thought of as being special cases without much relationship to ordinary life and death. On the other hand, one may look upon them as simply more brilliantly colored examples of what is generally true but is not always so easy to discern. Any dying patient whose life is unduly prolonged imposes serious costs on those immediately around him and, in many cases, on a larger, less clearly defined "society." It seems probable that, as these complex interrelationships are increasingly recognized, society will develop procedures for sharing the necessary decisions more widely, following the examples of the committee structure now being developed to deal with the dramatic cases.

It is not only probable, but highly desirable that society should proceed with the greatest caution and deliberation in proposing procedures that in any serious way threaten the traditional sanctity of the individual life. As a consequence, society will certainly move very slowly in developing formal arrangements for taking into account the interests of others in life-and-death decisions. It may not be improper, however, to suggest one step that could be taken right now. Such a step might ease the way for many dying patients without impairing the sanctity or dignity of the individual life: instead, it should be enhanced. I refer here to the possibility of changing social attitudes and laws that now restrain the individual from taking an intelligent interest in his own death.

The Judeo-Christian tradition has made suicide a sin of much the same character as murder. The decline of orthodox theology has tended to reduce the sinfulness of the act, but the feeling still persists that there must be something wrong with somebody who wants to end his own life. As a result, suicide, when it is not recognized as a sin, is regarded as a symptom of serious mental illness. In this kind of atmosphere, it is almost impossible for a patient to work out with his doctor a rational and esthetically satisfactory plan for conducting the terminating phase of his life. Only rarely can a great individualist like George Eastman or Percy Bridgman (*8*) transcend the prevailing mores to show us a rational way out of current prejudice. Far from injuring the natural rights of the individual, such a move can be regarded as simply a restoration of a right once greatly valued by our Roman ancestors, who contributed so much to the "natural law" view of human rights. Seneca (*9*), perhaps the most articulate advocate of the Roman view that death should remain under the individual's control, put the matter this way: "To death alone it is due that life is not a punishment, that erect beneath the frowns of fortune, I can preserve my mind unshaken and master of myself."

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Death as an Event: A Commentary on Robert Morison

Attempts to blur the distinction between a man alive and a man dead are both unsound and dangerous.

Leon R. Kass

As I understand R. S. Morison's argument, it consists of these parts, although presented in different order. First: He notes that we face serious practical problems as a result of our unswerving adherence to the principle, "always prolong life." Second: Although *some* of these problems could be solved by updating the "definition of death," such revisions are scientifically and philosophically unsound. Third: The reason for this is that life and death are part of a continuum; it will prove impossible, in practice, to identify any border between them because theory tells us that no such border exists. Thus: We need to abandon both the idea of death as a concrete event and the search for its definition; instead, we must face the fact that our practical problems can only be solved by difficult judgments, based upon a complex cost-benefit analysis, concerning the value of the lives that might or might not be prolonged.

I am in agreement with Morison only on the first point. I think he leads us into philosophical, scientific, moral, and political error. Let me try to show how.

Some Basic Distinctions

The difficulties begin in Morison's beginning, in his failure to distinguish clearly among aging, dying, and dead. His statement that "dying is seen as a long-drawn-out process that begins when life itself begins" would be remarkable, if true, since it would render dying synonymous with living. One consequence would be that murder could be considered merely a farsighted form of euthanasia, a gift to the dying of an early exit from their miseries (*1*). But we need not ponder these riddles, because what Morison has done is to confuse dying with aging. Aging (or senescence) apparently does begin early

in life (though probably not at conception), but there is no clear evidence that it is ever the cause of death. As Sir Peter Medawar has pointed out (*2*):

> Senescence, then, may be defined as that change of the bodily faculties and sensibilities and energies which accompanies aging, and which renders the individual progressively more likely to die from accidental causes of random incidence. Strictly speaking, the word "accidental" is redundant, for all deaths are in some degree accidental. No death is wholly "natural"; no one dies *merely* of the burden of the years.

As distinguished from aging, dying would be the process leading from the incidence of the "accidental" cause of death to and beyond some border, however ill-defined, after which the organism (or its body) may be said to be dead.

Morison observes, correctly, that death and life are abstractions, not things. But to hold that "livingness" or "life" is the property shared by living things, and thus to abstract this property *in thought*, does not necessarily lead one to hold that "life" or "livingness" is a thing in itself with an existence apart from the objects said to "possess" it. For reification and personification of life and death, I present no argument. For the adequacy of the abstractions themselves, we must look to the objects described.

What about these objects: living, nonliving, and dead things? A person who believes that living things and nonliving things do not differ in kind would readily dismiss "death" as a meaningless concept. It is hard to be sure that this is not Morison's view. When he says, "These objects *we elect to call* 'living things' [emphasis added]," is he merely being overly formal in his presentation, or is he deliberately intimating that the distinction between living and nonliving is simply a convention of human speech, and not inherent in the nature of things? My suspicions are increased by his suggestion that "substitutes can be devised for each of the major components [of a man], and the necessary integration can be provided by a computer." A living organism comprising mechanical parts with computerized "integration"? Morison should be asked to clarify this point: Does he hold that there is or is not a *natural* distinction between living and nonliving things? Are his arguments about the fallacy of misplaced concreteness of "death" and "life" merely secondary and derivative from his belief that living and nonliving or dead objects do not differ in kind (*3*)?

If there is a natural distinction between living and nonliving things, what is the proper way of stating the nature of that difference? What is the real difference between something alive and that "same" something dead? To this crucial question, I shall return later. For the present, it is sufficient to point out that the real source of our confusion about death is probably our confusion about living things. The death of an organism is not understandable because its "aliveness" is not understood except in terms of nonliving matter and motion (*4*).

One further important distinction must be observed. We must keep separate two distinct and crucial questions facing the physician: (i) When, if ever, is a person's life no longer worth prolonging? and (ii) When is a person in fact dead? The first question translates, in practice, to: When is it permissible or desirable for a physician to withhold or withdraw treatment so that a patient (still alive) may be allowed to die? The second question translates, in practice, to: When does the physician pronounce the (ex)patient fit for burial? Morison is concerned only with the first question. He commendably condemns attempts to evade this moral issue by definitional wizardry. But regardless of how one settles the question of whether and what kind of life should be prolonged, one will still need criteria for recognizing the end. The determination of death may not be a very interesting question, but it is an extremely important one. At stake are matters of homicide and inheritance, of burial and religious observance, and many others.

In considering the definition and determination of death, we note that there is a difference between the meaning of an abstract concept such as death (or mass or gravity or time) and the operations used to determine or measure it. There are two "definitions" that should not be confused. There is the conceptual "definition" or meaning and the operational "definition" or meaning. I think it would be desirable to use "definition of death" only with respect to the first, and to speak of "criteria for determining that a death has occurred" for the second. Thus, the various proposals for updating the definition of death (*5*), their own language to the contrary, are not offering a new definition of death but merely refining the procedure stating that a man has died. Although there is much that could be said about these proposals, my focus here is on Morison's challenge to the concept of death as an event, and to the possibility of determining it.

The Concept of Death

There is no need to abandon the traditional understanding of the concept of death: Death is the transition from the state of being alive to the state of being dead. Rather than emphasize the opposition between death and life, an opposition that invites Morison to see the evils wrought by personification, we should concentrate, for our purposes, on the opposition between death and birth (or conception). Both are transitions, however fraught with ambiguities. Notice that the notion of transition leaves open the question of whether the change is abrupt or gradual and whether it is continuous or discontinuous. But these questions about *when* and *how* cannot be adequately discussed without some substantive understanding of *what* it is that dies.

What dies is the organism as a whole. It is this death, the death of the individual human being, that is important for physicians and for the community, not the "death" of organs or cells, which are mere parts.

> The ultimate, most serious effect of injury is death. Necrosis is death but with this limitation; it is death of cells or tissue WITHIN A LIVING ORGANISM. Thus we differentiate between *somatic death*, which is death of the whole, and *necrosis*, which is death of the part.
>
> From a tissue viewpoint, even when the whole individual dies, he dies part by part and at different times. For instance, nerve cells die within a few minutes after circulation stops, whereas cartilage cells may remain alive for several days. Because of this variation in cellular susceptibility to injury, it is virtually impossible to say just when all the component parts of the body have died. Death of composite whole, the organism as an INTEGRATED functional unit, is a different matter. Within three or four minutes after the heart stops beating, hypoxia ordinarily leads to irreversible changes of certain vital tissues, particularly those of the central nervous system, and this causes the INDIVIDUAL to die (*6*).

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The same point may perhaps be made clearer by means of an anecdote. A recent discussion on the subject of death touched on the postmortem perpetuation of cell lines in tissue culture. Someone commented, "For all I know, I myself might wind up in one of those tissue-culture flasks." The speaker was asked to reconsider whether he really meant "I myself" or merely some of his cells.

Is Death a Discrete Event?

A proof that death is not a discrete event (*7*)—that life and death are part of a continuum—would thus require evidence that the organism as a whole died progressively and continuously. This evidence Morison does not provide. Instead he calls attention to the continuity of the different ages of man and to growth and decay, but he does not show that any of these changes are analogous to the transition of death. The continuity between childhood and adolescence says nothing about whether the transition between life and death is continuous. He also mentions the "postmortem" viability of cells and organs. He says that "various parts of the body can go on living for months after its central organization has disintegrated." It should be clear by now that the viability of *parts* has no necessary bearing on the question of the whole. His claim that the beginning of life is not a discrete event ("the living human being starts inconspicuously, unconsciously, and at an unknown time, with the conjugation of two haploid cells"), even granting the relevance of the analogy with death, is really only a claim that we do not see and hence cannot note the time of the event. Morison himself more than once identifies the beginning as the discrete event in which egg and sperm unite to form the zygote, with its unique chromosomal pattern.

Only in a few places does Morison even approach the question of the death of the organism as a whole. But his treatment only serves to discredit the question. ["The nervous system is, of course, more closely coupled to personality than are the heart and lungs (a fact that is utilized in developing the new definitions of death), but there is clearly something arbitrary in tying the sanctity of life to our ability to detect the electrical potential charges that managed to traverse the impedance of the skull."] Lacking a concept of the organism as a whole, and confusing the concept of death with the criteria for determining it, Morison errs by trying to identify the whole with one of its parts and by seeking a single "infallible physiological index" to human personhood. One might as well try to identify a watch with either its mainspring or its hands; the watch is neither of these, yet it is "dead" without either. Why is the concept of the organism as a whole so difficult to grasp? Is it because we have lost or discarded, in our reductionist biology, all notions of organism, of whole? (*8*).

Morison also attempts to discredit the "last gasp" as indicative of death as a discrete event: "Observers of such a climactic agony have found it easy to believe that a special event of some consequence has taken place, that indeed Death has come and Life has gone away." But if we forget about reification, personification, spirits fleeing, Death coming, Life leaving—is this not a visible sign of the death of the organism as a whole? This is surely a reasonable belief, and one which, if it now seems unreasonable, seems so only because of our tinkering.

Morison credits "the constant tinkering of man with his own machinery" for making it "obvious that death is not really a very easily identifiable event. . . ." To be sure, our tinkering has, in some cases, made it difficult to decide when the moment of death occurs, but does it really reveal that no such moment exists? Tinkering can often obscure rather than clarify reality, and I think this is one such instance. I agree that we are now in doubt about some borderline cases. But is the confusion ours or nature's? This is a crucial question. If the indeterminacy lies in nature, as Morison believes, then all criteria for determining death are arbitrary and all moments of death a fiction. If, however, the indeterminacy lies in *our* confusion and ignorance, then we must simply do the best we can in approximating the time of transition.

We are likely to remain ignorant of the true source of the indeterminacy. If so, then there is absolutely no good reason for insisting that it is nature's, and at least two good reasons for blaming ourselves. (i) It is foolish to abandon or discredit nature as a standard in matters of fundamental human importance: birth, death, health, sickness, origin. In the absence of this standard, we are left to our tastes and our prejudices about the most important human matters; we can never have knowledge, but, at best, only social policy developed out of a welter of opinion. (ii) We might thereby be permitted to see how we are responsible for confusing ourselves about crucial matters, how technological intervention (with all its blessings) can destroy the visible manifestations and signs of natural phenomena, the recognition of which is indispensible to human community. Death was once recognizable by any ordinary observer who could see (or feel or hear). Today, in some difficult cases, we require further technological manipulation (from testing of reflexes to the electroencephalogram) to make manifest latent signs of a phenomenon, the visible signs of which an earlier intervention has obscured.

In the light of these remarks, I would argue that we should not take our bearings from the small number of unusual cases in which there is doubt. In most cases, there is no doubt. There is no real need to blur the distinction between a man alive and a man dead or to undermine the concept of death as an event. Rather, we should ask, in the light of our traditional concepts (though not necessarily with traditional criteria), whether the persons in the twilight zone are alive or not, and find criteria on the far side of the twilight zone in order to remove any suspicion that a man may be pronounced dead while he is yet alive.

Determining whether a Man Has Died

In my opinion, the question, "Is he dead?" can still be treated as a question of fact, albeit one with great moral and social consequences. I hold it to be a medical-scientific question in itself, not only in that physicians answer it for us. Morison treats it largely as a social-moral question. This is because, as I indicated above, he does not distinguish the question of when a man is dead from the question of when his life is not worth prolonging. Thus, there is a conjoined issue: Is the determination of death a matter of the true, or a matter of the useful or good?

The answer to this difficult question turns, in part, on whether or not medicine and science are in fact capable of determining death. Therefore, the question of the true versus the good (or useful) will be influenced by what is in fact true and knowable about death as a medical "fact." The question of the true versus the good (or useful) will also be influenced by the truth about what is good or useful, and by what people think to be good and useful. But

we can and should also ask, "What is the truth?" about which one of these concerns—scientific truth or social good—is uppermost in the minds of people who write and speak about the determination of death.

To turn to Morison's paper in the light of the last question, it seems clear that his major concern is with utility. He abandons what he calls "esoteric philosophical concerns," his own characterization of his scientific discussion about death, to turn to "practical matters of great moment." Despite his vigorous scientific criticisms of the proposals for "redefining" death, he thinks they have "great practical merit," and thus he does not really oppose them as he would any other wrong idea. Am I unfair in thinking that his philosophical and scientific criticism of the concept of death is really animated by a desire to solve certain practical problems? Would the sweeping away of the whole concept of death for the unstated purpose of forcing a cost-benefit analysis of the value of prolonging lives be any less disingenuous than a redefinition of death for the sake of obtaining organs?

Morison properly criticizes those who would seek to define a man out of existence for the purpose of getting at his organs or of saving on scarce resources (*9*). He points out that the redefiners take unfair advantage of the commonly shared belief that a body, once declared dead, can be buried or otherwise used. His stand here is certainly courageous. But does he not show an excess of courage, indeed rashness, when he would decree death itself out of existence for the sake of similar social goods? Just how rash will be seen when his specific principles of social good are examined.

The Ethics of Prolonging Life

We are all in Morison's debt for inviting us to consider the suffering that often results from slavish and limitless attempts to prolong life. But there is no need to abandon traditional ethics to deal with this problem. The Judeo-Christian tradition, which teaches us the duty of preserving life, does not itself hold life to be the absolute value. The medical tradition, until very recently, shared this view. Indeed, medicine's purpose was originally *health*, not simply the unlimited prolongation of life or the conquest of disease and death. Both traditions looked upon death as a natural part of life, not as an unmitigated evil or as a sign of the physician's failure. We sorely need to recover this more accepting attitude toward death (*10*) and, with it, a greater concern for the human needs of the dying patient. We need to keep company with the dying and to help them cope with terminal illness (*11*). We must learn to desist from those useless technological interventions and institutional practices that deny to the dying what we most owe them—a good end. These purposes could be accomplished in large measure by restoring to medical practice the ethic of allowing a person to die (*12*).

But the ethic of allowing a person to die is based solely on a consideration of the welfare of the dying patient himself, rather than on a consideration of benefits that accrue to others. This is a crucial point. It is one thing to take one's bearings from the patient and his interests and attitudes, to protect his dignity and his right to a good death against the onslaught of machinery and institutionalized loneliness; it is quite a different thing to take one's bearings from the interests of, or costs and benefits to, relatives or society. The first is in keeping with the physician's duty to act as the loyal agent of his patient; the second is a perversion of that duty, because it renders the physician, in this decisive test of his loyalty, merely an agent of society, and ultimately, her executioner. The first upholds and preserves the respect for human life and personal dignity; the second sacrifices these on the ever-shifting altar of public opinion.

To be sure, the physician always operates within the boundaries set by the community—by its allocation of resources, by its laws, by its values. Each physician, as well as the profession as a whole, should perhaps work to improve these boundaries and especially to see that adequate resources are made available to better the public health. But in his relations with individual patients, the physician must serve the interest of the patient. Medicine cannot retain trustworthiness or trust if it does otherwise (*13*).

On this crucial matter, Morison seems to want to have it both ways. On the one hand, he upholds the interest of the deteriorating individual himself. Morison wants him to exercise a greater control over his own death, "to work out with his doctor a rational and esthetically satisfactory plan for conducting the terminating phase of his life." On the other hand, there are hints that Morison would like to see other interests served as well. For example, he says: "It appears that parts of the dying body may acquire values greater than the whole." Greater to whom? Certainly not to the patient. We are asked to consider that "Any dying patient whose life is unduly prolonged imposes serious costs on those immediately around him and, in many cases, on a larger, less clearly defined 'society.'" But cannot the same be said for any patient whose life is prolonged? Or is Morison suggesting that the "unduliness" of "undue" prolongation is to be defined in terms of social costs? In a strictly patient-centered ethic of allowing a person to die, these costs to others would not enter—except perhaps as they might influence the patient's own judgment about prolonging his own life.

In perhaps the most revealing passage, in which he merges both the interests of patient and society, Morison notes:

> . . . the life of the dying patient becomes steadily less complicated and rich, and, as a result, less worth living or preserving. The pain and suffering involved in maintaining what is left are inexorably mounting, while the benefits enjoyed by the patient himself, or that he can in any way confer on those around him, are just as inexorably declining. As the costs mount higher and higher and the benefits become smaller and smaller, one may well begin to wonder what the point of it all is. These are the unhappy facts of the matter, and we have to face them sooner or later.

What are the implications of this analysis of costs and benefits? What should we do when we face these "unhappy facts"? The implication is clear: We must take, as the new "moment," the point at which the rising cost and declining benefit curves intersect, the time when the costs of keeping someone alive outweigh the value of his life. I suggest that it is impossible, both in principle and in practice, to locate such a moment, dangerous to try, and dangerously misleading to suggest otherwise. One simply cannot write an equation for the value of a person's life, let alone for comparing two or more lives. Life is incommensurable with the cost of maintaining it, despite Morison's suggestion that each be entered as one term in an equation (*14*).

Morison's own analogy—abortion—provides the best clue as to the likely consequences of a strict adoption of his suggestions. I know he would find these consequences as abhorrent as I. No matter what one can say in favor of abortion, one can't say that it is done for the benefit of the fetus. His interests are sacrificed to those of his

mother or of society at large. The analogous approach to the problem of the dying, the chronically ill, the elderly, the vegetating, the hopelessly psychotic, the weak, the infirm, the retarded—and all others whose lives might be deemed "no longer worth preserving"—points not toward suicide, but toward murder. Our age has witnessed the result of one such social effort to dispense with "useless lives."

To be fair, in the end, Morison explicitly suggests only that we make acceptable the practices of suicide and assisted suicide, or euthanasia. But in offering this patient-centered suggestion for reform, he challenges the ethics of medical practice, which has always distinguished between allowing to die and deliberately killing. Morison questions the validity of this distinction: "The intent appears to be the same in the two cases, and it is the intent that would seem to be significant." But the intent is not the same, although the outcome may be. In the one case, the intent is to desist from engaging in useless "treatments" precisely because they are no longer treatments, and to engage instead in the positive acts of giving comfort to and keeping company with the dying patient. In the other case, the intent is indeed to directly hasten the patient's death. The agent of the death in the first case is the patient's disease; in the second case, his physician. The distinction seems to me to be valuable and worth preserving.

Nevertheless, it may be true that the notion of a death with dignity encompasses, under such unusual conditions as protracted, untreatable pain, the right to have one's death directly hastened. It may be an extreme act of love on the part of a spouse or a friend to administer a death-dealing drug to a loved one in such agony. In time, such acts of mercy killing may be legalized (*15*). But when and if this happens, we should insist upon at least this qualification: The hastening of the end should never be undertaken for anyone's benefit but the dying patient's. Indeed, we should insist that he spontaneously demand such assistance while of sound mind, or, if he were incapable of communication at the terminal stage, that he have made previous and very explicit arrangements for such contingencies. But we might also wish to insist upon a second qualification—that the physician not participate in the hastening. Such a qualification would uphold a cardinal principle of medical ethics: Doctors must not kill.

Summary

1) We have no need to abandon either the concept of death as an event or the efforts to set forth reasonable criteria for determining that a man has indeed died.

2) We need to recover both an attitude that is more accepting of death and a greater concern for the human needs of the dying patient. But we should not contaminate these concerns with the interests of relatives, potential transplant recipients, or "society." To do so would be both wrong and dangerous.

3) We should pause to note some of the heavy costs of technological progress in medicine: the dehumanization of the end of life, both for those who die and for those who live on; and the befogging of the minds of intelligent and moral men with respect to the most important human matters.

References and Notes

1. This calls to mind the following exchange from Shakespeare's *Julius Caesar*, immediately following Caesar's assassination (Act III, scene i, ll. 101–105): "Casca: Why, he that cuts off twenty years of life/Cuts off so many years of fearing death. Brutus: Grant that, and then is death a benefit. So are we Caesar's friends, that have abridg'd/His time of fearing death."
2. P. B. Medawar, *The Uniqueness of the Individual* (Basic Books, New York, 1957), p. 55.
3. Would A. N. Whitehead himself have considered life and death as exemplifying his "fallacy of misplaced concreteness"? I seriously doubt it. See, for example, two of his essays, "Nature Lifeless" and "Nature Alive" [in *Modes of Thought* (Free Press, New York, 1968), pp. 127–147, 148–169]; and *Science and the Modern World* (Mentor, New York, 1948).
4. For an excellent discussion of the problematic status of "life" in modern scientific thought, see H. Jonas [*The Phenomenon of Life: Toward a Philosophical Biology* (Dell, New York, 1968)], especially the first essay (pp. 7–37).
5. The most prominent proposal is contained in the report of the ad hoc committee of the Harvard Medical School, H. K. Beecher, chairman [*J. Am. Med. Assoc.* **205**, 337 (1968)].
6. H. C. Hopps, *Principles of Pathology* (Appleton-Century-Crofts, New York, 1959), p. 78. This passage also suggests, in opposition to Morison, that the notion of death as a discrete event has a distinguished medical and scientific history and is not simply an artistic, literary, or legal fiction. The dead body that was lately alive is a concrete fact, a fact understood to some extent even by animals. One must wonder about the sort of scientific understanding of the world which tells us that the apparent change in state from a man alive to a man dead is but an illusion. If this is an illusion, then what is not?
7. To say that something is a discrete event does not mean that it need be instantaneous. Moreover, even instantaneous events take time, for how long is an instant?
8. See works by Whitehead (*3*) and by Jonas (*4*) for consideration of the problem of organism.
9. Such second-party benefits are, without embarrassment, admitted to be a major (if not *the* major) reason for updating the criteria for pronouncing a man dead [See especially the opening paragraph of the Harvard committee report (*5*)]. In support of the new criteria, Beecher has written: "[I]t is within our power to take a giant step forward in relieving the shortages of donor material. . . . The crucial point is agreement that brain death is death indeed, even though the heart continues to beat." And again: "Thus, if these new criteria of brain death are accepted, the tissues and organs now consigned to the grave can be utilized to restore those who, although critically ill, can still be saved" [*Daedalus* (Spring 1969), p. 291 and p. 294]. Indeed, the new criteria have been so linked with transplantation that one physician has publicly referred to them as a "new definition of heart donor eligibility" [D. D. Rutstein, *Daedalus* (Spring 1969), p. 526]. It can be only regarded as unsavory and dangerous, both for medicine and for the community at large, to permit the determination of one person's death to be contaminated by a consideration of the needs of others. Having said this, however, I hasten to add that the redefiners also think that their criteria do happen to fit the fact of death. The authors claim that they are true criteria, capable of scientific, and not simply utilitarian, justification. All the experience to date in using these criteria for pronouncing a patient dead supports the validity of this claim.
10. More generally, modern biomedical science needs to come to terms with human mortality. With the President making the conquest of cancer a national goal, and with others proposing crash programs to conquer genetic disease, heart disease, stroke, and aging (to each his favorite malady), medicine will soon be called upon to do battle with death itself, as if death were just one more disease. Fortunately, such a battle will not succeed, for death is not only inevitable, but also biologically, psychologically, and spiritually desirable.
11. E. Kübler-Ross, *On Death and Dying* (Macmillan, New York, 1969).
12. See P. Ramsey [*The Patient as Person: Explorations in Medical Ethics* (Yale Univ. Press, New Haven, Conn., 1970), pp. 113–164] for an excellent account of this ethic.
13. The exceptional cases cited by Morison (battlefield or civilian catastrophes) do not provide a precedent for allowing considerations of "the welfare of third parties or 'society'" to intrude upon the doctor's treatment of his patient under ordinary circumstances. What is special about these cases is that the survival of the entire group or community, as a group or community, is in jeopardy, not simply that they represent "conditions of special stress where available medical resources are clearly inadequate to meet current needs." There is an overriding, acknowledged single principle, the survival of the group, which justifies the practice of "triage" or "disaster medicine" under conditions of battle, great fires, floods, or shipwrecks. Those who are most able to be returned to function and most able, when functioning again, to save others are treated first. No such danger to community safety or survival is entailed by the ordinary (though by no means simple or trivial) problems that result from the usual scarcity of medical resources. See Ramsey (*12*, pp. 256–259) and P. A. Freund, *Daedalus* (Spring 1969), pp. xiii–xiv.
14. Morison writes: "Another significant parameter will be the sanctity *accorded to* any human life [emphasis added]." Life either has sanctity or it does not. Sanctity cannot be given or taken away by human accord (indeed, "sanctity" implies and requires "the sacred" and the divine), although men can, of course, choose to deny or ignore that human life possesses it. The difficulties and dangers of the cost-benefit approach to matters of life and death would not be lessened by placing the decisions in the hands of public committees. A widely-discussed citizens' committee in Seattle, which selected, on grounds including "social worth," from many medically fit candidates those who could use the few artificial kidney machines, has been disbanded. Its members felt incapable of judging the comparative value of individual lives when life and death are at stake. The problem resides not in any deficiencies of the Seattle citizens, but in the human impossibility of their task.
15. Strictly speaking, I doubt if we could establish the *right* to be mercifully killed. Rights imply duties, and I doubt that we can make killing the *duty* of a friend or loved one.
16. I am genuinely grateful to R. S. Morison for his stimulating and provocative paper. He has helped me begin to see more clearly what some of the serious and important questions are.