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Some Non-Religious Views against Proposed 'Mercy-Killing' Legislation Part I

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

Yale Kamisar

Part I

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

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

When a legal scholar of Williams' stature⁴ joins the ranks of such formidable criminal law thinkers as America's Herbert Wechsler and the late Jerome Michael,⁵ and England's Hermann Mannheim⁶ in approving voluntary euthanasia, at least under certain circumstances, a major exploration of the bases for the euthanasia prohibition seems in order.⁷ This need is underscored by the fact that Williams' book arrives on the scene so soon after the stir caused by a brilliant Anglican clergyman's plea for voluntary euthanasia.⁸

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

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to indict, acquittals, suspended sentences and reprieves lend considerable support to the view that

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

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

The criticism is also made that

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

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

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

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

As an ultimate philosophical proposition, the case for voluntary euthanasia is strong. Whatever may be said for and against suicide generally, the appeal of death is immeasurably greater when it is sought not for a poor reason or just any reason, but for "good cause," so to
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speak; when it is invoked not on behalf of a "socially useful" person, but on behalf of, for example, the pain-racked "hopelessly incurable" cancer victim. If a person is in fact (1) presently incurable, (2) beyond the aid of any respite which may come along in his life expectancy, suffering (3) intolerable and (4) unmitigable pain and of a (5) fixed and (6) rational desire to die, I would hate to have to argue that the hand of death should be stayed. But abstract propositions and carefully formed hypotheticals are one thing; specific proposals designed to cover everyday situations are something else again.

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

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

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

If the law were to remove its ban on euthanasia, the effect would merely be to leave this subject to the individual conscience. This proposal would . . . be easy to defend, as restoring personal liberty in a field in which men differ on the question of conscience. . . .

On a question like this there is surely everything to be said for the liberty of the individual.\(^{29}\)
I am perfectly willing to accept civil liberties as the battlefield, but issues of "liberty" and "freedom" mean little until we begin to pin down whose "liberty" and "freedom" and for what need and at what price. This paper is concerned largely with such questions.

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

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

A Close-Up View of Voluntary Euthanasia

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

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

The English Society would require the eligible patient, i.e., one over twenty-one and "suffering from a disease involving severe pain and of an incurable and fatal character," to forward a specially prescribed application—along with two medical certificates, one signed by the attending physician, and the other by a specially qualified physician—
to a specially appointed Euthanasia Referee “who shall satisfy himself by means of a personal interview with the patient and otherwise that the said conditions shall have been fulfilled and that the patient fully understands the nature and purpose of the application”; and, if so satisfied, shall then send a euthanasia permit to the patient; which permit shall, seven days after receipt, become “operative” in the presence of an official witness; unless the nearest relative manages to cancel the permit by persuading a court of appropriate jurisdiction that the requisite conditions have not been met.

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

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

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

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

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

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

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

We all realize the intensified horror attached to the death-penalty by its accompanying formalities—from the phraseology of the judge's sentence, and his black cap, to the weight-gauging visit of the hangman to the cell, and the correct attendance at the final scene of the surpliced chaplain, the doctor, and the prison governor. This is not irrelevant to the problem of legalized euthanasia. ... After discussing the many procedural steps of the English Bill Dr. Roberts observed: "I can almost hear the cheerful announcement: 'please, ma'am, the euthanizer's come.'"
Evidently, the presumption is that the general practitioner is a sufficient buffer between the patient and the restless spouse or overwrought or overreaching relative, as well as a depository of enough general scientific know-how and enough information about current research developments and trends, to assure a minimum of error in diagnosis and anticipation of new measures of relief. Whether or not
At a meeting of the Medico-Legal Society, Dr. Kenneth McFadyean, after reminding the group that

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

commented on the English Bill:

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

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

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

[The reformers might be well advised, in their next proposal, to abandon all their cumbersome safeguards and to do as their opponents wish, giving the medical practitioner a wide discretion and trusting to his good sense.]

[The essence of the bill would then be simple. It would provide that no medical practitioner should be guilty of an offense in respect of an act done intentionally to accelerate the death of a patient who is seriously ill, unless it is proved that the act was not done in good faith with the consent of the patient and for the purpose of saving him from severe pain in an illness believed to be of an incurable and fatal character. Under this formula it would be for the physician, if charged, to show that the patient was seriously ill, but for the prosecution to prove that the physician acted from some motive other than the humanitarian one allowed to him by law.\(^{41}\)]

Evidently, the presumption is that the general practitioner is a sufficient buffer between the patient and the restless spouse or overwrought or overreaching relative, as well as a depository of enough general scientific know-how and enough information about current research developments and trends, to assure a minimum of error in diagnosis and anticipation of new measures of relief. Whether or not
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the general practitioner will accept the responsibility Williams would confer on him is itself a problem of major proportions. Putting that question aside, the soundness of the underlying premises of Williams' "legislative suggestion" will be examined in the course of the discussion of various aspects of the euthanasia problem.

B. "The Choice"

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

But is the adult patient really in a position to concur? Is he truly able to make euthanasia a "voluntary" act? There is a good deal to be said, is there not, for Dr. Frohman's pithy comment that the "voluntary" plan is supposed to be carried out "only if the victim is both sane and crazed by pain." By hypothesis, voluntary euthanasia is not to be resorted to until narcotics have long since been administered and the patient has developed a tolerance to them. When, then, does the patient make the choice? While heavily drugged? Or is narcotic relief to be withdrawn for the time of decision? But if heavy dosage no longer deadens pain, indeed, no longer makes it bearable, how overwhelming is it when whatever relief narcotics offer is taken away, too?

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

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

The situation is further complicated by the fact that

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

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

Anyone who has been severely ill knows how distorted his judgment became during the worst moments of the illness. Pain and the toxic effect of
disease, or the violent reaction to certain surgical procedures may change our capacity for rational and courageous thought. 50

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

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

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

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

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

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

[T]he problem can be exaggerated. Every law has to face difficulties in application, and these difficulties are not a conclusive argument against a
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law if it has a beneficial operation. The measure here proposed is designed to meet the situation where the patient’s consent to euthanasia is clear and incontrovertible. The physician, conscious of the need to protect himself against malicious accusations, can devise his own safeguards appropriate to the circumstances: he would normally be well advised to get the patient’s consent in writing, just as is now the practice before operations. Sometimes the patient’s consent will be particularly clear because he will have expressed a desire for ultimate euthanasia while he is still clear-headed and before he comes to be racked by pain; if the expression of desire is never revoked, but rather is reaffirmed under the pain, there is the best possible proof of full consent. If, on the other hand, there is no such settled frame of mind, and if the physician chooses to administer euthanasia when the patient’s mind is in a variable state, he will be walking in the margin of the law and may find himself unprotected.55

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

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

Even if the patient’s choice could be said to be “clear and incontrovertible,” do not other difficulties remain? Is this the kind of choice, assuming that it can be made in a fixed and rational manner, that we want to offer a gravely ill person? Will we not sweep up, in the process, some who are not really tired of life, but think others are tired of them; some who do not really want to die, but who feel they should not live on, because to do so when there looms the legal alternative of euthanasia is to do a selfish or a cowardly act? Will not some feel an obligation to have themselves “eliminated” in order that funds allocated
for their terminal care might be better used by their families or, financial worries aside, in order to relieve their families of the emotional strain involved?

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

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

And what of the relatives? If their views will not always influence the patient, will they not at least influence the attending physician? Will a physician assume the risks to his reputation, if not his pocketbook, by administering the coup de grace over the objection—however irrational—of a close relative?58 Do not the relatives, then, also have a "choice"? Is not the decision on their part to do nothing and say nothing itself a "choice"?59 In many families there will be some, will there not, who will consider a stand against euthanasia the only proof of love, devotion and gratitude for past events? What of the stress and strife if close relatives differ—as they did in the famous Sander case60—over the desirability of euthanatizing the patient?

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

The chronic illness and persistent pain in terminal carcinoma may place strong and excessive stresses upon the family's emotional ties with the patient. The family members who have strong emotional attachment to start with are most likely to take the patient's fears, pains and fate personally. Panic often strikes them. Whatever guilt feelings they may have toward the patient emerge to plague them.

If the patient is maintained at home, many frustrations and physical demands may be imposed on the family by the advanced illness. There may develop extreme weakness, incontinence and bad odors. The pressure of caring for the individual under these circumstances is likely to arouse a re-
sentiment and, in turn, guilt feelings on the part of those who have to do the nursing.\textsuperscript{62}

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

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

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

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

Might it not be said of the existing ban on euthanasia, as Professor Herbert Wechsler has said of the criminal law in another connection:
It also operates, and perhaps more significantly, at anterior stages in the patterns of conduct, the dark shadow of organized disapproval eliminating from the ambit of consideration alternatives that might otherwise present themselves in the final competition of choice.  

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

Professor Williams notes as "standard argument" the plea that

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

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

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

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

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

Until the euthanasia societies of England and America had been organized and a party decision reached, shall we say, to advocate euthanasia only for incurables on their request, Dr. Abraham L. Wolbarst, one of the most ardent supporters of the movement, was less troubled about putting away "insane or defective people [who] have suffered mental incapacity and tortures of the mind for many years" than he was about the "incurables." He recognized the "difficulty involved in the decision as to incurability" as one of the "doubtful aspects of euthanasia."
Doctors are only human beings, with few if any supermen among them. They make honest mistakes, like other men, because of the limitations of human mind.\textsuperscript{75}

He noted further that

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

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

He was given the case records [complete medical histories and results of careful examinations] of two patients and asked to diagnose their illnesses. . . . The patients had died and only the hospital pathologist knew the exact diagnosis beyond doubt, for he had seen the descriptions of the postmortem findings. Dr. Cabot, usually very accurate in his diagnosis, that day missed both.

The chief pathologist who had selected the cases was a wise person. He had purposely chosen two of the most deceptive to remind the medical students and young physicians that even at the end of a long and rich experience one of the greatest diagnosticians of our time was still not infallible.\textsuperscript{77}

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

One answer is:

It must be little comfort to a man slowly coming apart from multiple sclerosis to think that, fifteen years from now, death might not be his only hope.92
To state the problem this way is, of course, to avoid it entirely. How do we know that fifteen *days* or fifteen *hours* from now, "death might not be [the incurable's] only hope"?

A second answer is:

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

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

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

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

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

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

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

Three years ago, Dr. William D. McCarthy presented the results, to date, of an effort begun in 1950 to open a new approach in cancer palliation, 98 a report whose findings of "remarkable improvement" in nearly a third of the cases invoked strong editorial comment in the *New England Journal of Medicine*. 99 At the time of Dr. McCarthy's report, 100 "hopeless" patients with a wide variety of neoplasms had been treated with a combination of nitrogen mustard and ACTH or cortisone.
All patients in the series were in advanced or terminal phases of disease, and were accepted for treatment only after the disease was determined to be progressive after adequate surgery or radiation therapy.\textsuperscript{100}

Dr. McCarthy summarizes the results:

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

Unusual temporary remissions for intervals as long as three years were obtained. . . .\textsuperscript{101}

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

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

The most striking beneficial response to adrenalectomy was relief of pain. Three of the patients were confined to bed with pain prior to surgery and were taking narcotics frequently. . . . All three had striking relief of pain postoperatively and became ambulatory. One (J.W.) was in a stuporous condition preoperatively, confined to bed, and unable to feed himself. Following adrenalectomy his general condition improved remarkably. He became ambulatory and was able to return home to live a relatively normal life. This improvement has been maintained until the present, 218 days after surgery. . . .

Summarizing the prostatic cancer cases, all seven effective cases had striking subjective improvement. Only two cases showed objective improvement. Improvement was temporary in all cases.\textsuperscript{105}
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From all indications "J.W." was a most attractive target for the euthanasiasts. He was suffering from

... severe pain requiring frequent injections of narcotics for relief ... was extremely lethargic and relatively unresponsive ... had to be fed by the nursing staff.\textsuperscript{106}

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

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

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

The dynamic state of current cancer research would appear to be amply demonstrated by the indication, already, that in the treatment of advanced breast cancer adrenalectomy, itself still in the infant stages, may yield to hypophysectomy.\textsuperscript{113}
True, many types of cancer still run their course virtually unhampered by man's arduous efforts to inhibit them. But the number of cancers coming under some control is ever increasing. With medicine attacking on so many fronts with so many weapons who would bet a man's life on when and how the next type of cancer will yield, if only just a bit?114

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

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

D. “Mistakes Are Always Possible”

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

It may be allowed that mistakes are always possible, but this is so in any of the affairs of life. And it is just as possible to make a mistake by doing nothing as by acting. All that can be expected of any moral agent is that he should do his best on the facts as they appear to him.117

That mistakes are always possible, that mistakes are always made, does not, it is true, deter society from pursuing a particular line of
conduct—if the line of conduct is compelled by needs which override the risk of mistake. A thousand Convicting the Innocent’s or Not Guilty’s may stir us, may spur us to improve the administration of the criminal law, but they cannot and should not bring the business of deterring and incapacitating dangerous criminals or would-be dangerous criminals to an abrupt and complete halt.

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

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

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

Let us first examine the qualitative need for euthanasia:

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

The short answer is the witticism that whatever the incidence of death in connection with different types of operations “no doubt, it is in all cases below 100 percent, which is the incidence rate for euthanasia.” But this may not be the full answer. There are occasions
where the law permits action involving about a 100 percent incidence of death, for example, self-defense. There may well be other instances where the law should condone such action, for example, the “necessity” cases illustrated by the overcrowded lifeboat, the starving survivors of a shipwreck, and—perhaps best of all—by Professor Lon Fuller’s penetrating and fascinating tale of the trapped cave explorers.

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

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

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

Let us next examine the quantitative need for euthanasia:

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

The picture of the advanced cancer victim beyond the relief of morphine and like drugs is a poignant one, but apparently no small number of these situations may have been brought about by premature or excessive application of these drugs. Psychotherapy “unfortunately . . . has barely been explored” in this area, although a survey conducted on approximately 300 patients with advanced cancer disclosed that “over 50 percent of patients who had received analgesics for long periods of time could be adequately controlled by placebo medica-
tion." Nor should it be overlooked that nowadays drugs are only one of many ways—and by no means always the most effective way—of attacking the pain problem. Radiation, roentgen and X-ray therapy; the administration of various endocrine substances; intrathecal alcohol injections and other types of nerve blocking; and various neurosurgical operations such as spinothalmic chordotomy and spinothalmic tractomy, have all furnished striking relief in many cases. These various formidable non-narcotic measures, it should be added, are conspicuously absent from the prolific writings of the euthanasiasts.

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

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

How many are "some"? I do not know, but I think they are a good deal more than de minimus. The business of predicting what cures or temporary checks or measures of relief from pain are around the corner is obviously an inexact science. And as for error in diagnosis, doctors, as a rule, do not contribute to True Confessions. But I venture to say that the percentage and the absolute figures would not be as small, certainly not any smaller, than the grants of federal habeas corpus petitions to set aside state convictions. Federal habeas corpus so operates that only a handful of petitions are granted and only a small
fraction of these cases are ultimately discharged. Yet its continued existence has been ably defended as but another example of the recurrent theme that it is better that many guilty go free than one innocent be convicted. So long as this is the vogue, I do not hesitate—although Williams evidently thinks it is "no contest"—to pit the two or three or four who might be saved against the hundred who cannot be.

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

(To be Continued.)

NOTES

2. 1957. (This book is hereinafter referred to as "Williams.")

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


3. Euthanasia has a Greek origin: eu (easy, happy, painless), thanatos (death). The term apparently first appeared in the English language in the early seventeenth century in its original meaning—a gentle, easy death. The term then came to mean the doctrine or theory that in certain circumstances a person should be painlessly killed, and, more recently has come to mean the act or practice of bringing about a gentle and easy death. In its broad sense, euthanasia embraces a variety of situations, some where the patient is capable of consenting to his death, others where he obviously is not. Thus, two generations ago, H. J. Rose defined the euthanasia circumstances as "when owing to disease, senility, or the like, a person's life has ceased to be either agreeable or useful." In Hastings (Ed.) Encyclopedia of Religion and Ethics, 1912, Vol. 7, p. 598. In the 1930's there sprung up organizations in both England and America which dramatized the plight of the patient in "unnecessary" pain and urged euthanasia for the incurable and suffering patient who wanted to die. Consequently, a current popular meaning of the term is painless death "releasing"
the patient from severe physical suffering. An advocate of euthanasia has been called a "euthanasiast"; to subject to euthanasia has been called to "euthanatize." These terms will be so used throughout this paper. See generally Fletcher. Morals and Medicine. 1954, pp. 172-3; Sullivan. The Morality of Mercy Killing. 1950, pp. 1-3 (originally a dissertation entitled "Catholic Teaching on the Morality of Euthanasia"); Banks, Euthanasia. Practitioner, 161:101, 1948.

4. Williams' admirable treatise, Criminal Law: The General Part, 1953, stamps him as one of the giants in the field.

5. Wechsler and Michael. A Rationale of the Law of Homicide: I. Colum. L. Rev., 37:701, 739-40, 1937. Since the article was written before the Nazi euthanasia venture, it is conceivable that Prof. Wechsler, who had ample opportunity to study the Nazi experience as Technical Adviser to American Judges, International Military Tribunal, would come out somewhat differently today.


7. Since the proposals for reform which have commanded the greatest attention have urged complete immunization of voluntary euthanasia, this paper is concerned with whether or not such killings should be legalized, not whether or not they should be regarded as murder, which is now the case, see infra 9, or some lesser degree of criminal homicide. One way to achieve mitigation would be to give recognition to "good motive" generally; another would be to make a specific statutory reduction of penalty for voluntary euthanasia alone. For a discussion of these alternatives, see Kalven. A Study In Comparative Criminal Law. U. of Pa. L. Rev., 103:350, 386-9, 1954. The Royal Commission on Capital Punishment (1949-53) took the position that "mercy killings" could not feasibly be reduced in penalty. See text at ref. 34 and 34, infra.

8. Fletcher, supra 3, pp. 172-210. The book is quite similar to Williams in that it deals with the moral and legal issues raised by contraception, artificial insemination, sterilization and right of the patient to know the truth. It is the subject of an interesting and stimulating symposium review, N.Y.U.L. Rev., 31:1160-1245, 1956, by two lawyers, Prof. Harry Kalven and Judge Morris Ploscowe; two theologians, Emanuel Rackman and Paul Ramsey; two philosophers, Horace M. Kallen and Joseph D. Hasset; and a physician, L Phillips Frohman.


In a number of countries, e.g., Germany, Norway, Switzerland, a compassionate motive and/or "homicide upon request" operate to reduce the penalty. See generally Helen Silving's valuable comparative study, supra 7. However, apparently only Uruguayan law completely immunizes a homicide characterized by both of the above factors. Id. p. 369 and n. 74. The Silving article only contains an interesting and fairly extensive comparative study of assisted suicide and the degree to which it is treated differently from a direct "mercy killing." In this regard see also Friedman, Suicide, Euthanasia and the Law, Med. Times. 85:681, 1957.

10. See Williams, p. 342.


12. See, e.g., the Sander, Paight and Braunsdorf cases discussed at 172-6, 183, infra.

13. See, e.g., the Repouille case discussed at 181, infra.
14. See, e.g., the Brownhill and Long cases discussed at 178-9, infra.
17. Both Williams, p. 328, and Prof. Harry Kalven, supra 7, p. 1235, cite a single authority for the proposition that the prevailing system does not afford equality of treatment of mercy killers. That single authority is Helen Silving's study, supra 7. Silving in turn relies on a single case, that of Harold Mohr, who was convicted of voluntary manslaughter and sentenced to from three to six years in prison, for the slaying of his blind, cancer-stricken brother. Unlike other "mercy killing" cases which resulted in acquittals, Mohr's victim had apparently made urgent and repeated requests for death. Id. p. 354 and n. 15. Silving fails to note, however, that Mohr's defense that he "blackened out" just before the shooting was likely to be received with something less than maximum sympathy in light of the fact, pressed hard by the prosecution, that immediately prior to shooting his brother he made a round of taprooms and clubs for seven hours and consumed ten to twelve beers in the process. N.Y. Times, Apr. 8, 1950, p. 26, col. 1. Nor was the jury likely to consider it insignificant that two other brothers of Mohr testified on behalf of the state. Ibid. So far as I know, this is the only "mercy killing" case where relatives testified against the defendant.

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

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

In any event, the legislation urged by Williams, Fletcher and the English and American euthanasia societies would in no way relieve the plight of a "mercy killer" such as Noxon, for his was an act of involuntary euthanasia and hence beyond the scope of present proposals.

18. "Not a great many years ago, upon the Norfolk circuit, a larceny was committed by two men in a poultry yard, but only one of them was apprehended; the other having escaped into a distant part of the country, had eluded all pursuit. At the next assizes the apprehended thief was tried and convicted; but Lord Loughborough, before whom he was tried, thinking the offense a very slight one, sentenced him only to a few months imprisonment. The news of this sentence having reached the accomplice in his retreat, he immediately returned, and surrendered himself to take his trial at the next assizes. The next assizes came; but, unfortunately for the prisoner, it was a different judge who presided; and still
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more unfortunately, Mr. Justice Gould, who happened to be the judge, though of a very mild and indulgent disposition, had observed, or thought he had observed, that men who set out with stealing fowls, generally end by committing the most atrocious crimes; and building a sort of system upon this observation, had made it a rule to punish this offense with very great severity, and he accordingly, to the great astonishment of this unhappy man, sentenced him to be transported. While one was taking his departure for Botany Bay, the term of the other's imprisonment had expired; and what must have been the notions which that little public, who witnessed and compared these two examples, formed of our system of criminal jurisprudence?"


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

To take another example, the difficult area of criminal law dealing with causal relationship between conduct and result, “as has often been said, the question usually presented is not whether there is cause in fact, but rather whether there should be liability for results in fact caused.” Wechsler and Michael, supra 5, p. 724. Herbert Wechsler, the Chief Reporter of the Model Penal Code, favors the “culpability” rather than “causality” approach, ALI Proceedings, 32:162-3, 1955, and this view may very well be ultimately adopted. See section 2.03 (2) (b) of the Model Penal Code (Tent. Draft No. 4, 1955) and the appropriate comment to this section, id. p. 135, for a discussion of the advantages and disadvantages “of putting the issue squarely to the jury’s sense of justice.” To take still another example, the elusive distinction between first and second degree murder has well been described as “merely a privilege offered to the jury to find the lesser degree when the suddenness of the intent, the vehemence of the passion, seems to call irresistibly for the exercise of mercy.” Cardozo. What Medicine Can Do For Law. In Law and Literature. 1931, p. 100. This view is buttressed by the subsequent disclosure that of some 700 cases, every homicide case contained in the New York reports at that time, “only three cases have been found where on a murder charge, the indictment was for second degree murder.” New York Revision Commission. Communication and Study Relating to Homicide. 1937, p. 82, n. 202. Cardozo pointed out that he had “no objection to giving them [the jury] this dispensing power, but it should be given to them directly and not in a mystifying cloud of words.” From the frequency with which the dispensing power is exercised, and the manner in which it is viewed by the press and public generally, it seem fairly clear that nobody is mystified very much in the “mercy killing” cases.

21. Williams, p. 312. This seems to be the position taken by Bertrand Russell in his review of Williams’ book supra 2, p. 382: “The central theme of the book is the conflict in the criminal law between the two divergent systems of ethics which may be called respectively utilitarian and taboo morality. . . Utilitarian morality in the wide sense in which I am using the word, judges actions by their effects. . . In taboo morality . . . forbidden actions are sin, and they do not cease to be so when their consequences are such as we should all welcome.” I trust Russell would agree, if he should read this paper, that the issue is
not quite so simple. At any rate, I trust he would agree that I stay within the system of utilitarian ethics.


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


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

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

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27. See Fletcher, supra 8.

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

Undoubtedly the most extreme expression of this view is the bitter comment of Viscount Esher, upon concluding from the run of the speeches that he and his allies would be overwhelmed in the House of Lords debate on the question (169 H.L. Deb. [5th ser.] 551, 574-76, 1950): Voluntary euthanasia "is certainly an evolutionary extension of liberty of great importance, giving to the individual new rights to which, up till now, he has not had access. . . . What we propose this afternoon is, in point of fact, a new freedom, and undoubtedly it will antagonize the embattled forces of the official world.

. . . I believe that posterity will look back on this refusal you are going to make this afternoon. . . . as people look now on the burning of witches—as a barbarous survival of mediaeval ideas, an example of that high-minded cruelty from the entanglement of which it has taken mankind so many centuries to emerge. In that day we few, we five or six shall, I believe, be remembered." At the end, the euthanasiaists avoided a vote by withdrawing the question, id. p. 598. In an earlier House of Lords debate, proposed voluntary euthanasia legislation was defeated by a 35-14 vote. 103 H.L. Deb. (5th ser.) 466, 506, 1936.

29. Williams, pp. 341, 346.


Perhaps as good an example as any may be taken from Glanville Williams' own text, Criminal Law: The General Part §180, 1953. With a deep concern for the parents' "freedom not to conform" as his starting point, Williams makes a strong policy argument for immunizing from criminal law sanctions those "peculiar people" who for sincere religious reasons fail to summon medical aid to their sick children. One who takes the health and welfare of children as his starting point might well reach a somewhat different conclusion.

31. Section 2 (1) of the English Bill. The full text is set forth in Roberts, Euthanasia and Other Aspects of Life and Death, 1936, pp. 21-6.

32. Section 301 of the American Bill. The full text is set forth in Sullivan, supra 3, pp. 25-8. Fletcher, supra 3, p. 187, regards this bill as "perhaps the model legislation." Such bills have been unsuccessfully introduced in the legislatures of Nebraska, N.Y. Times, Feb. 3, 1937, p. 7, col. 1; Feb. 14, 1937, p. 17, col. 1; and, some ten years later, New York, Fletcher pp. 184-5.

33. I venture to say there are few men indeed who will not so much as smile at the portion of the American Society's Bill, Sullivan supra 3, p. 28, which provides that if the petition for euthanasia shall be denied by a Justice of the Supreme Court, "an appeal may be taken to the appellate division of the Supreme Court, and/or to the Court of Appeals."

34. Royal Commission on Capital Punishment, Report, Cmd. No. 8932, para. 179, 1953. Cf. Bentham. In Ogden (Ed.) The Theory of Legislation. 1931, p. 256. "Let us recollect that there is no room for considering the motive except when it is manifest and palpable. It would often be very difficult to discover the true or dominant motive, when the action might be equally produced by different motives, or where motives of several sorts might have cooperated in its production. In the interpretation of these doubtful cases it is necessary to distrust the malignity of the human heart, and that general disposition to exhibit a brilliant sagacity at the expense of good nature. We involuntarily deceive even ourselves as to what puts us into action. In relation even to our own motives we are wilfully blind, and are always ready to break into a passion against the oculist who
desires to remove the cataract of ignorance and prejudice.” Cf. Roberts, supra 31, pp. 10-1: “Self-deception as to one's motives, what the psychologists call 'rationalization,' is one of the most powerful of man's self-protective mechanisms. It is an old observation of criminal psychologists that the day-dreamers and the rationalizers account for a very large proportion of the criminal population; whilst, in murderers, this habit of self-deception is often carried to incredible lengths.”

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

35. 103 H.L. Deb. (5th ser.) 484-5, 1936.
39. Earengey, supra 24, pp. 91, 106 (discussion following the reading of Judge Earengey's paper).
40. Williams, p. 334: "The promoters of the bill hoped that they might be able to mollify the opposition by providing stringent safeguards. Now, they were right in thinking that if they had put in no safeguards—if they had merely said that a doctor could kill his patient whenever he thought it right—they would have been passionately opposed on this ground. So they put in the safeguards.

* * *

Did the opposition like these elaborate safeguards? On the contrary, they made them a matter of complaint. The safeguards would, it was said, bring too much formality into the sick-room, and destroy the relationship between doctor and patient. So the safeguards were wrong, but not one of the opposition speakers said that he would have voted for the bill without the safeguards."

41. Id. pp. 339-40. The desire to give doctors a free hand is expressed numerous times: “[T]here should be no formalities and . . . everything should be left to the discretion of the doctor (p. 340). . . . the bill would merely leave this question to the discretion and conscience of the individual medical practitioner . . . (p. 341). It would be the purpose of the proposed legislation to set doctors free from the fear of the law so that they can think only of the relief of their patients . . . (p. 342). It would bring the whole subject within ordinary medical practice.” (Ibid.) Williams suggests that the pertinent provisions might be worded as follows (p. 345):

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

* * *

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

2. It shall be lawful for a physician, after consultation with another physician, to accelerate by any merciful means the death of a patient who is seriously ill, unless it is proved that the act was not done in good faith with the consent of the patient and for the purpose of saving him from severe pain in an illness believed to be of an incurable and fatal character.”
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The completely unrestricted authorization to kill by omission may well be based on Williams' belief. p. 326, that under existing law "'mercy killing' by omission to prolong life is probably lawful" since the physician is "probably exempted" from the duty to use reasonable care to conserve his patient's life "if life has become a burden." And he adds—as if this settles the legal question—that "the morality of an omission in these circumstances is conceded even by Catholics." Ibid.

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


Nor am I at all certain that the Catholics do "concede" this point. Williams' reference is to Sullivan, supra 3, p. 64. But Sullivan considers therein what might be viewed as relatively remote and indirect omissions, e.g., whether to call in a very expensive specialist, whether to undergo a very painful or very drastic operation. The Catholic approach raises nice questions and draws fine lines. E.g., how many limbs must be amputated before an operation is to be regarded as non-obligatory "extraordinary," as opposed to "ordinary" means, but they will not be dwelt upon here. Suffice to say that apparently there has never been an indictment, let alone a conviction, for a "mercy killing" by omission, not even one which directly and immediately produces death.

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

It is difficult to discuss the consultation feature of Williams' proposal for affirmative "mercy killing" because Williams himself never discusses it. This fact, plus the fact that Williams' recurrent theme is to give the general practitioner a free hand indicates that he himself does not regard consultation as a significant feature of his plan. The attending physician need only consult another general practitioner and there is no requirement that there be any concurrence in his diagnosis. There is no requirement of a written report. There is no indication as to what point in time there need be consultation. Probably there need be consultation only as to diagnosis of the disease and from that point on the extent and mitigatory nature of the pain, and the firmness and rationality of the
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desire to die is to be judged solely by the attending physician. For the view that even under rather elaborate consultation requirements, in many thinly staffed communities the consulted doctor would merely reflect the view of the attending physician see Life and Death, Time, Mar. 13, 1950, p. 50. After reviewing eleven case histories of patients wrongly diagnosed as having advanced cancer, diagnoses that stood uncorrected over long periods of time and after several admissions at leading hospitals. Doctors Laszlo, Colmer, Silver and Standard conclude: "[I]t became increasingly clear that the original error was one easily made, but that the continuation of that error was due to an acceptance of the original data without exploring their verity and completeness." (Errors in Diagnosis and Management of Cancer. Ann. Int. Med., 33:670, 1950.)

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

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

The most recent petition of physicians for legalized euthanasia was that signed by 166 New Jersey physicians early in 1957 urging in effect the adoption of the American Society's Bill. See Anderson. Who Signed for Euthanasia? America, 96:573,1957. According to this article, the American Society had sent a letter to all the doctors in the
state asking them to sign such a petition. The doctors were asked to check either of
two places, one indicating that their name could be used, the other that it could not. The
1950 census records over 7,000 physicians in New Jersey. Characteristics of the Popula-
tion, Part 30, p. 203. Thus, about 98 percent of the state medical profession declined to
sign such a petition. The Medical Society of New Jersey immediately issued a statement
that “euthanasia has been and continues to be in conflict with accepted principles of
morality and sound medical practice.” See Anderson, supra. When their names were
published in a state newspaper, many of the 166 claimed they had not signed the petition
or that they had misunderstood its purpose or that, unknown to them, some secretary
had handled the matter in a routine manner.

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

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

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

It should be noted that under what might be termed the “family plan” feature of Wil-
liams’ proposal, minors may be euthanatized, too. Their fate is to be “left to the good
sense of the doctor, taking into account, as he always does, the wishes of the parents as
well as those of the child.” Williams, p. 340, n. 8. The dubious quality of the “volun-
tariness” of euthanasia in these circumstances need not be labored.

31:1215, 1222, 1956.

The disturbing mental effects of morphine, “the classic opiate for the relief of severe
pain,” Schiffrin and Gross, Systematic Analgetics, In Schiffrin (Ed.) Management of Pain
In Cancer, 1956, p. 22, and “still the most commonly used potent narcotic analgesic in
treatment of cancer pain.” Bonica, The Management of Cancer Pain, GP, Nov. 1954,
pp. 35, 39, have been described in considerable detail by Drs. Wolff, Hardy and Goodell
in Studies on Pain: Measurement of the Effect of Morphine, Codeine, and other Opiates
on the Pain Threshold and an Analysis of their Relation to the Pain Experience, J. Clin.
Investig., 19:659, 664, 1940. It is not easy to generalize about the psychological effects
of drugs for there is good reason to believe that the type of drug reaction is correlated
with “differential personality dynamics, primarily in terms of the balance of mature,
socially oriented controls over impulsive, egocentric emotionality,” von Felsinger, La-
sagna and Beecher, Drug-Induced Mood Changes in Man, JAMA, 157:1113, 1119, 1955,
that for example, persons with atypical reactions to drugs are likely to be those with pre-
exisimmaturity, anxiety and hostility, id. p. 1116. See also Lindemann and Clark.
Modifications In Ego Structure and Personality Reactions Under the Influence of the
Effects of Drugs. Amer. J. Psychiat., 108:561, 1952. It would seem, however, that the
severely ill person would be likely to experience substantially more pronounced effects
than those described by Wolff, Hardy and Goodell, supra, because in that instance the
“subjects” studied were the authors themselves, representing both sexes and different body
types, experiencing various degrees of pain by exposing portions of their skin surfaces to thermal radiation, but in the case of an illness due to a malignancy or suspected malignancy, we start with a situation where "all kinds of irrational attitudes come to the fore." Zarling, Psychological Aspects of Pain in Terminal Malignancies. In Schiffcrin (Ed.) supra p. 205.

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

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


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

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


54. Williams, pp. 343-4.

55. Id., p. 344.

56. Dr. James J. Walsh in Life Is Sacred, The Forum, 94:333-4, recalls the following Aesop’s fable: “It was a bitter-cold day in the wintertime, and an old man was gathering broken branches in the forest to make a fire at home. The branches were covered with ice, many of them were frozen and had to be pulled apart, and his discomfort was intense. Finally the poor old fellow became so thoroughly wrought up by his suffering that he called loudly upon death to come. To his surprise, Death came at once and asked what he wanted. Very hastily the old man replied, ‘Oh, nothing: nothing except to help me carry this bundle of sticks home so that I may make a fire.’”


58. The medical profession is apparently already quite sensitive about the “sue consciousness” on the part of the public. See Caswell. A Surgeon’s Thoughts on Malpractice. Temple L. Q., 30:391, 1957. (Symposium) There is good reason to think that “the greater incidence of suits and claims against physicians alleging medical malpractice and a greater financial success in prosecuting these” has led to “insecurity” on the part of many physicians, and “the insecure physician is going to play it safe.” Wachowski and Stronach. The Radiologist and Professional Medical Liability. Temple L. Q., 30:398, 1957. Apparently, in some fields fear of claims and litigation has already set “the psychological stage for undertreatment.” Id., p. 399.

59. Cf. the examination of Sir Harold Scott, Commissioner of Police of the Metropolis by the Royal Commission on Capital Punishment, Minutes of Evidence, Oct. 7, 1949, p. 151: “1599. Nobody at present, except the law, has to decide that a particular person should be sentenced to death, no individual?—No individual at present, except the Home Secretary, has to decide that a particular person sentenced to death must hang.

1600. The Home Secretary is in a different position is he not? He does not primarily prescribe the death penalty; the law does that. The Home Secretary says whether or not he deems it right to interfere with the course of the law?—Yes, that is the legal position. It is a different position, technically, but it seems to me that morally there really is no difference. The responsibility upon the Home Secretary is really to decide whether this man shall die or not die. The machinery may be by interference or non-interference with the law, but the responsibility to me seems the same.”

60. See infra 172. See also the Mohr case; supra 17, where two brothers testified against a third who had euthanatized a fourth.

61. See infra 176.


63. Id., pp. 213-4. See also Dr. Benjamin Miller to the effect that cancer “can be a ‘horrible experience’ for the doctor too” and that “a long difficult illness may emotionally exhaust the relatives and physician even more than the patient.” Miller, supra 50, p. 103; and Stephen, Murder from the Best of Motives, L. Q. Rev., 5:188, 1889, commenting on the disclosure by a Dr. Thwing that he had practiced euthanasia: “The boldness of this avowal is made particularly conspicuous by Dr. Thwing’s express admission that the only person for whom the lady’s death, if she had been allowed to die naturally, would have been in any degree painful was not the lady herself, but Dr. Thwing.”


65. “As I looked at her face and all of the thoughts of the past went through my mind, something snapped in me, and I felt impelled or possessed to do something, and why I did it, I can’t tell. It doesn’t make sense.” N.Y. Times, Mar. 7, 1950, p. 19, col. 1.

66. “I didn’t use a tourniquet, which is also rather a ridiculous thing, because ordinarily in
a normal patient we put on a tourniquet to bring up the vein so that we can see it. Her veins were collapsed anyhow and I couldn't have been thinking the way I ordinarily do at the time. Otherwise I wouldn't have acted this way."

Ibid. 67.

"[J]ust the appearance of her face and the combination of all the thoughts of her long suffering and of her husband's suffering also—this expression on her face might have just touched me off and made me feel obsessed that I had to do something and what I did does not make sense." Ibid. 68.

See infra 172, and accompanying text.

69. Wechsler. The Issues of the Nuremberg Trial. Pol. Sci. Q., 62:11, 16, 1947. Cf. Cardozo, supra 20, pp. 88-9: "Punishment is necessary, indeed, not only to deter the man who is a criminal at heart, who has felt the criminal impulse, who is on the brink of indecision, but also to deter others who in our existing social organization have never felt the criminal impulse and shrink from crime in horror. Most of us have such a scorn and loathing of robbery or forgery that the temptation to rob or forge is never within the range of choice; it is never a real alternative. There can be little doubt, however, that some of this repugnance is due to the ignominy that has been attached to these and like offenses through the sanctions of the criminal law. If the ignominy were withdrawn, the horror might be dimmed."

70. Williams, p. 318.

71. Id. pp. 317-8.

72. "What to do with the hopelessly unfit? I had thought at a younger time of my life that the legalizing of euthanasia—a soft gentle-sounding word—was a thing to be encouraged; but as I pondered, and as my experience in medicine grew, I became less sure. Now my face is set against the legalization of euthanasia for any person, who, having been well, has at last become ill, for however ill they be, many get well and help the world for years after. But I am in favor of euthanasia for those hopeless ones who should never have been born—Nature's mistakes. In this category it is, with care and knowledge, impossible to be mistaken in either diagnosis or prognosis." Kennedy. The Problem of Social Control of the Congenital Defective. Amer. J. Psychiat., 99:13, 14, 1942.

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

At the February, 1939, meeting of the Society of Medical Jurisprudence, Charles E. Nixdorff, treasurer and board chairman of the Euthanasia Society of America stated that the case of a 19 year old girl in Bellevue, with a broken back and paralyzed legs, who "prayed for death every night" was sufficient reason for the Euthanasia Society "to carry on the fight." "Dr. [Foster] Kennedy [then President of the Euthanasia Society], in conversation, said later he did not think that was a particularly good example. He said he had known many such cases where the patients 'got around' and only recently he had 'danced with one.'" N.Y. Times, Feb. 14, 1939, p. 2, col. 6.

73. Banks, supra 3, pp. 101, 106. According to him, neither "pain" nor "incurability" "is capable of precise and final definition, and indeed if each case had to be argued in open court there would be conflict of medical opinion in practically every instance." Id. p. 104.


75. Id. pp. 330, 331.

76. Id. p. 332.

77. Supra 49, p. 39.

78. As to how bad the bad physician can be, see generally, even with a grain of salt, Belli, Modern Trials, 1954, §§327-53, Vol. 3. See also Regan, Doctor and Patient and the Law, 1956, pp. 17-40. Third edition.

79. See supra 41, and accompanying text.
80. As Williams points out, p. 330, Dr. Millard introduced the topic of euthanasia into public debate in 1932 when he advocated that “mercy killing” should be legalized in his presidential address to the Society of Medical Officers of Health. In moving the second reading of the voluntary euthanasia bill, Lord Ponsonby stated that “the movement in favour of drafting a Bill” had “originated” with Dr. Millard. 103 H.L. Deb. 466-7, 1936.


82. Euthanasia opponents readily admit this. See e.g., supra 49, p. 38.

83. Supra 81, p. 702.

84. Supra 37, pp. 1215, 1216. Dr. Frohman added: “we practice our art with the tools and information yielded by laboratory and research scientists, but an ill patient is not subject to experimental control, nor are his reactions always predictable. A good physician employs his scientific tools whenever they are useful, but many are the times when intuition, chance, and faith are his most successful techniques.

85. Laszlo, et al., supra 41.


89. Id. p. 83.

90. Id. p. 82. Consider also the following: At the 1951 annual meeting of the American Cancer Society, devoted to cytologic diagnosis of cancer, Dr. Henry M. Lemon noted: Proceedings, Symposium on Exfoliative Cytology, Oct. 23-24, 1951, p. 106: “The problem of false positive diagnoses has always been a difficult one. About 5 percent of the 541 non-cancer patients in whom cancer secretions have been studied in the past had false positive diagnosis made, and in our experience, gastritis has been a common cause of false positive diagnosis.” At the same meeting, Dr. William A. Cooper told of “fifteen misses” in X-ray gastric cancer diagnosis out of one hundred cases (Id. p. 102): “Four of the twenty-five cases of cancer were said to have benign lesions, while eleven of the seventy-five benign lesions were said to have cancer.”

91. See Williams, p. 318.


94. Thus, Doctor Millard, in his leading article, supra 81, p. 710, states: “A patient who is too ill to understand the significance of the step he is taking has got beyond the stage when euthanasia ought to be administered. In any case his sufferings are probably nearly over.” Glanville Williams similarly observes, pp. 342-4: “Under the bill as I have proposed to word it, the consent of the patient would be required, whereas it seems that some doctors are now accustomed to give fatal doses without consulting the patient. I take it to be clear that no legislative sanction can be accorded to this practice, in so far as the course of the disease is deliberately anticipated. The essence of the measures proposed by the two societies is that euthanasia should be voluntarily accepted by the patient.

"... The measure here proposed is designed to meet the situation where the patient's consent to euthanasia is clear and incontrovertible."


96. Ibid.; supra 49, p. 39.

97. This is not to say that progress in the treatment of cancer cases has been limited to the last decade. Over twenty years ago, Lord Horder, 103 H.L. Deb. 466, 492, 1936, opposing the euthanasia bill in the House of Lords debates, observed: “[A]lthough it is common knowledge that the essential causative factors of cancer still elude us, there are patients
today suffering from this disease, not only living but free from pain, who would not have been living ten years ago, and this as the result of advances made in treatment."


100. Supra 98, p. 468.

101. Id. pp. 470, 475. Some of the results were little short of spectacular. See, e.g., Case 1, p. 470, the case of a woman whose reticulum-cell sarcoma "was considered too disseminated for radiation therapy" who responded so well to therapy that she returned to employment as a nurse for three years; Case 3, Ibid. that of a man taken to the hospital "in a terminal state" with "a massive lymphosarcoma of the pelvis" which had received X-ray therapy and which was increasing rapidly in size, who returned to his occupation and but for a short interval when he underwent a second course of therapy "continued working up to the time of his death . . . eighteen months after the first course of combination therapy"; Case 11, p. 472-3, that of a stomach-cancer victim "in a terminal condition, unable to retain solids or fluids" who, after three months of the therapy, regained her normal weight, returned to her occupation and enjoyed excellent health for a full year.

On the other hand, some 40 percent of the group were considered failures (those who died within a month and those who survived longer but received little benefit); 29 percent were classed as fair in response (moderate but brief palliation), p. 470.

102. See also Ravich, Euthanasia and Pain in Cancer, Unio Internationalis Contra Cancrum, 9:397, 1953, a report of the promising experimental chemotherapeutic measures (n-Butanol, glycerine and sodium thiosulfate) of Dr. Emanuel Revici and the staff of the Institute of Applied Biology. A number of patients whose cancers "had advanced beyond the point where any help was to be anticipated from surgery, X-ray or radium, according to the opinions of the attending physicians," p. 398, returned to their normal occupations after the onset of treatment and remained on the job for several years.

103. Drs. Huggins and Scott had reported the first total bilateral adrenalectomies in patients with prostatic carcinoma in 1945, but since cortisone was not then available all patients died in adrenal insufficiency. The authors therefore concluded at that time that the operation was not practical and temporarily abandoned this approach. See Huggins and Scott. Bilateral Adrenalectomy in Prostatic Cancer: Clinical Features and Urinary Excretion of 17 Ketosteroids and Estrogen. Ann. Surg., 122:1031, 1945.


105. Id. pp. 1012-3. Dr. M. P. Reiser of the University of Minnesota Medical School and his colleagues have planted radon-filled seeds of gold into the prostate area in an effort to save patients with "inoperable" cancer of the prostate gland. As a result, thirteen of twenty-five patients have lived at least a year; six have lived from three to seven years. Radon is the gas of radium. See Cohn. 'U' Reports Victories over Cancer. Minneapolis Morning Trib., Apr. 4, 1958, p. 13, col. 4.

106. Supra 104, p. 1010.

107. An addendum to the report discloses that J. W.'s postoperative "subjective improvement" lasted 220 days and that he survived for 294 days, id. pp. 1016-7. What pain J. W. suffered in his last days is not revealed, but in general discussion the authors state that "... [I]n the majority of the cases, the pain never did return to its preoperative intensity even though the patient later died of cancer." Id. p. 1015.


Furthermore, an additional nine patients who underwent no demonstrable regression experienced marked objective improvement in relief of bone pain, disappearance of respiratory symptoms and return of a sense of well-being. An earlier report on adrenal-
ectomy disclosed that of five “effective” breast carcinoma cases, a sixth having died of other causes a short time after undergoing the operation, “all had severe pain pre­operatively, and all had either partial or complete relief of pain following adrenalectomy.” Supra 104, p. 1014.

110. Id. p. 1796.

111. Ibid.


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

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

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

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

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

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

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

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

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

116. For a discussion of the legal significance of “mercy killing” by omission and Williams’ consultation feature for affirmative “mercy killing,” see supra 41.

117. Williams, p. 318.


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


123. "I believed that the figures showed that if you abolish capital punishment you do not, in fact, lose more human lives. Other noble Lords took the opposite view: they believed that if capital punishment were abolished we should lose more lives. Both sides, however, believed that there is an ultimate value in human life. That was what the whole debate was about." 169 H.L. Deb. (5th ser.) 551, 591, 1950.

124. The remaining pockets of resistance would be manned by those who would utilize the death penalty as an instrument of vengeance, as a device for placing a special stigma on certain crimes, and as a means of furnishing the criminal with an extraordinary opportunity to repent before execution. See the discussion in the Royal Commission Report, supra 121, paras. 52-4.


In February, 1956, the House of Commons on a free vote of 292 to 246 passed a resolution calling for the abolition or suspension of the death penalty which stated in part that "the death penalty for murder no longer accords with the needs or true interests of a civilized society" 548 H.C. Deb. (5th ser.) 2556, 2652, 2655, 1956. The House of Lords, however, rejected the legislation passed in the spirit of this resolution. See Hart, supra 122, p. 434. Bertrand Russell recently commented, supra 2, p. 385: "I have not the relevant statistics, but I think if a poll had been taken [of the House of Lords in 1936] it would have been found that most of those who objected to euthanasia favoured capital punishment, the dominant consideration in each case being faithfulness to tradition." Perhaps, but I would speculate further that if such a poll had been taken, it may well have been found that most of those who favoured euthanasia objected to capital punishment. And on such grounds as the irrevocability of the death sentence and the inevitable incident of error in the selection of its victims, the insufficient showing that such a drastic method is needed, and, perhaps, the sanctity of life.

126. See Silving, supra 7.

127. See, e.g., Fletcher, supra 3, p. 198; Euthanasia Society of America, Merciful Release, art. 7; Millard, supra 81, p. 717.


132. Cardozo, supra 20, p. 113.

133. Hall. General Principles of Criminal Law. 1947, p. 399. Cardozo, on the other hand, seems to say that absent such certainty it is wrong for those in a "necessity" situation to escape their plight by sacrificing any life. Cardozo, supra 20, p. 113. On this point, as on the whole question of "necessity," his reasoning, it is submitted, is paled by the careful and intensive analyses found in Hall, supra, pp. 377-426, and Williams, supra 4, pp. 577-86.

See also Cohn. The Moral Decision. 1955. Although he takes the position that in the Holmes' situation, "if none sacrifice themselves of free will to spare the others—they must all wait and die together," Cohn rejects Cardozo's view as one which "seems to deny that we can ever reach enough certainty as to our factual beliefs to be morally justified in the action we take." Pp. 70-1.
Some time after this paper was in galley, Section 3.02 of the Model Penal Code (Tent. Draft No. 8, 1958) made its appearance. This section provides (unless the legislature has otherwise spoken) that certain "necessity" killings shall be deemed justifiable so long as the actor was not "reckless or negligent in bringing about the situation requiring a choice of evils or in appraising the necessity for his conduct." The section only applies to a situation where "the evil sought to be avoided by such conduct is greater than that sought to be prevented by the law," e.g., killing one that several may live. The defense would not be available, e.g., "to one who acted to save himself at the expense of another as by seizing a raft when men are shipwrecked." Comment to Section 3.02, id. p. 8. For "in all ordinary circumstances lives in being must be assumed . . . to be of equal value, equally deserving the protection of the law." Ibid.

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

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

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

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

"Chordotomy is perhaps the most useful and most effective neurosurgical operation for the relief of cancer pain. When skilfully carried out in properly selected patients, it produces complete relief in about 65 percent of the patients, partial relief in another
25 percent, and no relief in approximately 10 percent.” Bonica and Backup, supra, p. 25.

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

137. Bonica and Backup, supra 135, p. 22; Bonica, supra 135, p. 35.
138. Ibid.

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

Bonica and Backup, supra 135, pp. 24-5; to the same effect is Bonica, supra 135, p. 38.

See also Schiffrin and Gross, supra 135, p. 17:

"Factors facilitating the development of tolerance include the administration of the drug at frequent, regular intervals and the use of successively larger doses. The appearance of clinically significant tolerance can be delayed by using the minimal effective dose as infrequently as possible and by limiting the use of addicting drugs to their primary characteristic, analgesia, and not to secondary properties such as sedation. The writing of such an order as '½ gr. morphine q. 4 h.' is to be deplored. Addicting analgetics are to be ordered on the basis of pain, not according to the clock or nursing habits.”

140. "The opinion appears to prevail in the medical profession that severe pain requiring potent analgesics and narcotics frequently occurs in advanced cancer. Fortunately, this does not appear to be the case. Fear and anxiety, the patient's need for more attention from the family or from the physician, are frequently mistaken for expressions of pain. Reassurance and an unhesitating approach in presenting a plan of management to the patient are well-known patient 'remedies,' and probably the clue to success of many medical quackeries. Since superficial psychotherapy as practiced by physicians without psychiatric training is often helpful, actual psychiatric treatment is expected to be of more value. Unfortunately, the potential therapeutic usefulness of this tool has barely been explored." Laszlo and Spencer, supra 86, pp. 869, 875.

141. Ibid. “Placebo” medication is medication having no pharmacologic effect given for the purpose of pleasing or humoring the patient. The survey was conducted on patients in Montefiore Hospital, N.Y.C. One clear implication is that “analgesics should be prescribed only after an adequate trial of placebos.”

142. See supra 135.

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

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

144. See text at 49 and 52, supra.

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

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

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

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

148. It is not surprising that the cry has gone out that federal habeas corpus is not worth it, that "one swallow does not make a summer," Baker, supra 147, p. 1042, and that "he who must search a haystack for a needle is likely to end up with the attitude that
the needle is not worth the search." Jackson, J., concurring in Brown v. Allen, 344 U.S. 443, 537 (1953). But these views have not prevailed. As Illinois Supreme Court Justice Walter Schaefer recently observed in his Holmes lecture: "Even with the narrowest focus it is not a needle we are looking for in these stacks of paper, but the rights of a human being. And if the perspective is broadened, even the significance of that single human being diminishes, and we begin to catch a glimpse of the full picture. The aim which justifies the existence of habeas corpus is not fundamentally different from that which informs our criminal law in general, that it is better that a guilty man go free than that an innocent one be punished. To the extent that the small numbers of meritorious petitions show that the standards of due process are being honored in criminal trials we should be gratified; but the continuing availability of the federal remedy is in large part responsible for that result. What is involved, however, is not just the enforcement of defined standards. It is also the creative process of writing specific content into the highest of our ideals. So viewed, the burdensome test of shifting the meritorious from the worthless appears less futile..." Schaefer, supra 147, pp. 25-6.

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

149. Williams, p. 318.