On Living Wills

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"Cessation of nutrition may become the only efective way to make certain a large number of biologically tenacious patients actually die."

To a great extent, there has been poor recognition of the philosophical bases for current arguments about euthanasia, abortion, and suicide. The traditional Judeo-Christian weltanschauung or world view is that humans have intrinsic, God-given value; indeed, man is made in the image of God. This is juxtaposed to the prevalent pagan world view that humans have attributive value; they are what we say they are; man decides. These two weltanschauungen are irreconcilable and are the reason for the interminable war over these subjects. To resolve the issues of euthanasia, suicide, and abortion one must first reconcile the basis of moral judgment. There is no reconciliation possible between these two world views, no fellowship between God and Belial. No attempt will be made in this paper to dissect all the ramifications of euthanasia but only those that press closely upon a special case for implementing euthanasia, "living wills."

The author has served in some seven nursing homes as well as practiced medicine for over three decades. His experience includes dealing personally with a "living will" which was drawn without his knowledge by a loved one in his own family. It is his conviction, after many years of deliberation, much reading, and experience with his patients, that the notion being set forth to legalize the "living will" will lead in a negative direction and create many problems for patients, families, society, and physicians; it is a slippery slope.

The primary thing that needs to be said at the outset concerning "living wills" is that there is no need for them. Since time immemorial patients and physicians have discussed their problems and what could be done about them. In the main, they have drawn up reasonable plans of action. The patient is, at present, fully protected by law in directing his/her own care. No further laws are needed; indeed, patients can now refuse treatment of any and every sort. There is no need to pass further laws to implement any, however well-intended, legislation that could lead to entrapment of patients, families, and physicians in patterns of care that are unjustified and undesirable. Although attempts at implementing euphemisms such as "dying with dignity" are usually well meant, they are ill-conceived by many patients and families. Indeed, recent reports of malfeasance regarding the behavior of guardians ad litem incarcerating in nursing homes rational, functional elders against their will points up the ease with which humans corrupt apparently rational, "good ideas."

One often hears the expression, "Dying with dignity." It is strongly pushed by some pro-euthanasia groups. "The right to ...abortion...should be recognized. To enhance freedom and dignity the individual must experience a full range of civil liberties in all societies. This includes ...a recognition of an individual's right to die with dignity, euthanasia, and the right to suicide."z What does that mean? Is it not required of all of us, family, nurse and doctor to always secure the most dignified management of every case? We all want that. Such phrases and buzz words cloud the issue. They inject the false notion that many people are not dying with dignity: that there are those in the medical profession who are not keenly aware of these matters. Those who use such words cast aspersions and raise a false issue, for all wish for a dignified end to life. This ploy is calumniation.

It is instructive to examine some of the tenets of the "living will" drawn by the author's own family member.

That "living will" was prepared on a document supplied by "Concern for Dying, an Educational Council." After declaring the obvious, everyone must die, the first paragraph ends by stating that the signer wishes to make known his/her wishes and directions "while I am still of sound mind." How is a physician to be sure if that was in fact the case? How indeed can a patient, years before the final death process, really know what wishes might occur at time of death? We all wish not to suffer. We all wish to be warm and comforted, free of pain, and, certainly, that is an obligation that every physician or health worker owes to the sufferer. But that is already a tenet of our faith. No matter how many laws we pass, this cannot be implemented any more than it already is. There is real consideration in this document concerning how accurately one can project into the future even if indeed one were of sound mind. Such action may well preclude the use of a new treatment not available when the will was signed.

The second paragraph of the document begins with even more difficult language and reads as follows: "If at such a time the situation should arise in which there is no reasonable expectation of my recovery from extreme physical or mental disability, I direct that I be allowed to die and not be kept alive by medication, artificial means, or `heroic measures.' I do, however, ask that medication be mercifully administered to me to alleviate suffering even though this may shorten my remaining life." The first clause dealing with the judgment of a reasonable expectation of recovery indicates how nondirective this apparent directive is. The doctor is not helped by this statement at all because the doctor still has to make judgment concerning what expectations there are for the recovery of his patient. In fact, the patient is simply saying to the doctor that he should do his job. Medicine is not a science, it is an art that uses science. Prognostication is more artful and experiential than scientific. That is the reason why patients constantly, wondrously tell of "miraculous" recoveries when the doctors "gave me no hope." It is not always possible to know about recovery from even extreme physical and mental disability. To lock off the possibility of treatment in an attempt to restore a person years before the event is, to say the least, shortsighted.

The language becomes even more vague in the second part of that first sentence where the document talks about being kept alive with medications. What, in fact, is medication? What is natural and what is artificial? What are heroic measures? This is a grossly ill-defined statement. If a patient, for example, is placed on a respirator and recovers, is that a heroic measure? If a patient is placed on a respirator and does not recover, is that a heroic measure? Is insulin given to a 30-year-old diabetic artificial? Could it not also be heroic in the sense that it is saving the life of the patient? One does not need to reflect very much on these nebulous terms to see that many differentiations, definitions, and individual interpretations are possible.

To be an effective document, a "living will" would have to be drawn up repeatedly by a host of lawyers, and then, unfortunately, it would only be interpretable by lawyers and not of any great help to the physician. It is the author's considered judgment that the law to implement "living wills" to cover all eventualities, which are unbelievably complicated and extensive would be impossible to write, impossible to interpret, and impossible to apply.

The last sentence in the second paragraph is even more troubling. In essence, the last statement which asks for medications "that may shorten my remaining life" could easily be taken as a mild version of "kill me." That statement could be construed as a request that life be terminated by a drug. If so, it is a statement of voluntary euthanasia or "mercy killing" which is a euphemism for suicide or murder. Suicide has long been held to be an unacceptable act in our society. Most religions proscribe suicide. Old and New Testament scriptures seem to teach against such killing. However, in search of specific Biblical references to suicide and euthanasia, no explicit statements that would bear on these current situations are found. One must guard against the poor, confused, chaotic hermeneutics and exegesis that are the norm of our day: everything and anything are read into and out of otherwise very specific scriptures, "wresting," as Peter says, these to our own destruction. The citing of the suicide of Abimelech, Saul, Judas, and others, although harshly judged by our contemporaries, receives no explicit scriptural indictment for the act. The sixth commandment "Thou shalt not kill" should be translated "Thou shalt do no murder." (Heb., ratsach)

the long-held view of that pronouncement is that it proscribes willful, evil termination of the life of another without regard for moral standards and involves malice and lawbreaking. In the context of the second half of the decalogue, this commandment governs the actions of one human against another. How then does it extend to cover the personal, uncoerced decision of a patient to end his life or request that others allow (passively) or help (actively) him to die? Further, one must not confuse prolongation of dying with prolongation of living. Nor should one confuse sustaining less-than-human existence with the full meaning of life.

It seems to this author that to terminate a treatment, drug, respirator at a time of best medical judgment and in appropriate due course is simply to relinquish all control and responsibility, returning it to the Creator who gave the life to be the final arbiter. But, having so said, it must be admitted that one is hard pressed to sustain any position from explicit Biblical text or necessary inference there from. It is noted that Christian scholars, writing on this subject, use little or no scripture to justify their positions, however well reasoned they may be.

First Corinthians 6:19 is often cited as a prohibition against suicide or euthanasia. It well may be in a general sense, but the context clearly places it. in connection with fornication (v.18), normative behavior in Corinth. The twentieth verse would seem to make a stronger case, taken with verse 15, q.v. Here, Saint Paul, guided by the Holy Spirit, argues that one's body belongs to Christ who in fact "bought" one. Paul elsewhere denominates himself as a slave or "doulos" (Romans 6:150. A doulos was a bought slave or bondservant not in charge of anything but the complete servant of another. As in all things, we own nothing, not even our bodies, but, in fact, are only stewards of things, talents, and our bodies. So the passage can be read generically to proscribe killing of the "temple of the Holy Spirit," but it must be averred that the primary intent of the passage was to condemn moral laxity in general and whoredom in specific.

The case of Job, in a general sense, indicts suicide or euthanasia. If anyone ever had a "need" or "right" to die, it was this miserable patriarch. Yet he never "cursed God" and died. Indeed, he sang a hymn to his creator, "Though he slay me yet will I hope in Him." Job recognized his trial was from God, and, although he did not understand it (so argued God in chapter 38), he resolutely accepted it and was richly blessed. What a loss to the world of a great lesson had Job been killed by his family or taken his own life. We would never have understood a fraction as much concerning the meaning of suffering. The case of Job, however, must not be extended to include the terminally comatose, artificially forced-by-man-to-stay-alive; here we venture to interfere with God's prerogatives, claiming the life He gave.

Kirn correctly argues that, "among peoples of simple civilization and those with a fixed code of morals and an unshaken belief, suicide is very rare, and is deemed unnatural and reprehensible."; He observes that this was the view of the early Greeks: Pythagoras, Plato, Aristotle, with the notable exception of Socrates. "... with decay of national thought and character, Stoicism taught indifference to life and death as mere external phenomena, and advocated voluntary surrender of life as a means of gaining independence for the soul."[3] Indeed, Cebes asked Socrates why if death was so blessed, a man could not be his own benefactor. Later, the Roman materialist, Lucretius, argued that death was nothing. Such arguments and those more recently set forth, Sartre's, are predicated upon a counterpoint to Judeo-Christian world view, namely, that life is absurd, an empty nothing with little justification for continuance.[4] However, in contrast to Sartre, the nihilist Camus states, "... even if one does not believe in God, suicide is not legitimate."[5]

By the decline of ancient Rome, Seneca argued for suicide. There was, however, a contradiction in Stoicism, specifically, a virtuous man should submit to the universe and, one could kill himself. These points were never reconciled in the later Stoae. Biblical sentiment of the period, in contradistinction, not only failed to endorse suicide/euthanasia, but countered despair with hope and uselessness with divine purpose for man. Christianity created an attitude of mind antithetical to suicide or euthanasia, interpreting suffering as having connection with God's providence even if not

seen and understood.

By the time of Eusebius, Chrysostom, and Jerome, it was held by some that a Christian woman might commit suicide to escape dishonor in times of severe persecution. Augustine (De Civitate Dei 1:16f) condemned the position, was upheld by later church councils to the extent that honorable burial was forbade to those committing suicide.

In the period of the Enlightenment, notables such as John Donne (Biathanatos) and David Hume (Two Essays) advocated suicide as permissible. Rousseau, Montesquieu, and Goethe seemed to more favorably discuss suicide in general moral or psychological terms, being less rigorously against it, yet the theologians and the best philosophers of the period, Spinoza, **Wolff, Mendelssohn, Kant, Fichte,** condemned it. "Modern pessimism maintains a rather indeterminate position towards the problem."[3] Suicide and euthanasia are seen to make invalid the Christian position which affirms purpose in life, hope in God, reliance upon God for all things, even in suffering. Suicide to many Christians is an abnegation of divine grace and trust (faith) even carrying an eternal fear of divine wrath. Although the Christian can and must be tenderly affectioned to those who in extreme measure end their lives, the Christian concept of a "New Creation" or "New Birth" allows for no compromise.

How did we as a society move so closely to the extreme moral position of killing our elders and encouraging and implementing self-death? The 1960s witnessed a massive rebellion, especially by those under forty, against established moral order in America. Man's oldest sin, rebellion and rejection of God's ways, is always his point of departure from tested and tried ways of righteousness. One saw in the 60s the rise of situational ethics and moral looseness: we ventured onto the slippery slope. The American mind had been prepared for three decades by major pervasive, perverse thought, such as the teachings of Freud. Freud was a nihilist after the Nietzschean mold rejecting even the notion of God. (Nietzsche hated Christianity with its emphasis on love and compassion for the weak.) Although Freud's contemporary, Jung, taught that no man ever found himself until he found God, the more dominant of the two, Freud, was the most well known and followed. It became even fashionable to be "in analysis" in the 1940s. Freud had a distorted deterministic view of man causing him to expect less of man in the way of self-discipline because he was a pawn of his environment.

Another driving force of moral permissiveness was the writing and teaching of the author of situational ethics, Fletcher.[6] Situational ethics was a "natural" given the fertile ground in this country by the tacit acceptance of pluralism: there is more than one kind of ultimate reality; there is no one standard. Singular, traditional, established moral and ethical standards were rejected in favor of many: a pluralistic absolutism was accepted. "We affirm that moral values derive their source from human experience. Ethics is autonomous and situational, needing no theological or ideological sanction. Ethics stems from human need and interest... We strive for the good life, here and now."[5] This was easily compounded by the extreme solipsistic cant of the era, the "me" generation. Edward Gibbon observed in the 18th century in his analysis of the fall of the Roman Empire, "The various modes of worship, which prevailed in the Roman World, were all considered by the people as equally true; by the philosopher, as equally false; and by the magistrate, as equally useful. And thus toleration produced not only mutual indulgence, but even religious concord.

This solipsism was no rational self interest, only gross self centeredness. One heard, "Do your own thing" with little regard to the consequence of what happens when "your own thing" runs into "their own thing." But "truth" was not monistic either--truth was many. Truth was what works, and this was judged by the individual with little regard for the wisdom of older people, our prior decisions as a people, let alone arcane writings such as Holy Writ. It may be that the pluralism and varied ethnicity that gave birth to the country, America, that which we have held to be one of her greatest marks, may become the Achilles heel by which she is falling. We prize plurality, but consensus in America becomes ever more elusive.

Solpsism is a reductio ad absurdum which states in effect, "I alone exist (solus5 alone, plus, ipse5 self). It is the essential error of Joseph Fletcher's Situation Ethics: "Anything and everything is right or wrong according to the situation. [116] Although Fletcher held love to be the motive principle, each person was to decide for himself right, wrong; the standards were to be his/her own. The "love" Fletcher espoused was not a reasoned Christian agape (John 15:12), an intent of the will that does not depend on the object for impetus, a love that can love the unlovable. Although eros (erotic, sensual love) and phileo (familial love or friendship) were well used and understood at the time of Christ, the Holy Spirit selected a word, agape, less used but already in the language and elevated it to signify the kind of love God has for us and that is required of us. Solipsistic love has no Fletcherism and the 60s was nearly all erotic; such that we see today young men and women living together, using each other's bodies with no commitment to enduring vows to each other in matrimony. Situationalism became the ethics of utilitarianism. Jesus said, "Ye shall know the tree by the fruit it bears" (Matthew 7:20), whether good or evil.

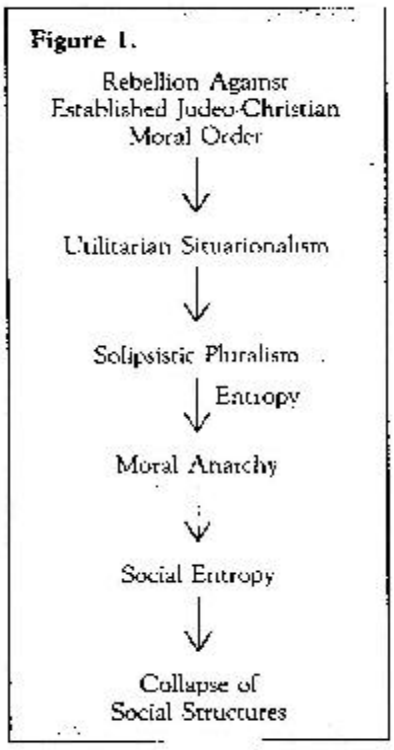
It is easy enough to move from rebellion to situationalism, pluralism, solipsism to ultimate moral anarchy: there is no God (see Figure 1). Justice and righteousness are the right of the stronger. What Socrates rejected in Thrasymachus' argument in The Republic is normative today. Justice is the right of the stronger. Moral anarchy is easily seen in Russia where it is no longer expected that one would tell the truth about anything, yet we move toward the same end. Moral anarchy requires man to be his own God. Man is the measure of man, secular humanism. The Bible is an arcane construct; it is no longer relevant. Even common wisdom would dictate that measuring a thing by itself without regard to external standard does not arrive at an informed judgment.

Moral anarchy ultimately extends to social anarchy with dissolution of social structures: home, courts, schools, commerce, government, church. We have entered a phase of social entropy where the countervailing forces of destruction and edification no longer balance or weigh toward upbuilding. Confusion of moral will ensues and conflicts arise between social will and social structures. We cannot put to death horrid, blatant, multiple murderers, but we can kill newborns and unborn babies. Why is that? Because they have no sacred or intrinsic worth? We cannot seem to carry out the death penalty, properly adjudicated, reinstated by statutes and the Supreme Court, but we lay plans to put to death the old and sick and the physically undesirable. Such is the telos and nadir of moral-social anarchy.

None of these forces (situational ethics, pluralism, solipsism, moral looseness) are new in history. They have only been rekindled, released with new vigor onto the current world scene. They give permission to us to think of killing humans even as a summum bonum. Whereas, before it was only right to defend oneself and country against the wicked (Hitler, Stalin), it now becomes okay to dispatch the non-wicked, the weak, the defenseless. Where will this end? Will we desensitize ourselves enough to apply this ever more broadly throughout society?

In graduate teaching in universities in the 60s and 70s, one heard concerning sex courses that an undergirding pedagogical principle was at work, viz., to desensitize our youth about any and all sexual behavior. Modesty and moral restraint borne of centuries of Judeo-Christian ethics were sown to the wind, and society has reaped a whirlwind of lust, sexual disease and death from sex such as has not been seen ever in this country nor in a long time in the world. Such may have been normative in Saint Paul's Corinth but waned rapidly in the first few centuries of the Christian era. We have made a social structure of sex. We institutionalized "Planned Parenthood" (more properly, Planned Non-Parenthood) and funded its permissiveness, moral debauchery and death-serving with federal dollars. This is a bare mention of only one facet of the social-sexual disease that is rife. Where will "living wills," euthanasia, assisted suicide lead? The libertine who thought it a good idea a quarter century ago to teach the youth not to be sexually inhibited, never envisioned the sorrow, disease and growing worldwide epidemic of death now upon us. "Living wills" are the thin edge of a wedge to further unseat another facet of our moral-social structures. Will they not desensitize us to killing our old?

How many pillars can a society sacrifice before no support for its structure is left? Does not the loosing of one structure lead to the weakening of another? Do not two lost lead to three, and so on till moral decadence claims a society? Arnold Toynbee traces the history of 19 notable civilizations that died. They did not die by conquest from without; they died because of moral rot within. But decay begins small - a gangrenous spot on the tip of a toe, so to speak. But, ultimately there is loss of an entire limb or life of its victim. We find it hard even to correct our moral faults now, no one will agree on the standard of judgment; indeed, we cannot even make the diagnosis of decay. If there are "many right ways" in conflict, not resolution will be found. If our social doctors (judges, courts, lawmakers, thinkers) cannot agree on the diagnosis as to whether we are sick or how we are sick or why we are sick, how then can a proper remedy be found? We are in a moral-social morass for which there is no exit. Sartre was right, we have morally anathematized ourselves.4 The One Way was rejected for the many, and they are in interminable conflict.



Now, having known the patient who tendered this "living will," signed and witnessed, the author can state categorically that her doctor, her family, and her friends knew exactly what she wished for herself before she wrote the document, and after she wrote the document, even without reading it. She never intended to commit suicide or be killed. The document was really irrelevant to her care, and, although she did ultimately die of her disease, as was expected, the document played no significant role that was not already designed by a conversation with the patient, honoring her wishes without the document. So we come back to the point that there was no need for the document; the document could have created more problems than it solved.

Any document that directed this author to kill his patient, whether actively or passively, could not be honored. He would have to violate the law or withdraw from the case. Withdrawing from the case, according to state statutes, requires that he give proper notice to the patient and/or guardians allowing a reasonable amount of time for the patient to secure other medical care. In more remote areas of the United States, an appropriate physician for that patient might not be secured in a short period of time, and some actions might have to be taken by the attending physician which would be against his ethical and moral position. The author must state categorically that he will never kill his patients, no matter who directs it. He does not intend to help others kill his patients. He does not intend to help his patient kill himself/herself. He did not come to medicine as a hired killer, he came to bring comfort, cheer, warmth, medical skill, and to alleviate suffering the best he could, leaving decisions about who lives and who dies to the giver of life. This is not to be construed as foolishly giving all manner of extreme, unwise, vain treatments. Indeed, it means that many times he would only give comfort and basic nursing care.

Recently, the Commonwealth of Kentucky circulated the following:

"WITHHOLDING OR WITHDRAWING LIFE-PROLONGING TREATMENT

The social commitment of the physician

> *is to sustain life and relieve suffering. For humane reasons, with informed consent to permit, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally-ill patient to die. However, a physician should not* intentionally cause *death.*
>
> *See AMA Council on Ethical and Judicial Affairs Opinion (2.18) for further discussion."*[5]

Although truth is never properly derived from tradition or popular opinion, this quote is evidence that the long revered ethos of our society still remains and must not lightly be abrogated by misguided, woolly thinking so common today.

A "living will" is a death warrant for the old and sick, and so similar notions were used in Nazi Germany. It began as a noble idea to put the old out of their suffering, to put the young deformed out of their misery. Over a quarter of a million Germans, non-Jews, died at the hands of "reputable" pediatricians and psychiatrists in the early Nazi attempts at euthanasia.

> *"Even before the Nazis took open charge in Germany, a propaganda barrage was directed against the traditional compassionate nineteenth century attitudes toward the chronically ill ... Sterilization and euthanasia of persons with chronic mental illnesses were discussed at a meeting of Bavarian psychiatrists in* 1931. *By* 1936 *extermination of the physically or socially unfit was ...openly accepted ...The first direct order for euthanasia was issued by Hitler on September* 1, 1939 *... The decision regarding which patients should be killed was made entirely on the basis of...brief information by expert consultants, most of whom were professors of psychiatry in the key universities. These consultants never saw the patients themselves.*

It was only later, as the spirit of this evil caught on, that the holocaust of Jews took form and was perpetrated. Are "living wills" to become a new pogrom? There can be little doubt in the author's mind that such laws are a step toward state-controlled killing of "undesirables."

Who indeed is "incurable" or "irreversible"? An eight-year-old diabetic is incurable with an irreversible, terminal disease. Shall we kill him? Shall we help him commit suicide? Indeed, the author has seen patients in the last remaining moments of life have beautiful family reconciliations and beautiful religious resolutions of guilt, fear, and anxiety that were worth the waiting and worth the struggle. Such events must never be abrogated by law. All patients must have the opportunity, at every point, to live as best they can, as nobly as they can, and be assisted by us, rather than hindered by us, themselves, or family making rash judgments and preconceived decisions ahead of time.

The folly of euthanasia can be seen simply in asking the question, "Who decides?" Do we decide for the patient? Does the state decide? That is too horrible to contemplate. Does the patient decide? Perhaps the following case may illuminate this problem.

> *"...a woman in respiratory failure ...after several days of intensive care withdrew her endotracheal tube with the balloon inflated [ordinarily that would have been deflated by a physician before extubation] in order to remark that she had `had enough of tubes,' and `why did we not just write her off?' Intensive care was stopped forthwith. It so happened that she survived. Later, she recollected none of the therapy, but thanked everyone cordially for it... "*[10]

The author thinks this experience speaks volumes to us and we had best heed it. This patient was not predicting the future with a "living will." This patient was in the

throes of therapy and was making an inappropriate judgment. Even an on-the-spot best judgment was not a good judgment.

The author recently spent 30 minutes with a daughter and an 84-year-old white female who is functioning and living on her own. The purpose of the meeting was to decide with the elder what she wanted in the way of terminal care. She was totally unable to comprehend the modern medical scene. Although we, her nurse daughter and the author, tried our best to explain, she could not comprehend what might be done in a hospital today. She would in no wise be able to sign an "informed consent," a "living will."

"Living wills" can deny patients the benefit of future medical discoveries and advancements. What seems heroic or difficult to do today may not later on be anything but a routine treatment - although it might still be "artificial"- most medicine and surgery is in some way.

And what of "quality of life"? Who decides that? By whose standard do we measure that? What criteria do we use? Often the best of ourselves and others surfaces in the throes of life, not in its fairer days. To provide "mercy killing" as a premature solution to a problem case may not be very merciful in the end.

It should be well understood that doctors are not the cause of the present problem. Many times physicians would withhold certain types of therapy even at present and desist from extreme measures to prolong life, but for the false expectations of family and the ever present threat of lawsuit. The public has the wishful fantasy that really, in fact, one can "live forever." That, "doctors can do anything nowadays." When, in fact, if one views what physicians really do, how much longer people live, and the tremendous expense involved, one wonders how much progress we have in fact made. Over and over again in this author's practice, and in the practice of acquaintances, one would have withheld certain extreme measures in patient care had it not been for the foolish and unwise counsel of close members in the family for whatever reason: sometimes that is love, sometimes it is guilt for not having acted better toward the dying one, sometimes it is simply confusion and bewilderment. The author cannot see how it would be possible for "living wills" to make much difference in the resolution of this matter.

Serious questions have been raised about "organ snatching." The question runs, "If a patient may be dying, might not he or she be hastened on in an effort to harvest a body part for another patient?" The slippery slope phenomenon always leads to many unforeseen ramifications; witness the tragic outcome of the Mary Beth Whitehead surrogate debacle. It is not possible to predict all the consequences of active or passive killing of "undesirables." A shift of emphasis from care of the living to promotion of death is a serious concern."

Another consequence seems obvious; will not being cast in the role as healer and executioner cause fear and suspicion in the mind of patients for their doctors? How can a doctor find the line between his role as healer and his appointed role as executioner? The Dutch Royal Academy of Medicine and the legislative body of the Netherlands will soon enact legislation that will mandate doctors wear both hats, healer and executioner. The Dutch Pharmaceutical Society has recently drawn up a list of lethal drugs with directions for their use, making this available to the public for suicide. Yet, how many times have physicians saved people in suicide attempts to restore them to sanity and a happy outcome. With readily encouraged death means, such happy outcomes will decrease and a macabre, diabolical process will begin. In the execution of criminals, a long "due process" with many checks and balances takes place over many years and still most are not executed. Are we to give such power to doctors to act as sole judge and executioner? It must be obvious that "living wills" will have no effect on "dying with dignity" or "relief of undue suffering" in the many patients who are unconscious or who have reached a vegetative state.

A "living will" could deprive a family loved one, wife, husband, child, of their right to be consulted in the terminal illness of the loved one. Such seizure of rights could have brutal consequences to those who must live on. Instead of a reasoned decision, the "living will" could transfer to a total stranger unprecedented power

over life and death with no checks and balances. Where "living wills" are now law, there is no evidence that they are used or have solved problems. Indeed, only one in five doctors and nurses have signed "living wills."[11]

So one comes full circle with the question, "What is needed?" Certainly, not more legal encumbrance. There is, however, a need for close communication between the patient, the patient's family, and the physician as to what real expectations exist and what measures can be employed to implement the wishes of all. That is already being done. It needs no laws beyond those already in force. The author closes with the awesome thought that killing a human life cannot be mollified by any euphemism that one applies to it. As a physician, he will continue to love his patients and give them his attention, his concern, the best of his skills, but not extend to them passive or active lethal means, for such is against his oath and covenant before Almighty God.

References

1. Callahan, D., On Feeding the Dying. In: Hastings Center Report, Vol. 13, No. 5, October 1983, p. 22.

2. Humanist Manifesto II. New York: Prometheus Books, 1973.

3. Kirn, O. The New Shaff-Herzog Encyclopedia of Religious Knowledge. Grand Rapids, Michigan: Baker Book House, 1957, Vol. 11, pp. 132-3.

4. Sartre, J.P. Being and Nothingness. New York: Washington Square Press, Inc. 1966, pp. 762, 766, 479, 556.

5. Camus. A. The Myth of Sisyphus and Other Essays. New York: Alfred A. Knopf, Inc. and Random House, Inc.; 1955.

6. Fletcher, J. Situation Ethics: The New Morality. Philadelphia: Westminster Press, 1966.

7. Gibbon, E. Decline and Fall of the Roman Empire. Chicago: Encyclopedia Brittanica, Great Books of the Western World, 1952, Vol. 1, Ch. 2, p. 12.

8. Kentucky Board of Medical Licensure Newsletter, August 1987.

9. Alexander L, Medical Science Under Nazi Dictatorship. New England Journal of Medicine, Vol. 241, July 14, 1949, pp. 39-47.

10. Payne, F.E., Jr., Biblical Medical Ethics: The Christian and the Practice of Medicine. Milford, Michigan: Mott Media, Inc., 1985, p. 200.

11. Stanton, J.R., The Oath of Hippocrates and the Living Will. M.C.F.L. Educational Trust, Massachusetts Citizens for Life, Inc., Newton, Massachusetts.

Acknowledgement: The author expresses his heartfelt gratitude for the steadfast support, both editorial and stenographic, that he has received from his research division and manuscript preparer, Judith Sochor.