

MERCY KILLING: HISTORY AND MEDICINE

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INTRODUCTION

This paper is a personal recollection of certain highlights in the history of mercy killing in Western civilization during the twentieth century. I hope to show that there are disturbing similarities between the development of the current mercy killing movement and the rise of mercy killing in Germany and other Western countries during the 1930s.

I have chosen the term “mercy killing” rather than “euthanasia” since definitions of euthanasia usually include the concept of a good or painless death, to which nobody could object, as well as the bringing about of that death. I believe that, as academics, we are obliged to be especially careful with our language and that we must consider the impact of this language upon the general public. For instance, I wonder how the abortion debate would have developed if the word “fetus” was struck from the language of the debate and if only the term “unborn baby” had been used. (After all, most women who become pregnant soon begin talking of their “baby,” and only the most sophisticated and scientific people, or those with prejudice against the unborn, would refer to their unborn child as a “fetus.”) It is not unusual to hear babies who are born alive or dead referred to as fetuses. Fetus is certainly the acceptable scientific term, before birth, but is “baby” any less scientific?

Similarly, if all our discussions consistently referred to mercy killing instead of euthanasia, I wonder whether there would not be a significant effect on public opinion. I am not sure if etymology, the study of word origins, includes the impact of the sound of words, but I believe that mercy killing has an unpleasant sound, whereas euthanasia is more soothing to the ears.

My first conscious memory of mercy killing, like that of many in my generation, occurred at the revelation of the Nazi atrocities after the end of World War II. I was just finishing high school at that time and was about to enter premedical studies, and I can clearly recall a radio report of

the Nuremberg trials in which a convicted Nazi doctor wondered aloud: “How did this all begin?” I can also recall the words of the American Judge who supplied an answer: “When you first considered there were human beings not worth living.” It would be many years later before I fully understood this conversation in the course of reading *A Sign for Cain* by Frederick Wertham, M.D.¹

In discussing the history of the German euthanasia programs, he refers to a small book which promoted mercy killing, *The Release of a Life Devoid of Human Value*, published in 1920 in Leipzig, Germany. I could immediately see the similarity of the title to the remarks by the American judge back in 1946. This book was written by a Professor of Psychiatry, Hoche, and a Professor of Jurisprudence, Binding—both highly respected men in their respective fields.

The strategy used by Binding and Hoche is a clear instance of the technique of “gradualism” as a way to accomplish the perversion of the truth without allowing their distortion to be so easily discovered. In this respect the authors follow a path all too common today in justifying mercy killing and assisted suicide. The first case discussed is that of a young woman dying a horrible death from throat cancer that would make anyone sympathetic to her cry for mercy killing or assisted suicide (except someone familiar with palliative care and pain control). This was followed by less heartrending cancer cases, then by mentally retarded children, mentally ill adults (all in institutions), physically handicapped children, and finally bedwetters! All of these were considered an economic burden on the State or unfit on eugenic grounds. Apparently this little book was widely read and quoted, even in medical journals, and was mentioned by some of the defendants at the Nuremberg trials to justify or explain their horrendous experiments on prisoners and sometimes their execution.

PRE-NAZI MERCY KILLING

The conventional wisdom concerning the Holocaust and lesser horrors in Germany is that this was all started by the Nazis after they came to power in 1933. However, as John Hunt has outlined so well in his paper, the history of the Weimar Republic in Germany (1918-33) shows that the

concept of eugenics, pioneered in England by John Galton and by Margaret Sanger in the U.S., had been enthusiastically embraced by important sections of German society, including scientists and physicians. In 1928 there were secret discussions of eugenics and the use of sterilization and abortion to eliminate mental defectives. At a meeting of psychiatrists in Bavaria in 1931, compulsory sterilization and the mercy killing of mentally defectives was discussed. Propaganda supporting this practice became common in the form of motion pictures and even in the programs of mathematics and economy offered in schools. A National League for Birth Control and Sterilization was formed to exterminate the “unfit.” The practice was well established by 1936, when extermination of so-called “physically and socially unfit” was mentioned without embarrassment in a leading German medical journal. One estimate has indicated that 275,000 “undesirables” were killed by the time World War II started.ⁱⁱ In 1938 abortion was allowed for Jewish women only—this should have been taken as a sinister warning of the Holocaust to come. In this way supposedly decent people in a Christian and democratic Society can do dreadful things.

WORLD WAR II IN GERMANY

The pre-war and pre-Nazi practices were gradually extended by officials of the German (Nazi) State. Eventually they escalated to the well-known genocide of Jews, Gypsies, and Catholic priests, among others. In Holland, the medical profession refused to participate in the Nazi mercy killing programs, even when their “contracts” were couched in apparently harmless terms. One hundred Dutch physicians died in concentration camps rather than participate in the Nazi programs.ⁱⁱⁱ The current state of Holland's doctors as the leading practitioners of mercy killing (in sad comparison to the heroic stand of their forebears during the war) may be a classic illustration of what William Blake termed “fearful symmetry.”

THALIDOMIDE BABY KILLED IN BELGIUM

In this celebrated case, which occurred in Belgium soon after World War II, a physician killed a baby born without arms or legs at the request of the parent. After a much publicized trial, the doctor was acquitted. The

justification offered was the hopeless incapacity of such a baby. Now we see grown up thalidomide victims, using amazing mechanical devices, earning their living and raising families.

AMNIOCENTESIS AND PRE-NATAL MERCY KILLING

Another example of Blake's fearful symmetry, I believe, occurred with the development of amniocentesis, a technique developed to diagnose an unborn child by obtaining a sample of the amniotic fluid that surrounds the baby. This technique was originally used to diagnose and treat unborn babies with Rh disease, and this development led to intra-uterine transfusions and to the concept of "the fetus as a patient." My team was the first to use these techniques in Eastern Canada, following the work of Sir William Liley of New Zealand, and in Winnipeg where I trained. However, to my dismay, soon after these early triumphs, it was discovered that various genetic diseases, including Down's syndrome, could be diagnosed by the same amniocentesis technique, and this diagnosis usually led to abortion of the baby. Sir John Peel, the Queen's Obstetrician, remarked that this was the first time in Medical History that a patient was diagnosed in order to be killed. I testified with Dr. André Hellegers at a Federal District Court case concerning the liberal abortion law in Connecticut, using our research and clinical experience of having unborn patients (circa 1970). I believe that this was the first time that evidence on behalf of the unborn was entered into Federal court Records.

NEONATAL MERCY KILLING

Since unborn babies with defects could now be diagnosed and dispatched, it wasn't surprising that abnormal newborns with defects would be left to die, *e.g.*, the classic cases of Down's syndrome babies with duodenal atresia (an easily correctable bowel obstruction) left to die of starvation. Also babies with meningomyelocele (spinal cord defects, correctable with surgery) were being left to die of infection.

Fortunately, the courts used child abuse and custody legislation to override the parents and doctors and thus to save some babies. The first case in Canada occurred in my home city of London at another hospital.

The first I knew about it was when the media interviewed me. I can remember my excitement, for I had written a letter to the editor of the *Canadian Medical Journal* some time before, asking why the child abuse legislation, which we had used to save Jehovah witness babies by having them transfused against parental objections, could not be used in other similar newborn cases, as in the U.S.

I liked the concluding comments of the Judge in that case: "I cannot be persuaded that it is in this infant's best interests to die." The baby was made a ward of the state and operated upon. The child survived. Years later I had the mother speak to my medical class during the Medical Ethics course I supervised. She was very bitter that the doctors had convinced her and her husband (after they had decided to go ahead with the operation) that the best course was to let the baby die. To reinforce this she brought her delightful six year old Down's syndrome girl to the class to show that the little girl was worth saving! So much for "informed consent" when the parents are upset and confused and not able to make a proper judgment.

Then, of course, there was the Baby Doe legislation in the U.S., designed to protect newborns from mercy killing and led by pediatric surgeon Dr. C. Everett Koop, a champion of the neonates. (Unfortunately, he was not quite so much a champion for the unborn when he became U.S. Surgeon General.) Pediatricians and surgeons were not pleased with this, for surveys have shown that the majority were in favor of passive mercy killing of defective neonates.

THE PALLIATIVE CARE/HOSPICE MOVEMENT

As I was struggling in the 1960s to cope with my pediatric cancer cases, almost all of whom died despite treatment, the hospice/palliative care movement started with the pioneering work of Elizabeth Kubler-Ross in the U.S., Cicely Saunders in England, and Balfour Mount in Canada. Because no one seemed interested in research in palliative care of children at that time, I became involved at a national and international level. Our pediatric oncology team became a leading center for research about pain control in children and death at home (which was unheard of for children in those days). Contact with the leading experts in the field

of palliative/hospice care revealed, to my delight, that they had a strong religious or spiritual base and were strongly opposed to mercy killing in cancer cases when proper pain control would prevent the apparent necessity of mercy killing.

In the earlier struggle to prevent liberalized abortion laws, the pro-life movement had few allies, except in the Catholic and Fundamentalist churches. Now with mercy killing, we have a small but high-profile group of doctors, nurses and other health care workers in the hospice/palliative care movement to assist in educating the public and politicians about this critical debate, as well as advocates for the handicapped, many of the Christian and Jewish communities, and of course a much bigger better organized pro-life movement, compared to the early days of the abortion debate.

MERCY KILLING IN HOLLAND

As reports filtered out of Holland in the sixties, it gradually became clear that mercy killing was widely practiced there and not prosecuted. Ironically, this was happening in the country where doctors had died during the war in opposition to mercy killing. It has become increasingly difficult to get accurate information about what is happening in Holland, for the Dutch resent their country's reputation as being the mercy killing capital of the Western world (even though this appears to be true). The Rummelink Report and others like it did indicate irregularities in the protocol which doctors were supposed to follow in cases of mercy killing, and from all I know it is clear that doctors no longer bother to report cases, falsify documents, and so on. Indications for voluntary mercy killing (which started with terminal cancer patients in uncontrollable pain) have spread to include anorexia nervosa and psychological problem, *e.g.*, depression, as featured on a recent television report. Increasing numbers of cases are involuntary, as several eye-witness accounts from Dutch friends returning from Holland has made clear. So much for the so-called "safeguards" that proponents of mercy killing believed would stop excesses and the slippery slope to indiscriminate mercy killing.

In trying to understand how this situation in Holland developed, it

became clear that one important factor was the lack of any palliative and hospice care movement, coupled with a severe lack of knowledge about pain control on the part of Dutch physicians. Thus, with as high as 50% of patients in some cancer wards dying from mercy killing, it was clear that pain control was poor, since 95% of patients in palliative/hospice setting can be relieved of their pain. I have also heard first-hand reports of senior citizens who carry cards in their wallets saying "don't kill me." Other senior citizens have cards which designate that certain hospitals are safe and others unsafe. When senior citizens begin to fear the approach of the doctor, lest they be the next victim, medicine has reached a very low point.

As Iain Benson mentioned in his excellent paper, it is significant that members of various leading groups who have visited Holland, including the House of Lords from England, the New York State Legislature, the Canadian Senate, and the Council of the Canadian Medical Association, have all recommended against legalization of mercy killing.

ATTITUDES OF PALLIATIVE CARE-GIVERS TO END-OF-LIFE DECISIONS

The leaders of the palliative/hospice care movement certainly appeared to be opposed to any type of mercy killing. However, our Institute had a unique opportunity to document this when we obtained the mailing list from the Ninth International Conference on Terminal Care in Montreal. This meeting featured a vigorous debate on mercy killing at several plenary sessions, and half the registrants were randomly sent questionnaires with 68% (371) responding. About 75% were opposed to any type of direct killing, with a higher percentage among the doctors and registered nurses compared to the non-medical care-givers. The Academy of Hospice Physicians did a similar, less detailed survey and found that about 85% were opposed to mercy killing. It would be interesting to repeat these studies now, some ten years later.

One of the major problems in this area is that many (if not most) terminal cancer patients do not have access to proper palliative care, and the education of doctors and nurses is improving, but not ideal, in most areas of North America.

In a hard hitting editorial in the prestigious *New England Journal of*

Medicine entitled “The Quality of Mercy” (from Portia's famous speech in *The Merchant of Venice*),^{iv} editor Marcia Angell decried the poor pain control in cancer patients and the myths surrounding the supposed dangers of narcotics. This problem still exists today as doctors and nurses continue to leave terminal cancer patients in pain for fear of depressing respirations, causing addiction, or actually killing the patient with an overdose (the so-called “twilight sedation), despite the increasing growth of research and publications to the contrary. These patients do not need to be killed with narcotics, but simply given enough to control their pain (occasionally the doses have to be very large, due to acquired tolerance).

Until these logistic problems are solved, there will continue to be a fertile field for the mercy killing of suffering cancer patients, which will inevitably lead to other less dramatic conditions being considered, as has happened in Holland. Dr. Margaret Somerville of the McGill Institute of Law and Medicine suggested several years ago that families or even patients sue their doctors for incompetent pain control, and I believe this has happened in one case at least in the U.S. Not to their credit, doctors sometimes respond better to threats of lawsuits than to other forms of education. (The lectures on this topic to our medical students were always better attended than the ethics lectures.)

THE LAW AND MERCY KILLING

We should remember that mercy killing is still officially illegal in Holland and has spread slowly and insidiously as more and more doctors have reported their cases to the public prosecutors with few if any convictions, to the point where they do not bother reporting cases at all.^v

So, although we should vigorously oppose attempts to legalize mercy killing under any guise (including even “better palliative care”), we should also be alert to cases where the doctor is charged but not punished, or not even charged because of legal technicalities. For example, in a recent case in Halifax, a doctor who deliberately killed a respirator patient with potassium chloride, was not charged or brought to trial, although the Crown prosecutor wants to re-open the case. Robert Latimer, the Saskatchewan farmer who killed his physically and mentally

handicapped daughter, was given a light two-year (minimum) sentence, and that case is being reviewed by the Saskatchewan courts. I do not believe that the infamous Dr. Kevorkian has yet been sentenced for any of his misdeeds.

Similarly, at the Maryland Institute for Emergency Medicine in 1987, four quadraplegics were given morphine and valium before their respirators were turned off without informing the patients or the families.

Although this was well reported in the press, no charges were laid. Dr. Genereux in Toronto apparently is the first doctor in Canada, if not the U.S., to be convicted of mercy killing, for giving lethal doses of barbiturates to two AIDS patients who were depressed but not terminal (one died). His sentence, I believe, was two years in jail and the revocation of his license.

Oregon has passed a Death with Dignity law legalizing assisted suicide and supported by Janet Reno, the U.S. Attorney General. Thus we now have a living experiment in mercy killing on our side of the ocean, and it will presumably be under more open scrutiny than the situation in Holland.

THE OPPOSITION

The more active mercy killing proponents have a good deal of support among the public and the media. Perhaps the Exit Society in England is an exception—its two leaders were convicted of assault when one of their customers changed his mind but the Exit executioners wouldn't take no for an answer! Derek Humphrey, founder of the Hemlock Society, has been under a cloud since the much publicized assisted-suicide of his wife may not have been as voluntary as he said.

With the terrible financial burdens facing health-care institutions and with the promotion of living wills, which are now compulsory in most state institutions, we had better watch out lest the right-to die movements gets in bed with the medical economists.

POLITICS AND RELIGION

Some may have noticed that I have left out any reference to theology, the Bible, or religion in general. I have a strong faith system—it originally

drew me into this arena and for this I am grateful. However, we are working in a largely post-religious society, certainly in Canada and other Western Countries. The U.S. is unique in having a strongly religious political base that has even led presidential candidates to profess religion in public and be elected on a pro-life, pro family platform. How we Canadians envy you, for it would be assumed to be political suicide for any politician to espouse such a stand in Canada.

In an introduction to a book about mercy killing, Cardinal Heenan of England said, "It is a great mistake to let people know that moral issues involve religion—everyone knows that politics and religion are a matter of opinion. You can take your pick." This may seem ironic or cynical, but we know we must be able to argue against mercy killing on medical, legal, practical, social, and psychological grounds if we are to produce a public opinion that is opposed to mercy killing and assisted suicide.

For instance, one of the great injustices of the aggressive mercy killing in Holland is that the patient and the family are often robbed of those precious last few days or weeks when family wounds can be healed, reconciliations can happen, and religious faith can be regained, none of which can happen after the patient dies. In a few pediatric cancer cases that I dealt with, where symptom control had not been ideal, I prayed for a quick end to the child's suffering. Then there was a rallying of the patient, a lessening of the symptoms, and a touching final coming together of the child's family before death. There is a terrible finality about death, and if it happens prematurely, certain opportunities are lost forever. Joyce Brothers, the well known psychologist, wrote a touching article about how grateful she was for the time she had with her physician husband during his slow, pain-free death from cancer compared to a sudden death from a heart attack, accident, or the like.

The history of pre-Nazi Germany, the living experiment taking place in Holland, the lessons from the palliative care movement, the positive approach to suicide so well described by Rabbi Novak (remembering that most attempted suicides did not want to die but were crying for help), the loving and caring attitude that our most helpless senior and handicapped citizens deserve, are examples of areas where we as academics should be able to bring research and knowledge to the public as we have been

charged to do with our students. Although I am a relative neophyte to University Faculty for Life, I believe that the aims and purposes of the wonderful and dedicated colleagues with whom I have worked for the last fifteen years at our Institute are very similar to UFL.

Having naively entered academic life with the concept that truth had no boundaries or editors, I am still amazed how the facts concerning life issues, such as the post-abortion problems we know from research and publications, can be diverted by the bias of editors, official scientific societies, research-granting bodies, university administrators, and so forth.

However, we have a unique (and, I believe, a God-given) role to play, and meetings such as this are critical to our further development and knowledge. I would like in closing to thank all those who worked so hard to make this meeting such a success, particularly Teresa Collett from UFL and Keith and Betty Cassidy, who brought the Institute and UFL together in the first place. I look forward to further enriched contacts with the wonderful people we have met here this weekend, and I wish you all Godspeed and safe journey home.

NOTES

i. Frederic Wertham, *A Sign for Cain: An Exploration of Human Violence* (New York: Macmillan, 1966).

ii. Leo Alexander, M.D., "Medical Science under Dictatorship" in *New England Journal of Medicine* 241 (July 14, 1949) 39-47.

iii. *Ibid.*

iv. Marcia Angell, M.D., "The Quality of Mercy" in *New England Journal of Medicine* 306 (Jan.14,1982) 98-99.

v. *Euthanasia and Assisted Suicide: The Current Debate*, edited by Ian Gentles. (Stoddart Publishing Co., 34 Lesmill Road, Toronto, Ontario, M3B 2T6), Ch.4: "As Life Ends."