ADVANCE MEDICAL DIRECTIVES IN THE AUTONOMY WILDERNESS

Anthropology, Culture and Meaning



Christ Bestowing Life Upon Those
Who Were in the Tombs

Thomas J. Davis, Jr.

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Deacon Thomas J. Davis, Jr., JD, LLM, MA

To Mary Lowe

A Christian who accepted suffering beyond obligation, so that others might gain,
in union with Jesus, for the sake of His body, the Church (Col 1:24),
by which she showed generosity in the service of humanity.

"The creative action of the Christian's life is to prepare his death in Christ."

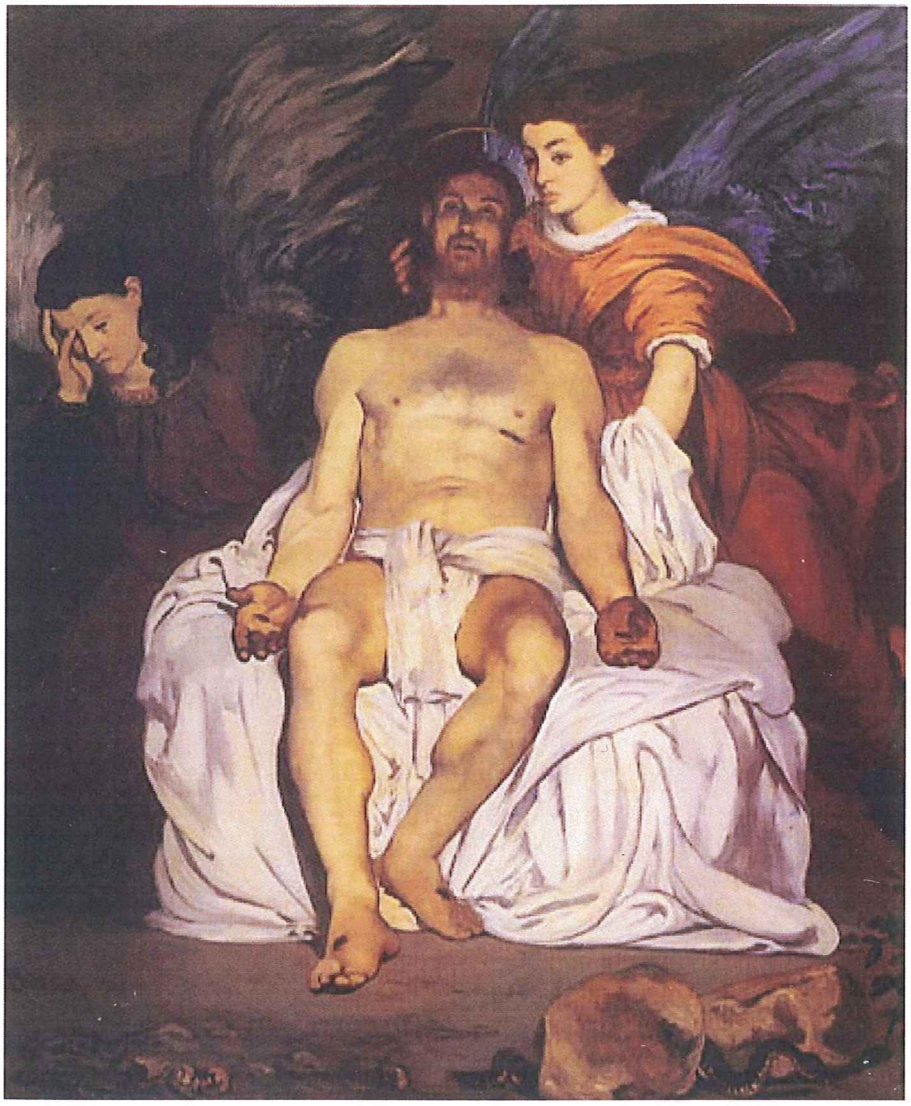
Flannery O'Connor
From the Introduction to *A Memoir of Mary Ann*

TABLE OF CONTENTS

I.	INTRODUCTION:	5
II:	NO CULTURE IS AN ISLAND	16
III:	THE AUTONOMOUS SELF	48
	A. The Development of American Constitutional Doctrine	48
	B. Legislative Developments in Health Care Autonomy	69
IV:	A CHRISTIAN UNDERSTANDING OF THE VALUE OF LIFE AND SUFFERING AND THE MEANING OF DEATH	77
	A. Human Life	77
	B. Suffering and Death	81
V:	ORDINARY AND EXTRAORDINARY CARE IN CATHOLIC TRADITION	94
VI:	SOME PERSPECTIVES ON ADVANCE DIRECTIVES	100
APPENDIX OF STATE DIRECTIVES		

I. INTRODUCTION

In 1864 the French impressionist, Edouard Manet, presented two of his classic works at the Paris Salon: *Dead Christ* and *Dead Toreador*.



The former depicts the wounded Christ with halo. An angel, grave yet serene, supports the propped corpse and cradles the head. Another has turned away in grief, face in hand. The

wounds are fresh and graphic. The powerfully built body is limp, yet regal, sharply contrasted by the unfurled white burial shroud. A serpent-snake slithers across the foreground between two stones headed for the shadows and darkness. Beneath the breathless flesh one is struck by the majesty of the victim and the greatness that sleeps but days. The scene, for all its horror, vibrates with transcendence. In the course of even a casual viewing, despair is gradually overwhelmed by hope.



In the later Manet depicts death against a background that distorts space and in which death looms large. The toreador, attired with great dignity, is "spread out under the sun, seen from a lively photographic angle".[1] The victim is solitary and hopeless. His swords hilt peeks behind his body, utterly useless. There is no visible wound but blood appears to slowly flow and pool in the earth beneath him. He is tragic and one wonders what cosmopolitan ideas died with him. The author suggests that Manet has "faked death … arriving at a sort of dignity, though also at the frightening and inexorable finality of solitude" and at the same time presents the viewer with

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[1] *Manet*, Jean-Jacques Leveque, p. 43 (Crescent Books, 1990 ed.)

an image akin to "a vulgar news item covered by the gutter press... [but] with a sort of dignity that offers its subject a rare beauty and a unique grandeur."[2]

These two works of Manet offer starkly contrasting views of death and reflect a deep conflict in modern man about the meaning of life. Christ, dead yet teeming with the hope and glory of the resurrection, with the sure guarantee of the reconciliation of humanity with the Father and the reality of transcendence, is set against the dull meaninglessness of being suggested by the hopeless bullfighter. The notion that Manet's *Dead Toreador* presents a "faked" or falsified death in order to arrive at a sort of dignity reflects the profound emotional malaise of the materialist view of the human condition increasingly evident in cultural expression, common sentiment, and law. It is a fear, ceaselessly knocking at the conscious self not otherwise distracted by sense experience, that life is mere coincidence and therefore ultimately meaningless. In *Dead Christ* there is a future amid sorrow and expectation. Dignity is not "faked"; it is inherent. In the other there is the inescapable ache of the modernists who doubt all things and "have so undermined the foundations of knowledge as to raise the question about the very existence of reality".[3] The former calls forth gratitude; the later pity.

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[2] Ibid.

[3] Cardinal Angelo Sodano, Address to Meeting of Friendship Among Peoples, Communion and Liberation, Rimini, Italy, August 23, 1998, published in L'Osservatore Romano (weekly English edition), September 2, 1998, p.4. One cannot help but recall the homily of Cardinal Ratzinger, as Dean of the College of Cardinals, prior to his election as the Bishop of Rome, delivered at the Mass *"Pro Eligendo Romano Pontifice"* on 18 April, 2005:

> How many winds of doctrine have we known in recent decades, how many ideological currents, how many ways of thinking. The small boat of the thought of many Christians has often been tossed about by these waves – flung from one extreme to another: from Marxism to liberalism, even to libertinism; from collectivism to radical individualism; from atheism to a vague religious mysticism; from agnosticism to syncretism and so forth. Every day new sects spring up, and what St. Paul says about human deception and the trickery that strives to entice people into error (cf. Eph 4:14) comes true.

Christian claims of transcendence open up the true meaning behind suffering and death; a meaning that posits an immaterial source of reason as the source of material *being*. Creator God is the prerequisite to such meaning, both in life and through corporeal death to eternal vocation. Manet's work evidences the dramatic conflict between that mode of thought and material determinism. Whereas Christian faith asserts everything about man can and must have meaning, materialism, positing the irrationality of chance as the source of all reality, cannot but end in dismissing reason itself as meaningless.[4] And should reason itself bear no ultimate value, then certainly the gaunt face of suffering and death are a miserable joke reaching out of randomness and mocking man. The conflict is thus one between a claim of truth and a claim of hopelessness. Between truth calling man to discovery and the ordering of life in accordance with the values

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> Today, having a clear faith based on the Creed of the Church is often labeled as fundamentalism. Whereas relativism, that is, letting oneself be "tossed here and there, carried about by every wind of doctrine", seems the only attitude that can cope with modern times. We are building a dictatorship of relativism that does not recognize anything as definitive and whose ultimate goal consists solely of one's own ego and desires.

Homily of His Eminence Card. Joseph Ratzinger Dean of the College of Cardinals, 18 April, 2005 available at: www.vatican.va/gpII/documents/homily-pro-eligendo-pontifice_20050418_en.html

[4] See *Truth and Tolerance: Christian Belief and World Religions* (English language title), Joseph Cardinal Ratzinger, Ignatius Press, 2004, pp. 162-183. The author, now Benedict XVI, offers a fascinating discussion of the idea that material reality takes its origin from immaterial reason and the debate this stirs with certain trends in modern philosophical thought which seem to have abandoned the quest for truth, having concluded that it is either too remote from man to determine or that the idea of "truth" is simply a human construct that has no reality. Particularly insightful are the Holy Father's comments drawing out the common links between J. Rousseau, K. Marx, and J.P. Sartre (Id. pp. 231-245) in which he identifies the "whole seriousness and stature of the question":

> Sartre regards the freedom of man as being his damnation. ... [T]he being of man is undetermined. It is open to question. ... Man has no nature but is simply freedom. He has to live his life in some direction or other, yet it runs out into nothingness even so. His meaningless freedom is man's hell. What is exciting about this proposition is that the separation of freedom and truth is carried through quite radically here: there is no truth. Freedom is without direction or measure. Yet this complete absence of truth, the complete absence of any kind of moral or metaphysical restraint, the absolute anarchic freedom of man constituted by his self-determination, is revealed, for anyone who tries to live it out, not as the most sublime exaltation of existence, but as a life of nothingness, as absolute emptiness, as the definition of damnation.

Id. at 244.

therein revealed, and hopelessness, dismissing any possibility of moral measures for human acts or any positive meaning in suffering and death.[5]

Levesque's commentary on *Dead Toreador* declares: "What is modern about this painting was that it was about the greatest disaster that could befall man, one which haunts him: death."[6] In this observation Levesque is both right and wrong. He correctly, if inadvertently, points out the modern tilt toward skepticism, relativism, individualism and naturalism. It is this train of modern thought that sees death as the greatest disaster that could befall man, because it cannot admit a moral order that transcends bodily life. It forms the basis of the modern legal recognition of radical individual autonomy and is manifest in recent efforts to legalize various forms of euthanasia.[7] It is also present in the development of so-called "living will" and "death with dignity" legislation. In the course of a single generation, fundamental shifts in notions of morality have gained wide acceptance in public opinion and have greatly impacted matters relating to a perceived individual sovereignty over one's body. Without doubt, this is most

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[5] This conflict manifests itself in a "massive crisis of confidence. The man of today is essentially diffident ... because he is too often deceived. The man of today no longer believes what is said, because he distrusts all words. He knows that publicity lies; he knows that propaganda lies. He knows that he is in a world in which everything is distorted or invented, and he ends by no longer giving credence except to what he has power to verify for himself. And perhaps this is one of the principal causes of the crisis of faith. For faith consists in believing in things which we cannot verify for ourselves, but about which we have confidence in those who have verified it for themselves." Cardinal Jean Danielou, *Crisis of Confidence in Essential Values*, L'Osservatore Romano, Weekly English Edition, March 6, 1969, p. 10 available at www.ewtn.com/library/Theology/CRISCON.HTM This is why we must develop an adult faith, "not a faith that follows the trends of fashion and the latest novelty [but one that is] deeply rooted in friendship with Christ. It is a friendship that opens us up to all that is good and gives us a criterion by which to distinguish the true from the false, and deceit from truth." Homily of His Eminence Cardinal Joseph Ratzinger, 18 April, 2005, footnote 3, supra.

[6] ***Manet***, supra.

[7] e.g. Oregon voters passed Ballot Measure 16 in 1994 (Oregon Legislative Statute secs. 127.800 to 127.995) thus becoming the first United States jurisdiction to authorize physicians to administer a lethal dose of medication to a person suffering from a terminal disease. "Terminal disease" is defined in the legislation as "an incurable and irreversible disease that...will, within reasonable medical judgment, produce death within six months." Oregon Legislative Statute sec. 127.800(13).

evident in matters of sexual morality ranging from the respect given to authentic marriage to abortion, contraception, conjugal relations outside marriage, homosexuality, exploitation of women and children and pornography. It is the same root that has given rise to the modern demand for individual sovereignty over corporeal death, betraying the deep confusion in modern thought about the meaning of life. [8] It flows from a false anthropology, which in the final analysis, shares Levesque's lament that death is "the greatest tragedy that could befall man".

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[8] A provocative discussion of the massive cultural displacement of human sexuality from its truth and meaning and linking that phenomenon with violence, war and human annihilation is explored by Walker Percy in his aptly titled *Lost in the Cosmos*. Percy asserts that so-called sexual "liberation" has emptied genital expression of fulfilling passion and replaced it with mechanics and technique. Positing an inherent human need for the experience of transformative and self-transcending passion, he allows his thoughts a certain digression: "Suppose the erotic is the last and best recourse of the stranded self and suppose then that, through the sexual revolution, recreational sex becomes available to all ages and all classes. What if then even the erotic becomes devalued? ... [D]oes the demoniac spirit of the self, frustrated by the failure of Eros, turn in the end to the cold fury of Saturn?" He continues:

> *World War I:* Joyce Kilmer's poetry, Colleen Moore in Lilac Time, "Mademoiselle from Armentieres"; the erotic diminished to the sentimental and to good-natured sex between the doughboy and the French farm girl; with a decline in passion and the spirit of the erotic, and in increase in violence with the rise in technology: 20,000,000 dead.
>
> *World War II:* Betty Grable, Anne Frank, Adolf Eichmann, Stalin: the subsidence of the erotic in favor of the rise in the dispassionate, abstract violence of ideology, Fascism, Nazism, Communism ... the decency of Truman and Oppenheimer contrasted with the death of 100,000 women and children in Hiroshima and Nagasaki ... 50,000,000 dead.
>
> *Period between World War II and World War III:* The ascendancy of the erotic; the eroticization of all sectors of culture: work and play, films, TV, novels, plays, commercials ... [T]he spirit of violence vented in spectatorship sport ... 100 million people watching the Superbowl; Little League moms screaming curses at umpires, and dads punching out other dads and later beating up their own kids.
>
> *World War III:... the demoniac spirit of the erotic no longer posited by Christianity but triumphant* in its own right, perfected as genital technique but deprived of the charm of the forbidden ... the perfection of contraceptive technique, the conquest of Herpes II virus and all homosexual "aids" diseases; the perfection of visual and tactile aids ... erotic elevated to a major literary and art form. War without passion: one billion dead.

Walker Percy, *Lost in the Cosmos, The Last Self-Help Book,* Picador USA/Farrar, Straus and Giroux, (1983) pp.186, 190-91.

Christianity's response is anything but ambiguous: sin, and it alone, is the great tragedy of man. It is the source of death's entry into human reality and its remedy is realized only through the divinization of human nature made possible, in the language of the Byzantine Paschal Torparion, by Christ's trampling down death by death and his bestowing life upon those in the tombs. Man is offered participation in this victory of the risen and glorified Christos, through the Spirit, as children of the same Father.[9] It is precisely here, in the reality of divine filiation, that man's dignity abides. That relationship enfolds all intra-human relationships and is embraced or disfigured, in varying degrees, by human acts flowing from individual exercise of free will. Virtue or vice are the inescapable options made elemental by the cosmic DNA of freedom characteristic of the human person.

A parallel nightmare to Levesque's "greatest tragedy" is the inversion of the creation-fall-redemption drama: death itself becomes the great sin rather than its consequence. Definitive and integral, it leaves no hope for its conquest. Its origin in rebellion and self assertion is lost to the modern mind. Suffering and biological death are not pretty and should not be romanticized, but they can never constitute ultimate evils. Their acceptance as such obscures the dignity of man, risks denial of his freedom and responsibility, and stimulates cynicism which ultimately bears bitter fruit of unhappiness, misery and despair.

Without conviction in the redemptive value of human suffering, the solidarity of the human family, the communion of saints and the transcendent destiny of each person, modern thought is depressed and narcissistic. This error in the anthropological understanding of man has

[9] See, e.g., Romans 8:14 – 17.

given birth to the opposed notions that death is both "natural" and something to be tamed by individual choice as to time, place and manner.

Perhaps no two events in recent memory more concretely juxtapose these underlying tensions than the judicially sanctioned homicide of Terri Schiavo and the holy death of John Paul the Great in the Spring of 2005. Dependent on mechanical assistance in obtaining nutrition and hydration, Ms. Schiavo was killed after her husband's assertion that she would have preferred death to non-cognitive incapacity was given determinative credence by judicial fiat. Unquestionably alive, yet severely disabled and presumptively unaware, her "quality of life" was simply unacceptable to those who held decision making power. Functional death, and thus meaninglessness, had already come in the view of a cultural construct that elevates doing over being. In contrast the world witnessed the long deterioration of the suffering Pope, who did not shake his fist at the darkness, but awaited the light. Suffering, even death, with all the attendant physical limitations and burdens, became paths of service and leadership through his embrace of creatureliness. Circumstance did not rob his dignity, but confirmed it. To those who would hasten to a "final exit" his suffering was pointless, and certainly not something they would accept for themselves. "That may be his choice, but I have the *right* to death with dignity", goes the dismissive refrain. By this is meant the right to end suffering, even preempt it, and "grasp" death as the way out of a life no longer considered bearable, much less meaningful. The argument is offered that dignity as the measure of life's value turns on the absence of suffering and relative freedom from physical and mental limitations. Carried through rationally, a pleasure principle emerges which proportions value with enjoyment, and dismisses life as no longer truly human when it fails to maintain a certain experiential threshold, thus excusing its termination.

Dignity becomes an exercise in self assertion, even if a final one. In the wake of such claims come the surrogates who claim "mercy" for the sickle-cell suspected embryo[10], the nursing home patient with advanced Alzheimer's, and any number of the many examples one can identify of imperfection in the broken condition of humanity. It is here, in the deformed notion of dignity as circumstantial, that assisted suicide, mercy killing, and the devaluation of the disabled, infirm

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[10] See *Genetic Technique Prevents Sickle-Cell Births*, Wall Street Journal, May 12, 1999, wherein Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania (Philadelphia) describes preimplantation genetic screening of in vitro fertilized embryos. The procedure, designed to facilitate the rejection and ultimate "disposal" of genetically suspect embryonic human beings, is described as "morally preferable" to post-implantation testing that leads to abortion. Similarly disturbing is Dr. Caplan's comment that "[s]ickle-cell disease is so burdensome to a child that it makes sense for parents to do what they can to avoid it." The obvious meaning is that such children are better off killed during their earliest embryonic stage of development than they are by being born. The procedure is described in greater technical detail in *First Unaffected Pregnancy Using Preimplantation Genetic Diagnosis for Sickle Cell Anemia*, The Journal of the American Medical Association, Vol. 281, pp 1701-1706, May 12, 1999. (www.ama_assn.org/special/womb/library/readroom/vol_281c/joc81498.htm) by noted in vitro specialist Zev Rosenwoks, M.D., et. als. The authors' detachment from the living reality of the embryonic human being is evident in their description of the rationale and benefits of preimplantation diagnostic testing (PGD):

> Children affected by sickle cell anemia experience recurrent episodes of pain (during sickle cell crises) and increased susceptibility to potentially life-threatening conditions, including bacterial infections, cerebrovascular accidents, and organ failure.
> ...
> Early prenatal diagnosis of the disease is critical because it allows a couple to consider pregnancy termination as an option.
> ...
> With PGD, the genetic status of an embryo can be determined before transfer into the uterus after in vitro fertilization (IVF), thus eliminating the risks of bearing a child with the disease.
> ...
> Our results demonstrate that PGD for detection of sickle cell anemia is a powerful diagnostic tool for carrier couples who desire a healthy child but wish to avoid the difficult decision of whether to abort an affected fetus.

Ibid. The article describes two attempts at in vitro fertilization, screening and transfer. In all, twelve embryonic human beings were produced in vitro. The first attempt saw four embryos produced; three intentionally destroyed; and one transferred but without successful pregnancy. In the second attempt, eight embryos were produced; five intentionally destroyed; and three were transferred to the womb resulting in two live births. Despite the authors' claim that the procedure allows carrier "couples" to avoid implantation of affected embryos, it is interesting to note that "the patient" [referred to in the singular – presumably the mother] accepted one carrier status embryo. That would not only appear to undermine one of the rationales for the procedure, but clearly suggests an emotional investment by the patient that made her willing to either accept the "difficult decision of whether to abort an affected fetus" or proceed contra Dr. Caplan's presumption that "it makes sense for parents to do what they can to avoid" bearing children with the disease.

and elderly are embraced. The rejection of morally obligatory health care is both a consequence and a conceptual predicate.

Although advance medical directives and related documents can be valuable tools in morally sound medical decision making, they are most often viewed as a means to terminate health care intervention – and life - when an ambiguous "quality" once favored appears beyond reach. This short essay proposes a fundamental shift in such thinking. Advance medical directives may adequately protect from futile and excessively burdensome medical interventions, but they must be carefully insulated from "qualitarian" dominance and artfully nuanced to respect the sovereignty of God and the great good of life. In order to adequately present those proposals, the following pages will explore some of the current cultural realities impacting end of life medical decision making and the stark contrast evident between those trends and the Christian understanding of suffering as revealed in scripture and tradition and expounded in magisterial teaching. Relevant legal principles developed in American constitutional and statutory jurisprudence are presented, as well as the principals and analysis employed by catholic moral tradition in arriving at specific judgments in particular cases. In order to make practical suggestions to the greatest degree possible, specific proposals for advance medical directives, appointments of surrogate decision makers and various other directives are contained in the Appendix covering eighteen state jurisdictions and the District of Columbia. These jurisdictions represent well over two thirds of the population of the United States. These directives are crafted to proclaim the correct anthropological and total vision of man in his supernatural vocation and inherent dignity, thus precluding any option for active or passive euthanasia while at the same

time permitting the withholding or withdrawal of ethically disproportionate care – with apologies to Messer. Manet.

II NO CULTURE IS AN ISLAND

> *Here's the hottest political issue of the day: euthanasia. Say the euthanasists not unreasonably: let's be honest, why should people suffer and cause suffering to other people? It is the quality of life that counts, not longevity, etcetera. Every man is entitled to live his life with freedom and to end it with dignity, etcetera etcetera. It came down to one curious squabble (like the biggest theology fight coming down to whether to add the* que *to the* filio*): the button vs. the switch. Should a man have the right merely to self-stimulation, pressing the button that delivers bliss precisely until the blissful thumb relaxes and lets go the button? Or does he also have the right to throw a switch that stays on, inducing a permanent joy – no meals, no sleep, and a happy death in a week or so? The button vs. the switch.*
>
> *And if he has such a right and is judged legally incompetent to throw the switch, cannot a relative throw it for him?*
>
> *The debate rages. The qualitarians, as the euthanasists call themselves, have won in Maryland and New York and Hawaii where legislatures have passed laws that allow sane oldsters to choose a "joyful exitus" as it is called in Maryland, or a* kawanee-olaua *as it is called in Hawaii, and throw the on-switch on. In the case of the insane, the consent of both physician and spouse is necessary.*
>
> Dr. Tom More in *Love in the Ruins: The Adventures of a Bad Catholic at a Time Near the End of the World,* a novel by Walker Percy

No serious attempt to understand the development of advance directive law and custom can ignore the parallel development of the euthanasia and assisted suicide movements. Although the categories are distinct, the motivating cultural developments intersect and are at

times synonymous. Catholic opinion articles have long noted this[11] and respected moral theologians have commented that both movements are historically promoted by various euthanasia and assisted suicide proponents, such as Choice in Dying (formerly The Euthanasia Society of America) and The Hemlock Society.[12] The common thread in these often allied movements is the idea that life is worth living only so long as one may experience and/or share certain elements of a material definition of meaning: pleasure, happiness, intellectual achievement, and other measures of *function*.

Daniel Callahan notes that certain social forces turned public opinion toward acceptance of euthanasia and assisted suicide in the last quarter century, in particular "the highly visible string of court cases from Quinlan in 1976 to Cruzan in 1990".[13] As the public was exposed to the cases of Karen Ann Quinlan and Nancy Beth Cruzan, there emerged a notion that a person entering a hospital in a permanently unconscious state would be hooked up to a myriad of mechanical devices and be subjected to extensive medical interventions such that their biological existence would be extended beyond any reasonable point. It mattered not that the notion was unsupported by the vast majority of practices followed at hospitals or extended care facilities. Fear of a pointless and seemingly undignified existence took hold. The response was to develop means by which individuals could retain control of medical decision making after an illness or accident rendered them incapacitated. Although medical interventions can be excessive, the question begged is by what measure? A brief survey of opinion discloses that the cultural

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[11] See, e.g., Dwight G. Duncan, *Roe v. Wade Goes Suicidal,, The Catholic World Report*, May, 1996, p. 42; *The Sanctity of Life Seduced, A Symposium on Medical Ethics*, First Things, April, 1994, p. 13; James F. Bresnahan, *Killing vs. Letting Die, A Moral Distinction Before the Courts*, America, February 1, 1997, p.8.

[12] William May, *Catholic Bioethics and the Gift of Human Life*, p. 235.

[13] The Sanctity of Life Seduced, supra.

context for end of life medical decision making is more about control, power, money and a distorted view of human dignity grounded in vitality and function than the sanctity of life.

The last half of the nineteenth century and the first half of the twentieth century saw the development of industrial world movements that strongly advocated a eugenic development of population. Realized in the horror of Nazi medical experiments and breeding houses, the same movement was much more respectfully accepted in the United States and other western republics. Margaret Sanger, the founder of Planned Parenthood, was one of the more vocal and infamous proponents of that movement. She championed the goal of eliminating defective persons whom she defined as those whose condition or behavior evidenced "insanity, epilepsy, criminality, prostitution, pauperism, and mental defect".[14] She argued that their conditions were "organically bound up together". Her solution to what she referred to as "this dead weight of human waste"[15] was elimination through sterilization and massive segregation:

> Every feeble-minded girl or woman of the hereditary type, especially of the moron class, should be segregated during the reproductive period...The male defectives are no less dangerous. Segregation carried out for one or two generations would give us only partial control of the problem....we prefer the policy of immediate sterilization, of making sure that parenthood is absolutely prohibited to the feeble minded.[16]

Because man was rapidly advancing in the control and manipulation of his physical environment, Sanger advocated manipulation of human population as a moral duty. She repeatedly asserted that the economic cost of humane institutions and the "vast system of international charity" was excessive, and she sharply rejected philanthropy, which she viewed as

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[14] Margaret Sanger, *The Pivot of Civilization*, Chapter IV, 1922. Sanger's book may be viewed or downloaded at various online sources, including www.worldwideschool.org and www.pro-life.net.

[15] Ibid, Chapter V.

[16] Ibid, Chapter IV.

the result of corrupt Christian ideas about the sanctity of human life, lamenting international relief efforts as "a general orgy of international charity."[17] She was not alone. In one sense, Adolph Hitler merely projected the idea of "lebensunwertes Leben", or "life unworthy of life", into the structures and instrumentalities of the modern industrialized state. Forced sterilization, euthanasia and genocide are all grounded on the notion that certain lives are unworthy of life. Hitler himself declared that the unhealthy – physically or mentally – were unfit to beget children.[18] But his ideas were not original or exclusively his own. Indeed, already in 1923, Fritz Lenz, who later became a "leading ideologue in the Nazi program of 'racial hygiene' ", challenged his fellow German's for failing to match the United States in embracing compelled sterilization of the unfit; "complained that provisions in the Weimer Constitution (prohibiting the infliction of bodily alterations on human beings) prevented widespread use of vasectomy techniques", and lamented the absence in Germany of eugenic research institutions similar to those in England and the United States.[19]

In 1920 Karl Bindling and Alfred Hoche authored *The Permission to Destroy Life Unworthy of Life (Die Freigabe der Vernichtung lebensunwerten Lebens)* wherein they proposed medical killing of the unfit, including "the incurably ill … large segments of the mentally ill, the feebleminded, and retarded and deformed children", as a therapeutic action, much in the manner of the present day defenders of abortion of "defective" pre born children.[20] In 1933, writing in

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[17] Ibid, Chapter V.

[18] See, Robert Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide*, Basic Books, 1986, p. 22

[19] Ibid at 23

Sanger's Birth Control Review, German eugenicist Ernst Rudin advocated forced sterilization of the feeble minded *and their relatives* so as to prevent further growth in abnormal population.[21] American eugenicist, Harry Laughlin, advocated similar measures in the pages of Sanger's *Review*. Specifically, he touted the "new sterilization laws" that would support the "now proven legal right of the American state to prevent reproduction by those ... poorly endowed with hereditary qualities."[22] Eugenicist Foster Kennedy, writing in the Journal of the American Journal of Psychiatry in 1942 opined:

> I believe when the defective child shall have reached the age of five years – and on the application of his guardians – that the case should be considered under law by a competent medical review board; then it should be reviewed twice more at four-month intervals; then, if the board, acting, I repeat, on the application of the guardians of the child, and after three examinations of a defective who has reached the age of five or more, should decide that that defective has no future or hope of one; then I believe it is a merciful and kindly thing to relieve that defective – often tortured and convulsed, grotesque and absurd, useless and foolish, and eventually undesirable – of the agony of living.[23]

Kennedy's opinion was not an isolated one. In the same issue of the American Journal of Psycharity, the editorial strongly endorsed his view and urged that the proper role of psychiatrists was to convince parents that keeping their defective children alive was inhumane and that euthanasia was the appropriate solution.[24]

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[20] Bindling and Hoche specifically argued that elimination of unworthy life was "purely a healing treatment" and a "healing work". See R.J. Lifton, *The Nazi Doctors*, supra at p. 46

[21] Elizabeth R. Skoglund, *Life on the Line*, Tyndale House Publishers, 1992, p. 117 - 118

[22] Ibid.

[23] Kennedy, F. *The Problem of social control of the congenital defective: education, sterilization, euthanasia*. Am J Psychiatry, 99:13-6 (1942) cited in *Eugenic Sterilization and a Nazi Analogy* by Jay A. Nathanson and Michael A. Grodin, Annals of Internal Medicine, Volume 132, page 1008 (June 20, 2000).

[24] Ibid. In addition to the *Editorial* (Am J Psychiatry, 99: 141-43 (1942), the authors identified a Presidential Address in the July, 1931 issue which strongly endorsed involuntary sterilization. An excellent review of this

The notion that the useless and ineffective were surplus baggage and "eventually undesirable" had been circulating with increased fervor for some time. The now infamous United States Supreme Court decision in *Buck v. Bell* in 1927 had given judicial fiat to a growing trend of forced sterilization laws for "mentally defective" persons. The State of Virginia was one of thirty five states with such laws.[25] The Virginia statute asserted that "heredity plays an important part in the transmission of insanity, idiocy, imbecility, epilepsy and crime." It authorized the forced sterilization of such "defective persons" because their reproduction was deemed "a menace to society". A seventeen year old girl named Carrie Buck was the first person in Virginia selected for the procedure. Her mother was a resident in a state mental asylum. Various medical "experts" testified that Carrie Buck shared her mother's hereditary traits. She was unmarried and had recently given birth to a child. Testimony included assertions that she was likely to share her mother's traits of immorality, prostitution, untruthfulness and the like. The County Superintendent opined that her family was shiftless, ignorant, worthless. Noted eugenicist Harry Laughlin of the Eugenics Record Office sent a written deposition confirming his review of documents and agreeing that Carrie Buck was "feebleminded" and morally delinquent. Finally, Sociologist Arthur Estabrook testified that he and a Red Cross nurse examined Carrie Buck's baby and that the child was "below average" and "not quite normal."[26] Based upon that record, the court ordered that Carrie Buck be sterilized so as to prevent

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movement and its parallel development in Germany and the United States is *Eugenic Sterilization and a Qualified Nazi Analogy: The United States and Germany*, 1930-1945, Andre N. Sofair, et als. Annals of Internal Medicine, Volume 132, pages 312-319 (February 15, 2000).

[25] Breeding Better Citizens, www.abcnews.go.com/onair/2020/2020_000322_eugenics_feature.html (March 22, 2000)

[26] References to the trial testimony in *Buck v. Bell* are accessible at many web sites, including, e.g., www.eugenicsarchive.org, which contains and excellent summary by Paul Lombardo, University of Virginia.

additional "defective" babies. Ms. Buck challenged the order and the appeals made their way to the United States Supreme Court. Oliver Wendell Holmes, Jr., considered a giant in legal, academic and literary circles, wrote the opinion for the court. He sustained the Virginia law and sent Ms. Buck to the operating table with this famous rationale:

> We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. Three generations of imbeciles are enough.[27]

It should be clear from the foregoing that Social Darwinism was firmly ensconced in American social, cultural and legal thought before the emergence of the Nationalist Socialist movement in Germany. The nightmare of Nazi murder and human rights violations took the eugenic movement underground for a period of time. But the idea that certain lives were simply not worth living was etched in the mind of state planners, medical professionals and social engineers. In 1933 the remarkably influential *Humanist Manifesto I*[28] was published. It was a statement of radical secularism which rejected the notion that human persons had any transcendent destiny. Indeed, it held that the "universe is self-existing and not created"; that "modern science makes unacceptable any supernatural or cosmic guarantees of human values"; that "the complete realization of human personality [is] the end of man's life and seeks its development and fulfillment in the here and now"; and that "the quest for the good life is still the

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[27] *Buck v. Bell*, 274 U.S. 200 (1927)

[28] *Humanist Manifesto*, The New Humanist, Vol VI, No. 3 (June, 1933).

central task for mankind".[29] While these points are selective of the *Manifesto*, they are not misrepresentative. If anything, they only scratch the surface of a world view that rejected any notion of traditional religion or objective truth, demanded the adoption of "a socialized and cooperative economic order", and declared that the "distinction between the sacred and the secular can no longer be maintained".[30] The *Manifesto* clearly maintains that human life has meaning and value in so far as it advances the enjoyment of life and is capable of contributing to a materialist concept of "the good life". Signed by various influential public personalities, including John Dewey and R. Lester Mondale, *The Humanist Manifesto* had an immediate impact in religious, social, academic and cultural circles.[31] It was followed forty years later by *Humanist Manifesto II* which purported to advance the ideas of *Humanist Manifesto I* and adapt them to the changes in society that had occurred in the ensuing forty years. Representative of its claims are that there is "insufficient evidence for belief in the existence of a supernatural"; that "[p]romises of immortal salvation or fear of eternal damnation are both illusory and harmful"; that "[e]thics is autonomous and situational, needing no theological or ideological sanction"; that "[t]he right to birth control, abortion and divorce should be recognized"; and that "a full range of civil liberties ... includes a recognition of an individual's right to die with dignity, euthanasia, and the right to suicide"[32] should be guaranteed. The ideas, values and understanding of human anthropology implicit and explicit in the *Manifestos* have been adopted by many influencial

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[29] Ibid.

[30] Ibid.

[31] *Humanist Manifestos I and II*, Prometheus Books, 1973.

[32] Ibid at 16 – 19.

opinion makers. Among the signers of the *Humanist Manifesto II* are well known author Isaac Asimov, Nobel laureate Francis Crick, Edd Doerr of Americans United for the Separation of Church and State, Alan Guttmacher, then President of Planned Parenthood Federation of America, Paul Kurtz, editor of The Humanist, Andre Sakharov, noted Soviet nuclear scientist, dissident and human rights activist, B. F. Skinner, one of the better known and controversial scientists of the Twentieth Century, Betty Freidan, Founder of the National Organization of Women (NOW), and Sir Jullian Huxley, former head of UNESCO.[33]

By the time *Roe v. Wade* was decided in 1973, *Humanist Manifesto II* made it clear that the secular understanding that assessed human value and meaning solely in materialist terms was a powerful force and had asserted itself again after the interlude occasioned by the Second World War and the Nazi horrors that were then and subsequently disclosed. Nobel Prize winning scientist James Watson, who together with Francis Crick, discovered the double helix structure of DNA, has opined that children should not be declared alive until three days after birth so that parents may have the option of allowing defective offspring to die, thereby saving "a lot of misery and suffering."[34] For his part, Francis Crick, one of the signatories of *Humanist Manifesto II*, went even further in 1978: "No newborn infant should be declared human until it has passed certain tests regarding its genetic endowment. ... If it fails these tests it forfeits the right to live."[35] Lest the impression be left that these are fringe opinions, it is worth noting that in 1988 Dr. Watson was the director of the National Center for Human Genome Research (now

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[33] Ibid at 24 – 29.

[34] Skoglund, *Life on the Line*, supra, p. 121.

[35] Ibid.

renamed the National Human Genome Research Institute) established within the National Institutes of Health.

While Watson and Crick were commenting on abortion, sterilization and infanticide, the rationale that drove their views stems from the idea that human personhood and dignity is tied up with function, health, vitality and other circumstantial measures of "quality of life". Having embraced a wholly contingent view of reality as ultimately undirected and random, they reflect the social Darwinist inability to recognize the innate value of human life and the inherent dignity of each individual, regardless of vitality. This was precisely the force that fueled the eugenic movement of the 1920s and 1930s that eventually labored forth state imposed euthanasia in the Third Reich. It is the same inability that drives the Watsons and Cricks of the present day. The new development is that the mass of public and medical opinion has rapidly accepted the notion that some lives are simply not worth living, not because death is imminent and unavoidable, but because life on the terms proposed appears pointless and shocking. This development is clear in the two landmark cases of *Quinlan* and *Cruzan* and more recently in the saga of Terri Schiavo. In each case a woman was diagnosed as being in a persistent vegetative state. None had any reasonable hope of cognitive function or behavioral response to external stimuli.[36] They each received care that included assisted nutrition and hydration, antibiotics and regular nursing interventions. In each case, family members sought a court order authorizing the removal of life sustaining interventions. In *Quinlan*, it was a ventilator. In *Cruzan* and *Schiavo* it was assisted nutrition and hydration. In each case, commentary contained in the court's opinion or in separate

[36] This analysis assumes the factual findings of the various courts.. Whether Terri Schiavo or others could have benefited from earlier rehabilitative intervention or sould have been diagnosed other then PVS is a medical question beyond the scope of this analysis.

opinions of individual Justices, discloses a troubled understanding of human dignity and the meaning and even the definition of life.

In *Quinlan*[37], the New Jersey Supreme Court was confronted with a father's desire to withdraw a respirator from his severely disabled daughter. The court described her condition in vivid detail:

> Karen Quinlan is not dead... She does have some brain stem functions ... and other reactions one normally associates with being alive, such as moving, reacting to light, sound, noxious stimuli, blinking her eyes, and the like. The quality of her feeling impulses is unknown. She grimaces, makes stereotyped cries and sounds and has chewing motions. Her blood pressure is normal.... She is nourished by feeding by way of a nasal-gastric tub ... Karen is described as emaciated ... Her posture is described as fetal-like and grotesque ... Karen is in a chronic and persistent vegetative state. No form of treatment which can cure or improve that condition is known or available ... she can never be restored to cognitive or sapient life.[38]

The court, relying on expert testimony, carefully distinguished two function of the brain in describing Karen Quinlan's condition. It identified "internal vegetative regulation" as one category and "sapient" activity which it noted to be "more highly developed" and "uniquely human which controls our relation to the outside world [such as] our capacity to talk, to see, to feel, to sing, to think".[39] The court expressed the view that it had no doubt that Karen Quinlan,

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[37] *Matter of Quinlan*, 70 NJ 10, 355 A. 2d 647 (1976)

[38] Ibid, 355 A.2d at 654-55.

[39] Ibid, 355 A 2d at 654. The description of Karen Quinlan's existential circumstances has since been labeled variously as "permanent vegetative state" or "persistent vegetative state" (PVS). Pope John Paul II cautioned that use of such terminology is not without dehumanizing risks:

> Faced with patients in similar clinical conditions, there are some who cast doubt on the persistence of the "human quality" itself, almost as if the adjective "vegetative" (whose use is now solidly established) which symbolically describes a clinical state, could or should be instead applied to the sick as such, actually demeaning their value and personal dignity. In this sense, it must be noted that this term, even when confined to the clinical context, is certainly not the most felicitous when applied to human beings.

had she the capacity to communicate an informed choice, given her condition and prognosis, would have the right to elect removal of her ventilator. However, the court also held that it was not possible to determine her wishes since there was no probative evidence of her desire.[40] It was clear to the court that any effort by the state to compel her to remain on the respirator would have been rejected since it would "compel Karen to endure the unendurable, only to vegetate a few measurable months with no realistic possibility of returning to any semblance of cognitive or sapient life."[41] The court eventually held that Karen's father, acting in her best interests, and pursuant to the doctrine of substituted judgment[42], could order removal of the respirator. This was the result of the court's conclusion that although the use of a respirator could be ordinary care "in the context of the possibly curable patient ... [it was] 'extraordinary' in the context of the forced sustaining by cardio-respiratory processes of an irreversibly doomed patient."[43] It is thus clear that the court decided that the maintaince of life itself was insufficient to classify care

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> In opposition to such trends of thought, I feel the duty to reaffirm strongly that the intrinsic value and personal dignity of every human being do not change, no matter what the concrete circumstances of his or her life. *A man, even if seriously ill or disabled in the exercise of his highest functions, is and always will be a man,* and he will never become a "vegetable" or an "animal".
>
> Even our brothers and sisters who find themselves in the clinical condition of "vegetative state" retain their human dignity in all its fullness. The loving gaze of God the Father continues to fall upon them, acknowledging them as his sons and daughters, especially in need of help.

Address of John Paul II to the Participants in the International Congress on "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas", n.3, March 20, 2004. Full text available on the Vatican web site: www.vatican.va./holy_father/john_paul_ii/speaches/2004/march/documents/hf_jp-ii_spe_20040320_congress-fiamc_en.html.

[40] Ibid, 355 A 2d at 653 and 664.

[41] Ibid, 355 A 2d at 663.

[42] For a discussion of the substituted judgment doctrine see notes 150 to 156, infra, and accompanying text.

[43] *Matter of Quinlan*, 355 A 2d 647, 668. Interestingly, Karen Quinlan's father did not seek removal of her feeding tube which he viewed as ordinary care. See Ann Carey's excellent article *A decision at Hand* at the web site of Our Sunday Visitor, www.osv.com/periodicals/show-article.asp?pid=951.

as "ordinary". Some curative aspect which would afford the patient "sapient" life would be essential. That reading on the decision is buttressed by the opinion's final order:

> We repeat for the sake of emphasis and clarity that upon the concurrence of the guardian and family of Karen, should the responsible attending physicians conclude that there is no reasonable possibility of Karen's ever emerging from her present comatose condition *to a cognitive, sapient state* and that the life-support apparatus now be administered to Karen should be discontinued, they shall consult with the hospital "Ethics Committee" ...[and if it] agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition *to a cognitive, sapient state*, the present life-support system may be withdrawn....[44]

Given the court's description of her condition as utterly hopeless, one almost forgets that Karen Quinlan was alive. Its description of her appearance as "grotesque" and its view that her continued maintaince would be nothing more than "unendurable, only to vegetate a few measurable months" is remarkably similar to the description of "defective" children in Foster Kennedy's 1942 article in the American Journal of Psychiatry.[45] While the Quinlan case is generally regarded as a substantial advance in medical-legal treatment of the dying and is often hailed as the original "right to die" case, Karen Quinlan was not dying. In fact, her predicted demise within a short time after the removal of the respirator did not materialize. Rather, she continued to breathe on her own for nine years before she eventually died from pneumonia. What the case truly suggests at the cultural level is that our society has arrived at the judgment that some lives are not worth the trouble. Life may be understandable if it is consciously

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[44] Ibid, 355 A 2d at 671-72 (emphasis added)

[45] See footnote 23, supra, and accompanying text. The court's language is a prime example of the dehumanizing risk that the term "vegetative" carries when inappropriately applied to a sick human person as such, rather then properly employed to symbolically describe a clinical state. See footnote 39, supra, for the text of John Paul II's caution in this regard.

experienced, but absent proof of such conscious experience, many have concluded that it is pointless.

A more radical expression, although by no means philosophically distinct, of the view that human worth is dependant on function and capacity has been offered by Peter Singer, Princeton University DeCamp Professor at the University Center for Human Values. He advocates an ethical system in which choices are made based of the ability to realize the greatest total of human good. Left unresolved is what measure of "good" is normative, since Singer rejects the notion of any objective truth. Described as both a utilitarian and a proportionalist, Singer is touted by some as "arguably the most influential philosopher in the world today."[46] In his book *Practical Ethics,* Singer argues that human life has value only so long as it is conscious. Indeed, he holds that any sentient being with consciousness is within the sphere of "equal consideration" of interests.[47] By the he means that, human or animal, a conscious, sentient being has a greater interest in life than a fetus, a new born baby or Karen Quinlan:

> I have argued that the life of a fetus (and even more plainly, of an embryo) is of no greater value than the life of a nonhuman animal at a similar level of rationality, self-consciousness, awareness, capacity to feel, etc., and that since no fetus is a person no fetus has the same claim to life as a person. Now it must be admitted that these arguments apply to the newborn baby as much as to the fetus.
> ...
> If we can put aside these emotionally moving but strictly irrelevant aspects of the killing of a baby [Sanger is referring to notions of helplessness and innocence which he considers no more significant for a newborn human baby than a "laboratory rat"] we can see that the grounds for not killing persons do not apply to newborn infants.
> ...
> Newborn babies cannot see themselves as beings who might or might not have a future, and so cannot have a desire to continue living... [A] newborn baby is not

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[46] Philosophy Under Fire: The Peter Singer Controversy, available at www.animalliberationfront.com.

[47] P. Singer, Practical Ethics (Second Edition), Cambridge University Press (1993) p. 74

> an autonomous being, and capable of making choices, and so to kill a newborn baby cannot violate the principle of respect for autonomy. In all this the newborn baby is on the same footing at the fetus, and hence fewer reasons exist against killing both babies and fetuses than exist against killing those who are capable of seeing themselves as distinct entities, existing over time.[48]

Singer defends his position against its apparent "shock" value by arguing that "our present absolute protection of the lives of infants is a distinctively Christian attitude rather than a universal ethical value".[49] He argues that several ancient cultures considered infanticide "the natural and humane solution to the problem posed by sick and deformed babies" and concludes that their "superior" moral sense was subverted by the Christian "doctrine of the sanctity of human life".[50] He makes no effort to demonstrate the "universal ethical value" of infanticide nor does he address the existence of cultures that predate Christianity which recognized moral norms respecting newborn human life. Most glaringly, he seems oblivious to the most obvious implication of his treatment of Christian respect for human life: that Christianity's holding of objective moral norms is, in fact, a morally superior system of thought and ethics than his own subjectivism. But lest there be any doubt that his model of ethics is pure materialist subjectivism, Singer's conclusions are telling:

> [T]he fact that a being is a human being, in the sense of a member of the species Homo sapiens, is not relevant to the wrongness of killing it; it is, rather characteristics like rationality, autonomy, and self-consciousness that makes the difference. Infants lack these characteristics. Killing them, therefore, cannot be equated with killing normal human beings, *or any other self-conscious beings.*
> ...

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[48] Ibid at pp 169-171.

[49] Ibid at 172.

[50] Ibid at 172-73.

> When the death of a disabled infant will lead to the birth of another infant with better prospects of a happy life, the total amount of happiness will be greater if the disabled infant is killed. The loss of a happy life for the first infant is outweighed by the gain of a happier life for the second. Therefore, if killing the haemophiliac infant has no adverse effect on others, it would, according to the total view, be right to kill him.[51]

Given Singer's notion of reflective self-consciousness as the critical element of personhood, it is not surprising that he dismisses any idea of intrinsic value for the newborn infant:

> I cannot see how one could defend the view that fetuses may be "replaced" before birth, but newborn infants may not be.
> ...
> [K]illing a disabled infant is not morally equivalent to killing a person. Very often it is not wrong at all.[52]

The implications of Singer's "total view" theory of ethics are clear. Persons have no greater claim on life than other animals. It is self-consciousness and autonomy that supply value to life. As applied to disabled persons, elderly Alzheimer's patients, persons in coma or persistent vegetative state, and a myriad of other debilitating conditions, their claim of a right to live is directly challenged. Singer does not pull his punches. He strongly advocates euthanasia

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[51] Ibid at 182-86

[52] Ibid at 188 – 191. Singer's view weighs total pleasure against total pain in order to judge appropriate conduct. That view is properly defined as "hedonism", which is the most widespread of various worldviews that see "badness" as a positive reality on par with "goodness". Germain Grisez comments: "In this view, the good is pleasure and the bad is pain. This view rests on a confusion between sensible and intelligible good and bad." The Way of the Lord Jesus, Vol. 1, *Christian Moral Principles*, p. 120. Grisez identifies historical examples of the mistaken view that badness is a positive reality rather then a privation or the real lack of something that should be present, including the Pharisees who thought that evil could be avoided by separation, and the Manicheans, "who identified badness with bodiliness". Ibid. Even today, Manichean impulses remain in some Christian communities that view the body and human sexuality as something sinful, rather than something holy. Grisez also identifies John Dewey and Karl Marx as secular humanists who regarded badness as a positive reality to be overcome. Ibid at 119-120.

as "the killing of those who are incurably ill and in great pain or distress, for the sake of those killed, and in order to spare them further suffering or distress."[53] He also supports such killing for those in permanent states of non self-consciousness, since "their lives have no intrinsic value".[54]

> The lives of those who are not in a coma and are conscious but not self conscious have value if such beings experience more pleasure than pain, or have preferences that can be satisfied; but it is difficult to see the point of keeping such human beings alive if their life is, on the whole, miserable.[55]

In an invited article appearing in the journal *Pediatrics* published by the American Academy of Pediatrics in 1983, Singer made clear his view that active euthanasia was not morally distinct from withholding treatment:

> Although many doctors would sharply distinguish the active termination of life from a decision not to treat a patient for whom the foreseen outcome of this decision is death of the patient, the distinction is a tenuous one, and the claim that it carries moral weight has been rejected by several academic philosophers[56]

Singer's claim that killing by commission or omission is the of the same moral species holds up well in the case of the patient who is not imminently dying. However, his point was to legitimize active killing of non-self conscious persons or those in great suffering, regardless of the imminence of death. While his appointment to a distinguished chair at one of America's

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[53] *Practical Ethics* at 175.

[54] Ibid at 192.

[55] Ibid.

[56] P. Singer, *Sanctity of life or quality of life?* Pediatrics, 72: 128-29 (1983). By this statement Singer is rejecting the traditional concept of "double effect". For a discussion of double effect and its application in the context of end of life medical decisions, see notes 241 - 243, infra, and accompanying text.

outstanding centers of higher education caused some protests[57], Singer's text is now considered a classic in applied ethics and is a standard text assigned in college ethics and philosophy courses worldwide. His emergence since the 1970s as a faculty member and visiting scholar at universities and international opinion shaping organizations[58] is witness to the prominence radical utilitarian thought achieved in the last quarter of the Twentieth Century.

The development of the ideas discussed thus far have enormous consequence for our culture, laws, medical practices, and the choices people make as they are encouraged to adopt advance medical directives. Approximately two million people die in the United States each year.[59] Of that number about eighty percent die in hospitals and long term care facilities.[60] Seventy percent of patients who die in intensive care units die after a decision has been made to

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[57] See, Statement of Marca Bristo, April 17, 1999, Chairperson, National Council on Disability, available at www.ncd.gov. The Wall Street Journal accused Princeton of abandoning the principals that protected human life in civilized society for two millennia. But protest was mute in comparison to the reaction to his book in Germany, Austria and Switzerland, where he was banned from speaking because his ideas are considered ideologically indistinguishable from the rationales used by the National Socialists in the 1930s and 1940s to dispose of "useless mouths" and build a neo-Darwinist society. See, *On Being Silenced in Germany*, P. Singer, The New York Review of Books, August 1991 wherein Singer expresses his outrage at European protests against him. Singer's essay on his experience in Germany is also printed as an Appendix to the Second Edition of *Practical Ethics*. In it he attempts to paint his critics as unfairly smearing him with Nazi associations. I would agree that he is no Nazi. However, his system of ethics, both in its definition of "person" and its acceptance of the notion of human life without intrinsic value is precisely the foundation of the eugenic and death dealing concept of "life unworthy of life". Singer cannot escape analogy to the National Socialists because his ideas in many respects are, in fact, very similar.

[58] Singer's Curriculum Vitae can be reviewed at www.prinction.edu/~uchv/faculty/singercv2.pdf and includes reference to his association with Princeton University, University College Oxford, La Trobe University, Monash University, Woodrow Wilson International Center for Scholars (Smithsonian Institution), University of British Columbia, University of Colorado, University of California, University of Rome and the University of Canterbury. Interestingly, he was invited as the Sissel Bok Lecturer in the Program for Ethics in the Professions, J.F.K. School of Government, Harvard University, in 1987, some nine years after the publication of *Practical Ethics*.

[59] President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life Sustaining Treatment*, p. 15

[60] Ibid.

withdraw or withhold life-sustaining treatment.[61] Oregon has adopted the nation's first physician assisted suicide law, Washington and California narrowly defeated similar legislation in the 1990s, and it has been reported that an overwhelming majority of Americans - some 90% - favor patient self determination in decisions to accelerate death by refusing or terminating medical treatment.[62] A 1994 Harris survey found that seventy three percent of Americans favored legalizing physician assisted suicide, while a 1998 CBS News poll put that figure at fifty eight percent and 2004 poll figures revealing a statistical dead heat of forty six percent favoring and forty five percent opposed.[63] The Journal of the American Medical Association reported that among patients actually suffering from terminal illnesses, the support was sixty percent, but that was in abstract situations.[64] Upon re-interview, the support for euthanasia and physician assisted suicide dropped to fifty-four percent when it concerned patients with unremitting pain and thirty-two percent when it concerned patients without significant pain but who considered their illness too burdensome.[65] As concerned their own circumstances, ten percent of terminally ill patients had considered euthanasia or physician assisted suicide[66], about five percent had discussed it

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[61] Thomas J. Prendergast, *Withholding or Withdrawal of Life-Sustaining Therapy, Hospital Practice,* www.hosppract.com; See also, Lipton, *Do-Not-Resuscitate Decisions in a Community Hospital: Incidence, Implications and Outcomes*, 256 JAMA 1164, 1168 (1986).

[62] See, Sanford Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 Cal.L.Rev. 857, 860 and notes.

[63] David Cannella, *Physician-Assisted Suicide, Fight Rages in Several States: Issue Expected to Go the Supreme Court*, The Arizona Republic, May 13, 1995. A similar figure was reported by a national poll concerning terminally ill patients who request active physician assistance in dying. See, New York Times, November 4, 1991, page A 16. See also Poll: Physician Assisted Suicide, November 24, 2004 at www.cbsnews.com/stories/2004/11/24/opinion/polls/main657617.shtml.

[64] Ezekiel J. Emanuel, et als. *Attitudes And Desires Related to Euthanasia and Physician-Assisted Suicide Among Terminally Ill Patients and Their Caregivers*, JAMA, 2460, 2463, November 15, 2000.

[65] Ibid at 2463.

with caregivers and less then two percent had discussed it with their physician.[67] These figures suggest that popular opinions and cultural attitudes toward euthanasia and physician assisted suicide run ahead of the actual interest of terminally ill patients. That may have the result of placing the additional burden of third person expectations on terminally ill patients to accept death accelerating decisions. Undoubtedly, it advances a cultural expectation that availability of euthanasia and physician assisted suicide represent an advance in personal liberty and enlightened health care public policy.

A clear example of such a development was a New York Times Op-Ed column by Joseph C. d'Oronzio, a consultant and writer in bioethics and an assistant professor of social medicine at Columbia University. He advocated requiring "all registrants for Federal entitlement programs – Medicare, Medicaid and Social Security benefits – to consider *and complete* an advance directive."[68] In context, it is clear that d'Oronzio was advocating mandatory advance directives as a means of halting what he views as excessive and costly end of life medical intervention. His obvious purpose was to encourage, perhaps compel, patients to "elect" the withholding or withdrawal of life support systems should their condition become terminal or should they lapse into a permanently non-cognitive state. In an interview in 1997 the late John Cardinal O'Connor disclosed that an insurance company threatened to cut off insurance payments to Calvary Hospital, a facility dedicated to the care of dying persons, because "it was keeping its patients

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[66] Ibid at 2464.

[67] Ibid at 2465.

[68] Joseph C. d'Oronzio, *Good Ethics, Good Health Economics*, New York Times Op-Ed, June 8, 1993 (emphasis added).

alive too long."[69] "In the past, the typical length of stay [at Calvary Hospital] was six weeks ... Now, because of better pain management techniques and treatment regimes, patients might stay alive for six months to one year".[70] A New York Archdiocesan spokesman disclosed that the incident occurred in 1995, although the insurance carrier did not follow through on its threat. Cardinal O'Connor noted that both hospitals and patients were being "pressured to bring life to an end".[71]

It is the development and encouragement of such ideas on a mass cultural scale, along with the concepts and ethical systems addressed above, that must be understood as the platform from which state and federal legislative initiatives have been launched. While no one seriously questions the right of a dying patient to refuse futile or disproportionate care, it is the now common practice to withhold life sustaining (and thus, by definition, non-futile) care from patients who are either not terminal (e.g. Karen Quinlan, Nancy Beth Cruzan, Terri Schiavo) or are not so close to death that continued treatment would be futile. The standard yardstick to judge the appropriateness of medical intervention has become the likihood that a given patient's condition can be cured or improved. Mere *status quo* maintaince of a person in a persistent vegetative state is almost always considered "excessive", "disproportionate" or "extraordinary". The Quality Standards Subcommittee of the American Academy of Neurology has developed Management Guidelines for the care of PVS patients that stress the need for physicians and family members to "determine appropriate levels of treatment relative to the administration or

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[69] Catholic News Service (CNS), April 8, 1997.

[70] Ibid.

[71] Ibid.

withdrawal of: 1. Medications and other commonly ordered treatments; 2. Supplemental oxygen and use of antibiotics; 3. Complex organ-sustaining treatments such as dialysis; 4. Administration of blood products; and 5. Artificial hydration and nutrition."[72] Theses guidelines assume that the withholding or withdrawal of any or all of the above modes of medical intervention is appropriate in a PVS case where there is no reasonable expectation of recovery to a cognitive state. They also advise that a "Do not resuscitate" order (DNR) is appropriate in all PVS cases considered permanent, and may be elected earlier in the course of illness if an advance directive or surrogate makes provision for it.[73]

The progress of the "quality of life" ethic in public, medical and legal thought was plainly evident in certain dissenting opinions of the United States Supreme Court in *Cruzan v. Director, Missouri Dept. of Health*[74]. In that case, Nancy Cruzan, a woman who had previously expressed her opinion that she would not want to be maintained alive on life support systems if her condition was such that she would never regain cognitive awareness[75], suffered a massive anoxic insult to the brain following an automobile accident. She was discovered by paramedics at the

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[72] Practice parameters: Assessment and management of patients in the persistent vegetative state, Report of the Quality Standards Subcommittee of the American Academy of Neurology, *Neurology* 1995; 45: 1015-1018.

[73] Ibid.

[74] 497 U.S. 261, 110 S.Ct. 2841 (1990)

[75] The Missouri Supreme Court held that statements Nancy allegedly made to her roommate were unreliable for the purpose of determining her intent. *Cruzan v. Harmon*, 760 SW 2d 408, 424 (1988). Renewed legal proceedings following the United States Supreme Court decision produced additional testimony from some of Nancy Cruzan's co-workers which lead to a finding that her intent would be to refuse further assisted nutrition and hydration. Her physician testified that her existence was a "living hell" – an odd notion considering the diagnosis that she was unaware of her existence. Her feeding tube was removed the same day and she died twelve days later on December 26, 1990. See *Nancy Cruzan Dies, Outlived by a Debate Over the Right to Die,* New York Times, December 27, 1990.

scene of the accident without detectable respiratory or cardiac function.[76] After emergency care at the accident scene restored both functions, she was transported to a hospital where she remained in a coma for three weeks, after which she regained consciousness and was able to orally ingest nutrition. A gastrostomy feeding and hydration tube was implanted to ease feeding. She was subsequently diagnosed as PVS.[77] She was able to breath on her own and her heart maintained circulation without assistance. Both her respiration and circulation were normal for a woman her age. She had a massive brain injury that could never be reversed, she grimaced in response to painful stimuli "indicating the experience of pain and apparent response to sound", and she was a spastic quadriplegic.[78] The Missouri Supreme Court held: "She is not dead. She is not terminally ill. Medical experts testified that she could live another thirty years."[79]

The Missouri Supreme Court had reversed a trial court decision permitting the removal of Nancy's feeding tube. The court held that the evidence of Nancy's wishes was too thin to permit such a death accelerating decision. In reaching that conclusion, the state court applied a standard of proof termed "clear and convincing evidence", a standard in between the usual civil case standard of "preponderance of the evidence" and the high criminal case threshold of "beyond a reasonable doubt". In other words, it held that in order to remove Nancy's feeding tube and allow her to die from a lack of nutrition and/or hydration, the petitioners (in this case her parents) would have to prove Nancy's wishes by evidence that satisfied that mid level standard of proof.

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[76] Ibid, 110 S. Ct. at 2845.

[77] Ibid.

[78] *Cruzan v. Harmon*, 760 SW 2d 408, 411 (mo. 1988) (en banc).

[79] Ibid.

The United States Supreme Court affirmed. While the court recognized the right to refuse life sustaining treatments[80], the court agreed that the standard of proof adopted by the state court was a constitutionally permissible means of ensuring that such decisions, when made in the absence of a living will, are based on inherently reliable evidence. However, much of the ink of the *Cruzan* decision went further. A dissenting opinion by Associate Justice John Paul Stevens pressed the "right to die" agenda full force. Without deciding the issue, Stevens suggested that the biological existence of Nancy Cruzan was not life:

> Nancy Cruzan is obviously "*alive*" in a physiological sense. But for patients like Nancy Cruzan, who have no consciousness and no chance of recovery, there is a serious question as to whether the mere persistence of their bodies is "life" as that word is commonly understood, or as it is used in both the Constitution and the Declaration of Independence.[81]

By implication, intentionally or not, Justice Stevens had questioned whether Nancy Cruzan's being had any dignity, meaning or value whatsoever. Indeed, the cases he cites in footnotes to this part of his dissent are more bold. One held that medical intervention in such cases "degrades the very humanity it was meant to serve"; another held that a PVS patient "has no health, and, in a true sense, no life, for the state to protect".[82]

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[80] For a discussion of the status of constitutional law as it applies to a person's right to refuse medical treatment, see section III infra.

[81] *Cruzan*, supra, 497 U.S. at 344-45, 110 S. Ct. at 2886 (Stevens, dissenting).

[82] Ibid, at fn. 19 and cases cited therein. In 2004 John Paul II addressed the issue of assisted nutrition and hydration of PVS patients. His forceful intervention in defense of human dignity precludes the option advocated by Justice Stevens, et. als.:

> The sick person in a vegetative state, awaiting recovery or a natural end, still has the right to basic health care (nutrition, hydration, cleanliness, warmth, etc.), and to the prevention of complications related to his confinement to bed. He also has the right to appropriate rehabilitative care and to be monitored for clinical signs of eventual recovery.

Associate Justice Brennan raised other issues in his dissent, wherein he described Nancy Cruzan as a "passive prisoner of medical technology":

> For a patient like Nancy Cruzan, the sole benefit of medical treatment is being kept metabolically alive....Dying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence..... [PVS] conditions are, for many, humiliating to contemplate, as is visiting a prolonged and anguished vigil on one's parents, spouse, and children.[83]

As with Justice Stevens' dissent, Justice Brennen opened certain lines of reasoning that suggest, intentionally or not, that what ones does, rather then what one is, defines the dignity, value and meaning of a human person. This suggests that Justice Brennan, like Justice Stevens

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> I should like particularly to underline how the administration of water and food, even when provided by artificial means, always represents a *natural means* of preserving life, not a *medical act*. Its use, furthermore, should be considered, in principle, *ordinary* and *proportionate*, and as such morally obligatory, insofar as and until it is seen to have attained its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering.
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> The obligation to provide the "normal care due to the sick in such cases" (Congregation for the Doctrine of the Faith, *Iura et Bona*, p. IV) includes, in fact, the use of nutrition and hydration (cf. Pontifical Council "Cor Unum". *Dans le Cadre*, 2,4,4: Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter of health Care Workers*, n. 120). The evaluation of probabilities, founded on waning hopes for recovery when the vegetative state is prolonged beyond a year, cannot ethically justify the cessation or interruption of *minimal care* for the patient, including nutrition and hydration. Death by starvation or dehydration is, in fact, the only possible outcome as a result of their withdrawal. In this sense it ends up becoming, if done knowingly and willingly, true and proper euthanasia by omission.
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> In this regard, I recall what I wrote in the Encyclical Evangelium Vitae, making it clear that "by *euthanasia in the true and proper sense* must be understood an action or omission which by its very nature and intention brings about death, with the purpose of eliminating all pain"; such an act is always " a *serious violation of the law of God*, since it is the deliberate and morally unacceptable killing of a human person" (n. 65).
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> Besides, the moral principle is well known, according to which even the simple doubt of being in the presence of a living person already imposes the obligation of full respect and of abstaining from any act that aims at anticipating the person's death.

Address of John Paul II to the Participants in the International Congress on "Life Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas, footnote 39, supra, at n. 4 (emphasis in original).

[83] Ibid, 110 S.Ct at 2868-69 (Brennan, dissenting).

and the New Jersey Supreme Court in *Quinlan,* was more than a bit troubled at the physical condition of the disabled persons whose lives came before them for judgment. It was not so much the supposed burden of medical interventions to maintain their lives as it was their continued "humiliating to contemplate" existence itself that discomforted the New Jersey Supreme Court and Justices Stevens and Brennen. Indeed, the medical interventions themselves caused no experiential cognitive burdens for Karen Ouinlan or Nancy Cruzan. They were, after all, presumably unaware of them. It was something in the observer rather than the disabled person that drove the jurists' thinking. They were shocked. As increasingly evident in the culture at large, they were interiorly governed by a particular kind of tenderness: one that recoils at the notion of suffering, aging, disability, impaired cognitive function and dependence. It is a tenderness offended by the continued life of those who, according to that view, are denied the "quiet, proud death, bodily integrity intact" that Justice Brennan so lavishly extolled. One imagines a splendid corpse.

Flannery O'Connor's *Introduction to A Memoir of Mary Ann* offers a keen insight to development of social norms that judge human value by what one does rather then what one is; by value measured in production rather than in being. Mary Ann was a terminally ill child in a home for the incurably ill operated by Dominican Nuns in Georgia. Her condition was, by all reports, particularly gruesome. However, she was recognized by those who cared for her to be a person of unusual grace, dignity and holiness. Flannery O'Connor never had occasion to witness the interaction of the nuns with Mary Ann and when they asked her to write the story of Mary Ann's life she demurred, offering to do some minor editing if the nuns themselves produced a manuscript. She had hoped her reply would end the project and that she would be spared the torture often visited upon gifted writers of being obliged to review a novice's pathetic attempt at

literature. She was mistaken. The manuscript arrived and she struggled through it, tempted to cut and edit extensively. However, after finishing the manuscript, she realized that the story was profound. The story of Mary Ann's life was the story of a creative growth in goodness and beauty from imperfection and deformity. It was the story of fulfilled human destiny. She wrote an Introduction to the Memoir which included a reflection on the meaning and consequence of illness, suffering and human imperfection. What follows is her reflection on the homily preached by the Bishop who presided at the funeral Mass:

> He said that the world would ask why Mary Ann should die. He was thinking undoubtedly of those who had known her and knew that she loved life, knew her grip on a hamburger had once been so strong that she had fallen through the back of her chair without dropping it, or that some months before her death, she and Sister Loretta had got a real baby to nurse. The bishop was speaking to her family and friends. He could not have been thinking of that world, much farther removed yet everywhere, which would not ask why Mary Ann should die, but why she should be born in the first place.
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> One of the tendencies of our age is to use the suffering of children to discredit the goodness of God, and once you have discredited His goodness, you are done with Him. ... Busy cutting down human imperfection, they are making headway also on the raw material of good. Ivan Karamazov cannot believe, as long as one child is in torment; Camus' hero cannot accept the divinity of Christ, because of the massacre of the innocents. In this popular pity, we mark our gain in sensibility and our loss in vision. If other ages felt less, they saw more, even though they saw with the blind, prophetical, unsentimental eye of acceptance, which is to say, of faith. In the absence of faith now, we govern by tenderness. It is a tenderness which, long since cut off from the person of Christ, is wrapped in theory. When tenderness is detached from the source of tenderness, its logical outcome is terror. It ends in forced labor camps and in the fumes of the gas chamber.[84]

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[84] *A Memoir of Mary Ann* with an Introduction by Flannery O'Connor, Farrar, Straus & Cudahy, Inc., New York, pp.18-19 (1961). O'Connor's reference to a modern tendency to use the suffering of children to discredit God's goodness echoes a similar use by modern medical eugenicists to justify the destruction of embryonic persons, either as a means to rescuing them from a life deemed too burdensome, or to provide the experimental material upon which to carry out medical research. See footnote 10, supra.

O'Connor noted that the nuns who cared for Mary Ann seemed utterly at ease with her, even in the face of her horrible deformity – a condition that others were repelled by. She saw that the Sisters were not disturbed. They, like Blessed Mother Theresa's Sisters of Charity, were accompanying Christ in each person they served. They loved and did not find love displaced by shock, terror, "popular pity" or distaste. O'Connor took the opportunity to recall a short story written by Nathanial Hawthorne entitled "The Spot". In it a gentlemen informs his wife that he wondered if she would consider having a spot removed from her face. The spot was not new. His wife tried to dismiss the moment casually, suggesting that "it has so often been called a charm that I was simple enough to imagine it be so." But her husband, so disturbed by the slight imperfection on his wife's face that he could not drop the matter, persisted:

> Ah, upon another face perhaps it might be," replied her husband, "but never on yours. No, dearest Georgiana, you came so nearly perfect from the hand of Nature that this slightest defect, which we hesitate whether to term a defect or a beauty, shocks me, as being the visible mark of earthly imperfection."
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> "Shocks you, my husband!" cried Georgiana, deeply hurt, at first reddening with momentary anger, but then bursting into tears. "Then why did you take me from my mother's side? You cannot love what shocks you!"[85]

Georgiana's response was driven by her tearful realization that she was not loved for the sake of what she was - a person and a wife - but was actually disvalued because of her human imperfection. Hawthorne's point beautifully illustrates the world's view of Mary Ann and the millions like her. O'Connor's insight is to draw a parallel between Mary Ann and the human

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[85] Ibid, p. 6-7

condition. It is precisely in our imperfection that we are "the raw material of good", and yet it is the presence of imperfection that a new ethic rejects and is busy cutting away in sterilizations, abortions, genetic screening, euthanasia, and withdrawal and withholding of food, fluids and medical care from those deemed too "imperfect" to keep.

O'Connor returns to Hawthorne and a story he wrote entitled *Our Old Home* in which he recounts the particular discomfort of a fastidious nineteenth century English gentleman who is confronted at a Liverpool workhouse by a grotesque sickly child. His natural response is to avoid the child at all costs. In the end, in an act of heroic virtue, he "took up the loathsome child and caressed it as tenderly as if he had been its father".[86] As it turned out, the story was autobiographical, mimicking an event in Hawthorne's life. His posthumously published notebooks described the actual encounter as an "undesirable burden" and he described the child as "a wretched, pale, half-torpid little thing, with ... scurvy", and of which he commented: "I never saw ... a child that I should feel less inclined to fondle."[87] Nevertheless, he did, holding the child and allowing it to hold his hand after he put it down. He evaluated the significance of that encounter by noting: "I should never have forgiven myself if I had repelled its advances".[88] From that experience Hawthorne learned the value of every human life. His daughter, Rose, became a Catholic and eventually founded of the order of nuns who cared for Mary Ann. It was their calling to care for the incurable. O'Connor saw a transcendent unity between Hawthorne's transformative experience with the small, deformed child in Liverpool, Rose Hawthorne's conversion to Catholicism and her vocation of caring for incurables, and the life of Mary Ann:

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[86] Ibid, p. 8.

[87] Ibid, p. 9.

[88] Ibid. pp. 8-9.

> There is a direct line between the incident in the Liverpool workhouse, the work of Hawthorne's daughter, and Mary Ann – who stands not only for herself but for all the other examples of human imperfection and grotesquerie which the Sisters of Rose Hawthorne's order spend their lives caring for. Their work is the tree sprung from Hawthorne's small act of Christlikeness and Mary Ann is its flower. By reason of the fear, the search, and the charity that marked his life and influenced his daughter's, Mary Ann inherited a century later, the wealth of Catholic wisdom that taught her what to make of her death. Hawthorne gave what he did not have himself.
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> This action by which charity grows invisibly among us, entwining the living and the dead, is called by the Church the Communion of Saints. It is a communion created upon human imperfection, created from what we make of our grotesque state. Of hers Mary Ann made what, like all good things, would have escaped notice had not the Sisters and many others been affected by it and wished it written down. The Sisters who composed the memoir have told me that they feel they have failed to create her as she was, that she was more lively than they managed to make her, more gay, more gracious, but I think that they have done enough and done it well. I think that for the reader this story will illuminate the lines that join the most diverse lives and that hold us fast in Christ.[89]

O'Connor's insight is twice applicable to our topic. She has identified the source of the anxiety with which modern thought views a disabled person. Human imperfection is tolerable to a degree, and even an occasion for admiration, such as that felt for the paraplegic who completes a New York City Marathon in a wheelchair. But where the imperfection is terminal or grotesque or excessively disturbing by the standards of that world O'Conner called "farther away yet everywhere" – such as the case of the totally disabled PVS patient - "popular pity" drives for its elimination because it is repelled by its own self imposed emotional burden.[90] It is shocked. It is

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[89] Ibid, p.20.

[90] This kind of third person burden, often operative though silent, found expression by Judge George W. Greer in his infamous ORDER authorizing the discontinuance of Terri Schiavo's life sustaining nutrition and hydration:

> Initially, there is no question that Terri Schiavo does not pose a burden financially to anyone and this would appear to be a safe assumption for the foreseeable future. However, the court notes

terrorized by its own tenderness which is "cut off from the person of Christ". Second, O'Connor keenly identifies the Communion of Saints as an invisible unity of persons, deformed in body, mind or spirit, yet built up charity in our midst. Her raw phrase about the "raw material of good" being present in human imperfection is a part of that communion. Those imperfections are the occasion and opportunity for solidarity rather then the alienation so plainly manifest in the delicate yet deadly tenderness lamented by O'Connor. It is the Communion of Saints concretized that is witnessed in the ongoing care provided by the Hawthorne nuns to Mary Ann, by Mary Ann in her acceptance of circumstance, her good spiritedness and her love of life, by those who care for the disabled PVS person, the aged and terminally ill patients who still have years or months to live, and the Downs syndrome baby whose value is recognized in who he is rather than what he can do. Pope Benedict XVI has given an economical expression of this communion in his description of the human person as derivative of Trinitarian relation. "[T]he true God is, of his own nature, being-for (Father), being-from (Son), and being-with (Holy Spirit)."[91] Man is in the image of this relation-being, the image of God, and no theory of individualism, personhood, meaning or freedom can deny this primordial structure of the human subject without doing violence to the solidarity demanded by our "basic anthropological shape."[92] This is reflected well in the haunting prose of John Donne:

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that the term "burden" is not restricted solely to dollars and cents since one can also be a burden to others emotionally and physically.

In Re: The Guardianship of Theresa Marie Schiavo, Incapacitated, p. 9, Circuit Court for Pinellas County, Florida, Probate Division, February 11, 2000.

[91] Joseph Cardinal Ratzinger, *Truth and Tolerance, Christian Belief and World Religions*, supra footnote 4 at p. 248.

[92] Ibid.

> The church is Catholic, universal, so are all her actions; all that she does belongs to all. When she baptizes a child, that action concerns me; for that child is thereby connected to that body which is my head too, and engrafted into that body whereof I am a member. And when she buries a man, that action concerns me: all mankind is of one author, and is one volume; when one man dies, one chapter is not torn out of the book, but translated into a better language; and every chapter must be so translated; God employs several translators; some pieces are translated by age, some by sickness, some by war, some by justice; but God's hand is in every translation, and his hand shall bind up all our scattered leaves again for that library where every book shall lie open to one another. ...
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> No man is an island, entire of itself; every man is a piece of the continent, a part of the main. If a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as if a manor of thy friend's or of thine own were: any man's death diminishes me, because I am involved in mankind, and therefore never send to know for whom the bells toll: it tolls for thee.[93]

With this background in place we shall next examine the current state of constitutional and statutory law as regards the right to direct one's own medical treatment, as well as the ability to provide for future events by way of advance directives, living wills, appointment of health care agents and the like.

[93] John Donne, *Devotions Upon Emergent Occasions*, "XVII. Nunc lento sonitu dicunt, morieris. XVII. Meditation."

III THE AUTONOMOUS SELF

A. The Development of American Constitutional Doctrine

American jurisprudence has long recognized the special status of the individual. Various constitutional provisions directly implicate individual liberties, ranging from first amendment freedom of religious worship and speech to the recognition of special privacy in one's home (fourth amendment) to the protection of life and liberty embedded in the due process clause of the fifth and fourteenth amendments. The tripartite division of government power between executive, legislative and judicial branches is itself one of the great bulwarks of freedom, with its intra and inter branch checks and balances. One well settled element of individual liberty is the right to be free from unauthorized physical touching. The notion of a personal privilege to bodily autonomy is so strong that the common law not only recognizes a cause of action for battery, or "the intentional infliction of bodily harm"[94], but also guards against intentional contact deemed "offensive", that is to say, conduct that "offends a reasonable sense of personal dignity".[95] The common law goes even further and protects against intentionally induced apprehension of harmful or offensive contact, even where actual contact does not, in fact, occur,[96] this latter category of tort being recognized as civil assault.

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[94] 1 Restatement (Second), Torts, sec. 13 and Chapter 2, Topic 1, p. 23.

[95] Ibid, secs. 18 and 19.

One natural development of the protections afforded by the common law against assault and battery has been the emergence of the doctrine of informed consent. In *Schloendorff v. Society of New York Hospital*[97], Justice Benjamin Cardozo penned his famous expression of the doctrine:

> Every human being of adult years and sound mind has the right to determine what shall be done with his own body; and a surgeon who performs an operation without the patient's consent commits an assault, for which he is liable in damages.[98]

The informed consent doctrine has its roots in the idea of personal autonomy. An earlier expression of that concept was formulated by the United States Supreme Court in *Union Pacific R. Co. v. Botsford* in 1891.[99] The case involved a woman's objection to a medical examination sought by a civil defendant in order to determine the extent of personal injuries she was suing for. The issue evoked strong criticism form the court at the very idea that one could be compelled to undergo a medical examination:

> No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law .... The right to one's person may be said to be a right of complete immunity; to be let alone.[100]

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[96] Ibid, sec. 21 and Topic 3, p. 31

[97] 211 N.Y. 125, 105 N.E. 92 (1914)

[98] Ibid, 211 N.Y. at 129-30, 105 N.E. at 93.

[99] 141 U.S. 250, 11 S. Ct. 1000 (1891)

[100] Ibid, 141 U.S. at 1001 (citations and internal quotation marks omitted)

Connecticut courts have long expressed approval of Justice Cardozo's eloquent expression of bodily autonomy in *Schloendorff*.[101] The theory of battery as a basis of recovery in a civil lawsuit against a physician who fails to obtain informed consent has been extended over time so that it is now includes not only the failure to obtain consent to a particular treatment, or cases where the doctor knows that the patient does not understand what the proposed treatment entails, but also the physician's duty to disclose the nature of the procedure, its risks and hazards, potential alternatives, and the anticipated benefit of the procedure.[102]

The development of the "informed consent" doctrine in medical liability cases is now so much a part of our cultural landscape that it is generally assumed. The necessary corollary of the doctrine of informed consent, the right to refuse such treatment, is also commonly asserted. As applied to incapacitated patients, the trend began with the *Quinlan* case and various state court decisions that emerged along side the increasing technical ability of modern medicine to provide life-sustaining care for various medical conditions. Prior to *Quinlan*, the development of a parallel line of cases introduced in to American jurisprudence the notion of substantive due process, often expressed as a "right to privacy", including the right to control matters affecting one's own body. The underlying cases reach back to disputes over parental rights to direct the education and upbringing of children[103], and public elementary school teachers' right to teach in

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[101] *Schmeltz v. Tracy*, 119 Conn 492, 495-96 (1935)

[102] 4 Restatement (Second) Torts, sec. 892B (2) and comment i in accompanying text; see also, *Logan v. Greenwich Hospital Assn.*, 191 Conn 282, 289-92 (1983).

[103] *Pierce v. Society of the Sisters of the Holy Name of Jesus*, 268 U.S. 510, 45 S.Ct. 571 (1925)

a language other then English[104]. While such disputes may seem far removed from the issues of bodily autonomy, the language of those cases was critical to later developments:

> While this court has not attempted to define with exactness the liberty thus guaranteed [by the due process clause of the fourteenth amendment] ... it denotes not merely freedom from bodily restraint but also the right of the individual to contract, to engage in any of the common occupations of life, to acquire useful knowledge, to marry, establish a home and bring up children, to worship God according to the dictates of his own conscience, and generally to enjoy those privileges long recognized at common law as essential to the orderly pursuit of happiness by free men.[105]

Griswold v. Connecticut[106], the 1965 Supreme Court decision that elevated the distribution to, and use of contraceptives by married couples to a constitutional liberty, relied on these earlier decisions for the concept that various "specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance".[107] The court concluded that marriage was a relationship that existed "within the zone of privacy created by several fundamental constitutional guarantees" and that the law prohibiting the use of contraceptives by married couples "seeks to achieve its goals by means having a maximum

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[104] *Meyer v. Nebraska*, 262 U.S. 390, 43 S.Ct. 625 (1923)

[105] Ibid, at 399.

[106] 381 U.S. 479, 85 S.Ct. 1678 (1965)

[107] Ibid at 484, 381 S.Ct. at 1681. In dissent, Justice Stewart pointed out that the majority was involved in a slight of hand. The earlier cases it cited as foundation for its "zone of privacy" and "penumbra" theory do not actually recognize the concept advanced by the majority: "In the course of its opinion the Court refers to no less than six Amendments to the Constitution: the First, the Third, the Fourth, the Fifth, the Ninth, and the Fourteenth. But the Court does not say which of these Amendments, if any, it thinks is infringed by this Connecticut law....What provision of the Constitution, then, does make this state law invalid? The Court says it is the right of privacy "created by several fundamental constitutional guarantees." With all deference, I can find no such general right of privacy in the Bill of Rights, in any other part of the Constitution, or in any case ever before decided by this Court." 381 U.S at 527-28, 530.

destructive impact upon that relationship."[108] Then came what autonomy advocates consider the *coup de grace* from the pen of Justice Douglas:

> Would we allow the police to search the sacred precincts of marital bedrooms for telltale signs of the use of contraceptives? The very idea is repulsive to the notions of privacy surrounding the marriage relationship. We deal with a right of privacy older than the Bill of Rights – older than our political parties, older than our school system. Marriage is a coming together for better or for worse, hopefully enduring, and intimate to the degree of being sacred. It is an association that promotes a way of life, not causes; a harmony in living, not political faiths; a bilateral loyalty, not commercial or social projects.[109]

A studied or even casual reading of *Griswold* clearly discerns the import of the marriage relationship to the court's conclusion that contraceptive sexual intercourse was a constitutionally protected activity. Subsequent developments, however, turned the nature of "privacy" sharply towards individual, rather then marital, autonomy. Explaining *Griswold's* reliance on marriage as merely dicta[110], the Supreme Court, in 1971, held that the rational behind *Griswold* applied to unmarried persons:

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[108] Ibid at 485, 381 S.Ct. at 1682. The Court did not explain further how prohibiting contraceptive use had "a maximum destructive impact" on marriage. Taking for the moment what appears to be the majorities' perspective, it could have meant that pregnancy and children are an impediment to a fulfilling marriage as a whole *or* that sexual intimacy in marriage is frustrated by the possibility of the procreative noose around the spouses' collective neck. In either case I must confess that I do not understand what the court is talking about. Certainly subsequent developments plainly show that the author of the opinion, Justice William O. Douglas, was not interested in marriage as a sacred institution whatsoever. See footnote 103, infra.

[109] Ibid at 486, 85 S.Ct. at 1682.

[110] Subsequent disclosers have revealed that marriage was never the intended basis of the *Griswold* decision. Justice Douglas, the author of the majority decision in *Griswold*, had circulated a proposed decision which rested not on the marriage relationship, but individual autonomy. Apparently in response to Justice Brennan's concern that so radical a development would not command a sufficiently large majority of the court to win broad public support, Justice Douglas modified the language to introduce marriage as the relationship being "protected" by the holding of the case. See, Bruce Allen Murphy, *Wild Bill: The Legend and Life of William O. Douglas* (Random House) (2002). Additional revelations concerning Justice Douglas personal conduct and character are detailed in Murphy's book and in an article by respected United States Court of Appeals Justice Richard Posner which appeared in The New Republic on February 24, 2003. Those revelations shed considerable light on the real rationale and personal motives

> If under *Griswold* the distribution of contraceptives to married persons cannot be prohibited, a ban on distribution to unmarried persons would be equally impermissible. It is true that in *Griswold* the right of privacy in question inhered in the marital relationship. Yet the marital couple is not an independent entity with a mind and heart of its own, but an association of two individuals each with a separate intellectual and emotional makeup. If the right of privacy means anything, it is the right of the *individual,* married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.[111]

Having determined that constitutional privacy as an individual liberty, rather than one associated with marriage or any other social relationship, the court set the course for the development of an even more radical individual autonomy. In *Roe v. Wade*[112] the court took the fateful step of extending constitutionally protected individual autonomy to include a woman's decision to abort her child. The court identified the various burdens of pregnancy, including "[s]pecific and direct harm medically diagnosable even in early pregnancy" and included in its enumeration of other "burdens" the possibility that maternity or offspring may force a woman to live a "distressful life"; that mental and physical health may be taxed; that additional distress is

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that lurked behind the flowerily if dishonest language of the *Griswold* decision. Justice Posner describes Douglas as "a flagrant liar...a compulsive womanizer, a heavy drinker, a terrible husband to each of his four wives, a terrible father...a bored, distracted, uncollegial, irresponsible, and at time unethical Supreme Court justice". He was "[r]ude, ice-cold, hot-tempered, ungrateful, foul-mouthed, self-absorbed, and devoured by ambition". Posner, who knew Justice Douglas personally from his days as a law clerk to Justice Brennan, went on to explain that in the last decade of Douglas' service on the Court, beginning a year before the *Griswold* decision, he deteriorated "morally and psychologically from an already low level" marked by "bizarre behavior toward women", including an assault on a young airline stewardess in his office, an impulsive and short lived marriage to a much younger woman with whom he had been having sexual relations in his office and whom he had to hide in his office closest to avoid discovery by his then second wife, followed by a series of adulterous affairs with two young women, one of whom he married only to resume intimacies with the other while still married to the first. That was the character and contemporaneous conduct of the author of *Griswold,* which claimed to rest its constitutional condemnation of anti-contraceptive laws on the "sacred" nature of marriage. Justice Posner's New Republic article, *The Anti-Hero,* can be accessed online at www.law.uchicago.edu/news/posner-antihero.html.

[111] *Eisenstadt v. Baird*, 405 U.S. 452, 452, 92 S.Ct. 1029,1038.

[112] 410 U.S. 113, 93 S.Ct. 705 (1973).

associated with unwanted children; and that the stigma of unwed motherhood may be involved.[113] Additional support was suggested in the position adopted by various medical/health interests. The court cited The Committee on Human Reproduction of the American Medical Association, which in 1967 had endorsed abortion in cases were the life or health of the mother was implicated, as well as those instances where the child "may be born with incapacitating physical deformity or mental deficiency" or in some cases where pregnancy was the result of rape or incest.[114] The court noted that by 1970 the AMA had gone even further and declared that the principles of medical ethics were not violated when a physician performed an abortion so long as he did so in accordance with "good medical practice" and did not violate any state laws.[115] While some of this discussion suggested that the court was influenced by its concern over the familial effects of unwanted children, the difficulties faced by unwed mothers, the suffering that may accompany physical or mental disability of a "defective" child, the health of the mother, and the weight of the opinion of the medical community, the overriding issue driving the courts decision was personal autonomy. Although the court stated that the right to terminate pregnancy was not absolute, but subject to "important [state] interests in safeguarding health [of the woman], in maintaining medical standards, and in protecting potential life", the suggested limitations are illusory to the extent they would place any effective limitation on a woman's autonomy as it relates to abortion. Health concerns and medical standards do not limit that autonomy. They merely protect her from various dangers in a manner similar to those which a state may impose

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[113] Ibid at 153, 93 S.Ct. at 727.

[114] Ibid at 142, 93 S.Ct. at 721.

[115] Ibid.

on the performance of cosmetic surgery to "improve" physical appearance or virtually any other medical procedure. As for the interest of protecting potential life, the accompanying decision of *Doe v. Bolton*[116] made it clear that *any* proposed limitation on abortion would have to yield in the face of a woman's claim that pregnancy impacted on her "well being", defined as "all factors – physical, emotional, psychological, familial, and the woman's age".[117] Although not directly mentioned in *Doe*, that decision, taken in tandem with *Roe*, left little doubt that the factors would also include marital status, financial circumstances, or any other concern by which a pregnant woman could assert her personal autonomy as superior to any opposed interest, including the protection of what is oddly referred to as "potential life".[118] Indeed, no one seriously questions today that the right of a woman to abort her unborn child at any stage of pregnancy and at any stage of viability, is mandated by the *Roe-Doe* duo. Indeed, a requirement that a woman explain her reason for seeking an abortion, or even particularize it, would likely be held to violate the "liberty" now recognized to terminate pregnancy. While a woman may find it difficult to locate a medically qualified practioner who would accommodate a wholly arbitrary or malicious decision to abort a nearly full term unborn child, there is no question but that *Roe* and *Doe* establish her right to do so. The essential element of *Roe* by which all else then followed was the critical holding that unborn life in the womb is not a constitutional "person". Obviously, if the unborn child is a "person" for constitutional purposes, the mother could be constitutionally prohibited from killing it, just as the state may prohibit murder of those born. In fact, a compelling case can be made that the state would be obliged to do so since equal protection of persons is mandated by

[116] 410 U.S. 179, 93 S.Ct. 739 (1973).

[117] Ibid at 192, 410 S.Ct. at 747.

[118] The *Roe* Court, and courts since, typically use of the term "potential life" when referring to unborn children.

the fourteenth amendment. Thus the overwhelming significance of the court's holding that the term "person" as used in the constitution had no "prenatal application".[119] That was the final step in the declaration, albeit with a wink and a nod[120], that a pregnant woman possessed an unqualified right to kill her child.

Subsequent case law confirmed the extreme reach of *Roe* and the depth to which the philosophy of the autonomous self has penetrated constitutional jurisprudence. In *Planned Parenthood of Central Missouri v. Danforth*[121] the court held that a woman can not be required to obtain the consent of her husband for an abortion,[122] nor could a minor be required to obtain the consent of her parents or even notify them that she was pregnant.[123] The individual right proclaimed in *Roe* thus denied the father any compulsory legal means to protect his child from execution and vested in children as young as early puberty the power to judge so fundamental a question without advice of parents, much less their supervision.

In *Casey v. Population Services International*[124] a startling development in the cultural landscape went largely unnoticed. The case held that distribution of non-medical contraceptives to persons under the age of sixteen years is constitutionally protected.[125] While the notion that

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[119] Ibid at 157, 93 S.Ct. at 729.

[120] Justice Blackmun's majority opinion actually claimed that the right it recognized to terminate pregnancy was a limited right and was not an unqualified right of abortion on demand. However, given the impact of *Doe* and the subsequent development of abortion jurisprudence, that assertion has proved illusory.

[121] 428 U.S. 52, 96 S.Ct. 2831 (1976).

[122] Ibid, 96 S.Ct. at 2840-42.

[123] Ibid, 96 S.Ct. at 2842-44.

[124] 431 U.S. 678, 97 S.Ct. 2010 (1977).

[125] Ibid, 97 S.Ct at 2019-2022.

provision of contraceptives to minors is constitutionally protected may strike some as an obvious corollary to the court's earlier holding that minors hold a constitutional right to abort, the truly astounding development – and one pointing to the extreme individualism driving both cultural norms and judicially sanctioned radical autonomy – was the court's failure to clearly and explicitly reject the claim by Population Services International that a state policy to discourage sexual activity by minors is itself unconstitutional. While the court assumed that state regulation of sexual activity by minors extends beyond the scope of similar authority over adults, it held that its conclusions in the case did not require it to resolve that question[126] and it did not. That apparent unease over the truly radical argument advanced by Population Services International that minors hold a constitutional right to engage in private consensual sexual activity is particularly strange in view of the courts citation to other cases[127] in which it held that state regulation of "conduct" by children "reaches beyond the scope of its authority over adults".[128] It would have been a simple matter to declare that minors, other then those married with parental consent,[129] do not hold a constitutional liberty to engage in sexual intercourse. Failing to so hold leaves open the possibility that minors do, in fact, have such a liberty interest. If that is the case,

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[126] Ibid, 97 S.Ct. at 2021, fn 17.

[127] *Prince v. Massachusetts*, 321 U.S. 158, 64 S.Ct. 438 (1944); *Ginsberg v. New York*, 390 U.S. 629, 88 S.Ct. 1274 (1968)

[128] *Carey*, supra, 97 S.Ct. at 2020, quoting *Prince v. Massachusetts*, supra, 64 S.Ct. at 444.

[129] Most states set a minimum age for marriage. Some allow a minor as young as fourteen to marry provided parental consent is obtained. Connecticut requires parental consent of any child under the age of eighteen and the consent of a probate judge in the case of a minor under the age of sixteen. Conn Gen Stat. sec. 46b-30. No other minimum limitation is established. Presumably, so long as a probate judge agrees, there is no legally established minimum age in Connecticut. When *Carey*, supra, was decided by the Supreme Court, New York state permitted a girl as young as fourteen to marry with the consent of her parents and a family court judge. N.Y.Dom.Rel. Law sec. 15-a, 15(2), 15(3) (McKinney 1964 and Supp. 1976-77).

many laws prohibiting sexual activity between minors and adults may be open to constitutional attack. I do not suggest that they are, in fact, in danger of being declared unconstitutional. However, the court's failure to definitively answer the question evidences either a hesitancy to limit radical individual autonomy, or the equally troubling prospect that the proposition lacked a sufficient number of votes among the nine justices who by this stage in constitutional development had morphed into a kind of supra legislative oversight committee, striking down legislation it deemed offensive to it's elitist social agenda.[130]

Another example of the extremes to which some members of the Supreme Court have been wont in matters of individual autonomy is represented by Justice Marshall's dissenting opinion in *Beal v. Doe*.[131] That case merely held that government funds need not be allocated to pay for non-therapeutic abortions for poor women, although they could be so allocated if a particular government entity so decided. The case in no way restricted the right to abortion declared in *Roe*. In response, Justice Marshall revealed an underlying attitude of racial motivation, "quality of life" ethic, class hostility, and a bizarre understanding of logic:

> The enactments challenged here brutally coerce poor women to bear children whom society will scorn for every day of their lives. Many thousands of unwanted minority and mixed-race children now spend blighted lives in foster homes, orphanages, and "reform" schools. Many children of the poor, sadly, will attend second-rate segregated schools. And opposition remains strong against increasing Aid to Families with Dependent Children benefits for impoverished mothers and children, so that there is little chance for the children to grow up in a decent environment. I am appalled at the ethical bankruptcy of those who preach

[130] Justice Scalia has perceptively identified this development as the emergence of "the mullahs of the west." See *Once Again, Scalia's the Talk of the Town,* The Washington Post, April 15, 2006, p. A02.

[131] 432 U.S. 438, 97 S.Ct. 2366 (1977)

> a "right to life" that means, under present social policies, a bare existence in utter misery for so many poor women and their children.[132]

Any notion that radical autonomy was not the goal of this line of cases was put to rest with the 1992 decision in *Planned Parenthood of Southeastern Pennsylvania v. Casey.*[133] Appealing to the nation to put the abortion controversy behind it, Justice O'Connor stressed that the court's prior "privacy" decisions afford "constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing and education."[134] Abortion, like other issues confronted by the court's privacy jurisprudence, concerned matters "within the zone of conscience and belief"; is "too intimate and personal" for government regulation; involves "intimate relationships"; has a "deep, personal character"; and touches on matters of "personal autonomy and bodily integrity".[135] Justices Blackmun and Stevens, writing separate concurring opinions, used similar language, holding that abortion was one of the "most intimate and personal choices"; "central to personal dignity and autonomy"; an "empowering decision"; and a choice "basic to human dignity".[136] In a breathtaking passage more akin to psychology than constitutional analysis and striking for its unabashed assertion of the most radical notions of individualism, Justice O'Connor declared for the court:

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[132] Ibid, 97 S.Ct. at 2396. The implication of Justice Marshall's logic is that children of poor minority women are better off dead because they will either live in difficult material circumstances, go to second rate segregated schools or live in a foster home. The logic between premise and conclusion is difficult to follow, but it certainly has its roots in a "quality of life" ethic that assumes some lives are just not worth living. Indeed, there seems no other way to read his ethically and logically challenged attack on "right to life" proponents.

[133] 505 U.S. 833, 112 S.Ct. 2791 (1992).

[134] Ibid, 112 S.Ct. at 2807.

[135] Ibid, 112 S.Ct. at 2807-2811.

[136] Ibid 112 S.Ct. at 2840, 2844, 2846.

> These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. ***At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life.*** Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State. ...
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> Abortion is a unique act. It is an act fraught with consequences for others: for the woman who must live with ***the implications of her decision***: for the persons who perform and assist in the procedure: for the spouse, family, and society which must confront the knowledge that these procedures exist, procedures some deem nothing short of an act of violence against innocent human life; and, depending on one's beliefs, for the life or potential life that is aborted. ...[T]he liberty of the woman is at stake in a sense unique to the human condition and so unique to the law. The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear. ... ***The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives*** and her place in society.[137]

It is clear that the emotionally driven concepts behind radical individual autonomy now rule the land. Justice Scalia observed as much in his dissent when he noted the majority's heavy handed use of emotionally laden terms such as "zone of conscience", "personal autonomy" and "intimate relationships" to sustain a constitutional right to abortion. Those same expressions could apply with equal validity to "homosexual sodomy, polygamy, adult incest, and suicide, all of which are equally "intimate" and "deep[ly] personal" decisions involving "personal autonomy and bodily integrity," and all of which can constitutionally be proscribed because it is our unquestionable constitutional tradition that they be proscribable."[138] Of particular interest was

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[137] Ibid 112 S.Ct. at 2807 (emphases added)

[138] Ibid, 112 S.Ct. at 2876. Subsequent case law has witnessed the unrelenting "great march" of the court's sexual libertinism. In 2003 the court pulled one of Justice Scalia's tripartite example by overruling prior case law that recognized the competence of the state police power to prohibit homosexual sodomy. See footnotes 147 to 150, infra, and accompanying text. The mullahs simply changed their minds (something known to accompany a change in the membership of the court)

Justice O'Connor's striking admission that "in some critical respects the abortion decision is of the same character as the decision to use contraception. ...[F]or two decades of economic and social developments, people have organized intimate relationships and made choices that define their views of themselves and their places in society, in reliance on the availability of abortion in the event that contraception should fail."[139] Her opinion on this point was offered in view of wide public acceptance of contraception and was intended, no doubt, to suggest broad public acceptance of abortion. One may argue that the similarity in character between the abortion decision and the decision to use contraceptives actually exposes the malice and narcissism that drove the *Griswold* decision and the idea of radical personal autonomy it enshrined.[140]

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[139] Ibid, 112 S.Ct. at 2807.

[140] Perhaps the finest analysis of the link between abortion and contraception is presented by Janet Smith in her commentary following Justice O'Connor's acknowledgement of the link in *Planned Parenthood v. Casey*:

> The Supreme Court decision has made completely unnecessary any efforts to "expose" what is really behind the attachment of the modern age to abortion. As the Supreme Court candidly states, we need abortion so that we can continue our contraceptive lifestyles. It is not because contraceptives are ineffective that a million and a half women a year seek abortions as back-ups to failed contraceptives. The "intimate relationships" facilitated by contraceptives are what make abortions "necessary". "Intimate" here is a euphemism and a misleading one at that. Here the word "intimate" means "sexual"; it does not mean "loving and close." Abortion is most often the result of sexual relationships in which there is little true intimacy and love, in which there is no room for a baby, the natural consequence of sexual intercourse. Contraception enables those who are not prepared to care for babies, to engage in sexual intercourse; when they become pregnant, they resent the unborn child for intruding itself upon their lives and they turn to the solution of abortion.
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> ...
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> We have lived for about thirty years with a culture permeated with contraceptive use and abortion; no longer can we think that greater access to contraception will reduce the number of abortions. Rather, wherever contraception is more readily available the number of unwanted pregnancies and the number of abortions increases greatly.
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> The connection between contraception and abortion is primarily this: *contraception facilitates the kind of relationships and even the kind of attitudes and moral characters that are likely to lead to abortion.* The contraceptive mentality treats sexual intercourse as though it had little natural connection with babies; it thinks of babies as an "accident" of pregnancy, as an unwelcome intrusion into a sexual relationship, as a burden.

Two years before *Planned Parenthood v. Casey*, the court had assumed a right on the part of Nancy Cruzan to the removal of assisted feeding. Other cases around the country were more explicit. In Connecticut, the state Supreme Court held that patients had a common law right to refuse medical care and the majority explicitly recognized a constitutional right to refusal of care, relying on *Griswold*, *Roe* and the related line of cases.[141] It was not long until the court was

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Professor Smith's insights are entirely consistent with those offered by John Paul II. In addressing a group of Bishops on the teaching of *Humanae Vitae* he stated: "The invitation to contraception as a supposedly 'harmless' manner of the relation between the sexes is not only an insidious denial of man's moral freedom. It fosters a depersonalized understanding of sexuality which is restricted mainly to the moment and promotes in the last analysis that mentality out of which abortion arises and from which it is continuously nourished." In *Evangelium Vitae* John Paul noted that the pro-abortion culture is particularly strong wherever the Church's teaching on contraception is rejected. "[C]ontraception and abortion are often closely connected, as fruits of the same tree."

Professor Smith's article, *The Connection between Contraception and Abortion,* can be accessed online at www.goodmorals.org/smith4.htm. The Holy Father's comments and many more of a similar character may be reviewed in *Contraception and Abortion*, www.armyofgod.com/Contraception1.htm1.

[141] *McConnell v. Beverly Enterprises-Connecticut, Inc.*, 209 Conn. 692, 699-702. This case merits additional comment if only because it demonstrates the confusion that can enter into discussion concerning end of life care and the terminally ill. Terminal illness is a broad term. It may mean a short illness or a lengthy one. One thing is clear: it does not apply to the definition of a PVS patient without more. Certainly a PVS patient may be terminally ill, but that is not part of the PVS diagnosis. Recall that Karen Quinlan and Nancy Cruzan were both PVS. Neither was terminal. When *McConnell* reached the Connecticut Supreme Court, Carol McConnell had been PVS for four years. The court noted that the majority of courts confronted with similar cases had held that a PVS patient has a constitutional right "to the removal of medical treatment that artificially prolong[s] life". Id. at 702. The court cited *Quinlan* and several other cases to support that assertion. However, in a footnote, it cited two cases that refused to "sanction the removal of artificial nutrition and hydration, including *Cruzan v. Harmon*, the state court decision which, on appeal, became the U.S. Supreme Court decision in *Cruzan v. Director, Missouri Dept. of Health of Health*, 110 S.Ct. 2841 (1990), which is discussed in more detail at footnotes 74-83, supra, and accompanying text. The Connecticut Supreme Court then declared that the state court decision in *Cruzan* and another case were "distinguishable because, contrary to the present case, neither patient was terminally ill." 209 Conn. at 702, fn. 10. However, that rational is senseless. Carol McConnell was in the same PVS condition as Nancy Cruzan. Neither was "terminal" in the sense that they had an underlying illness that was going to kill them. If they died, as they both eventually did, it would only be through starvation when their feeding was stopped. What is truly disturbing is the manner in which words can be manipulated. "Terminal" in Connecticut was held to apply to a PVS condition, because the treating physician said the patient was terminal. But the only condition leading to that conclusion was PVS. It was a label that fit convenience. One of its sinister results may be discernable from the concurring opinion of Justice Healey. He would have held that Ms. McConnell had a "right to refuse medical care in the form of extraordinary nutrition and hydration..." and that "McConnell's expressed desires, when she was competent to exercise that common law right, were to refuse such extraordinary medical care under her current condition." Id. at 715-16. Justice Healey plainly concluded that assisted nutrition and hydration constitute extraordinary care. But assisted nutrition and hydration to PVS patients is not *ethically* extraordinary care. If, as it is reasonable to assume, Justice Healey was referring to *the means* by which McConnell was given food and fluids (e.g. tube feeding), one can understand how he concluded that it was *unusual*. But unusual does not constitute extraordinary. Extraordinary

obliged to explore the scope of Justice Scalia's warning in his dissent in *Planned Parenthood v. Casey*. The challenges came in assisted suicide and homosexual sodomy cases.

In 1996 the United States Ninth Circuit Court of Appeals in San Francisco decided *Compassion in Dying v. State of Washington*.[142] Relying on the extraordinary language of *Planned Parenthood v. Casey* and the Supreme Court's earlier decision in *Cruzan*, the Ninth Circuit held that assisted suicide for the terminally ill was a constitutionally protected liberty.[143] The Supreme Court reversed the Ninth Circuit's truly reckless and imprudent approach and held that assistance in suicide is not a constitutionally protected liberty.[144] At least for now. Several justices explicitly left open the possibility of revisiting the issue after allowing for individual state experimentation with assisted suicide laws at the legislative level.[145] Such experimentation is now underway. In Oregon, physician assisted suicide was adopted by state referendum in 1994. Similar efforts have failed in Maine and California, but did manage to garner forty six percent of the vote.[146] Proposals have been introduced in state legislative committees nationwide and have met with various levels of success. Physician assisted suicide is an issue that, for the present, seems committed to the individual states' political process, much as Justice Scalia advocated in

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care relates not to the means used as being atypical or uncommon, but as *morally* extraordinary. Further discussion of this issue is found at footnotes 230 - 248, infra, and accompanying text.

[142] 79 F. 3d 790 (1996)

[143] Ibid at 816.

[144] Washington v. Glucksberg, 521 U.S. 702, 117 S.Ct. 2258 (1997).

[145] Id at 2293 where Justice Souter plainly states: "While I do not foreclose for all time that respondants' claim should not be recognized, I acknowledge the legislative institutional competence as the better one to deal with that claim *at this time*." (emphases added).

[146] See Cheryl Smith, What About Legalized Assisted Suicide, 8 Issues In Law & Med. 503 (1993).

his concurring opinion in *Cruzan* for the so-called "right to refuse treatment". But the assisted suicide case did not mark the end of the court's extension of autonomy based individualism as constitutional doctrine.

In the summer of 2003 the court released its decision in *Lawrence v. Texas*[147] striking down a state criminal law prohibiting homosexual sodomy. Although the court did not expressly state that homosexual sodomy was a fundamental liberty on par with its recognition of abortion and contraception, its rationale produced the same result. Apparently recognizing that the traditions and history of the nation did not support the creation of a new fundamental liberty, the court relied instead on what it claimed was the emergence in the last fifty years of a new "awareness" that sexual choices should be left free from state interference. From that foundation the court reasoned that there was no legitimate state interest advanced by criminalizing same sex sodomy. That reasoning is extremely troubling and dangerous. The obvious state interest is a moral judgment on homosexual conduct. The court appears to reject that as a legitimate basis for state regulation. If that is so, the question immediately arises as to whether adult consensual incest, polygamy, bigamy, prostitution, consensual sex between adults and minors, adultery, or fornication can be prohibited.[148] Clearly, the answer is "no" with respect to fornication. Given

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[147] 539 U.S. 558, 156 L.Ed 2d 508 (2003).

[148] This is precisely the point made by Justice Scalia in his superb dissenting opinion. Just in case one thinks the point is too extreme a criticism, it is useful to ponder the sexual mores of other traditions, such as Islam, which are rapidly increasing in the United States. Muslims have no cultural or religious objection to polygamy. Muhammad himself contracted multiple marriages, one to a child of six with whom he consummated the relationship when she was nine years old. More recently, the Ayatollah Khomeini married a ten year old when he was twenty-eight. She was pregnant by age eleven. In Iran, the legal minimum age for a girl to marry is nine. A recent attempt to raise the age to fourteen was successfully vetoed by a legislative oversite committee controlled by traditional clerics. See Robert Spencer, *Islam Unveiled*, Encounter Books, pp. 46-49. If the *Lawrence* decision is ultimately extended to prohibit legislatively imposed moral choices based upon history and tradition, which is precisely the kind of legislative choice that *Lawrence* proscribes, it is difficult to see how practices common to other traditions can be

the court's reverence for autonomy in all things sexual, there appears no rational way to distinguish the other categories of conduct. Same sex marriage appears unavoidable given the rationale of the case, despite protests from some members of the majority to the contrary. What is truly significant for the purposes of our analysis is the court's assertion that a moral judgment by Texas as to the wrongness of homosexual acts could not constitute a legitimate state interest sufficient to ban such conduct. The court appears to have reached that conclusion without expressly finding homosexual sodomy to be a "fundamental liberty" protected by the due process clause.[149] Rather, it held that there is no rationality behind a legislative judgment outlawing such

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precluded, such as those now and long current in the Islamic tradition. It is no reply to assert the immaturity of a child bride or the lack of her true consent – that it merely one more expression of a culturally determined norm. If an early menstruating child of eleven holds a constitutional liberty to abort without parental consent *or even notice*, as current jurisprudence holds, how may a state rationally prohibit her from marrying? Indeed, the question goes further: why should her freedom of sexual expression be limited by marriage? Perhaps we are approaching the point where the question *Carey v. Population Services International* dodged must be answered: do minors have a constitutional right to engage in sex, even in the face of parental instruction to the contrary?

[149] The case is not entirely clear on this point, although Justice Scalia's dissenting analysis that the case does not create a "fundamental liberty" to engage in sodomy is not challenged by the majority. The majority opinion makes no express holding that the due process clause protects sodomy as a "fundamental liberty". That is not to say that sodomy does not constitute a form of "liberty", generally understood as something one is capable of doing, just as trout fishing, bank robbery and ear piercing constitute "liberty", generally understood. In American jurisprudence, liberty, as a general category, is subject to governmental limitation that has a "rational basis". Rationality does not require perfection or even wisdom, but merely a rational nexus between the regulatory aim and the means chosen. The existence of other less intrusive means or more efficient choices does not invalidate rational, albeit imperfect, legislation. However, "rational basis" is not the standard applied to "fundamental liberties". When the liberty interest implicated by legislative or administrative regulation is deemed "fundamental", the governmental interest advanced must be "compelling" and the means chosen by the state to advance it must be carefully tailored to avoid unnecessary intrusion upon that "fundamental liberty". The majority in *Lawrence* did not claim this stricter standard, but merely concluded that the "Texas statute furthers no legitimate state interest." This would suggest that the constitutionality of the Texas statute was measured against the "rational basis" test. However, the court also discussed the nature of the homosexual relationship (and the liberty of each person to determine their own concept of meaning and relationship) as the real target of the legislation and may have been sowing the seeds of a newly protected group classification. Justice Scalia also renewed his critique of the majority's use of this "sweet-mystery-of-life" rationale, a critique he raised in dissent in *Casey v. Planned Parenthood of SE Penna.* His point is that the Constitution is silent about sodomy, abortion and many other topics recently and currently at issue in the great cultural struggles of modern society. In such matters the court should limit strict scrutiny interventions to "fundamental liberties", which in turn are limited to realities deeply rooted in the nation's traditions. Otherwise the Court – and the nation - will be subject to the latest social theories advanced by any then current five justice majority. Witness *Lawrence,* which amounts to little more than judicial imposition of a social theory more properly vested in legislative bodies.

conduct, thereby effectively dismissing communal moral decisions as a valid basis for legislative action in matters related to sex.[150] If that is so, and if the autonomy in matters related to sex is really an autonomy related to the body, as I believe the court's rationale compels, then to the extent state legislation may seek to advance a moral judgment that suicide is wrong or that starvation of a PVS patient is wrong, that judgment may be insufficient to proscribe such conduct. We have surely not heard the last judicial word in the cultural war over what lives are worth living and worth protecting.

In summary, it may be said that the law recognizes a common law right to refuse unwanted medical treatment. That right appears to be constitutional teaching as well, in light of *Cruzan.* For the present, physician assisted suicide is committed to the legislative process pursuant to *Washington v. Glucksberg.* The rational behind *Lawarence* may drive a further development prohibiting states from criminalizing suicide, and may place in doubt a wide array of laws

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[150] As referenced in the preceding footnote, Justice Scalia pointed out that the majority did not expressly find homosexual sodomy to be a constitutional liberty interest on par with fundamental liberties such as freedom of speech or the right to petition government for the redress of grievance – or the abortion and contraception rights established by the holdings in *Roe, Casey* or *Griswold.* His observation is keen, since the majority relied on rational relationship analysis The decision may be on a trajectory more akin to *Griswold,* where the Court pointed to various Constitutional Amendments without expressly finding a right of privacy in any one of them, only to arrive in later cases, such as *Planned Parenthood v. Casey,* at the conclusion that privacy is a fundamental "liberty" interest protected by the due process clauses of the Fifth Amendment (with respect to federal legislation) and the Fourteenth Amendment (with respect to individual State's legislation). The *Lawrence* holding may be destined to be further refined by an express declaration of "fundamental liberty". In this respect, Justice Scalia's dissent in *Lawrence* is much the same as Justice Stewart's dissent in *Griswold.* Both exposed the methodology of results driven jurisprudence. In each the court was determined to get its way, regardless of merit. Justice Thomas, in his brief one hundred and fifty word dissent in *Lawrence,* invoked Justice Stewart's *Griswold* dissent directly, quoting from it three times and invoking precisely that passage which rejected a general right of privacy not textually included in the Constitution and expressing the obligation of a Supreme Court Justice to "decide cases 'agreeably to the Constitution and the laws of the United States" rather then present personal opinion as constitutional doctrine. 156 L.Ed 2d at 543. See footnote 107, supra, for a discussion of Justice Stewart's dissent in *Griswold.* The alternative is a bracketing of *Lawrence* as a "one way ticket" that will not be applied to other legislation governing sexual activity nor receive any further attention beyond that already expressed in the majority opinion. That view was expressed by Justice Scalia in response to a question from this author at his address to the Hartford Connecticut chapter of the Federalist Society on April 11, 2006.

regarding morality based criminal laws related to sexual activity, although it remains to be seen how far the court will allow notions of radical individual autonomy to expand.

Along side judicial developments, state and federal legislative actions have helped identify the specific means by which certain rights associated with bodily integrity and health care are exercised by persons who lose decision making capacity, either by agent or proxy, through an advance directive like a "living will", or by the appointment of a guardian who may act on behalf of the patient to enforce the patient's own wishes. In addition, some courts recognize the concept of substituted judgment.[151] The substituted judgment doctrine provides that medical choices made on behalf of those incapable of informed decision making, including decisions to accept or refuse medical care and treatment, are to reflect the choice the patient would have made if able to express his wishes. It is not an objective "reasonable person" standard which judges what most people in similar circumstances would do. Rather, the critical inquiry is subjective: what would this particular patient have desired. However, as the *Quinlan* case and the often cited *Superintendent of Belchertown v. Sainkewicz*[152] demonstrate, the line between the two can be murky, subject to the "quality of life" ethic so prevalent today. Recall that in *Quinlan*, the court, in the absence of any evidence of Karen Quinlan's own preferences, decided that it would defer to her father's election to withdraw ventilator support if the doctors agreed that there was no hope of improvement or recovery from her non-cognitive condition. The inquiry into the patient's subjective choice turned into an application of the court's preconceptions about the meaning and purpose of being.

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[151] An extensive discussion of the substituted judgment standard can be found in *Superintendent of Belchertown v. Saikewicz*, 370 N.E.2d 417, 427-432 (1977). This was also the standard applied in the *Quinlan* case.

[152] 370 N.E.2d 417 (1977).

Cultural trump played an arguably greater role in *Superintendent of Belchertown*. The patient there was not PVS, but mentally retarded and unable to make informed medical decisions. He also had acute myeloblastic monocytic leukemia.[153] Chemotherapy was the treatment of choice and there was mixed evidence as to how effective it would be. If chemotherapy was provided, the patient would initially feel sicker from the treatment. The undisputed testimony was that most patients opt for treatment and its side effects rather then accept the death sentence of the illness.[154] However, because the patient was conscious and cognitive, albeit with an I.Q. of ten and a mental age of two years and eight months[155], the court concluded that the patient should not be treated. The reasoning was that the mental limitations on the patient were such that he would not understand what was happening to him, he would be frightened by it, he would experience the side effects without comprehension, the treatment was of uncertain value, and he would have only a limited quality of life if the treatment was successful.[156] Since the patient could not make a choice, the court was deferring to the choice of a Probate Court appointed guardian *ad litem*, which means that a third party was exercising "substituted judgment" as to the best interests of the patient, with the ultimate objective of trying to determine the patient's preference or, if not discernable, his best interests. The guardian could have opted for treatment and his judgment would certainly have been respected. What is clear is that the prejudices of the guardian, strongly supported by the court, drove the decision. Substituted judgment turned out to be more about

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[153] 370 N.E.2d at 419.

[154] Ibid at 421.

[155] Ibid at 420.

[156] Ibid at 430 – 35.

third parties' opinions than the desires of the patient. Nevertheless, as a general matter, a substituted judgment rule is the best guardian of respect for patient wishes. It is, however, no guarantee. The tenderness about which Flannery O'Connor warned has long been mainstream; it is the rare legal opinion that states it so plainly. The patient died about two months after the trial court refused treatment. The appellate court asserts that he died from pneumonia, a complication of his leukemia, "without pain or discomfort", noting that it was so advised in the briefs of the parties to the case.[157]

B. Selected Legislative Developments in Health Care Autonomy

Every state now recognizes advance medical directives. Some have passed specific legislation on the matter, ranging from durable power of attorney, living will, appointment of health care agent, attorney-in-fact for health care decisions, and conservator in the event of future incapacity.[158] Others have recognized the common law and constitutional right to direct medical intervention on one's body by advance declaration through court decisions. All share certain characteristics, such as a policy of promoting individual choice, recognition of a "quality of life" ethic, the availability of written advance directives and the like. The federal Patient Self

[157] Ibid at 422. Of course, briefs of parties who were involved in the decision to allow a mentally retarded person to die from leukemia related complications are unlikely to report a painful death. It is striking that the court felt the need to assert this point at all, but "popular pity" demands its own consolations. The fact remains that the patient's death was "elected" and whether it was painless has never been subjected to cross examination or independent analysis. In such circumstances, the court should have refrained from its "without pain" comment. It simply could not know if the statement was true.

[158] Connecticut has passed legislation covering each of these possibilities. See Conn. Gen. Stat. sec. 17a-570, et. seq. and 45a-562.

Determination Act requires that all medical facilities that receive federal reimbursement through Medicare or Medicaid provide all new admittees with a description of the rights available to the patient to maintain control over the medical treatment decision making process, including the opportunity to sign any advance directive or to make any appointment provided for in the law of the particular jurisdiction. These laws are often complex and demanding. The terms and definitions used in the acts and their interpretation in case law is so varied and confusing that few sweeping generalizations can be made.[159] While it is beyond the scope of this paper to do an exhaustive analysis of each state, a number of typical examples demonstrate the point.

Alabama defines "terminally ill or injured patient" as anyone whose "death is imminent or whose condition, to a reasonable degree of medical certainty, is hopeless unless he or she is artificially supported through the use of life-sustaining procedures,[160] while "life-sustaining treatment" is defined to include administration of drugs and antibiotics, as well as surgery, blood transfusions, renal dialysis, assisted ventilation, and cardiopulmonary resuscitation.[161] Artificially provided nutrition and hydration is limited to the administration of food or water through a tube or intravenous line and *expressly excludes* assisted feeding, such as by bottle or spoon and any feeding requiring the patient to voluntarily chew or swallow .[162]

Contrast those terms with Connecticut where "terminal condition" means the final stage of an incurable and irreversible medical condition which will result in death within a relatively short

[159] An excellent discussion of the use of language to manipulate results in this context is *Words, Words, Words* by Rita Marker and Wesley Smith, www.internationaltaskforce.org/fctwww.htm. The website contains excellent, well researched, and well reasoned articles on euthanasia, assisted suicide and the cultural forces driving the international "culture of death".

[160] Alabama Code sec. 22-8A-3 (14)

[161] Ibid, subsection (8)

[162] Ibid, subsection (2)

time, unless life support systems are used.[163] Life support systems are then defined to include any procedure or treatment that would only postpone the moment of death, including artificial means of providing nutrition and hydration.[164] Alabama defines terminal in terms of imminent death *or* hopelessness absent medical intervention. Connecticut defines it in terms of the "relatively short time" until death, absent intervention. Alabama also treats artificial nutrition and hydration differently than Connecticut. Whereas Connecticut simply defines it as another life support system, Alabama excludes any notion that spoon or straw feeding is included, as well as feeding that requires the patient to chew or swallow.[165]

Texas defines "terminal condition" as an "incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care."[166] Virginia also defines "terminal condition" as a condition caused by injury, disease, or illness but limits its application to persons whose "death is imminent", rather than "within six months", or, as in Connecticut, "within a relatively short time

Many states provide a model or form directive in legislation. Usually the form is vague, biased toward the withholding or withdrawal of treatment, or offers insufficient flexibility. For example, Hawaii's form "Declaration" provides for one of two options with respect to artificial nutrition and hydration for terminally ill or permanently non-communicative persons. The

[163] C.G.S. sec. 19a-570 (3)

[164] C.G.S. sec. 19a-570 (1)

[165] Connecticut defines artificial nutrition and hydration in terms of "mechanical or electronic devices" that provide same. That may appear to preclude withholding food or fluids by spoon or straw. However, the definition is immediately preceded by the phrase "including but not limited to" which suggests a possibly broader interpretation.

[166] Texas Natural Death Act, Health and Safety Code, sec. 166.002 (13).

choices are: "I do not want my life prolonged by tube or other artificial feeding or provision of fluids by a tube" or "I do want my life prolonged" by those means.[167] The problem with the black or white decision is that specific circumstances may warrant one election whereas other circumstances may warrant a different choice. The lack of sufficient flexibility is a result of an ingrained problem with advanced directives. They attempt to address future circumstances that require individualized factual analysis that very often cannot be adequately analyzed until the facts actually arise. Connecticut's statutory form living will provides for the withholding of life support systems unless the person signing it elects to check off certain pre-selected categories of care that are listed in the document. They include "cardiopulmonary resuscitation", "artificial respiration", "artificial means of providing nutrition and hydration" or "other specify" followed by blank lines. This means that unless a person signing the statutory form living will in Connecticut actually writes out "antibiotics" or "dialysis" or "surgery" or some other particular kind of treatment or care in the "other specify" section, that care will not be provided. This is obviously biased toward the termination of care. Connecticut's statute is also confusing, so much so that the Office of the Attorney General of the State of Connecticut has posted forms on its website that, in at least one respect, do not conform to the statute.[168] Some states mandate that a

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[167] Hawaii HRS sec. 327D-4.

[168] The Attorney General's form of advance directive that combines living will, appointment of health care agent, appointment of attorney-in-fact for health care decisions, and appointment of conservator in the event of future incapacity specifically separates the powers of the health care agent and the attorney-in-fact for health care decisions and document of anatomical gift. The former is authorized only to convey the principal's wishes about the withholding or removal of life support systems and to take action to give those wishes effect. The latter is authorized to exercise judgment about what health care interventions are to be provided or refused. The Attorney General's Question and Answer page on health care decisions confirms that distinction. However, the statutorily provided advance directive form for the same combination of instruments, found in Conn. Gen. Stat. sec. 19a-575a, does not make that distinction. Another statutory form for appointment of a health care agent (Conn. Gen. Stat. sec. 19a-577) does limit the health care agent's role in a manner similar to the Attorney General's form. The Attorney

statutory form document be used or that any other form be substantially in conformity with it. Other states expressly provide that an advance directive may be in any form the maker desires. Given the constitutional basis of the right to direct one's own health care and provisions in state laws requiring physicians to consult any source available in order to determine a patient's wishes, it is questionable if variance from a mandated form would typically be of any significant consequence in determining a patient's actual intent

One concept common to many statutory schemes is that a person who permanently lacks self-awareness or awareness of their environment and/or shows no behavioral response to their environment should be treated as an end stage, imminently dying, terminally ill patient. That follows the medical standard of care which now allows the withholding of nutrition and hydration to PVS persons, who then starve to death or expire sooner from the withholding of antibiotics or the negative effects on other body systems and functions from the lack of nutrition or hydration. This is so regardless of the likelihood that the person may live many more years. This is a clear endorsement of the ethic, apparent in the *Quinlan* decision and some of the opinions in *Cruzan*, that PVS patients and others who lack cognitive awareness, are pointless. Some states limit advance directives to end of life care issues, whereas some define "living will" to mean a written statement of the "declarant's wishes concerning any aspect of his heath care".[169] Most authorize the removal of feeding tubes, all authorize the withdrawal or withholding of "life-sustaining",

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General's combined instrument form adopts the restrictive usage of the individual health care statutory appointment form, thereby restricting the authority of a health care agent in a manner that the statutory combined form, on its face, does not. In a conversation this author has had with one of the assistant attorneys general who participated in the drafting of the form documents appearing on the Attorney General's website, the difference between the statutory combined instrument form and the Attorney General's combined instrument form was acknowledged and was explained as a corrective to inadequate legislative drafting of the combined instrument form. An interesting question is: whose form controls? The point here is that the legislation offers ample room for confusion.

[169] Conn. Gen. Stat, sec 19a-570(7)

"death-delaying" or "death prolonging" procedures, and some create surrogate appointments, vary the age at which such documents have legal effect, or require extensive advisories in the text of an advance directive highlighting the instrument's dramatic legal effect.

Typically, legislation provides that advance directives become effective when the patient is "incapacitated" or lacks "capacity", which is defined as inability to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment. Some states provide no definition of "capacity", but a fair reading of American case law would find broad support for the expression formulated above.

A critical provision in state "living will" acts is a provision shielding health care providers from any civil or criminal liability should death result from a decision to withhold life sustaining treatment in accordance with a valid advance directive. Colorado's act is typical:

> With respect to any declaration [i.e. a living will] which appears on its face to have been executed in accordance with the requirements of this article:
> ...
> (b) No physician signing a certificate of terminal condition or withholding or withdrawing life-sustaining procedures in compliance with a declaration shall be subject to civil liability, criminal penalty, or licensing sanctions therefore.[170]

Protection from liability, civil and criminal, is arguably the driving force behind living will legislation. A movement claiming its roots in the concept of patient autonomy also functions as a medical industry liability shield. Perhaps the two concepts are mutually dependent; few doctors would act in accordance with a death delivering directive if they could be prosecuted or sued for doing so, although actions in accordance with accepted medical practice would likely provide the same protection without the immunity legislation.

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[170] Colorado Medical Treatment Decisions Act, C.R.S.A. sec. 15-18-110.

A final comment on state legislation concerns the mandatory effect of advance directives. Connecticut provides that a physician "shall consider" the patient's wishes as expressed in an advance directive, but does not require a physician to do any act that would violate professional standards of medical practice.[171] It is unclear if a physician must follow an instruction in an advanced directive that does not violate the usual and customary standards of medical practice[172], although a health care agent or other surrogate may be able to compel that result. In any event, a physician in Connecticut is *always* obliged to try to determine a patient's wishes The statute sets up a hierarchy of documents and persons to consult in the search for that intent:

> If the wishes of the patient have not been expressed in a living will the attending physician shall determine the wishes of the patient by consulting any statement made by the patient directly to the attending physician and, if available, the patient's health care agent, the patient's next of kin, the patient's legal guardian or conservator, if any ... and any other person to whom the patient has communicated his wishes. ... If the attending physician does not deem the incapacitated patient to be in a terminal condition or permanently unconscious, beneficial medical treatment including nutrition and hydration must be provided.[173]

This section of the Act clearly shows the importance of drafting a life protective advance directive.[174] Absent instruction in an advance directive, a physician is going to begin an

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[171] C.G.S. sec. 19a-571

[172] One example may include a directive to remove artificial nutrition and hydration if the patient is PVS. A physician may well have a personal moral objection to removal of the feeding tube. On the other hand, an advance directive may elect for expensive, risky and extremely marginal care, even in the face of last stage terminal illness where death is not imminent. If that election saps scarce resources from other needy patients, a physician may have a well founded moral objection to providing the care.

[173] C.G.S. sec. 19a-571 (a)

[174] Several exist, although those contained in the Appendix to this paper are, in the author's opinion, the best available. Other sources include Advance Directive for Health Care and Treatment and Durable Power of Attorney for Health Care from the Pope John XXIII Center in Braintree, MA. Excellent articles discussing the various issues surrounding end of life care, organ donation, assisted suicide and related topics can be found at the American Life League website, www.all.org. The Union for Traditional Judaism (261 East Lincoln Ave., Mount Vernon, NY) has

examination of secondary sources in order to determine a patient's intent. A spouse, parent, sibling, friend or stranger may provide information impacting on the interpretation of a person's wishes. This points out the necessity of some form of advance directive or appointment of surrogate in order to assure accurate transmission of the patient's wishes. With medical, ethical and moral standards rapidly evolving in undesirable ways, it is critical that appropriate steps be taken to protect against death dealing tenderness. This is particularly important for nursing home and elderly persons without a network of family contacts. No one can safely presume immunity from the culture in which he lives. Friends, family and loved ones may find it difficult to accept another's debilitating condition. Faced with the advice of well intentioned but ethically opposed health care providers, they may elect withholding or withdrawal of life sustaining treatment that is morally obligatory. It is at this point that the critical distinction between morally optional and morally obligatory treatment arises. Before reviewing Catholic teaching in that regard, it will be useful to first explore the Christian understanding of life, suffering and death, since a clear grasp of these realities is critical to understanding the ordinary/extraordinary care dichotomy and its application in the Advance Directives proposed in the Appendix.

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also developed a "Living Will" and a Power of Attorney for Health Care that are life protective. The Ad-Hoc Committee of Americans for the Protection of the Sick, Disabled and Elderly, which includes Msgr. William Smith, S.T.D., an outstanding moral theologian at St. Joseph Seminary in New York, has also developed two Patient Self-Protective Documents, one being Instructions for My Health Care and the other being a Durable Power of Attorney for Health Care. Similar documents have been prepared by the International Anti-Euthanasia Task Force. Another example can be found in the very helpful "Death & Life Issues and Ohio Law on Advance Directives" issued by The Catholic Conference of Ohio in 1992 and revised in 2000. The brief advance directive contained therein is accompanied by a very clear and helpful discussion of what advance directives are, what ethical and moral considerations a Catholic must consider, and provides a glossary of terms and definitions. Its summary explanation of the distinction between morally, as contrasted to medically, ordinary and extraordinary care is excellent.

IV A CHRISTIAN UNDERSTANDING OF THE VALUE OF LIFE AND SUFFERING AND THE MEANING OF DEATH.

A. Human Life

The Christian understanding of the value of life begins in its reality as a creative action of God. That which He has willed is good.[175] The good of life is obviously something to be protected. The fifth command of the Decalogue[176] prohibits killing as well as those things detrimental to the good of life. This is the source of the obligation to care for one's health and body. "Human life is sacred because from its beginning it involves the creative action of God and it remains for ever in a special relationship with the Creator, who is its sole end."[177] Man is created "to the image of God" who set "him over all earthly creatures": a being "able to know and love his creator".[178] He is different from the rest of creation, a being both material and spiritual, and thus "in his own nature he unites the spiritual and material worlds".[179] He is a communion of body and soul. The Second Vatican Council draws the following implication:

> Man, though made of body and soul, is a unity. Through his very bodily condition he sums up in himself the elements of the material world. Through him they are thus brought to their highest perfection and can raise their voice in praise freely given to the creator. For this reason man may not despise his bodily life.

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[175] Gen. 1:31; 1 Tim 4:4-5; Germain Grisez, The Way of the Lord Jesus, Vol 1, *Christian Moral Principles*, Ch. 5, Q. A, p. 115

[176] "Thou shall not kill": Ex. 20:13; see also Deut. 5:17.

[177] Congregation for the Doctrine of the Faith, Instruction, *Donum Vitae*, Introduction 5.

[178] Vatican Council II, *Gaudium et Spes (GS)*, n. 12.

[179] Catechism of the Catholic Church (CCC), section 355.

> Rather he is obliged to regard his body as good and to hold it in honor since God has created it and will raise it up on the last day.[180]

This unity of body and soul is so profound that it must be understood to be a single nature, not two natures merely joined to one another.[181]

Since man's being is itself good and his being experiences itself in a nature which is of essence both flesh and soul, both must be seen as inherently good. Moreover, it is a flesh that is destined to be raised up and, provided communion was maintained between the person and God, to be glorified. The body is then more than an instrumental good by which a person – somehow radically distinct from body – achieves his end.[182] Such a view is dualistic and implies that a "human person or some parts of the human person are one thing and a person's living body is quite another thing."[183] The doctrine of the resurrection exposes the error of dualism ingrained in the instrumental view of bodily life. It supposes that the body merely serves, and that its service is limited to the purpose of making communion with God possible through the manner in which one lives earthly life.[184] That view has the paradoxical effect of risking an over emphasis on

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[180] GS, n. 12.

[181] CCC sec. 365.

[182] The following discussion is drawn from Germain Grisez, The Way of the Lord Jesus, Vol. 1, *Christian Moral Principles*, Chapter 5, Appendix 4: Bodily life a basic human good. His treatment of basic human goods is an invaluable foundation for much of the thought that follows in this section. Similar analysis may be found in William E. May, An Introduction to Moral Theology, pp 68-72, 1994 ed.

[183] Grisez, *Christian Moral Principles*, supra, p. 137.

[184] An example of this can be found in an article by Kevin O'Rourke O.P. and Patrick Norris, O.P., *Care of PVS Patients: Catholic Opinion in the United States*, www.op.org/documcentral/study/kor/pvscare.htm which is taken from the same authors' article published in The Linacre Quarterly 68:3 (August 2001) 201-217. The article is a useful, if slanted, presentation of the instrumentality view of bodily life. The authors state: "If a person does not have the potential for cognitive-affective function ... the person cannot pursue friendship with God, the purpose of life, through his or her free actions. Therefore, the moral imperative to help the person toward health and existence is no longer present..." That view clashes with those who hold bodily life to be an intrinsic good of the human person. The debate between these views is most acute in the case of the PVS patient. The notion that there is no

"acts" and human initiative, while at the same time implicitly devaluing the body as though it is a distinct and severable part of human nature. However, after bodily death man has an intimacy with God before the resurrection in the particular judgment and in the experience of the afterlife. Grisez points out that St. Paul anticipated an incorporeal existence prior to the resurrection. (Phil. 1:20-24 and 2 Cor. 5:2-10). Thus it cannot be successfully argued that bodily resurrection is necessary to the experience of God in the afterlife. That experience will happen before the resurrection of the flesh. Since the resurrected body is not *essential* to the post earthly experience of God, yet is essential to our faith (1 Cor.15:13-26), the significance of the body cannot be its mere instrumental relationship to man's end. Rather, it is essential to the fulfillment of the human

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moral imperative "to help the [PVS] person toward ... existence" clearly exposes the inadequate anthropology of the instrumentality position. A "person" is a not merely a body and the death of the body does not mean that the person ceases to exist. To the extent instrumentalists merely misuse the word "person" when they mean "bodily life before the resurrection", their notion of "person" devalues the body, accepting a dualist view that it somehow secondary or non-essential to the body-soul communion that is a human person. The better view sees that bodily life is an intrinsic good, not merely an instrumentality to an end. Two outstanding moral theologians have offered powerful critiques of Fr. O'Rourke's position and similar positions. See, William May, *Catholic Bioethics and the Gift of Human Life*, p. 255-259 and Germain Grisez, The Way of the Lord Jesus, Vol. 2, *Living a Christian Life*, 524-532. Fr. Francis X. Hinkley of the Archdiocese of Hartford has written a superb doctoral dissertation which thoroughly treats these issues of the PVS patient. It is titled *A Catholic Analysis: The Moral Duty to Provide Nutrition and Hydration to Patients in the Persistent Vegetative State*. A copy has been filed with the library at Holy Apostles College & Seminary in Cromwell, Connecticut.

A March 20, 2004 address by John Paul II has greatly impacted the issue of artificial nutrition and hydration of PVS patients. *Address of John Paul II to the Participants in the International Congress on "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas"*, footnotes 39 and 82, supra. The Holy Father forcefully rejected the analysis advanced by O'Rourke and Norris, specifically noting that the introduction of quality of life judgments in this context necessarily implies that human dignity is relative, "thus introducing into social relations a discriminatory and eugenic principle". Ibid at n. 5.

Most recently the debate between what may be referred to as the "instrumentalists" and the 'integrationists" over the issue of assisted nutrition and hydration of PVS persons reappeared in the Fall, 2005 issue of the National Catholic Bioethics Quarterly. Of particular interest is an article by Rev. Donald E. Henke, *A History of Ordinary and Extraordinary Means*. Fr. Henke collects relevant articles, Papal addresses, and Bishop's Statements in a thoughtful analysis.

person – that is to say, it is an "intrinsic good of human persons"[185], since true human nature demands the intimate union of the material and spiritual as "image and likeness of God".

The duty owed to reverence and nurture the human body is more than a respect for a created thing that is good. That would be much, indeed. But with human life two intersecting lines of thought demand such reverence. The exalted nature of human persons, standing alone above all creation, gifted with an interior life ordered to loving and returning to our Father is one such line. The other is a corollary of the anthropological understanding of man as a body-soul communion: the body is essential to human personhood. Therefore:

> Whatever is opposed to life itself, such as any type of murder, genocide, abortion, euthanasia or willful self destruction ... all these things and others of their like are infamies indeed. They poison human society, but they do more harm to those who practice them than they do to those who suffer from the injury. Moreover, they are supreme dishonor to the Creator.[186]

The teaching that suicide and euthanasia are gravely wrong is well attested by Christian tradition, including the above cited passage from Vatican II, standard texts in moral theology[187], the Catechism of the Catholic Church[188] and magisterial teachings of the Church.[189] Yet, in the face of great suffering and perhaps seemingly hopeless physical decay, combined with the increasing technological ability to preserve bodily life, it is not always easy to determine if a

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[185] Germain Grisez, *Christian Moral Principles*, supra, Ch. 5, Appx. 4, p.137-38.

[186] Vatican II, *Gaudium et Spes*, n.27.

[187] Fr. Heribert Jone, *Moral Theology*, Tan Books and Publishers, Inc. sec. 207, 211; William E. May, *Catholic Bioethics and the Gift of Human Life*, pp. 235-282; Germain Grisez, The Way of the Lord Jesus, Vol.2, *Living a Christian Life*, pp. 477-78, 863.

[188] Sections 2276 – 2283.

[189] CDF, *Declaration on Euthanasia*; John Paul II, *Evangelium Viate*, nn. 64-67.

particular action constitutes a violation of the duty to preserve and nurture life. Suffering and death may cast a dark shadow over joy and judgment alike. It is therefore useful to recall the principles of Christian discipleship as they relate to the experience of suffering and death.

B. Suffering and Death

Jesus did not conceal the role suffering would play in the lives of his disciples. As he made his final journey toward Jerusalem, he responded to the request of the mother of the sons of Zebedee who sought assurance "that these two sons of mine sit one at your right and one at your left in your kingdom"[190], by asking James and John: "Are you able to drink of the cup that I drink or to be baptized with the baptism with which I am baptized?"[191] He was speaking to them of suffering and death. It was a mystery to them, as it was to St. Peter who attempted to divert Jesus from his anticipated passion after our Lord promised him the keys of the kingdom.[192] In this respect, the Apostles were not different from the generations that preceded them or those that followed. Vatican II recognized the universal mystery that has perplexed man from his very beginning:

> It is in the face of death that the riddle of human existence grows most acute. Not only is man tormented by pain and by the advancing deterioration of his body, but even more so by a dread of perpetual extinction. ... All the endeavors of technology, though useful in the extreme, cannot calm his anxiety.[193]

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[190] Matthew 20:17-23

[191] Mark 10: 38.

[192] Matthew 16:21-23.

[193] Vatican II, *Gaudium et Spes*, n. 18

Before Christ's revelation and outside the history of the Hebrews all kind of myth and all kind of religion tried to address death and suffering. Without an adequate anthropology they were doomed to approach these central mysteries of man by way of superstition, hopeless resignation, or denial. It is only in the recognition of a difficult truth that we can begin to unravel the mystery of death and suffering - they are the consequence of sin. God created man in the state of original justice, where he was to live in God's presence free of sin and he intended to move us immediately from a temporal paradise to eternal glory, but that was lost through sin.[194] "Even though man's nature is mortal, God had destined him not to die."[195] Vatican II expresses this truth in these words:

> Although the mystery of death utterly beggars the imagination, the Church has been taught by divine revelation and firmly teaches that man has been created by God for a blissful purpose beyond the reach of earthly misery. In addition, that bodily death from which man would have been immune had he not sinned will be vanquished, according to the Christian faith, when man who was ruined by his own doing is restored to wholeness by an almighty and merciful Saviour.[196]

The Catechism of the Catholic Church addresses the original and present state of humanity in its treatment of the first article of the Apostles Creed: "I believe in God the Father Almighty, Creator of heaven and earth". God created man in His image and likeness as male and female. He established man "in friendship with his Creator and in harmony with himself and with creation around him".[197] This state of grace, know as "original justice" was lost through a primeval event

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[194] Catechism of the Catholic Church, secs. 374-379; 1008.

[195] CCC, sec. 1008. See also, CCC sec. 376.

[196] GS, n. 18.

[197] CCC sec. 374.

"*at the beginning of the history of man*".[198] It was an event, presented in Genesis in metaphor, by which man let his trust in God falter, abused his freedom, and disobeyed God's command.[199] In the attempt to be like God but "without God, before God and not in accordance with God"[200], the first man embraced the temptation to grasp what is beyond his nature and in his pride brought on the consequences so apparent in the fallen nature of man: original justice was lost, the soul's mastery over the body was shattered, the harmony of male and female was subjected to tension, domination and lust, and malice emerged in the heart of man.[201] "Finally, the consequence explicitly foretold for this disobedience will come true: man will 'return to the ground,' for out of it he was taken. *Death makes its entrance into human history.*"[202]

St. Paul affirms the consequence of Adam's sin: "sin came into the world through one man and death through sin, and so death spread to all men because all men sinned."[203] Adam had received original justice in his nature, and thus for all human nature. When Adam and Eve sinned personally, their nature was affected and was transmitted as a fallen nature – that is, deprived of original justice – to all mankind. It is thus a sin and consequence that all humanity shares in by propagation.[204] Original sin is thus a fallen state of being rather than a personally imputed moral

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[198] Ibid, sec. 390 (emphasis in original).

[199] Ibid, sec. 397.

[200] Ibid, sec. 398 quoting St. Maximus the Confessor.

[201] Ibid, sec. 400.

[202] Ibid (emphasis in original).

[203] Romans 5:12.

[204] CCC sec. 402-404. The Council of Trent asserted that original sin was injurious to the first man's descendents as well as himself, and caused the loss of holiness and justice for all humankind, "which is death of soul, and not merely death and punishment of the body." Grisez, supra, *Christian Moral Principles*, p. 335. The long running

debate in and out of the Church concerning this question necessarily involves discussion of developing theories of evolution and the relationship of such ideas to monogenism and polygenism. Obviously, any account of evolution, in order to accord with Christian revelation, must be reconciled with the essential teaching on original sin. The issue is a theological study in itself and far beyond the scope of this work. But a brief digression is appropriate. "Both Pius XII and Paul VI warned that polygenism, which some expressions of evolutionary theory seem to demand, appears incompatible with the Church's teaching" *Ibid,* at p. 340. Grisez nonetheless maintains that "it is not clear that either of those popes proposed monogenism as the position to be held definitively. Hence, if a Catholic can show how polygenism is compatible with the essential elements of the Church's teaching on original sin, then he or she may admit polygenism on the evidence for it." *Ibid.* Grisez suggests such a case "[f]or the sake of argument" in which he posits a community of interbreeding subpersonal creatures in which man as communion of body and soul "emerged from the hand of God but also organically ... from [such] subpersonal antecedents." *Ibid* at p. 342. He then attempts to reconcile that notion with the essential elements of the Church's teaching on original sin by positing a divine intervention by which the capacity for free choice was given "to a group of individuals small enough and cohesive enough to function socially as a single body." *Ibid.* By this "hominization ... solidarity in sin by the whole of humankind was possible at the beginning. As additional groups were hominized, they emerged into an already given existential situation, and so shared prior to any personal act in the moral condition of mankind. In this sense, they shared 'by propagation not by imitation', even if not all humans were lineal descendants of a single couple." *Ibid.* From this original community, "a single leader whose action was decisive" was the original "Man" through whom original sin was introduced to the human family. *Ibid* at p. 343. Although I have the greatest respect for Grisez, I fail to grasp how additional groups of subpersonal beings would be "hominized into an existential situation so that, without any personal act or lineal reception of human nature from the original "Man", they would share in the fallen state of that "Man". The consequence does not seem fitting. The necessity of lineal descent seems more respectful of the significance of the body to the essence of "human person", whereas its lack suggests a dualist influenced exaggeration of the immaterial aspect of "human person", which would seem to be the primary, if not exclusive locus of the existential fallenness in such secondary "homonized" groups. Still, Grisez's effort shows that the essential teachings on original sin are something quite apart from mythological language used in scripture to convey its reality. Some recent developments in intelligent design theory (ID) may be read as a renewed efforts to show the compatibility of evolution with those essential teachings. See M.J. Behe, *Darwin's Black Box*; W. Dembski, *Design Inference.* Additional sources are well collected at the Discovery Institute web site, www.discovery.org. Some ID theory is quite restrained, focusing its analysis on the apparentness of reason and purposefulness behind evolutionary process. Other approaches posit the sudden emergence of complex and highly developed biological organisms. ID, and any theory of human emergence, must, if proposed as an explanation conforming to reveled truth, reconcile its thesis with humanities loss of original justice by propagation, not imitation. This is not to suggest that ID itself must develop such an explanation, since that is not the purpose of ID theory. However, such an explanation is incumbent on Catholic authors who take recourse to the ID corpus.

Critical commentary on these issues is contained in the International Theological Commission's *Communion and Stewardship: Human Persons Created in the Image of God*, published in July, 2004 with the permission of the Commission's then President, Cardinal Joseph Ratzinger.

> Modern physics has demonstrated that matter in its most elementary particles is purely potential and possesses no tendency toward organization. But the level of organization in the universe, which contains highly organized forms of living and non-living entities, implies the presence of some "information" (n. 30)
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> ...
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> According to the widely accepted scientific account, the universe erupted 15 billion years ago in an explosion called the "Big Bang" and has been expanding and cooling ever since. Later, there gradually emerged the conditions necessary for the formation of atoms, still later the condensation of galaxies and stars, and about 10 billion years later the formation of planets. In our own solar system and on earth (formed about 4.5 billion years ago) the conditions have been favorable to the emergence of life. While there is little consensus among scientists about how the origins of this first microscopic life is to be explained, there is general agreement among them that the first

offense.[205] Because it is now the experienced state of man's nature – the very condition of his body-soul communion – it is the core anthropological truth for the proper understanding of the meaning of suffering and death. It is confirmed by St. Augustine in his monumental *City of God* where he refers to man as different than the angels, who were "completely incapable of death, even if they sinned. The condition of human beings was such that if they had continued in perfect

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> organism dwelt on this planet about 3.5-4 billion years ago. Since it has been demonstrated that all living organisms on earth are genetically related, it is virtually certain that all living organisms have descended from this first organism. Converging evidence from many studies in the physical and biological sciences furnishes mounting support for some theory of evolution to account for the development and diversification of life on earth, while controversy continues over the pace and mechanisms of evolution. While the story of human origins is complex and subject to revision, physical anthropology and molecular biology combine to make a convincing case for the origin of the human species in Africa about 150,000 years ago in a humanoid population of common genetic lineage. However it is to be explained, the decisive factor in human origins was a continually increasing brain size, culminating in that of *homo sapiens*. With the development of the human brain, the nature and rate of evolution were permanently altered: with the introduction of the uniquely human factors of consciousness, intentionality, freedom and creativity, biological evolution was recast as social and cultural evolution. (n. 63)
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> Pope John Paul II stated some years ago that "new knowledge leads to the recognition of the theory of evolution as more than a hypothesis. It is indeed remarkable that this theory has been progressively accepted by researchers following a series of discoveries in various fields of knowledge"("Message to the Pontifical Academy of Sciences on Evolution" 1996). In continuity with previous twentieth century papal teaching on evolution (especially Pope Pius XII's encyclical *Humani Generis*), the Holy Father's message acknowledges that there are "several theories of evolution" that are "materialist, reductionist and spiritualist" and thus incompatible with the Catholic faith. It follows that the message of Pope John Paul II cannot be read as a blanket approbation of all theories of evolution, including those of a neo-Darwinian provenance which explicitly deny to divine providence any truly causal role in the development of life in the universe. Mainly concerned with evolution as it "involves the question of man," however, Pope John Paul's message is specifically critical of materialistic theories of human origin and insists on the relevance of philosophy and theology for an adequate understanding of the "ontological leap" to the human which cannot be explained in purely scientific terms. The Church's interest in evolution thus focuses particularly on "the conception of man" who, as created in the image of God, "cannot be subordinated as a pure means or instrument either to the species or to society." As a person created in the image of God, he is capable of forming relationships of communion with other persons and with the triune God, as well as of exercising sovereignty and stewardship in the created universe. The implication of these remarks is that theories of evolution and of the origin of the universe possess particular theological interests when they touch on the doctrines of the creation *ex nihilo* and the creation of man in the image of God. (n. 64)

The full text of *Communion and Stewardship: Human Persons Created in the Image of God* is available at www.vatican.va/roman_curia/congregations/cfaith/cti_documents/rc_con_cfaith_doc_20040723_communion-stewardship_en.html.

[205] Ibid, sec. 404.

obedience they would be granted the immortality of the angels and an eternity of bliss, without the interposition of death, whereas if disobedient they would be justly condemned to the punishment of death."[206] John Paul II stated: "The sign and consequence of original sin is bodily death."[207]

By grasping the truth about the "why" of death, that is to say about sin, we are searching for meaning that may surmount despair. It is to arrive at a meaning that will not be displaced by the experience of suffering or the witness of another's travail, and thus resist O'Connor's "death dealing tenderness". It is also, of course, the beginning of self knowledge, the reason for the conditional necessity of the mission of the Redeemer, and a reason for joyful imitation of the Jesus' self denial. As regards the shadow of the assisted suicide and euthanasia movements, knowledge of the "why" of death opens up the possibility of finding truth and meaning in the experience of suffering. Pride and theories of radical personal autonomy drive personal sin today, just as they did for Adam and Eve. In the face of death – inevitable and relentless – pride is easy prey to despair. Joined to a concept of absolute personal sovereignty, euthanasia and suicide may appear as legitimate choices to those who do not accept the concept of sin. By understanding that death originated in rebellion rather then creative love, and that it is something profoundly at odds with our reality as *imago Dei*, we are compelled to the ultimate purpose of freedom: the search for truth and meaning. It is a search that finds its object in God and His law. "[M]an has in his heart a law written by God; to obey it is the very dignity of man; according to it he will be judged."[208]

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[206] St. Augustine, *City of God*, Book XIII, 1.

[207] Weekly Audience, October 8, 1986.

[208] GS, sec. 16. This famous quote from Vatican II may be expressed, without any variance in essential content, in more personalistic terms: man's dignity lies in his divine filiation by which he is called to communion with the Blessed Trinity by and through his loving embrace of the God's will for his fulfillment, and by his response he will

Following our Lord's Ascension the captain of the Temple Guard and his officers brought the Apostles before the Sanhedrin. There they were accused, accurately enough, of preaching the mystery of Christ, although they had been ordered not to. St. Peter's defense was: "We must obey God rather then men. The God of our fathers raised Jesus whom you killed by hanging him on a tree."[209] In the face of the Sanhedrin's angry response ("they were enraged and wanted to kill them." Acts 5:33) Rabbi Gamaliel intervened and cautioned the council not to over react or they may find themselves opposing God. Heeding his advice the council ordered the Apostles flogged and then released. "Then they left the presence of the council, rejoicing that they were counted worthy to suffer dishonor for the name." This was an expression of the Christian obligation to endure, even embrace, suffering by uniting it to Christ's passion and redemptive action. It is an obligation that follows on Christ's explicit message: "Whoever does not bear his own cross and come after me, cannot be my disciple."[210]

Other Gospel accounts recall similar teachings and suggest that suffering and death are a means to union with Christ. At the Last Supper Jesus told his Apostles: "If the world hates you, realize that it hated me first. If you belonged to the world, the world would love its own; but because you do not belong to the world, the world hates you. Remember the word I spoke to you, 'No slave is greater than its master.' If they persecuted me, they will persecute you."[211]

The Catechism teaches:

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be judged. This is evident from Our Lord's priestly prayer in John 14 and 15 where he makes repeated reference to this elemental doctrine: "If you love me, you will keep my commandments." John 14:15. See also John 14:21, 23, 15:9-11, 14, and Luke 16:18 – 31 cited in the footnotes to GS sec. 16.

[209] Acts 5:29-30.

[210] Luke 14:27.

[211] John 15: 18-21.

> Because of Christ, Christian death has a positive meaning: 'For to me to live is Christ, and to die is gain.' 'The saying is sure: if we have died with him, we shall also live with him.' What is essentially new about Christian death is this: through Baptism, the Christian has already 'died with Christ' sacramentally, in order to live a new life; and if we die in Christ's grace, physical death completes this 'dying with Christ' and so completes our incorporation into him in his redeeming act".[212]

The Catechism then quotes the incomparable expression of St. Ignatius of Antioch written as he was being transported to Rome to be fed to the lions in the Coliseum. Death was certain and soon and brutal:

> It is better to die in Christ Jesus than to reign over the ends of the earth. Him it is I seek – who died for us. Him it is I desire – who rose for us. I am on the point of giving birth. ... Let me receive pure light; when I shall have arrived there, then shall I be a man.[213]

That suffering is an unavoidable, even beneficial, element of Christian life, is clear from St. Paul's Letter to the Romans:

> For all who are led by the Spirit of God are sons of God. For you did not receive the spirit of slavery to fall back into fear, but you have received the spirit of sonship. When we cry, "Abba! Father!" it is the Spirit himself bearing witness with our spirit that we are children of God, and if children, then heirs, heirs of God and fellow heirs with Christ, ***provided we suffer with him in order that we may be glorified with him.***[214]

The theme is repeated frequently in the New Testament. "[E]ven if you do suffer for righteousness' sake, you will be blessed"[215] ; "For it is better to suffer for doing right, if that is

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[212] CCC sec. 1010

[213] Ibid.

[214] Romans 8:14-17(emphasis added).

[215] 1 Peter 3:14.

God's will, than for doing wrong"[216] ; "Since Christ suffered in the flesh, arm yourselves with the same thought, for whoever has suffered in the flesh has ceased from sin"[217] ; "Beloved, do not be surprised at the fiery ordeal which comes upon you, as though something strange is happening to you. But rejoice in so far as you share Christ's sufferings, that you may also rejoice and be glad when his glory is revealed."[218] It is thus understood that suffering with Christ is union with him and a means to glorification with him. The sacrament of the Anointing of the Sick aids in this union, which the Catechism teaches is actually a participation in Christ's redemptive work:

> By the grace of this sacrament the sick person receives the strength and the gift of uniting himself more closely to Christ's Passion: in a certain way he is consecrated to bear fruit by configuration to the Savior's redemptive Passion. Suffering, a consequence of original sin, acquires a new meaning; it becomes a participation in the saving work of Jesus.[219]

Suffering is not only a "union" with Christ or an "identification" with Jesus – which would be much. It is a participation in his Passion and in his "saving work". This takes our search for the truth and meaning of suffering and death to its pinnacle. Suffering has a co-redemptive value. It is an offering from God to man to share in the redemptive act of Christ. St. Paul wrote to the Colossians: "Now I rejoice in my sufferings for your sake, and in my flesh I complete what is lacking in Christ's afflictions for the sake of his body, that is, the church".[220] St. Paul identifies

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[216] Ibid 3:17.

[217] Ibid 4:1.

[218] Ibid 4:12-13.

[219] CCC sec. 1521.

[220] Colossians 1:24.

Christ's body, the church, as the beneficiary of his sufferings. John Paul II reflected on the centrality of this passage to the proper understanding of the meaning of suffering:

> In this body [the church] Christ wishes to be united to every individual, and in a special way to those who suffer. ... [W]hoever suffers in union with Christ ... "completes" by his suffering "what is lacking in Christ's afflictions"
> ...
> Christ achieved the redemption completely and to the very limit; but at the same time he did not bring it to a close. In this redemptive suffering, through which the redemption of the world was accomplished, Christ opened himself from the beginning to every human suffering and constantly does so. Yes, it seems to be part of the very essence of Christ's redemptive suffering that this suffering requires to be unceasingly completed.
> ...
> [R]edemption, even though it was completely achieved by Christ's suffering, lives on and in its own special way develops in the history of man. It lives and develops as the body of Christ, the church, and in this dimension every human suffering, by reason of the loving union with Christ, completes the suffering of Christ. It completes that suffering just as the church completes the redemptive work of Christ.
> ...
> Suffering...has a special value in the eyes of the church. ***It is something good before which the church bows down in reverence with all the depth of her faith in the redemption.***
>
> Christ has made suffering the firmest basis of the definitive good, namely the good of eternal salvation.[221]

John Paul's teaching on suffering merits further citation:

> [It] is an invitation to manifest the moral greatness of man, his spiritual maturity.[222]
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> When the body is gravely ill, totally incapacitated, and the person is almost incapable of living and acting, all the more do interior maturity and spiritual greatness become evident, constituting a touching lesson to those who are healthy and normal.[223]

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[221] *Salvifici Doloris*, n. 24 and 26 (emphasis added).

[222] Ibid, n. 22.

[223] Ibid, n.26.

> It is suffering more then anything else, that clears the way for the grace which transforms human souls. ***Suffering, more than anything else, makes present in the history of humanity the powers of the redemption.*** [224]

Christ's passion, death and resurrection redeemed the world. The application of that redemptive work is still being carried out, in us, by the Holy Spirit. One manner of that ongoing redemption is the suffering endured in union with Christ. On October 13, 1986, after reciting the Sunday Angelus from Gemelli Hospital in Rome where he was recovering from surgery, John Paul II said: "During these days of illness I have been able to understand better the value of the service that the Lord has called me to render the Church as a priest, as a Bishop and as Successor to Peter: it is also given through the gift of suffering by which it is possible to complete in one's own flesh 'what is lacking in Christ's afflictions for the sake of his body, that is, the Church'."[225] In other reflections John Paul spoke of a "School of suffering" and a "world of suffering' wherein man achieves a deep solidarity with his fellow man. "People who suffer become similar to one another through the analogy of their situation, the trial of their destiny or through their need for understanding and care, and perhaps above all through the persistent question of the meaning of suffering. ... The answer has been given by God to man in the cross of Jesus Christ."[226]

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[224] Ibid, n. 27 (emphasis added).

[225] L'Osservatore Romano, Weekly Edition in English, October 16, 1996, p.1.

[226] *Salvifici Doloris*, nn. 8 and 13. The idea that suffering opens man to understand his reason for being was also expressed by Viktor Frankl in *Man's Search for Meaning*:

> The meaning of our existence is not invented by ourselves, but rather detected.
>
> ...
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> We can discover this meaning in three different ways: (1) by doing a deed; (2) by experiencing a value; and (3) by suffering."

In this lofty calling of man, in and through suffering, John Paul II identified both a redemptive and an evangelical dimension. "Christ did not come to remove our afflictions, but to share in them and, in taking them on, to confer upon them a salvific value. ... [T]he theological virtue of hope ... will help you to give new meaning to suffering, transforming it into a way of salvation, an occasion for evangelization and redemption. ... Your experience of pain, modeled on Christ's and indwelt by the Holy Spirit, will proclaim the victorious power of the Resurrection."[227] Here the Holy Father touched on the Communion of Saints and one recalls the passage by Flannery O'Connor in the *Introduction to A Memoir of Mary Ann* where she identified the Communion of Saints as manifest in the mysterious connection between Nathanial Hawthorne, his daughter Rose, and Mary Ann. This Communion exists between the sick and the dying, the disabled and incapacitated, together with all the members of Christ's body, particularly those who care for them. This is experienced in a special way by "health care and pastoral workers ... who continuously live in proximity to the needs of the sick. ... To take care of the sick and dying, to help the *outward man* that is decaying so that the *inward man* may be renewed day by day – is this not to cooperate in that *process of resurrection* which the Lord has introduced into human history with the paschal mystery and which will be fully consummated at the end of time?"[228]

It is thus clear that the Communion of Saints is built up and progresses on its path to a final plentitude through the oblation not only of those who suffer, but also of those who care for

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Washington Square Press, Simon and Schuster, pp. 157 and 176 (1963).

[227] Message for the Sixth World Day of the Sick, Reprinted in L'Osservatore Romano, Weekly Edition in English, July 16, 1997.

[228] Ibid (emphasis in original).

them, and those who share in the experience of their suffering, such as spouses, children, siblings, parents and friends.[229] This suggests that an adequate understanding of suffering and death cannot be gained by partial vision, but requires reference to the final end of man as a member of Christ's body together with the communion of all the faithful. In turn this suggests that the ethical resolution of questions that arise regarding end of life medical decisions or other medical-moral questions, must take into account not only the patient, but those who have a relationship with the patient marked by intimacy, solidarity, dependence and love. It may thus be suggested that even the permanently non-cognitive patient has a bodily life significance that extends beyond himself and merits care and support for the value he represents within the communal dimension of Christ's body.

Having probed the meanings of suffering and death, and with those meanings always informing our discussion, it is appropriate to set forth a brief summary of the Church's teaching on ordinary and extraordinary care.

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[229] "Since all the faithful form one body, the good of each is communicated to the others.... We must therefore believe that there exists a communion of goods in the Church." CCC sec. 947 *quoting* St. Thomas Aquinas, Symb., 10. This Communion is manifest in scripture:

> If one member suffers, all suffer together; if one member is honored, all rejoice together. Now you are all one body of Christ and individually members of it.

1 Cor. 12:26 – 27. The conclusion drawn by the Catechism of the Catholic Church, founded on this and other passages of the New Testament, is that :

> In this solidarity with all men, living or dead, which is founded on the communion of saints, the least of our acts done in charity redounds to the profit of all. Every sin harms this communion.

CCC sec. 953.

V. ORDINARY AND EXTRAORDINARY CARE IN CATHOLIC TRADITION

As discussed above, human persons are obliged to respect bodily life as a gift from the Creator. They must nurture and care for bodily life with all reasonable means.[230] "As the administrator of his life, [man]... has the duty to take the steps necessary for its conservation. ... Man then should guard it, protect it, care for it, and conserve it as he would any precious thing."[231] Traditional formulation of this duty requires that man avail himself of the ordinary means available for the conservation of life, whereas those means that are extraordinary are optional.[232] As medical science progressed in the last two centuries, the principle has had to be applied to changing circumstances, so that means once deemed extraordinary are now commonly accepted as ordinary.[233] Generally, those means which offer a reasonable hope of benefit without a serious risk of death or excessive burden are considered ordinary. Those which are useless, or become so in the course of treatment, or which pose a serious risk of death or impose an undue or disproportionate burden are extraordinary.[234] Specific application of such broad categories may

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[230] CCC sec. 2288.

[231] The Most Reverend Daniel A. Cronin, A Doctrinal Dissertation originally published under the title: *The Moral Law in Regard to the Ordinary and Extraordinary Means of Conserving Life*, republished in Conserving Human Life, Russell E. Shaw, Editor, The Pope John XXIII Medical-Moral Research and Educational Center, p.14-15 (1989).

[232] See Leis, McCarthy & Bayer, Handbook on Critical Life Issues, 3rd Ed., Part III, The National Catholic Bioethics (2004) (www.ncbc.org). See also Vol. 5, No. 3, The National Catholic Bioethics Quarterly, Autumn, 2005, *Ordinary and Extraordinary Means;* and Vol. 5 No. 4 of the same journal, *Consensus Statement on Dignity in Illness, Disability, and Dying and a Response to the UNESCO Universal Draft Declaration on Bioethics and Human Rights* by the International Association of Catholic Bioethicists (IACB) 2005, especially Part One: Life-Prolonging Treatment. The "Statement" is also available at IACB's web site: www.iacbweb.org.

[233] Ibid, pp. 33-113.

[234] William E. May, *Catholic Bioethics and the Gift of Human Life*, p.259-262 (2000); Catholic Conference of Ohio, *Death & Life Issues and Ohio Law on Advance Directives*, pp.5-6 (2000); See also Germain Grisez, The Way of the Lord Jesus, Vol. 2, *Living a Christian Life*, pp. 524-532 (1993).

present difficulties, but the general precept is clear. Some prefer to substitute the terms "proportionate" and "disproportionate" for the traditional terms "ordinary" and "extraordinary". This is because of the possible confusion between means that are "medically extraordinary" but "ethically ordinary" or vice versa.[235] Thus the *Declaration on Euthanasia* from the Sacred Congregation for the Doctrine of the Faith, in discussing the moral obligation to care for one's own health, states:

> In the past, moralists replied that one is never obliged to use "extraordinary" means. This reply, which as a principle still holds good, is perhaps less clear today, by reason of the imprecision of the term and the rapid progress made in the

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[235] Ohio Catholic Conference, supra, pp. 5-6. The breath of the cultural and linguistic confusion over the term "extraordinary" can be gleaned from the reflective yet ultimately misguided decision *In The Matter of Nancy Ellen Jobes*, 108 N.J. 394 (1987) Nancy Jobes was a diagnosed PVS patient at a nursing home. She was thirty-one years old at the time the case was decided in 1987. Prior to the 1980 automobile accident which resulted in her injuries she had no significant medical or physical handicap. She had also never expressed her intention, nor was there adequate evidence to infer her intention, concerning the maintenance of artificial nutrition and hydration should she be accurately diagnosed as PVS. Although there was conflicting expert medical testimony, the trail court and the appellate court found clear and convincing evidence that she was, in fact, PVS, with no chance of recovery. Because there was no clear evidence of Nancy Jobes own intention, the court adopted a "substituted judgment" rule which allowed her family to make the determination based on the presumption that family ties most often provide the best means to approximate the patients own desires. While that may or may not provide the most socially acceptable resolution, the point here concerns the understanding of "extraordinary" as applied to medical care and treatment. In a concurring opinion Justice Handler frankly admitted that life and death treatment and care decisions made by proxy are often fraught with doubt, most notably when the incapacitated person's choice cannot be determined. One might expect that such circumstances would trigger a default position in favor of continued nutrition and hydration, even from the radical autonomist perspective, since it favors the primacy of individual choice and dares not act against life without surer knowledge of the patient's election. However, at the start of the Justice Handler's opinion the following appears:

> Mrs. Jones is thirty-one years old. Because of a complication during a March 1980 surgery, she suffered massive and irreversible brain damage. Since that time, she has been in a permanent vegetative state and, since July 1980, she has been cared for in a nursing home. **No one would fail to characterize the extensive treatment that serves to keep her in a biologically-viable condition as extraordinary and heroic.**

108 N.J. at 429 (emphasis added). But that is precisely what *is* contested. This short study, the address by John Paul II on March 20, 2004, a steady stream of catholic thought post *Quinlan* have repeatedly asserted that those very same treatments – at least those involving artificial nutrition and hydration – are ordinary precisely because they do not impose an undue burden on the patient while at the same time providing a reasonable expectation of benefit – life. Justice Handler's unwarranted assumption that everyone would agree with his assessment of ordinary and extraordinary appear to be the common loaded dice in many so called right to die cases. If the assumption is given that life under PVS circumstances is not a benefit then the result is clearly optional, but if continued sustenance is really ordinary care then it must be continued.

> treatment of sickness. Thus some people prefer to speak of "proportionate" and "disproportionate" means. In any case, it will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources.
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> ...
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> It is also permissible to make do with the normal means that medicine can offer. Therefore one cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome.
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> ...
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> When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due a sick person in similar cases is not interrupted.[236]

Obviously, this formulation requires specification of what constitutes "burden" and "futility". Risk self evidently means serious risk of death or serious bodily injury. In addition to such risk, "burden" contemplates that "some treatment is itself painful or brings about other experienced conditions which are undesirable; ...[that] application of medical care [may]...interfere with the activities and experiences which one desires during the time [of life] remaining;...[that] there is a variety of reasons why persons find medical care psychologically repugnant; ...[and] in many cases medical care for one individual makes very severe demands upon others."[237] In addition, cost that is excessive or that may bankrupt a person or his family may well be an undue burden.[238]

> All these factors *are objectively discernible features in the treatment itself, its side effects, and its negative consequences that impose undue burdens on the patient and/or others*. One can rightly reject such treatments and withhold them or withdraw them. ... *[E]xcessive burdensomeness* is the major criterion for determining whether a proposed treatment is "extraordinary/disproportionate." ... [S]uch burdensomeness include the treatment's riskiness, its bad side-effects and bad consequences on the life of the person, the excessive pain of the treatment,

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[236] *Declaration on Euthanasia*, Part IV.

[237] Grisez and Boyle, *Life and Death with Liberty and Justice*, p. 260.

[238] May, *Catholic Bioethics*, supra, p. 261.

> treatments judged morally or psychologically repugnant, and excessive expense that would imperil the economic security of the patient, the patient's family, and/or the community. Withholding or withdrawing such treatment is not a choice to kill oneself... One does not judge a *life* excessively burdensome, one judges a *treatment* excessively burdensome.
>
> ...
>
> In addition...another criterion that enables us to judge whether a given treatment, for a given patient, is "extraordinary/disproportionate" ... is *usefulness*. In the Catholic tradition a means has been judged useless in the strict sense if the benefits it promises are nil or useless in a wider sense if the benefits conferred are insignificant in comparison to the burdens it imposes.[239]

What must be avoided in deciding whether to accept or refuse medical treatment is the intention to kill oneself or another for whom the decision is being made. The direct intention to end a suffering person's life by withholding care or administering lethal substances is euthanasia and is never permitted, even if requested by the patient.[240] The intention is direct and thus precludes any attempt to justify action by the principle of double effect.[241] It is the willing choice for death, and as such is either homicide or suicide.

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[239] Ibid, p. 261 9 (emphasis in original)..

[240] John Paul II, *Evangelium Vitae*, no. 57 and 66; *Declaration on Euthanasia*, SCDF (1980).

[241] The principle of double effect permits a choice for a good that has a known, but not intended, bad effect. In cases relevant to our discussion of medical care, an excellent comparison may be made between two recent culture examples. In the hit movie, "The English Patient", a nurse administers a lethal dose of morphine to a patient who is in great pain, is dying and actively seeks to be "put out of his misery" (murder for the nurse; suicide for the patient). In another smash hit film, "Saving Private Ryan", an army platoon leader authorizes the administration of morphine to a mortally wounded soldier who is in great pain and, like the English patient, is going to die. However, it is quite clear that the medication is used in "Saving Private Ryan" as a means to relieve great pain and not with the intention to cause death, although death is anticipated. Double effect permits the action in that case, whereas the intention to kill as the means to relieve pain and suffering in "The English Patient" is evil. The principle of double effect is more involved then just this example. A useful definition is: "It is allowable to actuate a cause that will produce a good and bad effect, provided 1) the good effect and not the evil effect is directly intended; 2) the action is good in itself, or at least, indifferent; 3) the good effect is not produced by means of the evil effect; and 4) there is a proportionate reason for permitting the foreseen evil effect to occur." Edwin Healy, S.J., *Moral Guidance*, Loyola University Press, p. 20, (1942), quoted in Archbishop Cronin's doctrinal dissertation *The Moral Law in Regard to the Ordinary and Extraordinary Means of Conserving Life*, supra at footnote 231.

Some assert that it is possible to intend that the patient be freed from the burden of technology or pain. That is true, but where that choice is elected as a "means" to realize the particular "end" of death, there is no morally significant difference because both are characterized by the intention for death. The principle of double effect precludes the use of evil cause as a means to a good effect.[242] Therefore, with regard to life and death medical choices, it may be properly stated that a choice that results in death may be acceptable so long as death is not chosen as the means to bring about the good effect of relief from excessive pain, and the other conditions applicable to double effect are satisfied.[243] It should go without saying that a patient is free to elect for the most advanced medical techniques, even if accepting them carries serious risk and even if they are experimental, provided no other sufficient remedies for the patient's condition exist.[244] Indeed, "[b]y accepting them, the patient can even show generosity in the service of humanity."[245]

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[242] See definition of double effect contained in the preceding footnote by E.Healy, S.J. in *Moral Guidance.*

[243] The *Declaration on Euthanasia*, reflecting on the meaning of suffering for Christians and the use of painkillers, made this interesting observation: "suffering, especially suffering during the last moments of life, has a special place in God's saving plan; it is in fact a sharing in Christ's Passion and a union with the redeeming sacrifice which he offered in obedience to the Father's will. Therefore one must not be surprised if some Christians prefer to moderate their use of painkillers, in order to accept voluntarily at least a part of their sufferings and thus associate themselves in a conscious way with the sufferings of Christ crucified." The *Declaration* does not mean to impose heroic suffering on the sick and, in fact, states that most persons will properly use medicines to suppress pain and that person incapable of expressing themselves should be presumed to want pain relief medication and it should be "administered according to the doctor's advice." However, the point so generously made, is that suffering is not simply an unmitigated evil. It has values, as we have explored at length, which make it possible to transform its experience from dread to, as expressed by John Paul II, "the gift of suffering by which it is possible to complete in one's own flesh 'what is lacking in Christ's afflictions..." L'Osservatore Romano, Weekly Edition in English, October 16, 1996, (quoting Col 1:24).

[244] *Declaration of Euthanasia*, Part IV SCDT (1980).

[245] Ibid.

The foregoing makes it clear that life itself can never be considered an undue burden. Burdensomeness refers to the treatment proposed, and as such, requires a case by case analysis of its impact on a patient. By the same token, a treatment or medical procedure that sustains life is, by definition, not useless or futile. It is not permissible to conclude that "treatments are to be withheld or withdrawn because of a judgment that the patient's *life* is either burdensome or useless".[246] Curing or improving the functioning of a patient is not a precondition to a determination that a treatment is useful. Those who label health care as "futile" if it does not accomplish such ends are resting their position on an "instrumental" view of the value of life, or on a "quality of life" judgment.[247] As we have seen, such views are seriously flawed. Yet it is precisely that kind of judgment that appears to have been made in cases like Karen Quinlan and Nancy Cruzan as well as in the positions taken by some moralists.[248] Such judgments seem clearly precluded by a proper application of the ordinary-extraordinary distinction.

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[246] Ibid, p. 262.

[247] Grisez, *Living a Christian Life*, supra, p.525.

[248] See footnotes 182 - 185, supra, and accompanying text.

VI SOME PERSPECTIVES ON ADVANCE DIRECTIVES.

Given that legislation, case law and standard medical practice require a search for a patient's desires concerning medical interventions, it seems clear that persons are well advised to make their wishes known so that others holding different values or agendas will not frustrate those wishes. This may be done is a variety of ways, depending on the state jurisdiction. A "living will" or advance directive can be a controlling statement of a patient's wishes, but it may lack flexibility and is often drafted without the benefit of a "here and now" illness and proposed treatment for reference. For that reason, it has been critised by Grisez.[249] William May offers similar criticism[250] and strongly recommends the appointment of an agent or surrogate decision maker. He favors the advice to persons executing an advance directive and appointing, or being appointed, as an agent that was included in a pastoral letter from the Catholic Conference for the District of Columbia in 1994:

> Appoint someone who has the strength of character to make good judgments in painful circumstances.
>
> Appoint someone who you know you can trust to make decisions on the basis of the Church's teaching. The prudent person will select an agent who will act as he or she would have acted in whatever circumstances evolve.
>
> No one should agree to act as an agent for another person if that person would expect or require the agent to make decisions which disregard the teaching of the Church. It is not morally acceptable to carry out immoral decisions on behalf of someone else. No agent and no physician should ever feel obliged to act contrary to their well informed consciences, even on behalf of another person.

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[249] Grisez, Living a Christian Life, supra, p. 528-29.

[250] May, *Catholic Bioethics*, supra, at p. 270.

> Appoint someone who is likely to be available to care for you in the distant future … it may be advisable to name alternate agents, in the event that your first choice proves unable or unwilling to act for you when the need arises.
>
> Discuss the specifics of your directive with the person whom you wish to choose as your agent….
>
> Generally avoid: 1. Stating that you wish to reject certain treatments under all circumstances except in case of imminent death or when one's present medical condition makes it clear in advance that such treatments would be futile; 2. Stating without qualification that you want medical remedies restricted in the event that you become permanently unconscious or terminally ill. Such stipulation can amount to providing a premature self-diagnosis. You should allow your health care agent and physician latitude to offer you appropriate care based on your actual condition.
>
> Include a provision regarding treatment at the time of imminent death. Recall that the Church allows a person on the verge of death to refuse a treatment which would result in only a burdensome prolongation of life. Your advance directive should authorize your agent to observe this norm.
>
> Periodically review the provisions of your directive…. Make copies of your directive and distribute them to your agent and each of your health care providers and anyone else you deem appropriate.[251]

These norms are excellent. However, one caveat should be considered. Some patients may favor accepting experimental or risky treatment even when death is imminent, either out of a desire to continue living or to provide experience for medical science and thus be of service to humanity.[252] If such a choice is willed, it would be import to modify the advice in the pastoral letter to make that clear. Most discussion of advance directive focuses on when it is permissible to withhold or withdraw treatment. Effort should be made to include instruction on treatments to be provided even when morally optional, if that is the patient's desire. Furthermore, any person wishing to

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[251] District of Columbia Catholic Conference, *Care of the Sick and Dying: A Pastoral Letter*, pp. 26-28 (1994)

[252] The experience of my wife's aunt, Mary Lowe, to whom this study is dedicated, was a singularly noble example of such service. When cure was beyond hope she underwent excessively painful surgery with the hope that the experience and knowledge gained by her physicians and the medical community may assist in the treatment and care of others. May her memory be eternal.

limit the administration of pain relief medication or treatment, especially when such measures will inhibit consciousness, must so state. No medical provider will withhold pain relief otherwise and few can be expected to anticipate a patient's desire for unusual moderation in its administration. Moreover, since an advance directive becomes effective only when the person can no longer express intention, such a clause must be carefully drafted so as to allow for the administration of such medication or treatment should pain become so extreme that a choice for it would have eventually emerged. For this reason, it seems best to adopt an advance directive in unison with the appointment of an agent so that flexibility remains with someone able to judge the appropriate response to changed circumstances.

Obviously, any "agent" must accept the relevant moral truths and be a person of sufficient character to withstand attempts to pursued him or her with pleas of "death dealing tenderness". However, it is also clear that some persons do not have resort to such a trusted friend or family member. Moreover, a carefully drafted advance directive can adequately state the relevant moral principles, including the ordinary-extraordinary distinction, provide a limited number of specific applications, explain the necessity of a "here and now" circumstance in order to make an informed application of proper moral principles, clearly prohibit euthanasia, and provide evangelical witness. By requiring all health care providers, agents and surrogates to apply morally sound and clearly articulated principles in medical matters, as well as making clear one's rejection of euthanasia, a highly attractive case can be made in favor of advance directives, with or without the appointment of an agent.

What follows in the Appendix is a series of Advance Directives and Appointments, together with optional provisions for organ/tissue donation which successfully apply the Catholic

tradition set forth in this paper. These directives and appointments apply to eighteen state jurisdictions and the District of Columbia with a population in excess of two-thirds of the nation. They are based on the specific legislation in place in the respective states or on court decision recognizing the validity of an advance directive. While they are clearly "life protective", they also limit intervention to "ordinary care" except in the case of pregnancy when extraordinary means are directed if such intervention may preserve the life of the unborn child. Therefore, they are appropriate for, and are contemplated for, persons who have terminal illnesses or who become permanently unconscious. Many persons, such as those who desire additional time with loved ones regardless of burden or those prepared to endure painful, risky or experimental treatment in order to be of service to humanity by advancing medical knowledge should make those views known to all of their health care providers. The Advance Directives annexed hereto are not for them. The documents provide for all those medical interventions that offer a reasonable hope of benefit without undue burden. They are preceded by a statement of faith intended as a form of evangelization, a method endorsed by the Episcopal Conference of Spain.[253] Because some of the statutory provisions in some of the jurisdictions for which directives have been prepared have been judged either morally unsound or too easily open to unsound interpretation, some jurisdictions have only an advance directive or an appointment of a surrogate decision maker or agent. Other jurisdictions, where statutory language was manageable, have both directives and appointments. Where appropriate and permissible in the particular jurisdiction, an option for or against organ donation has been included.

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[253] Antonio G. Spagnoio, *Patients Good and the Limits of Living Wills*, L'Osservatore Romano, Weekly Edition in English, p. 2, June 19, 1996.

Two practical caveats are appropriate. First, anyone electing to sign an advance directive should consult with an attorney licensed to practice law in the jurisdiction in question. Second, no one should sign a directive or an appointment that he or she does not clearly understand.

A final word. Secular advance directives often operate as the advance men for ideological currents allied with cultural elitism that flees any notion of the supernatural, thereby reducing man to clay. "The danger against which Christ Himself was always on guard was that of seeing Himself used for a temporal end while the essence of His message was to reveal to man the transcendent dimension of his vocation."[254] Today the risk is great that those seeking to express their legitimate desires in advance of final illness may find themselves unwittingly used by the advocates of the culture of death through statutory formula "living wills" crafted without transcendent vision. It is hoped that the comments set forth herein will give rise to prudent pause, and that the documents annexed hereto be employed with vigor.

[254] Cardinal Jean Danielou, Horizontalism, L'Ossesvatore Romano, English Edition, 17 October, 1968. Full text available at www.ewtn.com/library/Theology/HORZNTL.HTM.

APPENDIX

(ABRIDGED – CONNECTICUT ONLY)

CONNECTICUT
ADVANCE MEDICAL DIRECTIVE

This document effects important legal rights. If you do not understand the terms of this document, consult with an attorney before signing it.

As a Catholic I believe in the Blessed Trinity, the Father and the Son and the Holy Spirit, who call me into their very life if I keep faith. I believe in a God who is loving and merciful, and who has revealed Himself in His Only Begotten Son, Jesus Christ, my Lord and Savior. I believe that God is the author of human life, which is a great and glorious gift from Him, and that human life is sacred from the moment of conception to death. I believe that every human person, from the moment of conception, is unique, precious and unrepeatable. I believe that God alone has dominion over life. The Father sent His Son so that in union with Him we may have eternal life. When God gives life He gives it forever. I know that, like all human beings, I will suffer physical death. But I also know that "Christ has risen from the dead, and by His death He has trampled upon death, and has given life to those who are in the tombs." (Troparion of Pascha) Death has lost its sting (1 Cor. 15:54-55) and Jesus will raise his faithful disciples to eternal life. For them, through death, "life is changed, not ended." (Preface I, Funeral Mass) I believe that death means to go home, and to be with Christ forever. (Phil. 1-23) I also believe that the mystery of suffering is an unavoidable consequence of humanity's fallen state, but that suffering has a special and redemptive meaning when united to Christ's suffering offered in obedience to the Father's will. I believe that the dignity of each person is inherent and cannot be diminished by illness, suffering or death.

As a Catholic I believe it is always gravely immoral to directly kill innocent human persons, even for reasons of mercy. No one may permit such killing or ask for it either for himself or for another person entrusted to his care, nor consent to it explicitly or implicitly. Medical care and treatment decisions must always avoid any act or omission by which death is intended as an end or chosen as a means. Euthanasia is never permitted.

I acknowledge my moral obligation to take care of my health by preserving and nurturing it with appropriate means, commonly called ordinary or proportionate. I also accept, as the Catholic Church teaches, that I am not obliged to use extraordinary or disproportionate means to preserve life and health. Medical treatments and procedures are extraordinary or disproportionate if they are useless (i.e. without reasonable hope of benefit) or excessively burdensome and merely prolong my own dying, delaying my return home to God in whom "death shall be no more, neither shall there be mourning nor crying not pain" and Who makes "all things new." (Rev. 21: 4-5)

Because it is impossible for me to foresee all of the circumstances under which health care decisions may be made on my behalf and because I cannot know all the decisions I would make without knowledge of such circumstances, it is my desire to set forth the moral principles that I want others to observe in making health care decisions for me as well as provide specific instructions in certain cases. Those making decisions on my behalf should be guided by the moral teachings of the Catholic Church contained in, but not limited to, the following: *Evangelium Vitae,* Encyclical Letter, John Paul II (1995); *Address to the Participants in the International Congress on "Life Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Directives",* John Paul II (2004); *Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration,* Congregation for the Doctrine of the Faith (2007); *Declaration on Euthanasia,* Congregation for the Doctrine of the Faith (1980); *Ethical and Religious Directives for Catholic Health Care Services,* National Conference of Catholic Bishops (USA) (1994); and *Nutrition and Hydration: Moral and Pastoral Reflections,* Committee for Pro-Life Activities, National Conference of Catholic Bishops (USA) (1995).

TO ANY PHYSICIAN WHO IS TREATING ME:

These are my heath care instructions including those concerning the withholding or withdrawal of life support systems, together with the appointment of my health care representative, the designation of my conservator of the person for future incapacity, my election/disclamation regarding anatomical gift, and authorization for disclosure of health information. As my physician, you may rely on these instructions and any decision made by my health care representative or conservator of my person, if I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physicians as to my own medical care.

HEALTH CARE INSTRUCTIONS

Enter the name of the person making this Advance Directive

I, _____,
the author of this document, direct that, if my condition is deemed terminal or if I am determined to be permanently unconscious, and the opportunity to receive the Sacraments of the Church has been made available to me and I have received the Sacrament of the Anointing of the Sick, that all, but only, those forms of treatment and care be provided that offer a reasonable hope of benefit without serious risk of death or excessive pain, excessive expense to me or my family, or other excessive burden, consistent with the moral teachings of the Catholic Church. By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a

relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment. The continued sustenance of my life by any treatment or care and the benefit of life itself shall in no circumstance be considered a risk or burden in this analysis. There shall be a presumption in favor of providing me with nutrition and hydration, even by artificial means, so long as death is not inevitable and imminent, so that the effort to sustain my life is not futile. While some treatment or care may be futile in combating or curing a disease or defect, treatment or care which sustains life is not futile.

I direct that when decisions involve the question of the withholding or removal of a life support system, they be made in consultation with a Catholic Priest and after consultation with my health care representative, whenever feasible. In no event may anyone refuse or withdraw from me, or administer to me, any treatment, care or procedure by which death is intended as an end or chosen as a means.

In accord with the teachings of the Catholic Church, I have no objection to the use of medication or procedures necessary for my physical comfort even if they may shorten my life, provided my death is not intended as an end or chosen as a means. Accordingly, I direct that I be provided with compassionate nursing care and pain management.

PREGANCY
Optional provision for extraordinary care in the event of pregnancy. If so electing, you must initial the blank space at the start of the paragraph at right.

OPTIONAL PROVISION REGARDING PREGNANCY

_____ By initialing this paragraph I make the following specific directive if it is determined that I am pregnant during any period of incapacity. If it is determined that I am pregnant, I direct that all means, including extraordinary care and treatment, be utilized to maintain my life so that my unborn child may have the opportunity to live. Delivery by cesarean section or other means should be attempted only after my unborn child has reached such a state of development and viability that its survival outside my womb is reasonably probable, unless medical circumstances require earlier action if there is to be any hope of my unborn child's survival.

APPOINTMENT OF HEALTH CARE REPRESENTATIVE

Enter the name of the declarant first and then the name of the person appointed as health care representative.

I, _____, appoint

_____

to be my health care representative. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and am unable to reach and communicate an informed decision regarding treatment, my health care representative is authorized to make any and all health care decisions for me,

including the decision to accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law, including, but not limited to, psychosurgery or shock therapy, and the decision to withhold or withdraw life support systems. I direct my health care representative to make decisions on my behalf in accordance with my wishes, as stated in this document. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes, provided such decision is in accord with the teaching of the Catholic Church.

If I am pregnant my health care representative may consent to any course of treatment or care which, in the opinion of my attending physician, is reasonably necessary to maintain and preserve my life or the life of my unborn child, and is primarily directed to such end even if such a course of treatment or care may adversely, though unintentionally, affect the health or life of one or the other of us. In no event shall my health care representative consent to, permit or encourage any treatment or care or the withholding or withdrawal of any treatment or care which is intended to bring about my death or the death of my unborn child.

Enter name of health care representative.

Enter name of alternative health care representative.

If _____
is unwilling or unable to serve as my health care representative, I appoint

_____
to be my alternative health care representative.

DESIGNATION OF A CONSERVATOR OF THE PERSON

If a conservator of the person should need to be appointed, I designate

Enter name of conservator.

_____
be appointed my conservator.

Enter name of conservator.

If _____
is unwilling or unable to serve as my conservator, I designate

Enter name of alternative conservator

_____
as my alternative conservator. No bond shall be required of either of them in any jurisdiction.

DOCUMENT OF ELECTION/DISCLAMATION REGARDING ANATOMICAL GIFT

(Choose subsection A or B)

Select "A" if you DO NOT want to make an anatomical gift.

A. _____ **(check here if you do not want to make an anatomical gift)** I hereby declare that I do not wish to make any anatomical gift.

Select "B" if you want to make an anatomical gift,

Initial if selected "B" above and you want to make an anatomical gift.

OR

B. _____ **(check here if you want to make an anatomical gift)** I hereby make this anatomical gift, if medically acceptable, to take effect upon my death. I give any needed organ or body part for transplantation into a living human person or for therapeutic use in a living human person. If not medically acceptable for such purpose, I give them for any purpose permitted by law so long as such purpose is consistent with the moral teachings of the Catholic Church. Regardless of any statutory or common law definition of death, by the term "death" as used herein, I mean the complete and total cessation of all respiration and circulation from which resuscitation is not possible or the complete and total cessation of all brain activity, including the brain stem, confirmed by at least two electroencephalograms taken at least six hours apart, the results of which are confirmed by a neurologist. **This anatomical gift is effective only if I have selected subsection B above, and initialed the space directly below.**

_____ **(Initial here to confirm your anatomical gift)**

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I direct that all of my protected health information (as such term is defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")) and other medical records shall be made available to my health care agent, attorney in fact for health care decisions and conservator upon request in the same manner as such information and records would be released and disclosed to me, and my health care agent, attorney in fact for health care decisions and conservator shall have and may exercise all of the rights I would have regarding the use and disclosure of such information and records. In the event that the authority of my health care agent, attorney in fact for health care decisions and/or conservator has not yet been established, I authorize each of my health care providers to release and disclose all my protected health information and other medical records to the individual nominated hereunder as my health care agent, attorney in fact for health care decisions and/or conservator for the purpose of determining my capacity to make my own health care decisions, including, without limitation, the issuance and release of any written opinion relating to my capacity that such person may have requested. The foregoing direction and authorization shall supersede any prior agreement that I may have made with any of my health care providers to restrict access to or disclosure of my protected health information or other medical records, and shall expire with respect to any health care provider upon being revoked by me in a writing delivered to such health care provider.

Enter complete date.

Signature of Declarant.

Enter name of Declarant.

Witnesses sign and print name and address

DECLANANT'S STATEMENT AND EXECUTION

The instructions, requests, appointments, designations, authorizations, and, elections are made after careful reflection, while I am of sound mind. Any party receiving a duly executed copy or facsimile of this document may rely upon it unless such party has received actual notice of my revocation of it.

Date: _____, 2_____.

_____ L.S.
Declarant's signature

WITNESSES' STATEMENT

This document was signed in our presence by:

_____,
the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

_____	_____
(witness signature)	(witness signature)
_____	_____
(print witness name)	(print witness name)
_____	_____
(number and street)	(number and street)
_____	_____
(city, state and zip code)	(city, state and zip code)

Enter location of execution.

Enter complete date

Witnesses sign and enter address

To be completed by a Commissioner of the Superior Court or a Notary Public.

WITNESSES AFFIDAVIT

STATE OF CONNECTICUT :

: ss. _____

COUNTY OF _____ : (City/Town)

(name of county)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, appointment of health care representative, designation of conservator for future incapacity, document of election/disclamation regarding anatomical gift, and authorization for release of health information by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments, designations, election/disclamation and authorization in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request and in the presence of each other; that at the time of the execution of said document the author appeared to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this _____ day of

_____, 2_____.

_____ _____

(witness signature) (witness signature)

_____ _____

(number and street) (number and street)

_____ _____

(city, state and zip code) (city, state and zip code)

Subscribed and sworn to before me this _____ day of

_____, 2_____.

_____

Commissioner of the Superior Court
Notary Public
My Commission expires: _____