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1985, Vol. 10, No. 2, 87-94

"Euthanasia" of Persons with Severe Handicaps: Refuting the Rationalizations

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Article Descriptors
euthanasia, withholding medical treatment; infanticide; quality of life; Baby Doe regulations; public policy.

Many rationalizations have been proposed for the euthanasia of persons with severe handicaps. Those that are most convincing appeal to the alleged good to handicapped individuals of being allowed to die. This article examines two common rationalizations and presents arguments to refute them. The article calls for parents, professionals, and friends of persons with severe handicaps to be clear and vocal in refuting euthanasia and its rationales.

The past decade has witnessed a growing awareness about the "euthanasia" of persons who have severe handicapping conditions (Doudera & Peters, 1982; Guess et al., 1984; Horan & Delahoyde, 1982; Horan & Mall, 1977; President's Committee for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 1983; Robertson, 1975, 1982; Weir, 1977, 1984; Wolfensberger, 1981, 1984). "Euthanasia" is commonly used to mean mercy killing. However, despite its alleged merciful intent, euthanasia is a crime under traditional criminal law and considered by many to be murder (Horan, 1977; Kamisar, 1958; Louisell, 1973; Robertson, 1975, 1982). Recognizing the euphemistic overtones of the term, St. Martin (1975) referred to euthanasia as death-selection and Wolfensberger (1981, 1984) termed it one type of death-making.

In spite of the fact that many perceive it to be murder, the practice of euthanasia with persons with severe handicaps has received a great deal of support from ethicists, physicians, and even theologians (Fletcher, 1973; Lorber, 1978; Whytehead & Chidwick, 1977). Among them, there is considerable agreement that not treating infants with severe disabilities, with the intention of "letting them die," is a legitimate form of medical intervention. This process, called selective nontreatment, is accepted so widely as a type of treatment that some refer to it as "selection" or "selective treatment" (Lorber, 1973, 1978; Slack, 1984). Weir (1984) reviewed the positions of seven physicians who have been influential in shaping thinking about how to treat newborns with severe disabilities. Six of the pediatricians were "in agreement that some selective nontreatment of defective neonates is necessary" (p. 84); they considered it a viable and often reasonable form of medical attention. Only one pediatrician surveyed by Weir, C. Everett Koop, felt that the use of this means was wrong, saying that "the majority of pediatricians and pediatric surgeons are 'sanctioning infanticide' when they withhold medical treatments from neonates with congenital abnormalities" (Weir, 1984, p. 81).

Proponents of euthanasia have put forth many rationalizations for its use with persons who have severe disabilities (Diamond, 1982; Friedlander, 1982). Some arguments focus on the good to society of "allowing" disabled individuals to die. For example, at a time when care in a special nursery can cost thousands of dollars, questions are increasingly being asked about withholding treatment from some infants on the grounds that providing it is excessive in cost (Kramer, 1976). Other arguments for euthanasia center on the good to the individuals' families of "allowing" the family member to die. Fletcher (1975), for example, has proposed that the plight of parents should be heavily considered in deciding upon whether to treat an infant with severe disabilities. However, the most pervasive of the rationalizations for euthanasia—and the most convincing—appeal to the alleged good to the individuals themselves.

Rationales that allude to the good of the individuals can be particularly appealing to those of us who are parents, professionals, and friends of persons with disabilities. We are not easily convinced that euthanasia is the right practice when we are told that it costs society too much to service people with severe handicaps, or that it costs families too much in time, energy, and dollars to raise children with severe disabilities. But we find ourselves questioning our own beliefs about euthanasia when we are told that it is really the best alternative for handicapped persons themselves. Unless we are clear in our own position about the absolute worth of each life, we can be readily drawn into agreeing that individuals with severe handicapping conditions would be better off dead.

Thus it is imperative that we look at the rationalizations that are put forward to justify euthanasia of handicapped persons "for their own good" and consider some refutations of these rationales. In this paper, two common rationales that focus on the alleged benefit to the disabled individual will be explained. Several points will be suggested to refute each rationalization.

1)

Rationalization 1: The Individuals are Not "Really" People

In the first rationalization, it is proposed that the individuals in question are not "really" people, anyway; and therefore they would be better off dead than to exist as a nebulous species of nonpersons.

Central to this argument, according to Robertson (1975), is the notion that some offspring of man and woman are human and that some are not. "Conception and birth by human parents does not automatically endow one with personhood. . .some other characteristic or feature must be present in the organism for personhood to vest, and this the defective infant arguably lacks" (p. 247).

What are the characteristics that are required for humanness? Usually intelligence rates high. Proponents of this point of view say that if an individual lacks a certain level of intelligence, he or she is not really a person. Rickham (1969) put this view forward when he said, "One might ask whether class five (profound mental retardation) can be regarded as being humanly alive in the sense in which we usually understand these words" (p. 251). Fletcher (1972, 1973, 1974) also reflected this point of view when in all seriousness he claimed, "Any individual of the species homo sapiens who falls below the IQ 40-mark in a standard Stanford-Binet test. . .is questionably a person; below the 20-mark, not a person" (Fletcher, 1972, p. 4). Fletcher wrote that a father who gave instructions to withhold medical treatment for his son with Down Syndrome should feel no guilt, for guilt is only relevant when wrong is done to a person and (Fletcher's actual words) "a Down's is not a person" (Bard & Fletcher, 1968, p. 64).

2) Other characteristics that are thought to be required for humanhood are a sense of self-consciousness (Tooley, 1972) and the ability to have human relationships (Buber, 1947; McCormick, 1974; Whytehead & Chidwick, 1977). Whatever the characteristic, the individuals in question are not considered "really" people unless they have an adequate amount of the feature. "We see that the creature looks like a human being and that it was born of woman, though we know that it cannot possibly develop 'humanhood'" (Whytehead & Chidwick, 1977, p. 13). They are thus defined as nonpersons or nonhumans, and thought to be better off dead than to live an existence as a nonperson.

What are some reasons to refute this point of view, and consider all persons as fully human and fully worth letting live?

Abuse

One of the most compelling arguments for considering all persons as fully human is that abuse is typically imposed on those defined as subhuman. Robertson, a lawyer, argued that all persons *must* be considered persons because of the dangers inherent in calling some persons nonhuman. His position is simply stated: *All human offspring are human.* In this position, it is argued that all offspring of human parents are human, no matter what the limitations the offspring may have. "According to this view," said Robertson, "human parentage is a necessary and sufficient condition for personhood, whatever the characteristics of the offspring" (Robertson, 1975, p. 247). Walmsley (1978) agreed. "It is necessary that our society cease deluding itself by believing it can make a measure for humanness. It must be recognized that the offspring of the union of a man and a woman. . .are human" (p. 388).

Robertson explained that defining someone as nonhuman is the first step to abuse and even killing:

> Slavery, witch hunts and wars have all been justified by their perpetrators on the grounds that they hold their victims to be less than fully human. The insane and the criminal have for long periods . . .been deprived of the most basic necessities for similar reasons, and been excluded from society. . .
>
> Even when entered upon with the best of intentions, and in the most guarded manner, the enterprise of basing the protection of human life upon such criteria and definitions is dangerous. To question someone's humanity or personhood is a first step to mistreatment and killing. (p. 247)

He concluded his line of thinking in a pragmatic, down to earth manner. "Since reasonable people can agree that we ordinarily regard human offspring as persons, and further, that defining categories of exclusion is likely to pose special dangers of abuse, a reasonable solution is to presume that all living human offspring are persons" (p. 248).

When we look at the history of how persons with mental retardation have been treated, we have no reason to doubt the accuracy of Robertson's position. During this century alone, we have seen that persons with retardation who have been defined as nonhuman

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have been severely mistreated and even killed. Defining them as nonhuman has been related to their prolonged abuse in institutions. This abuse has been well documented by Blatt (1970), Blatt and Kaplan (1966), Bogdan and Taylor (1982), Rivera (1972), and Wolfensberger (1975); it has been attested to by people who have come out of institutions. "We will probably never know the full extent of the crimes perpetrated against mentally handicapped people and humanity itself within the walls of residential institutions around the world" (National Institute on Mental Retardation, 1981, p.61). How could such horrors take place? Blatt (1981) suggested that the residents were seen as nonhuman. He said that it is impossible to torture another human being "without agreeing and believing that the victim is not 'really' human" (p. 177).

In our own century, we have seen the mass extermination of people with handicaps on the basis that they were not really human. The Nazi euthanasia "program" was put into place after persons with severe handicaps were labelled as nonhuman, "creatures devoid of meaningful existence." Alexander (1949), Wertham (1966), and Wolfensberger (1981) recounted the horrors of this program. They showed that it was rationalized on the basis of persons with disabilities being defined as nonpersons, as having "absolutely worthless" lives, "lives devoid of value," and "lives not worth living." They were referred to as "those who cannot be rescued and whose death is urgently necessary," who "are mentally completely dead," or who "represent a foreign body in human society."

Thus, a strong argument for considering all persons as fully human is a very practical one that is easily understood. When people have been defined as subhuman, they have been abused, mistreated, and put to death.

Slippery Slope

A second argument for defining all persons as fully human and fully entitled to life is also practical and easily understood. How do we determine the cut-off points on who is human and who is not? How do we keep the cut-off points from changing? Will (1982) was referring to this idea when he asked: If we begin drawing the line of nontreatment with infants, will be able to resist drawing other lines with other handicapped people? Wolfensberger (1984) also alluded to this when he said, "When it comes to death-making, the so-called domino theory is indeed valid" (p. 72).

In the Nazi euthanasia "program," the criteria for who was not human changed rapidly and became increasingly global. The victims began with those who were severely impaired and grew to include those with odd-shaped ears or very dark hair:

> Initially selected for extermination were people in various institutions who had more severe physical or mental handicaps, e.g. those with severe handicaps in: mental retardation, mental disorders, tuberculosis, chronic illness, cerebral palsy, and epilepsy. However, with the quick and easy success of the early phase of the program, and the fact that a death-making apparatus had been structured and needed further victims for perpetuation, the criteria for inclusion broadened rapidly in four directions. These directions included individuals such as: (a) the less severely afflicted; (b) those who were physically atypical but not necessarily impaired (e.g. dwarfs); (c) those suspected of genetic and racial taints; and (d) those who were devalued entirely for their social identities, e.g. gypsies. In time, people were categorized into these groups if they had behavior problems or enuresis, odd-shaped ears, or, very dark eyes, hair or complexion. (Wolfensberger, 1981, p. 3)

This program of extermination, then, illustrates a second compelling reason to address all persons as persons. There is no adequate way to make a cut-off point on who is human and who is not; thus the cutting point can change drastically depending upon the whim of the one who is making the definition. It is a crucial issue in understanding the possible spread of involuntary euthanasia to increasingly large groups. Wertham (1966) noted that during the German euthanasia program, some institutions simply closed because all the residents had been *deinstitutionalized;* and Wolfenberger (1981) found that this program had been so *successful* that during his visit to Germany in 1963, he found few living units for mature adults because few mentally retarded adults were *living*. This problem has been referred to as the "slippery slope" (Kamisar, 1958). Kamisar contended that the slippery slope once begun is indeed difficult to terminate, and where it will terminate is anyone's guess.

A Spark of the Divine

A third argument for refuting the rationales for involuntary euthanasia is grounded in religious convictions as well as moral beliefs. This argument was stated eloquently by Ramsey (1972), who said that no human features are required in order to prove humanness because the newborn possesses humanhood of irreducible dignity as a free gift of God. Robertson (1975) said, "All creatures are sacred, contain a spark of the divine and should be so regarded" (p. 213). Gustafson (1973) agreed that "the intrinsic value or rights of a human being are not qualified by any given person's intelligence or capacities for productivity. . .rather they are constituted by the very existence of the human being. . ." (p. 553). Allen and Allen (1979) said, "Life is seen as a good gift because it comes from a good God. All human beings have an equal right to life, and everything should be done to uphold that right," (p. 49).

An illustration of religious convictions against euthanasia can be found in the affirmation by many

Jewish, Protestant, and Catholic theologians that all persons are fully human and that human life has infinite value (cf. Jakobovitz, 1977; O'Rourke, 1977; Pope Pius XII, 1977). "Infinite being indivisible, any fraction of life, however limited its expectancy or health, remains INFINITE in value" (Jakobovitz, 1977, p. 344). Examples in both Jewish and Christian teaching affirm the value of life and claim an "unqualified condemnation of euthanasia proper, that is, any active and deliberate hastening of death, branding such action as sheer murder" (Jakobovitz, 1977, p. 344). Paul Ramsey, a Christian theologian, probably summarized a great deal of thinking on involuntary euthanasia of children with handicaps when he said:

> Ordinarily, the neglected infants are not born dying. They are only born defective and in need of help. The question whether no treatment is the indicated treatment cannot legitimately be raised. . . As God is no respecter of persons of high degree, neither should we be. (Ramsey, 1975, as cited in Horan, 1977, p. 220)

Gustafson (1973) also appealed to unifying principles of religious belief systems in arguing against involuntary euthanasia of infants with handicaps. He cited a central theme of Old and New Testaments, "You shall love your neighbor as yourself" (Lev. 19:18) and "Love your neighbor as yourself" (Matt. 22:39) and "Each of you must regard, not his own interests but the other man's" (1 Cor. 10:24). Gustafson argued eloquently that "to be human is to have a vocation, a calling, and the calling of each of us is 'to be for others' at least as much as 'to be for ourselves'" (p. 556). He said that this central thrust in Judaism and Christianity has sustained our fundamental moral outlook, and called for us to adhere to it in decisions regarding saving the lives of children who are disabled.

Rationalization 2: The Individuals Lack Quality of Life

In this rationalization, it is proposed that the individuals lack a necessary quality of life; and therefore they would be better off dead than to exist in a meaningless life, often with suffering and sorrow.

Central to this argument is the notion that someone can judge whether another individual can experience meaning in his or her life. First, proponents of this point of view typically express their opinion on what makes life have value, meaning, and worth. Then, "one considers the handicapped person's potential for meaningful existence" (Allen & Allen, 1979, p. 49). If it is deemed that the person can have quality of life, then his or her life is seen to have value, and by implication, then, the person is worthy to live. If, on the other hand, it is thought that the person cannot experience this predetermined quality of life because of the severity of the disability, then it is decided that his or her life does not have value, and by implication, then, the person is not worthy to live.

What is the quality of life that is considered necessary for a meaningful existence? Several factors are usually used in trying to make a determination of the quality of someone's life. These include: the severity of the individual's disability, including the prognosis for development and/or prediction of future suffering; the stress or demands on the individual's family; and the cost to society of supporting the individual. In describing the quality of life perspective, Allen and Allen (1979) explained:

> Quality of life depends on the degree of the child's retardation or physical handicap, the disturbance his life would cause to his family, and the resources available in society to assure him of a meaningful life. Numerous value judgments determine the standard for adequate quality: the doctor's original diagnosis of the child's potential, the parents' commitment and expectations for their child, and the general attitude of the society toward unprofitable members. (p. 49)

Using the quality of life as a basis for deciding who should live and die is very common. A quality of life ethic has been advocated by many physicians who think that it should replace a sanctity of life ethic (Fletcher, 1973; Shaw, 1977). For example, potential quality of life was found to be the most important factor among physicians in making decisions about whether to treat infants with Down Syndrome (Affleck, 1980; Shaw, Randolf, & Manard, 1977). Quality of life has also been advocated as a basis for ethical and legal standards about whether to treat infants with disabilities. For example, a quality of life point of view was advanced by the participants, primarily physicians, of a conference on moral issues in the newborn nursery (Jonsen, Phibbs, Tooley, & Garland, 1975). They suggested that "prognosis about quality of life should weigh heavily in the decision as to whether or not to order live-saving intervention." As well, the quality of life perspective was clearly advocated by the Australian College of Pediatrics in 1983 when they said, "First and foremost the right of the child to live is paramount provided that survival is consistent with an acceptable quality of life. . ." (p. 220).

At its heart, the quality of life view depends on the value that is put on someone's life. The value of the person is judged to be relative to the predicted quality of his or her life (Gustafson, 1973). It is thought that lives that are not worthwhile—which are seen to have no worth to self, family, or society—can be legitimately terminated.

What are some reasons to refute this point of view, and to consider all persons fully worthy to live regardless of the alleged quality of their lives?

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Determining Quality

One argument against the quality of life rationalization is based on the impossibility of defining quality of life. How do we determine what comprises quality? How do we know whether there is adequate quality in life for it to be worthwhile, or for a person to be considered worthwhile? Most important, how do we determine what is worthwhile for someone else's life?

We cannot make a judgment on other peoples' behalf that their lives will not be worth living. Diamond (1977) pointed out that it is not up to parents, physicians, or the society at large to assume that a child with severe handicaps would rather be dead. He reported on a study in which a large number of children with severe impairments due to thalidomide were questioned. The study indicated that the children "do indeed value their lives, that they are glad they were born and they look forward to the future with hope and pleasant anticipation" (p.133).

A similar argument was put forth cogently by Robertson (1975), who asked how a "proxy" could possibly accurately conclude that someone with severe handicaps would not want to live. Would a "person with different wants, needs and interests, if able to speak, agree that such a life were worse than death?" (p. 254). How can someone else say, he questioned, that a child with an IQ of 20 would rather be dead than live the life he is living? He warned that the "proxy" making this judgment is probably not a disinterested party but one who would be responsible for the person's care, and he questioned who is being spared in the decision to withhold treatment. He argued that we cannot judge the meaning or worth that is inherent in life, even when life is severely restricted. "Life, and life alone, whatever its limitations, might be of sufficient worth to him" (p. 254).

Allen and Allen (1979) commented on the danger of making stereotypic judgments about what is meaningful in the lives of people with handicaps. Why, they asked, would persons who are impaired necessarily find life less worthwhile than people who do not have serious disabilities?

> If we ask what kind of people find life meaningless, meaningless enough to commit suicide, we find that it is not the retarded or severely ill who are most at risk for committing suicide, but rather college students. (p. 50)

Thus, one point in rejecting the quality of life perspective involves the difficulty of defining what quality of life means. It is virtually impossible to judge whether persons who are impaired, but who cannot speak for themselves, would choose to die rather than lead what someone else considers a meaningless existence. We hear it said that euthanasia relieves the burden of living, that an infant, for example, with Down Syndrome has the right to die (Bard & Fletcher, 1968). From whose life is the burden lifted when the person with a handicap is killed?

Pessimistic Predictions

Another difficulty with the quality of life perspective lies in the likelihood that persons making quality of life predictions about individuals with severe disabilities may hold unduly pessimistic ideas about their ability to grow, develop, and enjoy life. Have those advocating a quality of life perspective had extensive experience with persons with disabilities? Do they have accurate ideas about the disabled person's potential?

This issue has been visible in the debates over the euthanasia of infants born with spina bifida. Lorber (1973, 1978) is an outspoken proponent of the selective nontreatment of infants whom he has designated as too handicapped to have a good developmental prognosis. In 1973, he reported that his hospital did not treat 25 of the 37 newborns with spina bifida born during a 21-month period because their conditions were too severe according to his clinical criteria; all died within 9 months. In contrast, Zackary (1977) is "convinced that many pediatricians engaging in selective nontreatment of spina bifida infants are unduly pessimistic about the future awaiting such infants" (Weir, 1984, p. 77). He indicated that these children are often depicted as living completely miserable and unhappy lives, but he has not found this to be the case for the children with spina bifida whom he has treated.

Differing opinions about the potential development of persons with spina bifida became acutely apparent in April, 1982, when an infant with this condition was denied treatment and apparently was being starved, allegedly because of the physicians' and parents' pessimistic predictions about the future quality of the child's life. The Spina Bifida Association of America assumed an advocacy role in this case by publicly calling for "treatment of this baby and of every infant born with spina bifida" because "ninety percent of children born with this condition today grow up to live normal, healthy lives" (Weir, 1984, p. 130).

There has also been an enormous discrepancy in opinion about the extent to which children born with Down Syndrome can develop. Pediatricians who consider selective nontreatment for infants with this condition, such as Duff, Campbell, and Shaw (Weir, 1984) presumably hold low expectations for the children's development, growth, and enjoyment of life. For example, in 1975 a prominent physician, chief of the Reproductive Genetics Unit in an eastern university hospital, was quoted as saying, "You show me just one mongoloid that has an educable IQ. . . . I've never seen even one in my experience with over 800 mongols" (Restak, 1975). As recently as 1984, a text on selective nontreatment of handicapped newborns provided the following description: "The mental deficiency is such that older children and adults with

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trisomy 21 typically have an I.Q. ranging between 25 and 60. . .because they fail to keep up with normal peers, Down's individuals display progressively slower mental growth with the passage of years" (Weir, 1984, p. 45).

down syndrome

These projections stand in sharp contrast to those of Rynders (1982), an educator who has had broad experience with children who have Down Syndrome. After a thorough review of the literature about promoting learning in Down Syndrome students, Rynders concluded that physicians could tell new parents of Down Syndrome children that there is "a definite possibility that their children will be educable on a psychometric basis. . .the limits of Down Syndrome children's educability are virtually unknown. This more positive portrayal is not only appropriately optimistic, it is also *fair*" (p. 392).

In all, a major difficulty with the quality of life perspective lies in the problem of making predictions about the infants' development potential and future quality of life. The debate about euthanasia, at least as it is reflected in the literature, has taken place primarily among physicians, lawyers, and philosophers. Educators who have current information about advances in the development of students with severe disabilities seem to have little input into the discussion of the issues. Because it is likely that many using a quality of life perspective to rationalize euthanasia have had little or no extensive experience with children who have disabilities, their views about what life is like for the children or their families may be superficial, inaccurate, and mistakenly gloomy.

Quality Depends on Others

The quality of life argument is inherently troublesome for another reason, as well. Even if criteria could be established to determine quality of life, and even if accurate predictions could be made about the children's development, it is clear that the quality we enjoy depends on others and how others treat us. The quality of life experienced by people with disabilities may depend more on how others relate to them than on their problems at birth. If they are defined as vegetables, rejected by their families, left in the back wards of institutions, or shifted from one residence to another, then this terrible quality of life is imposed on them by their surroundings rather than their condition at birth. "The absence of opportunities for schooling, career, and interaction may be the fault of social attitudes and the failings of healthy persons, rather than a necessary result of congenital malformations" (Robertson, 1975, p. 253). In other words, meaningful relationships are required for meaningful lives, and meaningful relationships require others.

Vanier

Few authors have expressed this notion more eloquently than Jean Vanier (1971), who has chosen to live with previously institutionalized adults. Vanier spoke of the men with mental retardation with whom he has shared his life. He said that the men who had been institutionalized were deeply wounded by their severe rejection, isolation, and lack of love. Their lives in institutions were devoid of meaning and devoid of quality.

> Misery. . .is the person without a friend. . . The miserable person is he who, having lost all motivation, all hope, has no one. . . This is truly the miserable man, who feels abandoned because he is despised, because he feels unworthy of the respect and love of another. (p. 29)

What is the cause of the misery in their lives? Is the tragic quality of their lives a result of their condition at birth; or is the quality of their lives a result of the lack of human, caring treatment; perhaps the lack of even one person in the world caring about them? "We begin to feel inner happiness when we feel certain we are important to someone; that when we die, someone will cry over us; that we have left an emptiness not only in a bed but in a heart" (Vanier, 1971, p. 30).

To argue, then, that a person would be better off dead because he or she inherently lacks quality of life does not make sense. A person's quality of life depends on what others make it, as well as on what gifts or limitations are received at birth. As Panza (1984) said, "The quality of life is measured by how well *others* give meaning and value. . .quality of life is rooted in what others do for us to ensure our humanness, our dignity and our worth" (p. 2).

Conclusion

Wolfensberger has warned repeatedly against the "for their own good" mode of thinking. He pointed out (1972, 1975) that society's mistreatment of people with handicaps is usually justified on the basis that "it is for their own good." He indicated that women with handicaps were sterilized "for their own good"; people were isolated in remote institutions "for their own good"; and disabled children were segregated into separate schools "for their own good." He recently warned (1984) that euthanasia will be—and even is—called mercy, love, humanism, honesty, even good religion. He said, "If there is anything a society wants very badly, then its intellectuals and scientists will prove that it is good and desirable" (p. 74).

If the treatment suggested for persons who are impaired is inhumane or cruel, we must question whether it is for their own good, or whether it is primarily serving the good of someone else. We can ask ourselves: Is the same treatment being applied to people who are not impaired? Would we consider withholding medical treatment if the person didn't have a handicap? Kamisar (1958) expressed the essence of these points in the following quotation:

> "At the Crystal Palace Aquarium not long ago I saw a crab euthanastising a sickly fish, doubtless from the highest motives." (p. 969)

for their own good

The risk of involuntary euthanasia to persons with severe handicaps continues to exist, and rationales that appeal to the good of the person being killed will most likely be applied when the decision to select nontreatment is made. Some life and death decision-making will now be in the hands of hospital infant care committees. Many hospitals have been encouraged to give these committees the responsibility of defining policies about "types of cases, giving advice on specific cases, and making reviews when nontreatment is chosen" (Murray, 1984, p. 17). This implies that recommending the denial of lifesaving interventions is within the realm of their responsibilities. This may not be an issue for infants who are already dying, or whose condition makes it impossible for them to respond to treatment, because their lives cannot be saved. However, controversies will most certainly arise for children who are severely impaired and need treatment in order to live. The rationalizations described above are likely to be brought to bear when euthanasia is recommended and chosen. As advocates for people with severe disabilities we have to be clear and vocal in refuting these rationalizations and in affirming the absolute worth of each life.

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