

# Life Cycle

## **Active euthanasia and assisted suicide: Medical progress or human rights atrocity?**

What is meant by active euthanasia and assisted suicide? Is it legal to cause the death of patients? Is it ethical? How do physicians feel about intentionally causing death? What if the patient requests it? Who would be the most likely candidates subjected to either active euthanasia (with or without the patient's consent) or assisted suicide?

These are questions being raised today as society grapples with rising health care costs; a burgeoning population of older people; high numbers of people without health insurance; patient desire for medical self-determination; and growing acceptance of the notion that some individuals are too old, too ill, or too disabled to be allowed to live.

This *Life Cycle* deals with the emerging debate over whether society can say some lives are not worth living, and who has the power — real or potential — to directly kill a patient through active euthanasia and assisted suicide. After a description of what these terms mean, we hope to bring to readers an in-depth perspective on active euthanasia and assisted suicide historically, ethically, legally, and medically. The availability of positive alternatives will be discussed along with personal stories about people with conditions making them high risk potential victims of active euthanasia or assisted suicide.

We want to alert readers to the very real danger which exists today for many vulnerable people, and, ultimately, for us, of having our lives ended by the decision of others.

# They sent me home to die...

**by Robert Powell  
as told to Mark Torinus**

One day while I was playing in my crib, my parents noticed that I had a problem. I no longer was standing up. My mom would pick me up and put me on my feet, and I would fall down.

So she took me to the doctor because I also started to cry a lot, more than normal. He did some diagnostic x-rays and saw a mass in my chest.

They did surgery on an exploratory basis, and when they opened me up, found a tumor that was located between my heart and my lungs. It had already consumed my right lung and had attached itself to the spinal cord, thereby making me a paraplegic.

The doctors at that point determined that my quality of life had diminished so much, there was no point in trying to do anything. So they closed me up without taking out the tumor. They told my parents, "He is not going to live, we're not going to do anything. Just take him home to die."



*continued...*

## They sent me home to die...

Well, my parents refused to accept that prognosis and began to talk to other physicians. Another physician said he was doing some research in radiation therapy and would like very much to have me as a patient. The irony is that this physician was also a paraplegic.

I had in excess of 30 radiation treatments within a one month period. What he did was literally burn the tumor out of me. The other physicians kept telling him, "Well, he is not going to live six months." But I did.

When I went in after six months for a checkup, they continued to say, "Oh, well, he'll never live to be a year old, he'll never see his first birthday." Well, I was there on my first birthday.

It just continued. They'd set a new length of time, and I would still be there! It was almost comical because I'd keep showing up, and they'd keep pronouncing me a dead person.

Now I continue to be told by physicians, "You're not going to reach your 65th birthday, so you might as well enjoy yourself now." So, they're still labeling this death sentence on me before I'm really convinced it's my time. I have another goal, that I am going to visit this same doctor, if he's still alive, on my 65th birthday to say, "Wrong again!"

I was one of those cases where some doctors felt I was better off dead than disabled. I am a paraplegic. I am not sick. I walk with the assistance of braces and crutches; sometimes I use a motorized wheelchair if I want to go places faster than I can walk. But I attended public and private schools that were not really designed for people with disabilities. People with no disabilities hold the same type of job I do. I travel extensively, and I have gone to Europe.

What my history really made me realize is that in dealing with medicine and doctors, you have to make your own decisions. A doctor tells me one thing, and if I really don't think it's a good idea, I talk to another doctor. I make my own decisions. Period. Nobody makes them for me, not my family, not my friends, but me.

It's not really bitterness I feel toward doctors, it's outrage. They don't see the capabilities of people who have physical limitations.

The current attitude, it seems, in hospitals and among physicians, is how to help people die rather than how to help people live. So I am in the process,

along with a number of disability rights activists I know, of drawing up medical directives that say, "Yes, I want food and water; yes, I want a respirator." So it's perfectly clear to anyone who tries to go into court to decide whether or not I want to live or die, that I want to live.

There's an attitude out there in society that really bothers me when we talk about euthanasia and disabilities. Let's say we have two individuals; one has a disability, perhaps a quadriplegic, and has come to a point in his life where he feels like, "I'm tired. I'm hurting. I have all these medicines I don't want to take anymore. I may want to take advantage of euthanasia."

Then we have another person who is nondisabled, but is maybe going through a bad marital experience or who might be depressed, and is also thinking about euthanasia.

Well, the reaction in society toward the person who has the disability is, "We ought to help the poor guy out of his pain." But to the other person who is not disabled the reaction is, "Oh, he's in a depression. We've got to help this guy. We've got to talk him out of it. He really doesn't want to do this."

The current attitude out there is that society sees people with disabilities as persons to be pitied rather than valued. What our society should be moving towards is eliminating certain barriers to people with disabilities, *not* helping us die.

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*Robert Powell, 41, is an insurance underwriter in Galveston, Tex. At a very early age he experienced a tumor predicted by doctors to be fatal. Powell beat the predictions, however. He is active in local, state and national disability rights groups, including ADAPT (Americans Disabled for Access Power Today). Powell was invited to the White House to witness the recent signing of the Americans With Disabilities Act. He has been active in the leadership of the Texas Right to Life Committee, and is now vice-president of the National Right to Life Committee.*

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*Mark Torinus, the writer who completed the personal interviews for this issue of Life Cycle, is a college graduate with degrees in government and urban studies. Torinus has a background as a newspaper circulation manager, reporter and general manager of a family-owned newspaper. Most recently he was managing editor of the Janesville Gazette of Janesville, Wis. He is now a self-employed businessman.*

# The slippery slope

by Burke Balch

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*Burke Balch, J.D., is medical ethics director for the National Right to Life Committee. He formerly was chief staff counsel for the National Legal Center for the Medically Dependent and Disabled, Inc., a federally funded, legal services program that protects the right of poor people, especially older people and people with disabilities, to be free of discriminatory denial of medical treatment, food and fluids. Balch has co-authored legal articles on abortion, infanticide and suicide.*

Years ago, a principal argument used against euthanasia—one much derided by those who support euthanasia—was the “slippery slope.” If we accept the denial of lifesaving medical treatment to someone in a “hard case” situation, it ran, what logical or social barrier would prevent us, down the line, from directly killing someone with a disability, even against that person’s will? The tragic reality is that the pro-life and disability rights advocates, who made those arguments years ago, are now seeing those predictions coming true.

The trends in euthanasia have moved along two lines:

1. The extent to which a decision for death would have to be voluntary.

2. The method that would be used to cause death.

The debate began, in the first instance, with an argument for voluntary euthanasia, where a competent adult specifically expressed the wish to die.

From there, it moved rapidly to cases in which someone else made a death decision for an individual who was unable to speak for himself or herself, and who had left no clear indication of treatment desires. But the debate has moved even further, as evidenced by the Helga Wanglie case in Minnesota. Prior to becoming incompetent, Mrs. Wanglie clearly expressed a desire to have all life-saving treatment continued. But her physicians attempted to obtain a court order allowing them to remove the treatment, arguing that giving it to her was a poor use of resources given her perceived “low quality of life.”

Secondly, in the method of death, the debate initially centered around the circumstances when life-saving medical treatment could be withheld or withdrawn. In the 1970s, proponents of the withholding or withdrawal of life-saving treatment were quick to offer assurances that there was no intention of taking away such basic care as food and water. But the 1980s witnessed the rapid evolution of a consensus that “artificially provided,” even spoon-fed, food and fluids should be withdrawn as readily as medical treatment. Death by starvation and dehydration, now looked upon as a “good” death, will eventually be regarded as slow and inhumane. This will fuel the current debate which has

reached the final stages, to promote direct killing through lethal injection or other means.

These two euthanasia trends cannot really be separated — in fact, their convergence was inevitable.

As a matter of law, it is already established in nearly every state where courts have addressed the issue, that if competent individuals have a right to reject medical treatment or food and water, the same right can be exercised “on behalf of” an incompetent individual by a court or guardian deciding it is in the person’s “best interests” to die. Likewise, if direct killing of a competent individual at his or her own request becomes a legal right, the simple application of these now accepted legal principles will legalize direct killing of those who have made no such request. This will occur *without any further policy decision by voters or legislators*—simply by the action of the courts when an appropriate case is heard. In short, given current legal realities, if voluntary active euthanasia is legalized, it will, as a practical matter, directly bring about legalization of non-voluntary active euthanasia.

And how long would euthanasia be confined to private, rather than public, decisions? Already the Oregon legislature has adopted a health care rationing plan which denies Medicaid funding for medical treatment if the outcome does not change a perceived “low quality of life” for the patient. If active euthanasia gains the acceptance now accorded denial of lifesaving medical treatment, can government-mandated active euthanasia be far behind?

Why should there be concern about killing those who have made no such request? Dr. Pieter Admiraal, the successful leader of the euthanasia movement in the Netherlands, has predicted, “[Society] will start asking, ‘Why have that burden? Why have all those psychiatric patients and mongoloid patients, for instance, and the elderly?’ We can estimate that by 2020 or 2030, there will be the highest proportion of old people and the smallest amount of young people the world has ever known. We know already about the ratio of Alzheimer’s disease in such an old population. We realize there will be demented patients

by the tens of thousands. So I’m a little bit afraid. I really think that [by then] we may accept that for purely economic reasons, they can stop life after a period of three years of complete dementia, for instance....I don’t believe we can prevent it.”<sup>1</sup>

When Dr. Admiraal, the leader of the first successful, contemporary movement to legalize active euthanasia, predicts that it will become non-voluntary, and when an “emerging consensus” already supports denial of lifesaving medical treatment to people against their will, can there be serious doubt that non-voluntary or involuntary active euthanasia of older people and people with disabilities is close at hand?

Those now dying because of these trends are people with disabilities that prevent them from being able to speak for themselves. Those most imminently at risk in the near future are those depressed individuals whose suicidal attempts will no longer be met with the counseling and assistance that a cry for help deserves, but rather with the indifferent response, “It’s your right.” But the ones who come next are sure to be ourselves—when we become disabled enough, or old enough, to be “burdens.”

It was a man sent to the concentration camps, Minister Martin Niemoeller, who said, “In Germany they came first for the Communists, and I didn’t speak up because I wasn’t a Communist. Then they came for the Jews, and I didn’t speak up because I wasn’t a Jew. Then they came for the trade unionists, and I didn’t speak up because I wasn’t a trade unionist. Then they came for the Catholics, and I didn’t speak up because I was a Protestant. Then they came for me, and by that time no one was left to speak up.”<sup>2</sup>

Let Niemoeller’s words be a warning and spur to action for us, together with the words of George Santayana: “Those who cannot remember the past are condemned to repeat it.”<sup>3</sup>

### Notes

1 Allan Parachini, “The Controversy,” *Los Angeles Times*, 5 July 1987, p. 1.

2 Emily Morison Beck, ed., *Bartlett’s Familiar Quotations*, 15th ed. (Boston: Little, Brown and Company, 1980), p. 824.

3 *Ibid.*, p. 703.

## What is euthanasia?

In keeping with the root definition of "euthanasia"—literally "good death"—contemporary proponents of euthanasia insist they are talking about helping a terminally ill patient in insufferable pain die a dignified death—at the patient's request.

But this description bears no resemblance to the true picture of the actual practice of euthanasia in the United States and elsewhere.

As currently practiced, euthanasia often involves withholding food and water from a patient whose death is caused by starvation or dehydration rather than the patient's underlying disease. This topic was extensively dealt with in the April 1991 edition of *Life Cycle* titled "Withholding food and fluids."

Our focus in this edition is on other types of killing — active euthanasia and assisted suicide.

### Two dimensions to euthanasia

- To what extent, if any, the decision to be killed is made "voluntarily" by the patient.
- The degree of involvement by a second party in actually killing the patient.

### How "voluntary" is the decision to be killed?

- **Voluntary** - The patient specifically requests to be killed.
- **Non-voluntary** - The patient's wishes are unknown and another person requests that the patient be killed.
- **Involuntary** - The patient is killed even though the patient has expressly stated that he or she does not want to be killed.

### Second-party involvement in killing

#### I. Active euthanasia (direct killing)

- Definition: An affirmative action to directly kill a patient.
- Examples:
  - A physician **directly injects a patient with a lethal substance**. (A current cutting-edge proposal known as "physician-assisted suicide" would legalize a doctor killing the patient. This practice is not really an "assisted suicide" because the patient does not kill himself or herself.)  
**Legal Status:** Illegal in all fifty states.
  - A person **shoots, smothers, or otherwise causes the death of another**, allegedly for reasons of "mercy," for such conditions as a prolonged illness or perceived suffering.  
**Legal Status:** Considered homicide and prohibited by law in all fifty states.
  - Either **stopping or never starting food and fluids** for the patient and the patient dies of starvation or dehydration rather than the underlying disease.  
**Legal Status:** No universal legal standard with state courts reaching differing conclusions on who can make decisions when the patient is incompetent.

#### II. Assisted suicide

- Definition: Intentionally providing the means for someone to kill himself or herself.
- Example:
  - A physician **prescribes sleeping pills to a patient** and instructs the patient on how much to take to kill himself/herself.  
**Legal Status:** Prohibited by law in most states, but not all.

## Historical perspective and current trends

By Barbara L. Lyons

Society's flirtation with active euthanasia is as old as medicine itself. The 2,400-year-old Hippocratic Oath, which until recently was routinely taken by all physicians, condemns active euthanasia by stating: "I will neither give a deadly drug to anybody if asked for it nor will I make a suggestion to this effect." This oath was a mainstay of Western medical ethics for centuries and had the crucial effect of assuring that the physician would always be a healer, not a killer.

The first widespread manifestation of euthanasia in this century came, of course, with the Nazis. What is not widely known is that euthanasia was championed by the most respectable physicians in Nazi Germany even before Hitler came to power, and that the killing started with children.<sup>1</sup>

In 1938, in Leipzig, Germany, a baby was born who was blind, missing a leg and part of an arm, and was believed to have severe brain damage. Adolf Hitler, sensing this to be a good test case, dispatched his personal physician, Dr. Karl Brandt, to go to the clinic where the child clung to life. Brandt and other clinic physicians determined that the child could be killed because of the seeming hopelessness of the situation. They proceeded to end the child's life.<sup>2</sup> The following year, Brandt was authorized by Hitler to set up an official system to handle further "mercy killings." The program begun for children quickly broadened to include adults.<sup>3</sup>

The year 1939 was designated by Hitler as the year of "the duty to be healthy." He formed several medical organizations to administer the destruction of patients with mental illness and children with disabilities, and to oversee all euthanasia operations.<sup>4</sup>

By 1945, 275,000 men, women and children with mental illness, mental retardation, epilepsy, multiple sclerosis, and old age had been killed in established killing centers<sup>5</sup> because they had "lives not worthy of living." The meth-

ods of killing begun under this program, and the actual equipment and staff employed, were later put to use in the more extensive programs under which millions of persons deemed politically or racially "undesirable" were put to death.<sup>6</sup>

When revelation of the extent of the Nazi atrocities and killings during the Holocaust produced outrage in the world community, euthanasia became a dormant issue for several decades.

Many factors account for the reappearance of support for euthanasia.

Much of it stems from acceptance of the principle that some categories of people can be killed for the convenience of others. By the 1970s, bills attempting to legalize active euthanasia appeared in several of our United States. One "right to die" bill introduced in Wisconsin would have allowed any person aged seven or older to request death, and allow any person aged fourteen or older to "terminate the life of the requestor."<sup>7</sup>

In Montana, a bill was introduced allowing an adult to request death by lethal means, and providing protection for the person fulfilling that request. The individual requesting death could change his or her mind once, but could not prevent death from being carried out if a second request was followed by a change of desire.<sup>8</sup>

Society was not ready for measures such as these, regarded as too extreme, so many state legislatures and "right-to-die" groups focused very successfully in the 1980s on the recognition of advanced documents (or directives) to give legal authority to withholding or withdrawing life support systems from an individual when that individual became incompetent. These documents vary greatly from state to state and cannot automatically be considered "euthanasia" documents. But what they have done is fuel the progression from withholding or withdrawing medical treatment, to withholding or removing basic food and fluids. This has resulted in legal sanctioning of death by starvation and/or dehydration.

In recent years, assisted suicide and active euthanasia have been openly advocated in the United States by groups such as the Hemlock Society. Featured stories have appeared in some of the most prestigious medical journals. For example, the January 8, 1988 issue of the *Journal of the American Medical Association* featured an anonymous account of a gynecology resident who gave a lethal overdose of morphine to a young woman with cancer named "Debbie."<sup>9</sup> Debbie was described as

"sleepy" when she allegedly made her vaguely-worded request to "end it all" to the resident, who had never seen or cared for her before the incident.<sup>10</sup> In the March 7, 1991 issue of the *New England Journal of Medicine*, Dr. Timothy Quill described his role in assisting a woman suffering from leukemia to commit suicide by advising her as to how many sleeping pills to take.<sup>11</sup> Although his actions were illegal, a grand jury failed to indict Quill.

In Michigan, Dr. Jack Kevorkian, inventor of the so-called "suicide machine," assisted a woman recently diagnosed with Alzheimer's disease to commit suicide in June of 1990.<sup>12</sup> He was not criminally prosecuted because Michigan has no specific law against assisting suicide, but he was ordered by a civil court not to use his "suicide machine" again. Nevertheless, he assisted two more women, neither with a terminal illness, to commit suicide in October of 1991, again in Michigan.<sup>13</sup> In early 1992, Kevorkian was charged with murder in connection with the latter two deaths.

In 1988, the Hemlock Society attempted to place a referendum question on the ballot in California which would have legalized active euthanasia.<sup>14</sup> The effort failed when the required number of signatures was not obtained. However, the Hemlock Society successfully gained enough signatures to place a proposal to legalize euthanasia on the November, 1991 ballot in the state of Washington. Initiative 119, called "aid in dying," attempted to amend the state's living will law to create a "fundamental" right to be assisted to die if the person was terminally ill, had signed a death request or made an oral request, and was conscious and mentally competent.<sup>15</sup> Since the right was to be considered "fundamental," legal observers were certain that a proper case brought to court would extend this perceived "benefit" for competent patients to those that were incompetent.

Despite seemingly heavy initial support in the polls, Initiative 119 failed by a 54% - 46% margin. Supporting the pro-euthanasia measure were the Hemlock Society, the State Democratic party, the American Civil Liberties Union of Washington, and others. Opposing Initiative 119 were the Washington State Medical Association, the Washington State Hospice Organization, the Washington State Hospital Association, the Washington Catholic Conference, the Evangelical Lutheran Church of America, Human Life of Washington, the As-

sociation for Retarded Citizens, and others.

Fueling the impetus for such measures to be enacted are heavily-biased docudramas, produced by the major television networks, which portray those in favor of active death decisions as caring, humane individuals. Those opposed are invariably portrayed as harsh, rigid, and ignorant.

The concept of suicide as a "good" reached a low point when Derek Humphry, the head of the Hemlock Society, saw his book "Final Exit," become a best seller in 1991. In this book, Humphry teaches his readers various means by which they can end their own lives.

Advocates of euthanasia strongly resent comparisons between the practices they propose, and those of the Third Reich. They cloud the issue by focusing on *who* makes the decision for death, rather than the *results* of the decision. When the decision results in legally ending the lives of those deemed unworthy of living, does it really matter who made the decision?

The winds of euthanasia, blowing at gale force in Germany some fifty years ago, are once again gathering, threatening the very existence of those whose lives are deemed valueless.

## Notes

1. Robert Jay Lifton, *The Nazi Doctors*, printed in the United States of America, 1986, pp. 50-51.
2. Ibid.
3. Leo Alexander, MD, "Medical Science Under Dictatorship," *The New England Journal of Medicine*, 241, July 14, 1949, p. 39.
4. Ibid.
5. Ibid.
6. Ibid.
7. State of Wisconsin Assembly Bill 1207, 1975, pp. 1-2.
8. State of Montana House Bill 256, 1975, pp. 1,4.
9. "It's Over Debbie," *Journal of the American Medical Association*, Vol. 259, No. 2, January 8, 1988, p. 272.
10. Ibid.
11. Timothy E. Quill, MD, "Sounding Board: Death and Dignity," *The New England Journal of Medicine*, 324, March 7, 1991, p. 693.
12. Malcolm Gladwell, "Doctor Helps Woman Commit Suicide," *Washington Post*, June 6, 1990, p. 3.
13. Sandra Svoboda, "Kevorkian Helps 2 More Women Die," *Lansing State Journal*, October 24, 1991.
14. *The Humane and Dignified Death Act*, California Civil Code, Title 10.5, 1988, pp. 1-4.
15. "Initiative Measure 119," State of Washington, 1991, pp. 12-13.

Barbara L. Lyons is Executive Director of Wisconsin Right to Life. She has written extensively and appeared on numerous media programs and at forums for the past seven years on the subject of euthanasia. She is a member of two statewide councils advocating for the rights of those with disabilities.

# Physician participation in assisted suicide

by Curtis Harris, M.D.

Physician-assisted suicide has two elements: (1) A physician knowingly and purposely helps a patient to die, and (2) the patient performs the act that leads to his death. The medical profession and the legal profession have both consistently regarded the physician who assists another's suicide as a criminal, who could be tried for manslaughter in most states.<sup>1,2</sup>

But recent news events, especially those surrounding the use of a "suicide machine" by a retired pathologist, Dr. Jack Kevorkian, on an otherwise well and alert woman with Alzheimer's Disease, have raised the issue for public debate. As part of this debate, the Hemlock Society has called for repeal of our nation's laws against physician-assisted suicide, and for a change in what they consider "outdated" medical ethics. It may sometimes seem that our society has not yet decided what to do with Jack Kevorkian, M.D. Do we know whether to take his "suicide machine" seriously or to laugh at his ideas as absurd? Do we praise him or imprison him?

The uncertainty of some members in the society-at-large regarding the ethical validity of assisted suicide is not shared by the medical or legal professions. *No medical organization has endorsed physician-assisted suicide.* The American Medical Association (AMA)<sup>3</sup> and The American College of Physicians<sup>4</sup> have termed assisted suicide "...contrary to public policy, medical tradition, and the most fundamental measures of human value and worth."<sup>5</sup> Further, the General Legal Counsel for the AMA noted that such acts are illegal in most (if not all) states, and contrary to "deeply rooted

medical traditions and the guiding principles of medical practice."<sup>6</sup> Even the physicians in Washington State, the center of the "Initiative 119" controversy, "voted overwhelmingly to oppose Initiative 119," stating "it is not appropriate for physicians to be participants... in intentionally causing death."<sup>7</sup> Numerous scholars and ethicists, including Dr. Daniel Callahan of the Hastings Center, have called assisted suicide "a license to kill." "We don't want to expand the categories where one could kill *even in the name of mercy.*"<sup>8</sup> In the Netherlands, where physician-assisted suicide is openly practiced, "many Dutch physicians remain uncomfortable with professional and public tolerance of the practice."<sup>9</sup>

If the medical and legal professions seem clear in their judgment of Kevorkian and his "suicide machine," where is the dissension and confusion coming from?

One answer may be found in the common human experience of death and suffering. We all fear suffering; many fear death. So the question is asked: "If assisted suicide could somehow alleviate suffering, shouldn't we consider it?" However, the most important questions that need to be asked first are: (1) can the patient's suffering be relieved?, and (2) whose suffering is actually relieved by suicide?

In an insightful article titled "Mercy Killing: Mercy for Whom?,"<sup>10</sup> Dr. J. Goodwin makes the critical point that it is "the experience of every physician that individuals cling to life, fighting, as it were, to the last breath." Patients normally choose a life with suffering rather than death as a "solution." A desire for

death as an end to suffering may be a momentary *part of living*, but suicide is virtually invariably the result of a deep, often sudden, depression. A depressed patient needs love, support and the concern of many. However, when a physician assists suicide, he encourages and validates the mental illness of his patient. In a real sense, the physician should be like the football fan, encouraging the player to go on. When he instead becomes the person who provides the means of death, he has effectively abandoned his vulnerable patient. In reality, it is the physician who has decided that the suffering of the patient is just "too much" *for him to watch*. Rather than helping a life, he takes one. "There is nothing altruistic about mercy killing. It is...the ultimate selfish act."<sup>11</sup>

## Notes

1. "Physician Participation In Assisted Suicide," from the Office of the General Counsel, *JAMA* 262, p. 1844, (1989).
2. *Criminal Law* 2nd Ed., LaFaye and Scott, West Publishing, 1986, p. 651-652.
3. *Ibid.*
4. "American College of Physicians Ethics Manual," *Annals Of Internal Medicine* III, p. 327 (1989).
5. *Ibid.*, p.333.
6. Cited in note 1.
7. *AMA News*, January 7, 1991, p. 9.
8. *The Oregonian*, June 7, 1990, p. 13.
9. "Active Euthanasia In The Netherlands," M. DeWachter, *JAMA* 262, p. 3316 (1989).
10. "Mercy Killing: Mercy For Whom?" J. Goodwin, M.D., *JAMA* 265, p. 326 (1991).
11. *Ibid.*

*Curtis E. Harris, M.D., M.S., is president of the American Academy of Medical Ethics, an educational and legislative lobbying organization of physician members only. Harris is a practicing endocrinologist, specializing in diabetes care, and is a member of the American Medical Association, the American Society of Internal Medicine, and the American Diabetes Association.*



## Alzheimer's: A Caregiver Speaks Out

by Noreen Rackow as told to Mark Torinus

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*Noreen Rackow, 58, and her husband Martin, 60, have been taking care of Noreen's father and mother for almost four years. Noreen's father had suffered a stroke, and her mother had been diagnosed with Alzheimer's disease, when the elderly couple moved from their native Upper Peninsula of Michigan to Janesville, Wis. Noreen's father, Alfred Hoff, died of heart disease July 26, 1991 at age 89. Noreen says her mother, Petra Hoff, now 85, will live with her until she, too, dies.*

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Eight years ago the doctors told me my mother had Alzheimer's disease.

My mother did realize that something was wrong, and she would say, "I just don't understand it. I don't remember things, and I don't know why." To this day she tries real hard to remember things, and she just can't.

My husband and I talked it over, and we decided about three and one-half years ago that my parents should come and live with us, and we would see how it worked out. Since I am an only child, I would have to go home every month or so, sometimes every two weeks. Of course, they were always so sad to see me leave. It would break my heart, too. So I was real happy to have them come here and my husband was, too.

My mother is very independent. The only thing I have to do is make sure I set the temperature when she showers. Outside of that, she dresses herself, uses the bathroom facilities and feeds herself just fine.

Our friends accepted mother and dad as part of us. We belong to a couples' card club. They come to our house and visit with mom and dad. If we are invited to a picnic, our friends tell us to bring our folks along. My dad always had a smile on his face and he was easy to get along with.

Mother is handling dad's death well. The nurses were real nice up in the emergency room of the hospital when my dad passed away. I told them that my mother had Alzheimer's. They said just bring her in here, and you can stay as long as you like. Mother rubbed his arms and his head. She talked to him. I think it was peaceful for her to feel him and talk to him, things she had done for him at home.

My mother and dad always had love for me and helped me out, so I decided that is the way it should be for them now. I should do the same.

When my husband went to college, like most everyone else, we didn't have a lot of money and both of us worked, so my parents helped us out a lot.

I've had a couple of miscarriages and my mother came and stayed with me through those.

Children should take care of their parents if they are able to. I think most of us are able to, but we don't want to. We're just too selfish. People think it's a burden, but it's really the thought that's the burden. If they once tried taking care of their folks, it isn't so bad. Lots of things in life are hard. You have to work at it. You have to try it.

Some people say to me, "I was up all night cleaning the bathroom because my mom had a little accident. I'm so tired. I don't know how you do it. I can't put up with this." Hey, my mom didn't say that to me when I was a child, and I'm sure I had a lot of accidents. Whenever I had mumps or measles, she sat up with me at night, comforted me. She was real kind to me so I don't see why I shouldn't try to help her be comfortable now, too.

I never realized I had so much patience and understanding. I feel real comfortable and peaceful.

I really would like her to be with me until the end. I would never consider ending her life by euthanasia.

# The case against active euthanasia and assisted suicide

by Barbara L. Lyons

It has been said that if a fence has been built around something, one should determine why the fence is there before attempting to tear it down. For thousands of years, in virtually every culture, a legal "fence" has prohibited, and treated as homicide, active euthanasia and assisted suicide. The reason for this "fence" is extremely valid for it protects some of the most helpless members of the human family — the frail; older people; those with severe or terminal illness; those with physical or mental disabilities — from having their deaths caused by another. It also prohibits the granting of legal authority for one person to end the life of another.

Current trends indicate a willingness to dismantle the fence, picket by picket, fueled by slogans for "patient self-determination," "death with dignity," and "the right to control the time of death." In fact, the first "picket" for which removal is advocated is the one which prevents someone from making a "voluntary" choice to have their life ended. What harm would there be, the argument goes, if the choice is freely made, strictly regulated, and purports to achieve a good end—namely, release from suffering, or choosing one's own time?

In this article, we will explore the following three questions:

1. Why is voluntary euthanasia dangerous?
2. Could we stop at voluntary euthanasia?
3. How would voluntary euthanasia affect us all?

## Why is voluntary euthanasia dangerous?

One of the most common reasons used to justify active euthanasia or assisted suicide is to relieve the patient from pain. Yet, improvements in pain control are widely recognized by virtually all segments of the medical profession as rendering this argument virtually obsolete.<sup>1</sup>

In addition, euthanasia proponents argue that the right of the individual to make medical treatment decisions should include the right to request and

receive active euthanasia or to be assisted with suicide. As compelling as this argument appears on the surface, voluntary euthanasia should be rejected for the following reasons:

1. First and foremost, a misdiagnosis could occur, leading the patient to make an irreversible decision believing he or she has an incurable or fatal illness. The August 18, 1991 issue of *The Milwaukee Journal* featured a story about a Colorado woman who shot herself with a gun brought to her by her son. She was told she had liver cancer, but an autopsy revealed a liver infection instead. Her son has been charged with manslaughter.<sup>2</sup> Experienced physicians recognize the dangers of such final actions since predictions, even educated ones, are notably unreliable.

2. How voluntary is voluntary? In the Netherlands, 65% of family physicians offer the choice of euthanasia without first receiving a request from the patient.<sup>3</sup> Physicians exercise powerful influence over decisions that patients and families make, especially because of their superior base of knowledge. Medical professionals pressure patients, husbands pressure wives, wives pressure husbands, family members pressure relatives. Many physicians admit they kill patients on their own initiative.<sup>4</sup> One must conclude that while a voluntary decision might be legal, it is not necessarily freely chosen.

3. If a patient is killed, who is to substantiate that the choice was freely made? The only witness is dead and society is notoriously reluctant to prosecute physicians.

4. Patients facing a long-term or serious illness vacillate — at times they want to live and at other times, they don't. Who is to determine at what point the patient has reached a final decision?

5. Although euthanasia and assisted suicide are generally perceived as a "solution" in cases of physical illness — either terminal or long term — they would inevitably become accepted for individuals suffering from mental anguish. Who would have the ability to deter-



mine that a depression or mental anguish is irreversible before taking such a final action and causing such a final result?

6. Societal endorsement of euthanasia invariably has a "teaching" effect for the weak and frail, leading them to devalue their own existence and feel they have a "duty" to die, and, therefore, to make a request to have their lives ended.

### Could we stop at voluntary euthanasia?

The answer is clearly NO — for legal, moral and practical reasons. Legally, we have already moved from recognizing the right of competent patients to refuse medical treatment, to granting that "benefit" to those unable or unwilling to make the decision for themselves. The same legal principles would apply if "voluntary" active euthanasia is allowed. For example, if a person not in pain can request and receive a lethal injection, then how can the injection request be denied to a person with mental retardation perceived to be suffering? The law would not allow such a perceived "inequity" to stand.<sup>5</sup>

From a moral standpoint, if killing a person because he/she is suffering is deemed a benefit, is it morally justifiable, then, to withhold that benefit from someone unable to make such a request?

From a practical standpoint, one only has to view what happened in Nazi Germany and now the Netherlands as proof that allowing only voluntary euthanasia to be legal is unworkable.

### How would voluntary euthanasia affect us all?

It is naive to believe that someone else's voluntary "choice" would not affect or impact us all. In the December, 1989 issue of the *American College of Surgeons Bulletin*, Dr. T. Douglas Kinsella and others stated: "Medicine's professional integrity will be lost if it does not reject the legalization of active euthanasia. The tradition of medicine is to resist death and illness on behalf of those who have not the knowledge or skills to resist; active euthanasia seeks death on behalf of those who have not the desire

to resist. The latter formulation of death as a goal cannot be reconciled with the teaching or practice of medicine as a healing art."<sup>6</sup>

If healing and killing both become equally valid goals of the medical profession, and if death becomes a legal "right," then physicians will feel obligated to offer death as an "option" to patients or to families on behalf of patients. Given the powerful influence of physicians, would one be able to trust information given if the physician believed that a patient's death was a "benefit?"

Legalized euthanasia would quickly lead to abandonment of the patient, whether the person wishes to choose death or not. In the face of pressure from medical professionals, family or friends to choose death, the patient, who by definition, is weak, helpless and vulnerable, will feel an obligation to choose death. The increased isolation felt by the patient when the necessary caring support collapses will fuel the decision. If the logical path which has governed the withdrawal of treatment to date is followed, or the course of real events occurring in the Netherlands comes to pass in the United States, others could choose death for any of us, even against our wills. Insurance or government coverage for health care could dwindle, based on the age or condition of the patient, leaving no realistic option but death even for those who do not wish to die.

As in the Netherlands, those at risk in this country of being killed without consent or against their own wishes, would become fearful of seeking a physician, being hospitalized, or entering a nursing home.<sup>7</sup> One would view one's family with fear and suspicion. Would family members apply pressure to choose lethal injection for you without your consent or against your wishes?

Finally, what would legitimization of assisted suicide and lethal injections teach our young? The notion of calculated, premeditated death as a noble action, mixed with the immaturity of the adolescent, would indeed become a lethal potion.

## Conclusion

In the words of Professor Hadley Arkes and others in the November 27, 1991 issue of *The Wall Street Journal*, in an essay titled "Always To Care, Never To Kill:" "If life is a thing that can be renounced or taken at will, the moral structure of the human community, understood as a community of persons, is shattered. The result is a brave new world in which killing is defined as caring, life is viewed as the enemy, and death is counted as a benefit to be bestowed."<sup>8</sup>

We must limit human "choices" when those choices victimize ourselves, others, and society as a whole. We must minister compassionately to those who suffer and those who fear death. We must maintain the healing tradition of medicine.

To splinter the fence which protects the vulnerable among us is to relegate countless victims, and eventually ourselves, to death at the hands of another.

## Notes

1. *Deciding to Forego Life-Sustaining Treatment: Ethical, Medical and Legal Issues in Treatment Decisions*, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. March, 1983, pp. 19-20, 73, 277-286.
2. Tad Bartimus, "Promises to Keep," *Milwaukee Journal*, August 18, 1991, pp. 1ff.
3. "Medische Beslissingen Rond het Levensende, II: Het Onderzoek voor de Commissie Onderzoek Medische Praktijk inzake Euthanasie" (Medical Decisions About the End of Life, II: The Study Ordered by the Committee to Investigate Medical Practice Concerning Euthanasia). *The Hague*, v. 2, 1991, p. 83.
4. *Ibid.*
5. Atty. Thomas Marzen, General Counsel, National Legal Center for the Medically Dependent and Disabled, Inc. Remarks, Bioethics Conference, "The Slide Toward Euthanasia: There Are Alternatives," Milwaukee, WI, Nov. 22, 1991.
6. T. Douglas Kinsella, MD, et. al., "Legalized Euthanasia: An Aesculapian Tragedy," *American College of Surgeons Bulletin*, 74, December 1989, p. 8.
7. Richard Fenigsen, MD, "Euthanasia in the Netherlands" *Issues in Law & Medicine*, Vol. 6, No. 3, 1990, p. 243.
8. Hadley Arkes, et. al., "Always to Care, Never to Kill," *Wall Street Journal*, November 27, 1991.

# Euthanasia in the Netherlands

by Richard Fenigsen, M.D.



The following article, "Euthanasia in the Netherlands," written by Dr. Richard Fenigsen, noted Dutch cardiologist and author, was originally printed in *Issues in Law and Medicine*, Volume 6, Number 3, 1990, pages 229-245.

Permission has been granted by both *Issues in Law and Medicine* and the author to paraphrase and reprint only portions of the original article. New information which has become available since the article was originally printed has also been added.

In 1973, a doctor who had killed her sick mother was sentenced by the court in Leeuwaarden to a one-week suspended prison sentence. The trial initiated the present open practice of euthanasia in the Netherlands.

During the Leeuwaarden trial, it was revealed that some practice of euthanasia had already existed in the Netherlands. In support of the defendant, eighteen doctors declared that they, too, had actively terminated the lives of their patients. It is certain, however, that after the Leeuwaarden trial the practice of euthanasia increased.

## The legal situation

In theory, euthanasia is still illegal in Holland since no bills have been passed authorizing its legalization.

The actual practice is to some limited extent regulated by guidelines accepted by the Secretary of Health, the Health Council, the Board of the Royal Dutch Society of Medicine, and the judiciary. According to these guidelines, doctors performing euthanasia are not prosecuted if they conform to the so-called "rules of careful conduct."<sup>1</sup> The doctor should inform the patient about his condition and, in particular, about the measures that could be taken to alleviate his sufferings. Unless the patient objects, his nearest relatives should be consulted. The doctor is supposed to consult at least one other physician and keep a written record of all proceedings.

The final provision states that consent of legal guardians is required to perform euthanasia when the request is submitted by a child or a minor. However, the country's leading specialist in pediatric oncology, Professor P. Vouté,

revealed that he has supplied some of the children under his care with a poison that enables them to commit suicide when they feel so inclined. He did so in six cases a year on the average, sometimes with consent of the parents and in other cases without the parents' knowledge.<sup>2</sup>

## Actual practice of euthanasia

A major study, conducted on behalf of the Dutch government by the Committee to Investigate the Medical Practice Concerning Euthanasia, and released in 1991, reveals the extent of the actual practice of euthanasia in the Netherlands.<sup>3</sup> (See Table 1.)

In round figures, there were about 12,000 cases in which doctors actively caused death, of which about 6,000 were without the patient's consent. If the United States were to practice active euthanasia to the extent practiced in the Netherlands, taking into account the population differences, there would be approximately 200,000 euthanasia deaths annually in the United States, with approximately 100,000 deaths caused without the consent of the patient. (See Table 2.)

## The impact of the report on Dutch regulations

Following the release of the report of the governmental committee, the Dutch government presented new regulations for consideration by the Parliament in late 1991. No action has been taken yet on these proposed regulations. Since the practice of euthanasia, with or without the consent of the patient, is a reality, its existence had to be acknowledged, and the practice itself subjected to some control (the "pragmatic approach," in the vocabulary of Dutch politics). The following provisions were contained in the proposed regulations: 1) Euthanasia would remain a crime punishable by up to 12 years' imprisonment; 2) The doctors who practice euthanasia would not be prosecuted if they follow the "rules of careful conduct;" 3) The requirement to follow the "rules," and the freedom from prosecution, would apply not only to doctors who perform euthanasia upon request of the patient, but also to doctors who practice active euthanasia without the consent of the patient.

## Public acceptance of euthanasia

The public had been prepared for these events, first and foremost by the publication of Dr. Jan Hendrik Van den Berg's book *Medical Power and Medi-*

**Table 1**  
**DIRECT KILLING OF PATIENTS**  
**IN THE NETHERLANDS IN 1990\***

	<i>Active Euthanasia</i>	<i>Physician Assisted Suicide</i>	<i>Morphine Overdose Intended to Terminate Life</i>	<i>Total</i>
<b>With Patient's Consent</b>	2,300	400	3,159	5,859
<b>Without Patient's Consent</b>	1,000	—	4,941	5,941
<b>Total</b>	3,300	400	8,100	11,800

\* Figures used in this table are drawn from the source noted below: Medische Beslissingen Rokend Het Levensinde: Rapport van de Commissie Onderzoek Medische Praktijk inzake Euthanasie (Medical Decisions About the End of Life: Report of the Committee to Investigate the Medical Practice Concerning Euthanasia). The Hague (1991), ISBN 90 39 90124 4 (2 volumes).

cal Ethics in 1969.<sup>4</sup> In this work Van den Berg, a professor of neurology, declared that the ethics of unconditional respect for human life belonged to the past, to the time when medicine had been powerless. The new era of medical power required a new ethic allowing doctors to terminate human life. Van den Berg's vivid pictures of human suffering (supposedly created by doctors exercising their power), the serene descriptions of euthanasia, and the daring reversal of many habits of thinking immediately captured the public imagination.<sup>5</sup>

Since this work has strongly influenced Dutch public opinion on the issue of euthanasia, it is important to know the ideas it promoted.

Van den Berg insisted that "defective" children must not be allowed to live. In his view doctors are not only authorized but have the duty to terminate "meaningless" lives.<sup>6</sup> In his book Van den Berg did not mention voluntary active euthanasia, but advocated non-voluntary active euthanasia. In all the model case histories he cited, the decisions to actively terminate the patients' lives were taken by the doctors and the patients' families without the patients' knowledge. Van den Berg condemned the families who failed to request euthanasia and showed an attachment to hopelessly ill patients, this being a dishonor and an adherence to the old dismissed ethics.<sup>7</sup> Neither the patient's nor the family's consent was necessary to carry out euthanasia: in case of the family's refusal a committee of doctors and laymen should impose the decision.

The book was an enormous publishing success, going through twenty-five printings.

### The psychological cost of euthanasia

Understandably, doubts and remorse afflict many doctors and nurses who carry out euthanasia. Henry W.A. Hilhorst, a professor of social science at the University of Utrecht, conducted interviews with perpetrators of euthanasia which are quite revealing in this respect: a surgeon told him that he had "enormous difficulty" in carrying out the act;<sup>8</sup> a chest physician described his decision to perform active involuntary euthanasia as "weird," "horrible," and "very difficult to digest;"<sup>9</sup> a nurse complained that "it shocked you every-time;"<sup>10</sup> and an internist confessed that coming at a fixed time to cut short a patient's life gave him the idea of being an executioner.<sup>11</sup> A nurse suffered from severe mental depression and required psy-

	<i>The Netherlands</i>	<i>United States</i>
<b>Total population</b>	15,000,000 <sup>1</sup>	250,000,000 <sup>2</sup>
<b>Practice of active euthanasia</b>	12,000 <sup>3</sup> total deaths annually	200,000 est. deaths annually
<b>Practice of active euthanasia without patient's consent</b>	6,000 <sup>4</sup> deaths annually	100,000 est. deaths annually

1 World Book Encyclopedia, 1991 population estimate; World Fact Book, published by CIA, July 1990 census.  
2 USA Today, 4/19/91  
3,4 Medische Beslissingen Roknd Het Levenselnde: Rapport van de Commissie Onderzoek Medische Praktijk inzake Euthanasie (Medical Decisions About the End of Life: Report of the Committee to Investigate the Medical Practice Concerning Euthanasia). The Hague (1991), ISBN 90 39 90124 4 (2 volumes).

chiatric treatment after having been involved in active euthanasia on her own father.<sup>12</sup> A Dr. C., who is frequently called to carry out euthanasia at patients' homes, told the press that on these rides he lets himself be driven by a friend. After the deed, his nervous condition is such that he wouldn't dare drive a car.

### Concluding remarks

"Abuses" by families and by professionally inferior and emotionally unstable doctors; the expansion of the practice to include many patients whose condition is by no means desperate; the sick and older persons' distrust of hospitals, nursing homes, and their own families; and the social pressure felt by medically dependent people since euthanasia became available, are some of the consequences of euthanasia already manifest in the Netherlands.

### Notes

Reprinted by permission of the publisher, *Issues in Law & Medicine*, Vol. 6, No. 3, Winter 1990. Copyright © 1990 by The National Legal Center for the Medically Dependent & Disabled, Inc.

1. The "rules of careful conduct" were contained in an official statement issued by the Royal Society of Medicine in 1984, Number 31, pages 990-997.
2. "Arts Geeft Jongeren Dodelijke Pil Mee" (Doctor Supplies Boys with Deadly Pills), *Brabant's Dagblad*, October 10, 1987.
3. *Medische Beslissingen Roknd Het Levenselnde: Rapport van de Commissie Onderzoek Medische Praktijk inzake Euthanasie* (Medical

Decisions About the End of Life: Report of the Committee to Investigate the Medical Practice Concerning Euthanasia). The Hague (1991), ISBN 90 39 90124 4 (2 volumes).

4. J.H. Van den Berg, *Medische Macht En Medische Ethiek* (Medical Power and Medical Ethics, Nijkerk (25th ed. 1985), ISBN 90 266 0009 7.
5. *Ibid.*, p. 53.
6. *Ibid.*, *Ibid.*
7. *Ibid.*, p. 41.
8. H.W.A. Hilhorst, *Euthanasie In Het Ziekenhuis* (Euthanasia in the Hospital), Lochem-Poperinge (1983), ISBN 90 6087 971 6, p. 174.
9. *Ibid.*, p. 175.
10. *Ibid.*, p. 175.
11. *Ibid.*, p. 168.
12. H. Ten Have & G. Kimsma, *Geneeskunde Tussen Droom En Drama* (Medicine Between Dream and Drama), Kampen (1987), ISBN 90 242 7546 6, p. 82-84.

**Dr. Fenigsen** is a Dutch cardiologist, active in cardiological medicine until his retirement in 1990. He has published works in several languages on the subjects of cardiology, modernization of medicine, euthanasia and medical ethics. He is a member of the Dutch Physicians' Association and the Committee on Euthanasia of the Dutch Patients' Association.

# HOSPICE: Alternative to euthanasia

According to Dr. Richard Lamerton, a British expert on care for the dying, the hospice movement should be seen as the most effective alternative to euthanasia. When a dying patient is provided with pain control, a caring environment, and an opportunity to face death with the help of others who understand, euthanasia becomes not just wrong or repugnant but irrelevant.

While the modern establishment of hospices for the dying began in Great Britain, the hospice concept came to the United States in the mid-1970s and has spread quickly.

According to Mary Katherine Theis, who works as a volunteer at a hospice in Washington, D.C., no special professional skills are needed to become a hospice volunteer. "You soon find out," she says, "that the most important thing

you're there for is to be human, to let people know it's okay to feel what they're feeling because you would feel those things, too, if you were in their situation."

At all stages of the dying process, hospices offer caring services directed to a patient's entire family, with the recognition that an individual's final weeks in a hospice can provide an opportunity for families to express many unspoken needs, problems and emotions.

The most difficult part of hospice work comes when a patient is very near death. When that time comes, nothing can be done medically but the patient is never left alone.

People often assume that hospice work is particularly draining emotionally, or that it involves dealing with people in intractable pain. To Mrs. Theis,

neither assumption is valid. The work is satisfying rather than draining, she says, because "you know you are helping these people." And patients in a hospice can be kept relatively free of physical pain.

The chief problem faced by a dying patient is the mental or emotional suffering of confronting the "unfinished business" of his or her life, and a hospice can help enormously in dealing with this kind of pain.

While many hospices have an in-patient setting, some also help patients and families in their homes through frequent visits.

*Excerpted with permission. Richard Doerflinger; "Euthanasia: Gaining Ground," Respect Life, 1986, United States Catholic Conference, Washington, D.C.*

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# Euthanasia/Assisted Suicide Update

Since this Life Cycle was published in April 1991, some significant events have occurred which merit attention.

## **"The Slippery Slope"**

by *Burke Balch*

Attempts to create a constitutional right to die are moving so fast now that the "slippery slope" concerns have been replaced with a concern that the courts "have leapt from cliff into the abyss." In January 1997, the U.S. Supreme Court heard arguments in cases from Washington and New York where the lower courts struck down those states' prohibitions against assisted suicide. There is serious concern that the Court will use these cases to strike down statutes prohibiting assisted suicide that exist in most states, just as it struck down state abortion statutes in the 1973 *Roe v. Wade* abortion decision.

Although the cases technically were brought on a narrow set of facts dealing with competent, terminally ill, adult persons who voluntarily request assistance with suicide, the reasoning used by the lower courts can readily be extended to others in less dire circumstances. The lower court that struck down the Washington assisted-suicide law was especially expansive. Its ruling would also legalize assisted suicide for those with physical or mental disabilities, those who are in a permanent and irreversible state of unconsciousness, those with other impairments pressured to commit suicide because they feel they are economic burdens. The Washington case even went so far as to openly invite other cases which would involve *involuntary* euthanasia. The New York case tried to claim that its decision was more limited, but the logic of its reasoning would lead to the same results as the Washington case.

## **"Historical Perspective and Current Trends"**

by *Barbara L. Lyons*

The Hemlock Society was successful in passing a physician-assisted suicide referendum, known as Measure 16, in Oregon in November 1994. Oregon thus became the first jurisdiction in the world to expressly legalize assisted suicide. However, before the referendum, allowing

assisted suicide, could take effect, it was challenged in federal court and was ruled to be unconstitutional at the district level. The court viewed Oregon's existing law against assisted suicide as a protective measure, and held that Measure 16 was a denial of that protection to people with terminal illnesses and people with disabilities. Measure 16 is enjoined, temporarily keeping the ban in place, but the case is currently on appeal before the 9th Circuit Court of Appeals, and the injunction against the law could be lifted.

Meanwhile, Dr. Jack Kevorkian is still assisting suicides in Michigan with total impunity. Between 1990 and 1996, there were three attempts to prosecute him under Michigan's assisted-suicide laws and each time he has been acquitted by the jury. Many of Kevorkian's "patients" were not even terminally ill. At the end of 1996, Kevorkian has acknowledged attending 44 deaths since 1990.

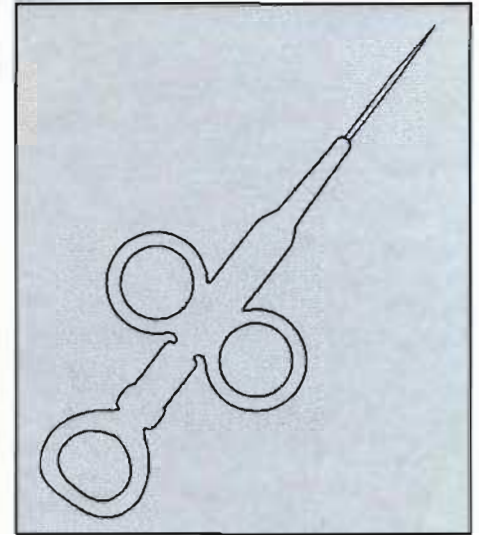
## **"Euthanasia in the Netherlands"**

by *Richard Fenigsen, M.D.*

There are many people who believe that assisted suicide and euthanasia can be safely legalized as long as appropriate safeguards are in place. Foremost among these proposed safeguards is a requirement that the assisted suicide or euthanasia may only be performed upon the explicit request of the patient. However, researchers who have studied the euthanasia experience in the Netherlands have repeatedly discovered that in actual practice these safeguards are not followed. In cases where Dutch physicians actively caused death, about half were done without the patient's consent.

In 1994, the Dutch parliament finally passed the first official regulations concerning euthanasia, over 20 years after the practice of euthanasia began in the Netherlands. The regulations do not officially legalize euthanasia, but they do acknowledge the existing practice of both voluntary and involuntary euthanasia and set forth "rules of conduct" intended to act as safeguards.

In 1995, a follow-up study to the 1990 Rummelink Report was conducted (See Table 1 in the *Life Cycle*). Voluntary active euthanasia increased from 2,300 (1990) to



an estimated 3,118 cases in 1995, and assisted suicide, from 400 to 542. The number of cases of active involuntary euthanasia remained virtually unchanged: from 1,000 (1990) to 949 cases in 1995. There was a significant drop in cases where doctors stated that they administered lethal overdoses of morphine with an intention to terminate life, but this is apparently only due to a change of research method resulting in a stricter formulation of the questions concerning the doctors' intentions.

Of particular interest are the results of opinion polls which show decreasing support for euthanasia from the all-time high of 81% in 1988 to 78% in 1993 and 71% in 1995. This is attributed to widely publicized cases of involuntary euthanasia on children and newborns, and euthanasia on healthy but grieving persons.

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Robert Powell, focus of "*They sent me home to die...*" passed away in 1995 at the age of 45. Prior to his death, Powell had been a staunch advocate of rights for those with disabilities, including working for passage of the American Disabilities Act. Noreen Rackow's mother, Petra Hoff, who is featured in "*Alzheimer's: A Caregiver Speaks Out*," has also passed away since this *Life Cycle* was originally published. Noreen stated that she never regretted her decision to care for her mother.

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