Imposed Death
Euthanasia and Assisted Suicide
History teaches us that a society which fails to respect and protect everyone’s life is not a safe place for anyone. The intentional ending of human lives by euthanasia and assisted suicide is becoming increasingly common.

Euthanasia literally translated from Greek means “good death.” In this publication, the more accurate term “imposed death” is frequently substituted for “euthanasia” and its partner “assisted suicide” (see Definitions, p. 3).

You may ask: Why do I need to read this publication? Because the whole human race has a stake in the answer to the question, “Should imposed death be permitted by law?”

In this publication we will examine imposed death from various angles, highlighting the experiences and opinions of those most intimately affected by it. In order to make informed decisions, you need the unvarnished truth about this vitally important topic.

Advocates of euthanasia and assisted suicide use seductive slogans like the “right to die,” “choice in dying,” and “aid in dying.” Giving governments the power to authorize the individual’s “right” to choose when and how to die begins the progression from voluntary imposed death to involuntary imposed death. At what point does a “right” become an expectation, even a duty? We encourage you to ponder this question as you read Imposed Death.

**WHY SHOULD YOU BE CONCERNED?**

**ACKNOWLEDGMENTS**

Human Life Alliance assembled a talented team of writers, researchers and experts who contributed to developing this publication. We are grateful to these men and women for their dedication to this project, as well as for their perseverance in defending the unalienable right to life of all human beings. Foremost, we want to thank our multitude of friends whose faithful support enables Human Life Alliance to continue its life-saving educational projects.
EUTHANASIA: DO WE REALLY WANT DOCTORS WHO ARE COMFORTABLE WITH KILLING?

The Euthanasia Educational Council introduced the “Living Will” in 1967 and marketed it as a means to avoid suffering. Originally, living wills only covered refusal of “unwanted” treatment for terminally dying people. The euthanasia movement intended this “first step”—promoting the “right to die” via living wills—to evolve into medically imposed death.

Exploitation of the natural fear of suffering has led to a growing acceptance of euthanasia and assisted suicide (see Euthanasia Around the World, p. 15). However, eliminating suffering is not the foremost aim of those who promote medical killing. Most people are unaware that the push to legalize the “right to die” has gone far beyond the stereotype of the terminally ill person in unbearable pain who voluntarily refuses treatment.

THE “RIGHT TO DIE” HAS EVOLVED INTO A “RIGHT TO KILL.”

Here are a few examples illustrating how acceptance of the “right to die” has led to acceptance of the “right to kill” without patient consent.

• In 1999, Texas enacted a law that allows doctors to stop life-sustaining treatment against patients’ wishes (see “Futile Care,” p. 4) on the basis that doctors know best.

• A 2012 segment of Dr. Phil McGraw’s popular TV show featured a Canadian woman who wanted her disabled adult children to die by lethal injection. When the studio audience was polled, 90% were in favor of killing them.

• The Human Life Alliance staff and the authors receive numerous calls for help from people who are trying to save a loved one from being overdosed with morphine or sedatives. There are even more calls and emails from people with heart-rending stories of how loved ones have been killed by “stealth euthanasia,” (see Definitions) without the family realizing what was happening.1

UNDER ATTACK! CONSCIENCE RIGHTS

Without medical participation, the euthanasia movement falls apart. Ominously, not only euthanasia activists, but also prominent academics, seek to exclude from the practice of medicine those who refuse to kill their patients. For instance, Udo Schuklenk, co-editor of Bioethics, a leading journal in the field of ethics, asserts that “Conscientious objection has no place in the practice of medicine.”2

Do we really want only health care providers who are comfortable with ending our lives? If not, we must protect the conscience rights of medical professionals. In 2017, Arizona enacted a law “intended to protect medical professionals and the facilities where they work from discrimination if they refuse to assist in end-of-life procedures.” Missouri had already enacted a similar law in 1992. These are models for other states and countries to follow. It may take a long time before killing sick or disabled people is again seen as abhorrent and unethical, but the effort will be worth it.


Julie Grimstad, LPN, Patient Advocate, Exec. Director of Life is Worth Living, Inc.

CASE IN POINT

“Eleanor” (not her real name) became ill with cancer in her 50s. Spirited and feisty with a wicked sense of humor, Eleanor regaled us doctors and nurses with tales about her event-filled life. But as cancer treatments failed to cure her, Eleanor’s mood darkened and she talked of plans to commit suicide before she became mentally diminished or physically dependent. We worked with Eleanor by treatment and especially by addressing her fears and the ramifications of a suicide decision. We were elated when she changed not only her mind, but her attitude, embracing life with gusto. Eventually, she died comfortably and naturally.

When Eleanor initially changed her mind about committing suicide, her friends tracked me down on the oncology unit where I worked to complain that we were “interfering with her right to die.” Instead of being happy or relieved, they were outraged that we took the usual measures we’d take with anyone to prevent a suicide.

Over the years, I’ve seen this disturbing enthusiasm for “choosing” death go mainstream. Consider the consequences for patients when expressing a wish to die is not viewed as a cry for help, but rather as a request to be killed; when encouraging a suicidal person to change her mind is deemed “interfering with her right to die.”

By Nancy Valko, RN

DEFINITIONS

Euthanasia: An act, such as a lethal injection, smothering, etc., or an omission, such as withholding or withdrawal of medical treatment and/or care—including food and water, with the intention to end the life of a person so that all suffering and other difficulties may be eliminated. When requested by a person, euthanasia is a form of suicide.

Assisted Suicide: Self-killing with the assistance of another. The means and/or instructions to kill oneself are provided by another person or by an organization that promotes assisted suicide.

Physician Assisted Suicide: A physician provides a patient with the means (for example, a lethal dose of barbiturates) and/or information needed to commit suicide. The last act, e.g., ingesting the drug, is done by the patient.

VSED (voluntary stopping of eating and drinking): A person refuses to eat or drink in order to cause or hasten their death. This is suicide. Furthermore, if a physician prescribes drugs to keep the person highly sedated while he/she starves and dehydrates to death, this is a form of assisted suicide.

Stealth Euthanasia: The intentional hastening of a patient’s death while pretending to provide appropriate treatment and care. Actions and omissions intended to cause death are hidden from those who may object, such as concerned family members.

Imposed Death: The more accurate term for ending the lives of human beings in order to eliminate their perceived suffering or to relieve others of the duty/cost of caring for them.

Conscientious Objection: When exercised by healthcare practitioners, this is a refusal to provide a legal “medical service,” such as euthanasia or assisted suicide, that conflicts with their deeply held moral convictions.

INFORMATION:

American Life League Inc.  
www.all.org 540-659-4171

Life Legal Defense Foundation  
https://lifelegaldenfensefoundation.org/
FUTILE CARE

Most people are unaware of a very real threat to their lives that may be lurking in their hospital—a “futile care” policy.

In recent years, a new bioethical theory of “futile care” has taken hold. When a patient reaches a certain stage of illness, injury, disability, or age, life-sustaining treatment is considered “futile” and withheld or withdrawn based on the attending physician’s opinion that the patient’s quality of life is low. Therefore, “allowing” the patient to die is deemed compassionate and cost-efficient.

In many “futile care” decisions, it is the patient who is considered useless, not the treatment.

Consider Texas. In 1999, lawmakers enacted the “10-day law” (Texas Health and Safety Code, Section 166.046), which gives full immunity to physicians and hospitals that remove life-sustaining treatment against the wishes of patients or their surrogates (usually family members), with no appeals process for patients. After a patient/surrogate is notified of the physician’s decision to refuse to comply with the patient’s treatment wishes, the decision is reviewed by the hospital’s own ethics committee. If the committee agrees with the physician’s refusal (which is the usual result), the patient/surrogate is given notice and 10 days to transfer to another physician or facility, after which, the law states, “The physician and health care facility are not obligated to provide life-sustaining treatment.” Transfer of a critically ill patient, particularly with a “futile care” decision in his or her medical record, often proves to be extremely difficult or impossible.

Texas has an unethical, inhumane law, but at least it requires hospitals to notify patients or their surrogates when medical futility decisions are made. In some places, doctors and hospitals make and carry out medical futility decisions in secret.

It was inevitable that the acceptance of the “right to die” when and how you choose would lead to the “duty to die” when and how someone else chooses for you.

HISTORIC MEDICAL ETHICS vs. MODERN BIOETHICS

Historic medical ethics has as its core principle the “sanctity of life.” About 2500 years ago, a Greek physician named Hippocrates codified reverence for life in an oath which prohibited physicians from deliberately killing patients and charged them “to do no harm.” Until recent times, physicians have sworn this oath upon graduation from medical school. Medical ethics, based on the Hippocratic Oath, has always obliged physicians to protect and preserve their patients’ lives and never to kill.

Modern Bioethics, which emerged in the 1960’s, has as its core principle the “quality of life.” Bioethics influences all areas of medical care. Most bioethicists today embrace a utilitarian view of human life: a human life burdened by advanced years, serious illness, or special needs is not worth living/a waste of resources. For example, in 1993, Dr. Ezekiel Emanuel, who would later be the chief architect of the Affordable Care Act (a.k.a. Obamacare), wrote, “Increasingly it will be our collective determination as to what lives are worth living that will decide how incompetent patients are treated.” [American Journal of Medicine, 1/1993, Vol. 94, p. 115]
Your life or the life of a loved one may depend upon having correct information about the ventilator, commonly called a “respirator.”

Many people with disabilities use ventilators every day to assist their breathing. For them, a ventilator is a necessity of life which allows them not only to continue living, but to breathe easier and enjoy life to its fullest. The ventilator is also commonly and effectively used to save lives. Sadly, the function it plays in the healing process is not widely understood. The vast majority of the population mistakenly believe a ventilator merely delays imminent death. Three real-life cases alerted me to the truth about the short-term healing role of the ventilator.

My 41-year-old nephew’s life hung in the balance. Injured in an automobile accident, he was suffering from shocked-lung syndrome—a condition in which the elasticity of the lungs is greatly curtailed.

To give my nephew’s body a chance to heal without fighting for breath, doctors induced a comatose state and put him on a ventilator.

His life depended on the ventilator for more than three weeks. When he was finally taken off this machine, his body took over, eventually completing the healing process. Today, he is back working at his heavy-duty construction job—thanks to excellent medical care, the ventilator, and endless prayers.

In the second case, a dear friend sustained a head injury. Because his traumatized body started to shut down following surgery to close the wound, he too was put into a medically induced coma and connected to a ventilator. After five days, he was taken off the ventilator and his natural breathing functions took over. This friend, who at 80 didn’t believe in retirement, went back to working fulltime. Imagine the outcome had he signed a Living Will that stated he would never want to be put on a “respirator.” If you have made a statement to this effect, either orally or in writing, I advise you to promptly and emphatically rescind it, preferably in writing.

Lastly, a middle-aged woman of my acquaintance suffered from Chronic Obstructive Pulmonary Disease (COPD), but was coping admirably well, living a very active, productive life in a political leadership position. One night she experienced extreme shortness of breath and was taken to an ER by her husband. When the attending physician mentioned a ventilator to give her relief, she shook her head "no." According to her wishes, the husband didn’t insist. She died shortly thereafter. If this woman or her husband had been made aware of the healing value of a ventilator, might she still be with us, carrying the political torch, and enjoying her grandchildren?

I am an enthusiastic champion of the ventilator. We must all do our part to dispel the mistaken assumption that use of a ventilator is an extraordinary or heroic measure which only temporarily prolongs life. Its role in protecting and preserving lives must be promoted until it becomes common knowledge. Providing accurate information about life and death measures gives patients and their families the ability to make truly informed treatment decisions.

By Marlene Reid
President Emeritus
Human Life Alliance

Are you sure you’d NEVER want to be “hooked up to a machine?”

Your life or the life of a loved one may depend upon having correct information about the ventilator, commonly called a “respirator.”

How a Ventilator Works

A ventilator pushes air with oxygen into the lungs of a person who needs assistance or cannot do this movement on their own. That is all the ventilator does. The person's lungs, heart and circulation do the rest, absorbing the oxygen and circulating the blood carrying oxygen to all of the person's cells, organs, and tissues. The blood picks up the waste product, carbon dioxide, and delivers it to the lungs. The ventilator does not and cannot make the body "respire," that is, exchange the oxygen and carbon dioxide. For carbon dioxide to get out, a person's lungs and breathing muscles must first have the ventilator push the air in. Then the lungs and breathing muscles can function effectively to allow movement of the air with carbon dioxide to go out of the body. The ventilator does not exhale. The ventilator does not make the heart beat. It is in the living person that these things occur. If the ventilator is effective, the patient is alive. There is no respiration or circulation in a cadaver.

By Paul A. Byrne, M.D. neonatologist, author of Life, Life Support and Death as well as other publications, www.lifeguardianfoundation.org
Nutrition and hydration, whether a person is fed with a spoon or through a tube, is basic care, not medical treatment. Insertion or surgical implantation of a feeding tube takes medical expertise, but it is an ordinary life-preserving procedure for a person who has a working digestive system, but is unable to eat by mouth.

Is it right or wrong to withhold or withdraw food and water from patients?

It is important to distinguish between appropriate medical decisions and discriminatory decisions based on value judgments.

During the natural dying process, when a person’s organs are shutting down or when a person is unable to receive food and fluids without harm, they are discontinued and the person is kept as comfortable as possible until death occurs naturally. This course of action is both medically and morally appropriate. In these circumstances, the direct cause of death is the disease or injury.

On the other hand, when a person is not dying—or not dying quickly enough to suit someone—food and fluids are often withheld to intentionally hasten death. In order to rationalize depriving a person of such basic, life-sustaining care, the person is first dehumanized, that is, described as having an unacceptably low quality of life and/or as a wasteful use of limited health care resources. In such a case, death is caused by starvation and dehydration, not by the underlying disease or injury. This is simply inhumane.

Dr. William Burke, a St. Louis neurologist, describes what happens to patients as they die an unnatural death from dehydration:

They will go into seizures. Their skin cracks, their tongue cracks, their lips crack. They may have nosebleeds because of the drying out of the mucus membranes, and heaving and vomiting might ensue because of the drying out of the stomach lining. They feel the pangs of hunger and thirst. Imagine going one day without a glass of water! Death by dehydration takes 10 to 14 days. It is an extremely agonizing death.¹

Tube-feeding and the Law

Tube-feeding is often simpler, less costly and safer than spoon-feeding a patient who is a slow eater or chokes on food. It may be necessary for comfort, to ensure adequate nutrition and hydration, or to sustain life when a person is unable to swallow.

Real food and water are delivered through a feeding tube, though often they are inappropriately referred to as “artificial nutrition and hydration.” It is the feeding tube that is artificial, much as a baby bottle is an artificial means of delivering real nourishment to an infant who is not breastfed.

Food and fluids do not become “treatment” simply because they are taken by tube any more than penicillin and Pepto-Bismol become “food” when taken by mouth. Those who claim otherwise do so to advance their own agenda. For instance, in 1984, at a World Federation of Right to Die Societies conference, bioethicist Dr. Helga Kuhse explained the strategy of euthanasia advocates:

If we can get people to accept the removal of all treatment and care, especially the removal of food and fluids, they will see what a painful way this is to die, and then, in the patient’s best interest, they will accept the lethal injection.

Deliberately causing human beings to painfully die of hunger and thirst is beneath the dignity of both patients and medical professionals. Nonetheless, in every state, advance directive laws permit imposed death by withholding or withdrawal of nutrition and hydration. These laws are the foot in the door for acceptance of medical murder by lethal injection.

Suicide by DEHYDRATION

Jane Gross, a New York Times journalist, encouraged and helped her 87-year-old mother to commit suicide by VSED with the help of care givers at her nursing home. According to Ms. Gross, her mother “wasn’t dying of anything.” It took 13 days without food or water for her to die. Afterwards, Ms. Gross wrote a book about it, A Bittersweet Season. Her most chilling line is, “I was twitching with impatience. I wanted my mother to hurry up and die.” The elderly “volunteering” to die of thirst and starvation, and their children and care givers aiding them, is a sign of a very sick society.

INFORMATION:

**PERSISTENT VEGETATIVE STATE**

The dehumanizing label “persistent vegetative state” (PVS) was crafted in 1972 just as the “right to die” movement took on steam. In the 1980s, bioethicists, courts, state legislatures, and physicians began to use PVS diagnoses to justify denying food and fluids to unresponsive patients.

Dr. Joseph Giacino, director of rehabilitation neuropsychology, Spaulding Rehabilitation Hospital, and Nicholas Schiff, a neurologist at Weill Cornell Medical Center, conducted experiments that prove this bleak diagnosis is often wrong. They discovered apparently “vegetative” people whose minds still imagine, recognize, and respond. The first “vegetative” patient Schiff saw was the victim of a stroke who had no sign of consciousness. Three years later, he met her again and was shocked to find her able to talk to him.1

According to the 1994 Multi-Society Task Force on the medical aspects of PVS (MSTF), a person in a coma is neither awake nor aware; a person in a vegetative state is awake but not aware. The MSTF defines PVS as a vegetative state that lasts more than one month.2 Individuals in PVS are seldom on any life-sustaining equipment other than a feeding tube. Some can swallow, others cannot. Some have been physically injured, others have had a stroke or have dementia. In simple terms, the diagnosis of PVS is based on lack of evidence of awareness of self and environment.

**Misdiagnosis is Not Uncommon**

In 2003, data gathered by the MSTF on a group of 434 patients in PVS showed that, by 12 months after injury, 52% had regained consciousness.3 A 2007 study showed around 40% of PVS patients were wrongly diagnosed.4

As early as 1996, London neurologist Dr. Keith Andrews reported that, out of 40 patients diagnosed as PVS, 17 (43%) were later found to be alert, aware, and often able to express a simple wish. Dr. Andrews said, “It is disturbing to think that some patients who were aware had for several years been treated as being vegetative.”5

Kate Adamson’s PVS diagnosis was rendered after a brain stem stroke. She was actually aware. Interviewed by Bill O’Reilly in 2003, she said, “When the feeding tube was turned off for eight days, I thought I was going insane. I was screaming out in my mind, ‘Don’t you know that I need to eat?’ It was sheer torture.”

Some patients who have a PVS diagnosis do exhibit evidence of awareness, but the diagnostician misses (or dismisses) it. They may be mute and immobile, but mentally alert and able to communicate by blinking or through aids such as computers—if someone gives them the opportunity. Other patients retain some measure of awareness even though they do not exhibit evidence of it. Those who have recovered recall things that were said or done to them while no one knew they were aware.

PVS patients (those not dehydrated to death) are often warehoused in nursing homes where they are deprived of rehabilitation and medical treatment. The unconscious world is far more complex than most of us can imagine. Those who have severe brain damage may still enjoy touch, scent, taste, and sound; they may also feel loneliness, fear, and despair.

**Their inability to satisfy our longing for response does not justify abandonment or imposed death.**

**CASE IN POINT**

A psychologist at Putney's Royal Hospital for Neuro-disability told John Cornwell, a writer for the Times (London), this amusing story: “Young man with motorbike head injury in a coma. His mum, a keen evangelical, comes every day with friends to sing “Onward, Christian Soldiers” by his bedside. She's hoping to stimulate his brain into action. It works: he comes round, but he can't speak. So they fit him up with one of those Stephen Hawking-type laptops, and the first words he speaks are: ‘For God's sake, Mum, shut it!’” Cornwell commented, “That's about as funny as it gets on a brain-injury ward, but there's a serious take-home message. Even minimally aware patients can retain emotions, personality, and a capacity to suffer—and, as the young biker showed, attitude.”

**Source:** The Sunday Times, 12/9/07

**INFORMATION:**


**What About Pain Control?**

What you don’t know can hurt you. This is especially true of ignorance about the great strides that have been made in the treatment of pain—both physical and emotional. Fear of unbearable pain is one reason many people feel drawn to favor physician-assisted suicide and euthanasia. The antidote to this fear is accurate information, not imposed death.

**THE GOOD NEWS:** There is an extensive range of treatment options—medications, various therapies, surgery, psychosocial care, etc.—to relieve pain. With modern pain management, even the most severe cancer pain can be eliminated or significantly relieved. For example, one advance in the care of patients with lung cancer is a machine that delivers air through a tube to a face mask (called noninvasive positive pressure ventilation) which can help relieve discomfort and difficulty breathing in a patient’s final hours, reducing the need for sedatives or pain medications such as morphine.

**THE BAD NEWS:** Some physicians don’t have the knowledge, time, patience, or empathy to treat pain effectively, even though they may be competent in other fields of medicine.

Patients and their families need to insist that their physicians make every effort to control pain. If your physician cannot or does not do so, find a physician or health care facility that focuses on the diagnosis and management of pain. Relief may be just a phone call away.

Pain is invisible. Others can’t see it. But it is very real and distressing. Don’t try to “tough it out.” Pain can lead to loss of sleep, depression, inability to work, impaired relationships, and a generally poor quality of life. So, don’t wait if you are in pain. The earlier that pain treatment is started, the more effective it will be.
1938 The Euthanasia Society of America (ESA) was founded to promote legalization of both voluntary and involuntary euthanasia, but was unsuccessful in changing laws until changing tactics in the 1960s.

1967 ESA established the Euthanasia Educational Council (EEC) which introduced the “Living Will,” a document drawn up by lawyer Luis Kutner and regarded by ESA as the first step toward winning social and legal acceptance of euthanasia.

1969 The Indiana Law Journal published Kutner’s “Due Process of Euthanasia: The Living Will, A Proposal.” Kutner, spelling out the “right to die” agenda, presented the living will as “limited in its initial creation to adult patients who are capable of exercising their will” and as a means to “permit inaction termination of a patient’s life.”

1975 ESA changed its name to the Society for the Right to Die (SRD).

1976 The California “Natural Death Act,” the first Living Will law in the U.S., was enacted.

1979 EEC changed its name to Concern for Dying (CFD) and split from SRD.

1980 Derek Humphry founded the Hemlock Society (HS) to promote death-on-demand—both euthanasia and assisted suicide. (Hemlock was the poison used in ancient Greece for executions and state-approved suicides.)

1986 At a conference named “A New Ethic for the New Medicine,” the American Medical Association’s Council on Ethical and Judicial Affairs endorsed imposing death by starvation and dehydration: “Even if death is not imminent, but a patient’s coma is beyond doubt irreversible...it is not unethical to discontinue all means of life-prolonging medical treatment (including) medication and artificially or technologically supplied respiration, nutrition and hydration.”

1994 Oregon voters approved the “Death With Dignity Act” and the Death with Dignity National Center (DDNC) was born. The DDNC works alongside CID promoting PAS laws in other states.

1997 Dr. Timothy Quill, the lead plaintiff in Quill v. Vacco, challenged laws against PAS as being “unconstitutional.” This case made its way to the U.S. Supreme Court, which ruled against Quill.

1997 After wending its way through court challenges and another popular vote, Oregon’s assisted suicide law took effect—doctors legally began to write prescriptions for suicide.

2003 HS started End of Life Choices, a political action committee, in Denver, CO.

2004 Final Exit Network (FEN) was started by disgruntled former HS and End of Life Choices members, including HS founder Derek Humphry. FEN counsels people on ending their lives and its “exit guides” have attended hundreds of suicides.

1999 Choice in Dying became Partnership for Caring (PFC). PFC managed the Last Acts program.

2004 PFC—tracing its roots back 66 years, through numerous name changes, to the ESA—merged with Last Acts to form Last Acts Partnership, which soon folded. Its assets went to the National Hospice and Palliative Care Organization (NHPCO), the largest organization representing Hospice and Palliative Medicine programs and professionals in the U.S. The President and CEO of NHPCO (2002-2016), J. Donald Schumacher, PsyD, also served as PFC’s Vice-Chair for Public Policy. Thus, the Euthanasia Society of America’s agenda infiltrated Hospice and Palliative Care.

1997 Last Acts, a coalition of more than 100 prominent organizations, funded by the Robert Wood Johnson Foundation, was established purportedly to improve the quality of end-of-life care. (“Improving care” is often code for hastening death.)

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1987 Ellen Jobes—who, according to the testimony of two neurologists, was aware and responsive—died of starvation and dehydration after the NJ Supreme Court upheld lower court rulings that surrogates may refuse medical care without clear evidence of a patient’s wishes. Within a few years, similar court decisions would set “right to die” precedent in a number of other states.

2005 On 3/31, Terri Schiavo died by starvation and dehydration in a Florida hospice after exhaustive efforts by her parents, siblings, disability rights and pro-life groups, and individual concerned citizens failed to overturn a FL judge’s decision. Nevertheless, 33-year-old Nancy Cruzan is starved and dehydrated to death after a lower court found new evidence—an alleged conversation she had 12 years prior—to be “clear and convincing.”

2005 Compassion in Dying (CID) merged in 1990—having renamed themselves Choice in Dying. SRD and CFD—having merged in 1990—describes itself as “working to improve care and expand choice at the end of life,” but its actual efforts have been directed at only one “choice”—suicide. C&C facilitates PAS deaths and vigorously leads campaigns to legalize PAS in state after state along with the DDNC.

2008 14 years after OR legalized PAS, WA became the second state to succumb when voters approved the “Death With Dignity Act.”

2009 The Montana Supreme Court created a defense for a physician charged with assisted suicide, but prosecutions still remain possible in MT.

2010 The U.S. Supreme Court, in its first termination of food and fluids case, Cruzan v. Missouri Department of Health, upheld Missouri’s requirement that there be “clear and convincing evidence” of an incompetent patient’s wishes. Nevertheless, 33-year-old Nancy Cruzan is starved and dehydrated to death after a lower court found new evidence—an alleged conversation she had 12 years prior—to be “clear and convincing.”

2010 The federal “Patient Self-Determination Act”—forcing healthcare providers to promote Living Wills—was enacted. Most states had already enacted Living Will laws. (By 1994, all states would have advance directive laws.)

2011 SRD and CFD—having merged in 1990—renamed themselves Choice in Dying.

1990 The Montana Supreme Court created a defense for a physician charged with assisted suicide, but prosecutions still remain possible in MT.

1993 The “visionary” Dr. Timothy Quill again sought to overturn NY’s law against assisted suicide as a plaintiff in Myers v. Schneiderman—a case initiated by End of Life Choices New York. In September, NY’s highest court, in an unanimous decision, thwarted his vision by finding no constitutional right to assisted suicide: “As to the right asserted here, the State pursues a legitimate purpose in guarding against the risks of mistake and abuse. The State may rationally seek to prevent the distribution of prescriptions for lethal dosages of drugs that could, upon fulfillment, be deliberately or accidentally misused.” Yes, indeed.

2013 The American Academy of Hospice and Palliative Medicine included Dr. Timothy Quill, a board member of the DDNC in Oregon, on a list of “Hospice and Palliative Medicine Visionaries.” Quill, proponent and self-admitted perpetrator of assisted suicide, was celebrated by his HPM peers as a visionary. Frightening!

2013-16 Three more states and the nation’s capital succumbed to the seductive rhetoric of “right to die” activists: VT (2013), CA (2015), CO (2016), Washington, DC (2016). PAS laws are hyped with words like choice, options, control, and dignity, which all sound good for patients. But what these laws really do is protect doctors, like Timothy Quill, who provide lethal drugs to suicidal people with no oversight.

2017 The “right to die” activists: VT (2013), CA (2015), CO (2016), Washington, DC (2016). PAS laws are hyped with words like choice, options, control, and dignity, which all sound good for patients. But what these laws really do is protect doctors, like Timothy Quill, who provide lethal drugs to suicidal people with no oversight.

Rhetoric can be used to convince people of either truth or falsehood. Purveyors of the “right to die” are like the snake oil salesmen of old. These groups all make claims that appeal to the emotions, but that are not backed by facts. They use nice sounding words like rights, compassion, dignity, self-determination, and choice, but every one of them sprang from the Euthanasia Society of America and the Hemlock Society—deadly names for deadly organizations. They know their agenda won’t sell if accurate language is used, so they continually change their names and rhetoric to peddle imposed death.
Hospice and Palliative Care Medicine (HPM) is a field of clinical expertise recognized by the American Board of Medical Specialties since 2006. We treat patients experiencing distress due to diseases that may threaten their lives and certainly burden them with symptoms which cause suffering. While most hospice patients face death within six months to a year, most palliative care patients have chronic life-threatening diseases, but still have viable treatment options offering them many more years of life.

**Different Approaches for Very Different Patients**

Unfortunately, many bioethicists have framed both palliative care and hospice care as ‘end-of-life’ care. HPM’s name and current practice reinforce this commonly accepted view of a single approach to the treatment of two very different kinds of patients. This is misleading and dangerous, especially today when hospice care and palliative care both are liable to be misused to limit treatment and/or hasten death to help rein in healthcare costs.

In palliative care, the HPM specialist’s approach is to help the patient live well as their disease is being treated. Patients with newly diagnosed cancer, heart failure, or early dementia are excellent candidates for palliative care. Here, we focus on easing the patient’s symptoms—pain, depression, constipation, loss of appetite, etc.—caused both by their disease and by the treatment they are receiving. Cancer treatment, for example, may extend the life of a patient and, with expert palliative care, their general well-being is vastly improved. This is clearly not ‘end-of-life’ care.

The goal of hospice care is to alleviate the painful and bothersome symptoms of patients who are dying from progressive, untreatable diseases. Hospice patients choose to forgo further treatment for their underlying diseases. They have determined to live out the remainder of their lives focusing on important relationships with family and friends, yet desire to be comfortable. Hospice is a holistic approach that expertly treats symptoms which cause patients and families distress. Hospice care focuses not on the disease, but on the disease caused by pain and suffering—physical, spiritual, psychological, and even intellectual. It involves a team of care givers trained in these domains. Dying is recognized as a communal event involving family, care givers, and community. Good hospice care prepares the person for death and allows it to occur naturally, never hastening it nor proposing death as a treatment for the suffering person.

**THE PHYSICIAN’S TRADITIONAL ETHICS**

Physicians, until more recent times, have been guided by their twofold oath to “do good” and “never to do harm” to individuals in their care. In this way, the public’s trust in doctors and the medical profession was justifiedly earned. Life, itself, was viewed as a great good, even life plagued by difficulties. Taking a life, for any reason, was taboo. Profound respect for the sanctity of life has always been the core principle of medicine. Is Hospice and Palliative Care Medicine losing its soul?

**The New Bioethics: A Seismic Shift from the Sanctity of Life Ethic**

There are changes being wrought by many elite academicians, including physicians, philosophers and lawyers, who profess that only certain lives are worth saving. What doctors once were trained to think of as an unassailable good—protection of every human life entrusted to their care—is being rejected.

In a clear rejection of the sanctity of life ethic, this new viewpoint—utilitarian bioethics—presents a quality of life approach that divides human life into two categories: “wanted” and “unwanted.” Like their brothers and sisters who are aborted at the beginning of their lives, the chronically ill, disabled, elderly, and mentally ill are seen as nuisances, sometimes even to themselves. The new bioethics has convinced many that the real kindness is to kill.

According to the new bioethics, when applied to certain people, “do no harm” implies further life is harmful and, therefore, killing them is beneficent. In hospice and palliative care settings, the administration of intentionally larger doses of analgesia, beyond what is necessary to diminish pain, is sometimes done to intentionally end patients’ lives. This is not a secret within the medical profession.

In September of 2000, the World Federation of Right to Die Societies (an association of organizations which promote euthanasia throughout the world) issued a declaration, stating in part:

> We wish to draw public attention to the practice of “terminal sedation” or “slow euthanasia” which is performed extensively today...A physician may lawfully administer increasing dosages of regular analgesic and sedating drugs that can hasten someone’s death as long as the declared intention is to ease pain and suffering...Compassionate physicians, without publicly declaring the true intention of their actions, often speed up the dying process in this way.

The arguments employed to justify killing patients encompass a seismic shift in medical ethics. Notice what is happening here: the medical profession (and society, too) is slowly turning away from the traditional sanctity of life ethic toward an arbitrary quality of life ethic.

**Guardrails for Good Medical Care in Hospice and Palliative Care**

The guardrails for good medical care begin and end with physicians’ commitment to treat individual patients according to their needs and the refusal to become agents of the government or other third parties interested in cutting costs and preserving resources. Physicians should be committed to doing the very best for each patient they encounter and directing patient care in cooperation with their patients. This traditional approach was and is based on recognizing the equal moral worth of every human life.

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**By Ralph A. Capone, MD, FACP. Dr. Capone is board-certified in Hospice and Palliative Care Medicine and Internal Medicine. He also teaches Catholic Bioethics at St Vincent College in Latrobe, PA.**
The source of most vital organs (heart, lungs, liver, kidneys and pancreas) for transplantation is patients who have been declared dead. **Are they truly dead?** The answer to this question is crucially important, for, if organ donors are not dead, removal of their vital organs will kill them.

**Donation after brain death (DBD):** The majority of “dead” donors suffer severe head trauma and are determined to be “brain dead.” “Brain death” is defined as the “irreversible cessation of all functions of the entire brain, including the brain stem” [Uniform Determination of Death Act (UDDA)]. However, DBD donors do not meet this standard since they do retain some essential brain functions, for instance, the secretion of hormones by the hypothalamus and certain functions of the brain stem, such as regulation of body temperature. These brain functions, apparently, are simply ignored in the pursuit of organs. Also, some functions of the brain may be only temporarily lost and recover over time, if the patient is given time to recover them. Consider:

- “Brain dead” patients have signs of life – vital signs. They are warm and pink, have a beating heart and blood pressure, and breathe with the support of a ventilator (see How a Ventilator Works, p. 5).
- Their wounds heal, they grow and mature sexually, digest food and excrete waste.
- Many cases of recovery after “brain death” diagnoses have been reported.

In order to determine “brain death,” an **apnea test** is required. The ventilator is turned off for up to 10 minutes to see if the patient will breathe spontaneously. Carbon dioxide increases to toxic levels that can increase brain damage and may even cause death. The apnea test only proves the patient needs a ventilator to assist respiration; it does not prove he is dead.

**Donation after circulatory death (DCD):** DCD allows patients who are ventilator-dependent, but not “brain dead,” to be organ donors. A patient or family agrees to stop life-support and a do not resuscitate (DNR) order is written. Then they consent to organ donation. The patient is removed from the ventilator. The medical team waits until no pulse or breathing can be discerned. A short 2-5 minutes later the patient is pronounced dead and organ removal begins. The definition of death used to justify DCD is the “irreversible cessation of circulatory and respiratory functions” [UDDA].” In DCD, the common meaning of irreversible—“not capable of being reversed”—is abandoned. The intent in DCD is to not attempt reversal by resuscitation, but that does not mean loss of circulation is irreversible nor that the patient is dead yet. Like DBD, DCD requires sleight of hand.

The **Uniform Anatomical Gift Act was revised in 2006 and most states have adopted it.** Everyone who has not explicitly refused to be an organ donor is now considered a “prospective donor.” This means that, if you are “at or near death,” your hospital must notify an Organ Procurement Organization (OPO). While the OPO searches for a “reasonably available” family member or other person who can legally consent or refuse to donate your organs, the medical team can treat you like a donor, subjecting you to medical procedures—not beneficial to you—solely to make certain your organs are in tip-top condition for the potential recipient.

Before organ transplantation was possible, physicians waited long enough to be certain that circulatory and respiratory functions had *irreversibly* ceased. Death was declared only when there were no vital signs—the body was cold, blue and stiff. Today, however, in the haste to procure vital organs before they begin to deteriorate due to loss of circulation, **death is often declared to enable organ transplantation, not to protect the donor from a death-dealing mistake.**

**PROTECT YOURSELF.**

Human Life Alliance (HLA) recommends signing and carrying a “Refusal to be an Organ Donor” wallet card at all times. To request cards, call HLA, **651-484-1040.**

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**CASE IN POINT**

Two-year-old Israel Stinson suffered an asthma attack while being treated at a hospital in Sacramento, California. He was placed on a ventilator and, soon thereafter, declared “brain dead.” Next, he was refused further treatment. Through the work of Life Legal Defense Foundation, as well as other pro-life organizations and individuals, Israel was airlifted to a hospital in Central America where brain scans showed he had active brain waves and did not meet the criteria for “brain death.” There, Israel was provided the medical care and nutrition that he was denied in the US.

Because Israel’s insurance company would not pay for his care overseas, Israel had to be transferred back to the U.S., this time to Southern California. Despite Israel’s improved health and evidence that he was not “brain dead,” the new hospital refused to re-examine Israel, would not permit an independent neurologist to examine him, and upheld the earlier “brain death” diagnosis.

Israel’s parents were in the process of making arrangements to care for their son at home when, despite the desperate pleas of his parents, the hospital withdrew his ventilator, causing him to die.

Numerous cases such as Israel’s show the great need for medical facilities —safe havens— ready and willing to provide life-sustaining treatment to patients who are denied such care against their or their families’ wishes.
“I WAS AFRAID TO LEAVE MY HUSBAND ALONE”

The Hawaii Free Press, February 15, 2011, published this incredible letter from an Oregon resident warning Hawaiians who were considering an assisted suicide bill.

Dear Editor,

When my husband was seriously ill several years ago, I collapsed in a half-exhausted heap in a chair once I got him into the doctor’s office, relieved that we were going to get badly needed help (or so I thought).

To my surprise and horror, during the exam I overheard the doctor giving my husband a sales pitch for assisted suicide. “Think of what it will spare your wife, we need to think of her,” he said as a clincher.

Now, if the doctor had wanted to say, “I don’t see any way I can help you, knowing what I know, and having the skills I have,” that would have been one thing. If he’d wanted to opine that certain treatments weren’t worth it as far as he could see, that would be one thing. But he was tempting my husband to commit suicide. And that is something different.

I was indignant that the doctor was not only trying to decide what was best for David, but also what was supposedly best for me (without even consulting me, no less).

We got a different doctor, and David lived another five years or so. But after that nightmare in the first doctor’s office, and encounters with a “death with dignity” inclined nurse, I was afraid to leave my husband alone again with doctors and nurses, for fear they’d morph from care providers to enemies, with no one around to stop them.

It’s not a good thing, wondering who you can trust in a hospital or clinic. I hope you are spared this in Hawaii.

Sincerely,
Kathryn Judson, Oregon

CASE IN POINT

In October 2014, Brittany Maynard, a beautiful young newlywed who had a brain tumor, announced her decision to commit physician-assisted suicide (PAS) on November 1st. Ms. Maynard and her husband were hoping, by publicizing her suicide, to raise money for the campaign to legalize PAS in every U.S. state. The media leapt on her tragic story, portraying her decision as “heroic,” and counting down the days until she killed herself. In the end, Brittany hesitated, saying, “I still feel good enough and I still have enough joy and I still laugh and smile with my family and friends enough that it doesn’t seem like the right time right now.” Perhaps she was hoping someone would stop her, but no one came to her rescue. Perhaps she didn’t want to disappoint anyone. Whatever the case, Mrs. Maynard took the deadly dose on November 2nd, a day later than she’d pledged.

The World’s GREAT LOSS

“We have to think about resources and you know he will never be able to contribute to society.” This was the response from the doctor when Mary Kellett asked him why she was given false information about her two-day-old son Peter. The false information was that there were no survivors over two weeks old with his condition, trisomy 18. Mary and her husband were advised to stop all treatment, wrap Peter in a blanket, and let him die. Tragically, many, many infants who die in pediatric hospitals do so after life support is withdrawn.

Pressure to have genetic testing and amniocentesis during pregnancy can be intense, even though there are risks of bleeding, infection and/or miscarriage. Abortion is seen by many as the solution for a child who may not be healthy. Many parents don’t know they have the option of continuing their pregnancy because they are not given that choice. There is a false sense of compassion that leads people to think abortion is the answer. The truth is, considering the advances in treatment and care now available, the future has never looked brighter for people with disabilities.

Imposed death by withdrawal of life-sustaining treatment or abortion would undoubtedly not be what the child would choose. Life itself is precious and every person has something good to contribute. Only when we embrace every human being with respect will we see the influence, promise, and potential they have. Until then, denying life to children who are disabled or seriously ill is not only their great loss, it is the world’s great loss.

Peter Kellett was always a great joy and gift to his family. In 2011, at six and a half years old, he went home to heaven. He died under suspicious circumstances while in the hospital following successful surgery to remove his appendix. An independent autopsy found that he bled to death.

Peter inspired the founding of Prenatal Partners for Life (PPFL), a worldwide nonprofit support group for families experiencing an adverse prenatal diagnosis, both before and after their children are born. Families in 47 countries have been helped by PPFL. Peter’s mother Mary, the group’s director, notes, “In the hundreds of families PPFL has supported, I have never heard a mother say she has had too much time with her child.”

INFORMATION:
www.prenatalpartnersforlife.org
Email: mary@prenatalpartnersforlife.org
ADVANCE DIRECTIVES are legal documents by which individuals express their wishes in case they ever become incapable of making health care decisions for themselves. There are two types: the Living Will (also called a Directive to Physicians) and the Durable Power of Attorney for Health Care (DPAHC).

The laws governing these documents permit the withholding or withdrawal of life-sustaining treatment, including food and fluids, even when the intent is to directly cause death. Thus, the wrong kind of advance directive in the wrong hands can be a deadly combination.

Federal regulations require every health facility and program that receives Medicare and Medicaid funds to inform patients about advance directives. Many hospitals and nursing homes offer patients a directive to sign when they are being admitted and are probably under stress and distracted by other paperwork and questions. This is not an ideal circumstance for considering a legal document with life and death consequences. It is wise to arrive with your own carefully prepared directive in hand.

BUT FIRST, YOU NEED TO UNDERSTAND THE SIGNIFICANT DIFFERENCES BETWEEN A LIVING WILL AND A DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

A Living Will (LW) is downright dangerous. It gives an attending physician, very likely someone you do not know, the power to make life and death decisions for you based on their interpretation of the directions in your LW. Real medical crises often involve complicated medical and ethical questions that can’t be foreseen when filling out a LW. Also, the directions you give in a LW, by law, must be followed. Therefore, you may tie the hands of a physician whose skills could restore you to health or save your life.

The wording of a DPAHC is critically important. Also, it must comply with the laws in your state. That is why Human Life Alliance recommends executing a state-specific Protective Medical Decisions Document (PMDD) formulated by the Patients Rights Council. The PMDD gives your “agent” the authority to act on your behalf and take legal action, if necessary, to ensure that your rights are protected. The PMDD clearly states that your “agent” does not have the authority to approve the direct and intentional ending of your life. This limitation not only protects you, but it also protects your “agent” from being subjected to pressure to authorize such actions.

A PMDD is absolutely essential for anyone who is 18 years or older. To be certain that a person you trust will be making medical decisions for you if you become incapacitated by an injury or illness, you must have specifically named that person in a legal document.

Filling out a PMDD takes only a few minutes - a few minutes that may mean the difference between life and death.

INFORMATION:
To obtain a PMDD packet specific to your state, contact the Patients Rights Council, P.O Box 760, Steubenville, OH 43952; 1-800-958-5678.


Beware of DeathWise
Barbara Coombs Lee, President of Compassion & Choices (the organization driving the assisted suicide movement in the U.S.), announced in March 2017 that it has merged with DeathWise. The DeathWise website describes itself as “an organization passionately committed to helping people talk about, make decisions and plan for the end of their lives.” Be very wary of any group that has a “shared mission” with C&C.
Medicare started paying for conversations about “advance care planning” in January 2016. Prompting refusal of medical treatment is the main reason for these discussions with patients in doctors’ offices, hospitals, nursing homes, and even in people’s homes. The goal is to get patients to utilize an insidious “planning” tool called POLST—Physicians Orders for Life-Sustaining Treatment. (POLST has various names and acronyms, such as MOST, COLST, POST, etc.)

The POLST is a brightly colored form with check boxes next to options such as “do not attempt resuscitation,” “comfort interventions only” (another name for hospice), “no medically assisted nutrition/hydration,” etc. There are also options to select the kinds of treatment you do want, but they are just for show. At the top of every POLST form is the statement: “Any section not completed implies full treatment for that section.” Thus, you don’t need a POLST if you want treatment.

Imagine that a kindly nurse or social worker (or some other “POLST facilitator”) sits by your hospital bed discussing “reasonable” treatment choices. She might ask, “Would you want to be kept alive on a machine?” Or, “Would you ever want a feeding tube?” She might very persuasively explain, “When food and water are not given, you will die naturally from your chronic illness. You will not feel hungry, and you will receive good care to make you comfortable.” (This is untrue propaganda). You answer her questions and sign the paper she has filled out. There may be no witnesses, but you have just signed a very powerful advance directive.

POLST only makes sense if a person wants to die without medical treatment the next chance they have to die. It does not matter why you need medical treatment. For instance, you could have a peanut allergy and suddenly be gasping for air. This could be easily remedied, but, if your POLST says “no breathing machine” you will die.

A POLST is no ordinary advance directive. The “facilitator” will present your POLST to a designated health care professional who will sign it. Presto! Your POLST is now a set of medical orders that go into effect immediately. In most states, medical providers are excused from discipline, medical malpractice, or criminal charges as long as they follow the checkboxes on a POLST. They don’t have to make a diagnosis or discuss treatment options with you or your health care agent or family.

RED FLAG: POLST is endorsed by Compassion & Choices, leading promoter of assisted suicide. C&C’s website calls POLST “the strongest, most explicit form of patient directive.” Completing a POLST is always voluntary. It is advisable to firmly state, “I have a health care agent (see Living Wills, p. 13) who will make decisions for me if I am unable to do so. Until such time, I want to discuss my condition and treatment options with my attending physician when decisions need to be made. Please respect my wishes.”

By Sara Buscher, Esq. Ms. Buscher, attorney and CPA, has served the elderly and people with disabilities throughout her professional career.

Julie Grimstad, LPN, Patient Advocate

**INFORMATION:**


In 1984, Mark Davis Pickup, a Canadian, developed degenerative and aggressive multiple sclerosis, after which he shifted much of his energy to working against the legalization of euthanasia and assisted suicide. His articles on life and disability issues are widely published and he speaks wherever he is invited.

Mark states, “I am convinced that, if a society does not embrace the sanctity, dignity, and equality of all human life (and North American society does not), any barbarity is possible. A truly civilized society includes in its tender embrace every human life—every person with a mental or physical disability, those with terminal conditions, derelicts, the old, and people who are not wanted or even loved by anyone. Impossible, you say? Perhaps, but I’m a sucker for hopeless causes. Maybe it comes from having what many consider a hopeless disease. Love is what defines enlightened and civilized society. But love needs the divine. The brotherhood of man needs the Fatherhood of God. Love without God becomes selective, coercive, and arbitrary—turning the lives of the weakest and most vulnerable into hell on earth. Yes, I am convinced that human enlightenment is impossible without God.”
EUTHANASIA AROUND THE WORLD

Most of the western world practices euthanasia in one form or another. In most western nations, “stealth euthanasia” and euthanasia by omission are common (see Definitions, p. 3). In some jurisdictions, euthanasia by lethal injection or self-administered pills (a.k.a. assisted suicide) is legally permitted. At this writing, euthanasia and assisted suicide are legal in the Netherlands, Belgium, Luxembourg, Columbia and Canada. Assisted suicide is legal in five U.S. states and Washington, D.C., Switzerland, and Germany.

Euthanasia advocates often point to Holland, where euthanasia has been practiced longer than in any other country, as an example of how voluntary euthanasia can work without abuse. The facts indicate otherwise.

For many years, euthanasia was practiced in The Netherlands without being codified in law. In 2002, Holland legalized euthanasia and assisted suicide, but only when a patient was terminally ill and suffering from uncontrollable pain—the two conditions most often cited to justify voluntary euthanasia. Now the law applies to people who are not near death—people of all ages with mental illnesses and chronic conditions, infants with disabilities and the elderly with dementia, and even people who are just “tired of living.” This is a perfect example of what is meant by the “slippery slope.” Once a country starts allowing people to be killed, where does it stop? According to the most recently compiled statistics for Holland, in 2015 there were 6,672 deaths by euthanasia, 150 by assisted suicide, and 431 lives were ended “without explicit request” (non-voluntary euthanasia). These were reported deaths. How many more were unreported?

Belgium legalized euthanasia in 2003 and now allows euthanizing people for just about any reason, including loneliness, autism and even fear of blindness or old age.

A growing percentage of people who are euthanized in Belgium, the Netherlands and other countries have treatable physical and psychological disorders.

Quebec legalized assisted suicide in 2015 and six months later all of Canada followed suit. Within a year there were over 1,300 deaths reported as a result. In Switzerland, assisted suicide is permitted as long as no one profits from it. Dignitas provides lethal drugs to people who want to kill themselves. Many Europeans, from countries where anyone assisting a suicide is liable for murder, have travelled to Switzerland to end their lives.

“The legalization of euthanasia and assisted suicide does not give you the ‘right to die.’ It gives another person the right to intentionally and directly cause your death.”

— Alex Schadenberg, Euthanasia Prevention Coalition, http://www.epcc.ca/

CASE IN POINT

England: March 6, 2017, in Great Britain’s House of Lords, during a debate regarding legalizing euthanasia/assisted suicide, Baroness Tanni Grey-Thompson, a Paralympic multiple gold medal winner in wheelchair racing, stated: “After the last debate in the Chamber I was told by a member of the public, as they looked me up and down, that I must have thought about killing myself many times. The answer is a resounding no, but I was shocked. I am resilient, but imagine if you are constantly told that you have no quality of life or you are persuaded that you are worthless. The disability rights campaigner Liz Carr has said that, ‘euthanasia denies the value of people who have illness or disability.’ The noble and learned Lord, Lord Falconer, stated in his commission report that assisted suicide is not meant for disabled people, ‘at this point in time.’ If legislation in this area is passed, I and others like me are merely in the waiting room.”

PROBLEMS WITH LEGALIZATION

The Oregon and Washington laws are a recipe for elder abuse and encourage people with years to live to throw away their lives. In Oregon, there are documented cases of the Oregon Health Plan (Medicaid) steering patients to physician-assisted suicide via coverage incentives. Oregon’s conventional suicide rate has increased with legalization of assisted suicide, which is consistent with a suicide contagion. Patients and families are traumatized.

The Oregon and Washington laws require the death certificate to be falsified to reflect a natural death via a terminal disease, as opposed to the actual cause of death, a lethal dose. The significance is a lack of transparency and an inability to take legal action against overreaching parties.

TRAUMA FOR PATIENTS AND FAMILIES

In 2012, a study was published addressing trauma suffered by people who witnessed a legal assisted suicide in Switzerland. The study found that one out of five family members or friends present at an assisted suicide were traumatized. These people “[E]xperienced full or sub-threshold PTSD (Post Traumatic Stress Disorder) related to the loss of a close person through assisted suicide.”

A PUSH FOR EXPANSION

In Oregon and Washington State, there have been proposals to expand “eligibility” for assisted suicide. The most disturbing was a Seattle Times column casually suggesting euthanasia for people unable to support themselves, which would be non-voluntary or involuntary euthanasia.

INFORMATION:

Excerpted from “Quick Facts about Assisted Suicide” by Margaret Dore, Esq., MBA. For the complete article, see http://www choi-ceilusion.org/2015/12/quick-facts-about-assisted-suicide.html

Since 1994, over 30 states have rejected 200-plus attempts to legalize PAS, recognizing that it is incompatible with the purpose of health care. Also, Washington, DC’s new PAS law may yet be overturned by the U.S. Congress. (Stay informed: subscribe to the PHA Monthly newsletter by emailing feedback@humanlife.org.)