
Euthanasia: The Time Is Now

Gerald A. Larue

The phone rings. The caller is a professor in Canada. Her mother is in the hospital, in extreme pain and slowly dying of cancer. Medications cause grogginess or put her to sleep, but even in her drugged state she experiences pain. She begs her daughter to help her die, to relieve the suffering, to take away the pain. Even as the daughter talks with me from the hospital room the mother is moaning in her sleep. I ask what the prognosis is. There is no cure. The pain will continue and become more severe as the cancer continues to invade vital organs. It is estimated that there will be two or three weeks of suffering before the exhausted, cancer-ridden woman will die. What can the daughter do?

I note the details, record phone numbers—the daughter's home, the hospital room. I have no magic prescription. I tell the daughter to talk to the doctor and then call me back.

Two days pass. I am haunted by the call, by the pain in the professor's voice, by feelings of my own helplessness. I dial the hospital room. The daughter answers. "Oh, I am so glad you phoned. I have just given my mother the lethal injection." I am stunned. What happened? "I did what you told me. I talked to the doctor. Today he came down the hall and put a syringe in my hand and told me he never wanted to talk to me again about this matter." I ask what is happening now. "My mother and I said goodbye. I gave her the injection. She is sleeping now and seems to be without pain. She has that wonderful little smile that I love. It is the first time I've seen it in weeks."

We meet a year later when she is in Los Angeles. What are her feelings now? "I feel wonderful. My mother's death was peaceful. The suffering stopped. We said how much we loved each other. She thanked me for what I was about to do. I gave her the injection and shortly afterward she died. I feel that I acted in love." But is there any guilt? "None at all. I feel proud of what I did. I stopped her agony. She wanted to die and I fulfilled her wishes. There is no guilt."

I have heard stories like this over and over again. Never have there been any feelings of guilt or of betrayal of trust or of having unnecessarily killed someone. In each instance,

the act of assisting death has been described as a final statement of love.

I have encountered guilt in those whose loved one died in agony, begging for death, and the friend or relative or lover did nothing to end the suffering. A rugged, elderly Norwegian said, "He was my best friend. He asked me to help him. He died in agony and I did nothing to help him die. I have carried that burden ever since." A man in Arizona, in pained reminiscence, said, "She cried and moaned in the morning, she cried and moaned at noon and during the night. She begged me to help her die. She died crying and moaning. I can hear her cries still. I feel that I failed my wife when she needed me most."

The phone rings. The call is from an East Coast man I met at a humanist conference nearly twenty years ago. He has AIDS and before the disease wastes his body and strength to the point where he becomes helpless and unable to act, he wants to stockpile medication and die by his own hand. I cannot recommend medication. I refer him to the book *Let Me Die Before I Wake*, by Derek Humphry.¹ He asks about euthanasia in Holland and I tell him of the magnificent work of Pieter Admiraal, but warn him that Dr. Admiraal helps only his own patients. I probably will not hear from him again.

His call reminds me of a young man who had had throat cancer. It was in remission when he talked to my Death and Dying class at the University of Southern California. Then, some eight months later, he phoned. He wanted to say goodbye. His voice was weak and hoarse. The cancer had returned and there was no cure. He owned a small, isolated cabin. He was inviting his closest friends (I was not one) to visit with him, one or two at a time, to make their farewells. He died a short time later by his own hand. He was in control of his own death. He determined the moment and the mode of his death. He was in charge. He had time to make closure with those who mattered most to him and even with some, like me, who were more distant friends. He died with dignity.

There are others who did not die with dignity. Max Ferber, who wrote the moving piece, "I Cried, but Not for Irma,"² told my class that he watched his wife die in a hospital with tubes attached to almost every orifice of her body. She was comatose because of her medications. As he looked at this woman whom he loved and to whom he had been married

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for nearly fifty years, he felt anger at the indignity of her death. He wept, not because she was dead, but because of the manner of her dying. She was receiving the best medical treatment, but her case was hopeless and the treatment simply prolonged her dying.

Max's anger drove him to actively support the California Natural Death Act, which gives individuals the right to deny "heroic treatment" by signing a living will. This document enables healthy persons to make known their wishes that heroic measures not be taken to prolong their lives should they become incompetent during a terminal illness.

I recall the young man I met at a Right to Die Conference at Oxford. He was a quadriplegic, confined to a motorized wheelchair that he maneuvered with amazing skill. He hated his life. It had no quality. He wanted to die, but nobody would help him. He once attempted to steer his chair over a cliff, but someone intervened. After I returned to America, I read about his death. He had purchased a considerable quantity of gasoline and spread it throughout the small cottage he owned. He then managed to ignite it and was cremated alive. What a horrible way to die! How much more dignified and merciful his death would have been if a compassionate medical friend had been able to provide a lethal injection.

Notions about the sanctity of life have meaning and significance only when we are healthy and life is under our control. The sanctity concept is reinforced by religious dogma and social abhorrence of killing except in extenuating circumstances, such as during wartime or in self-defense. To violate such generally accepted norms is to come under judgment from religion, from society, and most of all from the law. We are told that "God gives life and only God should take life." In nontheological language this means that "nature produces life, nature terminates." Life and death are natural facets of existence on planet earth. When this naturalistic concept is theologized, the caring dimensions of our common humanity are set aside. We are informed that it is legally right and just, and theologically and sociologically proper, to prolong the life of a terminally ill person who is in intractable pain. The doors of mercy and compassion are closed and legalistic thinking is in charge.

To challenge these beliefs is not to sanction suicide or murder. It is clear that the depression and despair that prompts normally healthy individuals to suicide can be dealt with psychologically; likewise, killing another for a selfish reason such as anger cannot be justified. But euthanasia is something quite different and must be separated from suicide and murder in the eyes of society.

The wonderful progress of modern medical science has given us longer lives, medications to fight disease and control illness, and engineering that can cleanse kidneys, maintain heart and lung functions, and so on. Our trained medical practitioners are committed to sustaining life through the fullest use of such technology, but there are times when this commitment can become a burden to the patient, to the family, to the hospital, and to modest bank accounts. When the illness is terminal and the patient is in intractable pain and has expressed the wish to die with dignity, the time has come when the medical doctor should be allowed to respond to

the request for death. This act is not murder, it is voluntary euthanasia—providing a good death, a dignified death. Similarly, when such a patient is able to end his life without assistance, the result should not be classified as suicide.

The word euthanasia means a good death, a beneficial death, a dignified death. It signifies the termination of life when the quality of life as defined by the patient has degenerated to the point of meaninglessness, when the illness has reached a stage beyond the help of any physician or medicine, when the pain has become unremitting and the palliatives are inadequate and ineffective. At that point the afflicted person should have a choice: to continue to live in

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pain or to die and end the suffering. Because many terminally ill persons have been reduced to helplessness by their disease, they need aid in dying. The time has come when the aid-in-dying should be as readily available as a palliative when the patient requests it.

A properly signed and witnessed living will justifies legally, morally and, in most instances, theologically, the removal of life-support equipment when a life that would otherwise end is being sustained artificially by machines. This form of euthanasia, popularly known as "passive" euthanasia, is widely practiced throughout the world. Nevertheless, there have been cases, like that of Karen Ann Quinlan, when the heart continued to beat and the lungs continued to function after the machinery was removed. In such cases, if the patient has made the proper request, a lethal injection should be legally available, lending moral and perhaps theological support.

Of course, some physicians may refuse to participate in euthanasia, and some hospitals may refuse the right to practice euthanasia. The objections rest on religious, moral, and ethical interpretations, and decisions based on them deserve respect. The patient and his family can find physicians and hospitals willing to cooperate. Indeed, the wise patient and family will check with both the physician and the hospital to be sure that the patient's wishes will be honored.

On the other hand, there is good evidence that some doctors currently do give assistance in dying. There are those who, like Dr. Meyers in Scotland, Dr. Admiraal in Holland, and Dr. Christiaan Bernard, formerly of South Africa, have made no secret of their participation in acts of active euthanasia. In addition, polls taken in France, California, and Australia have demonstrated that physicians are willing to admit to the practice of voluntary active euthanasia, as long as their identities are not revealed.³

In public, medical doctors generally maintain that they are opposed to euthanasia. Off the record, however, some will admit that on numerous occasions they have administered

huge overdoses of morphine to terminally ill patients for “pain control,” knowing full well that the dosage is lethal and the patient will die. They protect themselves from potential lawsuits or murder charges by using vague medical language to justify their actions; they do not practice euthanasia, they practice pain control. But in so doing they often bring about the patient’s death.

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At present, though most religious organizations oppose voluntary active euthanasia, they support “passive” euthanasia⁴ based on the belief that by removing life-sustaining machines, the physicians are not actively doing anything to bring on death, but are merely removing an impediment to natural death. This argument is obviously specious, for in the act of removing the machinery, death is engendered. There is fundamentally no difference between so-called passive euthanasia and active euthanasia where lethal medication causes death.

Humanist groups and Unitarian Universalists openly support active euthanasia. When I have talked with clergy belonging to denominations that oppose euthanasia, I have encountered some church leaders who are well acquainted with the indignities and agony of terminal disease. They have witnessed death without dignity among their parishioners and in their own families. But until their denomination takes a

Doctors Polled on Life Support

Nearly eighty percent of American physicians favor withdrawing life-support systems from “hopelessly ill” or irreversibly comatose patients if the patients or their families request it, according to a survey conducted by the American Medical Association.

The physicians were selected at random from the association’s files of active doctors, including members and nonmembers and physicians of various ages and both sexes.

The doctors were asked: “Would you favor or oppose withdrawing life support systems, including food and water, from hopelessly ill or irreversibly comatose patients if they or their families request it?” Fifty-eight percent answered “favor strongly,” twenty percent answered “favor,” five percent answered “oppose,” ten percent answered “oppose strongly,” and seven percent answered “unsure.” Sixty-seven percent of the doctors said they had been directly involved in such cases.

Fifty-four percent said they were uncertain of the legal risks and responsibilities, while forty-three percent said they were certain. Ninety percent said doctors should initiate discussions with patients or families, while 7 percent said they should not.

stand, they will maintain silence about their private beliefs.

The time has come to release medical personnel and hospitals from the fear of legal prosecution for practicing euthanasia with patients who are terminally ill and who truly wish to die. It is possible to provide protective legislation against abuse. It is important that families and caring nonmedical persons be relieved of the burden of employing secretive ways to assist those they love who suffer terminal illness to die with dignity.

One might argue against the young man in England who died in his self-made holocaust, but, horrible as his death was, he was in charge, he made the decision. It was not a good death, but there was nobody to help him to achieve that end. Of course, not all quadriplegics want to die. I have met many who, despite their limitations, are living wonderfully fulfilling, happy, and constructive lives. One world-class gymnast suffered a fall that left him quadraplegic. He controls his motorized chair by blowing into small tubes mounted near his face. He is now a sportscaster and a consultant to a firm that designs equipment for the handicapped. He exudes enthusiasm about life and has no desire to die.

But we are not all the same. I believe that if I were to become helplessly bedbound, limited in action and in the ability to perform for myself, I would want to have the right to choose for myself whether to continue to live. And should I, in my helpless state, decide not to live, I should like to have a caring physician administer a poison that would permit me to die quietly and with dignity. I should not like to have a nonmedical friend provide the lethal medication; there are just too many instances of bungled help. Furthermore, should I be terminally ill and in intractable pain, and should my continuing existence be a matter of only a few weeks, I should like to be able to bid farewell to those I love. To know that I am in control of my death would provide peace of mind even in the midst of pain. To be able to tell those who matter most to me how much I love them, to clear up any misunderstandings, to decide about the distribution of small possessions (my will takes care of other matters) would place me in control of my being and my life right up to the last moment.

Not everyone would choose euthanasia. There are those who would prefer to fight for life in the midst of pain up to their last breath. This is their right. But we should all have the power to choose. The time has come for the legalization of voluntary medical euthanasia for the terminally ill.

Notes

1. Derek Humphry, *Let Me Die Before I Wake*, Los Angeles: Hemlock/Grove, 1986.

2. Max Ferber, “I Cried, but not for Irma,” *Readers Digest*, April 1976.

3. *November 1987 Survey of California Physicians Regarding Voluntary Euthanasia for the Terminally Ill*, Los Angeles: The National Hemlock Society, 1988. See also Helga Kuhse and Peter Singer, “Doctors’ Practices and Attitudes Regarding Voluntary Euthanasia,” *The Medical Journal of Australia*, Vol. 148, 1988, pp. 623-627; and “5 French Doctors Aided in Deaths of Ill,” *International Herald Tribune*, September 30, 1984.

4. Larue, Gerald A., *Euthanasia and Religion*, Los Angeles: Hemlock, 1985. ●