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Assisted Suicide and Euthanasia: From Voluntary to Involuntary

While promoted and initially practiced in the name of personal autonomy, physician-assisted suicide (providing lethal drugs so patients can take their own lives) and euthanasia (direct killing of patients by doctors) do not remain limited to cases in which the victim gave his or her voluntary consent. This agenda ultimately embraces coercion and the death of unwilling victims.¹

The Case of the Netherlands

Since 1973 a series of court decisions has established that Dutch doctors need not fear punishment or prosecution if they kill, or assist the suicides of, patients in “unbearable suffering” who make a voluntary request to die. These guidelines were formalized by a Dutch court in 1981. When the Dutch government studied actual practice in 1991, it found: 2300 cases of voluntary euthanasia every year; 400 assisted suicides; and 1040 cases in which doctors killed patients without their knowledge or consent. In this last category, 72% of the patients had never expressed an interest in having their lives taken, and 14% were fully competent. In addition, 8100 patients died from overdoses of pain medications intended primarily to end life rather than relieve pain, and 61% of the time (4941 cases) this was done without the patient’s consent.

Patients Rights Council, *Background About Euthanasia in the Netherlands*, at www.patientsrightscouncil.org/site/holland-background/ (accessed June 9, 2014).

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Writes one investigator into Dutch practice: “Some euthanasia advocates defend the need for doctors to make decisions to end the lives of competent patients without discussion with them. One euthanasia advocate gave me as an example a case where a doctor had terminated the life of a nun a few days before she would have died because she was in excruciating pain, but her religious convictions did not permit her to ask for death. He did not argue, however, when asked why she should not have been permitted to die in the way she wanted... Other advocates admit that a system in which doctors become used to playing a predominant role in making decisions about ending life encourages some to feel entitled to make decisions without consulting patients.”

H. Hendin, “Assisted Suicide, Euthanasia, and Suicide Prevention: The Implications of the Dutch Experience,” 25.1 *Suicide & Life-Threatening Behavior* 193-204 (Spring 1995) at 201-2. For documentation on other cases see R. Fenigsen, “Other People’s Lives: Reflections on Medicine, Ethics, and Euthanasia,” 26.3 *Issues in Law & Medicine* 239-79 (Spring 2011) at 278.

¹ On how Oregon’s assisted suicide law opens the door to ending the life of people not able or competent to give consent, also see USCCB Secretariat of Pro-Life Activities, *Oregon’s Assisted Suicide Law: What Safeguards?*, at <http://www.usccb.org/issues-and-action/human-life-and-dignity/assisted-suicide/to-live-each-day/upload/Oregon-s-Assisted-Suicide-Law-What-Safeguards.pdf>.

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Newborn children, of course, cannot make a voluntary request for euthanasia. Yet in 1993, a Dutch physician was acquitted of wrongdoing after he gave a lethal injection to a four-day-old infant with spina bifida, because he was said to have faced a conflict between his duties to preserve life and to relieve suffering. By 1995, Dutch physicians had published an account of 22 similar cases. Parents had consented to the injections; however, in all but four cases it was the physicians who first made the proposal. That year the Dutch Association of Paediatrics approved the “Groningen Protocol,” which set standards for such nonvoluntary taking of life and found all 22 cases to be in accord with acceptable medical practice.

See T. De Jong, “Deliberate termination of life of newborns with spina bifida, a critical reappraisal,” 24 *Child’s Nervous System* 13-28 (2008) at 15-17.

Killing Without Consent in Belgium

In Belgium, where voluntary euthanasia was legalized with supposed “safeguards” in 2002, a 2010 study showed that half of nurses involved in the practice – 120 out of 248 – had taken the lives of patients without their request or consent. “We should take a warning from this that wherever you draw the line, people will go up to it and beyond it,” said Dr. Peter Saunders of Great Britain’s Care Not Killing campaign. “Once you have legalised voluntary euthanasia, involuntary euthanasia will inevitably follow.”

S. Caldwell, “Warning to Britain as almost half of Belgium’s euthanasia nurses admit to killing without consent,” in *The Daily Mail (London)*, June 10, 2010, www.dailymail.co.uk/news/article-1285423/Half-Belgiums-euthanasia-nurses-admit-killing-consent.html.

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In a study of 208 deaths in Belgium in 2007 involving “the use of life-ending drugs,” physicians reported that 66 of these deaths (about 32%) were “without an explicit request.” The study notes: “Use of life-ending drugs without an explicit request mostly involved patients 80 years or older, those with a disease other than cancer and those in hospital. Of the deaths without an explicit request, the decision was not discussed with the patient in 77.9% of cases.”

K. Chambaere, et al., “Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey,” 182.9 *Canadian Medical Association Journal* 895-901 (June 15, 2010) at 895.

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Children and Euthanasia

In 2014, Belgium became the first country to end age limits on euthanasia, extending the practice to terminally ill children of any age. Since 2002 the Netherlands has allowed euthanasia for children aged 12 or older.

A. Gerlin, “Child Euthanasia Law in Belgium First to End Age Limits,” *Bloomberg News* (March 26, 2014).

The Trend in the United States

The assisted suicide movement in the United States, as well, has shown that this agenda will not be limited to cases where a voluntary request is made by a competent patient.

Criticizing the murder conviction of Richard Rodriguez, a man who said he had fatally shot his ailing and elderly father out of sympathy, the executive director of Hemlock Society USA (now renamed “Compassion and Choices”) stated: “A judicial determination should be made when it is necessary to hasten the death of an individual whether it be a demented parent, a suffering, severely disabled spouse or a child. Consultants should evaluate what other ways might be used to alleviate the suffering and, if none are available or are unsuccessful, a non-violent, gentle means should be available to end the person’s life.”

Faye Girsh of Hemlock Society USA, “Mercy Killing: A Position Statement Regarding Richard Rodriguez,” *PR Newswire*, December 3, 1997, quoted in Patients Rights Council, 12.1 *IAETF Update* (Jan.-March 1998), www.internationaltaskforce.org/iaua12.htm.

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Writes the founder of the Hemlock Society: “In attempting to answer Why Now?, one must look at the realities of the increasing cost of health care in an aging society, because in the final analysis, economics, not the quest for broadened individual liberties or increased autonomy, will drive assisted suicide to the plateau of acceptable practice.... Is there, in fact, a duty to die – a responsibility within the family unit – that should remain voluntary *but expected nevertheless?*”

D. Humphry and M. Clement, *Freedom to Die: People, Politics, and the Right-to-Die Movement* (St. Martin’s Press 1998) at 313 (emphasis added).

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Oregon has taken steps toward an “expected” earlier death for patients whose care costs the government money. In 1995, Oregon’s State Health Services Commission voted 10-to-1 to include physician-assisted suicide as a form of “comfort care” for all low-income terminally ill patients covered by Oregon’s Medicaid rationing program. In response to criticisms that Oregonians never voted to support assisted suicide with taxpayer money, the head of Oregon’s Medical Assistance Program replied: “These are cheap prescriptions, and health care provider time will not be significant” (See Patients Right Council, *op. cit.*). Since then, some patients on the Oregon Health Plan have received letters from the state saying it will not pay for drugs that may help stave off their death but will fully cover assisted suicide. “It was horrible,” said one woman, cancer patient Barbara Wagner. “I got a letter in the mail that basically said if you want to take the pills, we will help you get that from the doctor and we will stand there and watch you die. But we won’t give you the medication to live.” Hemlock founder Derek Humphry reacted by saying that the Oregon Health Plan’s approach is sound.

S. James, “Death Drugs Cause Uproar in Oregon,” *ABC News*, August 6, 2008, <http://abcnews.go.com/Health/story?id=5517492&page=1>.

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According to the National Council on Disability, such cost pressures create an especially toxic environment when combined with longstanding social prejudice against the value of a life with disabilities: “The dangers of permitting physician-assisted suicide are large indeed. The pressures upon people with disabilities to choose to end their lives, and the insidious appropriation by others of the right to make that choice for them are already way too common in our society. These pressures are increasing and will continue to grow as managed health care and limitations upon health care resources precipitate increased ‘rationing’ of health care services and health care financing.... There is no doubt that people with disabilities are among society’s most likely candidates for ending their lives. As the experience in the Netherlands demonstrates, there is also little doubt that legalizing assisted suicide generates strong pressures upon individuals and families to utilize that option, and leads very quickly to coercion and involuntary euthanasia. The so-called ‘slippery slope’ already operates in regard to individuals with disabilities and decisions to discontinue life-support systems and ‘Do Not Resuscitate’ orders; it would expand dramatically if physician-assisted suicide were to become legal.”

National Council on Disability, “Assisted Suicide: A Disability Perspective,” Position Paper of March 24, 1997, reprinted in *14.3 Issues in Law & Medicine* 273-99 (Spring 1998) at 298.

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