

I am addressing you today about a topic of urgent concern not only for Catholics, but for our culture, that has recently come to the fore in California. A new bill has been introduced into the California Senate—SB 128--called “The End of Life Option Act.” It is being heavily promoted by the Hemlock Society (which has renamed itself Compassion and Choices). The objective of the proponents is to try to pass legislation permitting physician-assisted suicide this year, but failing that, to forward a Voter Initiative to the public in 2016. This would make California the fourth state permitting physician-assisted suicide without approval by a court.

It is important to recognize from the outset that this initiative is not concerned with “death with dignity” in the sense of people refusing excessive or overly burdensome treatment at the end of life. The Catholic Church and the USCCB have supported the freedom of Catholics to refuse such treatment, and even provides resources to help you make decisions about treatments at the end of life.¹ So what does this *new* legislation concern? It concerns the legalization of physician-assisted suicide—where physicians could provide lethal doses of pharmaceuticals to be self-administered by terminally ill patients. Some of you may be thinking—“so what’s wrong with that if this option is completely voluntary?—if people don’t want it, they don’t have to take it—the legislation is simply giving an option to those who want it.” The ethical and cultural issues may not at first be evident, but I think I can bring them to light by examining the three major militating principles given to us by Jesus and the Catholic Church. The principles are as follows:

1. Our duty to protect the life and dignity of the sick, weak, poor, and defenseless.
2. Our duty to assure that new laws do not impose onerous burdens -- such as the duty to die -- on the vulnerable.
3. Our duty to prevent cultural decline arising out of laws that devalue or degrade human life.

Let’s begin with the first principle – *Our duty to protect the life and dignity of the sick, weak, poor, and defenseless*. To begin with, most assisted suicide advocates admit—pain is not the reason for advocating suicide—because most pain from terminal illness can be adequately controlled by physicians. According to the 1992 manual produced by the Washington Medical Association -- “adequate interventions exist to control pain in **90 to 99% of terminally ill patients.**”² Additionally, most of the depression leading to suicide attempts can be treated adequately with current protocols and treatment.³ After extensive study of physician assisted suicide requests, Dr. Kathleen Foley, former Director of Palliative Care at the Memorial Sloan Kettering Cancer Center, concluded:

¹ See the California Catholic Conference’s document on End of Life Decisions and Directories <http://www.cacatholic.org/index.php/component/content/article/77-linked-articles-and-directories/583-frequently-asked-questions-end-of-life>

² Albert Einstein, 1992, “Overview of Cancer Pain Management,” In Judy Kornell, ed., *Pain Management and Care of the Terminal Patient* (Washington: Washington State Medical Association) p.4.

³ See Burke Balch and R. O’Bannon, 2000, “Why Assisted Suicide Should not be Legalized.” (<http://www.texasrighttolife.com/about/159/Why-assisted-suicide-should-not-be-legalized>)

When these fears [about pain, depression, and self-worth] are dealt with by a caring and knowledgeable physician, the request for an expedited death *usually* disappears.⁴ The developments in the treatment of pain and depression in terminally ill patients has caused the Hemlock Society to shift its focus away from pain and depression to the *indignity of the need for assistance* – as if the help we need and give to each other is some kind of enemy that must be overcome rather than the very part of life that makes us human and gives us the opportunity to give and receive love and compassion.⁵ This should concern us all, but has particularly alarmed the disability rights community, because it undermines the dignity of the disabled. Marilyn Golden, a policy analyst for the Disability Rights Education and Defense Fund, responds to this idea as follows:

As many thousands of people with disabilities who rely on personal assistance have learned, needing help is not undignified, and death is not better than reliance on assistance. Have we gotten to the point that we will [advocate for] suicides because people need help using the toilet?⁶

This is the reason that there is such a broad coalition against physician assisted suicide – from the World Health Organization to the American Medical Association, and beyond.⁷

If suicide is to be preferred over needing assistance, what does that say about the worth and dignity of disabled people? Are we telling the weak, the dependent, the vulnerable, and the poor that they are a burden and it would be better if they just *went away*? Are we not saying that death is better than compassion? Are we not reversing the teaching of Jesus Christ who said that love conquers death? The influence of culture and cultural trends is amazingly strong, and if this prioritization gains momentum, we will enter into a new level of the culture of death.

The second principle concerns our duty to *assure that new laws do not impose onerous burdens -- such as the duty to die -- on the vulnerable*. It runs as follows: A law permitting freedom to one group cannot impose an excessive or onerous burden on another group. At first glance, it might seem difficult to see how permitting assisted suicide for one group of people could impose an onerous burden on another group of people. Nevertheless, many physicians and ethicists have warned against this possibility precisely because “the mere *option* of assisted suicide” can put pressure on vulnerable people to request it against their wishes. This is particularly true for all people who could be persuaded that they, or their family, or the world

⁴ Kathleen Foley, M.D., and Herbert Hendin, M.D. 2002. p. 314.

⁵ R. Leiby 1996 “Whose death is it anyway? the Kevorkian debate; it’s a matter of faith, in the end.” *Washington Post*. 1996, Aug 11.

⁶ Marilyn Golden and Tyler Zoanni 2010. p.1.

⁷ In addition to the World Health Organization and the American Medical Association, the following are also opposed: The American College of Physicians, the National Hospice and Palliative Care Organization, the American Geriatrics Society, the American Hospital Association, the American Cancer Society, many other medical organizations; the League of United Latin American Citizens (LULAC)—as well as virtually every major national and international disability rights organization.

See Kathleen Foley, M.D., and Herbert Hendin, M.D., 2002, *The Case Against Assisted Suicide: For the Right to End-of-Life Care* (Baltimore: Johns Hopkins University Press) p. 3. And also see Marilyn Golden and Tyler Zoanni 2010 “Killing us softly: the dangers of legalizing assisted suicide” in *Disability and Health Journal* (<http://dredf.org/PIIS1.pdf>) p.1.

would be better off if they were dead. Ethicists and directors of palliative care⁸ write extensively about how seldom the decisions made by dying patients are truly autonomous, and how easily they are influenced or manipulated. For example, after the legalization of assisted suicide in Oregon, the physician of Kate Cheney refused to prescribe lethal medication for her because he thought the request was not her free choice, but came from pressure applied by her assertive daughter who was tired of caregiving. The daughter then found a more agreeable physician who wrote the prescription, after which Ms. Cheney took the lethal “medication” and died.⁹

It is irrelevant whether family members, friends, or physicians are well-intentioned or not—if they suggest that a person might be better off dead, then he or she could take that suggestion as a rejection of self-worth and lovability – and acquiesce to the perceived request to die.

Is this a real concern? The experience in the states of Oregon and Washington indicate that it is. Who are the populations most likely to feel the pressure to commit assisted suicide? Those who feel like a burden to their friends and family, those who feel badly about having a weakness or an illness, those who are reversibly depressed because they have been diagnosed with a terminal illness, those with clinical depression, and those who have low self-esteem—in other words, a huge segment of American society. Once again the victims are those who are most vulnerable—who need our protection—so that they might have what they truly desire—continued life! Recall that the majority of assisted suicide requests are *reversed* when pain and depression are treated adequately.¹⁰

The pressure to commit assisted suicide is also exerted by insurance companies who are carrying out the mandate of new euthanasia legislation. In Oregon, for example, a cancer patient named Barbara Wagner was sent a letter by a company administering the state’s insurance plans stating that they would not pay for a drug that would help treat her cancer, but instead would pay for her assisted suicide. She told the *Seattle Times*, “I was absolutely hurt that somebody could think that way. They won’t pay for me to live but they will pay for me to die.”¹¹ Such letters are not uncommon, and the pressure to die they exert did not exist before the legalization of assisted suicide. This onerous burden to die is not only contrary to ethical laws; it is radically contrary to the teaching of Jesus who loved the weak and vulnerable and held them in highest esteem.

The third and final principle concerns *our duty to prevent cultural decline arising out of laws that devalue or degrade human life*. This principle enshrines not only the teaching of Jesus,

⁸Two of the most prominent experts are Dr. Leon Kass, M.D., Professor of Medical Ethics at the University of Chicago, and Dr. Edmund Pellegrino, former Director of Bioethics at the Georgetown University Kennedy Institute of Ethics – now renamed after him. See Leon Kass 2002 “I Will Give No Deadly Drug: Why Doctors Must Not Kill” in Kathleen Foley and Herbert Hendin 2002, pp. 17 – 40. See Edmund Pellegrino 2002 “Compassion is Not Enough” in Kathleen Foley, M.D. and Herbert Hendin, M.D., 2002, pp. 41-49.

See also Leon Kass, M.D. 2001 “Preventing A Brave New World” in *The New Republic* June, 2001.

⁹ See Marilyn Golden 1999 “Why Assisted Suicide Must Not Be Legalized” in *Disability and Health Journal* (http://dredf.org/assisted_suicide/assisted-suicide.html)

¹⁰ See Kathleen Foley and H. Hendin 2002. p. 314.

¹¹ See Hal Bernton, “Washington’s Initiative 1000 is Modeled on Oregon’s Death with Dignity Act,” *Seattle Times*, October 13, 2008.

but also that of St. John Paul, Pope Benedict, and Pope Francis on the culture of life. Physician-assisted suicide threatens the culture in two respects:

- A. It reconfigures our view of “the quality of life.”
- B. It legitimizes and normalizes suicide as socially and morally acceptable.

With respect to the first point, Dr. Daniel Callahan of the Hastings Center for Bioethics Research states what Catholics have known for centuries -- “noble and heroic life can be achieved by those who have little or no control over the external conditions of their lives, but have the wisdom and dignity necessary to fashion a meaningful life without it.”¹² What Callahan is saying is that we have a fundamental option about how to define “quality of life.”

Should we define quality of life in terms of our strengths, abilities, intellectual acuity, and competitiveness—or should we define it in terms of a relationship with the loving God, the compassion we show to others, and the contributions we try to make to the various people and causes around us? If we define “quality of life” in the first way—then suffering has no meaning—and as we lose our mental acuity, physical agility, autonomy and competitiveness, we will see our quality of life slipping away—leading to a sense of purposelessness, worthlessness, emptiness, and malaise. However, if we define “quality of life” in the second way, and put on the mantle of Christ, then we will likely see a remarkable transformation take place during the time of our physical and natural decline—namely, an increased capacity for trust in God, and compassion for, and forgiveness of others. As St. Paul said, “I will boast in my weaknesses, in order that the power of Christ may dwell with me—for when I am weak, then I am strong” (2 Cor. 12: 9-10).

Weakness and diminishment are sublime dignities -- not scandals, impositions, or degradations. We as Catholics must stand up for this by word and example--as Pope Francis has encouraged us -- so that the most vulnerable in our society will not only be protected but flourish in their true dignity of imparting faith, wisdom, forgiveness and compassion to their loved ones before they pass to the next life.

The second major cultural problem brought about by physician-assisted suicide concerns the legitimizing of suicide itself. There is an old expression in the philosophy of law—“What becomes legal, soon becomes acceptable, and what becomes acceptable, soon becomes ‘moral’ -- because ‘everyone’ is doing it.”

What are we saying to our young people when we legalize assisted suicide? Of course – we are telling them that suicide is acceptable, which opens the door for them to conclude that it is moral. We are creating a cultural trend – not merely for the toleration of suicide, but for its *goodness* – its moral acceptability. We should not be surprised if suicide rates – of both young and old -- increase as we stoke this cultural trend. This has certainly happened in Holland, where lethal injection and assisted suicide rates have increased every year over the six years between 2006 to 2012 -- with a 13% increase in 2012. The Dutch now have “mobile euthanasia units” that will promptly come to a person’s home to administer lethal drugs upon request.¹³

¹² See Kathleen Foley, M.D. and Herbert Hendin 2002 p.9.

¹³ Kate Connolly 2012, “Dutch mobile euthanasia units to make house calls” in *the guardian* (United Kingdom) March 1, 2012.

If the California initiative succeeds, it will accelerate the assisted suicide trend in the United States – and if we are anything like Holland, it will cast not only a shadow, but a deep darkness upon our culture—not lifting us up to the light of Christ, but pulling us down into the eros of death.

Catholics have championed the above three principles throughout the centuries. Recall, almost immediately after the resurrection of Jesus, the *Church* started a healthcare system, a social welfare system, and an educational system extending far beyond the Christian community. It reached out especially to the weak and the vulnerable – particularly slaves.¹⁴ This concern for the weak, sick, poor, and marginalized eventually led to the diminishment of Roman slavery and to the largest international healthcare, social welfare, and public education system in existence.

Today, I am asking for your help. Would you please read some of the resources available at the back of the Church and seriously consider working against this legislation by *contacting your state senators and legislators*. Would you please go to the California Conference Website – www.cacatholic.org, click on the red icon which says, “Urge a ‘No’ Vote on Assisted Suicide” – and simply follow the prompts.

Let us pray and work together to help our culture understand the tragedy and danger this legislation presents to the vulnerable populations living within it.

Sincerely,

Bishop Kevin Vann

¹⁴ Helmut Koester 1998 “The Great Appeal: What did Christianity offer its believers that made it worth social estrangement, hostility from neighbors, and possible persecution?”
(New York: WGBH Educational Foundation)
pbs.org/wgbh/pages/frontline/shows/religion/why/appeal.html