

*Book Reviews***Euthanasia and Quality of Life***Voluntary Euthanasia*

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Reviewed by Marvin Kohl

The past two decades have witnessed both a notable increase of interest in voluntary euthanasia and considerable insurgence against the practice. Under the influence of what may broadly be called quality-of-life points of view, advocates have urged that sanity and wisdom consist not in the pursuit of life but in the pursuit of a quality life and conversely that, where a life is irreparably blasted by the most loathsome forms of disease and degradation, it may be desirable to exit. Despite great variety in the kinds of justifications offered, quality-of-life advocates basically agree that voluntary euthanasia is sometimes excusable, permissible, virtuous, or obligatory. Indeed, the quality-of-life group might well be called Promethean, since they are hostile to the idea of just letting nature take its course and insist that man should consciously and intelligently control his own destinies.

The contrary point of view is put forward with considerable vigor by anti-quality-of-life advocates or vitalists who argue that talk about worthwhile or worthless, meaningful or meaningless, quality or non-quality life generates formidable problems. Here too we find a diversity of philosophical and moral positions. But there is general agreement that life is intrinsically valuable or that a human life can never be cor-

rectly assessed as being worthless or to be sufficiently lacking in quality as to warrant the active pursuit of death. Against the euthanasia's position, it is argued that a judgment about the quality of a person's life cannot in principle be a reasonable basis for killing that person.

This volume is an enlarged and updated edition of *Euthanasia and the Right to Life* (1969). The majority of papers—including Anthony Flew, Joseph Fletcher, Granville Williams, and Christian Barnard's—are written from the quality-of-life perspective. Yale Kamisar and Luke Gormally represent the opposition, each making an able case against euthanasia. In addition to Barnard and Gormally's papers, the new material in the volume includes the Vatican's Declaration, Colin Brewer's discussion of the hospice movement, P.V. Admiraal's outline of the way euthanasia is and should be practiced in the Netherlands, and an insightful article about the suicides of Arthur and Cynthia Koestler.

Let us begin with Barnard's story about a patient named Eli Kahn. Aged 78, he was suffering from carcinoma of the prostate, obstruction of the bowel, and very severe emphysema. Mr. Kahn said to his doctor: "You mustn't try to save my life. I am ready to die. The machine is worn out, and the mechanic must now give up." "No," was the reply, "this is not a hospital which just allows patients to die like that. We treat you here, we don't just let you die."

Unfortunately what happened to Mr. Kahn is all too familiar. After pointless surgery he developed problems with his lungs, and was intubated. During the night he somehow managed to disconnect the respirator. And in bed there was a note, written in a shaky hand. The message read: "Doctor, the real enemy is not death—the real enemy is inhumanity!"

According to Barnard that also should be our

Marvin Kohl, PhD, is Professor and Chair of Philosophy, State University of New York, College at Fredonia, Fredonia, New York.

message. We should not allow medicine to become inhumane. And to become unconcerned about the quality of life is to become inhumane. Thus he writes:

It is not true that we become doctors in order to prolong life. We become doctors in order to improve the quality of life, to give the patient a more enjoyable life ... And the same is true when we are dealing with terminally ill patients: what we should ask ourselves is whether there is still any quality of life left. The doctor who is unconcerned about the quality of life is inhumane; and the real enemy is not death but inhumanity. (p 177)

Barnard's point about quality of life is well taken. We may attempt to dodge the issue and argue, as Gormally does, that quality of life arguments are not sound and that "the only reason for killing a man which is consistent with the true dignity of human beings is that the man deserves death." (p 89) But morality is not limited to a matter of desert. And the heart of Barnard's argument is that it is difficult to see how an inhuman act can be a moral one, even if it be one of omission.

But improving the quality of life is by no means the only function nor perhaps the most important function of medicine. And it is at best hyperbole to say that "the real enemy is not death but inhumanity." It is true that death may be a friend but more often than not it is an enemy. Thus it seems much closer to the truth to say that the general function of medicine is to improve both the quality and quantity of life. And even if we want to add that we are not talking about the prolongation of mere biological existence but the prolongation of life of at least minimal quality, undesirable death is still a very great enemy.

To prevent misunderstanding, let me say emphatically that I do not wish in any way to minimize the importance of the daily routine of most physicians who may not be engaged in combat against death but who decidedly help improve the quality of their patient's life. But I do wish to argue that because this function is important and must not be neglected, it does not follow that the fight against death is of no importance, or that it is a lesser function. What is often lost in the fury that accompanies public debates of this kind is the common sense understanding that being humane, improving the quality of life, *and* fighting against undesir-

able death are all necessary parts of modern medicine.

The harder question, the question of whether a patient still has any quality of life left or the more general question of what constitutes the lack of a quality life, stands on a somewhat different footing. All the evidence indicates that what we generally regard as a life of minimal quality is bound up with an individual's ability to satisfy certain kinds of reasonable desires or goals. It is undoubtedly true that men form different conceptions of what constitutes a life of high quality, even a life of sufficient quality, but many would unhesitatingly maintain that when a human being cannot possess or achieve any goals that life is devoid of quality. Quality of life advocates certainly think it reasonable to say that where an individual lacks both cerebral hemispheres (as in the case of the hydranencephalic infant), there is not even minimal quality life. They also think it reasonable to say that where an individual has permanently lost all higher brain function the same holds true.

When, however, we turn to cases where there is no brain damage or where there is less than full impairment, we find another judgment, which I will call the judgment that a life *lacks sufficient quality*. This is often blended indistinguishably with the judgment that there is *no quality*. Space does not permit full elaboration. But I do wish to suggest that, even if we admit that where there is no quality of life, death is not an injury to the decedent, it does not follow that this is true in all cases when a life lacks sufficient quality. To argue, as some libertarians do, that a life that merely tips on the side of a negative balance is sufficient to warrant voluntary death is, I believe, tantamount to saying that it is permissible for people to exit when life merely tips on the side of unhappiness. Such thinkers seem to forget that a life of this quality is not necessarily an empty, or nearly empty, one. It still may possess opportunity for great moments of satisfaction and achievement. So that exiting from a life that has just barely tipped to the negative side of the scale is one thing; exiting from a life devoid of any quality for its possessor still another.

Judgments as to quality of life become even more complicated. We can and should further distinguish between those who have just tipped to the negative side of the scale and those who

are close to being devoid of quality. Eli Kahn was ready to die. But he welcomed death not because of cognitive incapacity. Nor did he decide to die because his life had just tipped to the negative side. His decision to die was made on significantly different grounds. Because of advanced prostatic cancer and very severe emphysema the judgment was that his life was *almost devoid of any quality*. This indicates that there is a difference—a vital logical, if not moral difference—between *a life devoid of any quality, one almost devoid of quality, and one that has just tipped on the negative side of the scale*.

The essence of the quality-of-life position is that we are being inhumane when we do not actively respect the former conditions; that we are being inhumane when a patient correctly

judges his own life to be devoid or almost devoid of quality and wants to die, and we do not help. Thus doing good in the sense of being beneficent or helping others is an essential part of being humane. It is the duty of every man, we are told, to be beneficent, ie, to be helpful to men or women in need according to one's means. This duty becomes a stricter one (and a necessary condition for being humane) when there is dire need and it is relatively easy to help. Contrary to Gormally's suggestion that the minimally moral man is one who rewards and punishes only on the basis of desert, Barnard and other quality-of-lifers are urging that it requires the recognition of the duty to help others when their need is dire and it is relatively easy to do so.

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