

Physician-Assisted Suicide

We, as Christian physicians and dentists, believe that human life is a gift from God and is sacred because it bears God's image. Human life has worth because Christ died to redeem it, and it has meaning because God has an eternal purpose for it.

We oppose active intervention with the intent to produce death for the relief of pain, suffering, or economic considerations, or for the convenience of patient, family, or society.

Proponents of physician-assisted suicide argue from the perspective of compassion and radical individual autonomy. There are persuasive counter arguments based on the traditional norms of the medical professions and the adverse consequences of such a public policy. Even more important than these secular arguments is the biblical view that the sovereignty of God places a limit on human autonomy.

In order to affirm the dignity of human life, we advocate the development and use of alternatives to relieve pain and suffering, provide human companionship, and give opportunity for spiritual support and counseling.

The Christian Medical & Dental Associations oppose physician-assisted suicide in any form.

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Explanation

Physician-assisted suicide occurs when a physician helps a person take his or her own life by giving advice, writing a prescription for lethal medication, or assisting the individual with some device which allows the person to take his or her own life. The physician lends expertise, the person does the act.

Voluntary euthanasia occurs when another person, out of compassion, does an action with the intention of ending the life of a suffering patient at his or her request. Non-voluntary euthanasia is a similar compassionate act, but in circumstances where the patient is unable to make a voluntary request (e.g. an unconscious, retarded or demented adult; an infant or child). Involuntary euthanasia is a compassionate act to end the life of a patient who is perceived to be suffering and could make a voluntary request, but has not done so.

Distinction between active euthanasia and passive euthanasia is not helpful, and often confusing. It is clearer to limit the term euthanasia to situations in which one person acts to cause the death of another (which is what many people mean by active euthanasia). According to this understanding, acts of discontinuing treatment with the realization that patients will die of their disease do not constitute euthanasia. Thus using the term passive euthanasia to describe such acts is a misnomer. When discontinuation is done with the intention of ending the life of someone who is not already unavoidably in a dying process, it is morally objectionable for many of the same reasons that euthanasia is

objectionable. But since discontinuation in other situations is morally acceptable, it is helpful not to refer to discontinuation under any circumstances as a form of euthanasia.

Secular Perspective

Societal changes of the 1960's - 1980's have led to a focus and emphasis on an individual's right to self-determination. While this includes some increased acceptance of suicide as a rational option for an individual who feels that life has become too burdensome, the act of suicide is still often viewed by others as a tragic and lonely experience. This is especially true when the means of self-destruction involves violence (e.g. guns and other self-inflicted wounds, hanging, jumping from heights, etc.). Thus there has been a move to depersonalize suicide by involving others (assisted suicide) and to sanitize it by making it a medical procedure (physician-assisted suicide and euthanasia).

Proponents of legalization of euthanasia offer several reasons why society should allow physicians to be involved in these acts: some people have no loved one who can help them; some people are unwilling or unable to help their loved ones commit suicide; physicians know the prognosis so are better able to assess the appropriateness of a request; physicians have access to and know how to use lethal drugs; medical expertise can prevent botched up suicide attempts; physicians know how to obey standards; and, physicians can be more objective because they are not emotionally involved.

Legal Perspective

Euthanasia has been openly practiced by physicians in The Netherlands since 1984, and such acts were decriminalized in 1993, although legal and judicial oversight continues. The best estimates are that about 3% of all deaths in that country are induced by physicians. There is public debate about extending the availability of euthanasia to children and incompetent adults, and there is a professional inclination to change the system to physician-assisted suicide rather than direct physician involvement.

The Northern Territory of Australia legalized physician-assisted suicide and physician-administered euthanasia in 1995.

Attempts in several states in the U.S. to pass legislation allowing physician-assisted suicide and/or euthanasia failed by narrow margins in the late 1980's and early 1990's. In 1994, the state of Oregon passed a voter initiative to allow physician-assisted suicide with restrictions, but it has not gone into effect at the time of this writing because of legal challenges.

Case law (as opposed to statutory law) in the U.S. addressed the issue of physician-assisted suicide in early 1996. The 9th Circuit Court of Appeals in San Francisco and the 2nd Circuit Court of Appeals in New York declared unconstitutional state laws in Washington and New York (respectively) which prohibited physician-assisted suicide. Different legal arguments were used in the two cases. It is anticipated that these judicial rulings will be appealed to the U.S. Supreme Court.

Professional Perspective

Physician-assisted suicide and euthanasia were explicitly proscribed in the Hippocratic Oath. Although this was a minority opinion when introduced 2500 years ago, the Hippocratic ethic gradually became the dominant influence for practitioners of modern medicine and dentistry. Practitioners have adopted the role of healer with the goals of healing when possible, and relief of suffering. While there have doubtless been individual physicians and dentists over the centuries who have occasionally helped their patients to die, this activity has clearly remained outside the boundaries of acceptable medical treatment.

There is professional concern that acceptance of physician involvement in either direct or indirect induced death would seriously undermine the trust that is a necessary component of the physician-patient

relationship. If euthanasia becomes accepted, a physician might be tempted to end a patient's life without a request, either out of compassion, or out of self-interest (e.g. when the care of a patient becomes too difficult or burdensome). In addition, there is concern that there might be less impetus to continue work on the significant gains made in good palliative care in the past 20 years.

Christian Perspective

What is fundamentally wrong with euthanasia from a biblical perspective is that it involves the killing of human beings who are necessarily made in the image of God (Genesis 9:6). Physician-assisted suicide is wrong for similar reasons, in that people kill human beings (themselves) with the assistance of others who thereby become accessories to killing. As discussed further in the Explanation of the Statement on Patient Refusal of Therapy, patient autonomy (or better: freedom) must be understood within the limits of God's sovereignty and does not include the right to dispose of that which is not one's own (you are not your own---I Cor. 6:19).

Christians are indeed called upon to be compassionate and to relieve suffering, but not at any expense. If happiness were what life is all about, then suffering would be the ultimate evil to be avoided at all costs. The cross would represent the epitome of what is to be avoided. Its crushing load on Jesus' back and the nails driven through his hands and feet graphically display the burden of the fallenness of the world that Jesus had to bear, in fact, chose to bear. Yet, those who follow Jesus are not called to avoid such suffering but to suffer this fallenness with him, to take up crosses of their own.

The basic question, then, is whether God or suffering is going to set the agenda of one's life---and death. Christian physicians and their patients will not find God's way by trying to avoid all suffering at any cost. They will find it by remaining true to God's biblically-revealed character and will, especially in the midst of suffering. The ultimate test of what is setting the agenda of our lives may well be how we deal with suffering in the face of death.

Such was the case for Jesus in the garden of Gethsemane. He was overwhelmed with sorrow to the point of death (Mark 14:34) and zealously prayed to be spared from the suffering that he knew would only get worse. Yet he affirmed that his primary commitment was to the larger purposes of God, whatever suffering they might entail. The absence of suffering is, generally speaking, something good---which is why Jesus prayed for it. But it is not the highest good---which is why he was willing to forgo it.

Yielding to the call of compassion to kill or assist in the killing of a patient is misguided for another reason as well. It is all too easy to underestimate the fallenness (self-centeredness) of human nature, particularly when the people in view seem to have the needs of others at heart. The statements of so-called mercy killers in the past have often been telling in this regard. I killed her because I could not bear to see her suffer generally means what it says---that first and foremost the action reflected the killer's need to be free from his or her own discomfort. Barriers to killing patients or assisting them to kill themselves not only protect society in general and patients in particular but also protect physicians and surrogate decision-makers from their own weaknesses---from subtly self-centered decisions that may well haunt them for the rest of their lives. The CMDS statements on **Physician-Assisted Suicide** and **Euthanasia** are designed to uphold such protections while affirming more constructive expressions of compassion.

Abstracts

Kamisar Y. The Reasons So Many People Support Physician-Assisted Suicide – and Why These Reasons Are Not Convincing. *Issues in Law and Medicine* 1996; 12(2):113-131.

The 5 main reasons for the growing public support of the legalization of physician-assisted suicide (PAS) are:

1. "The compelling force of heartrending individual cases",

2. "The notion that the only substantial objections to legalizing assisted suicide or active voluntary euthanasia are based on religious grounds"
3. "Physicians are doing it anyway, so we might as well legalize it- and regulate it"
4. "There is no significant difference, the argument runs, between the termination of life support and active intervention to promote or to bring about death; in both instances the result is the same"
5. "If a right to physician-assisted suicide were established, we are assured it would only apply to the 'terminal ill'"

The author examines these reasons and discredits their authority in this debate. He concludes, "Today few people chuckle when PAS is classified as a medical procedure, or even when it is called a health care right, or even when we are told, at a time when tens of millions of Americans lack adequate health care and Congress has refused to do anything about it, that PAS is the one health care right that deserves constitutional status."

Stevens DL. Would Dad Be Better Off Dead? *Today's Christian Doctor* 1996; XXVII(4): 4-7.

After recounting the personal experiences of his family during the terminal illness of his father the author examines the title question. He writes, "the physician-assisted suicide movement is sweeping across the land....As in the years leading up to the Roe v. Wade decision, today the church and the medical profession are ill-prepared for the debate and in denial that physician-assisted suicide could happen here." He then lists key points in this debate that physicians should be aware of so as to "take the lead in educating the church and the public on this issue."

Hollinger D. Theological Foundations for Death and Dying Issues. *Ethics & Medicine* 1996;12(3):60-65.

Death and dying issues are influenced by one's world view. Hence, Christians must respond from within the theological environment. The author writes, "In the face of death and dying issues, we must hold together what humanity tends to pull apart: death as friend and foe, suffering as challenge to persevere and opportunity to overcome, and the dual affirmation of divine providence and human stewardship. These theological assertions do not solve every dilemma a physician or family of a dying patient faces. But they do provide a framework that can guide us to make wise decisions amidst the complexity and ambiguity we often face in death and dying issues. [On] the one hand they preserve us from playing God in biomedical ethics, but on the other hand they also prevent us from abdicating our responsibilities as human stewards made in the very image of an all-powerful God."

O'Mathúna DP. Did Paul Condone Suicide? Implications for Assisted Suicide and Active Euthanasia. *Ethics & Medicine* 1996;12(3):55-60.

Author Droge, in his book *A Noble Death*, concludes that it is possible Paul committed suicide or at the very least condoned it based on a passage in Philippians. The author takes another look at the Biblical passage and refutes Droge's claims. He concludes, "In Philippians 1:19-26, Paul acknowledges that death can look very attractive. The desire to die can be strong. But Christians should turn aside from that temptation, as he did, and find ways to love others and glorify God."

Weir AB. What Shall Decide: An Oncologist's Question about Physician-Assisted Suicide. *Today's Christian Doctor* 1997;XXVII(1):14-16.

The author begins with a personal story about a cancer patient who had unsuccessfully tried to commit suicide and details the family's reaction while the patient was in critical care and after the patient had recovered from his attempt. Highlighting the different changes in attitude, the author writes that neither the individual, the family, the doctor or society is capable of coherently deciding about physician-assisted suicide. He concludes, "There is not one this side of heaven who has the ability to make the correct decision regarding when our life should be extinguished. Until we find such a one, in this question of

physician assisted suicide, as in other policy decisions, society should err on the side of the precious nature of human life rather than that of personal choice."

Ganzini L, Lee MA. Psychiatry and assisted suicide in the United States. *New England Journal of Medicine* 1997;336(25):1824-26.

This article discusses the role of psychiatrists in physician assisted suicide and the questions of when a psychiatrist should evaluate a patient who has made such a request and if assisted suicide is "ever justified for patients whose intractable suffering is caused by a mental disorder, not a terminal illness." The authors point out several limitations in psychiatric evaluations - only a small percentage are confident that within one session one can ascertain whether mental illness is determining the request for assisted suicide, the label competent or incompetent is not as easy as such because there is no established threshold for determining "whether a person is competent to choose suicide", and bias of the particular psychiatrist (ones who do not believe in physician assisted suicide will likely not evaluate patients). The authors conclude that "our present knowledge base is inadequate for assessing the efficacy of psychiatric interventions when patients request physician-assisted suicide.... Psychiatrists rarely work with medically ill or dying patients. Their expertise and comfort in this role must be improved if such consultation is to be effective."

Meier DE, et al. A national survey of physician-assisted suicide and euthanasia in the United States. *New England Journal of Medicine* 1998;338(17):1193-1201.

This national survey gathered data about physician-assisted suicide and euthanasia by mailing questionnaires to 3102 physicians in the 10 specialties "in which doctors are most likely to receive requests from patients for assistance with suicide or euthanasia." The authors conclude, "A substantial proportion of physicians in the United States in the specialties surveyed report that they receive requests for physician-assisted suicide and euthanasia, and about 6 percent have complied with such requests at least once."

Sulmasy DP, et al Physician resource use and willingness to participate in assisted suicide. *Archives of Internal Medicine* 1998;158:974-78.

This article focuses on the "relationship between general internists' tendency to conserve medical resources and their willingness to participate in physician-assisted suicide (PAS)." The authors assessed the relationship by coupling the evaluation of conservation of medical resources of physicians with a scenario of a terminally ill patient requesting PAS. The authors conclude, "While the characteristics of their practices do not affect PAS, physicians who tend to practice resource-conserving medicine are significantly more likely than their resource-intensive counterparts to provide a lethal prescription at the request of a terminally ill patient."

Kaplan KJ, Schwartz MB. Watching over patient life and death: Kevorkian, Hippocrates and Maimonides." *Ethics & Medicine* 1998;14(2):49-53.

Jack Kevorkian has accelerated the right to die debate with his widely publicized assisted suicides. This article explores his philosophic base from Greek philosophy, culture and medicine and contrasts it with a biblical view from 12th century Jewish physician, Moses Maimonides. The authors conclude, "Our contemporary culture is obsessed over the terminality of a patient because it is afraid to face the fact that as mortals, we are all terminal. We are obsessed with control because we sense that we really have very little control over the most important things in our lives. 'Helping a patient die' is not the same as 'helping a patient commit suicide.' Rather, it is to help the patient through the dying process when his time to leave this world has come. Is not Kevorkian as phobic about death as the medical establishment he opposes? Shall the physician's role be to bring death or to apply as best he can the many methods, physician and psychological, of relieving pain and bringing the patient comfort? As Maimonides acknowledges, the

physician can help bring a patient into the world. He need not abandon the patient when he leaves the world, instead aiding him in the dying process with a similar application of technical skill and compassion.”

Orr RD, Bishop L. Why psychiatrists should not participate in euthanasia and physician-assisted suicide. *American Journal of Forensic Psychiatry* 1998;19(1):35-48

“Public and professional discussions have recently raised the question of whether the longstanding proscription against physician-assisted suicide for terminally ill patients should be eliminated or changed. In this article, we review the history of the centuries-long debate, and repeat the arguments stated for and against such a change. We present our opposition to such a change based on the adverse consequences which would occur in the patient-doctor relationship, and the very likely extension of the practice from only terminally ill patients to some who are suffering but not dying, including patients with intractable mental suffering. We review the 10-year social experiment with public toleration of euthanasia in the Netherlands, and note its considerable expansion beyond the clear guidelines. We then discuss why we believe psychiatrists should continue to oppose the legalization of physician-assisted suicide. In addition to our concern about the extension to assisted suicide for mental suffering, we point out the adverse affect such changes would have on both the psychiatrist’s and the patient’s perception of the role of the therapist in other suicide situations, and the difficulty of uncovering a competent patient’s motivation for a request for such assistance.”

Engelhardt HT. Physician assisted suicide reconsidered: Dying as a Christian in a post-Christian age. *Christian Bioethics* 1998;4(2):143-67.

“The traditional Christian focus concerning dying is on repentance, not dignity. The goal of a traditional Christian death is not a pleasing, final chapter to life, but union with God: holiness. The pursuit of holiness requires putting on Christ and accepting His cross. In contrast, post-traditional Christian and secular concerns with self-determination, control, dignity, and self-esteem make physician assisted suicide and voluntary active euthanasia plausible moral choices. Such is not the case with in the context of the traditional Christian experience of God, which throughout its 2000 years has sternly condemned suicide and assisted suicide. The wrongness of such actions cannot adequately be appreciated outside the experience of that Christian life. Traditional Christian appreciations of death involve an epistemology and metaphysics of values in discordance with those of secular morality. This difference in the appreciation of the meaning of dying and death, as well as in the appreciation of the moral significance of suicide, discloses a new battle in the culture wars separating traditional Christian morality from that of the surrounding society.”

Kaczor C. Faith and reason and physician assisted suicide. *Christian Bioethics* 1998;4 (2):183-201.

“Aquinas’s conception of the relationship of faith and reason calls into question the arguments and some of the conclusions advanced in contributions to the debate on physician assisted suicide by David Thomasma and H. Tristram Engelhardt. An understanding of the nature of theology as based on revelation calls into question Thomasma’s theological argument in favor of physician assisted suicide based on examples of Christ and the martyrs. On the other hand, unaided reason calls into question his assumptions about the nature of death as in some cases a good for the human person. Finally, if Aquinas is right about the relationship of faith and reason, Engelhardt’s sharp contrast between ‘Christian’ and ‘secular’ approaches to physician assisted suicide needs reconsideration, although his conclusions about physician assisted suicide would find support.”

Stempsey WE. Laying down one’s life for oneself. *Christian Bioethics* 1998;4(2):202-24.

“Roman Catholicism has long opposed suicide. Although Scripture neither condones nor condemns suicide explicitly, cases in the Bible that are purported to be suicides fall into several different categories, and the Roman Catholic tradition can show why some of these should be considered morally wrong and some should not. While Christian martyrdom is praised, it is not correct to argue that this Christian outlook

invites suicide, or that it recommends physician assisted suicide for altruistic motives. Church tradition, from its earliest days, has clearly distinguished martyrdom from suicide. The principles of double effect and cooperation, mainstays in Roman Catholic moral theology, enable one to see the moral difference between martyrdom and suicide, and to appreciate why physician assisted suicide is wrong for both patient and physician.”

Mitchell C. When learned doctors murder. *Ethics & Medicine* 1999;15(1):1.

When and how do inexplicably immoral acts become not only ethically correct but even noble? In this article, the author traces the path to justification of medicalized murder in Germany during Hitler’s reign and compares this to the current physician-assisted suicide movement. He comments, “The language we use to describe moral medicine is not merely a matter of etiquette; it is revelatory of the way we understand the practice of medicine.” When we look at today’s ethical environment, the author writes, “the spectre of euphemistic language applied to assisted homicide is upon us again....By sheer redefinition, lawmakers think they can take the sting out of a practice we would otherwise find unconscionable.” He concludes with a noble call to those committed to Christian and Hippocratic medicine. “We must be willing to verbalize the truth that assisted death is a form of homicide and that those who practise it are guilty of murder or are accomplices to murder. [If] we are unwilling to be forthright and honest about what is happening, we ourselves may become accomplices.”

Weithman PJ. Of assisted suicide and ‘The Philosophers’ Brief.’” *Ethics* 1999: 548-78.

When the cases *State of Washington v. Glucksberg* and *Vacco v. Quill* came up to the Supreme Court to be decided, six philosophers (John Rawls, T. M. Scanlon, Robert Nozick, Thomas Nagel, Judith Jarvis Thomson and Ronald Dworkin) wrote an amicus curiae brief urging the court to affirm that “patients have a constitutionally protected right to secure the help of willing physicians in terminating their own lives.” In this article, the author argues against the points put forth in “the Philosophers’ Brief”.

Keown J. ‘Double effect’ and palliative care: A legal and ethical outline.” *Ethics & Medicine* 1999;15(2):53-54.

In this article, the author explains Aquinas’ rule of double effect and differentiates between the intent to do harm versus the undesirable effect of doing good, though the end result of both is the same. “Morality”, he writes, “is not just about consequences ...intention is important in medical and nursing ethics because it can not only determine whether an act is right or wrong, but it can define the very nature of the act itself.” As for the legal aspect of the double effect, “while foresight can be evidence of intention, it is never the same as intention.” The author concludes, “[The principle of double effect] informs and guides good palliative care and distinguishes it from ‘euthanasia’- intentional killing of patients. The principle remains an essential aspect of sensible medical ethics, good palliative practice and sound criminal law.”

McConchie D. Redefining the active / passive euthanasia debate- Part 1.” *Ethics & Medicine* 1999;15(3):70-74.

“The debate about the morality of active versus passive euthanasia is confused in the American context because of definitional problems. In order to create an atmosphere for meaningful debate, redefinition is necessary. Furthermore, one of the chief proponents of removing the distinction between active and passive euthanasia has been James Rachels. Rachels fails to account for moral intuitions in making decisions about the morality of euthanasia. Part 1 of this article argues that Rachel’s thesis is deficient and that both intention and situation are two moral notions on which the debate about euthanasia ought to focus. The debate over the morality and legality of active euthanasia commands new prominence in American society. With the US Supreme Court ruling that the legality of physician-assisted suicide should be decided by each state, special interest groups are fervently attempting either to pass or block the legalization of active euthanasia. Despite the Court’s ruling, the debate seems as murky and confusing as

ever. There are, therefore, very good reasons to look for a new way to examine the issues surrounding euthanasia."

McConchie D. Redefining the active / passive euthanasia debate: Introducing new categories to aid proper moral contemplation. *Ethics & Medicine* 2000;16(1):6-11.

"In part one of this article, I argued that the 'active / passive' terminology and categorization confuses rather than helps the euthanasia debate. In part two, I argue that 'situation' and 'intention' are necessarily required in any euthanasia discussion and I offer a new categorical structure that incorporates more fully than has traditionally been the case."

McCormick RA. Physician-assisted suicide: flight from compassion. *Christian Century* December 4, 1991; 108(35):1132-1143

A Catholic theologian analyzes the drift toward acceptance of physician assisted suicide. He believes there at least five converging cultural trends which will regrettably cause society to accept this concept in the foreseeable future: (1) the absolutization of autonomy without considering whether choices are good or bad, and the consequent intolerance of dependence on others, (2) the secularization of medicine which has divorced the profession from its moral tradition and made it into a business, (3) the inadequate management of pain, (4) the nutrition-hydration debate and the distinction between killing and letting die, and (5) the financial pressures of health care. He states [a]ssisted suicide is a flight from compassion, not an expression of it. It should be suspect not because it is too hard, but because it is too easy.

Peteet JR. Treating patients who request assisted suicide. *Archives of Family Medicine* 1994;3(8):723-727

A psychiatrist laments that the debate on physician-assisted suicide has focused on establishing safeguards instead of on the unique opportunities and responsibilities inherent in the role of physician as healer. He believes that rather than assisting in their suicides, physicians should address the needs that prompt patients to request it. In addition to relieving their physical causes of suffering, they can help patients to establish realistic hopes by expanding their possibilities, bear suffering by assuring them that their suffering is understood, and by remaining with them and achieving perspective by reviewing the meaning of their lives. He states that these compelling responsibilities are rooted in the medical traditions of beneficence, virtue, and sharing of power. Physicians inability to meet all of their patients' needs does not detract from the importance of the psychological, personal, and pastoral aspects of their role.

Miles SH. Physicians and their patients suicides. *JAMA* 1994;271(22):1786-1788

A geriatrician/ethicist offers a profound and personal insight into the effect on the physician s psyche when a patient commits suicide. He concludes that the societal taboo against physician-assisted suicide is constructive because it may prevent suicides which are improperly based on the physician s own fear of dying and it enable and point to the necessity of an honest, painful intimacy to better understand and treat suffering patients.

Bernardi, Peter J. "Dr. Death s Dreadful Sermon." *Christianity Today* August 15, 1994; 38:30-32

The author maintains that the campaign to legalize physician-assisted suicide is gaining momentum due both to the depiction of such an act as a right and to current societal conditions. He points out that the right not to have to suffer has its roots in the right to choose and the right to privacy which were extolled in the Roe v. Wade case that legalized abortion. Such a case in effect set the stage for the potential legalization of physician-assisted suicide. Further, society s increasing ascription to the belief that people have a right not to suffer (because suffering has only negative consequences) and that they have a right to choose, or control their own destiny (even in dying), has resulted in mounting support for physician-assisted suicide. The widespread violence, increasing fragmentation of family, and overall lack of respect

for human life which characterize our society also contribute to a climate in which physician-assisted suicide may flourish.

Dyck, Arthur J. "Physician-Assisted Suicide--Is It Ethical?" *Harvard Divinity Bulletin* 1992; 21(4):16-17

In this discussion of physician-assisted suicide, the author considers the case of Dr. Timothy Quill, who assisted in the suicide of his patient Diane. This patient was diagnosed with leukemia and did not wish to undergo treatment estimated to give her a 25% chance of survival. In his analysis of the case, the author points out that although physician-assisted suicide is often portrayed solely as an act which bestows absolute autonomy on those who wish to die, the conditions and objectives of the physicians involved and of the medical profession as a whole also enter into such decisions to end life. Thus, physician-assisted suicide is most often not completely voluntary and may become, as in The Netherlands, increasingly involuntary.

Kass, Leon R. "Suicide Made Easy." *Commentary* 12/91; 92(6):19-24

In examining the increasing societal trend to favorably regard assisted suicide as a rational, humane, and courageous act, the author contends that the inherent evil of such an act is thereby dangerously disguised. Because assisted suicide is not depicted as overtly evil but is instead characterized as an act which serves humanity by delivering people from their suffering, its power to garner support is especially sinister. In a similar vein, Derek Humphrey, a prominent advocate of assisted suicide and the author of *Final Exit* (a handbook on how to end one's life), also masquerades as one who, apart from being evil, is exceedingly compassionate. Humphrey is here criticized for failing to honor the professional ethics of medicine which forbids physicians to assist in bringing about the death of their patients. While acknowledging that issues at the end of life are becoming increasingly problematic due to increases in technology, etc., the author nevertheless asserts that the professional ethics of medicine includes an absolute proscription against physician assistance in dying.

Kilner, John F. "Physician-Assisted Suicide: What's the Story?" *Christian Scholar s Review* 1994; 23(3):349-59

Instead of invoking considerations of biblical dictates or current trends in society as factors in the debate over assisted suicide, the author illuminates the issues involved in such a debate via the real life story of a family confronted with making a decision for or against such an act. In doing so, he illustrates how factors such as lack of sufficient health insurance, ineffective pain management, intolerable suffering, and the fear of loss of control can result in the regarding of physician-assisted suicide as a very favorable option. Gospel accounts of Jesus' life in which he endured suffering in order to maintain allegiance to God are used as basis for the absolute proscription of physician-assisted suicide.

Pellegrino, ED. "Physician-Assisted Suicide", in *Dignity and Dying: A Christian Appraisal*. Ed. John F. Kilner, et al. Grand Rapids, Mich.: Eerdmans; and United Kingdom: Paternoster, 1996.

While asserting that philosophical arguments may be employed to refute the bases for justifying euthanasia and assisted suicide, the author believes that such arguments constitute primarily a negative or defensive response to the case for assisted dying. He points out that both those who favor and those who oppose euthanasia and assisted suicide often cite the same bases for their disparate commitments. That is, both Christians and proponents of assisted dying intend to act in the name of compassion and human freedom and dignity. Because the Christian understanding of these concepts differs markedly from that which is used to support assistance in dying, Christians must introduce the theological meaning and implications of such concepts into the present debate.

Orr RD. "Physician-Assisted Death ", Chapter 12 in *New Issues in Medical Ethics*, Hollman J, ed; Bristol, TN: Christian Medical and Dental Society, 1995:181-188

After discussing the history of suicide, eugenics and euthanasia, the author outlines the pro and con arguments of the modern physician-assisted suicide/euthanasia debate. He then gives a more detailed history of the Netherlands experience of the last 15 years including data from the 1990 Remmelink Report. He draws a clear distinction between decisions to forgo treatment and physician-assisted death, showing differences of intention, attitude, means, and agency. He concludes that hospice care, the compassionate care of dying patients and their families, is the morally required alternative to physician-assisted death.

Hendin H. Selling death and dignity. *Hastings Center Report*, 1995; 25 (3):19-23

The author, a psychiatrist, uses two case descriptions from TV and the popular press to demonstrate that patients may be encouraged or even coerced into a suicidal decision or action. He maintains that the empowerment which is supposedly directed to the vulnerable patient is really being given to that person's relatives and physician.

Verhey A. Choosing death: The ethics of assisted suicide. *The Christian Century*, July 17-24, 1996:716-719

In commenting on two recent federal Courts of Appeals decisions, the author, professor of religion at Hope College, points out that the judges are trying to maximize freedom and personal autonomy. However, choosing this path then requires the weak and the sick to justify their continued existence. He acknowledges that Scripture presents life and its flourishing as goods, but not the ultimate good. Thus we need not cling desperately to life; other goods may be more weighty. At the same time, however, we may not kill. Christians must not choose death or intend death by their actions.

Bibliography

Pellegrino ED. "Evangelium Vitae, Euthanasia, and Physician-Assisted Suicide: John Paul II's Dialogue With the Culture and Ethics of Contemporary Medicine" in *Choosing Life: A Dialogue on Evangelium Vitae*. Washington, DC: Georgetown University Press, 1998. pp. 236-53.

Battin MP, Rhodes R, Silvers A, eds. *Physician Assisted Suicide: Expanding the Debate*. New York, NY: Routledge, 1998.

This book contains essays from prominent authors such as Daniel Callahan, Edmund Pellegrino and Allen Verhey.

Salem T. Physician-Assisted Suicide: Promoting Autonomy — or Medicalizing Suicide? *Hastings Center Report* 1999;29(3):30-36.

Watson RA. Doctor, Thou Shalt Not Kill. *The Linacre Quarterly* Aug 1998;65(3):23-42.

The author argues from different angles against physician assisted suicide.

Eber G. End of Life Decision Making: An Authentic Christian Death." *Christian Bioethics* 1997;3(3):183-187.