Massachusetts court expressly refused to adopt the Department's position on fear of contagion. The court noted that a person with AIDS "may also qualify as a protected handicapped person based solely on an employer's erroneous perception of him as someone who is contagious to co-workers."

Aggressive employers covered by the Act who have no fear of litigation may decide to focus on the fear of contagion in discharging employees, relying on the Department's interpretation. Other covered employees may choose to take a more conservative approach and treat even an asymptomatic person who might be capable of transmitting the AIDS virus as possibly protected by the Act. This latter approach is consistent with the mainstream of legal opinion from attorneys who have been most closely following the development of AIDS legal issues. The supposed fear of contagion defense for employers is not considered a safe harbor. Certainly, any employer who is contemplating discharging an employee, relying on the Department's fear of contagion defense should discuss the action with legal counsel knowledgeable in this area.

(1) 29 U.S.C. S 794 (1985).
(2) 29 U.S.C. S 706(7)(B) (1985); 41 CFR S 60-741.2 (1985).
(3) Memorandum from Charles J. Cooper, Department of Justice, to Ronald E. Robertson, Department of Health and Human Services, June 20, 1986.
(4) Id. at 1, 22-29.
(5) Id. at 29-36.
(6) *Cronan v. New England Telephone Co.*, CA No. 80332 (Mass. Sup. Ct., Suffolk County).

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The Killing Will

Ernest W. Johnson

Our spring 1986 issue concerning living will laws was generally in favor of them. This author presents another view.

A fashionable, widely practiced notion is the execution (double entendre) of a "living will." This document projects an exodus from a terminal sickness or injury...permission given ahead of time to relatives or physicians to detach or otherwise disable life-extending devices.

In other words, it suggests that spouse or physician murder someone. It prescribes a planned suicide with or without assistance from family, friends or health professionals. Witness the controversial recent book, *Last Wish,* in which Betty Rollin describes how she helped her 76-year-old mother with cancer to die prematurely.

The term "living will" is an oxymoron–an intrinsic contradiction akin to calling the MX missile a "peacekeeper." Perhaps it is appropriate to label it a euphemism–like "revenue enhancement" for "taxes."

My inclination as a physician is to approach these situations with flexibility and tolerance. Technology is changing our practice but we shouldn't be stampeded into supporting legal solutions for defining death. Judges can't practice medicine.

Brain death is human death. Determination of brain death is more accurate now but we still should exercise caution in shutting off the life support systems. Examples abound, even today, of individuals existing in "irreversible" coma for several months who then recover to have useful lives.

A recent TV segment presented an elderly man with ALS (Lou Gehrig's disease) and a tracheostomy and ventilator. His wife wanted to end his (her?) suffering. As the video interview continued, it seemed clear to many of the viewers that he didn't want to die in spite of his previous "living will."

We have ways of breathing (without compromising communication) for patients who need ventilation assistance. A ventilator is *NOT* an extraordinary means of survival. Ask the thousands of post-polio people who have been on ventilators for 30 years or more.

Only our brain makes us human, and technologies to keep the brain viable and thinking *ARE* rational and appropriate! If we need to use kidney dialysis, a heart pacemaker, a ventilator–hats off to technology. All of these life extenders are, in principle, no different than giving insulin to a diabetic or penicillin for pneumonia.

The Living Will is a license for murder or suicide. Or, more accurately, it can be described as a technique to minimize the suffering of the *relatives* and *health professionals* caring for the patient. William Osler, our honored forebear, reportedly philosophized that the most uncomfortable people in a terminal situation were the relatives, physicians and nurses–NOT the patients. Intractable and unbearable pain is almost always in the eyes of the beholder–either the health professional or the family member.

A "living will" is–as we used to say in the Army–"anticipating the command."Our will to live is strong and over-riding; "don't hasten death" is sound advice in most situations. A "living will," on the other hand, is permission for killing.

Reactive depression at these difficult times clouds clear thinking, fosters irrationality and may result in a wrong decision about giving permission to die prematurely. Whether passive or active measures terminate the life is irrelevant and only distracts from the crucial decision of killing someone. Programming death is murder if done by others, or suicide if unassisted.

Life is priceless and should not be "willed away." As Yogi Berra so inaptly phrased it: "It's not over 'til it's over."

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