia debate. If euthanasia is to be safe, public involvement is required — public involvement even more extensive than that which is inevitable in our welfare society in any matter related to

medical care. Indeed, the legislation we are proposing would involve a court in the mere refusal of treatment. Opponents of euthanasia can object very strenuously on libertarian grounds to the involvement of society in it, for such involvement is an infringement upon the liberty of those persons who regard euthanasia, even voluntary euthanasia, as gravely immoral. Such persons have the liberty to stand aloof from killing and they have a right to public institutions which remain clear of killing, for all necessarily participate in these public institutions.

We believe there is still time — but only a little time — for opponents of euthanasia to preempt the libertarian ground and to block "death-with-dignity" legislation in many states. Objectionable statutes perhaps can be replaced or at least amended within the framework of a philosophy consonant with respect for life and concern about the right to life. If this opportunity is lost, all who fail to seize it will share in the blame for what will follow. One's obligation is not only to love life and to resist its obvious enemies. Fidelity to the good of life and the dignity of persons also calls for a creative response to the challenge posed by the euthanasia movement.

NOTES

1. *Cal. Health & Safety Code* §§7185-7195 (1976).

2. Proper citations were not available at the time of writing. The acts are: Texas, Texas Legislative Service, S.B. 148, 6-255, as finally passed and sent to the Governor; Oregon, Oregon Legislative Assembly, Engrossed Senate Bill 438; Nevada, Assembly Bill No. 8; 1977 Idaho *Sess. Laws*, ch. 106; 1977 N. C. *Sess. Laws*, ch. 815; 1977 N. M. *Sess. Laws*, ch. 287; 1977 *Ark. Acts.*, act 879.

3. §§7186 and 7195.

4. See, for example, Richard A. McCormick and André Hellegers, "Legislation and the Living Will," *America*, 136 (March 12, 1977), pp. 210-211.

5. "History of Euthanasia in U.S.: Concept for Our Time," *Euthanasia News*, 1 (November 1975), pp. 2-3. The following paragraph (p. 3) is of special importance: "Legislative initiative had all but ceased and it was decided that there was no chance of getting any bills passed until there was a massive educational effort. By the end of the '60s there were two significant events: the Euthanasia Educational Fund was established in 1967 to disseminate information concerning the problem of euthanasia, and Luis Kutner suggested the Living Will at a meeting of the Society." Kutner published his proposal in an article concerned primarily with active euthanasia which switched with practically no transition to the proposal of the "living will": "Comments: Due Process of Euthanasia: The Living Will, A Proposal," *Indiana Law Journal*, 44 (1969), pp. 539-554, especially pp. 548-550.

6. "Society Names New President," *Euthanasia News*, 1 (February 1975), p. 1.

7. Compare the list inside the back cover of *Death with Dignity: Legislative Manual*, 1976 ed. (New York: Society for the Right to Die, Inc., 1976), with the list on the back cover of *Death and Decisions: Excerpts from Papers and Discussion at the Seventh Annual Euthanasia Conference* (New York: The Euthanasia Educational Council, Inc., 1976).

8. Compare "Model Bill," *Death with Dignity: Legislative Manual*, pp. 95-96, with the New Mexico statute.

9. The British bill is printed in A. B. Downing, ed., *Euthanasia and the Right to Die* (London: Peter Owen, 1969), pp. 201-206.

10. The close relationship between "death-with-dignity" and the matter of emptying public institutions is seldom made as explicit, for obvious reasons, as it is by "Statement of Walter W. Sackett, M.D.," in *Death with Dignity: An Inquiry into Related Public Issues*, Hearings before the Special Committee on the Aging, United States Senate, 92nd Congress, 2nd session, part 1, Washington, D.C., August 7, 1972 (Washington, D.C.: U. S. Government Printing Office, 1972), pp. 29-39.

11. See Angela Roddey Holder, *Medical Malpractice Law* (New York, London, Sydney, Toronto: John Wiley & Sons, 1975), pp. 225-234; "Notes: Informed Consent and the Dying Patient," *Yale Law Journal*, 83 (1974), pp. 1632-1647.

12. A great many articles have appeared recently on this subject. The best single treatment is Robert M. Byrn, "Compulsory Lifesaving Treatment for the Competent Adult," *Fordham Law Review*, 44 (1975), pp. 1-36.

13. See *Ibid.*, pp. 14-15, with note 64; Kenney F. Hegland, "Unauthorized Rendition of Lifesaving Medical Treatment," *California Law Review*, 13 (1965), pp. 863-864.

14. *In the Matter of Karen Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976) at 653-660. The record does not make clear whether the parents ever signed any consent to treat form; she was initially delivered to the hospital by others.

15. *Ibid.*, at 664. The crux of the decision is the argument that Miss Quinlan would refuse treatment if she could, and so her presumed nonconsent must be exercised — the Court conceived it in affirmative terms as a right of privacy — by Mr. Quinlan. The ground for judging that she could refuse if she could is the claim that the overwhelming majority of the members of society would in like circumstances refuse for themselves or for those closest to them. If this proves anything, it proves that the treatment was futile and of no benefit to the patient. In the event, it turned out that the respirator — which was the matter at issue so far as the plaintiff, Mr. Quinlan, was concerned — was *unnecessary*.

* Professor Robert M. Byrn and Mr. William B. Ball vigorously and very helpfully criticized an early draft of this article; neither, of course, should be considered responsible for it.

NATIONAL CATHOLIC REGISTER
Vol. L V, No. 1
January 7, 1979

Dialogue

Defining Death Is Dangerous But Needed

Dr. McCarthy De Mere is a Memphis surgeon who holds a law degree and teaches law. As chairman of the Law and Medicine Committee of the American Bar Association he led that committee in a two-and-one-half year search for a foolproof and genius-proof definition of death. Here he discusses with the Editor the dangers and deficiencies of a different definition of death now being pushed by advocates of euthanasia. And he explains why time is running out for prolifers if they want to fend this off.

Riley: This Uniform Brain Death Act which the National Conference of Commissioners on Uniform State Laws has drafted: to a person who is uninitiated in these matters, it seems perfectly innocuous.

De Mere: This is my great fear: that it's going to appear innocuous to the House of Delegates of the American Bar Association when they vote on it in February. As a matter of fact, it is so much like the definition of death which was adopted as policy by the ABA in 1975, that I strongly fear that unless there is a concerted effort to educate the delegates as to its dangers, it is going to pass. Then it will go to every state in the Union and probably supplant the laws from the 18 states which already have definitions of death. It will supplant the Common Law definition of death. More than likely, a Supreme

(Continued on Page 6)

(Continued from Page 1)

Court decision will be coming out of it.

Riley: If I'm not mistaken some of the euthanasia people are already preparing to bring a case before the Supreme Court.

De Mere: Yes. They were ready to do that several years ago. What they wanted was to incorporate the "cognitive" and "sapient" features into a definition of death. In other words, if a person's brain was not active, he was no longer a person, and could be declared legally dead. It would not be homicide then to do away with him.

Riley: Before you tell us more about these terms, *cognitive* and *sapient*, tell us why we even need a definition of death. And why all the furor at this time?

De Mere: In weeks the American Bar will act upon this, that's why the furor. To back up a little bit, we have been living under the Common Law definition of death right until the present time. The Common Law definition is that when the heartbeat stops and the respiration or lungs stop, the individual is dead. Now we know that this is not true because in every open-heart surgery that's done, they stop the heart and the lungs and the individual is not dead. But when we have an irreversible cessation of the brain, the function of the brain, the total Brain, then this is truly death. So the Common Law definition of death is incorrect. It was all right up until the present time when they developed all the means of recusitation and the new techniques for open-heart surgery and so forth. It is an absolute necessity that a correct legal definition of death be developed.

Now the reasons for it. In law we have cases where individuals have simultaneous death. For instance, a husband and wife are in an automobile struck by a train and one of them lives a few seconds longer than the other, then all of the funds from the estate of both would go to whichever one supposedly lived longer. Now it's absolutely necessary to have a definition of death in order to say which one was dead and which wasn't. We've had some very silly cases. One in Colorado where a husband and wife were in an automobile accident and his body was torn into many pieces and there was no question but he died instantaneously. But the wife was beheaded and a witness to the accident said that he saw blood spurting out of the neck; therefore, her heart was beating and her heirs inherited all of the money of the estate. Well, we know that that was wrong and stupid, but it is all the law had to go on. If her heart was still beating, then the Common Law said that that was life.

We also know that it's important in transplant surgery that the donor be pronounced dead accurately so that good fresh organs can be given to the recipient.

We've seen some economic reasons for a need for a definition of death with the people who've been kept on expensive machines for weeks after they were actually dead.

Now the ABA definition of death was formulated by the ABA Law and Medicine Committee of which I was chairman for two and a half years. We had 200 of the finest authorities on legal matters in the country working on this. We also had semanticists, journalists, legal scholars, medical scholars, theologians. Everybody contributed to it and the definition we developed we felt was good. It was adopted by the American Bar in February, 1975.

Dialogue

Defining Death Perilous, but Needed

That definition is fairly simple. It says that for all legal purposes, a human body with irreversible cessation of total brain function, according to usual customary standards of medical practice, shall be considered dead.

Riley: How has this ABA definition fared in the state legislatures?

De Mere: Five states have made this into law. When we proposed this at the American Bar Association we did it as policy, not as law. In the ABA, we don't write laws.

Riley: Now the National Conference of Commissioners on Uniform State Laws has been studying this definition.

De Mere: Since 1976. I actually was appointed as a representative of the American Bar Association to this Commission and I worked with the sub-committee developing this. They changed the name of the act twice as they were developing. They first named it the Determination of Death Act. This is not a good name because the determination of death is a medical function and not a legal function. Definition of death is a legal function. That may seem to be a matter of close semantics but it's absolutely true.

Riley: The prefatory note to the Uniform Brain Death Act of the National Conference of Commissioners on Uniform State Laws says that this act is silent on acceptable diagnostic and medical procedures. It claims to address the concept of brain death, not the criteria used to reach the medical conclusion that brain death has occurred.

De Mere: That's true. There are many truths in this act. It would not take very much to make this into something very good, but it was twisted. There are a lot of half-truths in what they're proposing, and half-truths are much more dangerous than out-and-out lies.

Riley: What's wrong with it?

De Mere: Take the name. It's called Uniform Brain Death Act. Well, the act itself is not describing what is brain death, so that's deceptive. It's not a good name. It is not describing brain death at all. What they are doing is giving a definition of death but they're more or less going in the back door.

Riley: What would you have preferred to call it?

De Mere: It should be called Uniform Definition of Death Act. Remember in law as in everything else, you have to be able to find things. Looking in the glossary, the lawyers will look for *definition of death,* they won't look for *brain death.* So it's going to be ambiguous and confusing.

They also have in quotations "brain death" and they're not describing brain death at all. They're intimating that there are several different kinds of death such as liver death, and kidney death, so the name is wrong.

The act starts with the words, "For legal and medical purposes." Well, actually, laws are really written for legal purposes to start with. This is redundant to say "legal purposes." No law is written for medical purposes. So this is incorrect as far as the medical profession is concerned. The AMA should oppose it if only for its very first words.

The next word is "an individual." This is ambiguous because an "individual" can be an individual chair, a horse, it can be either inanimate or animate. Probably if you're in conversation you might say "an individual" committed this or that act and you would know what you're talking about, but you could also say that we have individual automobiles that were wrecked. So this is not a word to use when we're talking about a human body.

The next words are: "with irreversible cessation of all functioning of the brain." Now this is the most tricky part of the whole act because it's so close to the American Bar Association's definition of death. Ours is "irreversible cessation of total brain function," and this is "cessation of all functioning of the brain."

Riley: Is there any difference?

De Mere: There is much difference. When we have *brain function,* the function of the brain and the brain cells is first to live, to exist, because brain cells are never replaced. The secondary function of the cells is to transmit electricity, and the tertiary function is to communicate with each other. Far down the line are to have the cognitive and sapient functions: the meaningful activity of the brain, so to speak. These sapient and cognitive functions are thinking, loving, remembering, knowing, tasting, etc.

Now this is the problem and this is probably where I fail in trying to explain this to the uninitiated. This part is the part that was insisted upon by the euthanasia advocates. They want "functioning of the brain" and they want "purposeful activity;" whereas true death is the irreversible cessation of total brain function.

(Next week Dr. De Mere delves into the language-traps which can turn a definition of death into a machine of death.)

NATIONAL CATHOLIC REGISTER
Volume LV, No. 2
January 14, 1979

Dialogue

Perfecting A Definition Of Death

Dr. McCarthy DeMere, who led the Law and Medicine Committee of the American Bar Association in perfecting a definition of death, continues his explanation of why the ABA definition of death is euthanasia-proof. He contrasts the ABA definition of death with the definition proposed by the National Conference of Commissioners on Uniform State Laws, which he holds was shaped by those favoring euthanasia.

Riley: The "Uniform Brain Death Act" proposed by the National Conference of Commissioners defines death as "irreversible cessation of all functioning of the brain." The definition your committee of the American Bar Association came up with defined death as "irreversible

(Continued on Page 6)

(Continued from Page 1)

cessation of total brain function." The difference between the two seems microscopic, but you think it's the difference between life and death.

De Mere: Let me make a comparison with an army. The function of an army is not primarily to fight. The function of an army is to be able to live, to exist. Its secondary function, down the line, is to be able to fight. An army can be in the field simply camped and not fighting, and not doing anything.

Riley: But it still fulfills its function?

De Mere: That's right. It has function because it's alive.

Riley: It frightens off an aggressor, for example?

De Mere: Well, it might not do that. It's just existing. If an army has been defeated and there are only a few soldiers scattered here and there, it no longer exists as an army. That's what we're trying to explain about the brain.

Another example: if you have an anesthetic, you lose all functioning of the brain. You don't feel, you don't see, smell, remember, taste or anything.

Riley: But you breathe.

De Mere: Well, you may not. Most anesthetics knock out the breathing center. But none of the cells are dead. The whole organ is alive so we have brain function, but we don't have functioning of the brain. There's the difference, and this is hard to explain. But think: Under an anesthetic, there is no functioning of the brain, but there is brain function.

Riley: Could we put it this way? When you have a total anesthetic, one that knocks out the functioning of the respiratory system and the functioning of the circulatory system—can it do such a thing, by the way?

De Mere: It's all dependent on the brain. You can stop it all.

Riley: Suppose you have such an anesthetic that halts all of the functioning of the various brain functions. The functions remain but they happen not to be functioning. Does that make sense?

De Mere: Well, yes. I think we need semantics that would explain it better and perhaps you or someone could come up with something better than *brain function,* because the words are too close and that makes it very dangerous. What we came up with was "total brain function." It was understood at that time, and the judges have understood, that when the brain is completely out, irreversibly so, and never able to function again as an organ, then this is death. But you could have all of your brain functions out and say they're not going to return, and the individual would not be dead. Even your respiratory center, as in polio, could be out.

Riley: The circulatory?

De Mere: The circulation is dependent on the brain. The heart only has intrinsic ability to beat for a few minutes after the brain has ceased. This is another confusing part. This physiology is difficult for people to understand. The lungs are completely dependent on the brain stem. There's no way for the lungs to work at all without the brain stem being active. The heart will not beat very long without stimulation from the brain and by that not very long, we usually say from 6 to 15 minutes would be the longest that any heart could beat and most of the time, it's very quick-within a few seconds, so we have a tricky situation.

If it were simple, we would long ago have had a good definition of death into the law. They've been trying for 80 years to come up with the semantics of a good definition of death. Black's Law Dictionary still quotes the 1906 definition of death which is the cessation of respiration and heartbeat and circulation. A lot of people say this is traditional and this is what we want to diagnose death by. But here we're separating definition from determination. It's

Dialogue

Perfecting a Definition of Death

up to the medical profession to develop stringent criteria for determining death.

Going further into this, the commissioners added: "including the brain stem." I suggested that and I think this might help it.

They said "is dead" instead of "considered dead." This puts too much responsibility on the medical profession. If medicine is an art and not a science, even though the pronouncement of death may be 99.9 percent accurate, it's still going to be "considered dead" because there is a slight room for error. But in the law they are proposing they are giving no room for error, as if every physician could diagnose this. It says "Determination of death under this act shall be made in accordance with reasonable medical standards."

That's the last part of the act and that is not palatable to the medical profession. I'm hoping that the AMA, before February, will object violently to that part. The part about "shall be in accordance with reasonable medical standards" is unacceptable to the medical profession. Everything else in law that refers to medical practice and the learned professions, calls for "the usual and customary standard." In malpractice, for instance, the physician is held to the standard of care which is usual and customary for the procedure which he was doing. He's not held to the "reasonable."

"Reasonable" sounds good, but I'll give you an example. *Reasonable* is determined in law by a jury and a judge after the act. *Usual and customary* is already established.

Riley: It's more concrete then.

De Mere: I can give you a couple of examples. An old case involved a tugboat that was in a river accident. It had a horn. The captain had used everything usual and customary for tugboats, and that was his defense. But the jury said it should have been reasonable to have radioed. It wasn't customary for every tugboat to have a radio, but they said it would be reasonable. So they held him to a standard that was more than usual and customary. There's a case in Washington concerning a young patient, under 30. The physician did not do the test for glaucoma because it was not usual and customary to examine every patient before surgery to check the pressure of the eye. It is customary with older patients to give the test, but not with young ones. The court said it would have been reasonable in every case to give a test to prevent the blindness that did occur. That's a more stringent standard than the medical profession can tolerate.

Riley: How does this affect the determination of death?

De Mere: Take a physician out in the country. He is determining brain death — the irreversible cessation of the total brain function — by examining the reflexes, and looking at the pupils of the eyes, and listening to the heart, the lungs, and the tests available there. Now that's usual and customary for determining death in his area. If later a case comes up, a jury might say "Why didn't you do brain waves? In the intensive-care unit of the hospital they determine death by using an electroencephalogram." Now here they're using something after the fact, while he was using what is "usual and customary." This is not going to be palatable or tolerable to the medical profession.

Riley: It doesn't seem to have any implications for euthanasia though.

De Mere: No, no. Down in the Comment. The Comment is adopted into the law also. In the second paragraph they go into detail. "A critical word in the draft is *functioning*. It expresses the idea of purposeful activity in all parts of the brain organ as distinguished from random activity."

Now, any judge or jury can take that and say, "I don't believe that this patient had any purposeful activity." What is purposeful activity? He couldn't recognize his family, he couldn't feed himself, he couldn't think, he couldn't remember. Therefore, he's dead.

That paragraph is the most dangerous in the entire law, as far as I'm concerned. It refers back up to the functioning of the brain.

Riley: It continues: "In a dead brain some meaningless cellular process, detectable by senstive monitoring equipment could create legal complexity if the word 'activity' were erroneosly substituted for 'functioning' ". So in that case instead of irreversible cessation of all functioning of the brain, it would become irreversible cessation of all activity of the brain.

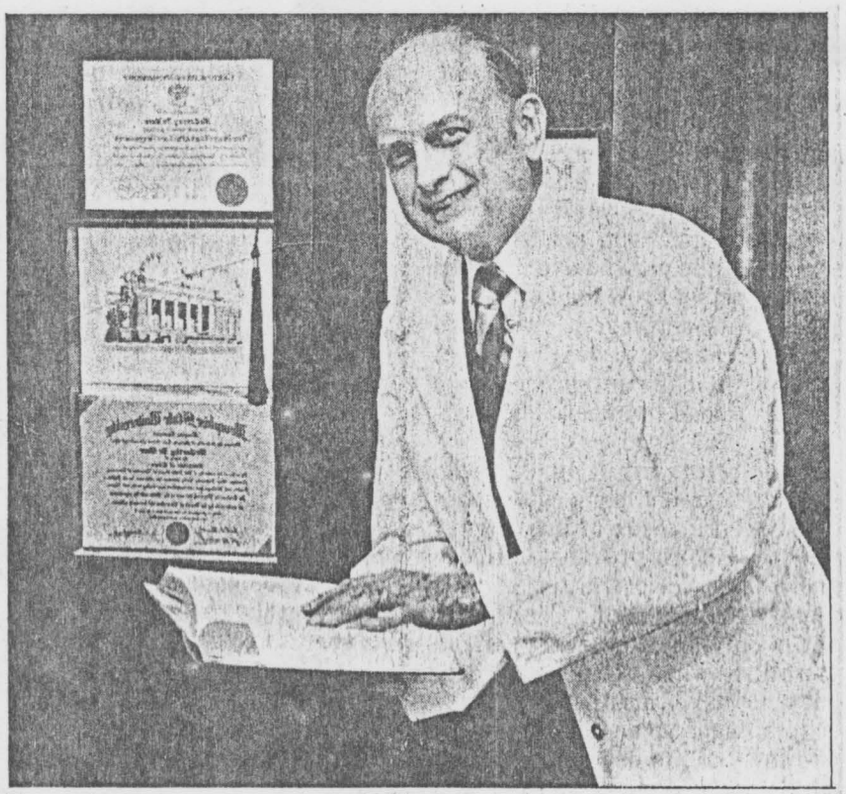
De Mere: I don't like either one of those. Neither is correct. The brain cells can have no activity whatsoever and still be alive. Brain cells do emit electricity, but you can have a depressed brain with deep anesthesia, or with freezing, or some drug, and there'll be no emission of electrical impulses, but the brain will not be dead. So, we're dealing with a very delicate subject and we have a supposedly simple and innocuous proposal that can easily be translated into something else.

If this is proposed to the Supreme Court we can see that the individual who is in the nursing home, the retarded child — you can do him in with this. They can

say he has irreversible cessation of all functioning of the brain, of its meaningful activity. All you'd have to have is a doctor to say this child will never have any meaningful activity of his brain.

This is what they did in Germany. They had persons whom the psychiatrists diagnosed as being irreversibly mentally ill, long before Hitler. They said this individual was irreversibly mentally ill, he was taking up space, he was of no use to himself or to society; therefore, it would be not murder or homicide to remove all life-supports from this individual. That was the first proposal in Germany: just to remove life supports. They did that with the severely mentally ill, but these individuals didn't die right away. They wasted away when they took away their food, so they then wanted to do something that was more merciful and quicker in eliminating these non-persons and they developed the carbon monoxide treatment and the gas chambers. This progressed, as everyone knows. The history is there very clearly that they finally expanded this to mean that when an individual was of no use to himself or to society, he could be mercifully eliminated. Now, that is the old and the true definition of euthanasia: *merciful elimination. Mercy killing* what it was called, and they extended that in the time of Hitler to political prisoners because they were only taking up space and eating food and they were a detriment to the country, so they simply declared them non-persons. It certainly was not homicide to eliminate a non-person.

Next week Dr. De Mere concludes his dialogue with the Editor by trying to explain why, if the proposed definition of death is so dangerous to life, prolife activists and the Catholic bishops have not intervened.)



DR. MCCARTHY DE MERE — They've been trying for 80 years to come up with the semantics of a good definition of death.

NATIONAL CATHOLIC REGISTER
Vol. LV, No. 3
January 21, 1979

Dialogue

The Definition Of Death and Euthanasia

Dr. McCarthy DeMere, who is both a surgeon and a lawyer, tries to explain to the Editor why Right to Life forces in the United States seem indifferent to the prospect that a dangerous definition of death will win approval of the American Bar Association's House of Delegates in Atlanta within less than three weeks. He explains why this definition of death could institutionalize euthanasia in this country. Dr. DeMere led a committee of the ABA in perfecting the definition of death which at present holds ABA approval.

Riley: Doctor, your prophecy that euthanasia is around the corner takes a certain strength from your prophecy years ago that abortion was on its way.

DeMere: It was no harder to see abortion coming than it is to see euthanasia coming today. If you're working in this field of legal medicine, the people with special interests are frank enough to tell you what they're going to do. Many years ago there were a great number of people working for legalized abortion and they made no secret about it. They went to all the medical societies and asked for resolutions.

Riley: Are the euthanasiasts making a secret about it?

DeMere: No secret about

(Please turn to page 6)

(Continued from Page 1)

this, absolutely not! And they are working very strongly for the Right to Die laws, the Living Will.

Riley: Do they state clearly and unequivocally and publicly that they are working for the day when a retarded child can be put to sleep permanently by euthanasia?

DeMere: Let's put it this way: They have had people on their programs who have told about the birth of a retarded child and putting him over in the corner and not resuscitating him; they have praised these people. This is happening right now without any special law to cover it, in some of the largest medical centers in the country.

Riley: At Yale it was publicized.

DeMere: That's right, and at John Hopkins. They've been on programs, sure. Recently there was a national case where the doctor said the child was dead before he touched her. He had attempted an abortion and the nurse saw activity in the child. I'm not passing judgment on this. I'm just going by the testimony that was reported in the paper. The nurse saw activity and she said he went over and placed his fingers on the baby's neck and then the pathologist later said the child had bruises on the neck but the doctor said this child was dead before he touched her.

Riley: A new trial has been ordered for this doctor because there was a hung jury. At one point, the jury seemed to be in agreement, but it fell into a deadlock when the judge called the jurors back into the court after eight days of deliberation and told them they had to go by a new definition of death. That there can be a death if a person has suffered a total and irreversible cessation of brain function. They were confused by that because their earlier instructions were that death is the disappearance of all vital functions. They couldn't determine whether the brain had ceased to function or not. For that reason they couldn't determine if there had been a murder.

DeMere: The problem there was that the judge didn't charge them as to what the definition of death is, and the determination of death is. It's very simple in that case. If they had had the ABA definition — they called me on that case, by the way and I talked to them over the phone — that doctor, in order to have fulfilled that definition would have had to use the *usual and customary* standards of medical practice. That would have been the test. Did he look at the baby's pupils? Did he test the reflexes? Did he check the heart and the lungs? Was the baby moving? You have to have brain function to be able to have any movement unless it is just muscle spasm.

Riley: The baby was moving, according to testimony.

DeMere: This just points up that we do need a good definition of death. I think the present American Bar Association policy is fine, with a slight commentary as to the difference between *brain functions* and *brain functioning*. The Uniform Law Commission could have developed this, but they had advice from special interests, from the Right to Die people and people who are very closely associated with them.

Riley: What is the present American Bar Association definition of death?

DeMere: "For all legal purposes, a human body (we don't say person and we don't

Dialogue

Definition of Death and Euthanasia

say individual) with irreversible cessation of total brain function, according to usual and customary standards of medical practice, shall be considered dead." I'd like to add "including the brain stem." That might clarify it a little bit.

Riley: How does adding "the brain stem" clarify it?

DeMere: The layman sometimes doesn't consider the brain stem as part of the brain because it has nothing to do with the thinking or the moving of the limbs or the body. It has to do with vital functions such as breathing and the heartbeat. And it is part of the brain. We didn't put it in our original definition because we felt that the judges and lawyers would understand that it's part of the brain. Since that time, however, we've found many people who didn't realize that the brain stem was part of the brain, so I think that that should be in there to clarify it.

Riley: If the Uniform Brain Death Act is as dangerous as you say it is, why haven't the Right to Life people stepped in? It seems to pose a pretty serious threat to the lives of many people in this country: the retarded, the very, very old, those who are very ill. Why haven't the Right to Life people worked against this definition of death?

DeMere: They are involved in a mammoth struggle against abortion. They're fighting with all of their strength on that.

Also, they clearly understand the nine-month development of the child and they want to prevent any interference with that. But after the birth of a human being, from then until the grave, there are a lot of gray areas where even some of the most ardent Right to Life people waver. There are some I have seen that say "Well, I think that individual lived too long," or "He should have been taken off of the machine," or "I had an uncle they kept alive too long in a nursing home." Well, what he's really saying is that there should have been some means to terminate his life, to kill him. So, some of them, while very prolife on one end of the scale, may not be very clear on the other end.

You don't see a lot of activity for retarded children, the preservation of their lives. You don't see a lot of activity for the severely mentally ill. I don't condemn any of them. They're very fine people. I've never belonged to Right to Life. I've tried to get them interested in this. If they could expend a little bit of energy on this I think they could convince the House of Delegates to turn down this proposal, to send it back to the Uniform Law Commission for further work, and for them to indicate that they know the forces that are in back of this definition before it goes into law.

Once this thing goes into law, it's extremely difficult to amend it or rescind it or repeal. If we can stop this right at the present time, then it will be so much easier. We don't have to go to all of the States.

I also feel that the Catholic bishops — I have tried to get them interested in fighting this because they've always advocated prolife and from pulpits they preach against euthanasia. But here we have a law that is being proposed that is fostered by the advocates of euthanasia, yet the National Conference of Catholic Bishops wouldn't even put it on the meeting agenda.

I went to Washington. I talked to Mr. George Reed, the chief counsel. I had a conference with Bishop **Thomas C. Kelly, General Secretary of the NCCB**, and several people. I spoke to them for three hours and tried to explain the imminent danger.

So many of the lawyers for the various dioceses around the country say we don't need a law on definition of death. This is ridiculous. We are going to have a definition because the Common Law definition is wrong. Therefore, the people who believe in the sanctity of life and believe that every human body has an immortal soul.

You know my own opinion about this whole thing is that if there is no God, if we just happen to be here by evolution, if each human does not possess an immortal soul that belongs to him now and after death, then all of these advocates of euthanasia and social planning are right. If our only value is a more perfect and pure society, we can easily see that it would be better to kill all the retarded children. If you want a perfectly functioning society you certainly don't want people in it who are not producing, so you would eliminate everybody over a certain age. You'd have a controlled life-span. (By the way, this is one of the things that is being advocated — a controlled life-span). You would eliminate everybody in the mental institutions. Why keep them? They're no use to themselves or society. I can see eliminating everybody on welfare.

Riley: A grim prospect.

DeMere: I don't enjoy this topic. I don't want to work in it. I was more or less drafted into it, being chairman of the Law and Medicine Committee of the ABA. I practice plastic surgery. I do over 900 operations a year. I have five children; I'd like to spend time with them. But I found when we went into detail with this, that there are very few people who understand what is happening and what is going to happen.

Riley: You think that's true of the American bishops and the Right to Life people as well?

DeMere: Absolutely true. I was very frustrated that the bishops were doing nothing. Then I talked to various individual bishops and when they realized what was happening, they see it — as individuals. Most of them will say, "I will consult my own attorney."

I think if the worst comes to pass, you can lay it more to the attorneys of the bishops.

What's going to be said is "Why didn't you tell us about the magnitude of this in time? But I've been shouting about this for the last five years. I've told everybody. I've given talks around the entire country. I've testified in over 20 states against the Right to Die laws. These are just directly out of the Euthanasia Society.

Another thing, a lot of people don't understand the difference between the American Bar Association and the National Conference | of Commissioners on Uniform State Laws.| The National Conference is a political organization. All of the members are appointed. Each state has a certain number of commissioners according to the population. Most states have about four to six commissioners. They're appointed by the governors of the states. They meet and they develop laws that apply across the nation to the various states.

It has nothing to do with the Congress. It is not part of the American Bar Association, but when they develop a prospective law they appear before the House of Delegates of the American Bar Association and present it. Occasionally — but very rarely — the House of Delegates will turn it down and they will take it back to the conference and work on it.

Riley: That's what you hope will be done.

DeMere: Yes, but I'm not getting any support. If every bishop in the U.S. would tell his attorney to have him contact and tell the delegates in his particular area, "Be careful of this, this is a dangerous proposal. Either table it or recommend that it go back to the commission. Do *anything* but don't approve it," it could be stopped immediately. This is what I was hoping the bishops would do.

Dr. McCarthy DeMere

The same thing could be done by the Right to Life people. They've got workers all over the United States. All they would have to do is contact the delegates, the lawyers and say there's something coming up that we're afraid of, we don't want it passed now. Delay it. It could be delayed, but they're not doing anything. One person can't do it. I'm tired and I'm just ready to throw in the sponge.

NATIONAL CATHOLIC REGISTER
Vol. LV, No. 3
January 21, 1979

The Definition of Death

An uncanny and alarming resemblance has arisen between the present and the months immediately proceding the Supreme Court's disastrous *Roe* and *Doe* decisions on abortion. Now, as six years ago, activists aiming to subvert the legal safeguards of human life are working quietly but with deadly efficiency to present the nation with a *fait accompli*. Now, as then, to halt them would be child's play compared with the herculean effort required to dislodge them once they have reached their goal. Now, as then, the very men and women destined to take up that herculean task in defense of life are strangely blind to what is impending.

Of course it is the enemies of human dignity who, despite their astuteness, are shortsighted. Never in history has the myopia of materialism been less justified. The seemingly limitless achievements of physical science have had the paradoxical effect of marking off its limits in stark bold lines. Only materialists can be surprised to learn that science cannot do everything, for the limits of physical science coincide with the limits of matter. In fact materialists dare not learn this lesson lest they unlearn their materialism. Maybe that is why they strive so desperately to solve more and more ethical problems with more and more materialistic solutions.

Militant materialism's most spectacular victory has been won in that field where law and medicine meet. It is the legalization of abortion. It has succeeded in demoting the child to a nonperson, and in so doing has corroded the very concept of person.

Now if materialism ever succeeds in banishing the person from our understanding, it will exercise the only palpable manifestation of spirit in the universe. On a deeper level it will destroy the notion of God Himself, for if God is not personal He is nothing at all.

So the final triumph of materialism, which is the defeat of God, can be achieved by destroying the notion of person root and branch. On the materialists' list of proscribed persons the unborn child was only the first victim. Fortunately for their strategy, that outrage against the most innocent and helpless of persons is so monstrous that it blocks a clear vision of their present maneuvers. Moreover, the struggle against the evil of abortion tends to engross the minds and energies of those engaged in it. Finally, prolifers have acquired a healthy suspicion of the dubious prolife causes which some try to thrust upon them, such as gun control and the abolition of capital punishment.

The net effect is that prolifers are overlooking this latest materialist assault on the human person. It is an attempt to change the law's definition of death into a warrant to kill.

This bold attempt is likely to succeed not only because prolifers are too little concerned about it. There are two further reasons why it seems headed for success (hence why the nation seems headed for a new disaster). One is that the booby-trapped definition of death proposed by the advocates of euthanasia is deceptively like the tamper-proof definition of death proposed by the Medicine and Law Committee of the American Bar Association; only the closest study of the two will reveal the vital (or lethal) differences. The other reason is that most students of the problem of defining death agree that a new definition of death is needed. The definition provided by the Common Law and much of statutory law no longer fits the medical realities.

The present Common Law definition of death holds that death is the total stoppage of spontaneous respiratory and cardiac function. This definition no longer fits the medical realities. With modern medical and surgical techniques, breathing and heartbeat can be halted for hours. Moreover a person whose spontaneous breathing and circulation have ceased can be sustained indefinitely by modern machines.

This technological ability to keep a patient's heart and lungs working raises the question of whether that patient is truly alive. In some cases there can be no doubt. A person, for example, whose respiration and heartbeat both depend upon machines may be able to talk and even to walk. Obviously such a person is not dead (and obviously the Common Law criterion of death is inapplicable). Here the machines clearly sustain life, and not just certain physiological functions. But where a patient supported by such machines is in a deep coma, is he or she truly alive?

We think the question is resolved by the ABA definition of death. The ABA definition states: "For all legal purposes a human body with irreversible cessation of total brain function, according to the usual and customary standards of medical practice, shall be considered dead."

This definition has been explained in the pages of the Register (Jan. 7, 14 and 21) by Dr. McCarthy DeMere, the Memphis lawyer-surgeon who led the ABA's Medicine and Law Committee in its two and one-half year search for a definition. Dr. DeMere also pointed to dangers in a rival definition proposed by the National Conference of Commissioners on Uniform State Laws.

In the formal comment attached to that rival definition by the National Conference of Commissioners on Uniform State Laws, it is stated that the definition "expresses the idea of *purposeful* activity in all parts of the brain organ . . . " (the emphasis is in the original). This statement of the drafters' intent is decisive. A person unable to direct his or her actions purposefully can be considered dead, hence fair game for the benevolent homicide of euthanasia. Moreover it leaves open the possibility of legal homicide against any person suffering severe damage in any part of the brain, since it demands "activity in all parts of the brain organ" before a person is considered living.

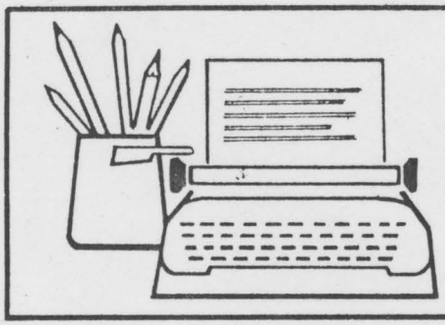
Perhaps the sharpest peril arises from an innocent-looking phrase in the definition itself, giving doctors the right to judge a person dead by "reasonable medical standards." Alas, the day is long past when doctors could be trusted to decide what are reasonable medical standards.

It comes as no surprise that this definition of death was shaped by declared proponents of euthanasia. Whereas the ABA had given us a prolife definition of death, this is a pro-death definition of death. Where the ABA took more than two years to achieve its definition of death, the National Conference of Commissioners on Uniform State Laws took a few days to accept a definition engineered by the promoters of euthanasia.

The safety of this nation's ill and helpless hinges first upon the assembly in Atlanta next month of the ABA's House of Delegates. Should the ABA delegates accept the lethal definition of death proposed by the National Conference of Commissioners on Uniform State Laws, that peril-fraught definition will supersede the sound definition adopted four years ago. Such is the prestige of the National Conference of Commissioners that the ABA delegates rarely oppose anything the commissioners propose. This lethal instrument could get ABA approval without opposition, for at this point no organized opposition has emerged.

With that definition in hand, sealed with ABA approval, the proponents of death with dignity merely have to look about for a likely court case. Their goal is the Supreme Court. Then we may well wake up one day to find we are living in a society saddled not only with abortion but with euthanasia.

NATIONAL CATHOLIC REGISTER
Vol. LV, No. 3
January 21, 1979



Letters

Euthanasia Can Be Prevented

Dear Editor:

I thank the *National Catholic Register* for calling attention to the terrible dangers of a poor definition of death. America could become a euthanasia society overnight, just as it became an abortion society overnight. A few dedicated people are working quietly for this, and success is almost within their grasp.

This easy success for euthanasia can be prevented, provided just a few citizens who understand the danger take a very little time and effort. But they must act now, without delay.

The euthanasia advocates have succeeded in getting the National Conference of Commissioners on Uniform State Laws to sponsor a definition of death which, despite its innocent appearance, can be used as an instrument of death. This pro-death definition of death is being presented to the American Bar Association's House of Delegates at its meeting in Atlanta, beginning Feb. 8. If the ABA delegates accept this definition of death, it will supplant the ABA definition of death which was approved by ABA delegates in 1975, and which is the result of more than two years of study by the ABA's Law and Medicine Committee. This ABA committee consisted of 200 legal scholars, 20 of them possessing degrees in both medicine and law.

If however the ABA adopts this other definition of death perfected by advocates of euthanasia, then the euthanasia team will be ready to make an end-run around the American people, around the state legislatures, right to the Supreme Court. It could be *Roe v. Wade* all over again.

But they can be halted at the ABA House of Delegates in Atlanta, meeting in a few weeks. They can be stopped fairly easily provided enough people act now. They need not be many people. They need not be "important" people. They need not even do very much. But they must do it right away.

I will gladly explain to them how to stop this disastrous definition of death. They can write me at 1460 Madison Avenue, Memphis, Tennessee 38104.

McCarthy DeMere, M.D., LL.B.

(Dr. DeMere headed the ABA committee which perfected the definition of death adopted by the ABA four years ago. The reader is referred to today's editorial, and to the Dialogue *with Dr. DeMere which began in the Jan. 7 issue of the* Register *and concludes in this issue.)*

TESTIMONY OF DR. FRED MECKLENBURG TO THE SENATE JUDICIARY SUBCOMMITTEE ON THE SUBJECT OF BRAIN DEATH

During the past year I have served on an Ad Hoc committee of the Minnesota State Medical Association which is studying the problem of brain death and related issues.

Over the past several years I have testified on several occasions in these halls in support of the pro-life viewpoint on various legislative issues. It is somewhat paradoxical to find myself testifying before this Senate subcommittee in support of a bill which many of my friends in the pro-life movement have taken opposition to.

This situation is not unique, however. Two years ago I found that my testimony in support of family planning legislation was also contrary to the testimony of some in the pro-life ranks. The fact of the matter is that the prevention of pregnancy and the termination of fetal life are two very different issues. They need not be either supported or rejected as a "package deal".

Similarly the issues of brain death and euthanasia are two closely related issues that are frequently confused by many as part and parcel of the same problem. From my perspective as a Protestant physician, I find relatively little difficulty in separating the two. Let me state clearly that I am strongly opposed to acts which would speed the death of living human beings, so-called euthansia or mercy killing. I am also firmly opposed to acts which would needlessly prolong the dying process and thereby prolong the pain and suffering of hopelessly ill patients who wish not to have their suffering prolonged.

But neither of these theoretical situations need enter into a discussion of brain death, since the patients to be affected by such legislation are not

patients who are suffering or in pain, but patients in whom death of the cells of the central nervous system has already occurred. For them the perception of pain is impossible, as is all other perception or feeling, be it pleasure, love or any other simple or abstract thought process.

Death is not an instantaneous process. Physicians through the ages in their struggle to save lives have recognized that certain tissues of the body can die without resulting in the inevitable death of the whole patient. Amputation of dead and necrotic digits or limbs and the removal of gangrenous organs can indeed be life saving procedures in patients who would surely die if left untreated. There are even some tissues like the liver which have the ability to regenerate if proper support and nutrition are provided to the critically ill patient.

Unfortunately, the brain is not such an organ. As brain cells die they are never regenerated or replaced. In a patient in whom the brain is dead, death of the remainder of the body's tissues is predictable in a very short span of time unless there is outside interference.

Modern technology has allowed physicians to intercede in very dramatic ways to halt the rapid advance of many disease processes. Often they are stopped precariously close to the irretrievable point with patients deeply comatose or in a cardiac standstill. Yet they are still salvagable by skilled and caring technicians using potent drugs and electronic devices undreamed of a few short years ago. In utilizing these near-miraculous tools an occasional patient is caught in the process of dying at the tragic point where the death of the brain has actually proceeded to a stage where recovery is not possible, and the brain tissue simply dies. Recognition of this state is not immediate or simple. Indeed it requires certain skilled observations over a period of time in order to be absolutely certain that the condition of brain death exists.

Perhaps advances in technology will someday make the diagnosis and confirmation of brain death somewhat simpler and faster, but simple physical examinations and confirmatory tests can now be done which will give an unerringly accurate diagnosis of the state of brain death. And when these conditions exist, no one has ever recovered. In fact, none of these patients' tissues can exist without continuous mechanical support to provide oxygen and circulation of blood, so called respirators.

I can claim no expertise in the areas of religious doctrine or ethical theory. The guiding principle of my personal morality has always been simply a reverence for human life and a profound respect for the human body. I feel greatly privileged as a physician to have had the opportunity to share in the treatment of disease and the alleviation of physical and emotional suffering. I am proud of the role which physicians have been allowed to play.

I am not proud of those branches of medical science which have abused and desecrated the human body, supposedly in the quest of medical knowledge. I am speaking now of human experimentation on unwilling subjects and aborted fetuses, ~~and fresh cadavers~~, that has been and continues to be promoted by certain enthusiastic investigators.

The needless continued expansion of the lungs and forced circulation of the blood in patients who have passed the point of no return in the dying process which is called "brain death" approaches very close to such practices. I find it both disrespectful to the human body and an exercise in futility.

In the absence of legal recognition of the concept of brain death, however, the specter of increasing numbers of oxygenated tissue preparations filling up Intensive Care units and tying up scarce resuscitative equipment and personnel is all too probable. Obviously, such a theoretical situation would prevent the use of those skills and devices from being applied to the salvagable critically ill.

How tragic the situation, where fear of legal reprisals and sanctions can prevent ~~the~~ physicians from applying their skills where some hope of benefit exists, and where scarce medical facilities are tied up in the hopeless task of supporting a collection of still viable muscle, skin and gland tissues which inevitably must progress to death of the entire organism.

In summary, it is simply <u>because</u> of my respect for human life that I feel the concept of brain death should be legalized, and that I have chosen to appear and testify before you in support of the bill.

Testimony given at the February 28, 1977 hearing of the Senate Judiciary Committee, State of Minnesota, in opposition to Senate File No. 253

Mr. Chairman and Members of the Committee:

My name is William Coughlin Hunt. I am a Roman Catholic priest and Director of the Newman Center at the University of Minnesota, Minneapolis/St. Paul Campus. I am on the Board of Directors of Minnesota Citizens Concerned for Life and American Citizens Concerned for Life. However, I am speaking on my own behalf in opposition to Senate File No. 253.

By its very nature legislation which attempts to define human death raises serious questions. Human death, like human life, is a profound mystery. Moreover, dying is a process, and there is no religious or philosophical consensus about the moment of death, the criteria for determining death, or even that there is such a thing as a moment of death.

Legislation which attempted to settle the issue in either the philosophical or the religious sense would not be acceptable. To define death in philosophical terms would presume knowledge of what it is in every case to be alive. To define death in religious terms would be an unconstitutional invasion of State power into the religious sphere.

Accordingly, in our American society the determination of death has been very pragmatic. It has been handled without laws to determine either the fact or the criteria of death, and the decision has been entrusted to a government official who is not necessarily a physician - the coroner. Until recently, there has been no attempt to determine in law the exact moment of death. Rather, there has been general societal agreement that at certain

stages in the dying process certain things can be done to the dying person or corpse, things such as to bury, to cremate, to embalm, or to use organs for humanitarian or research purposes.

All of this has been possible within our present social-legal system without a definition of death. This raises the question: who will benefit from legislation defining death? What need is there for such legislation?

Will it benefit relatives of the dying person and the society at large burdened with the care of the dying person? One might argue that if there were a precise definition of total brain death they would be spared the agonizing ethical decision about withdrawing extraordinary life support measures. In response, the proposed legislation does not affect that issue. The decision to withdraw extraordinary life support measures is only problematic prior to total brain death. At the present time it would not be a problem were it possible to demonstrate total and irreversable loss of brain function. Consequently, legislation is not needed to benefit this group of people.

Will it benefit the recipient of an organ from the dying person? This is already adequately taken care of by the Uniform Anatomical Gift Act. Further legislation is not needed.

Will it benefit physicians and other health personnel attending the dying person and potentially subject to malpractice suits? Possibly, it would to some extent. However, the total malpractice problem will not be affected substantially by the legislation in question. It is a much deeper and more pervasive problem that should be dealt with directly rather than piecemeal through this kind of legislation.

Finally, will it benefit the dying person? In my estimation,

this is the only question that is really pertinent. To pass legislation affecting the dying person for the benefit of any other person or group of people would be contrary to our entire legal tradition which safeguards the dignity of the human person.

From this perspective it escapes me how defining a dying person's death can in any sense be construed as a benefit to the dying person himself or herself. It is one thing to face the fact that we all must die and not to resist death at all costs. If we see dying as part of human life we will strive to make provisions for it to be as dignified as possible. It is quite another thing to remove the dying person from humanity by way of a legal definition. Certainly our experience with Blacks and Native Americans, if not our experience with unborn children, should make us extremely wary of definitional dehumanization in any form.

Furthermore, I am not very comfortable with the notion of brain death. As Hans Jonas and others have pointed out, it seems to be a revival of cartesian dualism. Instead of the body-soul split, the ghost in the machine, we now are dealing with a division between the brain and the rest of the body. I am not prepared to admit that a human being is basically a brain with appendages.

Also, it seems to me that the notion of brain death fits in too neatly with other attempts to standardize and quantify human beings which have had such devastating effects in our technological society.

In conclusion, I am opposed to brain death legislation such as S.F. 253 until such time as it can be clearly shown that it will benefit the dying person and not further undermine respect for the dignity of the human person.

Life NOTES

"If a man loses reverence for any part of life, he will lost reverence for all of life."
Albert Schweitzer

MISSOURI CITIZENS FOR LIFE WESTERN REGION (816) 444-4211
P.O. BOX 8238 KANSAS CITY, MO. 64105 APRIL 1977

LETTER FROM A FRIEND - March, 1977

Dear Workers for Unborn Children,

This past New Year's Eve was a very special one for us. It was the day God blessed us with an 8lb. 12 oz. baby boy. We couldn't possibly have rang in the New Year in a better way! But if the people at Planned Parenthood in Independence had had their way, that precious little life lying asleep in his crib right now would not be here. He would have been part of some discarded trash months ago.

It all started back in April when I walked into their clinic with a small bottle of urine) and stated that I wanted a pregnancy test. The young girl at the desk took the bottle, and asked if I wanted to be pregnant. Without thinking, and truthfully not wanting to be pregnant, I answered a quick "no". She jotted that down on a form paper in which she had also taken my name & address. She said it would take a few minutes before the nurse in charge could see me and analyze the urine. While I was sitting there waiting, a few other girls came in. The girl asked each one the same question, "Do you want to be pregnant"? Two of them said no, and stated that if they were pregnant, they didn't want to have the baby. She referred them to the Kansas City Planned Parenthood Clinic, where she said they could talk to a counselor and obtain an abortion.

My name was called, and I was guided into the back room where they do the tests. The nurse in charge of the clinic looked at my paper and said, "It says here that you don't want to be pregnant. If you are, do you want an abortion"? I was shocked at her attitude - how she said that so cooly, as of she was asking me what I wanted for dinner! I answered, "No! Just because I don't want to be pregnant doesn't mean I want to kill the baby if I am!"

Then while she was working on the test, she asked me what means I had been using to protect myself from pregnancy. I told her I'd been using the pill, but stopped it because of bad effects it was having on me. Also that my husband & I didn't trust the chemical makeup of the pill. She was obviously very disturbed by that comment because she immediately stopped what she was doing and demanded, "Who's body is it, yours or his?" Your the one who has to suffer the consequences if you get pregnant!" I made a brief statement or two on behalf of my husband, then shut-up because I suddenly realized my life was none of her business. All I was there for was a simple pregnancy test: not advice, or prejudicial statements in favor of women's lib!

She then said it was positive, and started telling me how quick and easy it was to get an abortion at the Planned Parenthood Clinic in Kansas City. She said, "Your can get an abortion very easily right there at the clinic if you get it before 10 weeks, and after that you can still get one, but it's a little more trouble because you have to go to the hospital". I walked out, and as I was leaving, she called to me saying, "Remember if you change your mind about the abortion, just call us at the K.C. Clinic."

The new Planned Parenthood Clinic and abortion referal service is trying to locate in the Truman Cornors Shopping Center. If you shop there, let the Merchants know how you feel. If they think they'll loose business, you'll see some action.

DID YOU KNOW If a girl under 16 goes to P.P. for an abortion, she can get one if accompanied by anyone over 21. If she has no "adult" companion or parental permission, she's sent to Kansas.

Many parents do bring their daughters in themselves. There ought to be a law against that kind of Child Abuse!

YOUTH NEWS

Kansas City Youth Pro-Life Coalition (KCYPLC) hosted its first, and probably not its last, Volley Ball Tournament. Twenty-four teams participated; the winners were The Hummers (an "adult" team - how humiliating). The event was held March 26-27 at O'Hara Gym. Total proceeds were $273 which will be split with Birthright (an organization offering positive alterna[illegible]s to abortion) and KCYPLC educational programs. The group plans more FU[illegible]ing events in the future. If you're young in body or spirit and would [illegible] KCYPLC, call Margie Despain 524-6677

HOW TO WRITE A LETTER TO THE EDITOR

How often have you read an article on abortion that made your blood boil or that maybe deserves a compliment because it is fair, or, on a rare occasion gives the right to life message the edge, or maybe you just want to share your thoughts. Who do you write and how?

There are 3 types. (1) The letter that will affect the most people is one to "Letter to the Editor" or "Speaking the Public Mind". (2) If your letter to the Editor (s) is not for publication, mark it "personal." (3) Check the article for a by-line (a name under the title) and write directly to the one who wrote the article. In all cases follow these pointers:

(1) If you know how to construct a sentence, you can write a letter to the Editor. Write your own thoughts, as you would express them to a friend. Don't worry that you don't know everything about the abortion issue. There is always somebody who knows more, but there are thousands who know less. Remember SINCERITY and CLARITY are more important than $4 words and arm loads of miscellaneous facts.

(2) BE BRIEF One or two points are sufficient. Too many words will cover up your message.

(3) If a factual error is made, point it out and give supportive information.

(4) BE COURTEOUS A flaming attack will label you and the right-to-life movement as fanatic. If you're angry, cool off, re-read your letter and act accordingly.

(5) GIVE COMPLEMENTS and thank you's when due. Imagine what you'd think of people who only criticize.

(6) JUST SIGN YOUR NAME - It's more effective than signing an organizational name.

(7) DON'T PASS UP THIS EASY EDUCATIONAL TOOL! Letter-to the Editor column is a terrific place to express the right-to-life message. Share a piece of information you find interesting or compelling, clear up a misconception. Remember, local papers are more well read than big Metropolitan papers!

(8) If you don't know the proper address - call papers! they'll be glad to help you.

EXAMPLE: Did you read "Getting An Abortion in Kansas City" April 3, Star Magazine? It cries out for a response!

SPEAKING THE PUBLIC MIND
Kansas City Star
1729 Grand
Kansas City, Mo. 64108

DON'T BE FOOLED by isolated statistics taken out of context! Information for the recent Jane Brody article on amniocentesis (K.C. Star 3/15/77) was furnished by the National Foundation M.O.D. The article states that about 5% of all cases tested reveal genetic defects. Please note that the above figure applies only to the test cases which are presumably a high risk group. It does not apply to the total population. According to Dr. Ralph Kauffman of K.U. Med Center (K.C. Star 3/19/75) only 3% of all babies born have any defect serious enough to attract medical attention. Furthermore, Dr. Paul de Bellefeuille of the University of Ottawa tells us (Uncertified Human 11/76) that only 5% of those cases will be from genetic cause. Using these figures, a few simple calculations indicate the following: about 99.85% of all babies born will be free of genetic defect from any cause whatever.

The right to life of that .15% is being quickly eroded by advocates of genetic screening backed up with abortion (March of Dimes & now Easter Seals) and those who promote merciful death for the 3% handicapped newborns.

SHOULD I SUPPORT THE MARCH OF DIMES? Sure, if you support eliminating birth defects by eliminating the defective!

---

call 765-5463 to learn something new!

focus DEATH LEGISLATION

Death Legislation, this same title is used by the print and broadcast media to refer to three completely different classes of laws and bills.

(1) DEATH PENALTY - dealing with establishing criteria for serving this penalty. No right to life organization is officially involved in this type of legislation.

(2) DEFINITION OF DEATH - attempts to statutorially define at what point the state considers you biologically dead for purposes of inheritance, insurance, physican liability and organ removal. Right to life groups are just entering this debate.

(3) DEATH WITH DIGNITY - legalizes documents which instruct a physican to remove life supporting treatment from the signer after a terminal illness or condition is diagnosised. It removes all liability from the physican who, in good faith carries out the request. Right to Life groups are fighting these bills.

• DEFINITION OF DEATH (See March Life*Notes)

Fourteen states have passed definitions, everyone is different. An additional 18 states are considering definitions. Traditionally, defining death has been simple - the cessation of life, ceasing of all functions body and brain - as diagnosised by a physican, nurse or non-medical personel (eg. county coronor). The defining of death becomes complex when laws are molded around specific technology or the needs of a special interest group. In Missouri SB50 and HB105 were drafted to accomadate the problems of resusitators and kidney transplantation. The recognition of brain death ("cessation of total brain function") is important for the physican whose patient is being maintained on a respirator. The diagnosis of brain death indicates to the physican that the machinery can be turned off, it's no longer benefiting the patients, then all body functions cease - death.

Technology now being advanced is profusion of the brain. Conceivably, in the future, patients could be maintained on brain profusion machines, preventing or delaying "cessation of total brain function." Other means of diagnosis will be developed to determine when brain profusion is no longer beneficail to the patient. The apparatus will be "turned off" and all functions - body and brain - will naturally cease.

If we adopt SB50 or HB105 which defines death as "cessation of total brain function" the law will need to be changed if brain profusion is used, because it will be out-dated by technology. The only accurate definition of death is "the cessation of life" (Senate Select Committee Report). In difficult cases, where support machinery is used, the physican makes the diagnosis of the patient's condition, and in consultation with the family, makes a decision. The physican is trained to make these decisions, not the legislature.

If any law is to be considered, it should protect the patient from the unscrupulous doctor. But as Dr. Clough, a K.C. Neurosurgeon, said in the Select Committee hearings on the definition of death "No, I don't honestly feel that the statute (SB50) as we've discussed would specifically protect the patient.

• DEATH WITH DIGNITY (Right to Die) These laws are promoted by the Euthanasia Council & the Society for the Right to Die and popularized by the Karen Quinlin Case. Missouri's proposed law is HB104. California was the first state to pass such a law -Natural Death Act - 1976 (has been amended already in '77). Thirty-six additional states have introduced similar legislation.

This issue, like the definition of death, has become extremely complex. And this complexity has been spawned by those groups who are using these seemingly innocous laws to advance their true purposes - legalized euthanasia.

Death with Dignity laws simply are not needed. No one, over the age of consent is required by any law to submit to medical treatment. For minors and those unable to respond, the attending physican and family together decided what is the best treatment or non-treatment for the patient. No physican has ever been convicted for discontinuing treatment which no longer benefits the patient and needlessly delays death.

Now, the patient's welfare is the most important consideration, not the family, cost of treatment, use of hospital facilities or the drain on society. Realistically, these are all factors which enter into a decision about treatment but the patient's welfare is the balance. But we can see that the balance is tipping toward cost-benefits and society's welfare. We are gradually being made to feel like burdens if we need intensive medical treatment - like we're cheating someone who is more worthy. We begin to see ourselves as unworthy — Thus, the Living Will, a document which in it's various forms instructs the physican to withhold treatment from you if you're diagnosed to be terminal or, in some wills, mentally or physically deficient.

Death, contd.

Missouri's HB104 makes such a document legally binding but it gives no suggested language. Request a copy of the bill from your representative, after reading it you'll find many loopholes. For example: you may destroy your Living Will by tearing it up but are not required by law to notify your physican of your action: treatment maybe withheld if a terminal illness or condition is diagnosed, but the diagnosis in many cases is difficult, and treatment may change the prognosis: if your physican removes treatment "in good fath" he is immune to civil and criminal liability: however, if in good faith, he continues to treat you he will be "guilty of a Misdemeanor." (These situations all pre-suppose you are unable to communicate or respond.)

These wills give you no new rights but they do establish precedent by removing civil and criminal liability from the physican who ceases to treat a patient. These bills do concentrate on the hard cases just like the first abortion debates did - you're asked empathize with the patient dying of cancer who's hooked up to all sorts of mechanical gadgets, just as you were asked to consider the plight of a 14 year old girl pregnant by her father. These things happen, rarely, but they prepare us emotionally and psychologically for further liberalization of the laws.

The Euthanasia Council and the Society for the Right to Die advocate the Living Wills as the first step toward legal Euthanasia. Literally, Euthanasia means "good death" something we all want. But if you look in a newer dictionary, you'll find that it is now defined as "putting someone to death painlessly" - Murder. This won't be the next step, it will probably be the legalization of assisted suicide or Voluntary Euthanasia - death for those society no longer finds useful or worthy. As Dr. Joseph Fletcher, father of Situation Ethics said "if fetal euthanasia, or abortion, is proper so is terminal euthanasia."

Are these projections farfetched? The following quotes will give you an idea of how close we may be.

CALIFORNIA MEDICINE _ Editorial, Sept. 1970

"Medicine's role with respect to changing attitudes toward abortion may well be a prototype of what is to occur. Another precedent may be found in the part physicans have played in evaluating who is and who is not to be given costly long-term renal dialysis. Certainly this has required placing relative values on human lives and the impact of the physican to this decision process has been considerable. One may anticipate further development of these roles as the problems of birth control and birth selection are extended inevitably to death selection and death control whether by the individual or by society, and further public and professional determinations of when and when not to use scarce resources.

EUTHANASIA NEWS Feb. '77

The Euthanasia Council reports that the American Civil Liberties Union supports "consensual euthanasia" which "involves an act or an omission by a second person at the request of an individual for the termination of the later's life." ACLU sees this as a "legitimate extension of the right of control over one's own body."

Jose C. Espinosa, M.D. from a talk given in Jefferson City, Oct. 30, 1976. He is a practicing Surgeon and Clinical instructor at Case Western Reserve University, Cleveland, Ohio.

"The Medical Aspects of death and dying are contained very succinctly in a happening that took place in upper state New York somewhere around Rochester, which is a big Medical Center area. A psychiatrist was involved in an auto accident and required intensive care treatment for a couple of weeks. He was hooked up to all those respirators and all that machinery. When he came out of it, the surgeons realized that they had a Medically knowledgeable personality to ask about the impressions of being in the intensive care unit.

"They asked him, What were your impressions, Sir? How did you feel? 'Well, you know, being in the intensive care unit hooked up to all that machinery I had a little fear and a big fear. My little fear was that with all that machinery around I hoped somebody in the unit know how they worked.' "They asked him, 'What was the big fear' 'My big fear was that I hoped nobody in the unit had read my article on the right to die.' "

DON'T SLEEP ON YOUR MEMBERSHIP APPEAL - answer it TODAY

Your support is our ONLY support!

Don't lock definition of death into state law

By NANCY KOSTER
Vice-president
Minnesota Citizens Concerned for Life

10-24-77 Star

A Guest Column

The Minnesota Legislature, like counterparts around the country, has been asked to consider legislation defining death as irreversible cessation of total brain function. Is such legislation necessary, and what are its potential drawbacks?

Minnesota, like most other states, has never defined death by statute. The judgment of when a human being has died is left to physicians, who rely on standards which have gained acceptance in the medical community and the courts over a long period of time.

Black's Law Dictionary describes death as a "total stoppage of the circulation of the blood and cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc." Those who want a brain death law contend that this description has become inadequate. They point to cases where circulation and respiration are prolonged artificially by respirators and similar technology, even though the patient's brain function has irreversibly ceased.

They argue that under the prevailing common law situation, physicians are reluctant to disconnect life support systems for fear of being sued for malpractice when the patients subsequently ceases to breathe and exhibit heart function, or worse, of being charged with criminal wrongdoing.

Yet, there are no reported instances in this or any other state of a doctor being successfully sued or prosecuted for stopping treatment of a patient diagnosed as brain dead. In fact, the concept of brain death is generally accepted by the medical community and the courts and is used when necessary along with the lack of respiration and circulation in judging when death has occurred.

The evolution of the present common law illustrates the wisdom of not locking a death definition into statute. What if an earlier legislature had defined death with the respiration-heart beat criteria used exclusively before the advent of respirators? Could the brain death concept then have developed and become accepted in light of changing medical knowledge without breaking the law or necessitating its revision?

Also, in the vast majority of cases, the respiration-circulation criteria are completely adequate. It is estimated that only about 2 percent of all patients are sustained by respirators or similar technology. For the average patient, diagnosis of death is easily made using the "old" criteria. Thus, writing brain death into law would cover only the exception to the rule.

Another reason put forth for enacting brain death laws is that organs "harvested" quickly are more successfully transplanted. While not many would argue against transplanting organs when the donor has freely consented to the gift, it is questionable whether a death definition law should be written for the benefit of the donee rather than the donor. Such an approach demeans the dying, viewing them not as persons to be treated with respect and love in their final moments, but rather as sources of spare parts for others.

It is even doubtful whether the proposed law would facilitate the transplant procedure. Minnesota is recognized as having one of the most successful transplant programs in the nation, yet we have not defined death by statute. Further, the Uniform Anatomical Gift Act, adopted by all 50 states, already provides for the bequest of organs in a manner designed to facilitate transplantation. (Significantly, authors of the act refrained from including a brain death definition and left the determination of death up to the patient's attending physician.)

The organ transplant situation brings up perhaps a more serious objection to enacting brain death laws. If there is a danger that life supports could be withdrawn prematurely, there is a great danger that they would not be stopped when the patient is diagnosed as brain dead. If a person can be declared dead when his brain dies, there is no obstacle to the rest of his body being kept "alive" with the respirator for use as a source of organs, for research and experimentation, or for a practice object for fledgling physicians and surgeons.

In fact, one writer, Willard Gaylin (Harper's, Sept. 1974), has coined a whole new vocabulary for this situation. He predicts a future population of "neomorts" maintained by machines in a "bioemporium" for such purposes. He says they could also be used as "manufacturing units" to produce needed substances like blood, hormones and antibodies. Gaylin says laws then could be further "refined" to define death as cessation of cortical function rather than total brain function. This can be done, he says, if "we are prepared to separate the concept of 'aliveness' from 'personhood' in the adult as we have in the fetus" (in order to allow abortion). Then, he writes, "one could . . . maintain neomorts without even the complication and expense of respirators. The entire population of decorticates residing in chronic hospitals and now classified among the incurably ill could be redefined as dead."

While some doctors favor brain death legislation, the American Medical Association is on record as opposing it, calling such laws "neither desirable nor necessary." Medical experts have also pointed out that cessation of total brain function cannot be measured infallibly. They maintain it should continue to be used in conjunction with heart and lung stoppage, which can be accurately observed, at least until there is consensus on how it is to be determined.

Most would agree that brain death can be used as an indication that artificial life supports are no longer appropriate, and when it is diagnosed such supports can be discontinued, allowing the heart and lungs to cease working, if that is inevitable. Such action is allowed and accepted in today's legal framework without the hazards of brain death laws.

Memo re: death definition legislation
From MCCL Legal Advisory Committee

At this time MCCL opposes any legislation which attempts to define death. This issue is basically a legal rather than a medical question. The usual purpose advanced for enacting such legislation is to have the law recognize the concept of "brain death." However, the law already does recognize this concept.

The courts have always relied upon the testimony of doctors to determine when death has occured, and they will not allow a doctor to determine the time of death by anything other than current criteria generally accepted by the medical profession. Current medically accepted criteria for determing the occurrence of death already include the concept of brain death. Thus, the primary purpose of the legislation has been accomplished and the legislation is unnecessary.

It is also argued that such legislation is needed to facilitate the transplant of organs. Organs removed immediately after death have a better transplant success rate. However, authors of the Uniform Anatomical Gift Act, in effect in at least 48 states including Minnesota, have recommended that determination of death be left to doctors in individual cases and not written into law.

Some have also argued that doctors fear civil and criminal liability in using the brain death concept. This fear is unfounded since the law has been protecting them adequately. No court has ever held a doctor responsible for any wrongdoing in using the brain death concept.

Would legislation defining death be dangerous? Any legislation which attempts to define death has inherent dangers. Once legislation is enacted, courts must interpret it and be guided by it rather than ny currently accepted medical criteria. For esample, suppose that thirty years ago the legislature had defined death as the cessation of cardiac and respiratory function. Under these circumstances, the concept of "brain death" would now be illegal even though the medical profession recognizes it. The same problem may exist thirty years from now in another context if death is "defined" in the law.

In addition, because of the broad and general wording of proposed legislation, a real danger exists that courts will make wrong but permissible interpretations. For example, laws speaking of brain function might comceivably be interpreted to equate "function" with the ability to be aware or to communicate.

Several states have enacted death definations. The subject of death is of obvious and tremendous importance. Minnesota can certainly wait until the courts of other states have interpreted their legislation. Clearly, there is no need to legislate now.

IN GENERAL, BRAIN DEATH LEGISLATION IS NOT WARRANTED BECAUSE:

(1.) The law already allows the use of the "brain death" concept.

(2.) The law is adequately protecting doctors utilizing brain death from either civil or criminal liability.

(3.) Legislating brain death could permit undesirable court interpretations which are not now permissible.

(4.) A number of states passing different statutes defining death could prompt the Supreme Court to take the matter into its own hands, as it did in the abortion issue.

(5.) Death definition legislation is aimed at benefiting doctors, not patients. Such legislation views the dying patient primarily as a source of transplant organs instead of as an individual human being experiencing the dying process, with dignity and worth in and of himself. There is no death definition statute on the books now and doctrines have managed to treat dying patients satisfactorily while still providing for the needs of patients needing organ transplants.

(6.) While accepting the concept of brain death, the American Medical Association has consistently opposed legislation defining it.

(7.) There is no need to rush into enacting a law on such a complex and important issue until the courts have interpreted legislation promulgated by other states.

THE BILL NOW BEING CONSIDERED BY THE MINNESOTA LEGISLATURE IS UNDESIRABLE BECAUSE:

(1.) It could be dangerous to say that a "person" is legally dead under any standards. Is there a difference between a "person" and a "human being"? In ordinary usage the two are synonymous, but we have seen what the Supreme Court said about personhood in the abortion decisions. If, according to the Court, it is possible for a human being (unborn child) to be excluded from the "person" category, the courts could interpret this law to mean that an individual's "personhood" dies at a time other than when his or her body dies.

(2.) The proposal says a person is "legally dead" under certain circumstances. Is there a difference between "legal death" and "medical death"? Isn't death one objective phenomenon, or can someone be legally dead and still medically alive?

(3.) The bill provides that other criteria can also be used to determine death, but it doesn't say what they are. It doesn't even say they must be generally accepted by the medical community. It also allows brain death to be the only criterion used to determine death, whereas doctors now usually measure death by a combination of criteria.

(4.) Minnesota is the first state to consider this exact wording for a death definition statute. There are no precedents to be used in judging it.

DEFINITION OF DEATH ACT

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. A person is legally dead if there is irreversible cessation of the function of the entire brain. Nothing in this section shall be construed to prohibit the use of other criteria for determining death.

S.F. 253 Authors:
Jack Davis, Dist. 60
Frank Knoll, Dist. 61
Emily Staples, Dist. 43
Howard Knutson, Dist. 53

H.S. 417 Authors:
Harry Sieben, Dist. 52B
John Clawson, Dist. 19A
O. J. Heinitz, Dist. 43A
Lyndon Carlson, Dist. 44A

Know Your Faith

We need Christian perspective on death

By THE REV.
ALFRED McBRIDE, O. PRAEM.
Director, National Forum
of Religious Education

The world is full of people with death wishes and death denials. The suicide rates dramatize the rising number of death wishers. The frantic race for material goods and cosmetic beauty points the finger at the death deniers. Death wishers want to tear the world around them down to the ground. They are bent on destroying the institutions of society in the midst of their misery that moves them to suffocate themselves.

The death deniers are engaged in rampant efforts to pollute the world with piles of consumer goods with never a thought about the meaning of life and a desperate desire to shut out the thought of the end. Death wishers jump off bridges. Death deniers keep building more bridges. Death wishers want to scramble institutions. Death deniers are bent on expanding bureaucracies. Death wishers are full of so much self hate that they insist on sharing their misery. Death deniers are so suffused with self love that they flaunt a phony immortality.

The point behind these observations is that the thought of death underlies much of the final motivations of people's actions. Either they become morbidly preoccupied with it and thus spoil their remaining days. Or they can't bear the thought of it and try to live as though it can never happen to them. The former become destructive pessimists. The latter look like naive optimists. Both have lost touch with reality since neither is able to face the absolute event of death with sense, faith and poise.

Freud has described the death wishers. Dr. Elizabeth Kubler-Ross has portrayed the death deniers. What the world really needs is the death accepters. Christian realism never ceases to keep the question of death before people. Crosses adorn every Catholic church and

This line drawing depicts Christ's Agony in the Garden.

death wisher nor denier. Jesus is a death aware that death will come to claim Him one day. He simply expects it and counts it as part of His future. To Mary at Cana he says, "My hour — that is my death — is not yet here."

The younger we are, of course, the less we think that death will happen to us or have an effect upon our present behavior. But that is only at the conscious level. The built-in intimation of death haunts everyone's subconscious and works upon one's motivations. It can shift one toward pessimism, optimism or realism. Seen as a defeat and a blind end, it can only cause a morbid dislike of self and other persons. Viewed as an impossibility for me, something that only happens to others, death induces a lifelong stroking of self and the building of illusions and delusions.

Faced realistically as something that will happen to me, and pondered in faith, death provides an opportunity for lifelong maturing. Faith tells us that death is neither a defeat nor an end, let alone an impossibility. Faith says death will happen, but that in Christ death will be overcome. In fact, by communion with Christ now, death is overcome. Every time we commune with Jesus in prayer and sacraments and acts of love, we affirm the factor of Easter and experience eternal life already.

This is why people of faith are not death wishers or deniers. This is also why people of faith avoid the pitfalls of pessimism and naive optimism. Already tasting the unique joy of eternal life, they are not mired in the illusions caused by the termination of temporal life. They know how to enjoy this life without being over-enchanted or imprisoned by it.

Reason is puzzled by death as a problem. Faith is solaced by death as a mystery. Reason stumbles before the end of life. Faith marches to it and through it. Reason's wrestling with death yields

Radio-TV log

"The Cuban Connection" is the subject of this week's "Concern" program at 7:30 a.m. Sunday on WTCN-TV, Ch. 11.

Bower Hawthorne, president of the Greater Minneapolis Chamber of Commerce, one of several Minneapolis businessmen who recently visited Cuba, will discuss trade relations.

Other programs of special interest to Catholics include:

Clip and Save

SUNDAY		
5:00-5:15 a.m. The Christophers	WAYL (FM)	93.7
5:15-5:30 a.m. Sacred Heart Program	WAYL (FM)	93.7
5:30 a.m. Moments from the Bible	WCCO	830
5:30-6:00 a.m. Grand Old Gospel Hour	WWTC	1280
5:45-6:00 a.m. Christopher Close-up	KSTP (FM)	95
6:30-7:00 a.m. Sacred Heart Program	KDWA	1460
7:00-7:45 a.m. Sunday Morning Show	WCCO	Ch. 4
7:00 a.m. The Catholic Church and You	WYOO	1000
7:00-8:00 a.m. Reaction	WWTC	1280
7:15-7:30 a.m. The Christophers	WLOL (FM)	99.5
8:00-8:30 a.m. Point of View	WYOO	1000
8:00-8:30 a.m. Concern	WTCN	Ch. 11
8:30-9:00 a.m. Church Service	WTCN	Ch. 11
9:00-9:15 a.m. The Christophers New Ulm	KNUJ	860
9:30 a.m. Sunday Mass (Queen of Angels church, Austin)	KAAL	Ch. 6
10:00 a.m. Sunday Mass from St. Olaf church	KRSI	950
10:15 a.m. Crosstalk	KQRS	1440
10:15-10:30 a.m. Sacred Heart Program (New Ulm)	KNUJ	860
10:30-11:00 a.m. Community Mass from St. John's Abbey	KSJN (FM)	91.1
11:00-11:30 a.m. Catholic Hour (Alexandria)	KCMT	Ch. 7
11:10 a.m. Religion in the News	KTME	1350
11:30-12:00 a.m. This is the Life	KTCA	Ch. 2
11:35-12:00 a.m. World Religion	WCCO	830
12:00-12:15 p.m. Church World News (Northfield)	WCAL	770
12:15-12:30 p.m. A report from Blue Cloud Abbey (Ortonville)	KDIO	1350
4:00-4:30 p.m. Radio Rosary	WMIM	1010
9:30-10:00 p.m. Brother DePaul's Mission of Mercy	KRSI	950
MONDAY		
2:30-3:00 p.m. Brother DePaul's Mission of Mercy	KUXL	1570
TUESDAY		
8:30 p.m. Insight	KTCI	Ch. 17
SATURDAY		
6:00-6:30 a.m. Sacred Heart Program	KUXL	1570
6:30-7:00 a.m. Concern	WTCN	Ch. 11
8:30-9:00 a.m. Bible Story Time	WTCN	Ch. 11
DAILY		
5:20 a.m. Moments from the Bible	WCCO	830
6:35 p.m. Radio Rosary	KDHL	920
1:15-1:30 p.m. Sacred Heart Program	KUXL	1570

TV mov