Foreword†

Today, people struggle to deal not only with the complexities of their daily existence but also with the complexities of the newly created or expanded powers of medicine to control the inception, quality, and termination of life.

The medical-moral-legal debate over questions of life and death is a specific crystallization of a more generic need which is delineated by Michael Harrington in his book *The Accidental Century.*[1] Mr. Harrington suggests that while unprecedented technological transformation of our environment has taken place, we have yet to make the corresponding transformations within our social, political, economic, and religious thinking.

How are the requisite transformations with regard to medical advances to be made? Many people, in order to elicit immediate answers to the problems generated by these new medical powers, tend to over-simplify, using such rubrics as "right-to-life" and "right-to-death with dignity." When scrutinized, this superficial approach is non-responsive and reveals a certain lack of comprehension of the importance of the issues involved.

Successful transformation will be achieved only by a series of well-planned steps. First, discussions are necessary to establish the elements of, and conflicts between, various medical-moral-legal viewpoints. The expression of diverse viewpoints in an interdisciplinary setting is an important first step in adapting to this advanced medical environment. Boundaries of specialization must be respected yet transcended. There must be faith in the interdisciplinary method as an antidote to any search for instant answers. People must realize that the results of their debate will be only as vibrant as the input from each source.

Second, after different viewpoints have been expressed and the inherent conflicts analyzed, the difficult task remains of successfully integrating the substance of the final positions presented into feasible standards. In synthesizing such standards, the ultimate goal of society and its leaders must be to preserve the value, sanctity, and individuality of life.

In this context, special care must be taken in adopting general phrases such as the "quality of life." Many ethicists and theolo-

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[1] M. HARRINGTON, THE ACCIDENTAL CENTURY.

gians, including Dr. Frederick Kittle of the University of Chicago and the Reverend Richard McCormack,[2] contend that life is measured not only by breath or by heartbeat, but by meaningful, worthwhile, or appropriate relationships to one's environment. From the legal perspective, a similar thought was expressed by the New Jersey Supreme Court in its ruling that the respirator which kept Karen Anne Quinlan alive, although in a state of coma, for almost a year could be removed. In its opinion, the court noted the absence of the medical capacity to restore her to a *cognitive* and *sapient* state of life. "Quality of life" has a certain—apparently constructive—meaning in this context; but in another context it might be used destructively. For instance, many people recently have equated the individual's "quality of life" with the quantity of his output. Such an approach, as a standard for deciding on the continuation or discontinuation of life, potentially threatens the elderly as well as the retarded, the deformed, and the handicapped.

Third, particular persons must be delegated the duty of making the requisite social decisions—through legislation, hospital policies, judicial rules, and so forth. Even if the physician ultimately is empowered by society to make many of the crucial bedside decisions concerning the use of advanced medical technology, the patient, his family, and other members of society must bear much of the responsibility for the establishment of the criteria upon which such decisions will be based. Physicians' medical expertise does not necessarily make them more qualified than others at setting moral and legal guidelines, nor should physicians be required to bear exclusively the burden of life and death decisions.

The articles in this issue of the *American Journal of Law and Medicine* constitute a positive step towards the expression of learned viewpoints; the developing of suitable standards; the as-

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[2] Whitlow, *Extreme Measures to Prolong Life*, 202 J.A.M.A. (1967). Reverend Richard McCormack has argued intensely and persuasively that restorative efforts should not be directed soley to restoration of biological life, but to life characterized by meaningful relationships. Father McCormack expressed this opinion as follows:

> One who must support his life with disproportionate effort focuses the time, attention, energy, and resources of himself and others not precisely on relationships, but on maintaining the condition of relationships. Such concentration easily becomes overconcentration and distorts one's view of, and weakens one's pursuit of, the very relational goals that define our growth and flourishing. The importance of relationships gets lost in the struggle for survival.

signment of decision-making responsibility; and, ultimately, the attainment of the transformations that will be needed in coping with emerging issues of life and death.

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