The following are some of the situations cited as reasons for or against the recognition of a right to die.

(DANGER: These reflections may be hazardous to your peace of mind!)

<table>
<thead>
<tr>
<th>Affirmative</th>
<th>Negative</th>
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<td>— In situations of intolerable pain.</td>
<td>— God is the giver of life and no one may take another's life not guilty of a proportionate crime.</td>
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<td>— An aged person with no dependents.</td>
<td>— We are obliged to exert all reasonable efforts to sustain life.</td>
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<tr>
<td>— A child born with severe and uncorrectable genetic defects.</td>
<td>— It is better to be than NOT TO BE.</td>
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<tr>
<td>— A slowly dying patient with no hope of recovery.</td>
<td>— There is a chance that medical science will discover a treatment for this particular condition.</td>
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<tr>
<td>— An extensively injured person facing a life with severe incapacitating handicaps.</td>
<td>— The State has moral responsibility to provide life-sustaining measures when individuals are not able to do so.</td>
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<tr>
<td>— A seriously ill indigent patient with no known relatives.</td>
<td>— Sustaining the sufferings of handicaps can be redemptive.</td>
</tr>
<tr>
<td>— A child with congenital severe mental retardation with an I.Q. below 40.</td>
<td>— Every human person has an intrinsic worth independent of age, socio-economic status, or productivity.</td>
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</tbody>
</table>

**DISTINCTIONS:** Clearly, an assumption has been made, namely, that the phrase “right to die” means the right to terminate a life at will. Probably most persons supporting the affirmative side would insist that such a meaning is not intended. The more common interpretation is to read it as the right to refuse treatment in situations where such medical intervention would only prolong dying or would sustain biological life below the level required for true human communication.

Another distinction is to consider the phrase really to mean, the right to die well. The West German Bishops, in their June, 1975 Pastoral Letter on Euthanasia, emphasized this aspect of the Death and Dying issue. They insisted that every human being has the right to die in a manner worthy of a human being. Included in the concept is the following:

— the sufferings of the sick person must be alleviated;
— the sick person should receive the best possible care in such wise that he realizes his humanity is recognized and esteemed;
— the spiritual needs of the sick person should be met so that faith is aided and a firm hope is promoted;
— when indicated, death is not to be artificially postponed by the undue use of all medical means;
— when there is a reasonable hope of recovery, all medical means are to be employed even if it requires the state to provide costly apparatus and expensive medications.

(Continued on next page)
From The Editor’s Memo Pad:

The Director-General of the World Health Organization, Dr. H. Mahler, in a speech made in Athens on September 15, 1976 to the 26th session of WHO Regional Committee for Europe developed the following principle:

“Health development is essentially a political and social process that should start off with the acceptance of the social function of health and should ensure that health technology is developed and applied in harmony with this social function.” (‘Problems of Medical Affluence,” WHO Chronicle 31:8-13, 1977)

Around this pivotal principle, Dr. Mahler makes a number of observations which, although originally addressed to Europe, are largely applicable to most countries. Among these are the following few examples:

- Drugs (including alcohol and tobacco) and traffic accidents nowadays kill more people than did all the epidemics together in earlier centuries.
- No country can afford to provide every citizen with every possible form of technology, nor would this necessarily be good for the health of the individual and of society . . . . It would tend to make people overdependent on a medical “aristotechnocracy.”
- There is often a disequilibrium between the types of services provided, too much being devoted to dramatic acute institutional care and too little to primary care of large segments of the population and to continuing community care of the chronic physically and mentally sick and disabled.
- How many countries can have an easy conscience that they are making optimum use of the technical and administrative resources available?
- Some of the reasons for the high cost of highly developed health services are the overlapping, increasingly complex, acute care technology, the technological refinements that bring only slightly marginal advantages to the doctor’s diagnostic and therapeutic arsenal and are of doubtful benefit to patients, the demand for placebo technology, the lack of primary health care, and the lack of cooperation between various health institutions.

In addition to these few cited remarks, Dr. Mahler advocates greater cooperation between the developed and the developing countries by the adoption of “twinning” of medical and research facilities. The same principle could be applied within a single nation between the developed and affluent regions and those which are developing and less affluent. Catholic hospitals could readily take the leadership in such inter-institutional cooperation.

Second Thoughts

Not for Physicians Only

By Lawrence J. Nelson

Medical ethics is not for physicians only. Nurses and other allied health professionals frequently face ethical dilemmas too. One of the most common ethically problematic situations nurses and other health professionals find themselves in occurs when a patient asks for information about tomorrow’s surgery, today’s prescribed drugs, or yesterday’s explanation of their condition by the physician which was simply not understood. Do nurses have a moral obligation to see that their patients have all the information they want and need about the course of their medical treatment?

Nurses and other health professionals do have a moral obligation to be sure that their patients have all information necessary for an informed consent to the procedures they’re undergoing and for active participation in their own healthcare. Of course the physician has the primary responsibility to keep the patient informed. Patient requests for information or a nurse’s suspicion that a patient really does not understand what is happening to them should be brought to the physician’s attention first of all. However, it is not rare that physicians, for one reason or another, fail to respond to such requests. Then what is the nurse to do?

(Continued on last page)

“Right to Die”

(Concluded from page one)

Not to be overlooked in assessing their words, is the fact that these Bishops are coming out of a national experience (Nazism) which promoted a program of euthanasia for the “unfit.” In their pastoral letter they make explicit reference to this heritage of national shame.

Pope Pius XII had explicitly taught that a person generally was not obligated to the use of extraordinary means of maintaining life. There are two basic reasons underlying this principle: 1) the obligatory use of measures which provide no reasonable hope of benefit would require a person to act in a senseless manner; 2) the obligatory use of measures which entail an excessive burden on the patient, or others, would place significant obstacle to the attainment of more important values, such as union with God, prayer, and other spiritual goods.

This teaching of the Church is today fairly well known, even though not always correctly understood or applied. But it is an entirely different question as to whether there need be legislation by the various States to protect the right to refuse treatment in the appropriate circumstances. The legislative aspect of the “right to die well” will be explored in the next issue of Ethics and Medics.