HLI Position Paper: Euthanasia

Human Life International, in its desire to uphold the sanctity of life and God-given dignity of each individual, categorically rejects the use of euthanasia for so-called hopeless cases or others who have been deemed incurable. As expressed by The Catechism of the Catholic Church, assisted suicide is morally unacceptable. (2277) Therefore, an act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person and to the respect due to the living God, his Creator.

The link between abortion and euthanasia has become more and more clear over the last two decades. Both abortion and euthanasia end human lives. Both are condemned by age-old medical, moral, and legal codes. Both introduce into modern-day law the principle of directly killing the innocent as a solution to problems. And together they put our country on a par with Assyria of old, which the Bible called a most insolent nation that will show no regard to the ancients, nor have pity on the infant (Deut. 28:50).

This explains why so many ardent pro-abortionists are nearly always euthanasians as well. For example, the pro-abortion theologian Joseph Fletcher (the father of situation ethics) was a member of the board of directors of the Euthanasia Educational Council (now Concern for Dying), as were the late medical columnist Dr. Walter Alvarez and the late Dr. Alan Guttmacher of Planned Parenthood. Similarly, the thousand-member Abortion Law Reform Association of England, which pushed the Abortion Act through Parliament in April 1967, was a reincarnation of a euthanasia group after the latter s early attempts at euthanasia legislation in Britain (in 1936, 1950 and 1960) had been defeated in the House of Lords.

Some pro-euthanasia elements of the medical profession were admitting the direct link between abortion and euthanasia, even before the former was legalized. The September 1970 issue of California Medicine, the journal of the California Medical Association, spoke thus of the part doctors play in making life-or-death decisions: One may anticipate further development of these roles as the problems of birth control and birth selection are extended inevitably to death selection and death control whether by the individual or society.

The euthanasians themselves assert that if we may kill unborn babies, we may kill other human beings. In an article published in the American Journal of Nursing in 1973, Joseph Fletcher calls it ridiculous to give ethical approval to the ending of a subhuman life by abortion while refusing to give approval to the ending of a subhuman life by positive euthanasia. Such thinking suggests a moral obligation to put an end to a pregnancy when an amniocentesis reveals a terribly defective fetus, and an equivalent obligation to put an end to a patient's hopeless misery when a brain scan reveals that a patient with cancer has advanced brain metastases.

We have seen the same link appear more recently during the trials of Dr. Jack Kevorkian of Michigan and in the decision of the 9th US Circuit Court of Appeals to overturn Washington state s ban on physician-assisted suicide. The logic is inescapable: If doctors will accept the money of parents to kill children (abortion), what's to stop them from accepting the money of children to kill parents (euthanasia)?

Suicide Techniques Published

by Paul Gallagher

As anti-life euphemisms go, "pro-choice" is hard to top. But a new one may be about to enter the national lexicon:

"Self-deliverance." That, at least, is how some in the pro-euthanasia crowd have been describing what they consider the dignified act of killing oneself. Not "assisted suicide, " mind you, with its legal complications and foot-dragging, conscience-stricken doctors- oh, no. Just you and the coroner.

And as the latest developments from Oregon and the Netherlands show, the death peddlers are more than willing to share their most effective techniques. In early February, two public access cable TV stations in the Oregon towns of Eugene and Springfield aired "Final Exit, " a video based on Derek Humphry's 1991 pro-suicide manifesto and "how-to" guide for those contemplating the ultimate act of despair.

Humphry, whose national fame as a suicide hustler is second only to "Dr." Jack Kevorkian, hosts the video. In it, he uses detailed pictures to demonstrate several methods of suicide. Drug overdoses are popular, of course, so Humphry goes over three different types of lethal substances (in order of potency) and shows how to mix them with yogurt, applesauce or fruit preserves.

There's also the plastic-bag method, and Humphry places one over his own head so that the viewers know exactly how to do it right. (Heaven forbid you make a mistake and accidentally survive). But don't do it the old-fashioned way; straight suffocation can take up to 30 minutes. Try inhaling some inert gas, he advises-helium, argon or nitrogen- so that it only takes about 5 minutes. (Leaving less time for any bothersome second thoughts to take hold, I'm guessing). A canister of helium gas for filling up balloons can be bought at the toy store for about $20, he adds.
At Humphry's website, other techniques are discussed. Another asphyxiation method, the "DeBreather" uses facemask apparatus that gradually decreases the amount of oxygen a person inhales. But maybe drugs are better, he seems to concede at one point, since with gases, "if the person is interrupted just before the point of death, and survives, then brain damage and paralysis is likely. This does not happen with barbiturates." You have to admit- the guy's always looking out for the welfare of others.

The World Wide Web, incidentally, is where our "progressive" friends from the Netherlands come in. A new Internet site known as "Thisbe's Self-destruction Site" has managed to provoke controversy in one of the few places on earth where so-called "physician-assisted suicide" is legal. (The site was named after Thisbe, a character in ancient mythology who committed suicide.) Its step-by-step instructions don't involve applesauce, however. Visitors learn the finer points of slashing wrists, jumping off buildings, and the "reasonably painless...death of carbon monoxide poisoning."

The politicians in the Dutch ruling elite don't like it, of course, but what, they ask, are they supposed to do about it? "It's extremely regrettable," Atzo Nicolai and Internet policy expert for the Liberal Party, told the Associated Press. "[But] everybody must be free to communicate with each other on the Internet." And the anonymous author of the Thisbe site does post a rather modern disclaimer: "I refuse to accept any responsibility for the consequences of putting to use the things I have written."

But the damage that such videos and websites can inflict is all too apparent to those who work with the suicide-prone. For one thing, since most first-time suicide attempts are unsuccessful, having

detailed instructions increases the chances that they'll be successful, according to Dr. Gregory Hamilton, a Portland psychiatrist. "What's even more dangerous is the devaluing message such a television show sends people," he told one reporter. "It serves a covert suggestive function that suicide is okay. For people who are on the edge, it pushes them over."

Moreover, it reinforces the societal imperative that the highest good for any human being consists of avoiding pain and misery altogether. But as Catholics, we know that for any suffering to have meaning, to have the true "dignity" that the pro-euthanasia supporter clamor for, it must be united to the infinitely greater sufferings of our Lord. It is He, after all , who gives life; it is therefore His to take.

"It is God who remains the sovereign master of life," the Catechism says. "We are obliged to accept life gratefully and preserve it for His honor and the salvation of our souls." These are alien concepts in a secularized world, to be sure, but eternally true.

Paul Gallagher, a former editor of HLI Reports, is a
freelance writer living near Washington, DC.

"Compassion" That Kills

Jesus, mercy! Mary, help! The Holy Names of Jesus and Mary are the perfect first words with which every Christian can ring in a new year—especially a Jubilee Year. That's why I'm starting this first of my HLIR columns of the year A.D. 2000 with them.

There's one more reason, too: This short but powerful aspiration is a supplication for compassion—and the whole subject of compassion sorely needs clarification nowadays.

That's because the Culture of Death has appropriated "compassion" to itself. To hear the anti-lifers tell it, we pro-lifers have no compassion. When we pray outside abortion centers, we're "oppressing women." When we offer women help and alternatives, we're "denying them choice." When we spotlight the dangers of abortion, we're "against women's health care." When we point out preborn babies' humanity, we're committing two offenses at once: "Hating women" and "not caring about babies after they're born."

But the pro-death forces claim they are the embodiment of compassion. They love women. That's why they ply them with contraceptives that fail, deceive and pressure them into aborting the babies that result, price-gouge them, let friends, family and strangers force them into abortions, hire the dregs of the medical profession, commit assembly-line abortions in filthy and unregulated back rooms, hustle aborted women out of the mills as soon as possible, and ridicule women who suffer post-abortion guilt and trauma.

The anti-lifers claim they are full of compassion for babies, too.
That's why they kill them, so every baby will be wanted.
That's why they deny that babies are human, feel pain and are alive. That's why they refuse babies anesthesia as they murder them.
Sure, the anti-lifers love babies. That's why, recent news reports strongly suggest, they pressure and deceive pregnant women into agreeing to late-term and partial-birth abortions, when their babies are more developed and their body parts will fetch better prices from researchers. That's why they murder babies who survive abortions and then sell their body parts. That's why they dissect some of these babies while they're still alive.

That's compassion, all right. Compassion in the spirit of Planned Parenthood foundress Margaret Sanger. Sanger is the compassionate soul who informed us that, "The most merciful thing that a large family can do to one of its infant members is to kill it."

Sanger's fellow eugenics enthusiast Adolf Hitler would have admired her definition of mercy: That Nazi mega-murderer said the greatest firmness could be the greatest kindness.

Flash forward: Pro-abortion Rep. Lois Capps (D-Calif.), recently professed her "inner Lutheran self," her "religious convictions" and her "love of God"—even as she praised experiments involving stem cells sliced from aborted embryonic human beings. She said, "This newly discovered technology holds out such promising hope ... funding of significant life-saving research should not be held hostage by the religious beliefs of a very vocal minority."Rep. Capps also stated, "Jesus taught us, 'If you do it unto the least of these brothers and sisters, you do it unto Me.' Such a moral imperative must inform my actions as a member of Congress on a range of priorities."

You could hardly find a clearer example of the pro-death mentality: Citing "life-saving" as the reason for life-taking and for trafficking in the flesh of new human beings.

The anti-lifers' mixing of morality and killing is familiar to readers of the late novelist Walker Percy. In his The Thanatos Syndrome, a character remarks, "Do you know where tenderness leads? Tenderness leads to the gas chamber … beware tender hearts. Never...have there been so many

civilized, tenderhearted souls as have lived in this century. … More people have been killed in this century by tenderhearted souls than by cruel barbarians in all the other centuries put together.”

You and I should make this new year’s resolution: To call things by their right name, and never to let anti-lifers get away with their false compassion that rationalizes and self-justifies their willingness to kill others.

Fr. Richard Welch, CSsR, JCD

The value of suffering

by Deacon Roy Barkley, PhD

Son though he was, he learned obedience from what he suffered; and when he was made perfect, he became the source of eternal salvation for all who obey him." (Hebrews 5:8–9)

Many advocates of the Culture of Death claim to be opponents not of life but of suffering. Arguments for abortion, euthanasia and assisted suicide usually assert that killing someone will alleviate some human problem or evil. The problem—the evil—is considered purely negative, to be escaped at all costs. When people seek the deadly services of such fake healers as ''Dr.'' Kevorkian, they do so because they are in pain but often don't realize that pain has any value. Even Christians, caught in the evil grip of suffering, are sometimes led to believe that death may be deliberately chosen as an appropriate remedy. The victim whose death got Kevorkian imprisoned for murder is an example. Kevorkian must have enjoyed recording on videotape the man's claim to be Catholic. Dr. Death took pleasure in snuffing a victim while jabbing a stick in the Church's eye.

Such supporters of euthanasia and assisted suicide claim to be on the humanitarian mission of relieving suffering. Their understanding of suffering is far too simple, and their "relief" always brings death, never healing. This pro-death position is radically opposed to the Christian understanding of suffering.

The euthanasiasts' calculus is simple: suffering is an evil incompatible with human dignity. It must, therefore, be quelled even at the expense of life. By this calculation, a man who suffered from nearsightedness could be "cured" by beheading. In its extreme form, this false compassion could lead to the preemptive killing of cancer patients, senior citizens and anyone else who is soon to suffer. Such measures are not only the stuff of science fiction. They have their real-life advocates.

Often the "suffering" against which the Culture of Death deploys its weapons is largely imaginary. A woman may kill her unborn child because she is uncomfortable about putting it up for adoption. Worse, she may abort it because she dreads a low "quality of life" for the child. In either case, the suffering has no present reality. It is no stronger than an anticipated discomfort. At the other end of the spectrum, however, is serious pain. This is the most problematic type of suffering. Many books have been written about its philosophical and theological implications. How, people ask, can such pain be reconciled with the goodness and omnipotence of God? Readers who are interested might see C. S. Lewis's The Problem of Pain, one of the best books on the subject.

My interest here is merely to clarify the teaching of the Church on the Christian attitude toward suffering, and on its value, if any. My subject is suffering that cannot be wholly escaped—such suffering as is associated with terminal illness. Terminally ill patients have the right, at times even the duty, to seek relief from pain so that they can live as normally as possible, be mentally present to their families and set their affairs in order. But not all serious pain, physical or psychological, can be avoided. It must be borne, and Jesus has set the standard for how.

According to the teaching of the Church, acceptance of suffering unites us with the Son of God in a special way. Because of the incarnation, His suffering resembles ours. Therefore, just as Jesus accepted the suffering that the Father asked Him to bear, we should accept our suffering and bear it in Christ's name. It connects us with Him. In her love for the sick, the Church acknowledges the initial shock and depression of a terminal diagnosis with great compassion—but also as a temptation. The Catechism of the Catholic Church teaches that "experiences of evil and suffering . . . can shake our faith and become a temptation against it" (no. 164). Pope John Paul II writes, in his great apostolic letter On the Christian Meaning of Human Suffering (Salvifici Doloris), that the "discovery of the salvific meaning of suffering in union with Christ transforms this depressing feeling" (no. 27). "Salvific meaning," that is, saving meaning.

Does suffering have value then? Not in itself, for suffering as such is evil. But it certainly has value when it is joined to the suffering of Christ—not only for the individual in pain, but for the whole Church. Just as the Lord was brought to the triumph of His Resurrection through acceptance of suffering, God can make our adversities, no matter how painful, lead to our own sanctification. Our suffering itself becomes holy when offered to our Father in heaven. Pope John Paul II locates suffering at the heart of the Gospel, because the suffering of Jesus was an integral part of His mission. It was part of the substance of the Good News. Since our suffering is like His, it can actually become a part of our vocation to accept it and bear it in imitation of Christ (Salvifici Doloris, no. 26). A leading theologian, Germain Grisez, writes that “conditions of life beyond one’s control can be elements” in one’s vocation “insofar as they provide special opportunities to live according to faith.” Through acceptance of suffering we prepare to share Christ’s triumph over death. This is the value of suffering for the individual.

And what about its value for others? The Church has taught ever since New Testament times that when we accept suffering in imitation of Christ, we fulfill His saving work for the Church. St. Paul writes, “In my flesh I complete what is lacking in Christ’s afflictions for the sake of his body, the Church” (Colossians 1.24). Not that Jesus’ sacrifice is insufficient, but that He allows us to share in His saving work through suffering.

Such is the great mystery of suffering—that it leads to salvation for ourselves and others. True dignity resides in bearing the crosses that God sends us in imitation of His Son, not in killing ourselves to avoid them.

Deacon Roy Barkley, PhD, is a member of the board of the Austin Diocesan Respect Life organization and a former president of the board of Natural Family Planning for Central Texas.

The Netherlands’ slippery slope

by Elaine Mueller

More physicians are ending the lives of patients as the slippery slope of physician-assisted suicide and euthanasia becomes more and more of a frightening reality in the Netherlands. In less than two decades the Dutch have moved from considering physician-assisted suicide, distinguished from euthanasia (and at the time preferable over euthanasia), to considering both physician-assisted suicide and euthanasia as permissible options for the infirmed. No longer are these medical ‘services’ just for the terminally ill, but the chronically ill as well; not only for the physically sick but the mentally anguished. No longer is it voluntary either, with a number of patients being ‘relieved’ by physicians who do not gain consent before making these grave decisions. Many of these patients are competent, according to the Journal of the American Medical Association (JAMA) analysis of a study on the state of physician-assisted suicide, euthanasia and the administering of lethal doses of pain medication in the Netherlands.1 The Dutch government initially commissioned the study in 1990, with subsequent one in 1995.

The JAMA article, “Physician-Assisted Suicide and Euthanasia in the Netherlands: Lessons From the Dutch” refutes two articles and an editorial that appeared in the 28 November 1996 New England Journal of Medicine. “Are the Dutch on a slippery slope? It appears not,” according to an editorial in the New England Journal of Medicine by Marcia Angell, M.D. In the articles, “Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life on the Netherlands, 1990-1995” and “Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands,” analyses of the Dutch study contribute the rise in the euthanasia rate to an aging populace and increased cancer mortality, not to the questionable Dutch system.

Comparisons of the 1990 and 1995 studies are “revealing” according to the JAMA article by Herbert Hendin, M.D., Chris Rutenfras, Ph.D. and Zbigniew Zylicz, M.D. The rate of euthanasia increased from 1.9% to 2.3% from 1990-1995 based on interviews with 405 Dutch physicians, while the rate of increase was from 1.7% to 2.4% based on questionnaires completed by 4600 physicians. According to the interview portion of the study the number of physician-assisted suicides rose from 380 in 1990 to 542 in 1995.

The supposed safeguards of the system in the Netherlands are the guidelines the doctors are required by law to follow. The new study shows that these guidelines have been changed substantially or are disregarded altogether. Dutch law requires that four conditions should be met before assisted suicide or euthanasia is performed. First, the patient must be competent, request the procedure voluntarily and repeatedly; second, the request must be reported; third, the patient must be suffering with no other means of relief (though the condition need not be terminal) and finally, the doctor must consult with an impartial doctor.

The guidelines set by the Dutch government have been distorted in every way imaginable, from underreporting the number of deaths from euthanasia, involuntary euthanasia, lack of consultation and suggesting euthanasia to patients who had not requested the act. Nearly 50% of doctors in 1990 said they had no problem suggesting euthanasia to patients. The effect of this on the voluntary nature of the process has not been explored, but is probably profound. For instance, one doctor said a woman with breast cancer agreed to euthanasia because “It could have taken another week before she died. I just needed this bed.”

Though the rate of reporting improved from 18% in 1990 to 41% in 1995, mainly because the notification process was simplified and doctors were assured they would be free from prosecution, the 59% rate of unreported cases is still disturbingly high. Only 11% of the unreported cases in the 1995 study had the consultation of another doctor. Twenty percent of these unreported cases did not have the consent of the patient.

Obviously the most disturbing development in the Netherlands is the transition from voluntary to involuntary euthanasia. Many analyses of the studies, such as the one from the New England Journal of Medicine, have failed to include deaths that resulted from the administration of pain medication with the "explicit intention of ending the patient's life" in determining the rate of involuntary euthanasia. While only a few deaths were attributed to doctors killing patients without their consent (0.8%, more than 1000 cases, in 1990 and 0.7%, less than 1000, in 1995) the number of deaths due to pain medication overdose rose considerably over that time, from 1,350 in 1990 to 1,896 in 1995. For more than 80% of the 1,896 deaths in 1995, 1,537 deaths, no request was made on the part of the patient.

If the number of deaths from all the catagories are totaled, the number of deaths resulting from "active intervention by physicians" has increased from 4,813 in 1990 to 6,368 in 1995, a jump from 3.7% to 4.7% of all deaths. According to the data gathered from the questionnaire study, "this is an increase of 2,7% in cases in which physicians actively intervened to cause death" while the interview study data reveals a 2,0% increase from 1990 to 1995.

The Dutch investigators claimed that the involuntary acts were performed on incompetent patients, but 2,1% of the patients in the 1995 study and 3,7% in the 1990 study were indeed competent. Though the numbers were not revealed in the studies, an estimated 2,0% of the patients who died from pain medication overdose did not give their consent. An additional 4,000 patients were given pain medication in doses that were likely to end their lives, though their doctors did not intend to end their lives. They were not informed of the effects of the high dosages.

Of the cases involving a lack of consent, doctors gave a number of reasons why they failed to get explicit consent from their patients. Many said they had discussed the issue previously with their patient, and rather than find the current views of the patient, acted on past and possibly changed opinions. One doctor admitted to killing a nun a few days before her death would have naturally come because she was in excruciating pain and he knew her religious convictions prevented her from asking for his help with her death. More than half of Dutch doctors do not report acts of euthanasia, half suggest it to their patients and one quarter admit to having committed euthanasia with no consent. The quality of care for the terminally or chronically ill has suffered. Palliative care and the Dutch hospice system are behind in progress compared to many other countries. One man died after his wife declared she was tired of caring for him and gave him the choice of euthanasia or a group care home for the chronically ill. Fearful of being abandoned at the end of his life, he chose death. One can hardly declare his decision voluntary.

As many countries confront the issue of physician-assisted suicide, such as Australia and Colombia, which just legalized euthanasia, and as many state legislatures struggle with the issue and the Supreme Court of the U.S. prepares to rule on the issue, all should learn from the mistakes of the Dutch. Namely, that no amount of regulations and good intentions can stop the inevitable decline towards involuntary euthanasia of the infirmed, handicapped and aged and that life must be protected at all stages or no life is truly secure.

1 Herbert Hendin, Chris Rutenfrans, Zbigniew Zylicz, "Physician-Assisted Suicide and Euthanasia in the Netherlands:

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British Weigh Limits on Care

by John Cavanaugh-O'Keefe

In the United States, the public debate over killing the elderly has unfolded largely in courts. The British are making a serious effort to have a debate in a more appropriate context, and the British Medical Association (BMA) has announced plans for a special meeting to discuss when and whether physicians should withhold or withdraw life-prolonging treatment. However, what matters is not the context for the debate, but the arguments put forward. At present, it appears that the British debate will be mannerly, but will fail to make any serious distinctions between humans and orangutans.

In preparation for the debate, the BMA has published a "discussion paper," outlining the issues they hope to address. The paper deals with dying, and recognizes that this is something we all do. However, there is no hint that humans have an eternal destiny, that life changes but does not end at death. There is not even any oblique reference to the observable fact that many people, rightly or wrongly, believe in a life after death. Instead, the paper is based firmly and resolutely on the unexamined assumption that death is the end. It is not possible to carry forward a serious discussion of death, or any aspect of death, with that unexamined assumption.

Similarly, the paper refers to human dignity, but the references are crippled by a militantly atheistic vision of humanity. It says that "treatment of patients must reflect the inherent dignity of every person," which is true. But exactly what is this "dignity"? Clues come out in subsequent passages that refer to patients who say that they "fear indignity more than death." Dignity in this context does not refer to our origin in God or our destiny of life with God; rather, it seems to refer to whether a patient is drooling or making other messes.

The BMA rightly rejects the way the term "dignity" is used in the Netherlands: "The BMA's Medical Ethics Committee feels some reservation about the 'indignity' argument as a reason for removing life-prolonging treatment from incapacitated people." The BMA notes that "the indignity involved in treatment is a reason given by relatives requesting euthanasia on behalf of a patient whose own wishes are unknown." However, even after noting a serious abuse that follows from a complete misunderstanding of human dignity, the BMA does not affirm a proper understanding.

The paper sets out to limit debate to withholding or withdrawing treatment, rather than the whole matter of killing the elderly. But in the past years, many serious commentators have put forth various "slippery slope" arguments, pointing out that contraception leads to abortion, and abortion leads to euthanasia, and euthanasia leads to death camps. These arguments are not trivial, and it is disingenuous to try to head them off by procedural limits on the debate. Further, the BMA paper, trying to shut down that part of the fight, says that they already have a policy opposing euthanasia and physician assisted suicide—"at present"! They want to avoid that battle for now, but do not want to close off their options in the future.

The paper refers to people in a "persistent vegetative state." The language is demeaning, and the fact that it is used widely does not make it acceptable. The term is not scientific. It is a blatant attempt to degrade a person. The term reveals a eugenics bias, insulting patients by pushing them down the evolutionary scale. It would be just as easy and accurate to refer to an "extended meditative state."

The paper contains a fascinating exploration of "quality of life." It rejects the openly eugenic proposition that people with limited mental abilities need not be treated. However, judgments about who is valuable and who is not persist, and the BMA reaffirms a decade-old position: "To be a human life of the type that we all regard as being of special ethical importance we require that there be a persisting capacity for sentience." This threshold is low; sentience is probably universal except for our brothers and sisters in an extended meditative state. Still, why is there any qualification whatsoever about who is regarded as having "special ethical importance"? Isn't simple humanity enough?

Britain has a history of euthanasia that should be pondered before it is extended. In 1936, Lord Dawson, a Royal Physician and a member of the Eugenics Society Consultative Council, killed King George V. This act of regicide was not prosecuted because it was apparently carried out at the request of the king. Still, not all of King George's commands were obeyed: he asked that he not be given a Christian funeral at Westminster Cathedral, and that order was set aside. In the procession on the way to the funeral, his crown was sitting on a pillow on a cart. As they approached the cathedral, a wagon wheel hit the curb, and the crown bounced off and rolled into a gutter, and the cross broke off the top of the crown.

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