

CHAPTER 26

EUTHANASIA

Qualifying euthanasia by calling it active or passive, direct or indirect, voluntary, nonvoluntary, involuntary, or assisted suicide only confuses the picture.

Euthanasia Is When the Doctor Kills the Patient

Where and when was euthanasia first legalized?

The *original* euthanasia program was to “purify” the German race. It was a creation of physicians, *not* Hitler. He simply allowed the use of the tools others had prepared.

The first gas chamber was designed by professors of psychiatry from 12 major German universities. They selected the patients and watched them die. Then they slowly reduced the “price tag” until the mental hospitals were almost empty.

They were joined by some pediatricians, who began by emptying the institutions for handicapped children in 1939. By 1945, almost 300,000 “pure blood Aryan” Germans had been killed. By then these doctors had so

lowered the price tag that they were killing bed wetters, children with misshapen ears, and those with learning disabilities.

Willke, *Assisted Suicide & Euthanasia*,
Hayes Publishing Co., Cinn, 2001, p. 24

What do you mean “price tag”?

When you take the giant step of placing a price tag on human life, judging that it has only relative value, then you have made a fatal move, for price tags can be marked down. The Nazis marked them down. Holland marked them down. Abortion demonstrated the same thing. Make no mistake, the slippery slope is a startling reality. Recall William L. Shirer who interviewed a Nazi judge condemned to death at Nuremberg. The judge wept saying, “How could it have come to this?” Mr. Shirer responded, “Herr Judge, it came to this the first time you authorized the killing of an innocent life.”

Hitler didn’t start with Jews, then?

No, Hitler, taking his cue from these physicians, after this eugenic killing of “defective” Aryan Germans, then used their gas chambers and proceeded to eliminate “defective” races. He destroyed an entire race of Gypsies, six million Jews, and perhaps almost as many captured Poles, Russians, and central Europeans.

ibid., Chpt. 3

But the program started with sterilization.

That’s true. The first and fundamental law change was the Law for the Prevention of Progeny with Hereditary Diseases, promulgated by Hitler on July 25, 1933. It was aimed at Aryan Germans, and its purpose was to purify the race by eliminating those with supposed heredity diseases. In six years, the law was responsible for the involuntary sterilization of an estimated 375,000 Germans.

W. Deuel, *People Under Hitler*,
New York, 1942, p. 221

This law also legalized abortion for women who were to be sterilized. Later, the “right” to legal abortion was extended to Jews, Poles, Gypsies, and other racial minorities.

ibid., par. 14

But didn’t Hitler oppose abortion?

Wrong! Hitler only opposed abortion for “pure blood” Aryan women. He allowed and even encouraged it for others.

In an order to the SS, SD, and police on June 9, 1943, Reichskommissar Kaltenbrunner directed: “In the case of Eastern female workers, pregnancy may be interrupted, if desired.” First, a racial exam was to be done and then, “If a racially valuable result is to be expected, the abortion is to be denied . . . if not valuable, the abortion is to be granted.”

After the war, the War Crimes Tribunal indicted ten Nazi leaders for “encouraging and compelling abortion,” which it considered a “crime against humanity.”

“Trials of War Criminals,” Nuremberg Military Tribunal, Washington, DC; USGPO, vol. IV, p. 610

You say Holland is now on this slippery slope?

Yes, Holland was the first modern nation to legalize euthanasia. What began as a few extraordinary cases, has now become routine. One hundred and thirty thousand people die each year in Holland, and over 20,000 are killed, directly or indirectly, by doctors. As many as half did not ask to be killed.

These now include newborn infants judged to have too poor a quality of life. A judge has okayed direct euthanasia for a depressed person who was physically well. Assisted suicide has also been allowed for depressed teenagers.

Hospitalized seniors are routinely visited by an organization that offers to oversee their case to prevent their doctor from killing them.

In April, 2001, the Dutch Parliament passed a law that set up qualifications that must be honored before a doctor can kill a patient. These include being of sound mind, a voluntary request, repeated requests to die, uncontrollable pain, “force majeure” (doctor has no other choice), witnesses, and two doctors who agree.

In practice, few of these criteria are even considered. The big one . . . a voluntary request by a rational person repeatedly made . . . has been routinely ignored.

Acquittal After Assisted Suicide, *Brit. Med. Jour.*, 2/7/94
Willke, *Assisted Suicide & Euthanasia*,
Hayes Publishing Co., Cin, 2001, p. 24

Really — involuntary?

“Documented cases of involuntary active euthanasia have been reported by C. I. Dessaur and C.J.C. Rutenfrans, by myself, and others. K. F. Gunning published his experience with the specialists who, when asked to admit an elderly patient to the hospital, advised the general practitioners to administer lethal injections instead. H. W. Hilhorst, in his extensive study (sponsored by Utrecht University and the Royal Dutch Academy of Science), found that involuntary active euthanasia was being practiced in eight hospitals.

“Anxiety is growing among threatened groups. Warnings have been published that elderly patients, out of fear of euthanasia, refuse hospitalization and even refuse to consult doctors. An inquiry among hospital patients showed that many fear their own families may ask for euthanasia without consulting them. The Dutch Patients’ Association placed a warning in the press that, in many hospitals, patients are being killed without their will or knowledge, or the knowledge of their families, and advised the patients and their families to carefully inquire on every step in the treatment, and when in doubt, to consult a reliable expert outside the hospital.”

Over 10,000 Dutch people carry a card in their wallet which says,

“I request that no medical treatment be withheld on the grounds that the future quality of my life will be diminished . . . I request that, under no circumstances, a life-ending treatment be administered.”

R. Fenigsen, “Involuntary Euthanasia in Holland,”

Wall Street Journal, Sept. 30, 1987

ibid., J. Willke,

Nat'l Right to Life News, May 23, 1989

J. Bopp et al., “Euthanasia in Holland,” *Issues in Law and Medicine*,

vol. 4, no. 4, Spring '89 pp. 455-487

What of other countries?

The Northern Territory in Australia in 1995 became the second nation in the late 20th century to pass legislation to legalize euthanasia.

This law was reversed by the federal parliament.

The U.S. State of Oregon passed a law legalizing “assisted suicide.” This became effective in November, 1997. Substantial details of this are available in your author’s book, *Assisted Suicide and Euthanasia, Past and Present*, Hayes Publishing Co., Cincinnati, revised year 2001.

Belgium legalized in 2002.

The courts could legalize?

This is what happened in the Netherlands where euthanasia was routinely practiced for almost two decades until its Parliament finally made it official in 2001.

In the U.S., two cases went to the Supreme Court, *Washington vs. Glucksberg* and *Vacco vs. Quill*. By a 9-0 vote in June 1997, the Court ruled that the federal constitution did not permit assisted suicide or euthanasia. It further ruled that an individual state could legalize, however.

Since then, by referendums, the states of Michigan and Maine have rejected it. In the states of Florida and Alaska, Supreme Courts have rejected it.

But only for the narrow reason of physician-assisted suicide?

Remember how abortion started — only for the most rare and tragic cases? And now 99% of abortions are for social and economic reasons. Plan on euthanasia following the same pattern. It did in Germany. It did in Holland. It'll do the same in other countries.

But I don't want the doctor keeping me alive artificially. Why not a law to permit death with dignity?

Proponents of euthanasia are quick to accuse doctors of not letting a patient die in peace. The typical picture drawn is of an old man strapped in bed, in constant pain, clearly dying. He has tubes in every natural body orifice and in several artificial ones. The doctor is keeping him alive, perhaps to obtain a larger fee, perhaps because the doctor does not want to admit that he has lost the battle for this man's life.

A common observation in a retirement community is, "I don't want to be kept alive with all those tubes and painful and expensive treatments."

Years ago, truly life-saving treatments were limited. Only too often, the physician's role was to comfort and eliminate pain as the patient progressed to an inevitable death. Then, with the advent of antibiotics, better surgery, intensive and coronary care units and new drugs, it became possible to prevent death from occurring. For physicians, there was a learning process, from excesses in keeping dying people alive "too long" to learning how to "let go" and allowing natural death to occur. Today, almost all doctors handle dying patients well. Except in rare cases, the caricature of the old man above is no longer valid.

But what if the pain is uncontrolled?

Pro-euthanasia literature constantly emphasizes pain, uncontrollable pain, constant, intractable pain, unrelieved, agonizing pain. Physical pain, with rare

exceptions, can be controlled. Sound advice, when confronted by a story of a person's loved one being in constant pain, is "Get another doctor." If your doctor doesn't know how to control pain, get one who does.

"The claim that serious physical pain is a valid reason to kill a patient does not hold up."

The second type of pain which is the main reason why people ask to be killed, is emotional pain, loneliness, despair, hopelessness, being unloved, anguish, isolation, loss of dignity, meaninglessness and weariness with life. Remedies for this are less apparent.

Editorial, Karl Singer, *Patient Care*, May 30, '94

Recent drug advances have given doctors long-lasting oral, I.V. pumps and dermal patch forms of morphine which now is the drug of choice for severe cancer pain.

"Contrary to popular belief, patients in severe pain are less likely than other cancer patients to approve of assisted suicide. . . . what they are really interested in is getting rid of their pain, not in dying." This study found that most people who do seek death are depressed, concluding, "There is a conflict between the avowed purpose and the probable practice of euthanasia."

E. Emanuel et al., Cancer Patients With Pain, *Lancet*, 6/29/96

Opposition to assisted suicide is strongest among the frail, elderly, and terminally ill, precisely those most directly affected by the issue.

H. Koenig, "Attitudes of Elderly Patients and Their Families Toward Physician Assisted Suicide," 156 *Arch. Intern Med.* 2240

Opposition is also strong among handicapped groups. One of these, openly opposing assisted suicide, in 1997 organized itself under the title, "Not Dead Yet."

Yes, but I don't want all those tubes in me!

Is the intensive care unit such a frightening, painful

place, that people do not want to return to it? A major study sheds light on this.

Senior patients, previously treated in an intensive care unit, were asked if they would be willing to again undergo treatment in an I.C.U. "if it prolonged your life as perfectly as it could be?" For 10 years? 96% said yes. The percent remained at a very high level when re-asked for 5, 2 and 1 year each, for 6 months and 3 months. 74% still said yes for just one month.

M.Sanis et al., "Patients & Family's Preferences for Medical Intensive Care," JAMA, vol. 260, no. 6, Aug. 12, '88, p. 797

Is life always preferable to death?

One look at this was a study (in the *American Journal of Medicine*, January '96) that asked critically ill patients how many would want CPR (cardio-pulmonary resuscitation) if their hearts stopped. In this survey of 1,664 such patients in five states, 72% wanted to be brought back, 27% said even a coma was preferable to death, and 42% were willing to stay on respirators indefinitely. These patients were in the advanced stages of acute respiratory failure, congestive heart failure, cirrhosis, lung cancer, etc.

R. Russell, Seriously Ill Want CPR, Beth Israel Hosp.,
AMA News, Feb. 26, '96

What about food and water?

To understand, we look at:

Comfort Care

Comfort care consists of TLC, Tender Loving Care. This includes bathing, clean sheets, a warm room, a smile, a bath, proper positioning, pillows, food, water, and other personal care.

Therapeutic Care

This entails the use of drugs, surgery, etc., directed toward curing a disease, repairing an injury, removing a tumor, etc. Such therapy can be divided into usual

and customary, such as administering an antibiotic, splinting a broken bone and removing an appendix, and extraordinary care, such as heart surgery, organ transplants, etc. The caregiver has always been seen as grossly negligent if comfort care is not provided. It is a duty. Extraordinary treatment has never been mandatory and has been judged in the light of many factors.

Mixed Up Priorities

Some have now moved food and water from “comfort care” into “treatment.” If then a decision is made to withhold further “treatment,” food and water can be removed. If the doctor removes therapy, the patient may sometimes die. If the doctor removes food and water, the patient will always die, and painfully. Removing food and water isn’t “letting him die,” it’s “making him die.”

Food and Water?

When a patient is unable to swallow, there are alternate means of giving food and water. Post-operative intravenous fluids and nutrition are, at best, a temporary measure. For a period of weeks, food and water can be given through a naso-gastric tube.

If swallowing is permanently impossible, a gastrostomy tube can be inserted through the abdominal wall into the stomach. This provides a permanent, convenient, painless way of feeding the patient. Euthanasia advocates label the above three methods “artificial feedings.” Rather, these are “artificially administered” feedings. Such tube feedings are clean, inexpensive, efficient and use simple nutritive milk-shakes. There are no soiled sheets or clothing to clean up, and the caregiver knows exactly how much was given.

But what of a terminal condition?

Patients who are dying do go on to die. While the proponents of euthanasia constantly speak about such

cases, these are not their target at all. They are rather concerned about those who somebody thinks ought to die, but who won't . . . the biologically tenacious. Commonly, such people are not in pain, are not on life support systems, but are, by some judgments, a burden to society. These are people with strokes, multiple sclerosis, Lou Gehrig's disease, head injuries, quadriplegia, etc.

Suicide among those with serious handicaps is almost non-existent. It is the "normals" around them who judge their quality of life to be unacceptable, and who want them dead.

With rare exceptions, those who commit suicide are clinically depressed. Clinical depression is usually a biochemical function that can be helped with drug therapy.

W. Peacock in Shewman, *Active Voluntary Euthanasia*,
Issues in Law & Medicine, Winter 1987, pg. 234

But couldn't billions of dollars be saved if we just let terminally ill people die?

In fact, that is what is happening. In a study of 1,150 critically ill patients who died during the study, in only 14% was there an attempt to resuscitate. Twenty years ago most would have been. If all life-prolonging care would be forbidden, it would only save one out of eight dollars spent on health care. Moreover, most of this saving would come from withholding care for relatively young, critically ill patients.

J. Lynn, *Terminally Ill, Forgoing . . . Care*, Dartmouth,
Boston Globe, May 21, 1994

After age 85, Medicare expenses decrease per patient in hospice and in conventional care due to less aggressive care.

"Influence of Age on Medicare Expenses, Care in the Last Year of Life,"
J.A.M.A. 9-19-01, pp. 1349-1355

Are there other reasons to oppose euthanasia?

Yes.

- Doctors are frequently wrong in judging that a patient will die.
- When the only remaining living witnesses are the persons who wanted her dead and the doctor who killed her, who is to confirm that she really did ask to die?
- If society approves euthanasia, how many elders will ask for it so as to no longer burden their loved ones?
- How voluntary is “voluntary”? Doctors and family can pressure a vulnerable patient into requesting death.
- Medical societies oppose it in the U.S. (Vote AMA House of Delegates, June 26, '96) and the Am. college of Physicians, Australia, the World Medical Assn., May '01. In Canada, the CMA, in August, 1995, stated, “Doctors should specifically exclude participation in euthanasia and physician-assisted suicide.”⁶

Toronto Globe and Mail, 8/17/94, pg. A1-3

What about “Living Wills”?

These are misnamed, for they have nothing to do with living and everything to do with dying. Nor are they wills; they are, rather, “directives.” Right to Life agrees that anyone who wants to can sign one, but totally opposes making them binding by law.

Why oppose legally binding “advance directives”?

- The Euthanasia Society started the idea, and that should give us pause.
- Informed consent just cannot be intelligently given in a generic fashion, for an unknown problem, at a future time.
- Legislation is not necessary; we have enough government intervention.
- The patient and family can always get another doctor if the present one seems unsatisfactory.

- A conscious patient can always refuse treatment.
- Many patients change their minds. With a signed document that is legally binding, it may be too late.
- What does “terminally ill,” or “artificial means,” or “heroic measures,” or “meaningful,” or “reasonable expectation” mean? These definitions change with time and are different in each case.

The Euthanasia Society started these wills?

Yes. The Euthanasia Society and its Foundation have since changed their names to The Society for the Right to Die, which then changed its name to The Society for Concern for Dying. They all have been headquartered at 250 W. 57th St., New York, NY 10019. On the Euthanasia Society’s advisory council as a founding member is Abigail Van Buren, the “Dear Abby” newspaper columnist, who constantly pushes these misnamed “living wills.”

Before his death, Dr. Alan Guttmacher, head of Planned Parenthood World Population, was also a prominent member of the Board of the Euthanasia Society of America.

But what if I’ve made up my mind?

What a person says at the church social, or even in a doctor’s office, is not necessarily what that same patient will say when actually confronted with the possibility of dying. Life, however limited it may become, is a good that most people cling to as long as they can. If you do honor their request, be sure to honor the most recent one, not one casually uttered years earlier.

There is an analogy to abortion?

Yes, they both kill living humans. They both are done for the same reasons.

REASON	ABORTION	EUTHANASIA
Usefulness	a burden	a burden
Wanted	unwanted	unwanted
Degree of perfection	handicapped	handicapped
Age	too young	too old
Intelligence	not yet conscious	not really conscious anymore
Place of residence	in the womb	in a nursing home
“Meaningful life”	“does not yet have” <i>Roe vs. Wade</i>	“no longer has” Euthanasia Bills
Cost	too poor	too poor
Numbers	too many children	too many old folks
Marital Status	unmarried	widowed

Is there an alternative to euthanasia?

The real alternative to euthanasia is to provide loving, competent care for the dying. A new concept for the dying arose in England, where institutions called Hospices specialize in compassionate, skilled care of the dying. This concept has spread throughout the Western world.

“Once a patient feels welcome and not a burden to others, once his pain is controlled and other symptoms have been at least reduced to manageable proportions, then the cry for euthanasia disappears. It is not that the question of euthanasia is right or wrong, desirable or repugnant, practical or unworkable. It is just that it is irrelevant. Proper care is the alternative to it and can be made universally available as soon as there is adequate instruction of medical students in a teaching hospital. If we fail in this duty to care, let us not turn to the politicians asking them to extricate us from this mess.”

R. Lamerton, *Care of the Dying*
Priority Press Ltd., 1973, p. 99

I've heard that many doctors are ignoring present laws and assisting at suicide now. Wouldn't it be better to legalize it, along with specific safeguards?

What makes a person think that if a doctor will today disobey the law and commit a felony, that he or she will obey future restrictions when a violation is only a misdemeanor?

So you don't think assisted suicide can be controlled?

No. In Britain, the House of Lords Select Committee on Medical Ethics examined this in detail. That committee, going in, was solidly prepared to accept euthanasia. They went to Holland and investigated it actually happening. They reversed their thinking completely saying that they "do not think it is possible to set secure limits." They found "evidence indicating that non-voluntary euthanasia was commonly performed. Vulnerable people — the elderly, the lonely, sick and distressed — feel pressured to request early death. . . . under this, the interest of the individual cannot be separated from the interest of society . . ."

R. Twycross, *Journal Royal Society of Medicine*,
Vol, 89, 1996, pg. 61-63

Shouldn't those in persistent vegetative states (PVS) be given a release and allowed to die?

Not unless you want to kill some people who are going to get better, if given enough time. Dr. Kay Andrews, Director of the Royal Hospital for Neuro-Disability, stated, "Over a two-year period, 15 out of 18 patients, thought to be in PVS, came around."

Sunday Telegraph, Feb. 11, 1996

And sometimes patients who have been in "vegetative" states for a long time wake up, e.g., following an anesthetic accident seven years earlier, the health authority in the north of England had discussed applying

to the courts to remove a patient's feeding — but — after those seven years he woke up and was “competent enough to indicate his refusal to be interviewed.”

Guardian (newspaper London), March 16, 1996

And many are aware. In a British study of 40 patients diagnosed as PVS, 17, or 43%, were later found to be alert, aware and often able to express simple wishes. This vital consciousness in their closed-in state, for some, lasted several years.

K. Andrews et al., *Brit. Med. Jour.*, 7/6/96

A PLEA TO LAWMAKERS

In the event that you do take the tragic step of legalizing euthanasia, please do not have a doctor do it. Rather, hire a professional executioner. For over 2000 years people have trusted their doctor to “do no harm.” This trust has been seriously undermined by legal abortion. Please do not complete the destruction of this trust and confidence.

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