

A matter of life and death: Defeating the Push for Doctor-Prescribed Suicide Historical, Ethical and Practical Considerations

Introduction

- A. I'm very happy to have the chance to return to Harvard, where 20 years ago this spring I participated in commencement and "began" using the education and experiences I gained here to serve others. During my undergraduate days I was always very conscious of Harvard's original motto, "Veritas: Christo et ecclesiae," that here there was not merely a search for truth but a recognition that the truth existed and that we were called to live and proclaim the truth for Christ, for the church widely understood and for the good of others. To proclaim that there is a truth is, both historically and actually, not only to challenge a moral and epistemological relativism, but also a clear indication that there also exists not falsities, fabrications, and lies. Harvard was founded so that in various disciplines people would seek the truth, find the truth, live the truth, teach the truth and defend the truth and it's real worth will always depend not on the billions it hands in its endowment, not on its impressive elenchus of alumni, not on the tens of thousands of top students that apply to each incoming class, but on how it continues to advance this essential relationship with the truth. Since its founding Harvard's supreme value has been the truth and it not only needs to be graded but its service to society as a whole needs to be measured above all by its service of the truth, especially the truth about the human person and the person's integral good.
- B. When I was here two decades ago, there was a string of suicides at the safe school located near Kenmore Square. The death of a young peer is always somewhat startling, even if you didn't know him or her, but when there were multiple ones, including those jumping off the top of towers, it hits everyone, as you begin more carefully to examine how you and how your roommates and fellow students are handling things like stress, academic pressure, depression, breakups, and more. I remember one dinner time conversation with a diverse group of students at Mather House — radicals and conservatives, males and females, seniors and sophomores, biochemists and French literature concentrators, religious and atheists — and everyone agreed that the suicide of these MIT students was a tragedy. It was a tragedy not merely because they were at a great school and the students had wasted a great future, but it was a tragedy because any time someone leaped from the top of a tower there was a failure to appreciate the fundamental goodness of life, a failure to grasp how one's death would impact others, a failure to avail oneself of support structures and friendships, a failure all the way around.
- C. Suicide is always a tragedy. It's never a dignified way to die. Most in our society readily understand that when someone is contemplating suicide at any age of life, he or she is normally suffering from a depression triggered by very real setbacks and serious disappointments and sees death as the only path to relief. The psychological professions know that people with such temptations need help to be freed not from life but from these suicidal thoughts through counseling, support, and when necessary, medication. The compassionate response to teenagers experiencing a crushing breakup, to unemployed fathers overwhelmed by pressure, to unhappy actresses feeling alone and abandoned, to middle-aged men devastated by scandalous revelations, is never to catalyze their suicide. Heroic police and firemen climb bridges or go out on the ledges of skyscrapers for a reason. Dedicated volunteers staff Samaritan hotlines around the clock for a reason. This same type of care and attention needs to be given by a just and compassionate society to suffering seniors or others with serious illnesses.
- D. We're now living at a time in which this clear truth isn't seen by all and where some are advancing that suicide, rather than a tragedy, is actually a good, moral, rational and dignified choice. A year ago, if you were exiting the Callahan Tunnel in East Boston, you would have been confronted with a billboard paid for by the Final Exit Network, with white letters against a black background proclaiming, "Irreversible illness? Unbearable suffering? Die with Dignity." To die with dignity, the billboard advanced, was to commit suicide with the help of a doctor. We would never tolerate a similar sign in Harvard Square, "Failing your courses? Unbearable heartbreak? Feel like the "one mistake" the Admissions Office made? End your Harvard career

with dignity. Take your life.” We would know that preying on the emotionally down and vulnerable is never an act of compassion but what John Paul II called a perversion of mercy.

- E. Yet, in Massachusetts, we now have a Citizens Initiative Petition called the Death with Dignity Act that seems to be headed to the ballot this November that will legalize suicide for a class of citizens not against the wishes and interventions of medical personnel committed to helping them physically and psychologically but with the active cooperation of doctors prescribing lethal overdoses of drugs. Such attempts to legalize physician-assisted suicide have been introduced here in Massachusetts and been rebuffed in 1995, 1997, 2009 and 2010, but this year seems to be the best chance for proponents of euthanasia to achieve their objective of making Massachusetts the East Coast Oregon and the North American Netherlands. A recent poll showed that support for the measure is ahead of the opposition 43-37 percent. So there is much work to do and much at stake. It’s literally a matter of life and death. Whether we become active in the fight against doctor prescribed suicide may make the difference between lives being saved or tragically ended.
- F. So tonight, in the brief time we have, I’d like briefly to do several things.
 1. Describe the cultural background for this push for doctor prescribed death.
 2. Next, I’d like to touch on Church teaching, in order to strengthen us in our conviction as believers.
 3. Third, I’d like to focus on the Death with Dignity Act, and what the problems with it are even from an agnostic, commonsensical point of view, to equip us with arguments that will meet citizens where they’re at, regardless of their belief in the dignity of every human life and that intrinsic evil of suicide.
 4. Lastly, I’d like to describe what we’re being called to do now, as Catholics, as Harvard students and alumni, simply as truly compassionate human beings.

I The Cultural Context

- A. The push for physician assisted suicide isn’t coming out of a vacuum. It’s a natural consequence of several factors that we need to be aware of if we are going to be able to persuade those who may unwisely be prone to support it.
- B. A great fear of suffering and death and a desire to control it
 1. Pope John Paul II pointed this out in his 1995 encyclical *The Gospel of Life* (64): “The prevailing tendency is to value life only to the extent that it brings pleasure and well-being; suffering seems like an unbearable setback, something from which one must be freed at all costs. Death is considered "senseless" if it suddenly interrupts a life still open to a future of new and interesting experiences. But it becomes a "rightful liberation" once life is held to be no longer meaningful because it is filled with pain and inexorably doomed to even greater suffering.
 2. USCCB 2011 document “To Live Each Day with Dignity,” said: “Today, however, many people fear the dying process. They are afraid of being kept alive past life’s natural limits by burdensome medical technology. They fear experiencing intolerable pain and suffering, losing control over bodily functions, or lingering with severe dementia. They worry about being abandoned or becoming a burden on others.”
- C. An exaggerated notion of personal autonomy or selfish individualism
 1. There is a notion that no one can tell me what is good for me.
 2. EV 64: When he denies or neglects his fundamental relationship to God, man thinks he is his own rule and measure, with the right to demand that society should guarantee him the ways and means of deciding what to do with his life in full and complete autonomy. It is especially people in the developed countries who act in this way.
 3. There’s a distinction to be made between a healthy individualism and an exaggerated one that excludes any real sense of duties owed to family members, to society, to others. Almost all the justifications for legalizing physician assisted suicide focus primarily on the dying person who wants it. Its harmful impact on society and its values and institutions are ignored.
 4. Euthanasia, we have to remember, is not a private act of “self determination,” or a matter of managing one’s personal affairs. As Cardinal O’Malley wrote back in 2000 in a pastoral letter on life as Bishop of the Diocese of Fall River, “It is a social decision: A decision that involves the person to be killed, the doctor doing the killing, and the complicity of a society that condones the killing.”
 5. (Rita Marker, *an attorney and executive director of the International Task Force on Euthanasia and Assisted Suicide*) If personal autonomy is the basis for permitting assisted suicide, why would a person only have personal autonomy when diagnosed (or misdiagnosed) as having a terminal condition?

6. If assisted suicide is proclaimed by force of law to be a good solution to the problem of human suffering, then isn't it both unreasonable and cruel to limit it to the dying?
- D. A legal positivism that believes that there are no universal moral norms, but just the values we impose, either by courts and legislatures or ballot petitions.
1. In yesteryear, the debate over euthanasia would take place within the context of moral and religious coordinates. No longer. There ceases to be common reference to anything higher than the debates that occur in the "secular cathedrals" of courthouses and legislatures. Believers have often abetted this secularization of discourse by allowing secularists to drive religious and moral values from normal discourse so that the public square becomes "naked" and our sacred scripture becomes court opinions and our prophets become the talking heads in the media.
- E. Materialism and consumerism
1. Our society has lost a sense of the sacred, of mystery of the soul. The body is looked at just as a machine and human life as a whole has become two dimensional. This abets the push for euthanasia because ideas that there is meaning in suffering, even in death, seems like outdated ideas and that we should treat these fundamental human realities of suffering and death the way we do cars, or pets, or other things that begin to break down. We dispose of them once their usefulness is no longer apparent.
- F. An anthropology based on scientific and mechanistic rationalism
1. Our scientific and medical progress, among other things in being able to produce life in test tubes and other practices, has led us to believe that if we can "create" life we should be able to manipulate it and end it, because life has lost its sense of mystery and its connection to a creator beyond us. We become what the raw material of human life becomes with time. We no longer are seen to be special in comparison with animals or robots. If we can euthanize our suffering pets, we should, so says Princeton's Peter Singer, be able to euthanize human beings and allow them to end their own lives.
- G. A misunderstanding of human dignity
1. American political scientist Diana Schaub says "we no longer agree about the content of dignity, because we no longer share ... a 'vision of what it means to be human'."
 2. Intrinsic dignity means one has dignity simply because one is human. This is a status model — dignity comes simply with being a human being. It's an example of "recognition respect" — respect is contingent on what one is, a human being.
 3. Extrinsic dignity means that whether one has dignity depends on the circumstances in which one finds oneself and whether others see one as having dignity. Dignity is conferred and can be taken away. Dignity depends on what one can or cannot do.
 4. These two definitions provide very different answers as to what respect for human dignity requires in relation to disabled or dying people, and that matters in relation to euthanasia.
 - a. Under an inherent dignity approach, dying people are still human beings, therefore they have dignity.
 - b. Under an extrinsic dignity approach, dying people are no longer human beings — that is, they are seen as having lost their dignity — and eliminating them through euthanasia is perceived as remedying their undignified state. Pro-euthanasia advocates argue that below a certain quality of life a person loses all dignity. They believe that respect for dignity requires the absence of suffering, whether from disability or terminal illness, and, as well, respect for autonomy and self-determination. Consequently, they argue that respect for the dignity of suffering people who request euthanasia requires it to be an option.
- H. We need to be aware of these aspects of our culture because we're really going to be able to change hearts and minds long term, to reevangelize the culture of death with a culture of life, only when we're able to get to the roots of the ideas that find euthanasia not only acceptable, not only worthwhile, but in some cases obligatory.
- I. The moral worth of our society hinges on how we respond to these false ideas and fears.
1. USCCB: Our society can be judged by how we respond to these fears. A caring community devotes more attention, not less, to members facing the most vulnerable times in their lives. When people are tempted to see their own lives as diminished in value or meaning, they most need the love and assistance of others to assure them of their inherent dignity.

II The teaching of the Catholic Church

- A. I presume most people here tonight would be aware of the Church's teaching with regard to euthanasia and doctor prescribed death.
 - B. We believe that human life is the most basic gift of a loving God, a gift over which we have stewardship not absolute dominion. As responsible stewards of life, we must never directly intend to cause our own death or that of anyone else. Euthanasia and assisted suicide, for that reason, are always gravely wrong. The fifth commandment applies to our actions toward ourselves and to others.
 - C. For this reason, John Paul II said in *Evangelium Vitae*: "To concur with the intention of another person to commit suicide and to help in carrying it out through so-called "assisted suicide" means to cooperate in, and at times to be the actual perpetrator of, an injustice which can never be excused, even if it is requested. In a remarkably relevant passage Saint Augustine writes that "it is never licit to kill another: even if he should wish it, indeed if he request it because, hanging between life and death, he begs for help in freeing the soul struggling against the bonds of the body and longing to be released; nor is it licit even when a sick person is no longer able to live". Even when not motivated by a selfish refusal to be burdened with the life of someone who is suffering, euthanasia must be called a <false mercy>, and indeed a disturbing "perversion" of mercy. True "compassion" leads to sharing another's pain; it does not kill the person whose suffering we cannot bear. Moreover, the act of euthanasia appears all the more perverse if it is carried out by those, like relatives, who are supposed to treat a family member with patience and love, or by those, such as doctors, who by virtue of their specific profession are supposed to care for the sick person even in the most painful terminal stages" (66).
 - D. The importance of palliative care
 1. We don't teach that we have to preserve life by all means no matter what the circumstances.
 2. Palliative care is a holistic approach to terminal illness and the dying process. It seeks to address the whole spectrum of issues that confront a person with a terminal diagnosis through information, high quality care and pain relief, dealing with the emotions, dispelling fear, offering spiritual support if required and including the family in every aspect of the patient's care.
 3. EV 65: Euthanasia must be distinguished from the decision to forego so-called "aggressive medical treatment", in other words, medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family. In such situations, when death is clearly imminent and inevitable, one can in conscience "refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted."
 4. USCCB: Respect for life does not demand that we attempt to prolong life by using medical treatments that are ineffective or unduly burdensome. Nor does it mean we should deprive suffering patients of needed pain medications out of a misplaced or exaggerated fear that they might have the side effect of shortening life. The risk of such an effect is extremely low when pain medication is adjusted to a patient's level of pain, with the laudable purpose of simply addressing that pain (CCC, no. 2279). In fact, severe pain can shorten life, while effective palliative care can enhance the length as well as the quality of a person's life. It can even alleviate the fears and problems that lead some patients to the desperation of considering suicide. Effective palliative care also allows patients to devote their attention to the unfinished business of their lives, to arrive at a sense of peace with God, with loved ones, and with themselves.
 5. This is the "infinitely better way" to care for the needs of people with serious illnesses," what Blessed John Paul II called "the way of love and mercy."
 - E. These considerations are very important in terms of forming our own people, to help them see more clearly and with greater confidence, thanks to the help of revelation, that doctor prescribed death is always wrong. These arguments won't necessarily work *ad extra*, in terms of the persuasion of the public as a whole, but they will be far more direct and persuasive to those who believe that God exists, that he speaks to us through Sacred Scripture and the Church he founded, to guide us to the truth in faith and morals.
- III Before we look at the situation in Massachusetts, I'd like to do a quick survey of the situation in our country and across the globe.

- A. I do this because euthanasia proponents sometimes give the impression that the advent of physician assisted suicide is inexorable and inevitable. It's not. There's, in fact, the total reverse and negation of a "domino effect."
- B. The state of Oregon made assisted suicide a medical treatment in 1994 and three years later legalized it outright. In 2008, Washington did the same. That same year courts in Montana said that patients have the right to self-administer lethal doses of medication as prescribed by a physician and determined that the doctor would not face legal punishment for doing so.
- C. But in the time since 1994 in Oregon, there have been 124 proposals in 25 states. All that are not currently pending were either defeated, tabled for the session, withdrawn by sponsors or languished with no action taken.
 - 1. Michigan defeated a Kevorkian led referendum in 1998.
 - 2. Maine defeated a referendum for physician assisted suicide in 2000 (51-49).
 - 3. California defeated the Compassionate Choices Acts in 2005.
 - 4. New Hampshire defeated an assisted suicide bill 242-113 in January 2010.
 - 5. Later that year, Hawaii's health committee unanimously rebuffed it.
 - 6. Earlier this month, the State of Vermont defeated it 18-11 in the Senate.
 - 7. The vast majority of times it has come up in states across the nation, it has been defeated.
 - 8. Doctor physician suicide remains an explicit crime in 44 states.
- D. The same thing has happened internationally.
 - 1. After the Netherlands legalized
 - 2. The Scottish Parliament overwhelming defeated an attempt to give "end of life Assistance" 85-16 in 2010.
 - 3. In the same year, the Canadian parliament defeated Bill C-384, a bill that would have legalized euthanasia and assisted suicide by a vote of 228 to 59.
 - 4. In Western Australia, a major effort was launched to pass a euthanasia bill, and it was struck down 24-11 in September 2010.
 - 5. Since the beginning of 2010 five countries have defeated efforts to pass more radical laws enabling not just assisted suicide but Netherlands-style euthanasia, which allows medical professionals to kill very ill or depressed patients.
- E. The bottom line is that we should have hope. If euthanasia can be defeated in California, in Vermont, in Britain, in Canada, it can be defeated here. The reason is because fundamentally those fighting against euthanasia are not primarily conservatives or, even more restricted, religious conservatives. Most current opposition coalitions include many persons and organizations whose opposition is based on progressive politics, especially disability rights groups and medical associations.

IV The Massachusetts Death with Dignity Act

- A. Let's turn now to the Death with Dignity Act that Attorney General Martha Coakley certified as a citizens' initiative petition on September 7, 2011.
- B. Presently assisting suicide currently is a common law crime in Massachusetts.
- C. This petition allows a Massachusetts adult resident, who has been diagnosed with a terminal illness that will likely result in death within six months, to request and receive a prescription for a lethal drug to end his or her life. If passed, the petition would legalize physician-assisted suicide. Two physicians will need to determine the terminal diagnosis, the mental state of the patient, and that the patient is acting voluntarily. The patient must make two oral requests within no fewer than fifteen days of one another. A written request is also required with a minimum of forty-eight hours between the written request and the writing of a prescription for the lethal drug.
- D. Let's begin parsing what this is all about.
 - 1. Technical issues with the actual petition
 - a. We see first the use of euphemisms to mask what's really involved
 - i. USCCB: Proponents ... avoid terms such as "assisting suicide" and instead use euphemisms such as "aid in dying." They note that The Hemlock Society has changed its name to "Compassion and Choices." They state, "Plain speaking is needed to strip away this veneer and uncover what is at stake, for this agenda promotes neither free choice nor compassion."

- ii. They scrupulously avoid the term suicide, instead opting for “compassion,” “dying with dignity” “humane” and “end-of-life care.”
 - iii. It’s important for us to keep the term suicide in the forefront, because people, especially in our culture, recognize that suicide is wrong. A voice for doctor prescribed suicide is a vote for suicide.
 - iv. As Cardinal O’Malley said in a powerful homily, “We hope that the citizens of the commonwealth will not be seduced by the language: dignity, mercy and compassion which are used to disguise the sheer brutality of helping some kill themselves.... We are our brother’s keeper and our sister’s helper. Cain who forgot he was his brother’s keeper ended up becoming his executioner. “Thou shall not kill” is God’s law and it is written in our hearts by our Creator.”
- b. It uses a vague definition of terminally ill
- i. There are many definitions for the word "terminal." For example, when he spoke to the National Press Club in 1992, Jack Kevorkian said that a terminal illness was "any disease that curtails life even for a day." The co-founder of the Hemlock Society often refers to "terminal old age." Some laws define "terminal" condition as one from which death will occur in a "relatively short time." Others state that "terminal" means that death is expected within six months or less, *without medical care*. Even where a specific life expectancy (like six months) is referred to, medical experts acknowledge that it is virtually impossible to predict the life expectancy of a particular patient. Some people diagnosed as terminally ill don't die for years, if at all, from the diagnosed condition. Increasingly, however, euthanasia activists have dropped references to terminal illness, replacing them with such phrases as "hopelessly ill," "desperately ill," "incurably ill," "hopeless condition," and "meaningless life."
 - ii. But it is extremely common for medical prognoses of a short life expectancy to be wrong. Studies indicate that only cancer patients show a predictable decline, and even then, it is only in the last few weeks of life. With every disease other than cancer, prediction is unreliable. Prognoses are based on statistical averages, which are nearly useless in determining what will happen to an individual patient. Thus, the potential reach of assisted suicide is extremely broad and could include many people who may be mistakenly diagnosed as terminal but who have many meaningful years of life ahead.
- c. No determination of the depression just a determination that the person does not have impaired judgment (Section 6).
- i. No mandatory psychiatric evaluation to handle depression.
 - a) USCCB: Medical professionals recognize that people who take their own lives commonly suffer from a mental illness, such as clinical depression. Suicidal desires may be triggered by very real setbacks and serious disappointments in life. However, suicidal persons become increasingly incapable of appreciating options for dealing with these problems, suffering from a kind of tunnel vision that sees relief only in death.
 - b) It is never rational to choose suicide.
 - c) In 2010, the Oregon Public Health Division found that the leading reasons people gave for asking for death were loss of autonomy (94%), decreasing ability to participate in activities that make life enjoyable (94%), and loss of dignity (79%). It is not pain but fear that drives people to suicide. Fear of dependence. Fear of “being a burden.”
 - ii. Depression is one of the main factors that drives one to suicide. It’s not pain.
 - a) The latest figures from Oregon show that while 95% of patients requested euthanasia or assisted suicide for “loss of autonomy” and 92% for “loss of dignity” only 5% (3 people) requested it for “inadequate pain control.” It should be noted here that hospice care is not as well developed in Oregon as in other US states.
 - b) The two professional associations representing oncologists in California wrote: It is critical to recognize that, contrary to belief, most patients requesting physician-assisted suicide or euthanasia do not do so because of physical symptoms such as pain or nausea. Rather, depression, psychological distress, and fear of loss of control are identified as the key end of life issues. This has been borne out in numerous studies and reports. For example, ... a survey of 100 terminally ill cancer patients in a palliative care program in Edmonton,

Canada, . . . showed no correlation between physical symptoms of pain, nausea, or loss of appetite and the patient's expressed desire or support for euthanasia/- PAS. Moreover, in the same study, patients demonstrating suicidal ideation were much more likely to be suffering from depression or anxiety, but not somatic symptoms such as pain.

- d. Multiple problems with criteria for witnesses and reporting structures
 - i. Witnesses can be strangers or those who seek to benefit from the death. Can be friends of the heirs.
 - a) Under Initiative 11-12, someone who would benefit financially from the patient's death could serve as a witness and claim that the patient is mentally fit and eligible to request assisted suicide. Initiative 11-12 requires that there be two witnesses to the patient's written request for doctor-prescribed suicide. One of those witnesses shall not be a relative or entitled to any portion of the person's estate upon death. However, this provides little protection since it permits one witness to be a relative or someone who *is* entitled to the patient's estate. The second witness could be the best friend of the first witness and no one would know. Victims of elder abuse and domestic abuse are unlikely to share their fears with outsiders or to reveal that they are being pressured by family members to "choose" assisted suicide.
 - ii. No one required to witness death, to report foul play, to report problems. Relatives don't have to be notified.
 - a) USCCB: In fact, such laws have generally taken great care to *avoid* real scrutiny of the process for doctor-prescribed death—or any inquiry into *whose* choice is served. In Oregon and Washington, for example, all reporting is done solely by the physician who prescribes lethal drugs. Once they are prescribed, the law requires no assessment of whether patients are acting freely, whether they are influenced by those who have financial or other motives for ensuring their death, or even whether others actually administer the drugs. Here the line between assisted suicide and homicide becomes blurred.
 - b) In Oregon, in only 28 percent of the patient deaths has the prescribing physician been present at the time of patient ingestion of the lethal dose, and in 19 percent of the cases, no health care provider has been in attendance.
 - e. Great potential for elder abuse and lack of consent
 - i. Jeremy Prichard doubts that many people in the community will be able to give full and voluntary consent to ending their lives. He contends that the growing prevalence of elder abuse suggests that aged people could easily be manipulated.
 - ii. Most elder abuse is at the hand of a relative. We must recognize that the prospect of euthanasia and assisted suicide becoming law in this country could effectively be aiding and abetting elder abuse with extremely grave consequences. It's not hard to imagine that a relative who has been systematically abusing an elder emotionally and financially could see euthanasia as the final (and most profitable) card to play for personal gain. It's not hard to imagine someone who has been emotionally abused over time succumbing to the suggestion that they 'do the right thing' once their frailty and ailments reach a certain point.
2. Larger issues involved
 - a. It's a false compassion
 - i. USCCB: The idea that assisting a suicide shows compassion and eliminates suffering is equally misguided. It eliminates the person, and results in suffering for those left behind—grieving families and friends, and other vulnerable people who may be influenced by this event to see death as an escape. The sufferings caused by chronic or terminal illness are often severe. They cry out for our compassion, a word whose root meaning is to "suffer with" another person. True compassion alleviates suffering while maintaining solidarity with those who suffer. It does not put lethal drugs in their hands and abandon them to their suicidal impulses, or to the self-serving motives of others who may want them dead. It helps vulnerable people with their problems instead of treating them as the problem.
 - ii. Blessed John Paul writes, "True 'compassion' leads to sharing another's pain; it does not kill the person whose suffering we cannot bear."

- b. It's an explicit governmental promotion of suicide
 - i. Once government begins to say under certain circumstances suicide is not only permitted, but a public good, then others in situations — that are by no means severe — start to take their own lives.
 - ii. We've seen this in Oregon. In the first decade after Oregon legalized physician assisted suicide, the suicide rate, which had been declining, rose to 35 percent above the national average; that 35 percent does not include doctor-assisted deaths in Oregon.
 - iii. By rescinding legal protection for the lives of one group of people, the government implicitly communicates the message—before anyone signs a form to accept this alleged benefit—that they may be better off dead.
 - iv. If these persons say they want to die, others may be tempted to regard this not as a call for help but as the reasonable response to what they agree is a meaningless life. Those who choose to live may then be seen as selfish or irrational, as a needless burden on others, and even be encouraged to view themselves that way.
- 3. It will lead to a weakening of palliative care.
 - a. The push for doctor prescribed death is a movement to kill not the pain a person suffers but the person with the pain.
 - b. Euthanasia advocates have pushed to confuse everyone on the palliative care issue:
 - i. They have conflated palliative care — the medical alleviation of pain and other distressing symptoms of serious illness — with intentionally ending the life of the patient. The pro-euthanasia lobby has deliberately confused pain relief treatment and euthanasia in order to promote their cause. Their argument is that necessary pain relief treatment that could shorten life is euthanasia; we are already giving such treatment and the vast majority of people agree we should do so; therefore, we are practicing euthanasia with the approval of the majority so we should come out of the medical closet and legalize euthanasia. Indeed, they argue, doing so is just a small incremental step along a path we have already taken.
 - c. USCCB: Even health care providers' ability and willingness to provide palliative care such as effective pain management can be undermined by authorizing assisted suicide. Studies indicate that untreated pain among terminally ill patients may increase and development of hospice care can stagnate after assisted suicide is legalized. Government programs and private insurers may even limit support for care that could extend life, while emphasizing the “cost-effective” solution of a doctor-prescribed death. The reason for such trends is easy to understand. Why would medical professionals spend a lifetime developing the empathy and skills needed for the difficult but important task of providing optimum care, once society has authorized a “solution” for suffering patients that requires no skill at all? Once some people have become candidates for the inexpensive treatment of assisted suicide, public and private payers for health coverage also find it easy to direct life-affirming resources elsewhere.
- 4. It creates tremendous pressure on those who are ill and on their care givers
 - a. If voluntary euthanasia is introduced, every dying person capable of doing so would have to decide not just whether or not his own pain had become too much to bear, but whether or not the emotional, physical and financial burden was becoming too much for relatives and friends to bear. What are the dying to do when their children and grandchildren have to travel long distances, endure enormous emotional strain and go through wearing physical fatigue to be with them during an awkwardly long and unpredictable “dying period”? What are the poor, vulnerable dying to do when they are made to feel that their continued existence is an intolerable public burden?
 - b. In cases where the dying elderly are not in a position to give formal consent to their own death, those legally vested with the right to make this decision on their behalf can never be sure that they acted out of the right motives. (Were they motivated by their dying relative's emotional strain or by their own, by the interests of the patient or by the prospect of securing an inheritance sooner rather than later?, and so on). The legalization of euthanasia would put almost “humanly impossible” demands on the dying and their relatives, especially if they are poor. Where voluntary euthanasia is illegal, the timing and extent of medical intervention in the lives of dying patients is more a matter of

“professional judgment” than of “personal choice” and this means that the health professions are able to protect the poor and vulnerable from pressures of this kind.

5. Financial incentive for euthanasia
 - a. In an era of cost control and managed care, patients with lingering illnesses may be branded an economic liability, and decisions to encourage death can be driven by cost.
 - b. Initiative 11-12 would give government bureaucrats and profit-driven health insurance programs the opportunity to cut costs by denying payment for more expensive treatments while approving payment for less costly assisted suicide deaths.
 - c. Assisted suicide is a deadly mix with our broken, profit-driven health care system, in which financial pressures already play far too great a role in many, if not most, health care decisions. Direct coercion is not even necessary. If insurers deny, or even merely delay, approval of expensive, life-giving treatments that patients need, patients will, in effect, be steered toward assisted suicide, if it is legal.
 - d. The force of economic gravity can lead to increased pressure on patients to request, and doctors to prescribe, assisted suicide. Patients in Oregon have already encountered that reality. In May 2008, 64-year-old retired school bus driver Barbara Wagner received bad news from her doctor. Her cancer had returned. Then she got some good news. Her doctor gave her a prescription for medication that he said would likely slow the cancer’s growth and extend her life. It didn’t take long for her hopes to be dashed. She was notified by letter that the Oregon Health Plan (OHP) wouldn’t cover the prescribed cancer drug. It also informed her that, although it wouldn’t cover the prescription, it would cover all costs for her assisted suicide. Wagner said she told the OHP, “Who do you guys think you are? You know, to say that you’ll pay for my dying, but you won’t pay to help me possibly live longer?” Wagner’s case was not isolated. Other patients received similar letters.
 - e. The cost of the lethal medication generally used for assisted suicide is about \$300, far cheaper than the cost of treatment for most long-term medical conditions. The incentive to save money by denying treatment already poses a significant danger. This danger is far greater where assisted suicide is legal. Direct coercion is not necessary. If patients are denied necessary life-sustaining health care treatment, or even if the treatment they need is delayed, many will, in effect, be steered toward assisted suicide.
 - f. As U.S. Solicitor General Walter Dellinger warned in urging the Supreme Court to uphold laws against assisted suicide: “The least costly treatment for any illness is lethal medication.”
6. Clearly it gets us on a slippery slope to involuntary euthanasia and other evils.
 - a. The “slippery slope” argument, a complex legal and philosophical concept, generally asserts that one exception to a law is followed by more exceptions until a point is reached that would initially have been unacceptable.
 - b. We’ve seen the path the slippery slope has taken in Belgium and the Netherlands.
 - i. In 30 years, the Netherlands has moved from euthanasia of people who are terminally ill, to euthanasia of those who are chronically ill; from euthanasia for physical illness, to euthanasia for mental illness; from euthanasia for mental illness, to euthanasia for psychological distress or mental suffering—and now to euthanasia simply if a person is over the age of 70 and “tired of living.” Dutch euthanasia protocols have also moved from conscious patients providing explicit consent, to unconscious patients unable to provide consent. Denying euthanasia in the Netherlands is now considered a form of discrimination against people with chronic illness, whether the illness be physical or psychological, because those people will be forced to “suffer” longer than those who are terminally ill. Non-voluntary euthanasia is now being justified by appealing to the social duty of citizens and the ethical pillar of beneficence. In the Netherlands, euthanasia has moved from being a measure of last resort to being one of early intervention. Belgium has followed suit, and troubling evidence is emerging from Oregon specifically with respect to the protection of people with depression and the objectivity of the process.
 - ii. For many years Dutch courts have allowed physicians to practice euthanasia and assisted suicide with impunity, supposedly only in cases where desperately ill patients have unbearable suffering. However, Dutch policy and practice have expanded to allow the killing of people with disabilities or even physically healthy people with psychological distress; thousands of patients,

- including newborn children with disabilities, have been killed by their doctors without their request. The Dutch example teaches us that the “slippery slope” is very real.
- iii. A recent study found that in the Flemish part of Belgium, 66 of 208 cases of “euthanasia” (32%) occurred in the absence of request or consent. The reasons for not discussing the decision to end the person’s life and not obtaining consent were that patients were comatose (70% of cases) or had dementia (21% of cases). In 17% of cases, the physicians proceeded without consent because they felt that euthanasia was “clearly in the patient’s best interest” and, in 8% of cases, that discussing it with the patient would have been harmful to that patient. Those findings accord with the results of a previous study in which 25 of 1644 non-sudden deaths had been the result of euthanasia without explicit consent.
 - c. The USCCB speaks about this:
 - i. USCCB: Taking life in the name of compassion also invites a slippery slope toward ending the lives of people with non-terminal conditions. Dutch doctors, who once limited euthanasia to terminally ill patients, now provide lethal drugs to people with chronic illnesses and disabilities, mental illness, and even melancholy. Once they convinced themselves that ending a short life can be an act of compassion, it was morbidly logical to conclude that ending a longer life may show even more compassion. Psychologically, as well, the physician who has begun to offer death as a solution for some illnesses is tempted to view it as the answer for an ever-broader range of problems. This agenda actually risks adding to the suffering of seriously ill people. Their worst suffering is often not physical pain, which can be alleviated with competent medical care, but feelings of isolation and hopelessness. The realization that others—or society as a whole—may see their death as an acceptable or even desirable solution to their problems can only magnify this kind of suffering.
 - d. There is a moral trickledown effect. First, suicide is promoted as a virtue. Then follows mercy killing of the terminally ill. From there, it’s a hop, skip and a jump to killing people who don’t have a good “quality” of life, perhaps with the prospect of organ harvesting thrown in as a plum to society.
 7. The disabled community is rightly concerned because once concerns about the quality of life come to the fore, they anticipate that they will be among the first to be killed under an anthropology focused on doing rather than being.
 - a. Many people with disabilities have long experience of prejudicial attitudes on the part of able-bodied people, including physicians, who assume they would “rather be dead than disabled.” Such prejudices could easily lead families, physicians and society to encourage death for people who are depressed and emotionally vulnerable as they adjust to life with a serious illness or disability.
 - b. Although the debate about assisted suicide is often portrayed as part of the culture war—with typical left-right, pro-con politics—the largest number of witnesses at the most recent hearing on Beacon Hill were 10 disability-rights advocates who oppose the initiative.
 - c. According to the National Council on Disability: “As the experience in the Netherlands demonstrates there is little doubt that legalizing assisted suicide generates strong pressures upon individuals and families to utilize the option, and leads very quickly to coercion and involuntary euthanasia.”
 - d. This is a fear that many people living with a disability and their families express over the idea of euthanasia. It’s not that they think that the advent of euthanasia will suddenly unleash modern day Joseph Mengeles. Rather, they fear that misunderstandings and false compassion could result in them being considered ‘better off dead’; devalued and perhaps even killed. They also fear being treated as second class citizens in respect to their medical care.
 - e. A policy of euthanasia will inevitably lead to establishing social standards of acceptable life. When “quality life” is more important than life itself, the mentally ill, the disabled, the depressed, and those who cannot defend themselves will be at risk of being eliminated.
 - f. The prohibitions against both euthanasia and assisted suicide treat all citizens equally. Making exceptions for the hard cases while advantaging the very few, risks placing far more people at a decided risk of disadvantage. We would be implicitly suggesting that the lives of the sick or disabled are less worthy of the protection of the law than others. Will these ‘vulnerable groups’ be heard?

- g. In Massachusetts, the disability advocates call their opposition group "Second Thoughts." They say that assisted suicide may sound like a good idea at first, but on second thought the risks of mistake, coercion and abuse are too great.
- h. SPO 9/2011: By rescinding the legal protection for the lives of a category of people, the government sends a message that some persons are better off dead. This biased judgment about the diminished value of life for someone with a serious illness or disability is fueled by the excessively high premium our culture places on productivity and autonomy which tends to discount the lives of those who have a disability or who are suffering or dependent on others. If these people claim they want to die, others might be tempted to regard this not as a call for help, but as a reasonable response to what they agree is a meaningless life. Those who choose to live may then be viewed as selfish or irrational, as a needless burden on others, and might even be encouraged to see themselves in that way. Many people with a disability who struggle for their genuine rights to adequate health care, housing and so forth, are understandably suspicious when the freedom society most eagerly offers them is the freedom to take their lives.

E. It will bring about a massive change in the nature of medical care.

- 1. American Medical Association, the American College of Physicians, the American Psychiatric Association, the American Nurses Association and the Massachusetts Medical Society all oppose doctor-prescribed suicide and for good reason, because it changes the nature of medical care and corrupts the medical profession.
- 2. Hippocratic oath: "I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan."
- 3. The American Medical Association holds that "physician-assisted suicide is fundamentally incompatible with the physician's role as healer."
- 4. Once we allow doctors to start to kill patients with terminal illnesses, the meaning of the medical profession changes, from one that seeks always to save lives, to one in which it is possible to end them. Once that occurs, then it's a small step to allowing them to assist non-terminal patients in taking their lives and another to putting pressure on those who are in terminal illnesses to do family members and society a "favor" by ending their lives so that medical resources can be spent elsewhere.
- 5. We've seen the consequences in terms of the doctor-patient relationship. In Holland, reports have been published documenting the sad fact that elderly patients, out of fear of euthanasia, refuse hospitalization and even avoid consulting doctors, because doctors and nurses become potential destroyers of life, rather than defenders. They become executioners.
- 6. There would also be a fundamental change in the way doctors are formed. A fundamental value and attitude that we want to reinforce in medical students, interns and residents, and in nurses, is an absolute repugnance to killing patients. It would be very difficult to communicate to future physicians and nurses such a repugnance in the context of legalized doctor prescribed death.

V Our mission

- A. With regard to the citizens' initiative petition, we need to know some facts.
- B. It's still in the "second quarter of the game," but we are slightly behind and therefore we must work harder and better, both on offense and defense.
- C. The recent poll:
 - 1. The recent poll by Public Policy Polling shows that 43 percent are in favor of the petition at the present, and 37 percent are against.
 - 2. But we saw some breakdowns that will teach us particular areas that we can emphasize:
 - a. Gender
 - i. Men were in favor of 48-34 percent.
 - ii. Women were opposed 41-38.
 - iii. Therefore we particularly need to work on men to become real protectors of the vulnerable and to accentuate woman's nature compassion.
 - b. Generation
 - i. 65 and older were opposed with 44 percent against it.
 - ii. Those 46-65 were the most in favor, with 49 percent supporting the bill.
 - iii. It's clear that our seniors will be opposed if the specter of people making the decision for them is brought to them.

iv. We need to help the care giver generation to recognize there's a better way, a way of returning love for the love received, of the availability of good palliative care in hospices.

D. The larger issue of how we should be getting involved was brought out by the US Bishops:

1. USCCB: Catholics should be leaders in the effort to defend and uphold the principle that each of us has a right to *live* with dignity through every day of our lives. As disciples of one who is Lord of the living, we need to be messengers of the Gospel of Life.
2. We should join with other concerned Americans, including disability rights advocates, charitable organizations, and members of the healing professions, to stand for the dignity of people with serious illnesses and disabilities and promote life-affirming solutions for their problems and hardships.
3. We should ensure that the families of people with chronic or terminal illness will advocate for the rights of their loved ones, and will never feel they have been left alone in caring for their needs. The claim that the "quick fix" of an overdose of drugs can substitute for these efforts is an affront to patients, caregivers and the ideals of medicine.
4. When we grow old or sick and we are tempted to lose heart, we should be surrounded by people who ask "How can we help?" We deserve to grow old in a society that views our cares and needs with a compassion grounded in respect, offering genuine support in our final days. The choices we make together now will decide whether this is the kind of caring society we will leave to future generations. We can help build a world in which love is stronger than death

E. This initiative petition is a time in which all citizens of the Commonwealth have the chance to choose the path of Cain and Kevorkian or the path of the Good Samaritan. It's the path of the executioner or of the truly compassionate care-giver, the life-affirming hospice nurse, the 24-hour operator at suicide prevention hotlines, and the heroic firefighter or policeman who climbs bridges, risking his life to save those who are contemplating ending their own. The path of the true brother's keeper will also be shown in the educational work of those who begin anew to educate others about the dignity of every human life and persuade legislators and fellow citizens to rise up to defeat soundly this evil initiative. It's a matter of life or death.