



State Medical Society of Wisconsin

Advancing the Science and Art of Medicine

**TO: Senator Lynn Adelman, Chair
Members, Senate Judiciary, Campaign Finance Reform
and Consumer Affairs Committee**

FROM: Armond Start, M.D.

DATE: October 22, 1997

RE: Opposition to SB 27

The State Medical Society of Wisconsin is opposed to legalizing physician-assisted suicide in Wisconsin. Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. We strongly believe that more research must be pursued to examine the degree to which pain relief reduces the request for euthanasia or assisted suicide. The societal risk of involving physicians in medical interventions to cause patients' deaths is too great to condone physician-assisted suicide.

The State Medical Society requests that committee members oppose SB 27.

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October 22, 1997

Testimony for public hearing of SB 27 in Madison

State of Wisconsin, 1997-1998 LEGISLATURE

1997 SENATE BILL 27

Introduced by Sens. RISSER and JAUCH, cosponsored by Reps. BOYLE, BALDWIN and KUNICKI. Referred to Committee on Judiciary, Campaign Finance Reform and Consumer Affairs. Same title as AB 32 above.

here: **SECTION 4:** Chapter 156 of the statutes is created to read:

**CHAPTER 156
DEATH WITH DIGNITY**

Thanks for the opportunity to express our view. My name is Ingolf Wallow, M.D. representing WPRC, the Wisconsin Physicians Resource Council, a group of doctors opposed to this bill.

When you become seriously ill, anticipate death or become afraid of it, you know that at present your doctors are to promote your dignity and autonomy by the following:

1.] Sustain life and relieve suffering.

2.] Help implement your right to control your medical treatment, e.g. when you decide against life-prolonging measures that seem futile, ineffective or harmful. Sen. Risser himself was instrumental in the passage of 'power for health care attorney' legislation, which permits discontinuation of life support if a person has so directed.

3.] Arrange effective palliative treatment, e.g. through HospiceCare that will alleviate physical pain even when this may foreseeably hasten death. There is no evidence that increasing numbers of patients are dying in severe physical pain. Recent studies also show that intolerable physical symptoms are not the reason for which most patients want to die [see Brief of AMA, ANA, and APA, et al. as *amici curiae* in support of VACCO v. QUILL and STATE of WASHINGTON v. GLUCKSBERG].

In summary, you are not coerced into a prolonged, painful, or overly medicalized dying process. Instead, you are protected against the temptation to seek an immediate irreversible solution to a burdensome problem. True compassion seeks to alleviate suffering, not eliminate the sufferer. This state of affairs has served society well. Admittedly, there are still too many patients who do not receive proper treatment for their physical pain, depression, psychological and spiritual distress. Therefore, our legitimate concern is to make the health care system work better. How?

p.2 Dr. I. Wallow for WPRC re. SB 27 for 10/22/97 public hearing in Madison

1.] Provide for better medical training of health care providers to emphasize hope, comfort and supportive options while minimizing suffering for people who are dying. HospiceCare has modeled this approach very effectively.

2.] Help people pay the costs associated with long term care. A common reason why people want to die is to spare families the burden of caring for them.

3.] Train the public to deal more compassionately with end-of-life issues, e.g.

--renew and expand efforts to use advance directives;

--emphasize that many groups in the health care system are vulnerable [those suffering from AIDS, Alzheimer's, other disabilities; the poor, the mentally confused, elderly, minorities, prisoners].

Compared to these positive steps the **legislation repeatedly proposed** by Boyle and Risser is a **dangerous distraction and a premature intervention**:

1.] Neither doctors nor the citizens of Wisconsin want physicians to take over end-of life decisions or to be suspected as their future executioners.

2.] The potential for abuse inherent in assisted suicide policies is manifold:

--the remaining life of an individual cannot be accurately predicted; --there is no clear line between those terminally ill and chronically ill; --recent widespread abuses of the euthanasia experiment in the Netherlands are troubling. They involved both lack of physician compliance as well as failure to separate between voluntary and non-voluntary procedures.

--outside pressures of personal withdrawal and current pressures of cost containment through managed care systems become coercive inducing a 'duty to die' rather than a will to live or a platform for an unhurried dying process.

--distress of survivors falsely rationalizing "s/he really wanted to die."

3.] Legislative intervention is premature. The public is just beginning to engage in the debate.

We urge you to distinguish carefully between 'the patient is dying' v. 'the patient is encouraged to die', between 'intent to kill' v. 'intent to alleviate pain and give comfort'. State regulations have not deterred a Dr. Kevorkian. What will be the impact if you legalize doctor-assisted killing of vulnerable people during a time of weakness in an environment aiming at health care rationing?

Along with the AMA and our SMS we hold that physicians must aggressively respond to the needs of patients near the end of life with emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. In civilized society the law exists to protect life. The proposed legislation would lead us in the opposite direction. Please take the high road!



Wisconsin Right to Life, Inc.

State Affiliate of the National
Right to Life Committee, Inc.
Washington, DC 20004-2293

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TESTIMONY

of

SUSAN ARMACOST

before the

**SENATE JUDICIARY, CAMPAIGN FINANCE REFORM,
and CONSUMER AFFAIRS COMMITTEE**

Senate Bill 27

October 22, 1997

Dedicated successfully since 1968 to advocating for and protecting precious human life.

Please remember the Wisconsin Right to Life Education Fund 501(c)(3) charity and its lifesaving programs in your estate plan. By doing so, you may be able to achieve significant income, gift or estate tax benefits. Please call our development department today for confidential help in successfully implementing the gift plan most suitable for you.

I am Susan Armacost, Legislative Director for Wisconsin Right to Life, and I am here on behalf of our 50,000 member households to strongly oppose Senate Bill 27, which would legalize assisted suicide in our state.

Viewing SB 27 from the perspective of the individual patient, it must be recognized that allowing physicians to kill, even with the patient's consent, threatens the patient's trust, the belief that the doctor is there for the patient's well-being. When physicians abandon the commitment to care for their patients, the resulting ambivalence is certainly not in the best interests of the physician/patient relationship. Even when a patient requests active euthanasia because of unremitting pain, many of those requests are really requests for pain relief or reassurances that one will not be facing death alone. If the point of SB 27 is to permit the killing of patients to relieve suffering, it is important to recognize that pain can be controlled. There is no reason for a patient to die in unremitting pain and to ask for death as a result. When that occurs, it often means that the physician has failed to administer adequate pain medications. Instead of promoting the killing of patients because they have not been sufficiently medicated, shouldn't we instead be advocating for more education for physicians in the area of pain relief?

Beyond the individual patient/physician situation, there are grave concerns about further abuses that can be expected to occur under SB 27. If the justification for assisted suicide is the unremitting and uncontrollable pain of the individual who is dying, then SB 27 addresses the problem by allowing assisted suicide only for competent, cognizant individuals who twice request to be released from pain by being helped to die. Is Sen. Risser suggesting that only the competent and cognizant deserve to be relieved of their pain? What about the incompetent individual? What limitations will we place on our "compassion" if we believe it is morally right to end the suffering of an individual who can ask to be killed? Once it is morally acceptable to

end the suffering of the cognizant through death, there will be pressure to extend active euthanasia to those who cannot request it, namely, the comatose, those with disabilities, including newborns and children, those with dementia, etc.

There are historical precedents that cause us grave concern. In the 1920's, the pro-euthanasia movement used the phrase "death with dignity" rather than active euthanasia in a book published in Germany entitled The Release of the Destruction of Life Devoid of Value. Dr. Leo Alexander, consultant to the office of the Chief of Counsel for War Crimes, described the situation among German physicians which resulted in the euthanasia of 275,000 people before the war even began. "It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as a life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted and finally all non-Germans. But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the nonrehabilitable sick."

Finally, in determining whether Wisconsin will legalize assisted suicide, it is crucial to discuss the Dutch experience with euthanasia. Currently, doctors in Holland who directly kill patients or help patients kill themselves will not be prosecuted as long as they follow certain guidelines, very similar to those in SB 27. Since 1981, these guidelines have been interpreted by the Dutch courts and the Parliament in ever-broadening terms. One example is the requirement that the patient must be experiencing unbearable pain. The court ruled that the pain guideline was not limited to physical pain, and that "psychic suffering" or "the potential disfigurement of personality" could also be grounds for assisted suicide.

In September, 1991, the results of the first, official government study on the practice of Dutch euthanasia was released. The study, called the Rummelink Report, indicates the following data for the year 1990:

- * 2,300 people died as a result of doctors killing them on request.
- * 400 people died as a result of doctors providing them with the means to kill themselves.
- * 1,040 people died from involuntary euthanasia, meaning that doctors actively killed these patients without the patients' knowledge or consent. Of these, 14% were fully competent. 72% had never given any indication that they would want their lives terminated, and in 8% of the cases, doctors performed involuntary euthanasia despite the fact that they believed alternative options were still possible.
- * 8,100 patients died as a result of doctors deliberately giving them overdoses of pain medication, NOT TO CONTROL PAIN, BUT TO HASTEN THE PATIENT'S DEATH. In 61% of these cases, the intentional overdose was given without the patient's consent.

The Rummelink Report figures do not include cases in which life-sustaining treatment was withheld or withdrawn without the patient's consent and with the intention of causing the patient's death. Nor do the figures include the cases of involuntary euthanasia performed on newborns with disabilities, children with life-threatening conditions, or psychiatric patients.

The population of Holland is about 15 million. The United States has a population of about 250 million. To apply the Rummelink Report data to the U.S., those figures would have to be multiplied 16.6 times.

Other Dutch sources give us additional insights into a society that has accepted active euthanasia. As of 1990, only two hospice programs were in operation in all of Holland. It

seems that where assisted suicide and active euthanasia are accepted solutions to pain and suffering, there is little incentive to develop programs to provide effective pain control.

In July, 1992, the Dutch Pediatric Association announced that it was issuing formal guidelines for killing handicapped newborns. Dr. Zier Versluys of the Association stated, "Both for the parents and the children, an early death is better than life."

In February, 1993, the Dutch Justice Ministry proposed extending the court-approved guidelines to formally include "active medical intervention to cut short life without an express request." In other words, to approve involuntary active euthanasia.

In 1990, the Dutch Patients' Association, a disability rights organization, developed wallet-size cards which state that if the signer is admitted to a hospital "no treatment be administered with the intention to terminate life." Many in Holland see the card as a necessity to help prevent involuntary active euthanasia being performed on those who do not want their lives ended, especially those whose lives are considered low in quality.

Senate Bill 27 will begin the same horrible process described by Dr. Alexander at Nuremburg that is paralleled in the current Dutch experience with euthanasia. Whenever a society and/or medical profession have it within their power to decide that some individuals' lives are unbearable, the door is opened to look beyond the original group of individuals to other groups whose lives may not meet the standards of others.

There is a connection between assisted suicide and the rationing of health care. As health care resources become more regulated, society will have to grapple with what limits, if any, should be placed on the availability of health care. Given the progression of events in Holland, we can expect that the dying will be seen as a reasonable place to begin rationing in an attempt to find savings in health care dollars. If the justification for rationing is couched in the socially

acceptable terms of "mercy" and "compassion," and not in economic terms, there could be widespread social support for limiting the provision of health care for the dying, and perhaps, other groups of vulnerable individuals. An obvious method of health care rationing would be assisted suicide and active euthanasia. It is predictable, then, that assisted suicide and active euthanasia would be characterized as a "health care benefit," thus making it seem socially acceptable.

Whether we are talking about the particular patients defined in SB 27 or broader categories of individuals who would inevitably be affected, it is clear that assisted suicide is not a humane solution to human suffering. Instead, legalized assisted suicide will lead to abandonment of the patient who will feel an increasing pressure to choose death when the necessary caring support system falls apart. Under such circumstances, choosing assisted suicide can hardly be called a decision that is carefully thought out and, in fact, could be described as a decision made out of coercion.

In the late 1700s, Hamilton and Madison addressed the need for government in The Federalist. They wrote, "Why has government been instituted at all? Because the passions of men will not conform to the dictates of reason and justice, without constraint." If there were ever a time for constraint, it is now. The prohibitions against assisted suicide that have existed in our country for centuries must be reinforced, not torn apart, as SB 27 would do.

PRO-LIFE WISCONSIN

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*Testimony of Michelle Grothe, PLW Director of Public Affairs
In opposition to SB 27
October 22, 1997
page 1 of 2*

*Mary C. Matuska
State Director*

Thank you for this opportunity to testify before you today on such an important matter. My name is Michelle Grothe and I am the Director of Public Affairs for Pro-Life Wisconsin, an educational and legislative organization representing more than 10,000 families in our state. I am here today to urge your **strong opposition to SB 27** which would legalize the tragic practice of physician-assisted suicide in Wisconsin.

My father would have been exactly the person to whom the sponsors of this bill would like to have given the option of physician-assisted death. At the age of 38, he was diagnosed with lung cancer which spread to his brain and eventually throughout his entire body. It was an extremely painful, oftentimes humbling, and, as we eventually discovered, terminal condition. My dad was a proud and stubborn man. Relying on others for help was the last thing he would ever have wanted. However, as his cancer progressed, that is exactly what he increasingly had to do.

But the degree of reliance on our family for help in daily living did not determine his quality of life, nor did it detract from his dignity as a human being. *Dignity is an inherent quality of the human condition.* My father did not lose his dignity because his body was covered by embarrassing and painful acne from medications. My father did not lose his dignity because he needed help in using the bathroom until he eventually became incontinent. My father did not lose his dignity because he was aphasic and could not communicate as effectively as in the past.

A safe environment was created by my mother and grandmother for my father to grieve what had been lost and explore the opportunities to view life in a new way which his illness presented to him. Although it was anything but easy, his suffering allowed him to see qualities in himself and others which he never took the time to discover before. It facilitated reconciliation with family members over past hurts and gave us a chance to show someone unconditional love--a rare opportunity in our society.

It pains me to think about what my father's outcome would have been like had physician-assisted death been an option for him rather than the loving arms of my mother who valued his intrinsic worth as a human being.

If physician-assisted suicide is legalized in Wisconsin, that safe environment for grieving will be stolen away. Those in despair will be handed death as a solution to their suffering



AN AFFILIATE OF
AMERICAN LIFE LEAGUE

rather than care. The "right to die" will soon become a "duty to die" as the sick, infirm, and disabled are increasingly discriminated against. Are those of us without disabilities so arrogant to think that once assisted suicide is in the picture, persons with disabilities will not suffer the deadly consequences? Currently, if someone who has a disability expresses a wish to die, their request is seen as rational, understandable. This is not so for non-disabled persons. Under legalized assisted suicide, the situation will only worsen.

By denying a certain class of people, in this case the terminally ill, protection from intentional killing, the state would subject life to utilitarian standards, judging it's value by how useful it is to others instead of on its inherent dignity and worth. We in Wisconsin cannot slide further into that mindset.

History has *not* shown us that physician guidelines will keep a provision to legalize assisted suicide from expanding to include involuntary euthanasia; rather, it has proven the opposite. How soon will it be before the requirement of a terminal illness turns into one of a severe disability, or chronic pain, or psychological suffering?

On behalf of the thousands represented by Pro-Life Wisconsin and citizens of our state like my father, I ask that you remain firm against the killing of innocent people and vote against SB 27.

Thank you for your time.



Wisconsin Council of Catholic Women

Founded 1915
Miss Mary Connor, Honorary Founder

Jan Holzbauer
5009 Glad Avenue
Madison, WI 53711

The Most Rev. Rembert Weakland, O.S.B.
Archbishop of Milwaukee, Spiritual Advisor

October 22, 1997

To: Chair and members of the
Senate Judiciary Committee

Re: SB27

From: Jan Holzbauer
WCCW Legislative Chair *JH*

Since 1973 when the U.S. Supreme Court rendered the Roe v Wade decision, pro-life groups have been alarmed by the escalation of the "slippery slope" pro-death syndrome.

In 1993 and 1996, when Assembly and Senate hearings were held on proposed Physician-Assisted Suicide legislation, the WCCW, as a pro-life advocate organization expressed concern about this final descent to the bottom of the slope, convinced that voluntary euthanasia would become involuntary euthanasia as the next logical step. Our position has not changed.

Despite supposed precautions, this situation has occurred in the Netherlands. Anyone interested in what would occur here, if assisted suicide were legalized is encouraged to read Dr. Herbert Hendlin's book entitled, "SEDUCED BY DEATH: DOCTORS, PATIENTS AND THE DUTCH CURE." (New York: W.W. Norton and Co. 1997)

Dr. Hendlin's book reveals how the Dutch have gone from accepting doctors killing people with terminal conditions, who ask for it; to killing people with chronic conditions, who ask for it; to killing people who are depressed with no organic condition, who ask for it; to killing people who don't ask for it because doctors think their time has come to die.

Hendlin warns that the U.S. perhaps more so than all other Western nations is likely to follow in the footsteps of the Netherlands. We too, he says, have developed a culture that distains moral judgment. Our relationships with our doctors, however, are not as trusting and with justification, we are concerned about doctors ignoring our health care wishes.

Hendlin warns that suicide rates are likely to rise. (This is already happening.) "Assisted suicide and euthanasia will become routine ways of dealing with serious and terminal illness just as they have in the Netherlands; those without means will be under particular pressure to accept the euthanasia option." We will create a "duty to die" rather than a "right to die".

What is needed now, say many pain specialists, is an informed active consumer group demanding pain relief. Dr. Ira Byock, M.D. has said, "I can state without equivocation that the physical sources of suffering

WCCW Legislative Position Paper on Physician-Assisted Suicide

associated with dying all can be controlled.

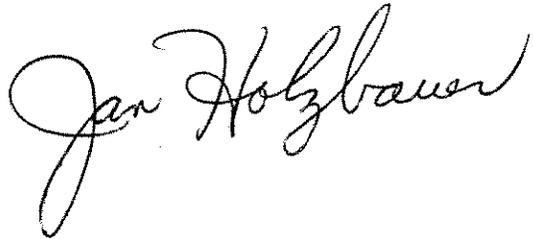
Hundreds of millions of dollars could be saved annually by making hospice care universally available. Our non-system of health care pauperizes people in their dying. This is especially true of the poor, those suffering from terminal illness and medical indigence.

Appropriate medical care includes withdrawal of treatment upon patient request, or if treatment serves no therapeutic purpose; and dispensing drugs to control pain. No pro-life organization opposes ceasing care when the time to die has arrived.

The Oregon legislature has voted to send its assisted suicide law, Measure 16, back to the voters who will have a second chance to determine if they really want physician-assisted suicide on November 14.

Both the Oregon Medical Society and the Michigan State Medical Society have echoed the American Medical Association position on this issue. They have declared assisted suicide "fundamentally incompatible with the physician's role as healer."

We ask that you oppose this proposed legislation. Thank you.

A handwritten signature in cursive script that reads "Jan Holzbauer". The signature is written in dark ink and is positioned in the lower right quadrant of the page.

Hearing - 10/22/97
SB 27
Physician Assisted Suicide

My name is Dottie Feder, I am co-chair of Wisconsin Information Network - WIN is a non partisan educational organization that informs several hundred liaisons through Action Alerts and a hotline who in turn share information with their churches and related organizations.

On June 26, 1997, President Bill Clinton stated, "I believe it is wrong and I have always believed it to be wrong. The risks and consequences of physician assisted suicide are simply too great." His statement was part of the official record at the time the Supreme Court upheld Pennsylvania's ban on physician assisted suicide.

In 1994, Oregon became the first state in the nation to legalize physician assisted suicide. Now three years later, many have discovered the law has fatal flaws and are calling for its repeal in the upcoming November elections. Half of the Oregon doctors surveyed admitted they could not confidently predict whether a patient has six months to live which is required for doctors to terminate life. Page 15 of SB 27 also defines "terminal disease" as one that is incurable and irreversible and will within reasonable medical judgment cause death within six months. Calling for the repeal of the Oregon law is the **Oregon State Council of Senior Citizens** - one of the state's largest advocacy groups, **Oregon Hospice Association, Oregon Medical Association and the Oregonian** - a newspaper which described a 25% failure rate of taking the prescribed 60 to 100 pills with results of vomiting, convulsions, brain impairment, kidney damage, comas and up to 8 hours of lingering agonizing deaths. One of the supporters of Oregon's assisted suicide bluntly admitted that "part of the process is having a plastic bag" nearby to cause suffocation and finish the job.

Included with copies of my statement are several Milwaukee Journal newspaper articles. The first has to do with doctors telling a 17-year-old he was going to die within one to eight months; however, his malignant brain tumor disappeared. The article states, "Doctors treating Tommy at Duke University Medical Center in Durham, N.C. are at a loss to explain his apparent recovery." The teenage was quoted as saying, "One month they're telling you you're going to die, and the next month they say you've got your whole life in front of you." Yes, doctors do make mistakes and miracles do happen!

Another newspaper article is entitled, "No trace of cancer found in latest Kevorkian suicide." A 58 year old patient feared ending up a vegetable following treatment for breast cancer, yet "the medical examiner later determined (she) had no lingering trace of the disease." The medical examiner expected to find cancer in her lymph nodes, liver and other internal organs, but found none.

Also included is a picture of a painting done by Mr. Kevorkian which shows a decapitated human head oozing blood on a platter with a wormy apple stuffed in its mouth. Kevorkian calls it symbolic of humanity and self destruction and contrasted next to it a picture of a painting done by Joni Eareckson Tada - a woman who is paralyzed from the shoulders down and paints by holding a brush between her teeth. She describes her painting as a method to give hope and encouragement to others. I can't imagine a better example of beauty and the beast than in these two painters and their paintings.

While Americans are sharply divided on the issue of assisted suicide, it is interesting to note that based upon a survey done by the AMA, only 13% favor assisted suicide once all the alternatives - such as hospice care - are discussed. The article is entitled, "The more patients know, the less they want suicide aid" and was published in the January 13, 1997 issue of the American Medical News. The American Medical Society and a coalition of 45 other medical groups asked the Supreme Court not to legalize the practice of assisted suicide calling it "misguided compassion at the expense of good medical care." A copy of the article is enclosed with this statement.

In conclusion, I urge this committee to reject SB 27. Thank you.

DOCTORS TOLD 17-YEAR-OLD HE WAS GOING TO DIE

5/12/95

Boy's brain tumor disappears

Chemotherapy didn't seem to be working, but cancer is in remission

Associated Press

Centreville, Va. — A month ago, Russell Cram began attending to the grim details of death. What kind of funeral service was right for his 17-year-old terminally ill son? Where should Tommy be buried?

"Every day I was preparing myself for what life would be like when Tommy was gone," Cram said. "In February, the doctors gave him absolutely no hope. They gave us one to eight months."

But last week, Cram and his family received news they are still struggling to comprehend: The latest tests showed no evidence of the brain tumor that had been killing Tommy.

"It's like a happy ending in a movie," Cram said. "You would say, 'Oh that's just Hollywood, but it would never happen in real life.'"

Tommy wears a baseball cap with "No Fear" emblazoned on it to cover a head gone bald from chemotherapy.

"It's hard to believe, really," the husky teenager said. "One month they're telling you you're going to die, and the next month they say you've got your whole

life in front of you. It's kind of hard to grasp."

Doctors treating Tommy at Duke University Medical Center in Durham, N.C., are at a loss to explain his apparent recovery, which is officially classified as a remission.

"We are not telling him he's cured. We will watch it very closely," said Henry Friedman, a cancer specialist who began treating Tommy in December.

Friedman has never seen or heard of another case in which a tumor like Tommy's disappeared after only brief chemotherapy treatment. "It's akin to hitting the lottery," he said.

Doctors found Tommy's brain cancer last August, and he had surgery to remove a tumor. But in December, doctors found the cancer had spread to his spine.

No trace of cancer found in latest Kevorkian suicide

Associated Press

Southfield, Mich. — Jack Kevorkian took part in a 26th suicide Wednesday — that of a 58-year-old cancer patient who the medical examiner later determined had no lingering trace of the disease.

"There was no cancer," Kanu Virani, deputy chief medical examiner for Oakland County, said Wednesday night after an autopsy.

The body of Patricia Cashman was found wrapped in a blanket in the back seat of an old car outside the morgue.

Cashman, who ran a travel agency in San Marcos, Calif., had feared ending up a "vegetable" unable to care for herself, Kevorkian lawyer Geoffrey Fieger said. He said the woman had suffered for three years from breast cancer that had spread throughout her body, and she had recently lost her

ability to walk.

Virani said he would have expected to find cancer in her lymph nodes, liver or other internal organs but found none. He said he hadn't examined her brain and spinal cord, but added it was highly unlikely the cancer would appear there if it hadn't shown up elsewhere.

Fieger did not immediately return a telephone call Wednesday night after the medical examiner released his findings.

In a July 6 letter, Cashman told Kevorkian that she "would go to almost any length to avoid ever being on pain pills again because of the terrible side effects that I suffered."

Sheriff's Lt. William Kucyk said his agency was investigating. Detectives were trying to contact Kevorkian, but Kucyk said that "we're certainly not optimistic he will submit to an interview."

Thursday, April 14, 1994

Kevorkian paintings to be auctioned



TO RAISE MONEY for his campaign to legalize assisted suicide in Michigan, Jack Kevorkian is auctioning off two stark, surrealistic oil paintings he created. This work, titled "War," shows a decapitated human head oozing blood on a platter with a wormy apple stuffed in its mouth. Serving bowls are filled with a variety of crosses, Stars of David and spent shell casings. In the background, Mars, the god of war, looks over the headless torso. "It's symbolic of humanity. It's self-destructive," Kevorkian says.

Associated Press photo



Being paralyzed and in a wheelchair can teach you many things — with years of practice, I learned how to draw holding pastel pencils between my teeth. While drawing these roses, I had to get close to my easel. I could almost smell their sweet scent! I hope this special card encourages you to look to the Lord so that you, too, can rise above your limitations!



— Joni Eareckson Tada

AMA poll: The more patients know, the less they want suicide aid

Although a slim majority of Americans favor legalizing physician-assisted suicide, a new AMA poll finds that most would choose other end-of-life options, such as hospice care, if they clearly understood their choices.

The poll, conducted for the AMA last month, also found that most Americans disapprove of the Dutch practice of euthanasia, in which the lives of some patients are ended without their request.

"This poll reinforces our belief that the American public needs to be educated on their options associated with dying and end-of-life care," said Linda L. Emanuel, MD, PhD, AMA vice president for ethics standards. "When told all their options, most people say they would prefer to seek palliative care and natural deaths."

Dr. Emanuel said she thought it was significant that only 13% of those interviewed said they would want physician-assisted suicide if they were terminally ill.

"Should the 13% who want physician-assisted suicide drive public policy for the rest of the nation — the majority of whom do not want this option?" she asked.

Two-pronged education effort

The AMA is involved in a two-pronged educational campaign for both physicians and the public on the issue of death and dying. See *SUICIDE*, page 22

Suicide

Continued from page 3

tional campaign for both physicians and the public on the issue of death and dying.

One is a "train the trainer" program that will teach physicians skills for quality end-of-life care, ranging from discussing and planning for death to offering appropriate pain relief and recognizing and treating depression.

The other effort seeks to reach the public through a variety of means, including participating in media interviews, testifying before Congress and filing amicus briefs in the assisted suicide cases that are now before the Supreme Court.

On Jan. 8, the high court was scheduled to hear two cases in which states' bans on physician-assisted suicide were challenged. The AMA and a coalition of 45 other medical groups asked the court not to legalize the practice, calling it misguided compassion at the expense of

good medical care.

They added that it would be "particularly ironic" if the first medical "treatment" to which patients had a constitutional right was physician-assisted suicide.

The poll, conducted for the AMA last month by the New York-based Global

● The terms "hospice" or "palliative care" were not familiar to 35% of respondents.

● After both terms were explained, 73% said they would choose hospice, palliative care or natural death if terminally ill; 14% said they were undecided and 13% said they'd opt for physician-

The AMA and a coalition of 45 other medical groups asked the court not to legalize the practice of assisted suicide.

Strategy Group Inc., involved telephone interviews with 1,000 adults nationwide.

Among the poll's findings:

● Of the respondents, 36% disapprove of intentionally ending a terminally ill patient's life, and an additional 13% are undecided.

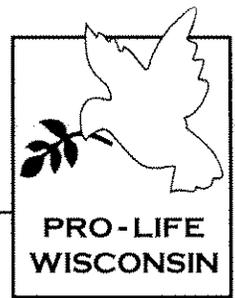
● Forty percent did not know it is legal to give pain medicine that could have the side effect of hastening death.

assisted suicide.

● More men (56%) than women (48%) say they approve of physician-assisted death; among men and women older than 65 years, only 41% approve. Those with higher incomes are more in favor of assisted death than those with lower incomes (66% of those making more than \$60,000 per year approve vs. 47% of those making less than \$20,000).

PRO-LIFE WISCONSIN

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Mary C. Matuska
State Director, Pro-Life Wisconsin
Re: SB 27

Mary C. Matuska
State Director

I am Mary Matuska, State Director of Pro-Life Wisconsin. I am also a wife, mother and grandmother and worked in Hospice for three years.

Assisted suicide sends a dangerous message to our society. To our young people, it tells them that suicide can be a way out. To the elderly, it tells them that when you become increasingly dependent on others and your "productivity level" is low, maybe it's time to check out early. To the disabled, it tells them that their quality of life just isn't acceptable, so suicide is an option. To the terminally ill, it tells them that there is no meaning in suffering, and, when they become a "burden" to others, suicide is the easiest answer for everyone involved.

Like it or not, a decision by one member of the human family touches all of us.

The propaganda pushed by the supporters of assisted suicide has deadly ramifications because it destroys something integral in the human spirit: **hope!** Do we really want to play God? Today I am speaking for my children and grandchildren and also the nine people I was privileged to tend to while working in Hospice. How many of these people would have opted for assisted suicide had it been legal? I would say half of them. Why? 1. Fear of pain. According to a study released by the World Health Organization, nearly 100% of a patient's pain can be controlled. But with the demon of assisted suicide lurking around the corner as an easy way out, our efforts to advance palliative care diminish. 2. They do not want to be a burden to their families emotionally or financially. In an age of rising health-care costs and cutbacks, assisted suicide is even more deadly. How much longer until the "right to die" becomes the "duty to die?" We have the power to bestow dignity to the terminally ill, and once that happens a wonderful change takes place. Depression fades and a new sense of purpose pervades. I know, I have been there not only with Hospice but with my own father who died of leukemia. We have the power, along with God's grace, to be the instrument of encouragement to these vulnerable people.

Assisted suicide, no matter how compassionate it may seem on the surface, is nothing more than a cruel lie. **Real compassion** takes time and commitment. **Real compassion** means suffering *with* someone else and bearing one another's burdens. **Real compassion** means bestowing dignity on the person at the end of life.

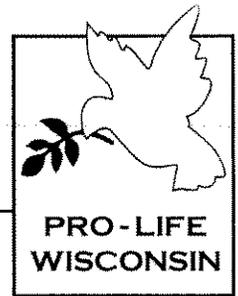
It is time that we look inside ourselves. We can choose to treat each human life as expendable and unworthy of our sacrifice, or we can nurture and respect each human life,



AN AFFILIATE OF
AMERICAN LIFE LEAGUE

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especially the people so near to meeting their Creator. Our answer will reveal much about ourselves and the society we live.

Mary C. Matuska
State Director

I ask you to look beyond the words and slogans and look to your heart. Deep down, I believe we all know we can do better than assisted suicide. We can begin to truly care instead of offering an unnatural death as an answer. For the sake of our future, and I am thinking of my grandchildren, we must choose life!

WELS Lutherans Life
National Convention, Appleton, WI
October 4, 1997

by Mark Pickup

I would like to begin by thanking you for inviting me to this beautiful state of Wisconsin to address you about an issue that is of deep concern to me: Physician assisted death. And I want to thank each and every one of you who have come to hear what I have to say and my concerns — as a citizen disabled with chronic progressive multiple sclerosis. Acceptance of assisted suicide and euthanasia in America and Canada poses an ominous threat to people like me because it will disproportionately affect the incurables and disabled. North America needs godly men and women during this hour of darkness to speak up resolutely for the innate value of *all* human life from conception to natural death. Yes! This great nation of the United States of America needs principled men and women of God, at this treacherous juncture in time, and to intervene for those at risk. Our great North America stands in an hour of moral darkness. What do I mean by that hour of darkness? The twilight started with discussions in the 1960s, about legalizing abortion and the twilight turned to darkness when North America accepted the notion that abortion was a way of solving what is, essentially a social problem. And the darkness deepened each year with the entrenchment of abortion rights and the continued slaughter of innocents. Now, our society fumbles and stumbles and tumbles in moral darkness by entertaining assisted death to those who have sunk beneath the waves of depression or circumstance, and ceased to believe in their own value. I am one of those you defend, and I thank you for valuing me, and those like me, even when we might cease to value ourselves.

Yes, my dear brothers and sisters in Christ, it's reassuring for me to know there are people like you, who accept that we are all made in the Image of God, and who will hold up a torch of light for a culture of life and hope in the midst of a culture of death and darkness. Shine the light of Christ that is within you during this time of darkness and bear witness to a better way than our culture of death.

We should not be surprised that our North American culture stumbles and gropes in the dark. It is the natural outcome of a society that has abandoned its Judeo-Christian roots that gave rise to our great culture in the first place. It was all so foreseeable!

1. I am a child of the 1960s and I did not understand the *reductio ad absurdum*¹ of a culture of moral relativism and situational ethics: Today, crippled with the chronic degenerative MS I think I am beginning to understand. The dying of our culture was expressed in the 1960s with the vogue theology of "God is dead." Remember? It led to a neo-orthodoxy of liberal Christianity (which is often little more than secular humanism² expressed in theological terms), moral relativism and the

¹Latin meaning disproof of a principle or proposition by showing that it leads to an absurdity when followed to its logical conclusion.

²See *The Humanist Manifesto II*. (New York Prometheus Books, 1973.)

legitimizing of situational ethics. A culture infiltrated by thinking that God-is-dead will, in the end, lead to cultural death. The same arguments applied to the *creator* will eventually be applied to the *creation*. The practical outworking of a humanity that no longer answers to a living God, is that they will, in the end, die themselves ... from the inside out. Such a humanity was destined to become treacherous with each other. When taken to its natural conclusion of the absurd conclusion of God-is-dead theology and that sort of thinking is manifested in wide-spread abortion and acceptance of euthanasia and assisted suicide. The same arguments used against the unwanted child in the womb can be applied to the unwanted granny in the old folks home, or the Mark Pickups of the world. Situational ethics prevail. Indeed, . . . indeed!

To me disability was — how should I say it? — the rudest shock I remember encountering in adult life. As a boy, I was healthy, agile, willowy and athletic. As a young father with a family, our lives were very active. At work, I was quickly admitted to the circle of power brokers. In March of 1984, I went dead from the waist down! It was rather like the sensation of having a spinal anesthetic. I knew something was seriously wrong. I couldn't distinguish a hot object from a cold object, or something sharp from something blunt. Then overnight I lost the use of my right hand. My wife had to help me dress. I could hardly hold a pencil. At work, I couldn't press the right floor button on the elevator and I could not dial properly on a rotary dial telephone. And I knew things were seriously wrong by how medical people around me changed; I am talking about their countenances.

My physician got me into a very busy neurologist within a few days who scheduled a lumbar puncture for me.³ The nurse who ushered me into the examining room at the hospital looked at me with an expression of pity. They dealt with me like I was delicate crystal. Their eyes darted amongst each other and the neurologist in much the same way eyes talk when people have a secret or are planning a surprise party. They seemed to be speaking out of the sides of their mouths in medical code language. Their movements were calculated, aloof and purposeful. I was merely a spectator. I must tell you that there was something oddly terrifying about that. I was removed from the process at the very time I felt most out of control.

After my spinal tap the examining room emptied except for the neurologist who was finishing his paperwork. I laid on the gurney and asked what he thought it was. He patted me on the shoulder, as casual as you please, and said he was pretty sure it was multiple sclerosis, then walked out of the room! He may as well have kicked me in the chest.

From 1984-87, I found myself on a relentless slide down hill; the pattern of attack/remission was extraordinarily volatile. It seemed like I was always on a cane or in a wheelchair.

- My vision was affected for a time;
- I lost my speech for a while and I looked like an imbecile frothing. I would gain my speech back, lose it, gain it back again;

³ Until the advent of magnetic resonance imaging, lumbar punctures (AKA spinal tap) were the primary diagnostic tool for *multiple sclerosis*

- I'd go incontinent for a time;
- I'd lose the use of my arm and hand, writing like a little kid;
- I'd lose sensation;
- I'd go spastic;
- I'd have crippling fatigue (I still do);
- Most frightening of all, I had cerebral symptoms where my memory and ability to think became clouded.

For 30 years my body had been mine — it listened to me — I controlled it. My body and I were one. Then these things started happening. My body no longer listened; I lost partial control of it. It was as though my body had been confiscated. I felt separated from it — rather like the out of body experiences we hear about. There was me ... and there was my body. They were separate entities. At times, it felt like I was watching a specimen that looked remarkably like me making movements that were remarkably foreign and unlike me. I felt removed from myself.

At times I saw my body as the enemy. At other times it seemed there was a menace loose in my body stalking me. I sarcastically dubbed the disease as "my friend." It had a personality (albeit a sadistic one). As attacks would come, even my wife would say, "I see your friend's back." — In case you haven't caught on, I am talking about the grieving process.

All these symptoms would come with no guarantee they would go away. Happily most of them have abated. With the passage of time, however, I found myself needing more and more assistance to walk to the point now whereon good days I use a cane around the house with a cane or canes and use my scooter outside for distance of more than 1/2 a block. During my bad times I am confined to my chair or even worse: bed. I know there is a good chance my destiny is to be bed-ridden — barring an effective treatment being developed. At this time there is nothing. There is no cure, there is not even an effective way to stop the course of MS. I share this with you because I want to illustrate that I could one day be a candidate for so-called "mercy killing." And I want to illustrate for you, too, that during the early, dark days of my disease I needed to grieve my loss. In fact, at about the 2-3 year point with MS my grief was so profound and unimaginable, my sorrow so deep, my heartache so sharp, that my judgment was clouded. I say to you today that I am glad there was nobody in the business of granting death wishes back in the mid-1980s. And I say this with the knowledge that my grieving may not yet be over; my disease is chronic and degenerative. Multiple sclerosis may not be finished with me.

But hindsight is 20-20, isn't it? I look back now with the understanding that I did not need somebody standing beside me to offer death with dignity. I did not need cliches, like the ever-nebulous "quality of life" or a misguided commitment to "self-determination." I did not need pat slogans or easy answers like "death with dignity" (whatever that means). I know very little about most things in life, but after 13 years of a chronic, degenerative disability I do know a simple truth: Give a man life with dignity and when it is time to die he will die with dignity too. Dying with dignity is a by-product of having lived with it. Dignity is not achieved by injecting a toxic substance into somebody's bloodstream when they are at their lowest ebb. The road to dignity is usually in the opposite direction from easy answers and pat solutions. What I did need was the freedom to safely

grieve by loss and departure from the world of the able-bodied to the world of the disabled.

Let me illustrate the need to grieve with a story. Music was a major part of my life. I played the guitar rather well. After the onset of MS, I lost my sense of timing and my fingers wouldn't do what they were supposed to do. One day (after about two years of not touching the guitar) I was making a casserole for supper. I could barely hold the casserole dish and it slipped out of my hands into the sink. I was so frustrated I pitched the dish down on the floor. It smashed into a 100 pieces and gouged the linoleum. My wife said, "That was bright! Now we have a hole to look at!" (My family was having a hard time watching me slide too). I went into the bedroom where my guitar was, grabbed it, found a saw, and commenced to cut it in half. My wife stood at the door watching me saw an expensive, beautifully crafted instrument and screamed, "You've gone mad! You need help!" I put the two pieces of my guitar back in its case. The rest of the day was spent in shocked silence. That night I couldn't sleep, I got up, looked at my guitar then wrote a note. I laid it on the instrument and closed the case. It felt good to see the guitar gone.

Why? Everything was slipping away. Remissions would return some function but not all. I was losing, bit by bit. It would have been easier if fate just took things away and not teased me. So, I finished something by sawing my guitar in half. I had to close a chapter of my life. May I read you the note I wrote that night.

I Sawed My Guitar In Half Today

I sawed my guitar in half today. It was the healthiest thing I have done in a long time. It gave me a release and a feeble way to express my grief. My love was music. As a youth I lived for my guitar and my music. I remember when I would rather play than eat. Now, my timing is gone, so too, is the strength in my hands.

On September 27, 1986, my new reality came into clear focus. Life will not be normal again. I realized I must pick up the pieces remaining in my life and forget what I've lost. Grief that would not surface for 2 years finally came to a head. I couldn't cry so I sawed my guitar in half.

I couldn't just give it away; that would only be more things quietly slipping out of reach. There has been too much of that already. I needed to sever the past with no tiny remnants to haunt me or taunt me.

I sawed to say goodbye to artistic expression. I sawed to say goodbye to a carefree youth. I sawed to say goodbye to life without a cane or other contraptions of the disabled. I sawed to release grief and say "I hurt!" But mostly, I sawed to say goodbye to an old and trusted friend — my guitar — a finely crafted instrument I can no longer play.

It didn't seem right to just leave it in its case. I sawed my guitar in half.

I'm trying to illustrate a point. In those early years with MS, my grief was so profound and unimaginable my sorrow so deep, my heartache so sharp, that my judgment was clouded. In the early years with my MS, my grief was so profound and sharp that my perspective could not be trusted. There were times when my family lifted me up as someone of value, even when I doubted my own value. Had my dear wife, LaRee, not been there, and a Jack Kevorkian offered to assist my suicide, I might have taken him up on it. Today I shudder to think of that prospect. You see people must grieve. Let me say that again. People need to grieve, to cry out and say the most outrageous things. It is unfair to hold them to a death wish sought when they are at their lowest point. Civilized societies do not do that.

A beautiful Fender guitar sawed in half at the height of grieving was harmless enough, — even therapeutic in a destructive way. But that was then and this is now. Now my sorrow is not for lost function but for our North American culture that once embraced a consensus of human life's sanctity. Much of our legal system and traditions have British Common Law at their core. In fact, Joseph Story stated in his 1829 inaugural address as Dane Professor of Law at Harvard University: "There never has been a period in which Common Law did not recognize Christianity as laying at its foundations."⁴

But now, in a span of 50 years that consensus is gone. A previous Judeo-Christian *consensus, ethic* or *ethos* has been replaced by the religion of secular humanism,⁵ moral relativism and situational ethics. My generation bought heavily into the fashion and convenience of moral relativism and shed any last remnant or memory of that previous Christian consensus.

Pop singer Taylor wrote a song for Christmas, in 1986, that carried the lines:

*Beware of royal welcomes,
Avoid a bit to-do,
A king who would slaughter
the innocents
will not cut a deal for you.*

⁴Quoted by Dr. Francis A. Schaeffer's *A Christian Manifesto* (Westchester, Illinois, Crossway Books, 1982, p. 38). Also see Perry Miller, editor, *The Legal Mind in America* (New York: Doubleday, 1962), p.178.

⁵*The Humanist Manifesto I* (New York: Prometheus Books, 1933), page 8, states: "Humanism asserts that the nature of the universe depicted by modern science makes unacceptable any supernatural or cosmic guarantees of human values." It should be noted that the word humanism originally meant atheist rather someone who was devoted to human interest or the human race. Humanism, as it is now used, is, perhaps, more accurately referred to as philosophical materialism (all that exists in the cosmos is made up of matter and is therefore open to scientific study). The word 'humanism' or 'humanist' has been pirated by philosophical materialists much like the word 'gay' has been pirated by homosexuals.

A king who would slaughter the innocents will not cut a deal for you, — do you see an application for the chronically ill of today? Indeed! James Taylor, you've said some pretty stupid things, but unwittingly you cut closer to the truth than you realized. A society that would slaughter its unwanted babies will not make a deal for the old, its incurably ill, the mentally frail and the disabled.

A king who would slaughter the innocents, will not cut a deal for you nor me.

Germany philosopher, G.W.F. Hegel, said in the Introduction of his book *Philosophy of History*:

“WHAT EXPERIENCE AND HISTORY TEACH IS THIS — THAT PEOPLE AND GOVERNMENTS NEVER HAVE LEARNED ANYTHING FROM HISTORY OR ACTED ON PRINCIPLES DEDUCED FROM IT.”

(Song: *Vincent*, Don McLean, EMI Records, 1:40 min.)

Vincent Van Gogh committed suicide in July, 1890. He suffered from mental illness yet despite this, his approach to painting changed the world of art. His works are, perhaps, better known than any artist. When we think of Van Gogh we are apt to think of his incomparable *Series of Sunflowers* or *Starry Nights*. We do not think of his seizures, his desperate cries in despair, cutting off part of his ear. He was excluded throughout his life beginning in childhood — the cruel butt of ridicule and isolation. Vincent Van Gogh's attempt at romantic love and his desire for human affection were rebuffed, after which he became increasingly solitary. He started painting at the age of 27 years, but his career as an artist was a short 10 years, ending with his suicide in 1890. From 1884-1890 he produced 700 drawings and 800 oil paintings. Do you know how many of those paintings Vincent Van Gogh sold? One. His brother Theo begged somebody to buy one of Vincent's works. While he was alive. His paintings were virtually worthless. He lived in wretched urban rooms, in barren rooms of rural cottages and the wards of mental institutions. Van Gogh's painting helped preserve him from utter madness. His grinding poverty, loneliness and mental illness drove him to the edge of a sad life. His last crippled work *Wheatfield with Crows* (a copy is out for your viewing) was painted just prior to his attempted suicide, on July 27th, 1890 and death two days later. His last words pitifully summed up his life: “The sadness will never go away” then “I wish I could go home now.” He died virtually unknown— his loneliness larger than life itself.

If you haven't read his biography I would suggest you make an effort to read it. Van Gogh expressed himself so vividly and analyzed things so acutely that his *Collected Correspondence* written to his brother is not only a great autobiographical account of his life but great literature. I was introduced to the story of Van Gogh when I was a boy. I remember thinking: “It's too bad he didn't live today. The world is kinder now.” No it's not. If he had been alive in 1996, he might be helped in his suicide, courtesy of Dr. Jack Kevorkian or the local chapter of *Death with Dignity* or *The Hemlock Society*.

If anyone is naive enough to think that the twentieth century is more apt to give the mentally ill more life with dignity than the 19th century ... take a tour of inner cities all across North America. We are no more enlightened, nor kind toward the mentally ill, the chronically ill or the disabled than

a 100 years ago.

A mere 46 years after Vincent Van Gogh's death Germany implemented a euthanasia program which lasted until 1945. Now, North America is discussing euthanasia and assisted suicide. We must not delude ourselves into thinking that things will be any different here than in Germany of 67 years ago, or Holland of today. These are two magnificent, highly developed cultures that gave the world the Dutch Masters, Vincent Van Gogh, Brahms, Goethe, Schiller,⁶ Humboldt⁷, Martin Luther, Bach, and Beethoven.

LUDWIG VAN BEETHOVEN: (Third movement of Beethoven's 9th Symphony: *Adagio molto e cantabile*). He was another example of how people with disabilities can enrich the world. The rewards of having the disabled and chronically ill amongst us to make their contributions cannot be overlooked. Ludwig Van Beethoven was one of the greatest composers who ever lived, yet by the age of 36 he began going deaf. It became total but his creative prowess was never restricted. His 9th symphony (you are listening to the third movement) was his crowning achievement. He never heard a note of it — except in his head. Most of us know he was profoundly deaf when he wrote it but fewer people are aware he was going deaf when he wrote his 1st symphony. When he started his 1st in 1797, deafness was detectable and when it was finished in 1800, his deafness had become serious — so serious that in 1802 his physician sent him out of the county for therapy — to no avail. All 9 symphonies were written in partial or complete deafness. His mind was so muscular — It's doubtful he heard much of his *5th Symphony*, or his *Pastoral Symphony #6*. His beloved *Moonlight Sonata* was written between 1803-1804 in serious deafness. The same applies to his overtures, concertos, music for string quartets, His *Fantasia for piano-chorus and orchestra*, his opera *Fidelio*. *Creatures of Prometheus* was written in silence. A deaf man writing symphonies! Jack Kevorkian might have thought it best to put the poor creature out of his misery!

And other people with disabilities helped to enrich our world:

THOMAS ALVA EDISON: He, too, had a severe hearing impairment from the age of 12. Yet that is not why we remember him We remember him for giving us the movie camera, the phonograph, the light bulb.

JOHN MILTON, was blind when he wrote *Paradise Lost* — the story of Satan's rebellion against God and the expulsion of Adam and Eve from the Garden of Eden. *Paradise Lost* is generally

⁶Schiller, Friedrich von, 1759-1805, German dramatist, poet, and historian, one of the greatest German literary figures, second only to Goethe. See his dramatic trilogy *Wallenstein* (1798-1799), *Mary Stuart* (1800) and *Wilhelm Tell* (1804), a superb study of history and hero.

⁷Humboldt, Alexander, Freiherr von, 1769-1859, German naturalist and traveler. His works include *Voyage of Humboldt and Bonpland* (1805-34) and *Kosmos* (1845-62). Humboldt and A. Bonpland did much to lay the broad foundations for the sciences of physical geology and meteorology.

considered the greatest epic of the English language.

ELIZABETH BARRETT BROWNING: Poet. She was crippled. Although an invalid and recluse, her gift for lyric poetry and contribution to the world of literature remains with us to this day.

JOHN KEATS, suffered from tuberculosis and died at the age of 25 years. Yet despite his illness and premature death, he is generally thought of as one of England's greatest poets. His best work occurred in the last 3 years of his life when he was his sickest. His poems are unequalled for dignity, melody, and richness of imagery.

GEORGE FREDRIC HANDEL: A manic depressive, yet he gave the world some of its most celebrated music, including the beloved *Messiah* written at the end of one of his bouts of depression.

WOLFGANG AMADEUS MOZART, is now thought to have had Turret's Syndrome.

Need I go on? — **Virginia Wolfe, Toulouse-Lautrec, Franklin Delano Roosevelt:** Crippled with polio and yet he led an entire nation. During his Presidency he changed the face of America to be a more compassionate America.

How much poorer the world would be thinking like advocates of assisted death for the terminally and chronically ill, and the disabled! Advocates of assisted death say they believe in freedom to choose the time and place of one's own death. It puts a false air of respectability around assisting in the requested death of someone who is overwhelmed by grief. What euthanasia advocates are advocating is what we used to call murder. To choose death is to choose to never choose again. Choosing anything under duress is never conducive to good decisions. Choosing death in the midst of pain, or suffering or grieving loss is not really freedom to choose. That is like Newspeak in George Orwell's novel 1984: The tale of totalitarianism gone amuck crushing individual freedoms: Now we have individual freedoms crushing the whole.

North America has bought into the myth of personal autonomy, self-determination and personal independence. Nobody makes decisions in a vacuum! Our decisions affects others! If I opt for euthanasia or assisted suicide it will affect my wife and children, my mother and my siblings. It will affect my doctor because she will have changed her role from healer to executioner. And, in a small but not insignificant way, it will affect my Nation by further entrenching the notion that there are lives not worthy to be lived. The fact is this: We are the Human Family. We never make decisions in a vacuum. We are not independent, we are interdependent. Words like "citizen," "nation," "community" and "family" attest to our interdependence. You cannot have, on one hand, autonomy and independence and on the other inclusion and community and family. Autonomy eventually translates into detachment, indifference, and if allowed to go too far, anarchy.

It was Seventeenth Century poet and divine, John Donne who said,

**"NO MAN IS AN ISLAND ENTIRE UNTO ITSELF; EVERY MAN IS A
PIECE OF THE CONTINENT, A PART OF THE MAIN: ... ANY MAN'S**

**DEATH DIMINISHES ME, BECAUSE I AM INVOLVED IN MANKIND:
THEREFORE NEVER SEND TO KNOW FOR WHOM THE BELL TOLLS:
IT TOLLS FOR THEE."**

America is not made up of 250-million little islands entirely unto themselves (3 million little islands in Canada)! We are responsible for each other. You to me and me to you. Most things of life I know nothing about, but I think I am beginning to grasp a sense of the only thing that matters... Do you know what really matters? Dr. Francis A. Schaefer stated it so succinctly in his last book *The Great Evangelical Disaster*, published in 1984 as he was dying of cancer:

"HERE IS WHAT REALLY MATTERS — TO LOVE THE LORD OUR GOD, TO LOVE HIS SON, AND TO KNOW HIM PERSONALLY AS OUR SAVIOUR AND IF WE LOVE HIM, TO DO THE THINGS THAT PLEASE HIM; SIMULTANEOUSLY TO SHOW FORTH HIS CHARACTER OF HOLINESS AND LOVE IN OUR LIVES; TO BE FAITHFUL TO HIS TRUTH; TO WALK DAY BY DAY WITH THE LIVING CHRIST; TO LIVE A LIFE OF PRAYER. AND THE OTHER HALF OF WHAT REALLY MATTERS IS TO LOVE OUR NEIGHBOR AS OURSELVES. THE TWO GO TOGETHER; THEY CANNOT BE SEPARATED. ON THESE TWO COMMANDMENTS HANG ALL THE LAW AND THE PROPHETS."

Dr. Francis A. Schaeffer,
The Great Evangelical Disaster
Crossway Books, 1984, Page 38.

But don't believe Dr. Schaeffer, read it for yourself in Matthew 22:37-40. The implications will reach into every corner of our lives. If we truly do love our Lord and if we truly do love our neighbor, our hearts will ache with compassion for humanity, to internalize our Lord's commandment when he said:

"THIS IS MY COMMANDMENT THAT YOU LOVE ONE ANOTHER AS I HAVE LOVED YOU."
[John 15:12. Also see John 13:34-35. & 1 Thess.4:9, 1 John 3:11, 1 John 5:2-5]

St. John later remembered these words of the Lord about what is really important:

"AND THIS IS HIS COMMANDMENT THAT WE SHOULD BELIEVE ON THE NAME OF HIS SON JESUS CHRIST AND LOVE ONE ANOTHER, AS HE GAVE US COMMANDMENT." (1 John 3:23)

And the Scriptures speak wider than just loving our neighbors as ourselves. 1 Thess.3:12 says:

"AND MAY THE LORD MAKE YOU INCREASE AND ABOUND IN LOVE TO ONE ANOTHER AND TO ALL [emphasis added] AS WE DO TO YOU," (Compare with He.13:1, Ja.2:8)

We do not love one another by killing each other. Any seven year old can tell you that. If we truly love

me another, we will lift each other up as having worth (St Paul referred to this in his letter to the Romans in Chapter 12.9-10, then again in Philippians 2.3-5.) We will value even imperfect people — *even* when they have ceased to value themselves. Why? Because we all are image bearers of God. (Gen.1.26 & 27 Also compare with Gen. 2.7, 5.2, 9.6, De.4.32, Job33.4, Ps.8.5, 100.3, Is.51.13. Ma.2.10, Acts17.28.) To be made in the image of God bestows certain innate value on human life because God himself has immeasurable love for us and values us. [Read the 3rd Chapter of John].

It is people like you who will turn around our great (albeit flawed) culture. It is people like you who keep reminding out culture that it is our Judeo-Christian roots that made our culture great. I submit that it is this distinction, and this distinction alone, that make our culture great. And I submit that without the recognition of a Supreme God who is the creator, and the final reality our North American culture is little more than dust. Those who designed the Declaration of Independence for America knew this. For if there is no creator of *inalienable rights* then the whole document is absolute nonsense. Even in Canada, the preface of our Charter of Rights and Freedoms begins with a preamble that says: "Whereas Canada is founded on the principle of the supremacy of God and the rule of law."

God is not what you or I perceive in our minds. If there is a God, (and there is) then God is what God is — regardless of what you or I perceive Him to be, or what is a fashionable mode of thinking at any given time. God described himself to Moses as **I AM WHO I AM**. [Ex.3.14] **I AM** *simply is*. **I AM** is the Law Giver. In fact, the Hebrew Old Testament was gathered into three collections, one of which was "the Law" (the first 5 books of the Bible). This is the Jewish Torah, meaning "instruction," of ten referred to as the *Book of the Law*, *the Law of Moses* or simply *the Law*. Christ claimed to be **I AM**. [John 8.58]. **I AM** in the mouth of Christ is affirmation of His Supreme, eternal self-existence. (Compare with other "I AM's" of Christ. John 4.25-26, 6.35, 8.23, 9.5, 10.7, 11, 14, 30, 10.36, 11.25, 13.13, 14.6, 15.1, Re.1.8 & 17, which express various truths about that essential existence, claiming deity alone.) I come back to Matthew 22:37-40. Christ himself, told us what is *really* important.

"AND JESUS SAID TO HIM, 'YOU SHALL LOVE THE LORD YOUR GOD WITH ALL YOUR HEART, WITH ALL YOUR SOUL AND WITH ALL YOUR MIND.' THIS IS THE FIRST AND GREAT COMMANDMENT AND THE SECOND IS LIKE IT: 'YOU SHALL LOVE YOUR NEIGHBOR AS YOURSELF.' ON THESE TWO COMMANDS HANG ALL THE LAW AND THE PROPHETS."

We do not love each other by killing. Any seven year old can tell you that. The word Love and the word kill are contradictory terms. And so somebody will say "What about the freedom to choose for those who chronically ill?!" (Freedom to choose is the mantra of the babyboomers). We get an inkling of God's value for life not just from Scripture like the Commandment not to murder (which would include participating in suicide), ... but God's voice calls out from the Old Testament — even to this generation.

"I CALL HEAVEN AND EARTH AS WITNESSES TODAY AGAINST YOU, THAT I HAVE SET BEFORE YOU LIFE AND DEATH, BLESSING AND CURSING; THEREFORE CHOOSE LIFE, THAT

YOU AND YOUR DESCENDANTS MAY LIVE.”

[De.30.19]

[Also compare spiritual “choices” with Ex.32.26, Jos.24.15, 1 Ki.18.21]

God places high value on his creation (even when that life is flawed, like me). It is people like you, in this generation, who can speak to choosing life. And I am humbled to surrounded by the people of God who seek to follow the Word of God:

A deaf man writing symphonies . . . who ever heard of such madness!

(Beethoven's Chorale Finale, Symphony No. 9 in D minor op.125.)

(1min. 28secs.)

We will not be richer without the incurables and the disabled. We will be poorer, much poorer.
Thank you and God bless.

- Mark Pickup

Rep Boyle

**Summary of Physician-Assisted Suicide Proposal
Introduced by Rep. Frank Boyle & Senator Fred Risser**

Individual requesting physician-assisted aid in dying must be:

- At least 18 years of age.
- Resident of Wisconsin.
- Suffering from a terminal disease (defined as an incurable and irreversible disease that will cause death within six months), confirmed by two doctors.
- Of sound mind & not incapacitated.

Procedure for request to physician:

- First request must be made orally.
- Not fewer than 15 days later, the patient must again make the request in writing, signed in the presence of 3 qualified witnesses.
- If the patient is in a health care facility, at least one of the witnesses must be a patients' advocate designed by the Board of Aging and Long-Term Care.
- After request is filed, patient must make a second oral request.

Witnesses must be at least 18 years of age and cannot be any of the following:

- Related to the patient by blood, marriage or adoption.
- An individual who has knowledge that he or she is entitled to or has a claim on any portion of the requester's estate.
- Directly financially responsible for the requester's health care.
- An individual who is a health care provider who is serving the patient at the time of the witnessing; an employee, other than a chaplain or a social worker, of a health care facility in which the requester is a patient.

The physician must:

- Inform the patient of his or her diagnosis & prognosis.
- Inform the patient of the probable results of taking the prescribed medication and alternatives to doing so.
- Refer the patient to a consulting physician for review.
- Refer the patient to a psychiatrist or psychologist for review, if that person is suffering from a psychiatric or psychological disorder.
- Certify that the statutory requirements have been met.
- Ask the patient to inform his or her next of kin about the request.
- Offer the opportunity for the patient to revoke the request.

Afternoon
Good Morning Ladies and Gentlemen,

My name is Jolene Churchill and my family and I have been long-time advocates for individuals with disabilities.

As a member and former counselor for the Association of Retarded Citizens, I was very pleased to learn that this national organization is actively opposing all efforts aimed at the legalization of assisted suicide throughout the United States. The Association of Retarded Citizens realizes that these types of laws will discriminate and cause undue harm to the wonderful individuals they represent. Assisted suicide legislation will further discriminate against individuals with disabilities and reinforce the world's perception that they are merely second-class citizens.

Presently I have several young children and adults under my care as a respite worker in Rock County. Every one of these individuals has a fundamental right to life and the right to be free from the unwarranted discrimination that assisted suicide forces upon them.

Assisted suicide strikes at the humanity and personhood of individuals that the world does not deem worthy of life. In August I volunteered to take members of a local group home to the Wisconsin Dells for the Apostolate to the Handicapped. I was surrounded by a sea of smiling faces, clapping hands, giggling voices, and people happy to be alive. It didn't matter that they sat in a wheelchair, or needed to walk with a cane, or needed to have the assistance of a personal aide. These so-called limitations didn't hamper their fun and excitement that day.

As Father Thomas Campion, Director of the Handicapped to the Handicapped, so eloquently stated, "We need to look deep within, and see the beauty God has created in each individual." Father Campion is so right. We are not the ones who should decide who should live or who should die. It is our job to love and assist everyone unconditionally during their journey through this life.

Even though I am very involved in helping and comforting individuals with disabilities, there is another reason why I am opposed to the legalization of assisted suicide. His name is David Churchill. He is my twin brother. He has Down's Syndrom.

David dearly loves life. Here is a picture of David and I with our little niece Katie, whom he loves very much. David enjoys listening to his numerous Johnny Cash tapes, riding his bicycle, eating pizza, and spending the paychecks he receives from his job.

We need to get back to the basics. When I was a small child I remember the popular song that went like this "He ain't heavy, he's my brother."

On behalf of my brother and all individuals with disabilities, I urge every one of Wisconsin's elected officials to oppose any attempts to legalize assisted suicide in our state and protect the vulnerable of our state. Please oppose Senate Bill 27.

**Jolene Rose Churchill
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discontinue tube feeding and allow the patient to die. In actuality, this kills the patient. To kill a patient by withholding food or water is not comfortable, kind, or right.

Hospice Care

A terminal illness can cause great distress for the patient and loved ones. Hospice care involves a team of medically trained professionals who specialize in pain and symptom control for the patient. The family is provided counsel for the emotional pain. The patient is provided the medical care necessary for a comfortable life and is allowed the opportunity to live at home or in another home-like setting during the last days of life.

Summary

Without the guidance of Biblical principles, terminal illness has rendered many people helpless and hopeless. Depression sets in and suicide is perceived as the solution.

The comfort of God's Word tells us that we have a purpose in life, even when we suffer. Medical technology has provided comfort and care for those who suffer. A patient has the right to receive pain management and should not spend the last days of life in severe pain.

There are many alternatives to euthanasia. Choose one that glorifies God.



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Living Choices

Alternatives to Euthanasia

*God-pleasing alternatives
to mercy killing*

You feel:

- ◆ Your life has no meaning
- ◆ There is nothing left in life that you can do
- ◆ Anything is better than this painful suffering

You have been told:

- ◆ Your quality of life is gone
- ◆ You are a burden on society
- ◆ You have the right to die

God's Word says:

"Do you not know that your body is a temple of the Holy Spirit, who is in you, whom you have received from God? You are not your own; you were bought at a price. Therefore honor God with your body."

(1 Corinthians 6:19-20)

"See now that I myself am He! There is no god besides me. I put to death and I bring to life, I have wounded and I will heal. And no one can deliver from my hand."

(Deuteronomy 32:39)

So, what do I do?

As a person who is suffering from a terminal illness, consider the attitude and the alternatives that you face. Seek guidance from God's Word for the right motive. Then select the right method to meet your needs.

Motive

Jesus tells us:

"I am the vine; you are the branches.

If a man remains in me and I in him, he will bear much fruit; apart from me you can do nothing."

(John 15:5)

The writer to the Hebrews states:

"And without faith it is impossible to please God."

(Hebrews 11:6)

Use every opportunity in your life to give glory to God. Even if you are suffering, you can still demonstrate your faith in that suffering.

Method

You very likely do not have to suffer great pain. Medical technology has progressed to the point of being able to make you comfortable.

However, many medical professionals, by their own admission, are inadequately trained in pain management.

We do not have the right to end life. We also do not have the right to prolong life when it seems clear God is taking it. We do have the right to manage pain and keep the patient comfortable.

Here are some ways to deal with the suffering from a terminal illness, when death is not yet imminent.
(Imminent, by definition, means death is coming within a few hours or days)

Pain Management and Depression

When a patient becomes depressed, suicide is considered by some as a desirable option. Depression sets in when a patient suffers great pain or when there is little family or social support. Through pain management, depression is also managed. Support from family and friends is a key component to overcoming depression in terminally ill patients.

Care Giving

As a loved one nears the end of life, there are many wonderful ways in which love can be communicated. Consider keeping your loved one in your home and providing the care yourself. If a nursing home is the best alternative, then make regular visits to the facility. Don't underestimate the importance of your efforts. To provide a meaningful touch, or to speak words of support and comfort, will provide special moments for both the patient and the loved one.

Tube Feeding

Many people are confused by references to tube feeding. The impression is that tube feeding is modern and heroic treatment that is extraordinary care. In fact, tube feeding has been around for over 100 years and is very comfortable for the patient. When a patient is in a coma or persistent vegetative state, there can be a strong desire to

place more emphasis on the right people have to die with dignity by not being kept alive insensate. There is no moral obligation, we should emphasize, to use extraordinary or burdensome means to sustain life.

I am not sure that one can make the claim that people have a right to be free of pain and suffering. This would be the equivalent of saying they should not be human. Moreover, it is critical to distinguish between the two.

Pain is physical and very real for the dying person. Everything possible should be done to reduce and alleviate it. We can do more to manage pain.

Suffering, though just as real, is less a matter of physical discomfort as it is emotional and psychological anguish. Persons near death anguish for their families and care-givers. Loved ones often suffer for those dying. We can never take away suffering without taking away our human nature, but we can ease most suffering. As individuals and as a society, we can assure dying persons that their lives retain meaning and that their continued presence is not a burden to us. We can be more open and candid about the fact that dependency does not diminish our humanity.

Together, we can change our culture so that terminal illness or the debilities of old age are viewed positively, not as something to be loathed, but as occasions for mutual support and care.

This new sense of bonding with the terminally ill could help us arrive at a new commitment to make health care accessible for all.

We also have in this moment the possibility for bridging divisions in our political community. To those conservatives who decry our society's abandonment of the unborn and to those liberals who decry the loss of the safety net for the poor, this debate provides the opportunity to come together in favor of a different choice about those who are near death. Those on both sides of the political center can seize this moment to start our society down a different, more compassionate, road than we have traveled of late, one that respects life in its most vulnerable moments.

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Catholic Position on Assisted Suicide

Testimony by Archbishop Rembert Weakland, April 1997
to Wisconsin State Legislature

I begin my testimony by recognizing that end-of-life decisions are, or certainly will be, a most personal matter for all of us. In the last year, I lost to cancer a colleague and close personal friend, Cardinal Bernardin. I have also had to confront illness of my own and with it the reality of my own mortality. In my years as a priest, I have walked with many others who have faced a terminal illness or that of a loved one.

So I appreciate the difficult choices and personal anguish people face at such times. Like many of you, I know the frustration of losing control of my future. I fear becoming a burden to others. I empathize with those who dread being bound to life-support machines and other technologies.

Yes, assisted suicide raises questions that are profoundly personal and heart wrenching. Yet, it is in these very moments that we are most in need of principles and values to guide our choices and to define the limits of our actions.

Though I speak from a Catholic perspective, the values of this point of view are consistent with our American tradition which recognizes the existence of truths that transcend time and culture. Any serious discussion of assisted suicide must honor two of these basic truths.

The first is that human life is sacred, a gift with which we are endowed by God. Hence, it is inalienable.

This is not a "Catholic" proposition, nor a uniquely Christian one. It is, rather, a "self evident" proposition, recognized as such by the Founders and reaffirmed by Lincoln at Gettysburg when he dedicated the nation to a new birth of freedom, but a freedom under God's providence.

The second truth is that human life is social. We humans, by our nature, are bound to each other. Any decision that violates basic rights or that devalues life impacts on other types of behavior and other choices. Such decisions are never a purely private matter.

Because human life is both sacred and social, we regularly exhort our fellow citizens to embrace a consistent life ethic that calls us to evaluate all decisions in the light of their impact on human life and dignity.

Physician-assisted suicide is a rejection of this ethic.

As Cardinal Bernardin wrote in his final days, assisted suicide is wrong because it involves a direct attack on innocent human life. It is bad public policy because it sanctions a violation of a fundamental human good, life itself.

Just as one life impacts others, so does one policy influence others. This should be apparent to all. For the logic that supports assisted suicide is grounded in attitudes that drive policies on abortion and assistance to the poor. In these instances, a person's dependency is allowed to weaken his or her claim on the support of the community.

Because unborn children depend on their mothers, they may no longer appeal to the community to recognize their right to life. Because young women and their children are economically dependent, they may no longer appeal to the community to honor their claim to the necessities of life.

Having made such judgements about those dependent at the beginning and in the middle of life, our society is now asking us to decide that the law, as could be predicted, need no longer protect those who are dependent at the end of life. The common good will not be achieved if those who are dependent will be made to feel that they owe it to society to choose death.

But dependency does not deprive us of our humanity. It should not be viewed as a burden. Rather, it should provide an opportunity for each of us to look beyond ourselves and serve one another.

The Bill's sponsors suggest that assisted suicide must not become an alternative to good comfort care. They say it must not deflect us from the goal of providing health care for all.

But the history of the last twenty-five years suggests that the opposite will happen.

A generation of legalized abortion has not strengthened our commitment to meeting basic needs of children. Having granted women the right to end pregnancy, society now expects a poor woman to go it alone in caring for those children she does not abort.

It requires no great leap to suggest that we will see a similar evolution should we enshrine the right to die. One can readily envision a society that tells seriously ill patients who decline to choose death to provide for their own needs after "time-limited health care" expires.

I also wish to engage the sponsors' definition of a "good death" as one in which we can end our lives "at the time and place of our choosing."

Such a definition is totally misguided. Goodness cannot be morally defined as freedom from restraint, but as a willingness to respect one's own life, that of one's neighbor, and by a commitment to truth.

"Slippery slope" arguments must be made with care. But the slope here is very real and very slippery. If choice is what matters, then it is difficult to justify imposing any time limit on that choice. Why must death be expected in six months, as the Bill provides? Why have any time limit at all?

And why should only physicians be permitted to assist in the suicide? Why deny the ability of others to assist? The slope is indeed slippery.

But all of this begs the question. The gift of freedom and personal choice can only be operative within defined limits. So, if the law says persons may not exercise their freedom to become slaves, how can it permit anyone to use the argument of freedom in order to be killed? Personal freedom and choice cannot trump the inalienable right to life.

It does not follow, however, that a terminally ill patient is obligated to accept or employ every means of treatment just to stay alive. There is a clear moral distinction between accepting death and choosing to cause it. As Cardinal Bernardin observed in the days before his own death, when one decides to forego treatment, he does not cause death. Rather, he chooses life "without the burden of disproportionate medical intervention." We would do well to

"Human life is both sacred and social."

-Archbishop Weakland

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.

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.

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.

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.”¹

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.”²

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.”³

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

Historical records indicate that active euthanasia was practiced in ancient Greece. The Hippocratic Oath, which is sworn to by all physicians practicing active euthanasia, states: "I will neither give a deadly drug to anybody who asks for it nor will I assist in such a request to this effect." This oath, the mainstay of Western medical ethics for centuries, and had the crucial effect of insuring that the physician who accepted a patient's plea not to be killed was not spreading the propagation of euthanasia to the entire class of medical practitioners. What is not widely known is that euthanasia was practiced by the most respectable people in the Third Germany, before Hitler, and in Germany and the U.S. after Hitler.

In 1938, in Dresden, Germany, a baby was born who was blind, missing a leg and part of an arm, and was believed to have cerebral brain damage. Adolf Hitler visited the baby in a private hospital, directed by the personal physician, Dr. Karl Schmidt, at the clinic where the baby was to live. Friends and other physicians in the government had the baby killed. The father was the only one who was not in favor of the situation. He had a doctor to kill the child's life the following year. Schmidt was authorized by Hitler to set up an official system to handle further "mercy killings." The program began to function quickly and efficiently in the U.S.S.R.

The year 1939 was designated by Hitler as the "year of the duty to be happy." He passed several medical ordinances to streamline the destruction of patients with mental illness and children with disabilities, and to oversee all euthanasia operations.

By 1943, 275,000 men, women and children with mental illness, mental retardation, epilepsy, multiple sclerosis, and other ailments had been killed in established killing centers, 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.⁶

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."⁷ 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.⁸

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."⁹ 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.¹⁰ 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.¹¹ 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 1990.¹² 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.¹³ 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.¹⁴ 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.¹⁵ 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.

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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.^{1,2}

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)³ and The American College of Physicians⁴ have termed assisted suicide "...contrary to public policy, medical tradition, and the most fundamental measures of human value and worth."⁵ 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."⁶ 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."⁷ 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.*"⁸ In the Netherlands, where physician-assisted suicide is openly practiced, "many Dutch physicians remain uncomfortable with professional and public tolerance of the practice."⁹

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?*,"¹⁰ 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."¹¹

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.*

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THE FACES OF EUTHANASIA



Alzheimer's: A Caregiver Speaks Out

by Noreen Rackow as told to Mark Torinus

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.

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.¹

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.² 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.³ 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.⁴ 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.⁵

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."⁶

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.⁷ 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."⁸

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.
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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."¹ 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.²

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.³ (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*

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

* Figures used in this table are drawn from the source noted below: Medische Beslissingen Roknd 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 1969.⁴ 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.⁵

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.⁶ 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.⁷ 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,⁸ a chest physician described his decision to perform active involuntary euthanasia as "weird," "horrible," and "very difficult to digest;"⁹ a nurse complained that "it shocked you every-time,"¹⁰ 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.¹¹ A nurse suffered from severe mental depression and required psy-

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

chiatric treatment after having been involved in active euthanasia on her own father.¹² 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

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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), *Bra-bants Dagblad*, October 10, 1987.
3. *Medische Beslissingen Roknd 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).

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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That Final Piece

Leaving With Life

Where do you start a life's story? At the beginning? Perhaps. However, in the case of my father, I feel that I must start at the end.

Although Clifford Brunner's life was full of meaning and importance, apart from his family and a few close friends, it probably wasn't evident. That's because we were witness to the many episodes of living that surrounded him over the course of his pilgrimage. Those pieces of life, apportioned and scattered throughout our days: birth, barefoot fishing, school, dating, war, cars, marriage, jobs, family ... and death. In a way, it's kind of like that terribly difficult jigsaw puzzle you once put together. Even though there were a thousand pieces and you had 900 of them assembled, those last 100 pieces held the meaning of the picture. It wasn't complete until the last piece was in place. For my father, a victim of Alzheimer's disease and seven long debilitating years in a nursing home, life wasn't complete until that gentle hand of death finally touched him and beckoned him home.

The story of this last stage of his life began three years ago when my mother, my sister and I were summoned to a meeting with the nursing home staff.

They grimly told us that my dad could no longer swallow his food effectively and that he could choke to death. We must, they continued, make a decision to either end feeding and hydrate only or put him on a feeding tube. They told us that many families make the "humane" decision and allow their loved one to die "peacefully." Tube feeding, they continued, would not guarantee survival. It would, however, prolong his life.

We looked at each other and, for a moment, I admit, we entertained the thought. Oh, if only the Lord would take him now and end this suffering. Initially, the thought of

just one more indignity and inconvenience was more than we could bear. It was at this point that the Lord bestowed upon me a most precious gift. He gave me a vision of time compressed into seconds. I saw my father's life and mine laid out before me. How could I do this to the father I loved? Why, his life wasn't over! There were pieces of the puzzle still waiting to be fitted. His picture was not complete and I sensed that the Lord still had wonderful plans for my father. I also sensed that similar thoughts were traveling through my mother's and sister's minds. No, the decision was easy. "Put in the tube," we all said in concert. "That is what dad would have wanted and the Lord expected."

The days, weeks, months and years passed and dad's health deteriorated, yet he lived. My mother would visit him faithfully and I often tried to visit once a week; but even that became difficult as time passed. What was the point I sometimes rationalized? He couldn't walk, so I had to sit in his lonely room. He had lost the ability to talk and even holding his head up was difficult. Yet, I felt compelled to visit him and talk to him. In a more distant time I had been the wayward son, the boy who he didn't understand, the young man opposed to everything he held dear. Now, as I had grown older and acquired a family of my own, I began to see my father's point of view. For the first time in my life I found

myself talking to a man that I always had a difficult time speaking with. The Lord opened my heart and I poured out my feelings to my dad. Although he lay there in a fetal position with no visible way of responding to my words, I knew that he could hear me and I relished the thought that someday he and I would once again be able to speak on the other side of eternity. I shed tears as I confessed to my father many a careless deed committed in youth. I shared everything that I could with this helpless figure of a man and, when



My son Daniel helps me steady Dad's head for a Christmas snapshot. Daniel was born on my Dad's birthday.

(Continued from Page 9)

That Final Piece Leaving With Life!

I was done. I found a peace so wonderful that I wondered why I had waited so long. I was glad that my father was alive to hear my words. I appreciated the feeding tube and steady drip of life-giving nourishment it represented. God had given me an opportunity to put the final pieces of the puzzle into place. There was a purpose even in the course of dying for my father's life, because his life itself was precious, not the living of it. For the first time I realized fully the importance of my dad's life. It was in his dying that he granted meaning to my living. I solved many a family and personal problem in the weeks and months to follow. Simply talking to dad seemed to help me put those pieces in place and I began to see the picture of my life develop as his was slowly but inexorably ending.

The final pieces of my dad's life were put into place on March 11, 1997. With his family gathered around him, this man who had no strength left in him, who hadn't opened his eyes in days or spoken in over a year, rose from his bed, opened his eyes and clasped our Lord's hands in life. My father was alive in the Lord and that was the final piece of his life's puzzle. I could see it in his deep blue eyes and hear it in his final groan of joy. Life had filled his body and he left this earth as he had come into it, filled with life. That final smile and gleam

from his eyes imprinted on my soul and I shall never lose its warmth. It was his final gift to me and I thank God he lived long enough to give it to me. Now, as I reflect back on it, I see it as more of a "hello" than a "goodbye." Besides, when you finally reach home and enter through that blessed door after a long journey, what would you say?

Life: You Make the Difference! You know, that's really true when you think about it. My father's life was in our hands and the decisions we made did make a difference. He left this earth when God wanted him to after numerous kisses, tear-felt stories and reminisces. He went home when God was ready to take him in, when that last piece of the puzzle had been put in place.

In so many ways, we all have opportunities to make a difference in the lives of those around us. Sometimes it is a kind word or thoughtful helping hand. And, sometimes, it is making the tough decisions that directly affect the lives of those we love. Life IS precious and worth living to its conclusion. At WELS Lutherans for Life, we care about life, from conception to eternity. You might say, the entire puzzle with no pieces left over. That's what this ministry is all about; to bring that message to everyone willing to hear it.

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with whom my father now dwells,
Mark Clifford Brunner*

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QUESTIONS AND ANSWERS ABOUT EUTHANASIA

Out of Christian love and concern, am I ever able to make a decision to remove a feeding tube?

Providing a feeding tube is what we do when a person is no longer able to take food by mouth. It is often a remedial step in one's health care. Patients are sometimes put on tube-feeding with the expectation that, following therapy, they are eventually able to take food by mouth. Others are put on tube-feeding simply because it is easier than spoon feeding. In each circumstance the intent is to provide a means by which food is brought into the body.

The reasons for stopping or removing a feeding tube are the same as those for stopping feeding by mouth. There may be circumstances in which continued feeding would be futile. The use of the term, "futile," means that whether or not feeding continues, death comes within a few hours or days.

There are also circumstances in which feeding may be harmful. There are certain medical conditions, such as an inoperable intestinal blockage, in which the body is unable to process food. In such a circumstance the continued administration of food actually agonizes and perhaps accelerates the dying process. So, as with feeding by mouth, feeding by a tube could and should be halted.

What does "futile" mean?

We often talk about ceasing "futile" treatment or care. Care or treatment is futile if it fails to provide the intended benefit of the care or treatment. For example, if cancer has progressed to the point in which death will occur in a day or so, it would be futile to have an optometrist perform an eye exam for new glasses. The exam would fail to provide the intended benefit of prescribing new glasses when death will surely come first.

In a previous example we note that tube feeding would be futile if no benefit can be derived from the food. The key element here, however, is to recognize the intended benefit of food. Food is not curative in nature. It is not intended to heal cancer, repair a damaged heart or to restore brain cells damaged in a stroke. Food is intended to fuel the body for continued functioning.

Some are tempted to call tube-feeding futile in the advanced staged dementia patient because, after feeding, the patient would still not know his or her surroundings. The misunderstanding, however, is that such a result is not the intent of feeding. Feeding simply maintains bodily functions. It is not intended to cure dementia.

My loved one is in a great deal of pain. Wouldn't it be better to end the suffering?

There are three distinct elements in this question that each need to be understood within the context of Christian decision-making. First of all, this is a "loved one." As such there is deep-seeded emotion at work. Doctors often will not provide medical care to close family members because they recognize that they would lack the necessary objectivity to always do what is right. Their familiarity and empathy with a loved one would cloud their judgment. So also, while many of us must make medical decisions for loved ones, the hard decisions are often best made after consultation with objective sources.

Secondly, there is pain and suffering. Some medical experts claim that the problem with modern medicine is that practitioners are poorly trained in pain management. In fact, some say that if a patient complains to his doctor of persistent pain it might be time to get a new doctor. A Christian will want to do all within his right to alleviate the pain. That should be the primary focus in this concern.

Finally, to seek the "better" route presumes that choices are made between two or more options. What defines "better" for the Christian is not what makes us happy or even what makes the patient happy—it is what makes God happy. To know that we must look at God's Word. From His Word we learn that suffering is a part of life. In fact, it often serves some very important purposes by making us mindful of God, giving us opportunity to praise God, and helping us to realign our priorities as we care for the suffering. So one cannot claim that he or she has some sort of "right" to be free of suffering. God may be using it for a very specific purpose.

Additionally, the implied suggestion is that ceasing care or treatment with the specific purpose of causing death is the preferred option to be exercised. It is not "better" to do that which is contrary to the will of God. To take specific action or to neglect specific care or treatment with the purpose to bring life to an end is wrong and for the Christian is not an option.

The rest of the family thinks Mom should be allowed to die peacefully. Should I agree to pull the plug?

No. If pulling the plug is intended to bring about her death, then one cannot, as a Christian, "pull the plug." God reserves for himself the right to terminate life. Even when we do not like the quality of life God has allowed to remain, we do not have the authority to take action to end that life.

Nevertheless, there is no denying the difficult predicament a Christian is in when a family feels this way. Nearly everyone hopes for a peaceful and quick death when it comes. That desire, however, is not a right. A Christian will want to patiently and with gentleness correct any misunderstandings in the family regarding this point and illustrate our role to care while it is God's role to terminate the life.

We can't afford to keep Dad in the hospital any longer. What are our alternatives?

Hospital stays are intended to be for the short term. When extended care is needed there are options such as adult care centers, nursing homes, hospices, home health care and visiting nurses programs. The hospital staff will help you sort through the options and provide you with direction.

Is it wrong for us to attempt to shorten the time of suffering for someone we love?

It is not wrong to take action to reduce or end suffering. It is wrong to take action with the specific purpose of shortening life. This becomes complex is when continued or necessary increases in medication to ease pain may, by its nature, shorten life. Here, motive is the important determinant of what is right or wrong. The motive is not to end life but to ease suffering. The result of death is not the expected or intended outcome but the unfortunate consequence of easing suffering.

What types of treatment are acceptable for a Christian to withhold from a dying loved one?

To answer this question we must examine the issues of futility and motive. If a treatment is futile, meaning it is ineffective in doing what it is supposed to, then that treatment could be discontinued. One must constantly search the heart to determine a person's motive for authorizing treatment or non-treatment. Care should be taken that the motive is NOT to end the life and therefore remove the burden of caring. Our motive is to always glorify God in these decisions. We act in acceptance of God's gift of life, regardless of its level of quality, and in acceptance of God's decision to bring death.

Isn't pain a good reason to die?

The Apostle Paul said that he and his fellow workers rejoiced in sufferings (Romans 5:3). Many people presume that because pain makes this existence less than perfect that we should have the *right* to escape it. Yet, God uses pain for some very important reasons. It was the result of the fall into sin (Genesis 3:16). It is used by God to discipline (Job 33:19). It also focuses our attention on God for deliverance and hope (1 Peter 2:19). Because of such beneficial effects pain may arguably be a good reason *not* to seek death! This does not, however, remove our responsibility to relieve pain. Bear in mind that to pursue death is to pursue an end which only God can authorize or make happen. Pain is not a good reason to die. Pain is a good reason for concerned Christians to take action to make a person comfortable in diminished pain.

What's the difference between *voluntary* euthanasia and *non-voluntary* euthanasia?

Voluntary euthanasia involves a competent and stated desire of someone to have his or her life terminated. Non-voluntary euthanasia pertains to the termination of someone's life by another without the patient's knowledge or consent.

What exactly does physician-assisted suicide mean?

Many advocates of euthanasia do not merely settle for the right to commit suicide. The methods employed by people to end their lives often do not work and leave the person in worse shape than before a suicide attempt. Rather, euthanasia advocates argue for the right to seek out a qualified physician to help terminate a person's life. The argument is that physicians know best in maintaining and stopping human life most effectively. In light of that fact many who wish to commit suicide want to be sure they do it right and therefore request the assistance of a physician to make sure they die.

What will the cases before the U.S. Supreme actually determine?

The two cases before the U.S. Supreme Court address the questions of whether there is a constitutional right to die and to receive assistance to that right from a qualified physician. Most insiders are saying that the court will not recognize such a right but, rather, turn the matter over to the states for individual determination.

Why are some people afraid of physician-assisted suicide?

When abortion was legalized in 1973 people warned that this was the beginning of the *slippery slope*. The slippery slope argument contends that once a segment of the population is devalued, it slowly spreads to other segments of society. In general those fears have already been realized. Today people talk about "lives not worthy living." Many look death not as the last sad consequence of sin but as the ultimate and most effective medical treatment for serious ailments. The result of this slippery slide is that more and more people presume that they should have the right to die or that, in the event of diminished health, they cannot allow themselves to become a burden on others. If physician-assisted suicide becomes legalized, what is seen as an option for some becomes a felt obligation for others. Out of fear of becoming a burden, some individuals feel obligated to bring their life to an end. This not only challenges God's authorship over life, it denies the Christian family and community the privilege of reflecting the sacrifice of Christ in carrying the burdens of others.

For more information, contact WELS Lutherans for Life at (414)774-1331
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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.

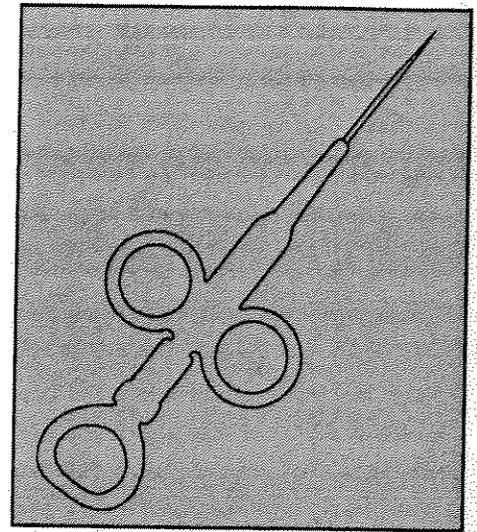
"Euthanasia in the Netherlands"

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.

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.

For additional Internet information, contact National Right to Life home page: <http://www.nrlc.org>