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A Study of Euthanasia

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A STUDY OF EUTHANASIA

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The purpose of this paper is to define euthanasia, give a brief outline of the history of the idea and practice, recognize some of the reasons it has become a current topic for controversy, and acquaint the reader with the multiplicity of factors that emerge in discussions on euthanasia. Perspectives from the medical, psychological, legal and moral realms will be advanced in the text. In the conclusion, each of these perspectives will be evaluated as to the validity of its assertions and its place within the framework on which to base decisions concerning euthanasia.

A STUDY OF EUTHANASIA

Introduction

There seems to be much confusion regarding the issue of euthanasia. This confusion probably is the result of a variety of reasons, one being that a precise definition is often not made at the beginning of the debate and, therefore, not everyone involved is discussing the same issue. It is also very difficult to construct the complete picture regarding euthanasia due to the fact that it can be viewed on so many different levels and requires the attention of so many different communities--doctors, nurses, theologians, ethicists and philosophers, to name a few. A third contributing factor that can account for this confusion is that euthanasia lends itself well to emotion-packed appeals. Opponents of euthanasia claim that those who favor it wish to play God and obtain a license to murder, while the accused, in turn, claim that their accusers go to great lengths to strip man of his last vestiges of dignity during his dying days.

Even when these causes for confusion can be eliminated, a neat solution to the problem of euthanasia is not insured. However, the issue will receive clarification and allow those involved in decisions concerning the problem to think intelligently on the subject. It is in the hopes of doing this and providing a few guidelines within which to operate that I now turn to the definition of euthanasia.

I. Definition

Originally, euthanasia was defined and thought of as a happy death. Since death is inevitable, euthanasia, in the sense of being a happy demise, was looked upon with favor and was indeed hoped for. In current usage, though, the term euthanasia, commonly called mercy-killing, seems to bring to the minds of most people an unfavorable impression. It is most generally taken to mean the deliberate killing of persons for a wide variety of medical reasons. Webster's Seventh New Collegiate Dictionary defines euthanasia as "the act or practice of killing individuals (as persons or domestic animals) that are hopelessly sick or injured for reasons of mercy." This definition definately narrows the scope of the previous one in which the broader interpretation allowed issues such as abortion to be considered under the title euthanasia. In this paper Webster's definition (confined to persons) will be used as a starting point.

It will be helpful here, however, to make a further distinction as to the definition. That is the distinction between active and passive euthanasia. Active euthanasia is a deliberate and direct act taken to terminate the life of a hopelessly ill or injured person.

Passive euthanasia, on the other hand, is not taking the action needed to keep a person alive and, thereby, indirectly causing death. Giving a fatal drug to a patient would be active euthanasia; while simply refusing to keep a patient on a respirator would be considered passive euthanasia.[1]

Joseph Fletcher has coined a new term for the case of passive euthanasia. He uses the term "anti-dysthanasia" meaning the indirect ending of a hard or bad death.[2] In the later case death is not induced but only permitted. Since I see no special value in using this new term, the more common terms "active" and "passive" will be used in this paper to distinguish the means through which euthanasia are accomplished.

II. History and Development of the Movement

Many people have the misconceived notion that euthanasia is a new phenomena brought on solely by our tremendous technical advances, but this is not so. Euthanasia dates far back to primitive man and has remained an unresolved problem up to this day.

Among certain primitive people, the killing or abandonment of aged or helpless members of tribes was a common and accepted practice. The Hottentots, for example, were known to have carried their elderly parents out into the bush where they would be left to die. P. Caraman writes of the Lapps that when their old folk were unable to trek the

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[1] For a case that concerns active and passive euthanasia see Appendix, Item 1, the case of Missy. A more complete discussion with reference to this case will be taken up below.

[2] Joseph Fletcher, "Anti-Dysthanasia: The Problem of Prolonging Death," Journal of Pastoral Care, (1964):77-84.

mountains with their families, they were left behind unattended to die in their tents. The corpse froze and was buried upon the family's return. Another method they used was to strap their old people to a sleigh alive and shoot them down a snow-covered precipice into a fjord. Practices very similar to these have been reported used by many other primitive peoples including Eskimos. It is thought that the old and sick people in the societies where these practices were common began to accept their end and submitted to it uncomplainingly.[3]

There are, however, some primitive societies which were known to have had elaborate social codes which actually protected the senior members of their tribes. Hospitality customs, property rights, and food taboos reserving certain choice dished for the aged and helpless were among some of the protections provided by these societies. Settled agricultural communities showed the highest level of solicitude for their elderly members, and this is well exemplified by the laws of the Hebrews in the Old Testament, forbidding the killing of the 'innocent and just,' and in their general attitude of respect for the old.

One of the important historical developments which is mentioned in many discussions of euthanasia is the Hippocratic Oath. Many say the oath expressly forbids any form of euthanasia.[4] Taken in its expressed terms, though, it also forbids abortion and many common practices of medicine today. However, most medical students today

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[3]Jonathan Gould and Lord Craigmyle, Your Death Warrant? (New Rochelle, New York: Arlington House, 1971), pp.20-29.

[4]For the content of the Hippocratic Oath see Appendix, Item 2.

take, not the original Hippocratic Oath, but a modified form which contains more general terminology and much more latitude in interpretation.[5] In short, people using the original Hippocratic Oath as a basis for argument against euthanasia will have to be prepared to defend the accepted and widespread practices the oath would also forbid, and those hiding in the protective ambiguity of the modified form have only their subjectivity to rely on.

The situation in classical Greece and Rome concerning euthanasia is not too clear, though the general attitude of the people toward suicide indicates that euthanasia was accepted. Suicide was an accepted form of death, especially in Rome, and was thought of very often as the honorable way out. Seneca the Younger stood firmly behind this premise saying that"...just as a long drawn-out life does not necessarily mean a better one, so a long drawn-out death necessarily means a worse one."[6] This does not mean, however, that suicide did not have any opposition, for it did, notably Cicero. There seems to be no real evidence that there was any policy of elimination for the sick and elderly at this time, but infanticide was widely practiced and met the approval of both Aristotle and Plato. In Sparta, especially, any weak or deformed babies were left exposed to the elements to die.

Another event in history that is used quite often in discussions on euthanasia, this time by supporters, is the writing of Utopia by Sir Thomas More (1478-1535), "the Catholic mercy-killer". More's

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[5]For the content of the modified form of the Hippocratic Oath, see Appendix, Item 3.

[6]Gould, Your Death Warrant?, p. 27.

Utopians allowed euthanasia as follows:

> "As I have said, they treat the sick with great kindness and leave nothing undone to restore their health, whether it is by drugs or by dieting. If anyone is suffering from an incurable disease, they console him by sitting with him, talking to him and supplying all the comforts they can. But if a disease is not merely beyond treatment, but also a constant source of pain and agony, the priests and magistrates remind him that he is not up to all the tasks of life, is troublesome to others and a burden to himself and is now outliving his own death. Then they advise him not to resolve to feed that pestilence and sickness any longer, nor to hesitate to die, since life is a torment to him. They bid him to take good hope and release himself from that bitter life, as if from a prison or torture rack, or at least give his permission for others to remove him. They tell him that since he is going to put an end not to pleasure but to punishment, he would be well advised to do it; and since in that matter he is going to take the advice of priests, the interpreters of God, his action will also be pious and holy. Those who are persuaded by this either end their own lives by abstinence from food, or ealse are released from it while they are asleep, without any sensation of death. But they never remove anyone against his will, nor are they any the less considerate to him. It is considered honorable to yield to persuasion and die like this. But they think a man unworthy of burial or cremation who commits suicide without having a reason approved of by the priests and Senate. Instead, in great disgrace, he is flung unburied into some bog."[7]

This was certainly an unusual stand for a Catholic to take. What those who use this argument fail to realize, though, is that what More was concerned with in his satire was to describe a non-Christian society and to show how in many ways it was to be preferred to the Renaissance societies of his own time. He himself wrote that he only explained and did not defend all the principles of the Utopian constitution. Therefore, since More's stand on euthanasia cannot be discerned, the use of Utopia in arguments for or against euthanasia is invalid.

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[7]Sir Thomas More, Utopia. (New York, New York: Washington Square Press, 1965) p. 88.

In 1873, L. A. Tollemache in an eloquent and persuasive article,[8] made a strong plea for the legislation of voluntary euthanasia. The problem with his plea was that the cases he considered severe enough to merit euthanasia, were ones so severe that the patient could not give consent. Thus voluntary euthanasia was impossible. A British newspaper[9] called this problem to his attention, and Tollemache at once issued an apologia stating that in cases where consent cannot be obtained, a dying person should be allowed to die a natural death.

This reversal did not, however, end the debate on euthanasia for on October 16, 1931, Dr. C. Killick Millard, Medical Officer of Health for the city of Leicester, in the Presidental Address to the Society of Medical Officers of Health presented a plea for the legislation of voluntary euthanasia. This was the birth of the euthanasia movement in Britain. He asserted that the majority of people who die do so in great pain and that increasing mortality from cancer would increase the proportion of painful deaths. He quoted at length from More's Utopia. In his speech Dr. Millard presented a long comparative study of the morals of suicide and euthanasia. He categorized suicide as an irrevocable step in which one can be so easily mistaken. He then stated that, "'Legalised voluntary euthanasia would come into quite a different category, as an act which was rational, courageous, and often highly altruistic.'"[10]

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[8]"The New Cure of Incurables," Fortnightly Review 19. (873):218.

[9]"Mr. Tollemache and the Right to Die," The Spectator 46. (1873):206.

[10]C. K. Millard, "Address to the Society of Medical Officers of Health," Public Health. (November, 1931):35.

Dr. Millard introduced a draft bill entitled "The Voluntary Euthanasia (Legislation) Bill" and as a result of the support he received established the Euthanasia Society in 1935. Many distinguished people were soon numbered among its members and its avowed objectives were:

> ...to create a public opinion favorable to the view that an adult person suffering severely from a fatal illness for which no cure is known, should be entitled by law to the mercy of a painless death if and when that is his expressed wish: and to promote this legislation.[11]

After the first reactions to Dr. Millard's draft bill were felt and after an ensuing debate, a second reading of the bill was refused by a vote of 35 to 14.

Three years after the establishment of the Euthanasia Society in Britain a similar society was established in America by Rev. Charles Potter. At first the Euthanasia Society of America proposed compulsory euthanasia of monstrosities and imbeciles, but as a result of answers to a questionaire addressed to physicians in the State of New York in 1941, decided to limit itself to voluntary euthanasia. In the last four years, the society has grown from 600 to over 50,000. They have been filling an unprecedanted number of requests for free copies of "A Living Will."[12]

Despite this growing interest in euthanasia, the movement was dealt a blow in 1950 when the General Assembly of the World Medical Association approved a resolution recommending to all national associations that they "'condemn the practice of euthanasia under any circumstances.'"[13]

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[11]Gould, Your Death Warrant? pp.25-26.

[12]The "Living Will" is not legally binding but seems to be making an impression on medical staffs, since the will expresses the patient's wishes. For its content see Appendix, Item 4.

[13]Gould, Your Death Warrant? p. 27.

This did not crush the movement for in 1952 a number of British and American clergymen, doctors and scientists presented to the United Nations a petition for the amendment of the Declaration on Human Rights to provide for incurable sufferers the right of voluntary euthanasia. It bore 2513 signatures, but an amendment was not passed.

Currently there have been several proposals made to different state legislatures, and many figures such as Joseph Fletcher, Paul Ramsey and Daniel Maguire have become prominent in the euthanasia movement. These recent developments will be taken up later, after some of the reasons for such a current interest in the movement are considered.

III. The Urgency of Euthanasia

Currently, there seems to be an "urgency" concerning decisions made about euthanasia. This urgency has been attributed to three main factors: (1) revolutionary developments in medical science, (2) the laggardly state of the law, and (3) important shifts in moral outlook.

These factors will be discussed in subsequent sections of this paper, but it will be helpful here to note the general population's outlook on death and its awareness of the subject of euthanasia.

Daniel Maguire has said that, hopefully, a healthier attitude toward death will emerge in our culture. Previously British historian Arnold Toynbee has charged that, "for Americans, death is un-American and an affront to every citizen's inalienable right to life, liberty, and the pursuit of happiness."[14] Maguire agrees with him on this point.

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[14] Daniel C. Maguire, Death By Choice. (Garden City, New York: Doubleday and Company, 1974) p. 1.

Man is the only animal who knows he is going to die. Poets and philosophers have proclaimed the significance of death-consciousness, yet, it would seem the average person would rather forget it. This is especially true if the average person is an American, since in this happiness-oriented land, death (outside of a military context) is seen as something of an un-American activity.[15] There seems to be, however, a very recent change in outlook in our country. Harvard professor Edwin Schneidman goes so far as to dub this the age of death.

> "In the Western World," he writes, "we are more death-oriented today than we have been since the days of the Black Plague in the 14th Century. There is a thanatology boom in colleges and in print and there are random reports from the lecture circuits that death is now outdrawing the perennials--sex and politics.[16]

Despite this new outlook on death,[17] the topic of euthanasia as a whole is still subterranean, and decisions are being made predominantly by thousands of doctors in millions of different situations and by undefined, particularized, ad hoc criteria. Bayless Manning, Stanford law school dean, believes that a partial solution to this would be a happily financed, well-managed, hard-working, yearly study meeting which would bring together doctors, lawyers, moralists of every stripe, insurance experts, nurses, social workers, morticians, sociologists, gravely ill persons, clergymen, journalists, etc., to discuss the current state of dying and publicize their results.[18]

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[15] Daniel C. Maguire, "Freedom to Die," New Theology no.10. (New York, New York: The Macmillian Company, 1973): 187.

[16] Edwin Schneidman, "The Enemy," Psychology Today. (August, 1970): 37.

[17] This new outlook on death is a sign of gain and health and not of decadence and morbidity, because it is only in a mature culture that death can come of age and be received and accepted as a natural companion of life.

[18] Maguire, Death By Choice, p. 2.

Perhaps if Mr. Manning's suggestion was followed, and a report released, the public would at least be more aware of the debate on euthanasia and its urgency. Most of the polls taken that deal with euthanasia in the past have shown that the majority of the people has not felt any real need as of yet to make a decision on this subject. However, the trend seems to be changing. A survey was conducted on the campus of Ouachita Baptist University in Arkadelphia, Arkansas which generally showed that some forms of voluntary euthanasia were favored, and only a very small percentage of those surveyed ruled it out entirely or wanted it to be involuntary.[19]

Public approval of the idea has increased sharply since a 1950 Gallup Poll, when 36 per cent of Americans said they approved of euthanasia. In a 1973 survey, 53 per cent expressed the view that physicians should be allowed by law to end the life of the incurably ill if the patient and family requested it. A national poll conducted by Life magazine in April, 1972 indicated that 90 per cent of the 41,000 readers who returned the questionnaire felt that a patient with a terminal illness should have the right to refuse treatment that would artifically prolong life. The Canadian Institute of Public Opinion published results of a Gallup Poll in October, 1972, which indicated that Canadian opinion over the years is swinging toward a permissive attitude about mercy killing. Some 20 years ago, 62 per cent of

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[19]This survey was conducted by Michelle Wasson in 1974. The contents of the survey and the statistical breakdown can be seen in the Appendix, Items 5 and 6.

Canadians were against euthanasia; today 52 per cent approve of a doctor taking the life of a hopelessly ill patient, at the patient's request.[20]

IV. Differing Perspectives on the Controversy

Medical Perspectives

The accepted aim of medical practice has long been to fight death, the enemy, with its complete power, and ease the suffering of the incurably ill as much as possible. Given the situation that faced early physicians it is no wonder the profession developed an ethic that placed a preponderant emphasis on preserving life at all costs. But as of now, medicine is not at all sure who the enemy is.

Medicine, for the moment, suddenly finds itself bereft of an agreed-upon definition of death. Death is seen now not as a "moment" but as a process and indeed a very changeable process. The traditional medical standard of death, accepted by the law, has been the definition of death in Black's Law Dictionary:

> . . . The cessation of life; the ceasing to exist; defined by physicians as a total stoppage of the circulation of the blood and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc.

Now that physicians can revive the heart after it has stopped beating (heart-death) a new definition of death (brain-death) has become necessary.

Clinical death occurs in humans when the heart and lungs stop functioning. This deprives the brain of oxygen and, unless

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[20]Eric Cameron, "Euthanasia: Mercy or Murder?", Liberty. (November-December, 1975): 5.

resuscitation begins immediately, brain death follows, because the brain cannot survive without oxygen and its tissues do not heal or regenerate as other tissues do. The brain dies in stages, beginning with the cerebral cortex, then the mid-brain, and lastly, the brain stem. Cellular death follows, with organs and tissues remaining alive a bit longer. The interest in brain function has become more refined, but what has provided a special urgency requiring immediate attention has been the parallel development in highly complex techniques of organ transplantation. Not only does it become a matter of concern how long biological life should be maintained artificially, if the brain has died, and at what social costs, but, more specifically, in order to proceed with organ transplants, there must be absolute clarity about when the donor is to be considered legally dead. Are some people to be considered more dead than others if their organs are needed? If a serious accident destroys a victim's brain, but his basic functions are maintained artificially, does he ever die? In 1968 an Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death proposed criteria which would enable a doctor to pronounce a patient dead when the traditional signs of death-respiratory and circulatory failure were obscured by the resuscitation machinery. "A Definition of Irreversible Coma" is as follows:

1. Unreceptivity and unresponsitivity (that is, no response even to painful stimuli).

2. No muscular movement and no spontaneous breathing for at least one hour, or for three minutes if a mechanical respirator is turned off.

3. No elicitable reflexes, ocular movements, or blinking, and the presence of fixed, dilated pupils.

4. A flat isoelectric electroencephalogram (EEG).

5. No change when all of these tests are repeated at least twenty-four hours later.

6. These criteria to be exclusive of two conditions: hypothermia (body temperature below 90°F) or central nervous system depression due to drugs such as barbiturates.[21]

Medical debate over this new definition of death appears to center around the length of time that cessation of brain activity must continue before death can be certified, since it is possible for brain wave activity to resume after it has stopped. The question is especially difficult where heart transplants are involved, for the organ must be removed as soon as possible after death, and the twenty-four hours specified in the Harvard definition may be too long a delay for the heart to remain in usuable condition.

However, the terms "brain death" and "heart death" still suggest an unsettling distinction, since there can be one without the other. Cases have even been known where autopsy has later revealed that the brain had been liquified while the heart and lungs were still functioning. In some cases where the cerebal cortex has been destroyed, the brain stem continues for a time to regulate heart and lung functioning.

Dr. Julius Korein, Professor of Neurology at the New York University School of Medicine, makes a further distinction between brain death (death of the entire brain including the brain stem) and cerebral death. He concludes that when cerebral death has been determined,

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[21]Henry J. Cadbury, Lorraine K. Cleveland, John C. Cobb, Elizbeth Conrad Corkey, Richard L. Day, John W. Elliot, J. Russell, and Joseph Stokes, Who Shall Live? Man's Control Over Birth and Death. (New York: Hill and Wang, 1970) p. 111.

the physician should pronounce the patient cerebrally dead and suggest the discontinuation of cardiovascular and pulmonary support systems. In other words, cerebral death is death. It is his opinion that advance in medicine has accelerated development of techniques that will allow the physician to define and diagnose cerebral death with accuracy and rapidity in an appropriate hospital setting. If this is true, the concept of cerebral death may be the best that can be done by way of updating the detection of death.

The rapidity with which cerebral death can be determined will help to solve the problem of potential organs available for transplant being damaged beyond use by asphyxia. The speed with which cerebral death can be determined will allow organs to be removed more promptly from a donor. Dr. Henry Beecher calculates that this would make available in the U. S. each year over 10,600 kidneys for approximately 7,600 needy kidney recipients and 6,000 livers for 4,000 potential liver recipients.

The speed and accuracy with which death can be determined is of importance also to the issue of euthanasia. For those cases where cerebral death can be determined to have occurred, the turning off of machines maintaining the vital signs need not be considered euthanasia.

Other problems have been created by our advanced medical technology. One of these is the high cost of medical care. There have been medical cases reported in which patients with irreversible drain damage have been maintained for up to eight years with tubes for feeding and release of bodily wastes. The patients were maintained in a state of absolutely no mental response. Expenses reached incredibly high proportions. Had the tube been taken away, many such patients would have died completely

within seventy-two hours.

A final consideration that the advent of medical technology has brought upon us is the problem of allocation of medical resources. If diseases of the heart and cancer are brought under substansive control and the process of aging could be manipulated, almost all death would be accidental or intentional. Given the track record of medical science, it is not hard to believe that cancer and heart disease may some day be curable. Current research in aging also seems very promising.

These advances are also going to place a strain on the population that one day might make it quite necessary to lay down a basis for allocation of economic resources as between those of advanced age, those who are younger, and those who are defective. Sociologists are predicting that today's "youth culture" will have disappeared by the year 2000, when the Western world will be dominated by the middle-aged, and pensioners will outnumber teen-agers. The trend toward an aging population is already under way in the industrialized countries of the West, the Communist world and Japan. One cause is decreasing birth rates. Another is that science has been increasing life expectancy with new drugs that prevent the elderly from succombing to once-fatal and common diseases such as pneumonia. The result is that we now have a medical crisis because hospitals are unable to cope with all the chronically ill old people suffering from cancer, heart trouble, strokes, etc.[22]

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[22]Eric Cameron, "Euthanasia: Mercy or Murder?", p.3.

Somewhere along the line a decision will have to be made as to who gets the bed, the machine, the blood, and/or the care that cannot be afforded everyone. Currently patients who would be candidates for euthanasia are using these resources, which in many cases could be much more valuable used elsewhere.

Psychological Perspectives

The predicted psychological effect euthanasia would have on patients and their families has been used as an argument against its enactment.

It is thought by some that if euthanasia were practiced, some persons, especially those who are elderly, would be afraid to enter the hospital when in need of help. If they were admitted and given medical treatment under such circumstances, the psychological effect might be the retardation of their recovery, even when no physical reason exists to impede their improvement.[23] However, this argument is valid only in cases of mandatory euthanasia and would not apply to voluntary euthanasia.

The psychological effect on a dying patient's family is tremendous. For them there are long, torturing waits in depersonalized hospital settings, heavy expenses to be met for medical treatment, grief for their dying loved-one to be coped with and feelings of guilt that must be allievated.[24] The question is, can they under such circumstances make

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[23]Robert S. Morrison,"Dying," Scientific American (September, 1973): 57.

[24]For a very good discussion of the psychological trauma of the dying patient and his family and how to deal with it, see Elizabeth Kubler-Ross' book, On Death and Dying.

a rational decision regarding euthanasia when the patient cannot make his own wishes known? It is certain they cannot make the decision alone. The physician must be relied upon to give his medical opinion as to the patient's chances and to make the implications of the various alternatives open to the family as clear as possible.

Still the decision is not an easy one, and many conclude that such a decision would be psychologically unbearable. Since each person makes decisions within his own, unique psychological perspectives, there would seem to be a self-limiting factor on the problems he would encounter (i.e. those who would be unable to bear the psychological burden would not opt for euthanasia).

Nevertheless, after the decision has been made, the questions may still arise. The family may wonder if their decision was really based on the patient's well-being or on their own concerns.

Legal Perspectives

The need for an accurate and speedy determination of death has already been considered. Although most physicians believe that the determination of death is a matter for legal decision and not codification by law, that codification would be necessary in order to protect doctors from legal proceedings. It would also be necessary in order to determine when cases of stopping medical treatment fall under the category of euthanasia.

Arguments against the legalization of euthanasia itself are based on the predicted psychological effect discussed in the previous section and on the grounds that euthanasia is morally wrong, which is the subject of the next section.

There is, however, an argument for the legalization of euthanasia that is set apart from the issue itself. Legalization of euthanasia

need not necessarily carry with it a commendation of the practice.

> "Indeed, it is among other things, precisely the helpless surrender to medical technology and management which the euthanasia movement attempts to counteract with its "living will" and its deliberate confrontation with irreversible illness. Advocates of euthanasia do not always in fact urge it as public policy, but merely as a possible private alternative which should be removed from the criminal category...Still, there is quite a large leap from legally permitting some people to request that their own lives not be unnecessarily prolonged by artificial means to a public policy requiring all lives to be terminated according to certain external criteria. Actually, euthanasia, like abortion and contraception, might become a private matter between the patient and his doctor. Large numbers of our citizens might continue to think euthanasia a sin, as they might contraception and abortion, but they could no longer insist it was a crime as well.[25]

There are at present bills for the legalization of euthanasia being considered in many states, and some have been passed. In Arkansas, a patient now has the legal right to refuse medical procedures to extend his life by signing a document similar to a will. If the patient cannot choose, the decision can be made by parents, spouse, children 18 and older, or any other nearest living relative. Two doctors must sign a statement saying extraordinary means are necessary to prolong the patient's life. The attending physician is not liable for complying or refusing to comply with the request.[26]

Moral Perspectives

The French physician J. Hamburg has coined the dilema significantly in the following quote:

> Science has made us god before we are even worthy of being man.

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[25]Sonya Rudikoff, "The Problem of Euthanasia," Commentary (February, 1974):66.

[26]This bill is HB 826 Act 879 sponsored by Henry Wilkins of Pine Bluff and passed in March, 1977.

Sentiment such as this seems to find expression among a great many.

Those who take the strongest stand against euthanasia often use as the basis for their argument the "absolute" priniple of the unconditional inviolability of innocent human life. Man seems to have a tendency to consider the physical and biological to be ethically normative and inviolable.

This is the basis of the official Roman Catholic opinion held in regard to euthanasia. It is stated, however, in the form of the tenth commandment--THOU SHALT NOT KILL. In 1957, Pope Pius XII gave a remarkable address on the prolongation of life in which he referred to some hopeless patients, whose soul may have left their body, by the ambiguous but interesting term "virtually dead", and added that only ordinary means need be used to perserve life. So perhaps the Roman Catholic view is not so "unconditional" after all.[27]

Maguire suggests that it is not so simple. This absolute principle cannot simply be asserted as self-evident. The users of the principle must bear the burden of proof, and the proof must come from whatever moral meaning is to be found; that is, it must come from a knowledge of the morally significant empirical data, the consequences, the existent alternatives, the unique circumstances of person, place and time, etc. "To say that something is morally right or wrong in all possible circumstances implies a divine knowledge of all possible circumstances and their moral meaning."[28]

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[27]For a general view of the Roman Catholic position see Appendix, Item 7, interview with a Catholic priest in Arkadelphia, Arkansas.

[28]Maguire, "Freedom to Die," p. 194.

Attempts have been made to base this principle on the predicted consequences which would result should the principle be violated. This is the cracked dike argument, a kind of ethical domino theory which says that if X is allowed, then Y and Z and everything else will be allowed. The deficiency in this theory is that it ignores the real meaning of the real differences between X, Y, and Z. It is, furthermore, fallacious to say that if an exception is allowed, it will be difficult to draw the line and therefore, no exception should be allowed.

Another expected consequence that violation of this principle would bring is a resultant lack of the awe for human life. This is assuming that anything which falls under our control and is subject to our own understanding is less deserving of awe. To the contrary, it might be our involvement through the decision-making process, the use of our own capabilities and responsible freedom, which would make us realize more the awesomeness of real human life.

Harmon Smith says that Dietrich Bonhoeffer and Karl Barth are representative of those Protestant theologians who hold that it is for God alone to make an end to human life and that any direct action taken against the lives of the sick or incurably infirm is tantamount to murder.

Bonhoeffer considers the question in his work, Ethics, of whether it is permissable to destroy painlessly an innocent life which is no longer worth living. Bonhoeffer's answer is that "the question regarding euthanasia must be answered in the negative."[29] The two assumptions

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[29]Dietriech, Bonhoeffer, Ethics. Edited by Bethge Eberhard. (New York: MacMillian Press, 1965) p. 121.

Bonhoeffer operates from are (1) that God alone has power over life and death and (2) all and any life is worth living. Smith also points out that Bonhoeffer doubtless knew of the systematic extermination of certain classes of peoples in Germany in the 1930's and 1940's, and this may largely account for the absolutely uncompromising position which he took regarding euthanasia. Yet Bonhoeffer was not so uncompromising as some betray him to be for he also says in Ethics that, "If a sufferer from incurable disease cannot fail to see that his care must bring about the material and psychological ruin of his family, and if he, therefore, by his own decision frees them from this burden, then no doubt there are many objections to such unauthorized action; and yet here too a condemnation will be impossible."[30]

Karl Barth treats the subject of abortion in his Church Dogmatics and makes an exception in his condemnation of it only when two lives, that of the mother and the child, are in conflict. Concerning euthanasia, however, Barth says another life is not in competition with that of the patient and, therefore, he maintains that there is no alternative but to respect life by preserving it. He feels euthanasia can be regarded only as murder, i.e., as a wicked usurpation of God's sovereign right over life and death. Barth admits that "tempting questions" are raised but says, "The central insight in this whole complex of problems is that it is for God and God alone to make an end of human life, and

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[30]John D. Bennet, "The Van Dusens' Suicide Pact," Christianity and Crisis. (March 31, 1975): 68.

that man should help in this only when he has a specific and clear command from God"[31] Barth leaves open the possibility of such a command.

What the question really seems to come down to, though, is what constitutes real human life? The termonology "quality of life" as opposed to "quantity of life" is used quite often. Although these phrases have a certain emotive appeal, they have no clear-cut definitions. The quality of life is what would be considered "real" human life, while quantity of life is continued through biological vitality. Is merely physical vegetative life sacred, or is it life that is actually or potentially personal that is sacred? In fact, should biological vitality even be considered life. Much discussion revolves around the question of when man is dead; perhaps it should be asked when does man stop living? Should our aim be to preserve life at all costs? To answer these questions we must consider what constitutes life, when saving of life really becomes a torturing of it, and if man can legitimately exercise any control over the manner and time of his death.

Life and death have traditionally been considered only from a biological standpoint in cases of euthanasia because it is in these terms that life and death can be more easily measured. Life and death in this sense are directly opposing one another--life being the "summon bonum" and death a thing to be fought at all costs. I Corinthians 15:26 depicts death as the last enemy left to conquer. Is it fair to say, however, that the death meant here is biological death? There are biblical passages which are used to support biological vitality as the

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[31]Karl Barth, Church Dogmatics. (Illinois: Allenson, 1936) p. 210.

criterion of life. Two such ones are Deuteronomy 12:23 and Leviticus 17:14 which intertwine life and blood so closely that is seems they cannot be separated. Pliny shows in Natural History how the two were so closely equated that epileptics would quaff the warm blood of a freshly killed gladiator to alleviate their condition.

Harmon Smith says,

> "Blood is preconditional to life, but man does not live by blood alone! More to the point, if what we conventionally mean by human life is no more than biological vitality, I would argue that man does not live by life alone. It is no abuse of the gospel to paraphrase Jesus in this way; and neither is it inconsistent with his proclamation that a man's life does not consist in his posessions, that we require more than bread for life, and that the "abundant life" does not denigrate but nevertheless transcends mere physical existence."[32]

It would be difficult on the basis of biblical evidence to simply affirm the lowest, common natural denominator, namely vitality, as life. The biological aspects need not be diminished, but neither should they be made solely determinative of human life and death. To differientate human life and death from that of plant and animal we must give it some significance not common to the rest.

Even when we should be able to satisfactorily determine what constitutes life there comes the question of when in our treatment of a patient are we prolonging life and when we are prolonging death. Relief of suffering and prolongation of life are not necessarily complementary and often come into conflict. Joseph Fletcher regards the issue of euthanasia not as one of life or death, but as one of which kind of death, an agonized or a peaceful one.

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[32]Harmon L. Smith, Ethics and the New Medicine. (Nashville: Abingdon Press, 1970) p. 125.

Harmon Smith points out that the Hippocratic Oath does not say that life is the "summon bonum", but that the patient's well-being is. These are often not the same thing. Can we say that doctors who will not let hopelessly ill patients die are aggressors against the well-being of the patients, the patient's family, and all their resources so long as the patient's death is artificially postponed?

We are still faced with the question of whether or not man can legitimately exercise a control over the manner and time of his death. Most agree that there is a fitting time to die, but will not say when that time is unless in retrospect. In other words, people are willing only to look back and say that it **was** his time to die.

Christians have typically held the belief that life is a gift from God and therefore ultimately his. Moreover, belief in the sovereignty of God has caused Christians to ascribe the entire spectrum of events, from life to death, to God's causative will. All of the good as well as the bad, including the contrdictions inderent in each, have been interpreted with a cause-and-effect correlation between God's will and human events. This reasoning equates what is "natural" with God's will.

Joseph Fletcher says, "We are not as persons of moral stature to be ruled by ruthless and unreasoning physiology but rather by reason and self-control." He maintains that the supreme value of life is personality and that we should in no way subordinate ourselves to natural law. He adds that our "customary morality" destroys human freedom and distorts human knowledge and thereby deprives man of the capacity to be a man.[33]

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[33]Ibid., p. 163.

Fletcher uses these concepts of "customary morality" and human freedom in his discussions concerning active and passive euthanasia. He signifies "act" as personal and professional interference with natural processes. Correspondingly "omission" is the abdication of further personal and professional responsibility to a vague kind of naturalistic determinism. We have again arrived back to submission to natural processes and this approach has long been the modus operandi of Western law and medicine, and often theology as well. The question is whether it should continue to be so.

I would again refer you to the case of Missy.[34] In considering her case, compare the desirability of death by active means as opposed to passive means. "Though omission and commission are different realities with a potential for different moral meaning, they have a suggestive similarity in that in both cases, someone is dead who would have been alive if a different decision had been made."[35]

Fletcher maintains that the goal, motive and foreseeable consequences in both forms, the direct and indirect voluntary courses of action, are the same: i.e., the death of the patient. "Because of these common ethical factors, I am personally unable to see any real ethical difference between the two, but there are other moral theologians who profess to find a difference, because the means employed are different."[36]

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[34] See Appendix, Item 1.

[35] Maguire, Death By Choice, p. 13.

[36] Joseph Fletcher, "Anti-Dysthanasia: The Problem of Prolonging Death," p. 78.

He sees the difference between doing nothing to keep a patient alive and giving a fatal dose of a pain-killing or other lethal drug as being a very cloudy one, because in both cases the decision is "morally deliberate."

Paul Ramsey says that, of course, the intention is the same either way--meaning the end in view. But he disagrees with Fletcher's assertion that the means employed in both instances have the same moral meaning. He sees no problem with the ethical validity of willing the end for even in the strictest religious ethics, "the desire for death can be licit."[37] He still, however, sees great moral difference in how that end is accomplished.

Fletcher makes the statement in the course of his argument that, "as Kant said, if we will the end, we will the means."[38] This is a statement from Kant's analysis of hypothetical imperatives, which are dependent on consequences. Ramsey answers in this way:

> One could argue that if one wills the end he wills the means--but not, just any old means...One could say that there are different means--and differences between action and omissions that make room for properly caring actions--that may let the patient have the death he not improperly or even quite rightly desires. While it might be argued that the Kantian maxim applies to means necessary to secure a desired and desirable end, still where there are more than one means to this same end, to will that end leaves open the choice among means. A means may be right, another wrong, to the same end.[39]

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[37]Gerald Kelly, "The Duty of Using Artificial Means of Preserving Life," Theological Studies 11 (June, 1950): 217.

[38]Joseph Fletcher, "The Patient's Right to Die," Harper's (October, 1960): 143.

[39]Paul Ramsey, The Patient as Person. (New Haven: Yale University Press, 1970) p. 153.

V. Conclusion

It is obvious by now that euthanasia has been spoken to by a variety of persons--physicians, nurses, theologians, philosophers, politicians, scientists, population experts, lawyers, psychologists, the aged, the sick--in a variety of ways on many different levels. Daniel Maguire suggests our nation's priorities are out of place,[40] and Harmon Smith says, "It is important that all the variables in the mix be self-consciously sorted out, assessed, and assigned a place of relative priority according to their respective bearing on the decision-making moment."[41]

This, to me, seems to be our job. We must sort out the arguments concerning euthanasia which are invalid or irrelevant and consider those which are relevant and valid. In this light, several observations can be made:

(1) It is easy to confuse arguments for the necessity of euthanasia, such as those concerning our limited medical resources and the need for organs for transplanting and for the "moral validity" of euthanasia.

(2) Medical knowledge and technology are invaluable in accurately determining death, and assessing extraordinary means and patient conditions. These considerations, however, deal with the classification of patients and the implementation of euthanasia--not with the rightness or wrongness of the act.

(3) The psychological consequences of euthanasia do bear on its validity. However, for the reasons that have already been considered, I believe the evidence to be

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[40] Maguire, "Freedom to Die," p. 194.

[41] Smith, op. cit., p. 156.

> to the contrary that the psychological risk involved is too great. Risk always exists when man has the freedom of choice. Careful regulation can minimize that risk, and there are appropriate and effective means of dealing with that risk when it is realized.
>
> (4) Neither can the state of the law be used as argument for or against euthanasia, because the law does not determine rightness or wrongness. Legislation reflects what we decide to be right on moral grounds. At least this is how it should be in the ideal situation. Our job, then, includes working for the legislation that would be the normal outcome of our conclusion regarding euthanasia.

We are left now with the moral deliberations concerning euthanasia. I think we can draw some logical conclusions from the evidence that has been presented in this paper. First of all, prolongation of life should not be in all cases our supreme goal. It is very hard to determine when prolongation of life ends and prolongation of death begins. Secondly, it is not so important that we determine the point between the two, when we regard the patient's well-being as our greatest concern. In some cases, the patient's well-being will even be in direct conflict with prolongation of life, especially when that life is considered the mere biological vitality common to all organisms. When a person has lost those characteristics which make him a person and distinguish his life from that of other animals and vegetables, then his demise is justifiable on the same grounds used to justify, say for example, the demise of an injured and suffering horse. If we then can concede that we do have the right to exercise control over ourselves, we need not yield ourselves to natural process. (In actuality, we interfer with natural process all the time considering that medical treatment of any kind changes or reverses the process.) Therefore, I would conclude that euthanasia is a morally valid end.

We still must decide on the issue of active euthanasia. Gerald Kelly has said and has been verified by virtually everyone, that the desire for death is licit. Kant has said as we will the means, we will the end. Since we have said that we need not yield ourselves to natural processes, why not active euthanasia? Ramsey's point is that when there are other than "active" means available, these other means are to be preferred since his concern is the best care for the dying patient. I would agree with him that in most cases active euthanasia would be "unnecessary" and even "unpreferable" but perhaps not immoral. But I also suspect on the basis of Ramsey's admition that it might be argued that the Kantian maxim does apply to means "necessary" to secure the desired end, that in cases where active euthanasia is necessary to secure the desired end, the patient's well-being, that even he would agree to its implementation. Therefore, I would also conclude that active means, when they are most in line with the patient's well-being, are morally valid means to the morally valid end.

In closing, I would say that the conclusions I have drawn, while I think them to be legitimate, are nevertheless, just my conclusions. Each person must draw his own conclusions. Joseph Fletcher sums it up like this:

> ...man's moral stature, his quality as a moral being, depends first upon his possession of freedom of choice and, second, upon his knowledge of the courses of action open to his choice. In a very real sense it is possible to regard freedom and knowledge as different sides of one prerequisite to ethical living, namely control of self and circumstances.[42]

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[42] Joseph Fletcher, Morals and Medicine. (Princeton: Princeton University Press, 1954) p. 100.

Thus, to put it in Fletcher's terms, once we have given an individual the knowledge of the courses of action open to his choice, we must give him the freedom to make that choice in order for him to live ethically.

APPENDIX

Item 1--The Case of Missy

Dr. Warren Reich, a senior research associate at the Kennedy Center for Bioethics at Georgetown University, posed a difficult case at the meeting of the International Congress of Learned Societies in the Field of Religion in September, 1972. The case involved a girl (Missy) who was born with spina bifida with meningomyelocele of the lumbar spine. Spina bifida refers to an opening in the spine and meningomyelocele is a condition in which portions of the spinal cord, as well as meninges and spinal fluid, have slipped out through the spinal opening and are enclosed in a sac. The child lacked reflex activity in both legs and could not control her anal or urinary sphincters. She had club feet.

Hydrocephalus, "water on the brain", develops in 90% of these cases. To treat that, a "shunt" has to be surgically inserted to drain the cerebrospinal fluid from the brain into the heart or peritoneum. Even with a shunt, the child would have a 50:50 chance of being mentally retarded. Missy's complications might eventually require a surgical procedure which would allow her urine to drain into a bag which she would wear on her abdomen permanently. Bowel control would be a lifelong problem for her. Kidney failure is a constant danger and the most common cause of death for children with this affliction. Broken bones and burns are the frequent lot of such children also, due to problems in mobility and sensation.

In the panel discussion of this case, Dr. Harmon Smith of Duke University Divinity School noted that until ten years ago, about 80% of such babies died. Today, 75% survive. Thus, again, medical advance brings on troubling new moral questions. Should this baby have been allowed to die from the meningities that would normally ensue in such cases? Or should the medics have begun at once what would be for the child a lifetime of extraordinary care? The panel at the congress (which along with Reich and Smith, included Dr. Eric Cassell of Cornell University Medical College) considered only these two options.

In the discussion, it was suggested to the panel that there were options, such as the direct termination of life. This was an option that no member of the panel would even consider. "I find it is absolutely incredible, even in a mere debate, to consider this a serious alternative in a group of moralists and theologians," said Professor Smith. The other panelists agreed that this line should never be crossed. A very fair question of course is why? Why is it so clear that these two alternatives exhaust the moral possibilities of the described case and that the path of direct termination is beyond the pale?

First of all, it is not clear that meningitis would be an efficient "friend". As Dr. Reich pointed out, babies have been known to survive the meningitis and live a number of years without being aware of anything and requiring a great amount of physical care. Thus the problem could be intensified by mere omission and reliance on the disease to achieve the desired results. Furthermore, as one of the doctors in the audience pointed out in this discussion, death by meningitis in such cases is not normally serene. It is not really a neat solution. Disease in this instance may not come to the aid of ethics.

There can be good reasons offered to keep a child like this alive. Advances are being made in the treatment of nearly all the symptoms of this affliction. It may even be argued that if people do not take a chance on life for such children, medicine will not be able to learn all that it needs to conquer and prevent this disorder. It may be further argued that we should be extremely cautious about opting for death for a child. Caution is further indicated by the basic fact that a decision is being made for another person.

Given the realities of the case as described, however, it is possible that death might be seen as preferable to the kind of life this child could have. The moral question then is whether it could be brought on by the administration of drugs or whether a compromise could be found whereby the drugs are used to comfort and to weaken in coordinatination with the meningitis. In the present state of legal and moral debate, the latter possibility would offer the advantage of protective ambiguity. There is no precise way of knowing whether a drug is accelerating death as it relieves discomfort since the unrelived discomfort might accelerate death too and since the degree of immunity to the drug is a variable. Still, this flight to ambiguity would represent a retreat from the question to be explored--Can it be moral and should it be legal to take direct action to terminate life in certain circumstances.

Item 2--The Hippocratic Oath

I swear by Apollo the physician and Aesculapius and health and all-heal and all the gods and goddesses that according to my ability and judgment I will keep this oath and this stipulation--to reckon him who taught me this art equally dear to me as my parents, to share my substance with him and relieve his necessities if required, to look upon his offspring in the same footing as my own brothers and to teach them this art if they shall wish to learn it without fee or stipulation and that by precept, lecture, and every other mode of instruction I will impart a knowledge of the art to my own sons and those of my teachers and to disciples bound by a stipulation and oath according to the law of medicine but to none others. I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked nor suggest any such counsel, and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practice my art. I will not cut persons laboring under the stone but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption, and further, from the seduction of females or males, of freemen and slaves. Whatever, in connection with professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge as reckoning that all such should be kept secret. While I continue to keep this oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men at all times, but should I trespass and violate this oath, may the reverse be my lot.

Item 3--The Hippocratic Oath in Modified Form

I solemnly pledge myself to consecrate my life to the service of humanity. I will give to my teachers the respect and gratitude which is their due; I will practice my profession with conscience and dignity; the health of my patient will be my first consideration; I will respect the secrets with are confided in me; I will maintain by all means in my power the honor and the noble traditions of the medical profession; my colleagues will be my brothers; I will not permit considerations of religion, nationality, race, party politics, or social standing to intervene between my duty and my patient; I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity. I make these promises solemnly, freely and upon my honor.

Item 4--Living Will

TO MY FAMILY, MY PHYSICIAN, MY CLERGYMAN, MY LAWYER--

If the time comes when I can no longer take part in decisions for my own future, let this statement stand as the testament of my wishes:

If there is no reasonable expectation of my recovery from physical or mental disability,

I, _____
request that I be allowed to die and not be kept alive by artificial means or heroic measures. Death is as much a reality as birth, growth, maturity and old age--it is the one certainty. I do not fear death as much as I fear the indignity of deterioration, dependence and hopeless pain. I ask that medication be mercifully administered to me for terminal suffering even if it hastens the moment of death.

This request is made after careful consideration. Although this document is not legally binding, you who care for me will, I hope, feel morally bound to follow its mandate. I recognize that it places a heavy burden of responsibility upon you, and it is with the intention of sharing that responsibility and of mitgating any feelings of guilt that this statement is made.

Signed _____

Date _____
Witnessed by

_____

Item 5--Survey Conducted by Michelle Wasson

1. Which best defines your concept of human life?
   a. A body that performs the fundamental processes through artificial means and the brain is virtually "dead" and no thinking or learning or communicating takes place.
   b. A body that performs the fundamental processes on its own, but the brain is virtually "dead" and no thinking or learning takes place.
   c. A body that can perform its fundamental processes on its own, can participate normally in day to day activities and has some degree of intelligence and comprehension.

2. A patient with incurable cancer is slowly dying but because of a good heart he may live several weeks. He has developed a toleration to the medicine that eases the pain. A doctor cuts off his intravenous feeding and the patient died in several hours. Do you agree with what the doctor did?
   a. Agree b. Disagree

3. Do you believe in "mercy killing?"
   a. Yes b. No

4. The parents of a mongoloid baby (severe mental retardation) requiring surgery for survival refused to give permission. It took the baby 15 days to die.
   a. Should the parents have been made to take the child home and bear the pain of standing the death watch?
   b. Should the state have taken legal charge of the baby from the parents and then authorized the operation?
   c. Should a court order have overruled the parents' decision?
   d. Should a speeding up of death have taken place such as increasing the dosage of medicine been added to the lack of an operation?

5. Do you believe in . . .
   a. indirect euthanasia (mercy killing)--such as not using any artificial means to keep someone alive and letting nature take her course?
   b. direct euthanasia--doing something to speed up the dying process?
   c. both

6. A diabetic patient who has been using insulin for years and who develops an inoperable and very painful kind of cancer can continue to use insulin and may live many months in agony. By discontinuing the insulin the patient would lapse into a coma and die painlessly. If you were the doctor would you continue or discontinue the insulin?
   a. Continue b. Discontinue

7. Would you believe in giving an overdose of medicine so a patient would die quickly rather than slowly dying for days or weeks in pain?
   a. Yes b. No

Item 5--Continued

8. Do you think the parents of a Mongoloid child should place it in an institution where it would be with children of the same condition or take care of it at home where the parents could take care of it even if there were other children in the family?
   a. at an institution b. at home

9. Would you believe in the "mercy killing" of a baby who has severe brain damage?
   a. Yes b. No

10. Would you shoulder the responsibility of caring for a child who is accutely deformed, or unable to progress beyond the mentallity of a totally dependant infant?
   a. Yes b. No

11. A preacher's son was born physically frail and severely brain-damaged because its oxygen was shut off in the womb. The doctor says the child will be close to an inanimate object. The doctor suggested action--taking away of oxygen--that implied if the baby could not survive on his own, he should not live at all. The father agreed. How do you feel about his decision?
   a. Strongly against d. Moderately for
   b. Moderately against e. Strongly for
   c. Indifferent or neutral

12. What is your opinion of mercy killing?
   a. It is o.k. to do it indirectly--not using artificial means to keep a person alive.
   b. It is o.k. to do it directly by giving an overdose, etc.
   c. Both a and b.
   d. It is murder.

13. If you were in an accident that caused severe brain damage which made you totally dependant on others and your bodily functions had to be carried on by artificial means would you look with favor on someone relieving you of your life?
   a. Yes b. No c. Undecided

14. If you were in an accident and your life was totally dependent on a machine and another person needed one of your organs to survive would you choose
   a. to stay alive with the help of the machine(s).
   b. to have someone "pull the plug" so the needy person could have your organ.
   c. undecided.

Item 6--Results of the Survey

OVERALL RESULTS OF SURVEY

1. a-2.27% b-21.27% c-95.45%
2. a-45.45% b-54.54%
3. a-59.05% b-34.09% ?-6.8%
4. a-13.6% b-27.27% c-11.3% d-27.27% e-20.43%
5. a-59.09% b-11.36% c-28.45% ?-9.09%
6. a-50.0% b-47.72% ?-2.27%
7. a-29.54% b-70.45%
8. a-78.18% b-22.72%
9. a-34.09% b-61.36% ?-4.54%
10. a-59.09% b-34.09% ?-6.818%
11. a-4.54% b-13.6% c-13.6% d-59.09% e-6.818%
12. a-59.09% b-2.27% c-18.18% d-18.18% ?-4.54%
13. a-45.45% b-13.6% c-40.9%
14. a-11.36% b-40.9% c-47.72%

Item 7--Interview with Father Cooper of St. Mary's Catholic Church in Arkadelphia, Arkansas

Father Cooper said that the Roman Catholics were, of course, against what is commonly called mercy killing simply because it is the taking of a life, and no one has the right to take a life for any reason except God. It's like abortion in that we consider it murder. I think our ideas are based on logic. The reasoning is there that the end might be good in cases of euthanasia, such as ones where a poor guy is a vegetable or something like that. But the means to accomplish this end would be bad and therefore would make the whole act bad. You can't use evil means to accomplish a good end. Our contention is that only God gave life and only God can take life. When we start saying who can live, we're like Hitler. Let's face it, soon it would be unproductive people or people who couldn't meet up to certain standards that would be put to death like they were in Hitler's concentration camps. As I said our basic contention is that euthanasia is murder because no one has the right to take life except God.

Now that could bring up the question of capital punishment and why the Catholics haven't taken such a strong stand on it as they have things like abortion. Well, we don't approve of it in a sense, but we uphold the right of the state to put someone to death who has committed a serious crime. We uphold the right of the state according to the will of the people. We're neither for or against it so to speak. In other words, it is just up to the people. If they want capital punishment, okay. And if they do we at least say the state does have a right to put someone to death who has committed a serious crime such as the taking of a life. However, I don't think the same thing holds for euthanasia for it is different from capital punishment. And when you think about it, God may have some purpose for the life that is inflicted with disease and retardation. I think a good Christian person can see good in everything and such a person could be a blessing in disguise. Basically, that's our stand.

There are a lot of practical considerations such as the great expense involved in a long hospital stay. We are not morally obligated to keep a person alive by extraordinary means. I think we have to take a neutral ground here. We can't say what is right or wrong in these cases, but I do not think this is so much mercy killing as just letting nature take its course. Personally, when I die I want to die by natural means, but I don't want to be kept alive by artificial means. But we have to be careful when we talk about extraordinary means because certainly a little bit of glucose would be far from extraordinary means.

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