Assisted Suicide and Euthanasia

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I'VE JUST COME BACK from two weeks in Poland. Let me give you a short account of that trip. Almost a decade ago, Barbara and I wrote *Abortion Questions and Answers*. It went into ten languages, including Polish. We were then asked to come to Poland, and we spent two weeks speaking in about ten cities in order to introduce this book. It was brand new information to most of those audiences at that point. Pro-lifers were then in the process of taking control of Parliament. Lech Wa__sa was their new Premier. They had inherited an abortion law from the time of Russian domination. For forty-four years they had had abortion-on-demand, state-paid, until three months. We spent several days and distributed over 10,000 copies. Our pro-life friends there pressed for a law to forbid abortion. This ignited a strong opposition. They said, "You want to pass a law to stop abortion? Look, that's impossible. For forty-four years, abortion has been deeply imbedded into the warp and woof of our culture. If you pass a law to forbid it, all you'll do is drive it underground." And this was the refrain taken up by the press, by the communists, and by all of the UN agencies. They all said the same thing. They said, "If you forbid it by law, women will be instrumented on the outside, then they will come into the hospitals, bleeding and infected. They'll all claim they've had a miscarriage. The result will be many women injured and many women dead. You just can't stop it." But in 1993 they did pass that law.

I recently went back to Poland, this time alone, for my dear Barbara had knee surgery and could not come. This time it was to introduce the Polish edition of my new book on assisted suicide. On this book tour I spoke in eight cities in as many days, plus three days at Parliament. During this time I gathered statistics on what has happened to abortion-rates. I knew they had cut abortion way back, but I did not know the results would be as

good as they are, for they are surprising. During the Russian occupation, Poland with its almost 40 million people, had been aborting 160 to 180 thousand babies a year. Last year, it was 250. Wow!

Is this an accurate figure? Yes, these are government figures. Hard to believe as they are, these statistics have been cited often in newspapers and argued about in the press, on radio, and on TV. These are accurate statistics.

I asked what about the number of miscarriages admitted to Polish hospitals. A massive increase had been predicted, but it has turned out to be fewer than it used to be. What about the total number of gynecologic admissions of all kinds to hospitals? It is also fewer than it used to be. What about the number of neonatal deaths–babies dying after delivery? As many of you know, if there are a lot of abortions, women develop incompetent cervixes and the result is more premature babies. Preemie babies die more often. Accordingly, what of deaths of preemies? This rate is down to about 25% from what it was.

Every statistic of female health in Poland has improved, and some, dramatically. These are figures that have been widely publicized and widely argued in that nation, so we can depend on their accuracy. I brought this information back and am now publicizing this internationally.

The short brochure "Never Was, Never Again"speaks to the issue of illegal abortions and their fancied toll of female damage. It tells you of the claims about how many illegal abortions there were in various countries, and then it documents in detail how many there were in the US. In every case there have been wildly exaggerated numbers.

Now, illegal abortions, by very definition, are not reported. Precisely because they are illegal, they are not reported, and so there are no accurate numbers. For instance, how many abortions are there illegally in Brazil? "It's a huge number," we are told. But what does this mean? Only that in Brazil and elsewhere, the claimed numbers of illegal abortion is a pure guess. Of course, if we were to give a number, we would be

guessing too. No one knows how many illegal abortions there are in any country on the globe. Is there no clue to help us to tell us how many? It is true that women die from abortions. Now, if we knew how many abortions it took to cause one maternal death, then answering the question would be easy. But we have no idea how many it takes to cause one maternal death. So, we're back at the start.

The US is one of the few nations whose statistics identify the number of deaths from illegal abortions. In most Third World countries, there is no reporting at all. Most Western nations report the number of abortions but group the spontaneous, the criminal, and the legal all in one number. So, that does not help us much. But in 1940 the US Public Health Service began to separate them. That office claims that in 1972, the year before *Roe v.* Wade, there were one million illegal abortions and that five to ten thousand women died that year. In fact, for the year before *Roe v. Wade*, in the whole US, the total number of women who died from illegal abortions was 39. There were also 25 more who died from legal abortions that year. Consider the following chart:

This information was used in the U.S. Senate when the Human Life Amendment and Human Life Bill were being debated in the early eighties.

The value of the Polish experience for pro-life work here is that in the case of Poland we have a Western nation of almost 40 million people that had a 44-year history of abortion-on-demand. Poland then passed a law to stop abortion. It did stop it and the health of their women has improved. Nothing went underground. How long since a woman has died from any abortion in Poland? Four years. If that can happen in Poland, it can happen in any Western nation.

Is there something unique about Poland? I have been in Lithuania four times. They're every bit as Catholic. They still have abortion-on-demand, for they still have the law they inherited. They have a good pro-life movement, but it has not been able to change the law. Slovakia is almost as Catholic, but they too still have the old abortion-on-demand law. The Czech Republic has not really changed that much. Although there has been some improvement in all of those countries, most of it has been an incidental sort of improvement and, as a matter of fact, there are not as many doctors doing abortions in those countries as previously. But Poland does have one unique difference and that is the influence of Pope John Paul II. His influence in Poland is pervasive, absolutely profound. I cannot think of another reason why they are different than any other Western nation.

Back to the U.S. When Senator McCain started his presidential campaign, he was asked about *Roe v. Wade*. His answer: "No, I don't think we should reverse it, because so many women would die." The press swallowed this, of course. So did most people: "That's right, so many women would die." Now we can say that it not true. We have had a trial run in a major country, and they did not die.

In a book I wrote about slavery and abortion some years back, there is an analogy that may be helpful. Following the lead of the British Parliament, the West Indies forbad slavery before the US did. First they forbad the slave trade and then they forbad slavery. But there were some one million black slaves in the West Indies; the Dutch and French islands went along with this as well. Many warned that if you freed these slaves, there would be riots and murderous gangs and "generalized incendiarism." But when they freed them all, nothing happened. To the total astonishment of many observers, it was completely peaceful. In a way, that is what happened in Poland on the abortion issue.

EUTHANASIA AND ASSISTED SUICIDE

In the US we also have the pressing issues of euthanasia and assisted suicide. We had a very close shave about three years ago at the US Supreme Court. They could have decided otherwise and we could have had the *Roe v. Wade* of euthanasia. Thankfully, they did not.

In the typical lecture on euthanasia the speaker will start with the Greek origin of the word "euthanasia"–its etymological roots mean "good death." But it is not a good death at all and it is simply verbal gymnastics even to mention this etymology. Then they define euthanasia and make such distinctions as direct and indirect, as well as voluntary, involuntary, and non-voluntary euthanasia; then they distinguish assisted suicide and euthanasia. I am convinced that all this does is to shade off the impact of what is under discussion. It is better to strip it to its bare bones. Be a little bit rhetorical about it. Euthanasia is when the doctor kills the patient. If you use that as your definition, you'll get a genuine argument. Euthanasia is when the doctor kills the patient. That's where I start.

I usually mention Hippocrates. He was a pagan physician who lived a half a millennium before the time of Christ. All doctors still took that oath when I became a physician but it is rarely done anymore. They first began by excising the sentences forbidding abortion. Then they took the sentence out that forbad euthanasia.

Then they quit using the oath altogether. Here was a pagan physician, who created an oath that passed into the Christian era intact and proved useful for more than1900 years. It starts by saying "I swear by Apollo" and other Greek gods, and even this passed into the Christian era. The reason was that it so succinctly stated exactly what an ethical doctor should do. In my new book I have a short chapter on oaths, the oath of the Arabian physician, the Declaration of Geneva, and others. In the revisions that I am making to this chapter, I mention the new oath that Dr. Joe Stanton stimulated and that several of us helped him with. We brought the language of the Hippocratic oath up to date. But since then I have been persuaded that maybe that is not too smart. I discovered that the Declaration of Geneva, which came right after World War II and the Nuremberg trials and which is beautiful, protects life from conception, has since been revised three times. Each time it has been watered down more. So I am not sure that we should ever revise the Hippocratic oath. I think that we are safer to stay with the original verbiage and not change anything, because if we succeed in changing to something new, however good the change, then what we have done may be again changed in another 30 to 50 years. So, my thinking now is that I think we should just leave it alone.

What Hippocrates did was earthshaking. Prior to his time, the doctor was like a witch doctor or a medicine man and had a dual role. It was to cure a patient, but it was also to cast an evil spell and kill the patient. Now I envision myself back in that time and going to the witch doctor and bringing a chicken so that he would cure my ill. He would dance around, shake his rattles, and give me some kind of a potent. But I would never really know that my enemy had not come a couple days earlier and given him two chickens and asked him to do me in. So, the uncertainty did not do much for the doctor-patient relationship. What Hippocrates did was to separate the killing and the curing role of the physician. He gave us *primum non-nocere*–first do no harm. And that is what my once honored profession stood for through the centuries. More recently it has gone astray in many cases.

A few clarifications. In the recent referendum in the state of Maine, like the referendum we won in Michigan just a year before, there were the usual stories of hard cases. Consider the hard cases cited in regard to aborton: the 14-year-old, inter-racial, rape victim who carried a deformed baby–how could you be so heartless as to have her continue that pregnancy? Whether it ever existed or not, that was the hard case we kept hearing about. What percentage of US abortions today are done (cumulatively) for forcible rape, incest, fetal handicap and life of the mother? It is less than 1%. Hard cases were the camel's nose under the tent, the wedge. But the wedge on euthanasia is far more dangerous than the wedge was on abortion. In euthanasia *you cannot allow the first one*. You see, abortion is fairly clear. You've either got, at the end of it, a live baby or a dead baby. Not much in between. Euthanasia shades off. And if you allow it here, pretty soon you will allow it there and then again and again–the slippery slope.

We can let death occur. In my maturity, my mid-70's now, I can look back and see vividly, in my last year in Med school, the professor coming on the ward, holding up this vial and he said, "Fellows (there were only three girls in our class), this is penicillin." We had two cases on the ward, a septic osteomyelitis of the knee and a subacute bacterial endocarditis. The first one was a bone infection that was spreading septically. He had blood poisoning. The second one was an infection of a valve of the heart. Both of these at that time were completely incurable. If you had that diagnosis, you called the priest or minister right now and you signed your will. He had only enough penicillin for one patient. He used it on the younger man, not the older lady. In any case, I go back that far. Now after my residency and military service, we were given, year after year, one new drug after another. The surgeons returning from the Korean battlefield and World War II had learned in the field many new techniques of surgery. And then in the sixties we installed intensive care units in all of our hospitals. Every year we had new cures available. We were curing diseases that we had never been able to cure before. It was a pretty heady business, for we could keep people alive

whom we could not keep alive before. In this atmosphere all of us overdid it at times–we did not let a patient die who definitely was in the process of dying. Sadly, in keeping them alive too long, we sometimes kept them in pain and discomfort as we prolonged this process. That is true.

You will be told the story of an old gentleman tied down in a hospital bed, clearly dying of cancer, in great pain with tubes in every natural body orifice and in two or three artificial ones. This poor devil is dying but the doctors will not let him die. You will be told that story, but it rarely exists anymore. There are two reasons why. One is that the members of my profession have learned how to let go. We now have "do not resuscitate" orders. The other reason: HMO's. Our problem today is not over treatment. It is over getting permission from the insurance company to give adequate treatment. And so, that old canard of over treatment dies hard, but it simply is not true anymore.

Pain. Anyone familiar with this area from having treated patients and from acquaintance with hospice and care of the dying will agree that the fear of disability and pain in dying is pervasive in all of us. None of us wants to die in a bed of pain. And yet, we think, "I've got a cancer–My God–I'll have pain, pain, pain." That's the fright. And will they ever emphasize this. Some years ago euthanasia was on the ballot in California and the Hemlock Society put out a major fund-raising letter. You know this type of fund-raiser: "We've got a questionnaire here, folks. Please answer these ten questions and send it back to us, with a check." You've all gotten some of these. Well, Hemlock did that. They had twenty questions. Eleven of them spoke of pain: intractable pain, agonizing pain, continuous pain, uncontrollable pain. But in Holland where doctors do kill patients, how many of those who ask for euthanasia mention pain as a reason? Only 5%. In the first year's experience in the state of Oregon, about 20 people were helped to die. How many mentioned pain? None. Pain can be controlled. I cannot tell you how many TV cameras I have looked into and said to those who were listening, "If you have a loved one who is ill, who is in pain, and that pain is not being

relieved, get another doctor. If your doctor doesn't know how to control pain, get one who does." Pain can be controlled.

I was at Stanford University a few years ago for a seminar. The professor had fifty minutes to talk about pain. He started by saying, "Now, I'm here to talk about pain, particularly pain in terminal illnesses. First of all, let me talk about physical or organic pain. I'll take about five minutes on this. That's the easy part. Then I'll take the other 45 or 50 minutes and talk about psychological pain, distress, loneliness and depression. That's the difficult stuff." And so remember, organic pain can be controlled.

Consider intensive care units. Let's go to Florida to a retirement community and have some tea. You'll hear this there and you'll hear it many other places from retired people: "Look deary. I've paid my dues. I've lived long enough. When my time comes, don't put all those tubes in me, just let me go." And all of the ladies around the table will nod their heads. This is a very common feeling. But guess what. Those ladies have never been a patient in an intensive care unit. There was an extremely interesting study about five years ago of people who had been critically ill, in intensive care, and had all those wires and tubes and ventilators and stuff and who had survived and gone home. They were asked: "Assume that you became ill again and were admitted again to an intensive care unit. Now, let's say we could guarantee that if you spent some time there, you could go back home and resume life, however, somewhat more limited than when you went in. How many of you would go back if it gave you twelve more months?" It was almost unanimous. They would all go back. Nine months? six months? three months? one month? two weeks? At two weeks, there was still a majority of these people who said they would go back into the ICU and accept all of this discomfort if they could have two more weeks at home after that. In a way, it is like asking people with disabilities if they wish they been aborted. There are plenty of normal people out there who think they should have been. But when you ask the kids, the people who have the disabilities, they disagree. I remember what

Dr. Koop told me one time. He had spent most of his life as a surgeon fixing nature's mistakes. He had been at a reunion of maybe 30 kids on whom he had operated and some of these had had 15 or 20 surgeries. He asked them, "How many of you, considering what you've gone through, think that it would have been better if you hadn't been born?" Not one. So, maybe it's a good idea to ask those who have been there rather than making our own judgments about them.

Let me go back to that old gentleman tied down in bed. Let me tell you that he is not their target. They will use him, but he is not their target. They do have a very clear target. They have even coined a term for these patients: the "biologically tenacious." This is the person who is in coma. This is the elderly lady with hemiplegia; she's had a stroke and she's confined to bed. She's incontinent. She is a burden. This is the person who is no longer useful. This is the person who is a care and an expense. This is the person who somebody thinks ought to die, but who won't. She is biologically tenacious and she is their target.

I saw this in Poland recently. At Auschwitz we stopped at a home for about 350 retarded boys. It was a Catholic institution and they were just getting ready for Mass when we arrived. All of the wheelchairs and the disabled ambulatory boys were in church. We walked in just as they were starting. I saw boys with acromegaly, Down's Syndrome, microcephalics, cretins, victims of trauma, of strokes, cerebral palsy, they were all there. The priest who offered the Mass preached. I thought, what's he going to do? The mental level here isn't very high. Here's what he said: "Now, today who are we going to thank?" They all chorused "Jesus." "That's right. Who are we going to pray to and thank Him for all the good things that have happened to us?" "Jesus." "Fine, let's just remember that." That was the homily.

When it was over, the good sisters fed us. Then I asked the Sister Superior if I could I have a tour. She took me through the entire institution. There were various types of disabilities. There were some bed cases, but most of them were at least semi-ambulatory. I don't think that there was an IQ there over about 50

or 60. After we finished, I said: "You're just in the shadow of Auschwitz here, aren't you? She said, "You know what happened when the Nazis came?" I said, "Tell me." She said, "We had a full house here then too. They backed trailers up, loaded into them every one of the patients and took them right down the road to the ovens." I said, "No." "That wasn't all. They took the nurses, caretakers and the doctors also."

Artificial Nutrition and Hydration. On the question of food and water, I simply note that if you stop certain types of life support, let's say a ventilator, for whatever good reasons, those patients may die or they may not. But if you stop food and water, those patients will die and within about two weeks, and painfully so. We are seeing a cleaning out of many of our nursing homes in this country as they simply decide to quit feeding some of their chronic patients.

A word about Jack Kevorkian, and I never call him "Doctor" because his license was revoked about six years ago. I have taken some time to look at his victims. There was not a single one who had family support. Everyone was a loner, either not supported by any family or actually rejected by them. One of the most obvious cases was a woman who had been abused by her husband. She was brought to him. He killed her. The husband inherited her estate and quickly married another woman. Kevorkian preyed on helpless people. That tells us something about how to push a person over the edge who has suicidal ideation.

Another suggestion. If your state is ever ready to pass a law that would allow euthanasia, try to get an amendment that says that the one who does the killing will *not* be a doctor. Rather, hire a paid executioner. That will make it much harder to pass such a law, but it will also safeguard the doctor-patient relationship. There are states that have lethal injection as capital punishment but (and without taking a stand on that) it never a doctor who gives the shot; they have a paid technician who does. The reason is the medical societies got their backs up and said "No, a doctor shall not kill." Without a doctor to do it, they then hired an

executioner.

One of the things we have learned from Oregon, and certainly from Holland, is that "the right to die" rather quickly develops into a "duty to die." This can be done overtly, or very subtly. Think of a person who has suicidal leanings. She goes to her spouse, who gives her no sympathy but rather agrees, "Yes, you do have an incurable illness and the doctor has done everything he can for you, hon." Or, think of Grandma, who really is a bit of a burden now. She has a pretty good head on her shoulders yet, but her care is costing money. She is subtly told that she is eating into her estate and using money that could go for the grandchildren's education. It is not directly said but it is nonetheless transmitted. Or worse yet, it can be the doctor, who does not object when she suggests euthanasia. If you are in Holland, the doctor could even say: "Well, now that's a consideration." Boy, that's hitting her straight in the face. That's telling her that "The doctor knows he can't cure me, he knows I'm only going to get worse, he knows I'm going to have a painful time. He's asking me to do it."

Let's take two grandmas. One is an old biddy who has imposed her wishes and will on her family all her life, a very selfish person. She is now disabled and a burden, and they let her know that she is. She has been self-centered all her life, and she is not going to ask for suicide now. The other grandma is a very gentle, kind, considerate person who has always thought of others. She is really mindful of the fact that she is spending all her money and maybe Jimmy will not be able to go to college. It is the kindly one like this who will ask for suicide.

One thing about euthanasia is that rich people don't get euthanized very often. Poor people do. But then the poor are usually the target. They have been the targets with abortion and they will be so here too. If you have to ask your HMO for certain procedures and you're the mayor's son, you will probably get them. But some poor homeless guy picked up off the street may well not. Euthanasia will be seen as a way of saving money.

The Nazi era is very relevant here. That was the first major field trial of euthanasia. It is not generally known, but this is well

documented. The first victims in German gas chambers were in the late 1930s and they were neither Jews nor Gypsies. They were pure-blooded Aryan Germans who were mentally retarded or handicapped. They were "useless eaters." Professors of psychiatry from major German teaching hospitals designed the first gas chamber and erected it on the wards of major German medical institutions–the first one was at Sonnenstein. The first group of mentally retarded men, about 15 of them, walked into that gas chamber and were killed. The professors watched through the windows as these men died. Then there were others, and yet others, and the price tag was slowly lowered.

"Price tag" is another little clue word here that we should remember to use. You go to Kroger's, buy a box of soap, and there's a price tag on it. Fine. You come back a few weeks later for another box and they've got a sale and the price has been cut down. It's cheaper. That's typical of price tags. Price tags get marked down. Any time you put a relative value, a price on anything, that price can be marked down. At the moment there is no price tag in this country on human life. Human life is beyond price–sacred, priceless. But if someone decides to put the poor guy in the bed that I mentioned out of his misery by killing him, then we have crossed the Rubicon by placing a price tag of only a relative value on his human life. From then on a precedent has been established: it is permissible to kill people who have this degree of disability. But then there is always the next one who is just a little less bad, and then a little less bad yet–the slippery slope. And this is why with euthanasia or assisted suicide, *we may not allow even the first one to be killed*– not in euthanasia. The Nazi doctors began by killing hopelessly insane adults, but by the end of the war they were killing World War II amputee veterans. They did not stop at the asylum for idiot children in Berlin. By the end of the war, they were killing pure blood Arian children who were bed wetters or who had misshapen ears, and down the slippery slope they went.

That was Germany. But supposedly it was never going to happen again. Everybody "knows" that it was just one horrible

time. We had learned a lesson. We had the Geneva Convention. But then it did happen again. It happened in the Netherlands, one of the countries that had put up the most heroic resistance against the Germans. There is a very interesting story here. The Reich's Commissar came in after the occupation by the Germans and told Dutch physicians that they would have to select out handicapped children, who would then be taken on vacation. They knew what was going to happen and they resisted this. Pressure was applied. The Royal Dutch Medical Association finally agreed to have a meeting and a banquet, and the Reich's Commissar came in smiling. He thought they had caved in like tte other countries had. There was a big box in the center of the room–a great big box. After it was over, they asked him to open the box . He did and in the box were the medical licenses of almost all of physicians in Holland. It was he who gave in and did not require the doctors to hand over their disabled.

But, of all things, this is the country that today has legalized euthanasia–the Netherlands. This began a couple of decades ago. A particular doctor killed her mother. This must have been a rather tragic case. She was brought before a judge and charged with murder. The judge left her off–this was a "mercy killing." But what it did was to set a precedent and then other patients in similar situations were allowed to be killed without prosecution. The slippery slope took hold. And then another not quite so severely ill, and another and another. In each case, doctors were brought before a judge, charged with the killing, and were let off. Over the period of a good decade, judge-made law legalized doctors killing patients in the Netherlands.

Now you will hear many different reports about the number of patients killed. These are usually in the low (one, two, or three thousand a year). Actually, it is far higher than that, for only a small fraction of those killed are reported. How many are actually killed? Using as a base government figures from the famous Remmilick Report, let me report the views of Dr. Karl Gunning, the dean of the pro-life movement in the Netherlands, founder and president of the World Federation of Doctors Who Respect Life,

an immensely respected person. A little more than 130,000 people die in the Netherlands every year. Twenty-five thousand is the number that he says are killed by doctors. Worse yet, half of these are killed without the patient's knowledge or consent. As I have mentioned, these killings are done under judge-made law. As of this time, the parliament has still not legalized euthanasia in Holland. It has been the judges who have slowly produced guidelines. These guidelines are for physicians and, if they are observed, the physician will not prosecuted. Let me itemize these, for they need to be kept in mind when considering reports about the Dutch program:

- The request for euthanasia must come only from the patient and must be entirely free and voluntary and the patient must be of sound mind.
- The patient's request must be well considered, must be repeated, and must be maintained.
- The patient must be experiencing intolerable pain with no prospect of improvement. Such suffering does not have to be physical; it can also be emotional.
- It must be performed by a physician.
- The physician must consult with other independent physician(s) who have experience in this field.
- It must be *force majeure*. This is a Dutch term that means that everything has been tried, nothing has succeeded, all alternatives have been considered, and now, as a last resort, the doctor must resort to euthanasia.
- All cases of euthanasia must be reported as such on death certificates.
- All cases of euthanasia must be reported to the proper authorities.

Now, certainly there are people who, when informed of these guidelines, would make the judgment, "Well, I'm against doctors killing patients, but my goodness, if these are observed, it certainly would be contained, it would be a rare thing. Maybe it's okay." But, in fact, these guidelines are all routinely ignored by the great

majority of physicians in Holland. They simply do not report, and half of those killed are done in without their knowledge or consent.

How are they killed? The majority of these are patients in hospitals who are ill, declining from cancer or what have you, and they are simply given a huge dose of morphine, or the drip is increased far beyond what the body can take, and in a few hours the patient is dead. That is what happens to most of them, but not to all. The rest are directly killed by a lethal injection by a physician. Let me just give you a few stories to illustrate how this works over there.

If you are admitted to a hospital in Holland and you happen to have gray hair, it will not be long before a person will call on you and for a modest fee, they will watch your case to insure that your doctor does not kill you. Many senior citizens in Holland carry a card in their wallet, protesting that they do not want to be killed and that they do want care.

A friend of mine in Rotterdam admitted a patient to the hospital who had cancer. By Friday afternoon they had a diagnosis. The cancer had spread. But she had walked into the hospital, she was not in pain, and so he said to her, "We'll keep you over the weekend and on Monday we'll get together and decide on radiation, chemotherapy, whatever the treatment will be." He went away for the weekend. Returning on Monday to visit her, he found another patient in the bed. He called the resident doctor and said, "Where did you move Mrs. VanderHoff?" "Oh, we euthanised her yesterday." "You what?" "Well, we euthanised her yesterday. Look, Doctor, she wasn't going to make it anyway, she had metastatic cancer." "Well, yes I know, but she wasn't in pain. She hadn't even been treated yet." "Well, that may be, but in any case, we needed the bed."

Another doctor friend of mine, a family physician, had been caring for an elderly couple at home. They were both ambulatory, taking care of each other. On this particular weekend, he had been away. Returning to his office on Monday morning, he turned on his answering machine to hear the voice of a very excited and upset elderly lady asking him "Come, come to my house

immediately." He hurried over. He was met at the door by a crying woman. Sobbing, she said, "Doctor, Doctor, why did he kill John? John didn't want to die." The story was this. John had developed a cough on Saturday. They had called for their doctor and the one taking his calls made a home call. He diagnosed an early pneumonia, gave John an injection, and he was dead within an hour. "Why did he kill John?"

Now both of these killings were entirely legal. And this happens repeatedly in Holland. It is not only elderly people, it is also babies. When I was there a few years ago, I interviewed the then president of the Royal Dutch Medical Association and asked about the treatment of handicapped newborns. I was told that nothing was written down but that it was their recommendation that if the attending physician, after examining a newborn, made a judgment that he was 2/3 sure that the child would not have a normal productive life, he could kill the infant over the parents' objections.

Finally, this is not done only for physical illness but also for psychologic illness. A year or so back, a psychiatrist treating a teen patient who was depressed wrote, at the teenager's request, a prescription for a lethal cocktail. The young man took it and died. Called before a judge, the man pleaded that psychic illness was just as much a reason to allow assisted suicide as physical illness, and the judge agreed. And so now in Holland, if you are a depressed teenager, you may be allowed and even assisted to commit suicide. That's how far down the line the slippery slope has gone in Holland.

In Australia a couple of years ago the Northern Territory passed a law permitting active euthanasia. Now, the Territory is under federal control, just as our District of Columbia and Guam are. After much discussion, the federal parliament reversed that law, and so euthanasia is not legal in Australia.

More recently, there was a referendum in the state of Michigan to legalize assisted suicide. That was voted down by an overwhelming margin. And there is the case of Oregon. In my book *Assisted Suicide and Euthanasia Past and Present* there's a

chapter on Oregon, whose citizens passed an initiative referendum allowing physician assisted suicide. Again, it had some fairly reasonable restrictions but also some gaping holes. Doctors do not have to report. So, all we have are the voluntary reports of a very few who did report that they had assisted at suicide. In the first year, of the two dozen who died in this way, what do you think the main reason was that they gave? A lot of people would guess that it was pain. As a matter of fact, pain was not even mentioned. The main reason given for requesting suicide was loss of personal autonomy, loss of what they called "personal dignity." Having to accept, perhaps down the line, somebody wiping their bottom–that was the main reason given.

In the second year of operation there, the Health Department report spoke only of successes, not of problems. But that is not true, for other publications in Holland have detailed some cases that certainly do not sound like successes. These are people who took the drugs given and who did not die. These are people who took the drugs and then became violently ill, convulsing, vomiting, in great pain. In one case the about- to-be-widowed called 911 and her about-to-die-husband was brought to the hospital and revived, and then went to a nursing home eventually to die. And there are other reports. Recently there was a report in *The New England Journal of Medicine* of such cases in Holland. It reported that "failures" ranged from 5 to 15% who therefore had to be actively terminated. How does one do that? Well, you put a pillow over the patient's head and smother him, or in Holland, the doctor can give a single lethal injection and kill the patient directly.

In the US we had a great threat. Two states whose laws forbad assisted suicide had those law reversed up through Federal Appeals Courts, one in California, one in New York. These two appeals courts would have legalized direct euthanasia in those areas. The cases went to the US Supreme Court, which, after deliberation, came down in a 9-0 ruling that there was no federal right to assisted suicide in the US Constitution. That was the good news. The bad news was that a state can authorize it. This case has repercussions internationally. It was long

anticipated, heavily lobbied for, and produced the largest number of *amicus* briefs ever submitted to the Supreme Court–almost 50 of them. Prominent among these were two briefs submitted by the American Medical Association, which had 45 co-signers, including liberal groups like the American Psychiatric Association. These two briefs are treasure troves. First of all, the AMA has been pro-abortion since *Roe v. Wade*, but they also are anti-euthanasia and with a passion. In the AMA briefs are contained the arguments and the answers to euthanasia. The great value of these two briefs is that it is the American Medical Association saying it, and this has far more weight than if you or I said the same thing. And so, here we have a treasure house of information and authoritative answers.

Finally, let's get to the answer. The answer is compassionate care. First, consider suicides across the board. We know that 95% of those who attempt to commit suicide are clinically depressed. Clinical depression is a bio-chemical illness. We have medicines that now treat clinical depression. So, if that is the case in the general population who commit suicide, it is certainly that or more among those who would ask for help in doing it.

The answer is compassionate care. The answer is to meet the patient's needs. Relive their physical pain, of course. That goes without saying. But also help to relieve their loneliness. Bring a clergyman to the bedside and get their own spiritual lives straightened out. Bring relatives to the bedside. Create reunions. In the final chapter of my book I recount various stories about how one's declining days can be made warm, fruitful, rewarding, with good memories.

- A son has been long estranged from his father for perhaps, in his mind, justifiably good reasons. The father is near death. That son can come back and, forgetting who was guilty of what, can tell his father that he loves him and ask for his father's forgiveness insofar as he himself was in the wrong. A father's response in such an instance is usually one of embracing him whom he sees as a prodigal son. Such an

exchange of love, very likely with tears, can release both from the emotional bondage of long-harbored anger and resentment and can also alleviate personal guilt.

- A grandfather can gather grandchildren about him and recall for them tales of his earlier life, of his own boyhood and growing up, of how he met their grandmother, their courtship and marriage, their bearing and rearing of the parents of these children. Stories such as these, often heard for the first time by these little ones, will not be forgotten. They offer a bridge to the past, a tie in blood between generations, a pride of "ownership" in having had this grandpa. This also serves as a positive and loving example to these children's parents, and to the children themselves, of the inter-generational role that grandparents can and should play, and that hopefully each of them will play someday.

- A divorced wife, long estranged from her husband, carrying with her, as does he, a wall of bitterness from that painful separation experience. Deep inside both of them, completely unspoken and fully repressed (most of the time), there usually yet remains some feelings of regret, of perhaps not having put forth the full effort each could have to preserve that union, of perhaps even being somewhat ashamed of oneself for having done or said some of the things that led up to that break. All of these can add up, deep inside of each, to unresolved emotional feelings. If she can come to this dying man, embrace him, tell him how she remembers their initial love and that some of that still remains in her heart, tell him she's sorry for whatever hurts she has caused him and ask him to forgive her. Almost certainly the wall between them will dissolve. He will accept, forgive and respond to her in kind. Now all of the façade, the built-up incrustations of time, the pride, the self-justifications fade away. In such a tender moment, the result can often be that he can die in peace, that she knows it, and that she herself can go back to her own life

with a lighter heart, a cleaner conscience, a burden lifted from her soul, and a peace of soul. It is much better to bury good memories than bad ones.

CONCLUSION

And so let me offer you along with many others who have cared for dying persons, a hope that each of you, when confronted with a person who is dying, will try to make those weeks and days a time to remember, a time of fulfillment, a time to consider the five last acts of the hospice movement. They are:

I forgive you
Forgive me
Thank you
I love you
Good-bye.