

THAT THEY MAY LIVE

**The President's Commission on the Sanctity of Life
2001**

The Lutheran Church—Missouri Synod
The President's Commission on the Sanctity of Life
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INTRODUCTION

Assisted-suicide and euthanasia present the church, society, families and individuals with one of the most profound and emotionally charged ethical challenges of the modern era. Few contemporary moral and cultural issues are as divisive, have such raw emotional impact, or cause such pronounced distress and discomfort. Few involve ultimate issues of the human condition: our mortality; the proper response to human suffering; the meaning of compassion; and our individual and collective moral responsibilities to people who are elderly, disabled, chronically ill, despairing and/or dying. Much is at stake. The manner in which these excruciating and complex issues are resolved will determine to a great extent, the public and private morality of the 21st Century.

The public controversy over assisted-suicide and euthanasia comes at one of the most challenging and potentially dangerous times in human history. We have entered an era of phenomenal technological and moral upheaval. The day of the self-evident truth has seemingly passed. Different moral understandings and philosophies vie for attention and acceptance. Society is being remade with such speed that change threatens to run out-of-control.

The question presented is whether our future will reflect God's glory or man's folly. Two contrasting and in many ways mutually exclusive moral views—the materialistic and the spiritual—are contesting for dominance to determine the very essence and nature of our future society. Boiled down to its essence, the current struggle pits an essentially nihilistic and “post-Christian” presumption that human life is a mere physical phenomenon in which chemical compounds and electricity have interacted in a manner that accidentally evolved into “life” versus the profound understanding that we are greater than the sum of our physical parts: that at our deepest and most essential level, we were made in the very likeness and image of the living God.

At the very heart of the matter is how we judge the moral worth of human life. No issue could be more fundamental to the purposes of organized society. The key question presented is whether our culture will adhere to understanding that all humans possess equal inherent moral worth (the sanctity of life ethic), or instead, base people's rights and perceived value upon their “quality of life,” as currently advocated by many ethicists, philosophers, academics, and medical and legal professionals. The fate of the most vulnerable among us, particularly people who are elderly, disabled, ill and/or dying, hangs in the balance.

Holy Scripture informs us that Christians are to be in the world but not of it. However, this does not mean that Christians have no interest in public morality or current affairs. To the contrary, a living faith leads Christians to stand steadfastly to prevent harm to our weak and vulnerable neighbors and to work to ensure that government policies and professional canons of ethics promote fairness, justice and a proper regard for the sanctity of every human life. It is with this understanding that this statement opposing assisted-suicide and euthanasia is presented.

THAT THEY MAY LIVE

Assisted-suicide and Euthanasia Defined

As the terms are generally used in public discourse, *physician-assisted-suicide* (PAS) means that a doctor issues a lethal prescription to a patient for the purpose of facilitating the patient's suicide. *Euthanasia* usually means that the doctor directly terminates the patient by lethal injection. The exact definitions of the terms "assisted-suicide" and "euthanasia" are often misunderstood among the general population. They are sometimes confused with morally distinct actions and concepts that are not necessarily immoral, such as withholding unwanted life supporting medical treatment. Morally, no distinction is to be drawn between euthanasia and assisted-suicide since both actions involve intentional killing of defenseless human life.¹

As Distinguished from Withholding or Withdrawing Medical Treatment

Assisted-suicide/euthanasia is sometimes confused with allowing to die by withdrawing or withholding life-sustaining medical treatment.² These are totally different concepts, morally, ethically and factually:

- Assisted-suicide and euthanasia involve the intentional taking of human life. Withholding or withdrawing unwanted treatment usually do not.³
- The cause of death in assisted-suicide or euthanasia is unnatural, usually caused by injected or ingested poison. When death follows the withholding or withdrawal of medical treatment, it is caused by the underlying medical condition.
- Euthanasia and assisted-suicide involve direct interference by man into the prerogatives of God. Generally, this is not so when withholding or withdrawing unwanted medical treatment.

One of the driving forces behind the assisted-suicide/euthanasia movement is the fear of "being hooked up to machines" against one's will at the end of life. This is not an irrational worry. Too often people have watched helplessly while an overzealous medical system prevented their loved ones from "letting go." The risk of such abuse, however, is lessening as the financial incentives of medicine change and as physicians become more sensitive and respectful of the autonomy of patients in medical decision-making.

It is important for people to know that they have the legal right to refuse unwanted medical treatment. No one must be tethered to high-tech medicine if they do not want such treatment. It is not immoral to refuse intensive medical treatment to extend life when death is imminent. Hospice and other forms of beneficent end-of-life care permit patients to reject curative treatment and medical procedures intended to extend life, focusing instead on keeping the patient comfortable and pain-free. Such loving care without unwanted, intrusive, or overly burdensome medical treatment is consistent with the Christian obligation to care lovingly for those who are dying.

As Distinguished From Death as an Unintended Side Effect of Pain Control:

Advocates of assisted-suicide/euthanasia often claim that the act of killing for the purpose of ending suffering is indistinguishable from providing medical treatments that control pain on the basis that palliative drugs occasionally hasten death. Pain control is a legitimate form of medical treatment. And it is true that pain control, like other forms of medical treatment such as surgery or chemotherapy, occasionally has lethal side effects. But when death occurs, it is unintended. However, killing is the goal of assisted-suicide/euthanasia. Attempts to create a moral equivalency between pain control and assisted-suicide/euthanasia are wrong. They may also lead to unnecessary suffering if they dissuade patients and doctors from aggressively pursuing pain control out of a misguided fear that such treatment is the moral equivalent of mercy killing.

Assisted-suicide/Euthanasia Is Bad Medicine

Assisted-suicide/euthanasia violates the Hippocratic Oath,⁴ the foundation for medical ethics for more than 2,000 years. The Hippocratic Oath explicitly forbids assisted-suicide/euthanasia by requiring doctors to pledge, “to give no deadly medicine to anyone if asked, nor will I make a suggestion to this effect.”⁵ The Christian ethicist, Gilbert Meilaender, interprets the Oath as creating a positive obligation for physicians to “be committed to the bodily life of their patients.”⁶ Assisted-suicide/euthanasia clearly conflicts with this moral obligation since it is an act *intended* to end the patient’s bodily life.

This is one reason why organized medicine—ranging from the World Medical Association, to the American Medical Association (AMA), to almost all of the state medical associations—overwhelmingly opposes legalizing assisted-suicide/euthanasia. As the AMA put it so well, “Physician-assisted-suicide is fundamentally incompatible with the physician’s role as healer, is difficult or impossible to control, and poses serious societal risks.”⁷

Legalized assisted-suicide/euthanasia would be bad medicine. There are many reasons for this conclusion:

Medicine is Capable of Alleviating Almost All Pain:

One of the driving forces behind the assisted-suicide movement is fear of pain during the dying process. And it is true: too many people have been forced to stand helplessly as their loved ones spent their last days in agony. But that isn’t because medicine can’t alleviate or eliminate most pain. To the contrary, drugs and medical techniques exist either to eliminate or to alleviate almost all pain. Indeed, new techniques in pain control have revolutionized this important field of medicine: automated delivery systems, topical creams, skin patches, implant pumps that work intravenously, as well as improved drugs and treatment techniques.⁸

The problem is that for a variety of reasons, doctors often do not treat pain properly. The proper response to this failure is improved medical training and patient/family education. The medical profession has already begun this important work. Providing inadequate medical relief

of pain and suffering is beneath acceptable standards of medical care.⁹ It should not provide a pretext to permit doctors to kill.

The Economics of Assisted-suicide could Corrupt the Practice of Ethical Medicine:

Medicine was traditionally a “fee-for-service” enterprise, in which physicians, hospitals, or other health care providers earned their living by charging patients (or their health insurance companies) for each medical service provided. In fee-for-service medicine, the more medical services provided, the more money was earned. That created the economic incentive to provide too much care, even when the patient wanted treatment discontinued.

In recent years, the economics of medicine have reversed. Tremendous emphasis is now placed on “cost containment” in health-care financing, whether as a way of increasing profits in private medicine, i.e., “managed care,” or for the purpose of controlling expenditures of publicly-funded health programs such as Medicare and Medicaid. In such a milieu, physicians are under pressure to provide fewer services. Often, insurance companies refuse coverage for some treatments. Indeed, many doctors receive financial incentives to reduce expenses and/or are threatened with termination if they spend too much on patient care. Similarly, because hospitals are often paid by insurance companies and Medicare in a lump sum for the treatment they provide patients, the fewer days patients spend in the hospital, the fewer tests or other procedures patients receive, the better economically for the hospital.

These economic changes are relevant to the issue of assisted-suicide/euthanasia. If killing seriously ill or disabled patients ever becomes a legitimate and legal “medical treatment,” weak and vulnerable people requiring extended hands-on care could be put at tremendous risk. This is a matter of simple economics: assisted-suicide/euthanasia is very inexpensive—the drugs cost less than \$100. On the other hand, proper medical care until natural death for a person who is dying, seriously ill or disabled may cost tens of thousands of dollars. With cost-cutting pressures likely to increase in coming years, legalization and legitimization of physician-assisted-suicide could lead to assisted-suicide becoming the economically preferred form of “treating” patients whose long-term care would be expensive. If there were ever a significant economic downturn, such dangers would grow even more acute, particularly if legalization desensitizes people to the immorality of killing.

In this regard, it is worth noting that Derek Humphry, the co-founder of the Hemlock Society, perhaps the nation’s largest assisted-suicide group, wrote that money and saving resources is the “unstated argument” for legalizing assisted-suicide:

A rational argument can be made for allowing PAS in order to offset the amount society and family spend on the ill. ... There is no contradicting the fact that since the largest medical expenses are incurred in the final days and weeks of life, the hastened demise of people with only a short time left would free resources for others. Hundreds of billions of dollars could benefit those patients who not only can be cured but who also want to live.¹⁰

We ignore this unintended warning at our peril.

Uninsured People Often Have Inadequate Access to Quality Health Care

Millions of Americans do not have health insurance, which means that they usually have inadequate access to quality health care. (Many doctors will not accept new patient without health insurance and most private hospitals will only accept them as patients in emergencies as required by law.) Uninsured people would be placed at particular risk in a system of legalized assisted-suicide. Unable to access quality (and expensive) medical treatment, they might, out of desperation, instead “choose” assisted-suicide/euthanasia to end their suffering. This scenario isn’t speculative. A California woman named Rebecca Badger went to Jack Kevorkian for assistance in suicide, in part, because she had lost her private health insurance in a divorce and grew despondent over the hours she had to wait at a hospital emergency room to receive proper medical care for the treatment of pain. Before going to Kevorkian, she gave an interview to a television station in which she claimed that if only her pain could be treated, she would decide to go on living.¹¹

Assisted-suicide Undermines the Hippocratic Oath

The drive to legalize assisted-suicide has already undermined some doctors’ commitment to the “do no harm” values of Hippocratic medicine. For example, a famous author and physician editorialized in the *New England Journal of Medicine*¹² that physicians should be allowed to assist the suicides of terminally ill patients, and indeed, that training in methods to effectively terminate life should be available (this at a time when medical schools still do not adequately train physicians in end of life care or pain control). As to the Hippocratic Oath’s prohibition against intentional killing, the author claimed that the oath is merely “a symbol of professional cohesion,” asserting, “a physician’s conduct at the bedside is a matter of individual conscience.”¹³

A doctor’s willingness to terminate the life of a patient confirms the patient’s worst fears about themselves

Physicians, as medical professionals, are held in high esteem and trust by their patients. Their opinions count: their perspective matters. Thus, for a physician to agree to end the life of a patient is not a neutral act. Rather, it is to confirm in the patient’s mind their own worst fears about being a burden, about having lost their worthiness to live, about dying in pain.

Assisted-suicide/euthanasia are rare occurrences and thus legalization is not necessary

Advocates for legalization often assert that legalizing assisted-suicide/euthanasia is necessary because doctors secretly engage in such practices. Since the practice is happening frequently, this argument goes, it is better to legalize and regulate physician-induced death, instead of prohibiting it, in order to protect better against abuses. The truth about the matter of surreptitious assisted-suicide/euthanasia is quite different than depicted by these advocates.

Several studies demonstrate that killing by doctors is actually quite rare in clinical practice. For example, a study in the *New England Journal of Medicine*¹⁴ found that while many of the surveyed doctors had received requests for hastened death, only 6 percent had ever done

so.¹⁵ One of the authors of the study found this finding so significant that she changed her position from favoring legalization to opposing it, writing that “legalizing assisted-suicide would become a cheap and easy way to avoid the costly and time-intensive care needed by the terminally ill.”¹⁶

Assisted-suicide/Euthanasia Is Bad Public Policy

Advocates for legalizing assisted-suicide/euthanasia promote their death agenda with a two-pronged political argument: first, they argue that assisted-suicide/euthanasia, like abortion, is about “choice”; then, to assure those worried that once unleashed into the medical system, killing would know few bounds, they promise “guidelines will prevent abuses.” Both arguments are demonstrably false.

The elderly, poor and powerless would be put at risk

The New York State Task Force on Life and the Law spent more than a year investigating whether assisted-suicide should be legalized in New York State. Its unanimous conclusion: it should not. A primary reason for the Task Force’s conclusion was that legalization would be dangerous to weak and marginalized populations. Specifically, the Task Force concluded, “In light of the pervasive failure of our health care system to treat pain and to diagnose and treat depression, legalizing assisted suicide and euthanasia would be profoundly dangerous for many individuals who are ill and vulnerable. The risks would be most severe for those who are elderly, poor, socially disadvantaged, or without access to good medical care.”¹⁷

Assisted-suicide/euthanasia is not about “choice,” but abandonment

The issue of personal autonomy is a potent one in the United States. We are an individualistic culture that values independence and self-reliance. But that does not mean that freedom is synonymous with social anarchy. Properly undertaken, the crafting of public policy is dynamic and three-dimensional. It seeks to maximize individual freedom, yes, but at the same time it recognizes that the law’s purpose is also to provide for the greater common good while protecting weak and vulnerable people. The Founders called this concept, “ordered liberty.”

Organized society’s most important role is protecting human life, including the lives of suicidal people. This was why suicide was once outlawed. The modern approach takes a more hands-on approach to preventing suicide. First, it recognizes that saving people from suicide is a high societal priority. Indeed, United States Surgeon General David Satcher recently declared suicide a public health crisis.¹⁸ As for law enforcement, police officers may use non-deadly force to prevent suicide. The State is also permitted to hospitalize suicidal persons for treatment, if they are proved to be a significant danger to themselves.

Laws against assisted-suicide and euthanasia also protect suicidal people. Most states punish assisted-suicide as a crime and all states prohibit euthanasia as murder, recognizing that permitting a third person to participate in the intentional ending of human life would undermine its value. Because of the existence of such humane and compassionate laws, there are many

people glad to be alive today who would be dead had society not intervened at their hour of self-destructive desire.

The use of the advocacy slogan “choice,” in the discussion over assisted-suicide/euthanasia seeks to elevate respect for personal autonomy above society’s overarching duty to protect human life. Advocates claim that while protecting the lives of the suicidal is appropriate for some people, it is paternalistic and condescending to prevent the suicides of the “hopelessly ill.”

This argument ignores the terrible emotional toll that extracted by serious illness—the fear, the anxiety and the worries people in such conditions have about becoming emotional or financial “burdens” on their families. It ignores the subtle and overt pressures that would push the weak and vulnerable toward the “choice” of hastened death. It also omits the potential impact that prospective inheritance, life-insurance benefits and the worries about high medical bills may have on all concerned. It also fails to take into account the terrible divisions that will rend the fabric of family life when relatives differ bitterly over whether killing is an appropriate answer to a loved one’s health difficulties. Indeed, legalizing assisted-suicide/euthanasia would cruelly result in the last days of many dying people being consumed by the bitter question of whether to take poisonous pills or a lethal injection, and then, when to commit the act.

It is worth noting that several studies conducted on terminally ill people demonstrate that decisions for assisted-suicide/euthanasia are anything but cool, deliberate and rational. Indeed, the cause of suicidal desires among people who are terminally ill turns out to be the same as suicidal desires among people who are physically healthy: clinical depression. One study that measured desires to die in the terminally ill found that most dying people did not wish to have their deaths hastened, and the few who did, were *all* clinically depressed.¹⁹ Another notable study into the causes of a desire to die among terminally ill patients found that there were three primary causes: clinical depression, untreated or under-treated pain and “low family support.”²⁰

A recent study of terminally ill people from Canada is also germane to this issue. The will to live of people dying of cancer was measured twice daily, and incorporated into an assessment of various symptoms, including pain, nausea, shortness of breath, etc. The study found that “Among dying patients, the will to live shows substantial fluctuation,” and concluded that “the likely transience of a request to die” should be “one of the most important considerations” when considering requests for assisted-suicide or euthanasia. In other words, people who want a lethal injection or prescription might very well change their minds.²¹ This is especially true if given access to proper end-of-life care. Of 17,964 terminally ill cancer patients treated at home by palliative care teams in another study, only five committed suicide.²²

Such studies are significant concerning the issue of “choice.” Clinical depression is a treatable medical condition. So is pain. Church, community and hospice intervention can ameliorate the lack of solid family support. People who want to hasten their deaths often change their minds. Thus, for physicians to terminate the lives of these patients instead of taking the time and effort to treat them does not value autonomy but instead surrenders to the hopeless impulses of patients in need of quality medical treatment, not hastened death. Rather than

honoring “choice,” assisted-suicide/euthanasia constitutes a most profound abandonment of people when they are most in need of care, treatment and support.

Protective guidelines will not protect against abuses

Assisted-suicide advocates contend that protective regulatory guidelines will differentiate between those whose requests should be honored and those whose requests should be refused. History, logic and human nature demonstrate that this assertion is at best, naïve and, at worst, disingenuous.

1: Assisted-Suicide/Euthanasia would not be Limited to the Terminally Ill

When people are polled by news organizations about their attitudes toward legalizing assisted-suicide, it is invariably presented in the context of a hypothetical patient who is terminally ill and for whom nothing can be done to alleviate pain or suffering. As described earlier, the example of a patient for whom nothing can be done to relieve suffering is based on a false premise. Moreover, once legitimized through legalization, assisted-suicide/euthanasia would not be limited to terminally ill patients. Indeed, most advocates of legalization have no intention of limiting the practice to dying people.

Proof of this is found in the statements made by assisted-suicide proponents themselves and in the language of some their proposed legalization statutes. After Oregon’s law permitting legalized assisted-suicide went into effect in October 1997, the advocacy group Compassion in Dying of Washington issued a fund-raising letter, claiming that the organization needed increased funding to move the line of legitimacy beyond those who are presently dying. The letter read in pertinent part:

We have expanded our mission to include not only terminally ill individuals but also persons with incurable illnesses that will eventually lead to a terminal diagnosis.²³

Along these same lines, proposed legislation in 1999/2000 to legalize assisted-suicide in New Hampshire, defined “terminal condition” as:

“Terminal condition” means an incurable and irreversible condition, for the end stage of which there is no known treatment which will alter its course to death, and which, in the opinion of the attending physician and consulting physician competent in that disease category, will result in premature death.²⁴

In addition to being vague, these definitions are extremely broad and widely encompassing. Many illnesses and disabilities that are not “terminal” are considered “incurable” with some possibility of causing “premature death” years down the road. Such “incurable” conditions may include: diabetes, Alzheimer’s disease, multiple sclerosis, quadriplegia, paraplegia, asymptomatic HIV infection, cancer, renal disease, emphysema, just to name a few. The use of such vague and all-encompassing language has a purpose: to appear restrictive while actually creating broad eligibility standards for requesting to be killed by a doctor.

Of even greater concern is the growing movement within the mental health professions to treat suicide as an act that should sometimes be facilitated rather than prevented. According to this approach, mental health professionals—when confronted with their patient’s/client’s desire to self-destruct—are to work through a decision-making process to determine whether or not the suicide would be considered “rational.” If the psychiatrist, psychologist or other licensed therapist considers the patient or client desirous of a “rational suicide,” he or she should not only refuse to impede the ending of life but may be professionally obliged to facilitate it.

According to advocates of this radical departure from the traditional unequivocal protective role of mental health professionals, those eligible for “rational suicide” would be people who have a “hopeless condition,” often defined as:

“Hopeless” conditions include, but are not necessarily limited to, terminal illnesses, severe physical and/or psychological pain, physically or mentally debilitating and/or deteriorating conditions, or quality of life no longer acceptable to the individual.²⁵

Read these words carefully. They would include almost any suicidal person who has more than a transitory desire to die. It can—but does not have to—include people with terminal illness. Suicidal persons need not be physically ill at all to suffer from a hopeless condition, since “psychological pain” and “mentally debilitating and/or deteriorating conditions” qualify under the definition. Indeed, *anybody* who is suicidal, by definition believes that their “quality of life is no longer acceptable,” or they would not want to die. Permitting “rational suicide” to become an accepted mental health diagnosis and practice would endanger the depressed and vulnerable to the extent that even their own mental health professionals could not be counted on to help save their lives.

2: Euthanasia in the Netherlands is not Restricted to the Terminally Ill

Abundant proof that “protective guidelines” do not protect the vulnerable can be found in the Netherlands. Assisted-suicide/euthanasia is not technically legal in the Netherlands. If physicians follow the legislative guidelines, they will not be prosecuted. These guidelines include:

- The request must be made entirely of the patient’s own free will and not under pressure from others.
- The patient must have a lasting longing for death: The request must be made repeatedly over a period of time.
- The patient must be experiencing unbearable suffering.
- The patient must be given alternatives to euthanasia and time to consider these alternatives.
- Euthanasia must be judged to be the only means by which to relieve a patient’s suffering.

- Doctors must consult with at least one colleague who has faced the question of euthanasia before.
- The euthanasia must be reported to the coroner with a case history and a statement that the guidelines have been followed.

Any reasonable review of the practice of assisted-suicide/euthanasia in the Netherlands demonstrates that the guidelines are virtually worthless. They are routinely ignored, violated with impunity, or have been so loosely interpreted by the courts that they have been rendered essentially meaningless. Several studies of Dutch euthanasia practice demonstrate that not only are terminally ill people euthanized who request it, but so too are chronically ill people. There are documented cases of euthanasia inflicted for asymptomatic HIV infection, anorexia, cognitive disability, upset over the scars caused by skin cancer, and other non-terminal diseases and conditions.²⁶ Families, rather than patients, are often the most influential in a decision to terminate a patient's life. Dr. Herbert Hendin, executive director of the American Foundation for Suicide Prevention and an internationally recognized expert on Dutch euthanasia, reported about the case of a woman who told her husband either choose to be killed or go to a nursing home. When the man chose to die, the doctor killed him despite knowing about the wife's coercion.²⁷ "Rational suicide" has become part of Dutch medical practice with depressed patients sometimes being euthanized—even if they have no physical illness. This resulted from a Dutch Supreme Court decision that ruled that a psychiatrist had not erred in assisting the suicide of a patient who had become obsessed about wanting to be buried between her two dead children. The psychiatrist visited with the patient four times over five weeks and never attempted to treat her. The Court ruled that suffering is suffering and it does not matter whether it has a physical or emotional cause.²⁸

Euthanasia has also entered the Dutch pediatric wards. According to several documentaries and medical journal reports, Dutch doctors kill disabled infants based on quality-of-life considerations, usually but not always, at the request of their parents. Indeed, according to a study published in *The Lancet*, eight percent of all Dutch infants who die are killed by their doctors—approximately 80 per year. In 21 percent of these cases, doctors had not obtained parental permission. The study also found that 45 percent of the responding neonatologists had killed infant patients, as had 31 percent of responding pediatricians.²⁹ It is worth noting that infants, by definition, cannot ask to be killed.

Dutch doctors also kill adult patients who have not requested to be killed. The United States Supreme Court noted this disturbing fact in its decision not to create a constitutional right to assisted-suicide:

The Dutch Government's own study revealed that in 1990, there were 2,300 cases of voluntary euthanasia (defined as "the deliberate termination of another's life at his request"), 400 cases of assisted-suicide, and more than 1,000 cases of euthanasia without an explicit request. In addition to these latter 1,000 cases, the study found an additional 4,941 cases where physicians administered lethal morphine overdoses without the patient's explicit consent. ... This study suggests that, despite the existence of various reporting procedures, euthanasia in the Netherlands has not been limited to competent terminally ill adults who are

enduring physical suffering, and that regulation of the practice may not have prevented abuses in cases involving vulnerable persons. . .³⁰

Some apologists for euthanasia defend these killings as occurring only among the sickest of patients. But a 1991 Dutch government study found that 14 percent of these patients who were killed without having asked for euthanasia, were, in fact, mentally competent.³¹ It is also worth noting that such killings, referred to by the Dutch as “termination without request or consent,” are rarely prosecuted or punished, despite being absolutely contrary to the “protective guidelines.”

As disturbing as these cases and statistics are, they do not tell the full story, nor fully disclose the depth to which assisted-suicide/euthanasia has penetrated Dutch medical practice. A recent study demonstrated that despite the requirement that all euthanasia and assisted-suicide deaths be disclosed to the coroner, between 59 and 77 percent of cases,³² in fact, go unreported, which means that no one really knows how many patients are actually killed each year by Dutch doctors. The study also found that the Dutch attempt to regulate euthanasia has failed, that in the Netherlands killing by doctors “remains beyond effective control.”³³ Worse, the population has become so desensitized to killing by doctors that euthanasia is popular despite the widespread abuses. Indeed, as of this writing, the Dutch Parliament is on the verge of formally legalizing the practice,³⁴ which will remove what few vestiges of restraint remain against assisted-suicide/euthanasia in the Dutch medical system.

3: The Oregon Experience:

It took more than 20 years for euthanasia in the Netherlands to spread from the deathbed, to the sick bed, to the nursery crib, to killing without request. Oregon, on the other hand, has had but a few years experience with assisted-suicide. Yet, there are significant indications that the practice of assisted-suicide in that state is already expanding.

Oregon voters legalized assisted-suicide by a 51-to-49 percent vote in 1994. During the campaign, proponents of the law depicted assisted-suicide as a fail-safe measure to be used on those rare occasions when medicine could not alleviate severe and unrelenting pain and suffering. Indeed, the major spokeswoman for legalization was a nurse who described in television ads the assisted-suicide of her daughter, whose bone cancer, she claimed, caused so much pain that she could not even be hugged or held.

Studies that have been published in the *New England Journal of Medicine* about Oregon assisted-suicides reveal that none of the people known to have committed legal assisted-suicide were in untreatable, unbearable pain in either the first or second years of legalized practice. Only a few feared future pain. Fear of needing assistance with the tasks of daily living and of the loss of the ability to engage in enjoyable activities were the primary reasons for requesting assisted-suicide, according to the first year’s report.³⁵ This pattern remained consistent in the second year.

This sad truth is epitomized by the death of “Mrs. A,” the first known Oregon legal assisted-suicide. The details of Mrs. A’s assisted-suicide were made at a public news conference

held by an assisted-suicide advocacy organization that had participated in arranging her death. Mrs. A had breast cancer. As the disease progressed, she could no longer do aerobics or gardening and decided to commit assisted-suicide. When her own doctor refused to write a prescription for lethal drugs, she went to a second doctor, who also refused, diagnosing her as depressed. So, she simply called the assisted-suicide advocacy group, which referred her to a doctor they knew would lethally prescribe. She died two-and one-half weeks after first meeting this doctor, leaving an audiotape describing her decision as being based on a desire “to be relieved of all of the stress I have.” Thus, from its inception as a legal act, rather than being engaged in only as a last resort when medical treatment does not work, assisted-suicide in Oregon has already become an alternative to proper medical treatment, where physicians with no meaningful relationship with patients willingly prescribe poison for the purpose of ending life.³⁶

There are abundant other reasons for alarm about Oregon’s assisted-suicide law and its functioning:

- Oregon doctors who care for dying patients in hospice or in hospitals can be sued for malpractice if they are negligent or provide substandard medical treatment. But Oregon doctors who assist in their patients’ suicides cannot be sued if they are negligent, so long as they participate in their patient’s killing in “good faith.” Thus, ending a patient’s life has a more privileged legal status in Oregon law than does providing that patient with proper end-of-life medical care.
- Doctors who engage in assisted-suicide in Oregon sometimes lethally prescribe for patients whose illness is outside their medical specialty. For example, an oncologist (cancer specialist) recently prescribed lethal drugs for a patient with ALS (Lou Gehrig’s disease), a neurological condition.³⁷
- An Oregon Deputy Attorney General wrote a letter asserting that disabled people who could not commit assisted-suicide under the law might have to be given “reasonable accommodation” in killing themselves by the state under the Americans with Disabilities Act (ADA) and/or the Oregon Constitution.³⁸ This presents the significant possibility that active euthanasia may be instituted in Oregon by court order.
- The lethally prescribing doctor does not have to be present when the patient dies. Assisted-suicide advocates estimate that between 20-25 percent of assisted-suicides will fail, meaning that the patient may vomit, experience convulsions, or suffer brain damage without dying. This may force family members into suffocating their loved ones with plastic bags.³⁹ Some assisted-suicide organizations sell “suicide bags” for that very purpose.
- Once the doctor has prescribed the lethal drugs, he or she has no further obligation to the patient, nor does the doctor have to be in attendance when the patient takes the poisonous drugs. Indeed, there are no effective protections for the patient in the Oregon law once they have received their lethal drugs.
- The Oregon law does not require families to be notified that a loved one has asked for assisted-suicide.

- Nearly twice as many people (27) committed assisted-suicide in 1999, the second year of the Oregon experience, as in 1998 (16),⁴⁰ indicating that as the state grows desensitized to doctor-hastened death, the number of assisted-suicides will continue to increase. Like the Netherlands, it is impossible to know whether these statistics accurately document the full extent of assisted-suicide practice in Oregon. For, as the 1999 study admitted, “Underreporting cannot be assessed, and non-compliance is difficult to assess. ...”⁴¹ Moreover, the only information obtained was that willingly provided by doctors who engaged assisted-suicide, who may or may not have been telling the truth.⁴²

4: Germany 1920-1945

History demonstrates the acute danger posed to the weak and vulnerable in any society that disregards the sanctity of human life. Between 1939-1945, German doctors willingly engaged in euthanasia, killing more than 200,000 disabled infants, and cognitively and physically disabled adults. Contrary to popular opinion, this mass killing was not engaged in due to coercion of doctors by the Nazis. Rather, physicians *voluntarily* participated directly and indirectly in euthanasia, which became a prelude to and a part of, the Holocaust.⁴³

“Euthanasia consciousness” had entered the German medical profession and greater society long before Hitler came to power. In 1920, two German academics, Karl Binding and Alfred Hoche, published a book titled *Permission to Destroy Life Unworthy of Life*, arguing that euthanasia of terminally ill people, unconscious people, and disabled people should be permitted.⁴⁴ Binding and Hoche called for protective guidelines, just as do euthanasia advocates today. These include an oversight board, the investigation by at least two physicians, and others, including a privilege against liability or criminal culpability for participating doctors.

Holocaust expert, Robert Jay Lifton has called *Permission to Destroy Life Unworthy of Life*, “the crucial work”⁴⁵ that sparked social changes in the German culture, opening the door to the horror of euthanasia. As a consequence of a shift from the belief in the sanctity of human life after the book’s publication, along with a growing acceptance of eugenics (dividing people between the “fit” and “unfit”), utilitarianism, and social Darwinism, disabled people and others were soon seen by many as “useless eaters.” Indeed, by 1925, a poll of the parents of disabled children found that 75 percent believed doctors should be permitted to painlessly euthanize their children.⁴⁶ By the time the Nazis took power, many in Germany already supported legalizing euthanasia.

Euthanasia actually began in Germany in early 1939, when Hitler authorized doctors to kill a disabled baby at the request of his father. The “success” of that killing induced Hitler to issue an executive order permitting disabled infants to be murdered by doctors without consequence. The infant euthanasia program soon led to the infamous “T-4” program in which disabled adults were killed by doctors based on physical or cognitive disability. (The T-4 program was named after the address of the German Chancellery, *Tiergarten* 4. It was during the T-4 program that the gas was developed used to commit genocide against Jews.)⁴⁷ Hitler eventually rescinded the T-4 program under public pressure, but doctors continued to kill their disabled patients anyway. Soon, the doctors completely disregarded the “guidelines” leading to years of what has come to be called “wild euthanasia,” in which disabled people were killed by

doctors virtually without any controls.⁴⁸ Some twenty doctors were tried for crimes against humanity for their participation in euthanasia. Most participating doctors, however, faced no significant legal sanction.

In the aftermath of such horror, Dr. Leo Alexander, a physician-investigator assigned to the Nuremberg Tribunals, drew important conclusions about the foundation of the Holocaust that are relevant to the debate over assisted-suicide/euthanasia today. He wrote in the *New England Journal of Medicine*:

Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitudes of the physicians. It started with the acceptance of the attitude, basic to 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, the racially unwanted, and finally, all non-Germans.⁴⁹

Dr. Alexander then turned his attention to disturbing trends in American medicine that were already evident in 1949:

In an increasingly utilitarian society these patients [with chronic diseases] are being looked down upon with increasing definiteness as unwanted ballast. A certain amount of rather open contempt for the people who cannot be rehabilitated with present knowledge has developed. ... At this point, Americans should remember that the enormity of the euthanasia movement is presently in their own midst.⁵⁰

What was a mere speck on the horizon when Dr. Alexander wrote these prophetic words, is now a raging hurricane! It is not too late to prevent the storm from sweeping over us. But we ignore Dr. Alexander's warning at our own significant peril!

Assisted-suicide is Bad Theology

Our society is shaped by the value we place on human life. If we believe that the life of every human being is of special worth, we will also choose to treat every person with care and respect. If we measure the worth of other human beings on other terms, such as the contribution they make to our own satisfaction, we will ultimately favor discarding them when they have nothing to offer. In choosing how life will be valued, society determines its most fundamental characteristic and ultimately chooses between kindness and cruelty, between civilization and the jungle.

This choice is also fundamental to decisions regarding the use of scientific advances in nutrition and medicine that have brought our society to the brink of social upheaval today. Human lifespan has been extended to such an extent that half of the people ever to reach the age of 65 in the history of the world are living today! Consequently, end-of-life issues have become increasingly urgent as societies begin to address the inevitable social, economic and moral issues that ensue. Such discussion unavoidably turns to the first and most fundamental ethical question: What value shall be placed upon human life?

There are only two possible responses: either every human being will be regarded as possessing inestimable worth, or the value of each human life will be estimated according to external circumstances. Responses will be determined by the “theology” that will be applied by those who answer this fundamental question.

Advocates for legalizing assisted-suicide/euthanasia often insist that “religion” is the only reason to oppose assisted-suicide/euthanasia. They even insist that they bring no theology to bear on this issue. But they do. Their blind faith holds that all things, including human beings, are chance byproducts of random and irrational material and chemical interactions in nature. In such a view, human life has no ultimate value, being no different in the final analysis from any other chance product of these natural forces. Indeed, under such a materialist view, the deaths of people are little different than acorns falling from a tree that are raked up and thrown into the fire. This is bad theology.

Although such “theology” is becoming more and more prevalent in today’s society, there are nonetheless many who maintain that there is an aspect to existence that transcends the material realm, whose theology recognizes that human beings are more than the chance byproduct of irrational material forces. Such recognition of the uniqueness and even sanctity of human life is supported by Christian theology in particular.

Christians understand that human life is a unique and special creation of God (Gen. 2:7, 21-23), and that each human life since that creation is likewise unique and specially made (Psalm 139:13-16). The spiritual, intellectual and physical dimensions of human beings reflect the goodness and character of God, who formed them (Gen. 1:26-27). They are to be fruitful and multiply and rule over all other creatures (Gen. 1:28-30).

Christians understand that when the first human beings rejected the life God had given them, bringing death into the world, God responded with a promise to restore life (Gen. 3:15).

This promise was spoken many times over thousands of years until the right time in history (Gal. 4:4) when God gave His Son to restore life to His human beings, the crown of His creation (John 3:16). The birth, sacrificial life, death and resurrection of Jesus of Nazareth restored real and abundant life for all humankind (John 10:10).

Christians also understand that when God endured such pain and cost to restore life to humankind, He underscored the uniqueness and value of human life (Rom. 8:32). Every human life has its own special value that cannot be measured in economic terms and is not diminished by age or infirmity. In today's culture, "really living" is marked by carelessness and irresponsibility at the expense of other lives. Christians though, remember the real and abundant life that God offers to all of His special creations and demonstrate their understanding of the sanctity of human life. This includes recognition of moral responsibility, compassion for those who suffer, and deep concern for fellow human beings whose lives are threatened in today's materialistic times.

Christians understand that such care and concern begins in the family. God has created the family not only to extend human life through procreation but also to nurture the gift of life in others when they are too helpless to care for themselves in youth or too infirm to care for themselves in old age (Eph. 6:1-4). The family is God's answer to human interdependence. It is within the context of the family that individual Christians fulfill their God-given responsibility to protect and preserve the gift of life—an important responsibility when in their society the lives of youngest and oldest alike are threatened.

When the patient has no family, or the patient's family is unable to provide necessary levels of care, society, and most specifically, the church, is obliged to provide necessary care, and emotional and spiritual support for people in their time of urgent need. (James 1:27). Indeed, it should be an imperative of any local church body, to ensure that no one in its community is isolated and that no one be abandoned to die alone.

Christians also understand that God has created civil government so that His creation and especially His gift of human life might be preserved and protected (Rom. 13:1-7). He has charged civil government with the responsibility to punish evil and promote good, especially when human life is endangered. He has commanded His people to pray and work for the welfare of the lands in which they live, and to exercise their vocation as citizens to help civil government fulfill its responsibility. Christians, therefore, actively work within civil order to preserve and protect human life, thereby fulfilling their God-given responsibility. This becomes an important responsibility, especially in a democratic society, when legalized assisted-suicide/euthanasia is being publicly advocated.

In its statement, "That They May Have Life," the President's Commission on the Sanctity of Life of The Lutheran Church—Missouri Synod spoke well for all Christians when it began,

Human life is not an achievement. It is an endowment. It has measureless value, because every individual, at every stage of development and every stage of consciousness, is known and loved by God. This is the source of human dignity and the basis for human equality. It must therefore be asserted without exception

or qualification: No one is worthless whom God has created and for whom Christ has died.

This is good theology. It provides for Christians the foundation for a loving, compassionate and committed interest in life issues, and it provides cause for serious opposition to all attempts, including those by advocates of assisted-suicide/euthanasia, to shorten or otherwise endanger human lives.

Our Moral Obligation to People who are Elderly, Ill or Disabled

Assisted-suicide/euthanasia fails every test by which history judges the compassion and morality of a society. Accepting the euthanasia mindset denigrates the worth of the lives of the most weak and vulnerable amongst us, denies their inherent equal moral worth, disparages rather than respects their dignity, and constitutes an abandonment of the most profound and disturbing kind. It breaks asunder the sanctity of life ethic that is the linchpin of human freedom and a prerequisite to the achievement of a truly free and enlightened society.

Assisted-suicide/euthanasia also degrades the ethics of medicine. It transforms the act of killing into a “medical treatment,” to the profound detriment of vulnerable patients, the morality of the health care professions, and the safety of society. Legalizing assisted-suicide/euthanasia would victimize people who are elderly, disabled, depressed, as well as those who are terminally ill. It would divide families, and, as in the Netherlands, lead down a slippery slope to ever-expanding levels of killing. Therefore, both are to be resisted unequivocally as immoral, unwise, and against the best interests of individuals and general society. And it is to be rejected forcefully at the bedside. Killing can never be an acceptable substitute for caring.

This does not mean that the status quo is acceptable. The assisted-suicide/euthanasia movement is driven by a growing lack of confidence in medicine to adequately treat patients and their pain. It is a symptom of a loss of cohesion in society, a breakdown of community and a sense of despair created by a materialistic society that has lost sight the love of the living God. This circumstance cries out for healing.

There is much to be done. In the coming years, our nation will have to grapple with the causes for the number of citizens who lack access to quality health care and craft appropriate solutions. The medical profession will have to continue to work diligently to improve end-of-life medical treatment, taking special care to ensure that no one dies in unalleviated pain. In this regard, education programs to heighten the public’s knowledge of hospice could lead to the amelioration of much patient and family suffering.

CONCLUSION

As Christians we must commit ourselves—both corporately and individually—to upholding the sanctity and inviolability of every innocent human life. Christ came so that we might have life and have it more abundantly. The “culture of death” in all of its myriad shapes and forms, stands against this great hope. We must turn away from the darkness and forge a renewed “culture of life” where *all* of God’s people know that they are welcomed and included at life’s bounteous table.

NOTES

1. In the public policy debates, the definition of euthanasia is often broken down into subparts:
 - Voluntary euthanasia: The killing of another person for purpose of ending suffering at the request or with the consent of the person killed;
 - Non-voluntary euthanasia: The killing of another person for the purpose of ending suffering without consent, generally because the person killed is incapacitated or otherwise unable to give consent;
 - Involuntary euthanasia: The killing of another person for the purpose of ending suffering when the person has asked not to be killed.
 - Passive euthanasia: Withholding life supporting medical treatment. This is generally a misnomer. As described below, withholding medical treatment is not killing and hence, is not euthanasia.
2. Withholding food and water when supplied through a feeding tube because a patient has severe brain damage or refusing to provide medical treatment for a disabled infant that would be provided for other newborns may, however, constitute “passive euthanasia” in cases in which such care is withheld or withdrawn with the intention of causing death when the patient is not otherwise terminally ill.
3. The morality of withholding or withdrawing medically supplied nutrition and hydration is an important subject in itself. It is not elaborated upon further in this document to prevent confusion and because under the law such action is not deemed to be mercy killing.
4. The Hippocratic Oath is named after the famous ancient Greek physician, Hippocrates.
5. The Hippocratic Oath: Text, Translation and Interpretation *Bulletin of the History of Medicine*, Supplement 1. (Baltimore, Md.: Johns Hopkins Press, 1943), as published on the University of Chicago Internet web page, Chicago, Ill.
6. Gilbert C. Meilaender, *Body, Soul, and Bioethics*. (Notre Dame, Ind.: University of Notre Dame Press, 1995), p.5.

7. American Medical Association, "Physician-Assisted-Suicide," (first issued December 1993, updated June 1996), Policy Number E-2.211.
8. John Horgan, "Seeking a Better Way to Die," *Scientific American*, (May 1997).
9. Editorial, "When Will Adequate Pain Treatment Be the Norm?" *Journal of the American Medical Association*, (December 20, 1995).
10. Derek Humphry and Mary Clement, *Freedom to Die: People, Politics, and the Right-to-Die Movement* (New York, N.Y.: St. Martins Press, 1998), p. 333.
11. Richard Leiby, "Just How Sick was Rebecca Badger?" *Washington Post*, July 29, 1996.
12. Sherwin Nuland, MD, "Physician-Assisted-Suicide and Euthanasia in Practice," *New England Journal of Medicine*, Vol. 342, No.8, February 24, 2000, pp.583-584.
13. Ibid.
14. The *New England Journal of Medicine* regularly publishes pro-assisted-suicide articles and editorials.
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18. Jenn Abelson, "Call to Action Over Suicides," *Newsday*, July 29, 1999.
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22. Carla Ripamonti, et al, "Suicide Among Patients with Cancer Care at Home by Palliative-Care Teams," *The Lancet*, November 27, 1999.
23. Kirk Robinson, Fundraising Chair; Rev. Fr. Michael Bonacci, Executive Director, Compassion in Dying of Washington, "Dear Friend of Compassion in Dying" fund-raising letter, December 1997.
24. New Hampshire Senate Bill 0044, dated December 2, 1999.
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26. Wesley J. Smith, *Forced Exit: The Slippery Slope from Assisted-Suicide to Legalized Murder*. (New York, N.Y.: Times Books, 1997), pp. 102-103.
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28. Herbert Hendin, MD, *Seduced by Death: Doctors, Patients, and the Dutch Cure*, W.W. Norton and Co. New York, N.Y.: New York, pp. 124-125. Wesley J. Smith, *Forced Exit: The Slippery Slope from Assisted-suicide to Legalized Murder*, *Supra*, pp. 103-106.
29. Agnes van der Heide, et al, "Medical End-of-Life Decisions Made for Neonates and Infants in the Netherlands," *The Lancet*, July 26, 1997.
30. *Washington v. Glucksberg*, 1997.
31. J. Remmelink, et al, "Medical Decisions about the End of Life: The Hague, 1991 (commonly known as the Remmelink Report). The 14 percent competent statistic refers to the 1,040 patients killed without consent in 1990 by lethal injection, not the 4,491 patients killed without consent with intentional overdoses of morphine. The number of those patients who were competent is not known.
32. The raw numbers of the survey responses used in this study indicated a 59 percent non-reporting rate. The authors of the study, however, estimated that the more accurate figure was 77 percent, based on study and other data.
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41. *Ibid*.
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45. *Ibid.*, p. 41, 46.
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