

## ASSISTED-SUICIDE AND EUTHANASIA

# Final Right or Ultimate Assault?

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Text of the Red Mass Homily • January 20, 2005, Cathedral of Our Lady of Peace, Honolulu

**W**e pray in earnest that the Holy Spirit's gifts of wisdom, prudence, and courage be showered generously upon all of you who have been vested with responsibility for serving the common good. Today we continue a tradition of the Catholic Church in Hawaii that at the opening of the State Legislature we gather in prayer for our public servants. And we know that prayer is needed. Public service has never been more challenging than in these times. Fiercely competing values and interests, incredibly complicated problems and issues, combined with a fast-and-furious mix of mind-boggling media, make your task such that Solomon, all his wisdom notwithstanding, would run the other way. But you don't. On behalf of our Catholic community, we thank you for accepting with honor and dignity the office entrusted to each of you. And before all else, please know of both our sincere gratitude and our prayers for you.

The Catholic community is as diverse as it is large. Virtually every culture, language, profession, and age is represented in the more than 230,000 Catholics in Hawaii. Almost one out of every five persons in Hawaii is Catholic. And over 65,000 of us gather at nearly 100 places of worship across the islands every single Sunday - and a lot more on Christmas and Easter! Our politics are diverse, as we struggle with putting our faith into action, justice into public policy, and compassion into life. The vast majority take our faith and our values seriously, even if we fall short more often than we would like to admit. The church does not exist for saints. We, all of us, are sinners.

But today we do not assemble just as Catholics. We gather from different religious beliefs, and for some, no religious belief. Yet, by our presence here, we acknowledge our common bonds of humanity, life and community. The sacred texts which we have just heard, coming from both the Hebrew Scriptures and Christian Scriptures<sup>1</sup>, remind us of the precious gift of life, which comes from God. Each of us is infinitely precious, gifted with the capacity to carry the very Spirit of God, to be His temple. John's Gospel communicates the Christian's fundamental belief that, by following Christ and His example, we discover the full abundance of life and joy. Even for those who do not embrace Christianity, these words about the uniqueness of the human person and our desire for the abundance of life, are appealing and represent a common ground.

It is in this context of the value of human life and community that today I address a very important and sensitive matter of public concern, physician-assisted suicide. In

1997 Oregon became the first state in the union to legalize physician-assisted suicide. In 1998 the Hawaii Governor's Blue Ribbon Panel on Living and Dying with Dignity, recommended the legalization of both physician-assisted suicide and euthanasia. Over the last several years, a small group of advocates has promoted assisted suicide in our state legislature. They come with good intentions. They argue that suicide can eliminate the pain, the dependency and the high cost of dying. They reason that suicide will bring dignity to an undignified process, hence the title of their bill.

I would argue that their pursuit of compassion is misguided. Every human person's dignity is indelible. Death, a natural passing we all must endure, cannot strip us of dignity. That is simply not possible. We may imagine a loss of dignity because of the judgment of others or a diminished perception of ourselves. But that is an illusion. Our worth is inherent, our humanity permanent. Society's task is to acknowledge our dignity and treat us accordingly.

The Catholic Church stands in strong and unqualified opposition to the legalization of physician-assisted suicide and euthanasia. But we are hardly alone. The Hawaii Medical Association, the American Medical Association, the American College of Physicians, the American Geriatrics Society, the Healthcare Association of Hawaii, the Hawaii Nurses Association, Not Dead Yet (a Disability Rights Organization), and the Hawaii Cancer Pain Initiative, are just some of the local and national groups who oppose the legalization of assisted suicide. Add to these private organi-

zations the state of New York. Its Task Force on Life and the Law, after ten years of vigorous and thorough study, opposed assisted suicide.

**T**he U.S. Supreme Court ruled unanimously in two cases in 1997 that there is no constitutional right to physician-assisted suicide.<sup>2</sup> The highest court of the land made two, among many notable, points. First, the community needs to be very concerned about the protection of “vulnerable groups ... from abuse, neglect and mistakes” (Glucksberg at 731). For such groups of people, there is, in the words of the court, a “real risk of subtle coercion” (Glucksberg at 732). Second, the court warned of the proverbial “slippery slope” (Glucksberg at 732). Individual laws and acts cannot be considered in isolation, but must be seen in terms of the direction they might lead. In other words, today assisted suicide; tomorrow voluntary and maybe even involuntary euthanasia. And this same court directly cited the clear and indisputable evidence of such abuse in the Netherlands, where assisted suicide has been tolerated for decades and legal since 2002. In fact, in the Netherlands, the slippery slope has reached a new low. Dutch law already allows physicians to euthanize terminally ill patients, over age 12. The Groningen Protocol of 2004 proposes allowing physicians to euthanize newborn babies and persons with severe mental retardation.<sup>3</sup> The fact is, there is no longer a slope; it’s a precipice and the Netherlands has gone over the edge.

What about Oregon? Advocates of assisted suicide have held up Oregon’s assisted suicide law and healthcare system as the model to follow. In reality, Oregon is an unfolding chaos. Some examples. While Oregon’s medical care program pays for assisted suicide, it denies payment on more than 150 important medical services for the poor. It even puts a \$1,000 cap on hospice care. Advocates have said that legalizing assisted suicide would improve palliative care, hospice availability, and end-of-life care in general. This has not happened. “Last Acts,” a national coalition of a thousand organizations committed to the improvement of end-of-life care, gave Oregon failing grades in a number of areas. Only 39 percent of hospitals in Oregon offer hospice programs and only 20 percent report palliative care programs.<sup>4</sup> To make matters worse, a 2004 study in the *Journal of Palliative Medicine* revealed an increase in pain and distress among the dying in Oregon from 31 percent to 48 percent since the state legalized assisted suicide.<sup>5</sup> The study indicates that those dying in Oregon are “approximately twice as likely [as before the law was passed] to be reported to be in moderate or severe pain or distress during the last week of their lives.”

In 2003, Oregon reported 42 deaths under the assisted suicide law out of a total population of approximately 3.6 million. Based on a Hawaii population of almost 1.3 million, that translates to about 15 people. So here’s the situation: Every major medical association, the disabilities rights associations, the most comprehensive State study on assisted suicide, and the highest court in the land have is-

sued words of warning and alarm. In addition, the grim reality of the Netherlands and a growing body of disturbing data from Oregon, both point in the direction of “danger.” And yet, some in our community want our Hawaii State Legislature to consider changing the law for 15 people. Please, please, we must think about this. The burden of proof for legalizing assisted suicide sits squarely with the advocates for change, not with those who wish to preserve existing law and improve end-of-life care. How can we even think of endangering thousands of our elderly for 15 people? It is not only extremely risky, as the U.S. Supreme Court has written, it defies every criteria of good public policy by endangering the common good.

This debate is not about rights. The U.S. Supreme Court has already determined that there is no constitutional right to assisted suicide. People can already commit suicide — not that we recommend it. In fact, as a community we do everything we can to prevent people from doing so. Suicide by a doctor’s assistance is an assault on four critical relationships: (1) the physician-patient relationship; (2) family relationships; (3) the relationship of society to its most vulnerable members; and (4) the relationship of the healthy to the dying as expressed in authentic end-of-life care. I will address each of these four relationships in turn.

**F**irst, let’s examine the impact of legal assisted suicide on the physician-patient relationship. Legalization of assisted suicide gives a new right to physicians, not to patients. And, frankly, it’s a right that most physicians do not want. The power that physicians exercise over patients is tremendous and real. Once the line between healer and executioner is blurred, the doors to the abuse of power will be flung wide open and the patient’s confidence and trust in his or her physician will inexorably be diminished if not lost. Add the growing pressure of escalating healthcare costs, and patient confidence will deteriorate further. And lurking in the background are the very real thoughts of a few radical purveyors of physician-assisted suicide. Derek Humphrey, founder of the Hemlock Society, described senior citizens as “greedy geezers” and admitted that the main drive for assisted suicide and euthanasia really is “cost containment.”<sup>6</sup> After all, the “suicide prescription” is only \$50. Palliative care and the diagnosis and treatment of depression, for example, take real skill, training, time and money. It takes no skill to write a “suicide prescription.” No wonder the elderly in the Netherlands worry about going to the doctor or staying in a nursing home. Some even carry cards saying, “don’t euthanize me.”<sup>7</sup>

It is revealing to note that in Oregon, close to 80 percent of those who have died under the assisted suicide law received prescriptions from physicians who publicly support assisted suicide. In other words, in their last days the vast majority of patients had doctors procured for their willingness to prescribe death than provide end-of-life care. The median length of these physician-patient relationships was 13 weeks. Twenty-five percent of them existed less than a month. These ultimate life decisions were hardly ones

made between a patient and a caring personal physician.

Second, let's look at how assisted suicide damages family relationships. Family is so important to us in Hawaii. We have a special respect for the elderly and the sick. If assisted suicide is legalized, family dynamics will change. For the elderly, a strange, perhaps subtle, new pressure will emerge to justify hastening the death of the dying person. Is not the dying person a burden on the family? Is she not an enormous financial drain? An exhausting emotional hardship? Would not the right "choice" be to move things along? Now, those around the dying person have the option of stepping up the inevitable. Good families already find it difficult to agree on "do not resuscitate" orders. Can you imagine a discussion about assisted suicide? Let's face it, many family situations are less than ideal, making the dying person even more vulnerable. As psychologist Sidney Callahan has written: "Once the taboo against taking life is breached, individuals and their families would be subject to disturbing pressures and wrenching negotiations."<sup>8</sup>

Imagine for a moment that your elderly mother is diagnosed with terminal cancer. You take her into your home to care for her as her condition worsens. Over the weeks of care, she expresses concerns about being a burden on you and your family. You assure her she is no burden, that it is a joy to care for her just as for so many years she cared for you as a child and for your own children. But she is all too aware of how difficult it can be and she becomes increasingly depressed. Two weeks later, you come home to discover your mother dead, with a suicide prescription on her nightstand, written by a doctor you have never heard of. You and your family are devastated. Her longtime physician of over 40 years tells you that she had asked him for a suicide prescription, but he had refused. Likewise, she refused his urging to see a psychiatrist for evaluation and treatment. You contact the suicide physician, whom she had known for only a few weeks, and he refuses to discuss the case citing "confidentiality." Imagine the scenario, imagine the devastation to the family: your kids didn't get the chance to say goodbye, your aunts never got the opportunity to hold her hand one more time, and you didn't get to simply say, "I love you."

**T**hird, what about the relationship of society to the vulnerable, including the disabled and those suffering from depression? We must listen to disability rights groups that overwhelmingly oppose assisted suicide. They tell us that when people are first disabled, they are often diagnosed as terminally ill, and frequently and understandably get very depressed. Then there is an adjustment period and their attitudes change. The concern of advocates for the disabled is that, if the depression is not diagnosed, the real plea for help will be interpreted as a request for suicide. The reality of depression in the realm of an established suicide option is a prescription for tragedy.

Several horrific cases have already emerged in Oregon. Consider the case of 85-year-old cancer patient Kate Cheney.<sup>9</sup> She requested assisted suicide, but her doctor

had doubts about her mental competency and referred her to a psychiatrist. The psychiatrist, also concerned about her competency and the pressure from her daughter who wanted her mother to commit suicide, refused to write a suicide prescription. Cheney accepted the psychiatrist's decision, but her daughter did not. A psychologist, brought in for a second opinion, also worried about family pressure influencing Cheney's decision. He, however, approved the lethal prescription. The final approval came from the HMO administrator who determined Cheney was competent. Cheney vacillated but eventually swallowed the pills. This case was clearly tainted by the shopping around for an agreeable physician, by family pressure, and by an HMO director's conflict of interest. But, perhaps most disturbing of all, none of these abuses was documented in the official Oregon state reports.

**T**he case of Michael Freeland may be even more alarming. Freeland, having been diagnosed with lung cancer, requested and received a suicide prescription from a suicide advocate physician. When six months passed and Freeland had not yet passed away from his illness, his doctor actually had the lethal prescription refilled. So much for the requirement that the patient have less than 6 months to live.

More than a year after obtaining the first prescription, Freeland was admitted to a psychiatric facility and treated for depression and suicidal tendencies. Despite the fact that his psychiatrist wrote to the court that his patient was not competent, and that he even required a guardian, and despite having the 32 guns and ammo in his house removed, Freeland was allowed to keep his suicide prescription. Long story short, eventually volunteers from anti-assisted suicide group, Physicians for Compassionate Care, assisted him, treating his depression and other symptoms. In time he died a good death, a natural death with compassionate palliative care some two years after having received the first suicide prescription.

Conclusion: Freeland was victim of a wrong prognosis, a suicide physician who violated the law by giving the refill, and a state that treated depression and incompetence with a lethal prescription. And while all of this is documented in his medical record and in court documents, there is no mention of these unambiguous abuses in the Oregon Department of Human Services report.

Ladies and gentlemen, the Oregon safeguards are an illusion. They do not work. This should not be surprising. The Oregon law has no peer review. Physicians are only required to show good intent. They cannot be prosecuted for a misdiagnosis or a botched suicide. Psychiatric evaluation, to determine competency, is not required and in fact, happens only 13 percent of the time. Even the recording process is misleading. The law makes it AGAINST the law to state death by assisted suicide on the death certificate. It must say death by a terminal illness. If we couldn't keep Jack Kevorkian from practicing assisted suicide when it was illegal, how can we expect it to be kept free from abuse and errors when it IS legal?

As I have demonstrated, physician-assisted suicide corrupts vital, sustaining, age-old relationships - between patient and doctor, between family members, and between society and its ill members. Finally, assisted suicide irreparably damages authentic end-of-life care. In the country that champions this practice, the Netherlands, there are only three hospice facilities — the same number there are on Oahu alone. There, palliative medicine and research has been largely marginalized and stifled. In Oregon, studies are already reporting the inadequacy of palliative interventions. In one review of 1999 statistics, 18 of 29 patients for whom data were available, nearly two-thirds, received suicide prescriptions without palliative intervention. Nine out of 17 died without such intervention.<sup>10</sup> According to the “Last Acts” report cited earlier, Oregon has the lowest possible grade for hospitals providing palliative care. The most recent data, released last October, show medical services access in Oregon is a growing problem, especially for the poor. Some 60 percent of primary care physicians, for example, limit or refuse to see Medicaid patients, primarily for economic reasons.<sup>11</sup> But the Oregon plan does cover assisted suicide for the poor. In short, if you are looking for a model for end-of-life care, stay clear of the Netherlands and Oregon.

The sad part, the ironic part, about this whole situation is that palliative medicine has made such incredible strides in recent years. Although surveys show that people still fear dying with pain, technological advancements in treatment have virtually eliminated that reality. Dr Linda Emanuel makes the point succinctly, “I simply have never seen a case nor heard of a colleague’s case where it (physician-assisted suicide) was necessary. If there is such a request, it is always — and I repeat, always — dropped when quality care is rendered.”<sup>12</sup>

That leads to my final point.

**Y**es, we must provide quality end-of-life care. And in this respect, there is still much to do. The science is available, but not always accessible. The care is possible, but not always offered. But first the good news. Here in Hawaii, thanks to our Hawaii state legislators, we have an excellent law on advance directives and surrogate health care decision-making — the Uniform Health Care Decisions Act of 1999. Patients can make important decisions, such as the withdrawing and withholding of artificial nutrition and hydration, as well as other treatments. The days of dying hooked up to machines unnecessarily are long gone. Other crucial legislation passed in 1999 made hospice care more accessible and more affordable. In 2002, the Hawaii Cancer Pain Initiative worked with the Narcotic Enforcement Division to pass legislation which ensured much more effective and aggressive pain management. As a result, Hawaii is number one in the nation for effective pain management in hospitals. But more needs to be done. And this is where legislative effort should be focused. We need more palliative care physicians. We need more palliative care nurses. Nursing homes need better

pain management programs. Hospice programs, especially home-based programs, need to be expanded. And much more public education needs to be done so that our citizens know what programs are available to help them manage their healthcare choices and options.

The legalization of assisted suicide, as I have demonstrated, is an assault on four critical relationships: (1) between physician and patient; (2) between members of families; (3) between society and its most vulnerable members; and (4) between the healthy and the dying as expressed in authentic end-of-life care. Legalization of assisted suicide is bad public policy. It undermines the critical societal relationships that public policy should support. It destroys crucial communal bonds that public servants should preserve and protect.

**W**hen it comes to end-of-life care, Oregon, like the Netherlands, is not a leader but an unfortunate aberration. In the eight years since it legalized assisted suicide, many more states, rather than follow suit, have strengthened their laws against the practice. They have recognized the destructive forces introduced in the Netherlands and in Oregon and have taken steps to protect the vulnerable and simultaneously improve end-of-life care. They have wisely heeded the advice of former surgeon general C. Everett Koop: “Let those who seek death with dignity beware, lest they lose life with dignity in the process.”

We in Hawaii have an opportunity to show the world what aloha really means. Let us support the family. Let us protect the vulnerable. Let us treat our elderly with dignity and our dying with compassion. Let us expand authentic palliative care. Let us instruct our physicians and healthcare professionals in more effective end-of-life treatment. Let us make hospice more widely accessible.

If we do all this - if we do not succumb to the fraudulent reasoning that would have us treat our dying citizens with the proposition of self-destruction - then each of us will be more fully human for having truly cared for one another.

1 Deuteronomy 30:19-20; 32:39; 1 Corinthians 6:15, 17-20; and, John 10:9-10

2 *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997).

3 Sterling, Toby. “Netherlands Hospital Euthanizes Babies.” Associated Press, November 30, 2004.

4 “Means to a Better End: A Report on Dying in America Today.” Last Acts, 2002. <http://www.rwjf.org/news/special/meansReport.pdf>.

5 Fromme et al., “Increased Family Reports of Pain or Distress in Dying Oregonians: 1996 to 2002,” vol. 7 *Journal of Palliative Medicine* 431-442 (June 2004).

6 Derek Humphrey and Mary Clement. “Freedom to Die: People, Politics and the Right-to-Die Movement.” St. Martin’s Press, April 2000.

7 The *Levenswensverklaringen* (Declarations of the Will to Live) have been printed and distributed by two associations in Holland since 1985.

8 Sidney Callahan. “A Time to Live, A Time To Die.” *Sojourners Magazine*, September-October 1997.

9 See the summary discussion of both the Cheney and Freeland cases in N. Gregory Hamilton, MD. “Testimony to the Select Committee on the Assisted Dying for the Terminally Ill Bill.” House of Lords, 10 December 2004.

10 Herbert Hendin and Kathleen Foley. “The Case Against Assisted Suicide: For the Right to End-Of-Life Care.” Johns Hopkins University Press (2002). 144, 153-54.

11 “2004 Workforce Survey Shows Patient Access to Physicians a Growing Problem.” Oregon Medical Association Press Release, October 26, 2004.

12 Linda Emanuel, M.D., Ph.D., director of the American Medical Association’s Institute on Ethics, as published in “The New Pro-Lifers,” *The New York Times Magazine*, July 21, 1996.