Freedom to Flourish:

A Catholic analysis of doctor–prescribed suicide and euthanasia

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Introduction†

The sheer amount of information that modern life brings offers innumerable topics of discussion. Everyday clamor provides ample distraction, and certain topics that might lack immediacy to the young or to the willingly distracted—such as the subject *of death—can be shelved indefinitely* in favor of the immediate. However, when a friend or loved one encounters the real and present possibility of death, many things that once seemed important recede into the distance and those things which are truly important cry out for immediate attention.

Generally, until a friend or loved one actually faces death, many people do not stop to consider their own mortality. Consequently, when the certainty of death finally comes, it overwhelms those who do not know how to approach it in a mature fashion. All too frequently, even those people who have serious illnesses do not want to talk about death with anyone, and important conversations about medical care never take place. It is important that one be able to think about and discuss these frightening issues with fortitude and compassion.

Sadly, when conversations about death do take place, they are frequently motivated by proponents of those doctors who are willing to help patients kill themselves. Known as "physician-assisted suicide" or "doctor-prescribed suicide," this dangerous trend is being discussed throughout America and the world. However, doctor-prescribed suicide and euthanasia are rooted in erroneous and incomplete concepts of human freedom and human dignity.

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† Significant sections of this booklet come from the following sources which form its theological core:

Saliga, Christopher M., O.P., RN, "Freedom at the End of Life: Voluntary Death versus Human Flourishing," *The National Catholic Bioethics Quarterly* 6.2 (Summer, 2006): 253-262.

Saliga, Christopher M., O.P., RN, "In Appreciation of John Paul II's *Redemptor hominis:* God as the Source of Intrinsic Human Dignity," *The Dominican Torch* 5.1 (2007): 25-27.

Saliga, Christopher M., O.P., RN, "Why do Human Beings Have Intrinsic Dignity," *Catholic Exchange,* 04 May 2010 <http://catholicexchange.com/2010/05/04/136382/>.

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Addressing the erroneous concepts which are used to justify doctor-prescribed suicide and euthanasia as viable solutions to suffering requires a careful and thoughtful response. The Church's absolute opposition to these practices is properly understood as both a protection of a person's full freedom to flourish, and as a promotion of the deepest dignity of each human being.

It should be mentioned here that on June 16, 2011, as this booklet was being sent to print, the US Bishops approved "To Live Each Day With Dignity: A Statement on Assisted Suicide" that specifically addresses many of these issues. For more information, please see www.usccb.org/toliveeachday.

Killing to End Suffering?

Both doctor-prescribed suicide and euthanasia simply amount to killing. Rather than merely having a "right to die" so as to avoid suffering, legalization of these practices amounts to permission to kill one's self, to help people kill themselves or to kill others.

Notwithstanding any of the usually offered justifications, the Catholic Church clearly recognizes euthanasia, and, by extension, doctor-prescribed suicide, as "an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated."[1] For example:

> (1) If a doctor prescribes a lethal dose of medicine to a patient so that the patient can kill himself in order to end suffering, the doctor sets the conditions by which the patient can kill himself. When the patient follows through by taking the medicine and then dying, this is a successful act of "doctor-prescribed suicide."
>
> (2) If a doctor withholds or discontinues something vitally important, such as water and food, in order to end a patient's

[1] Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, 05 May 1980 <http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html>.

suffering via death, or if a doctor gives a lethal dose of medicine to end a patient's suffering, the doctor kills the patient. If the patient actually dies, this is a successful act of euthanasia.

Whether desired and voluntarily entered into by the patient or not, the nature of the killing act remains the same. Regardless of the phrasing, killing is killing.

The Catholic Church clearly holds that no person, regardless of good intentions and/or bad circumstances, may "condone or participate in euthanasia or assisted suicide [also called "doctor-prescribed suicide"] in any way."[2] The prohibition is absolute, and the Church recognizes no exceptions to any such killing. One might wonder: Is the Church's absolute NO to suicide and euthanasia unreasonable? It is not unreasonable. Might there be some exceptions? There are no exceptions.

Crucial distinctions between the concepts of *autonomy* and *freedom to flourish* versus *attributed dignity* and *intrinsic dignity* show that the Catholic Church's NO to this type of killing is far more reasonable and nuanced than the use of similar terms which are often wielded in defense of doctor-prescribed suicide and euthanasia.

Rationale for Killing

Within the state of Oregon, doctor-prescribed suicide, legally recognized as "death with dignity," has been practiced for more than a decade. Within this time, Oregon has measured the "characteristics and end-of-life care of 460 Death With Dignity Act patients who died after ingesting a lethal dose of medication...."[3] The number of recorded deaths is almost certainly inaccurate. There is no penalty for failing to report DWDA deaths, thus there may be many suicide deaths that have

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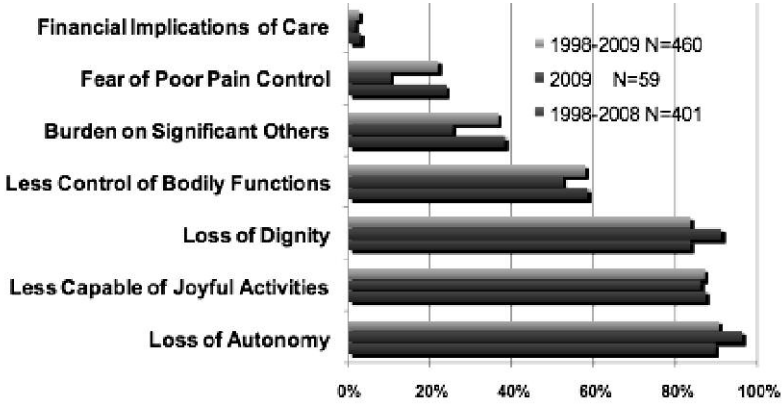
[2] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Healthcare Services*, Part 5, Directive 60 17 November 2009 < http://www.usccb.org/bishops/directives.shtml#partfive>.

[3] State of Oregon, *Death With Dignity Act Annual Reports,* 1998-2009, <http://oregon.gov/DHS/ph/pas/docs/yr12-tbl-1.pdf>.

gone unreported. Physicians in Oregon submit reports *voluntarily,* and there may be many suicide deaths that have gone unreported. However, this data is helpful in that it does reveal the reasons why patients ask doctors to assist them with suicide. The chart below taken from Oregon's 2009 Annual Report illustrates the reasons given by those who have voluntarily received lethal dose prescriptions within Oregon, which are mirrored by the reasons for suicide as measured in Washington.[4]



As this graph illustrates, the three major concerns of those who sought doctor-prescribed suicide under the Oregon "Death With Dignity" law were:

(1) Loss of autonomy

(2) Inability to engage in activities (a corollary of losing autonomy)

(3) Loss of dignity[5]

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[4] Washington State Department of Health, "2009 Death with Dignity Act Report Executive Summary," Center for Health Statistics Death with Dignity Act, http://www.doh.wa.gov/dwda/forms/DWDA_2009.pdf .

[5] Oregon Department of Human Services, "2009 Summary of Oregon's Death with Dignity Act," *Twelfth Annual Report on Oregon's Death with Dignity Act,* 04 March 2010 <http://oregon.gov/DHS/ph/pas/docs/year12.pdf>.

These reasons tend to resonate with many people, and they reflect the most commonly offered justifications for the legalization of assisted suicide and/or euthanasia.[6] They resonate with so many people because when a healthy person asks himself the questions "Would I want to lose my autonomy?" or "Would I choose to be unable to do X anymore?" the obvious response for anyone in his right mind is a vehement "No!" For who *would* want these things to happen? Those who are still enjoying good health have a hard time accepting the limitations of age and its effect upon the body, health and mind. Yet, these limitations are a part of life's natural progression. One cannot go through life unrealistically expecting to always be healthy and young.

Yes, the fear of losing autonomy and dignity lingers in the mind. That is why those in favor of doctor-prescribed suicide pose these situations to people, and suggest that no one would want to live if debilitated beyond a certain point. They capitalize on two very popular concepts in American culture – avoidance of suffering and the celebration of personal autonomy.

Suffering

Suffering can come in many forms. The Oregon data actually does reflect the concept of suffering in many forms: all of the concerns listed are things that might be "suffered" by the patient.

One very interesting thing to note is that "unbearable pain" – one of the most compelling reasons usually promoted by advocates of the legalization of doctor-prescribed suicide – was NOT cited as one of patients' top reasons for choosing suicide. Rather, below "lost control of bodily functions" and "being a burden," the number **seven** reason given

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[6] Back, A., Wallace, J. Starks, H., Pearlman, R., "Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses," *Journal of the American Medical Association* 275.12 (1996): 919-925.

Prior to legalization in Oregon, and later in Washington, patient concerns (207 cases) are reported by doctors as early as 1996: "Patients were most frequently worried about losing control [autonomy], being a burden, being dependent and losing dignity, whether they requested physician-assisted suicide or euthanasia."

by those who killed themselves in Oregon was: "inadequate pain control *or concern about it*" [emphasis added]. The "concern about it" portion of that statistic is critical, because it takes the issue of pain control outside of the realm of actual experience and into speculation. Fear of untreatable pain is very significant in some people's minds (one out of every five respondents in Oregon). This fear does push them to consider suicide, however, there is no way, within these statistics, to distinguish the *experience* of actual untreated pain from *the fear that it might happen.*

Modern medicine has produced not only many therapeutic treatments, but has also made great strides in pain alleviation/control. From Tylenol to morphine, there is an analgesic for every level of pain. In short, nobody in America needs to suffer agony, as the application of proper medication can dull even the most excruciating pain to a point of tolerance.[7]

However, some doctors are insufficiently experienced with pain control and still labor under the misconception that morphine cannot or should not be increased beyond a certain dosage level.[8] THIS IS NOT TRUE. Opiates like morphine can be used to deaden pain, can be gradually increased and combined with other measures as tolerance builds and pain worsens, and do not induce addiction for those who are truly experiencing pain.[9]

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[7] Muskin, P., "The Request to Die: Role for a Psychodynamic Perspective on Physician-assisted Suicide," *Journal of the American Medical Association,* 279.4 (1998): 325.

Muskin writes: "The availability of reliable and effective palliative care dramatically reduces the requests for physician-assisted suicide.... No more powerful statement can be made to a patient who is in pain than that of the physician who says 'I will do everything that can be done to alleviate your pain.' . . ."

[8] Muskin 325.

Muskin writes: "Inadequate pain control may cause rage, sadness, and hopelessness.... Some patients suffer from ineffective treatment of physical pain as a result of inadequate physician education and moralistic views regarding narcotics."

[9] Lachman, V., "Physician-assisted Suicide: Compassionate Liberation or Murder?," *MEDSURG Nursing*, 19.2 (2010): 124.

Lachman writes: "Nurses who frequently care for dying patients did tend to be less supportive of euthanasia." Although she does not explicitly tie this to excellent pain control and palliative care as a whole, it seems reasonable to assume that nurses who do not support euthanasia probably witness excellent pain control and overall palliative care in their collaboration with well-educated and experienced doctors.

It is beyond the scope of this booklet to fully treat the subject of pain control, but a good resource for those who want to understand and get better control over pain is the book *Power Over Pain*, published by the International Task Force on Euthanasia & Assisted Suicide and now available from the Patients Rights Council. Co-authored by a doctor and a lawyer, *Power Over Pain* is full of information about the nature of pain, and offers support and real-world practical guidance for those who need to better manage the pain they may be experiencing.

Loss of Autonomy

The idea of choice, of being able to do things for one's self without assistance, interference or control, is a powerful one for Americans. American value for autonomy is integral to national history, particularly in the revolt against the once oppressive and tyrannical rule of Great Britain. The concept has continued under the generic banner of "freedom" ever since. The Catholic faith, too, supports the dignity and integrity of the human person by acknowledging free will and by condemning any person, government or institution that unjustly impinges upon this autonomy.

Within the context of medical treatment, it is a patient's right to refuse treatment. If someone gives a patient care against his wishes, that person can be sued for battery. United States law already recognizes a person's legitimate freedoms in this regard.

Sadly, doctor-prescribed suicide, while appearing to serve personal autonomy, actually does violence – not only to the person involved but to others as well.[10] It legitimizes the feelings of despondency, uselessness, burden and depression that naturally occur

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[10] Safranek, J.P., "Autonomy and Assisted Suicide: The Execution of Freedom," *Hastings Center Report*, 28.4 (1998): 32-36.

This author draws the conclusion that ". . . autonomy-based arguments for assisted suicide are self defeating in two regards: first, acts of assisted suicide committed in the name of autonomy annihilate the very basis of individual autonomy [life itself]. Second, arguments grounded on autonomy ultimately depend on a view of the good that, if socially prescribed, would subvert individual's autonomy to attain alternative views of the good."

when a person is facing a terminal illness or debilitating condition, and which can encourage the idea that one would be "better off dead." This puts significant pressure on people who are already quite vulnerable to just "get out of the way." When loved ones, doctors, an insurance company or community offer suicide as a legitimate option, there is no doubt that people will be coerced. This coercion is real and has been attested to by many people.[11]

The faith provides moral guidelines which all Catholics are obliged to follow. All actions must be ordered accordingly. In short, just because one has the ability to do something does not mean that it should be done. This idea is, of course, wildly unpopular in modern America, which is still laboring under the mantra of "if it feels good, do it, so long as it doesn't hurt someone else."

When freedom is seen as synonymous with autonomy, then any limitation placed on a patient's autonomous choice is viewed as a curtailment of his freedom.[12] A person who understands freedom as such will agree with the bioethicists Tom Beauchamp and James Childress's assertion that:

> If a person freely elects and authorizes death and makes an autonomous judgment that the event constitutes a personal benefit rather than a setback to his or her interests, then active aid-in-dying [doctor-prescribed suicide or voluntary euthanasia] at the person's request involves no harm or moral wrong.[13]

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[11] Marker, Rita L., "Oregon's Suicidal Approach to Health Care," *American Thinker 14 September 2008* <http://www.americanthinker.com/2008/09/oregons_suicidal_approach_to_h.html>. Marker writes that a patient's doctor, after the patient's cancer had returned, wrote a prescription "that would likely slow the cancer's growth and extend her life." Unfortunately for the patient, the Oregon Health Plan did not cover the prescription. Moreover, she was informed that "although it wouldn't cover her prescription, it would cover assisted suicide." This is coercive.

[12] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* 5th ed. (New York: Oxford University Press, 2001) 358.

[13] Beauchamp 148.

For Beauchamp and Childress, "respect for autonomy" can justify not inhibiting – and even positively supporting – a patient's voluntarily chosen death.[14] Within this framework, one would take issue with accepted standards of professional care such as: "Nurses may never act with the direct intent of ending a patient's life."[15] After all, this high standard would prevent sympathetic doctors and nurses (and loving family members) from supporting patients' requests for doctor-prescribed suicide. One might wonder: Even if a person believes that voluntarily chosen death is wrong, who has the authority to step on another's autonomy by overriding his freedom to hasten death by suicide or euthanasia?

Autonomy-based reasoning is at the root of both an individual's choice to end his life, and the social and legal history of the so-called "right to die" movement in America. United States legal code is based upon John Stuart Mills' "do no harm" principle, which essentially states that a person should have the freedom to do as he likes, so long as the exercise of that freedom does not harm someone else.

There are differences between autonomy and freedom. "Autonomy" sees the unfettered right of each individual to make his own decisions as the highest good. By contrast, "freedom" encompasses not just the absence of coercion, but also takes into account the larger framework of man's proper end and his full flourishing. Prior to clarifying the distinction between autonomy and freedom, it is useful to consider a case of autonomy-based suicide.

Autonomy and the Case of Jo Roman

In his work of examining medical paternalism, James Childress presents the case of Jo Roman to illustrate his contention that suicide

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[14] Beauchamp 148, 150-152.

[15] Kevin G. Hook and Gladys B. White, "Code of Ethics for Nurses with Interpretive Statements: An Independent Study Module," *Nursing World,* 2001 <http://www.nursingworld.org/mods/mod580/code.pdf>, 8.

See also American Nurses Association, *Code of Ethics for Nurses*, 8.

may be an autonomous choice that ought to be respected by health professionals.[16] Rather, this case illustrates the concept of human freedom understood as autonomy, meaning the capacity to choose between various options for a sufficiently well-thought-out reason.

> On June 9, 1979, artist Jo Roman, 62, began fashioning her 'life sculpture' – a pine coffin-like box filled with personal mementos – with the help of her family and close friends. Early the next morning, having finished her project, written a farewell letter to sixty friends, and said goodbye to her family, she swallowed thirty-five sleeping pills, washed down with champagne.
>
> Mrs. Roman had planned her death for fifteen months. It was her view that 'life can be transformed into art,' and that a person should 'take command of making life's final brushstroke.' Her original plan had been to end her life at age 75; but when she learned in March of 1978 that she had breast cancer, which had spread to her lymph nodes, she decided to 'make the best possible calculation of a time frame within which [she] might count reasonably on being able to function to [her] satisfaction.' (It is significant to note that Roman's autopsy later indicated that her cancer had not spread and her death was not "imminent"). She said in her farewell letter that she had 'concluded that suicide need not be pathological ... that rational suicide makes possible a truly ideal closing of one's life span.'
>
> ... Jo Roman was described by her friends as anything but morbid and as a talented artist with 'a large lust for life.' Her suicide note, which she had notarized two days before her death, detailed her plans and stated that she wanted to spare herself, her family and friends the 'ravages' of cancer; it was also intended to absolve those close to her of any complicity in

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16 James F. Childress, *Who Should Decide?: Paternalism in Health Care* (New York: Oxford University Press, 1982) 221-222.

her suicide. She had undergone ten months of chemotherapy before deciding to end the treatment.... She later wrote: 'my medical team believed they had more right than I to command my life.'[17]

When freedom is equated with autonomy, denying Roman her wish to commit suicide is seen as a violation of her freedom to end her life on her own terms. Because Roman had sufficient decisional capacity, it is clear that she autonomously chose to kill herself with the collaborative support of her loved ones.

Respectful of the previous description of personal autonomy, well-intentioned people, including doctors, are often careful to avoid undue influence over patients like Roman who are considering such an option. The rationale is simple: Killing oneself is seen to be objectively neutral. Therefore, because Roman autonomously asserted suicide to be a "personal benefit rather than a setback, [her supporters caused her] no harm."[18]

This line of thought has significant limitations. Because it does not facilitate the patient's natural ability to consider a richer range of options, it risks leaving him inadequately informed. Thus, the patient is at risk for autonomously (but erroneously) concluding that voluntary death is a good option. As seen in the data regarding cases of doctor-prescribed suicide in Oregon and Washington, the fear of losing autonomy has a significant impact on patients who choose doctor-prescribed suicide.[19] In order to more carefully think through such desires, a fuller understanding of human freedom is essential.

Freedom to Flourish

In his writings on freedom to flourish, the moral theologian, Father Servais Pinckaers, O.P., demonstrates an important point about

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[17] Childress 221-222. The author states that "This case was prepared by James Tubbs from articles in the *New York Times*, June 17, 1979, and *Newsweek*, July 2, 1979."

[18] Beauchamp and Childress, *Principles of Biomedical Ethics* 148.

[19] State of Oregon, *Death With Dignity Act Annual Reports.*

free human activity by reflecting upon a person who is learning to play the piano. Just as a person with inherent musical aptitude can develop into a freely flourishing musical virtuoso, so a person with inherent moral potential (or natural inclinations) can develop into a freely flourishing moral virtuoso.[20]

More concretely, a person who has the necessary aptitude and educational opportunity can choose whether or not to learn to play the piano. Provided the person does so in accord with music theory (norms), he will progress from being a potential pianist into becoming an actual pianist. This progress is realized as the person's inherent aptitude is shaped by practice into the finely tuned skills (virtues) necessary for playing beautiful music. In the end, the person will have attained the freedom to play well whenever he chooses to do so. Although the pianist's basic choice-making capacity will not have changed, he will have measurably expanded his range of free activity.[21]

Like the person with the aptitude to become a musical virtuoso, the human person is free to flourish in accord with his natural inclinations.[22] Just as mathematical laws are knowable via music theory, God's law is knowable via natural law. As music theory and aptitude are essential for the potential pianist to shape his talent into the finely tuned skills by which he can perform beautiful music, natural law shapes a person's natural inclinations into finely tuned virtues by which he may happily and freely flourish in and through morally excellent acts.[23] In contrast with the inherent limits of mere autonomy/self-assertion, a freedom to flourish empowers people to develop into moral virtuosos.[24] With freedom to flourish in mind,

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[20] This presentation of the distinction between "Autonomy" and "Freedom to Flourish" is a concise rendition of the work of Pinckaers. See: Servais Pinckaers, O.P., *The Sources of Christian Ethics* (Washington, DC: Catholic University of America Press, 1995), 354-456. For a much shorter account, see Servais Pinckaers, O.P., "Aquinas on Agency: Beyond Autonomy and Heteronomy?" *The Pinckaers Reader: Renewing Thomistic Moral Theology*, ed. John Berkman and Craig Steven Titus (Washington DC: The Catholic University of America Press, 2005) 167-184.

[21] Pinckaers, *The Sources of Christian Ethics* 355.

[22] Pinckaers, The Sources of Christian Ethics 357-359,375,400-408.

[23] Pinckaers, The Sources of Christian Ethics 404-405.

[24] Pinckaers, The Sources of Christian Ethics 412.

people can better understand true and continuing human progress even in the face of terminal illness.

Freedom to Flourish: The Case of Christi Chronowski

At the age of 12, Christi Chronowski decided that she would live her life in accord with God's will.[25] She proceeded by laying out a systematic plan to progress into ever more Christ-like levels of free action. Like a student learning to play the piano, Christi began to practice her art consistently.

She began by reading scripture daily, with a special emphasis on the wisdom literature, her favorite book being Proverbs. Before long, she began to apply the lessons therein to her daily life. For example, she saw all other people as her brothers and sisters in the Lord, especially those less fortunate than herself. Like the piano student who must act in response to the notation on the musical pages in order to produce good music, Chronowski responded well to the words on the sacred pages of scripture by actively participating in her church's outreach program to the poor.

Christi was much more than an avid reader and church volunteer; she was also a strikingly beautiful athlete who was developing virtues such as perseverance and patience as a competitive swimmer and runner throughout her high school years. Like the diligent piano student practicing in preparation for a performance of the most difficult of music written by the best of composers, Christi Chronowski was developing a rich foundation of hard-learned virtues by which she would freely flourish in the face of a brutal illness.

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[25] The facts about this case were obtained through telephone interviews with Christi Chronowski's parents, Frances and Robert Chronowski, on August 11, 2005, September 23, 2005, May 12, 2009, and May 23, 2009. After the 2005 interviews, and later after the 2009 interviews, Mr. and Mrs. Chronowski provided full verbal permission to make use of the information obtained during the interviews and Christi's real name in presenting her case.

Christi's Diagnosis: A Virtual Guarantee of Suffering and Death

On August 12, 1991, while on summer break between her junior and senior years of nursing school, Christi Chronowski, at age 22, underwent surgical removal and biopsy of a grapefruit-sized tumor of unknown type at a hospital in Washington, D.C. Motivated to continue her nursing studies, Christi, in consultation with her physicians and family, decided to return for her final year of undergraduate nursing studies. Like the advanced piano student who stays on course even in the face of great difficulty, Chronowski did her very best to continue her progression into the nursing profession.

Late on Labor Day weekend, she was told that she was suffering with an adult-onset pediatric sarcoma, an extremely rare type of cancer for which there was no known cure. Rather than abruptly quitting school, she explored the possibility of undergoing cancer treatment at a medical facility in Pittsburgh, Pennsylvania, near the university at which she was enrolled.

By late September, after further consultation with physicians in both Washington and Pittsburgh, Christi saw that her best option was to take academic leave and return to Washington, D.C. in order to participate in several experimental protocols. Like a piano student who is forced to step away from the instrument by unforeseen circumstances, not knowing whether he would be able to return to practice, Chronowski stepped away from a field of study and a university that she really loved.

The experimental protocols were not without danger. For example, one study was designed to determine the toxic levels of certain experimental chemotherapeutic medications in order to establish safe future dosing parameters for pediatric patients. While Christi hoped to be cured of her cancer, she knew that such an outcome was highly improbable. Having consulted with several physicians and with her family, she chose to participate in the research protocols with the express

motive of helping the researchers find beneficial answers for future patients, while still hoping that she might somehow beat the cancer.

Rather than contemplating suicide as a convenient way to escape what Jo Roman called "the ravages of cancer," Chronowski faced her diagnosis with prudence, courage, hope, and love. She courageously walked through the fears of the terrible ravages of experimental medicine in the hope of experiencing a cure, and she reached beyond herself in the hope of helping others out of love for them. Rather than believing that suicide would be a convenient way to side-step her illness, and instead of reacting to her condition in a self-centered manner, Christi entered a realm of far richer possibility, in which such life-shortening options are not viable.

Christi's Progress: Facing Her Physical Decline

The ravages of Christi's cancer were substantial. In spite of the rapid and profound physical deterioration she suffered, Christi persevered in striving to live according to God's will, the pursuit of which she had begun at 12 years of age. She stayed in touch with close college friends and remained active in her church's religious education, music, and pro-life ministries. She, with her father, made a pilgrimage to Lourdes and Fatima, two Marian shrines she had always wanted to visit. Like the swimmer she once was, who had to dig deep during grueling practice, Christi continued to pursue her goal of becoming more Christ-like in the midst of increasingly difficult circumstances. Quitting was one option that Christi never considered.

In addition to persevering in her spiritual pursuits, Christi also responded to the side effects of the research protocols in a proactive manner. Early on, fully aware that she would lose her hair, she cut it as she began her chemotherapy. This is not to say she did not feel the sting of the decline in her own physical beauty. About six months into the chemotherapy, she told her mother, "I hate not having hair." Although she was responding gracefully to her losses, she was not in denial. She certainly felt the pain of those losses.

By November 1992, the cancer had spread throughout her entire body. As the disease progressed, she suffered periods of serious pain, disfigurement, and loss of function. For example, secondary tumors growing out of her sternum became so sensitive that, although she was on powerful pain medications, she could no longer wear any religious medals or scapulars, because even the lightest touch to those outgrowths was excruciating. This was spiritually painful for her as well, because of the rich religious meaning those medals held for her.

The cancer was rampant, and Christi was dying. In addition to the experimental protocols, she began undergoing radiation therapy to reduce the size of the tumors so as to maintain maximal function and comfort. One day, after radiation therapy, when her mother asked her how she was feeling, she responded "Mom, I feel two hundred years old today." Not one to complain, her statement disclosed just how poorly things were going. Yet her pursuit of living in accord with God's will was evidently flourishing. She continued to pray regularly, not only for herself but for many other people. She also saw her own suffering, and even the suffering of her family members, in the light of Christ's suffering on the cross and other scriptural reference points. In May 1993, for example, when she was close to death, her father said to her, "I'm really not enjoying this 'Job experience' at all," referring to the biblical character of Job. Without hesitation, Christi lovingly but firmly challenged him: "You should be proud! Dad, don't you realize how much God loves you to trust you with this experience?" She clearly saw both her own personal suffering and that of her family members as part of God's plan, which she was doing her best to embrace.

During her final days, many people came to pray over her and were pleasantly surprised when she would return the gift by praying over them. For example, two very close friends, one a registered nurse and the other a social worker, visited Christi in her final days. Although she was very close to death, with no bladder or bowel control, no use of her legs, and only partial use of one of her arms, she seemed to be radiant with deep peace and happiness. After a brief visit, the friends asked Christi if she would like them to pray over her. She

looked at them, smiled, and said yes, so long as she could then pray over them. As the two finished praying, she raised her hand and began to pray. This was remarkable because of her debilitation. Weighing less than one hundred pounds, she prayed with an energy and joy that seemed nearly unbelievable to the nurse and social worker. How could anyone so physically weak pray with such joy and strength? Christi was to die just one day after this encounter, at 24 years of age.

Rather than becoming ravaged and diminished both psychologically and spiritually, it was apparent that Christi had reached new levels of human flourishing. Christi had attained a level of freedom that helped her transcend the physical ravages of a profoundly devastating illness. Right up to the time she died, she excelled in truly virtuous activities such as praying for those who prayed for her. The prospect of quitting life to avoid her cancer's ravages never captured her interest, and she was able to continue to flourish in true freedom.

Roman's Autonomy vs. Chronowski's Freedom

The earthly lives of Roman and Chronowski came to a close with two very different understandings of human freedom. In accord with autonomy, Roman freely chose to end her life on her own terms. Bearing in mind the people in Oregon and Washington who have chosen suicide out of fear of losing their autonomy, one might consider Roman's choice to be understandable and thus supportable. If one were to pursue the question of freedom no further, he would consider Chronowski's pursuit to be exceptional–at best heroic and at worst grotesque.

If, on the other hand, one embraces Pinckaers' understanding of freedom to flourish–a far richer, more nuanced account of human freedom, he would see the courses of action of these two women quite differently. Having chosen to be free to flourish, Christi Chronowski realized profound human progress. Unlike Roman, who meticulously planned her own death in accord with her narrow reasoning, Christi opened her mind to the possibility that, in her remaining time, God might actually call her to an even higher level of free flourishing. As

time passed for Christi, such levels of flourishing became demonstrably clear, in that she was able to lovingly pray over two good friends even as death was making its final approach. In this line of thought, a person might feel sad for Roman, who settled for far less when she chose to end her life prematurely. At the same time, Christi Chronowski's response to her illness is an example of what can happen when a person freely embraces the totality of life, even in the midst of terrible circumstances.

In the end, a true knowledge of human freedom informs which options are understood to be morally good, neutral, or bad when helping loved ones respond well to devastating physical demise. By viewing freedom to flourish alongside autonomy, true human freedom is more easily understood:

Freedom to Flourish	Autonomy
God's Law + My Law; God's Law Interiorized by Me (natural law) = Human Freedom Fully Expressed	God's Law vs. My Law; my Freedom vs. God's Law; rejection of Natural Law as inescapably foreign and opposed to autonomy
Progress in self possession/free flourishing (skill/virtue); directed toward the goal of human happiness	Choosing between immediate options with no progressive continuity between points of choice; capacity to make choices
Complimentary action of faith and reason; right reason illumined by faith informs free will by presenting the true good to be chosen	Individuals create their own morality independent of faith; free will takes precedence over reason; personal good may be chosen and created
Consistent with objective hierarchy of goods to be sought by humans (spiritual> social> personal> biological)	Independent of an objective hierarchy of goods, focuses instead on the necessity of pleasure and the primacy of the individual will
Life is a gift; individuals have a right not to be killed, but no positive claim on length of life or time of death	Life is one's own; individuals have a right to live and to die on their own terms; self-referential autonomy

Those, sadly misinformed, who operate in accord with a stilted idea of freedom reduced to mere autonomy will erroneously view options such as voluntary suicide and euthanasia as morally neutral, whereas those who operate in accord with freedom to flourish will, rightly, not see voluntary death as an option. The pursuit of free flourishing, as demonstrated by Christi Chronowski's life, ends only when one dies. When life is cut off prematurely by an autonomous killing act, that person is robbed of the opportunity to achieve full moral virtuosity in accord with his God-given natural capacity.

In more practical terms, freedom to flourish provides a light by which one can seek new answers to an old question: How does one best help others to respond to terrible illness in a profoundly ennobling way?

People who spend a great deal of time with patients who are at the end of life have the opportunity to support them in attaining their fullest potential during their remaining time. Patients who express fear of the loss of their autonomy can be gently supported and encouraged to see that their potential for freedom extends far beyond their mere capacity to choose between treatment options. Patients like Roman and Chronowski can teach others about how they might best be supported through the dying process. Proposing and then prescribing suicide or voluntary euthanasia definitively ends any exercise of the patient's human freedom to flourish, rather than promoting human flourishing up to and through the natural end of life.

Dignity

The idea of life stripped of all dignity is terrible. Thus, it comes as no surprise that some people in Oregon and Washington rank loss of their dignity very highly among the motivating factors for choosing doctor-prescribed suicide. But what is dignity? Can a person really lose all dignity?

There are two real types of human dignity distinguished by Franciscan friar and doctor, Daniel P. Sulmasy: *Attributed dignity* which

is gained and lost and *intrinsic dignity* which cannot be lost.[26] As indicated within the data provided by Oregon and Washington, people readily grasp the fact that a certain amount of dignity can be lost.

This makes sense. For example, if Dad can no longer control his bowels, one rightly feels compassion for the loss of a part of his former dignity. Yet, Dad is still loved, and his family still strives to help him know that he is loved. His family knows that there is much more to Dad than the sum total of what he has lost.

Pope John Paul II, in his encyclical letter *Redemptor hominis,* helps to illuminate the truth that there is an intrinsic dignity, proper to every human being, that cannot be lost. There are three basic reasons why this intrinsic dignity cannot be lost: (1) each person is created by God in His image; (2) each person is loved and sustained by God as His child at every moment of existence; (3) each person is called by God to eternal union with Him. Although Dad, with his loss of capacity, may no longer be the physically capable leader he once was, he is still a son of God, a dignitary, royalty.

In *Redemptor hominis*, John Paul II carefully reflects upon the truth that all people are called to eternal union with God, and upon the impact that this call has upon each person from the moment of his creation and throughout the course of his entire life:

> Human nature, by the very fact that it was assumed, not absorbed, in Him, has been raised in us also to a **dignity beyond compare**. For, by His incarnation, He, the Son of God, in a certain way united Himself with each man (emphasis added).[27]

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[26] Daniel P. Sulmasy, "A Keynote Presentation: Dignity and Vulnerability," *The Catholic Health Association of the United States, 2003 Physician Leadership Forum.* Available from Catholic Health Association: www.chausa.org.

[27] Pope John Paul II, *Redemptor hominis*, 04 March 1979, Vatican Website <http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_04031979_redemptor-hominis_en.html> No. 8.

At the moment of Jesus' incarnation, He took on human nature. Having been cast out of the Garden, Adam and Eve and all of mankind who are their descendents suffered the loss of a nature undamaged by original sin. Man's communion with God and with one another was damaged, yet man still, even in his brokenness, possesses intrinsic dignity as beloved children of God, in whose image he has been lovingly created. By assuming human nature, Jesus Christ, who is both Son of God and Son of Man, repairs human nature. He elevates, sustains, and calls His people to new and everlasting life. That is to say, all are "newly created" by Him, and empowered by His grace and His love, to live in accord with a newly-elevated nature as active images of God to one another. Pope John Paul II continues:

> In the mystery of the redemption man becomes newly "expressed" and, in a way, is newly created.... Unceasingly contemplating the whole of Christ's mystery, the Church knows with all the certainty of faith that the Redemption that took place through the Cross has definitively restored his **dignity to man** and given back **meaning to his life in the world,** a meaning that was lost to a considerable extent because of sin (emphases added).[28]

John Paul II does not mean to imply that people who are not yet redeemed lack intrinsic dignity. Redeemed or not, all people are created and sustained by God with His divine call to redemption. God desires that all respond to His universal loving call to become His children, royal children of the King of kings. John Paul II cites Galatians 3:28:

> "'There is neither Jew nor Greek, there is neither slave nor free, there is neither male nor female; for you are all one in Christ Jesus.'"[29]

Intrinsic dignity cannot be lost because all people are created by God for eternal union with Him. God is a loving God who is Truth and

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[28] Ibid., no. 10.
[29] Ibid.

cannot contradict Himself. This is a basic fact, regardless of the presence or absence of specific attributes in any one person. Simply put, intrinsic dignity is as permanent as God's love for all, and is a love which all are called to actively image to one another.

One must actively image God's saving love to others by serving one another as Jesus Christ serves His children. This is at the heart of why Dad must be cared for in his final need. This is why Dad must be told of his family's true love for him which, in turn, will help to strengthen his self-love. This is why Dad's honor must be defended when some other person disregards his intrinsic dignity. Consistent with God's great call for all humanity to love God with every fiber of their being, and to love one another as we ourselves are loved by God, Pope John Paul II writes:

> ...One element seems to stand out...: The sharing in Christ's kingly mission, that is to say the fact of rediscovering in oneself and others the **special dignity** of our vocation that can be described as "kingship." This **dignity** is expressed in readiness to serve, in keeping with the example of Christ, who 'came not to be served but to serve' (emphases added).[30]

John Paul II helps to illuminate the truth that all are called to lovingly imitate Jesus Christ, the Servant King, who laid down His life for all. It is not enough to passively receive God's gifts, which are bestowed in order to aid each individual in an active participation in His universal call to salvation. Participation in this call necessarily pulls each person into the service of others in the Love and Truth of God Himself.

When understood in this light, one can begin to see that killing people who are terminally ill or prescribing medicines by which they can kill themselves in order to end their suffering, amounts to a direct violation of their intrinsic dignity. The presence of loved ones, carefully planned comfort measures and assistance at any level necessary,

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[30] Ibid., no. 21.

including spiritual care every step of the way, will ease the passing from this life into the next. Killing patients, or helping them to kill themselves, even in pain free fashion, actually amounts to an abdication of the responsibility to love one's neighbor as we ourselves are loved by God. To be compassionate is to walk with the person suffering, to be profoundly present and supportive in whatever trials this life may bring.

Again, consistent with those who rank loss of dignity as a top reason for seeking death with dignity, there are many people today who erroneously hold that human beings can exist with no dignity. Consequently, a certain percentage of people, as evidenced in Oregon and Washington, think that, in certain situations, doctor-prescribed suicide and euthanasia should be legally recognized as valid options. Their contention, simply put, is that human life completely devoid of dignity is untenable. How does a Catholic Christian respond to this error?

One can begin by voicing agreement. The idea of human life completely devoid of dignity really *is* untenable. However, there is good news! No matter how tough things may be, no person can be stripped of his intrinsic dignity, the source of which is God, who lovingly: (1) creates each person in His image; (2) sustains each person at every moment of his existence, and (3) calls each person to eternal union with Him. In the end, each individual's intrinsic dignity lies in the fact that God never stops loving His people.

Those to whom the seriously ill – fellow dignitaries loved by God – are entrusted are to provide nothing less than excellent care. The care provided must be nuanced, and all levels of need must be evaluated and addressed. In short, no patient should be left in despair. Rather than feeling as if there has been a total loss of dignity and total abandonment, the people who require this level of care should be helped to know something of God's love and comfort through the presence of a loving caregiver right up to the time of natural death.

By viewing intrinsic dignity alongside attributed dignity, one can more fully grasp the true meaning of dignity in its totality:

Intrinsic Dignity	Attributed Dignity
Equally proper to each person from conception through natural death; grounded ultimately in God's love of each person	Extrinsically accorded to persons based upon physical qualities, including intelligence, independence and functionality; grounded in being "of value" to society
Absolute; cannot be gained or lost; foundation for "sanctity of life" reasoning	Relative; transient; may be gained or lost; can be viewed as unattainable in the context of illness or disability; foundation for "quality of life" reasoning
Baseline point of equality between every person regardless of disability or illness Foundation of all universally inalienable, unconditional rights	Various points of inequality between persons; can give rise to admiration, compassion, beneficence Foundation for privileges and local, conditional rights
Grounded in God's unconditional love for each human being; God is the gift-giver of human life	Edifies, but is not necessary to, the good life; basis of the idea of "quality of life," which can be lost; can impel patients to seek termination of life when things are "bad"
Human being is an end in him- or herself; has intrinsic value	Human being has value as a means to an end; has extrinsic value, relative to his "usefulness" in society

God's love is nothing less than an inspiring breath, the wind of the Holy Spirit who denies any reduction of human dignity. Each person has been given the gift of life and has been called by God to image Jesus Christ to others. Called to baptism into the total life of Jesus Christ, and to the future glory of face-to-face union with God for all eternity, each individual is called to live every joyful, luminous, sorrowful, and glorious moment as a living image of Jesus Christ, until such time as he is called to the future glory of face-to-face union with God for all eternity.

Food and Fluids

One of the murkiest areas in end-of-life medical ethics is whether to start and/or whether to discontinue artificially-provided food and

water. There is a prevailing belief (recognized by law, unfortunately) that food and water, if delivered through a tube, are "medical treatment" rather than what they are – just food and water. Food and water amount to ordinary, everyday sustenance. This belief is probably tied to the visceral reaction many people have to "being hooked up to a machine," but one must get beyond initial repugnance and look at what is really happening.

All human beings need four things to stay alive: warmth, hygiene, food and water. Death will come to any person who is deprived of any one of these four things, whether an Olympic athlete or an 87-year old with Alzheimer's disease. Remove someone's warmth (i.e. – leave him outside in Northern Michigan in January without a coat or a source of heat), and he will die rather quickly.[31] Stay in the same position on the couch for four weeks without moving (or being moved), and pressure sores will develop, fester and become infected and will bring death. Prevent someone from eating, and he will of course die eventually. Prevent someone from drinking, and he will die within 5-21 days.

Legality vs. Morality

Far from being a mere "medical treatment," food and water are reasonably – and realistically – known to be ordinary sustenance. The United States Conference of Catholic Bishops has addressed this in their 2009 *Ethical and Religious Directives for Catholic Health Care Services.* This statement from the bishops, grounded in common sense, states that food and water are not usually considered "medical treatment," and should be provided to patients under most circumstances:

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[31] V. Lachman, "Physician-assisted Suicide: Compassionate Liberation or Murder?," *MEDSURG Nursing 19*.2 (2010): 124. As regards death by dehydration and starvation, Lachamn writes: "When a person stops eating and drinking, death usually occurs in 1-3 weeks."

> In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the "persistent vegetative state") who can reasonably be expected to live indefinitely if given such care. Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be "excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed." For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort.

Many hospitals – including many Catholic hospitals – have written policies that categorize artificial nutrition & hydration provided by means of tube-feeding as a "medical treatment," and as such, can be refused by the patient or his agent.[32] These ordinary necessities are seen by many as being "extraordinary." Perhaps one reason for this is that the artificial means of delivery (a G-tube or a J-tube) can seem offensive, and one might react by imagining that by disallowing "those awful tubes," the patient will somehow be allowed to "die peacefully and with dignity." However, nothing could be further from the truth. Here is one account from a 1986 court case of what dehydration looks like:

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[32]Lachman 124.

Lachman provides a quotation demonstrative of the problems that follow upon classifying food and fluids as medical treatment rather than ordinary care. She writes: "A legal alternative to [doctor-prescribed suicide] is for the patient to stop eating and drinking; this is seen as a choice of stopping life-sustaining treatment.... This is consistent with current law in most states, but does require support of caregivers. **Professional nurses must honor the patient's wishes and not intervene.**" (Emphasis added.) This seems coercive of doctors and nurses who desire to practice according to the fact that food and fluids are ordinary things a person consumes on a daily basis.

As a person dies from lack of food and fluids, his or her

- *Mouth would dry out and become caked or coated with thick material.*
- *Lips would become parched and cracked.*
- *Tongue would swell and might crack.*
- *Eyes would recede back into their orbits.*
- *Cheeks would become hollow.*
- *Lining of the nose might crack and cause the nose to bleed.*
- *Skin would hang loose on the body and become dry and scaly.*
- *Urine would become highly concentrated, leading to burning of the bladder.*
- *Lining of the stomach would dry out and he or she would experience dry heaves and vomiting.*
- *Body temperature would become very high.*
- *Brain cells would dry out, causing convulsions.*
- *Respiratory tract would dry out, and the thick secretions that would result could plug the lungs and cause death.*

At some point within five days to three weeks, the person's major organs, including the lungs, heart and brain, would give out, and death would occur.[33]

This is why heavy sedation is often given while patients are dehydrated and starved – so that the agony is suppressed and the patient does not fully realize the torture he must endure. Dehydration/starvation is not a "death with dignity," as some people claim. Its reality is an agonizing, painful death.

What Happened to Terri Schindler Schiavo

Terri Schindler Schiavo suffered an agonizing death that was largely ignored by the media in all of the hype over who would prevail. Her husband, as her court-appointed guardian, not only won the right

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[33] Brophy v. New England Sinai Hospital, no. 398, Mass. 417, 444 n.2, 497 N.E.2d 626, 641 n.2, 1986.

to remove her feeding tube, he also deliberately prevented anyone from feeding her orally or giving her any water. Here is what happened to her:

> During the nearly two weeks Terri was denied food and fluids, not so much as an ice chip was given to her. My family watched as her skin became increasingly mottled. Her breathing was rapid – almost as though she had just run a marathon, and eventually it became extremely labored. Her temperature spiked at times, and her face would become bright red. During her final days, Terri's appearance became increasingly grotesque as her skin became cold, veiny and horribly discolored. Her eyes sunk dramatically and her lips and tongue were cracked and brittle. Just before Terri died, blood had begun to pool in her eyes.[34]

This is the reality of death by dehydration. It is neither a peaceful nor a dignified way to die.

Is it OK to Stop Tube Feeding?

Although food and fluids are rightly considered to be ordinary care, this is not to say that the non-use or removal of a feeding tube is always unethical. When a person's body can no longer process or assimilate food and water, i.e., when the food no longer provides nutrition and the water no longer provides hydration, then their removal is permissible.

Experienced health practitioners will attest that, when death is imminent, the body begins to shut down, and even lucid patients will voluntarily refuse food and water. Note that, while there is no exact definition of what qualifies as "imminent," it refers to a situation where death occurs within a short period of time, (hours or days rather than weeks or months), ***as a result of the underlying condition, and not as a result of induced dehydration or starvation.*** The refusal/removal of

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[34] Observations of Bobby Schindler (brother of Terri Schindler Schiavo), September 2010.

food and water is simply a reflection of the physiological reality that is taking place: the patient's body is no longer able to process food and water. Their continued administration would be a burden – sometimes a painful one – on the dying person. Similarly, there are some conditions, such as stomach cancer, that make digestion excruciating. In such situations, removal of food and fluids would indeed be considered the proper medical course of action and would be ethical.

It is also important to recognize that, although food and fluids are, in fact, ordinary care and NOT medical treatment, they are sometimes refused by people who are ill, but not yet imminently dying. Those patients who can should be encouraged to eat. Also, when appropriate, in light of medical fact, these patients should be gently educated and encouraged to consent to the placement of a feeding tube through which they can receive proper food and fluids.

Of course, some patients may still refuse to consent to tube placement for reasons such as honest psychological repugnance. These concerns can and ought to be addressed through education and encouragement, so that the patient can move past repugnance and honestly consent to having a tube placed for purposes of proper nutrition and hydration.

What must be guarded against is the view that the method of delivery (through a tube or a straw) makes the food and water "medical treatment." Proper nutrition and hydration is not medical treatment, any more than swallowing an aspirin is a meal. Viewing food and water as medical treatment can play into the mentality that anyone receiving any care is *ipso facto* burdensome, whether to self or to others. One important way that one is able to guard against having food or water inappropriately withheld or withdrawn is to appoint someone trustworthy to make sound, moral medical care decisions in the event one is unable to make them for one's self. This safeguard is achieved through the preparation of an advance directive.

Two Types of Advance Directives

A critical component of end-of-life discussions is the advance directive. An advance directive is a legal document by which one can make provisions for health care decisions in the event one becomes unable to make those decisions independently. There are two types of advance directive that are most commonly used: the **Living Will** and the **Durable Power of Attorney for Health Care**.

A **living will** is a document that sets forth the desired medical care in anticipation of a time when one is no longer able to actively participate in medical treatment decisions. Doctors and other health care providers look to this document, prepared by patients in advance, and while of sound mind, for guidance and direction in providing care. Many living wills instruct an attending physician to withhold or withdraw medical interventions/treatments if the signer has "an incurable condition" or is "in a terminal condition."

However, there are serious problems with living wills. In the first place, not every state recognizes them as valid legal documents. Moreover, they can be unclear, insufficient and sometimes even dangerous. Their interpretation depends entirely upon who is interpreting it, whether a long-time family doctor, an HMO bureaucrat or an unknown physician.

Additionally, it is practically impossible for someone to anticipate every potential medical condition or combination of circumstances, so as to clearly state what treatment he might want in that particular case. Consider the situation of Mary Jo Estep from Washington State:

> In December of 1992, a very active retiree named Mary Jo Estep broke her hip. As part of her rehabilitation, she checked into a nursing home where, on admission, she signed a living will that stated (as almost all of them do) that she was not to receive extraordinary measures if she was dying. A few days before she was to go home, a tired nurse gave Estep the wrong medication – a dangerous mistake whose effects could have been reversed easily at

a local hospital emergency room. However, a doctor interpreted her living will to mean that Estep would not want intervention, so she received no treatment to counteract the incorrect medication. By evening, she was in severe distress, with her blood pressure falling and pulse weakening. She died that night.[35]

Mary Jo Estep signed a routine living will document that included what many people would think was "reasonable" language. Unfortunately, the language was interpreted by a doctor unknown to Mary Jo, and in a manner which most people would never think appropriate. This is just one sobering illustration of the danger of living will documents.

By setting an arbitrary future limitation on "how bad" things might be allowed to become before killing one's self, a blind decision is made, which will, most likely, be proved unsound. How can anyone possibly predict how he might feel about a given situation before the time comes? How can one decide today that "when incontinence strikes, it is time to die," without first knowing the circumstances surrounding the situation? Consider the case of Richard Rudd:

> Injured in an accident in October 2009, Rudd was completely paralyzed. He was kept alive with a ventilator, and was being fed through artificial means. Prior to his accident, he had explicitly stated to his family that he would never want to be kept alive in such a situation. A few months later, after having been unresponsive to any stimuli for weeks, his family made the decision to remove all life support equipment. The doctors asked Rudd three times if he wanted to carry on living, and Rudd unmistakably blinked "yes" in response to their questions. He had been perfectly aware of his situation, but unable – temporarily – to communicate. With continued therapy, nine

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[35] David Wasson, "Report Details Events Prior to Woman's Death at Nursing Home," *Yakima Herald-Republic* 04 March 1993.
David Wasson, "'No Code' Nightmare," *Yakima Herald-Republic* 14 March 1993.

months later, he was able to move his head from side to side, to smile and interact with his family.[36]

Rudd's is a case of someone who, while in full health, would not countenance the possibility of living with severely limiting injuries and dependent upon artificial means of support. However, when the time came, and the unthinkable actually occurred, he wanted to continue living. This case is quite instructive regarding the dangers of predicting desires regarding future health care in a living will.

Rather than attempt to enumerate every possible situation in a living will, it is considered a much better practice to use a well-drafted **Durable Power of Attorney for Health Care** to designate another person (one's "agent") to make medical decisions on one's behalf in case of incapacity. This designated agent's title may change from state to state, (in some states this person is referred to as a "health care proxy,""patient advocate" or "health care surrogate"), but the concept is the same. Designating an agent who shares one's beliefs and values and who can be an assertive advocate is the best option for ensuring one's wishes are followed.

Some people put guidelines into a Durable Power of Attorney for Health Care document to assist the designated agent. Doing so, however, may put potential limitations on an agent's ability to make decisions on one's behalf, as well as providing a potential legal basis for someone else to challenge the agent's decisions.

The Durable Power of Attorney for Health Care is a basic document that most estate planning attorneys will be able to draft. These documents must comply with the laws of the state of residence. Many hospitals provide versions of this document, and there are some good organizations which provide them as well, including the Patients Rights Council, which provides the Protective Medical Decisions Document (PMDD), which is their Durable Power of Attorney for

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[36]Caroline Gammell, "Richard Rudd Blinked to Save His Own Life," *The Telegraph* 14 July 2010 <http://www.telegraph.co.uk/health/healthnews/7888218/Richard-Rudd-blinked-to-save-his-own-life.html>.

Health Care, written in accordance with each state's laws, and which provides clear standards that protect the signer.

Sometimes, upon checking into a hospital, one might be presented with an advance directive to sign. Keep in mind a few important things:

- Signing an advance directive may nullify any previous or existing advance directive;
- Health facilities are not permitted to force patients to sign an advance directive, and may not make health services conditional upon doing so;
- Many institutional advance directives make presumptions regarding the sort of care a patient will or will not want.

The best manner of ensuring that one's wishes are carried out is to create a durable power of attorney for health care before it is needed, and to designate who it is that will make one's health care decisions. Choose someone trustworthy, who shares the same beliefs and values, and who can be assertive on one's behalf. Medical care providers will appreciate having someone clearly designated by their patient, to whom they may look for guidance. In addition to the primary agent, it is wise to name at least one backup, in case the primary agent is unable or unwilling to serve when needed.

It should be noted that many states allow hospitals and other health care providers to refuse to honor a patient's treatment decisions or those of the patient's agent, if the provider conscientiously objects to the desired care or treatment. This can cut both ways – whether the provider refuses to continue life-sustaining care (including food and fluids) if the treatment is deemed "futile," or insists that medical care be provided regardless of whether the patient or his agent desires the care. Under federal law, the health care provider must inform the patient or his agent of the facility's written policies regarding these matters in a timely manner, usually at the time of admission.

Conclusion

According to the data reported by Oregon for more than a decade, as well as the data that is beginning to emerge from Washington, well-intentioned people who support and seek out doctor-prescribed suicide do so with particular concerns in mind. After reflecting upon the most commonly occurring of those reasons, it becomes clear that those seeking to end their lives prematurely are only seeing part of the picture. While remaining compassionate, it is to be hoped that by providing clear, complete information, the reader will benefit from the illumination of truths that may not have been considered.

Those who, in the name of attributed dignity, freely support and embrace "death with dignity" contradict their own intrinsic dignity and that of others. Also, in the name of autonomy, people who freely support and embrace "death with dignity" contradict their full freedom to flourish, even in the face of approaching death. Full respect for intrinsic dignity and freedom to flourish are at the very heart of the Church's absolute NO to doctor-prescribed suicide and euthanasia.

The Church's NO is the flipside of her well-grounded YES to the full promotion of intrinsic dignity and freedom to flourish even in the midst of dying. Excellent support of loved ones through practical means, including excellent pain control, comfort measures and appropriate ordinary care, which usually includes food and fluids, are to be promoted and embraced. Designating a trustworthy person as a health care "agent" who will make medical decisions on one's behalf, within a well-drafted, Durable Power of Attorney for Health Care, will protect one's interests in case of incapacity.

In the final analysis, when good people are not given at least some key reasons for the Church's NO to assisted suicide and euthanasia, and when, consequently, they do not grasp what that NO actually means, they will sometimes support and embrace freely chosen "death with dignity." They base their decisions upon incomplete information regarding their own dignity and freedom. Therein lays the tragic irony of doctor-prescribed suicide and euthanasia under the guise of freely chosen "death with dignity."

APPENDIX I

The "Right to Die" Movement in Modern America

The push to legalize doctor-prescribed suicide in America goes back to the first part of the twentieth century. This section will chronicle the organizations formed and major efforts undertaken to achieve legal sanction and societal approval for euthanasia or doctor-prescribed suicide. This historical section was taken from the website of the Patients Rights Council: www.patientsrightscouncil.org and can be found in greater detail there.

In the Beginning

In 1938 the Euthanasia Society of America was formed, and offered a proposal to legalize "the termination of human life by painless means for the purpose of avoiding unnecessary suffering." Initially, the measure was to be limited to "voluntary" euthanasia, but the society "hoped eventually to legalize the putting to death of non-volunteers [who are] beyond the help of medical science." Dr. Foster Kennedy, the Society's new president, urged "legalizing of euthanasia primarily in cases of born defectives who are doomed to remain defective, rather than for normal persons who have become miserable through incurable illness."

The Euthanasia Society made little headway until 1967, when two crucial events took place. The first was the establishment of the Euthanasia Educational Fund – soon renamed the Euthanasia Educational Council (EEC) – as a tax-exempt, fund-raising branch of the Euthanasia Society. The second was the development of a new document, first proposed in the Florida legislature in 1968. Called the "Living Will," this innovation was designed to help "promote discussion of euthanasia."

New Names: Society for the Right to Die and Concern for Dying

Sensitivity to the word "euthanasia" led to major name changes in the mid 1970s. In 1975, the Euthanasia Society of America changed

its name to the Society for the Right to Die, and in 1979, the Euthanasia Educational Council became known as Concern for Dying.

Soon after its name change, Concern for Dying provided a platform for the then-little-known Derek Humphry. The society invited Humphry to its San Francisco Conference to discuss his newly published book, *Jean's Way,* which chronicled how his first wife died after he obtained a lethal dose of drugs and then administered them to her.

In 1990, the Society for the Right to Die and Concern for Dying announced that they were going to merge. The following year, the formal name of the combined organizations became "National Council for Death and Dying." Then, just six months later, its name was formally changed to "Choice in Dying." The newly-named group took on the mantle of an organization aimed at promoting better pain management and control over the end of life. In public statements, its officials depicted assisted suicide as nothing more than pain control, and child euthanasia as an issue that was open for debate.

In 1999, Choice in Dying was again re-cast as "Partnership for Caring." Yet another name variation also began in late 2000 when Partnership for Caring received a major grant from the Robert Wood Johnson Foundation (RWJF), to manage the Foundation's "Last Acts" program, which had been launched in 1997 as a multi-year, multi-million dollar program. Still another name change was announced in 2004, when Partnership for Caring, referring to its roots as "a 66-year-old organization," formally combined with the Last Acts program and began to operate as "Last Acts Partnership," relying primarily on funding from the RWJF. In 2004, the Last Acts partnership apparently collapsed, and their website was taken down, after RWJF voiced concerns over their financial status, including "unexplained financial anomalies." However, the corporation has not been formally dissolved. It remains to be seen if it will reappear under yet another name.

Hemlock Society

On August 21, 1980, Ann and Derek Humphry started the Hemlock Society "to discuss the training of counselors prepared to help

those who are considering self-deliverance [suicide]." Ann Humphry wrote that euthanasia should be considered an acceptable means of dealing with life-threatening conditions: "[W]e would like to strive towards an objectivity which considers any tenet of voluntary euthanasia a valid one."

In 1986, the Hemlock Society unveiled its first proposal to legalize assisted suicide and euthanasia – called the "Humane and Dignified Death Act" (HDDA) – at its third national conference. The HDDA was to be a ballot initiative that would amend the California constitution to permit "aid-in-dying," defined as "any medical procedure that will terminate the life of a qualified patient swiftly, painlessly, and humanely."

In his opening remarks to conference attendees, Derek Humphry explained that the Hemlock Society had facilitated the formation of another organization, called Americans Against Human Suffering (AAHS), to do the political heavy-lifting. For months, Hemlock Society activists gathered signatures that would be needed to place the HDDA initiative on the ballot, and AAHS spokespersons met with policy makers and professional organizations in an attempt to build support for their initiative. However, their efforts fell short, and they failed to obtain enough signatures.

With the failure of the California initiative, the Hemlock Society began looking for more fertile ground, and finally settled upon Oregon as a base from which it could work toward its goals. In the summer of 1988, its national headquarters were moved from Los Angeles to Eugene, Oregon, and the group soon announced plans to spearhead "physician aid-in-dying" initiatives in Oregon, Washington and California.

In April 1991, the Hemlock Society published *Final Exit,* their suicide manual, and on August 18, 1991, the book topped the *New York Times* bestseller list in the "Advice, How-to and Miscellaneous" category. "It tells you how, where and when to kill yourself or someone

else. It breaks the last taboo. Follow my instructions for a perfect death, with no mess, no autopsy, no post-mortem," Humphry said.

On November 5, 1991, the voters of Washington State refused to grant doctors the legal right to kill their patients. Initiative 119, the Death with Dignity Act, failed in Washington by a 54% to 46% margin. The following year, an identical "Death with Dignity Act" appeared on California's ballot as Proposition 161. Californians Against Human Suffering, (the new name for the most recent Hemlock spin off, previously called Americans Against Human Suffering), coordinated the campaign. On November 3, 1992, California voters rejected the measure by the identical margin as in the defeat in Washington the previous year.

ERGO Forms

By the end of 1992, Derek Humphry had resigned from Hemlock. Publicly, the reason for his resignation was his desire to be free of administrative duties so he could devote time to writing, public speaking and campaigning for law change. However, controversy surrounding the suicide death of Ann, his second wife, and allegations that he had smothered Jean, his first wife, had caused dissention within Hemlock in the preceding months. After his resignation, Humphry retained the title of Hemlock Society's "founder and consultant," and also identified himself as Vice President of Americans for Death with Dignity, the latest appellation for the group that had been called Americans Against Human Suffering and then Californians Against Human Suffering.

That same year, Humphry formed the Euthanasia Research and Guidance Organization (ERGO). Under the ERGO banner, Humphry established a right-to-die internet mailing list that continues to serve as an on-line forum for euthanasia and assisted suicide activists. ERGO also conducts seminars to explore new methods of assisting with suicide deaths. The new group's mission was "to identify and research aspects of physician-assisted suicide and active voluntary euthanasia for the terminally ill, and to educate the public about the complexities of

assistance in dying." One of ERGO's first public events was a seminar to teach the fine points of using a plastic bag to commit suicide. ERGO later released a pamphlet which provided step-by-step instructions on their method of suicide via plastic bag.

Another Spin-off: Compassion in Dying

Defeat of the 1991 Washington State initiative spawned yet another right-to-die group, called Compassion in Dying (CID). Ralph Mero, the group's first executive director, described CID as "an outgrowth of the Washington State Hemlock Society chapter." (Mero had directed the Washington State Hemlock Society chapter until taking the helm of CID.) According to Mero, "The Washington Hemlock chapter strongly wanted to expand its mission" to offer suicide assistance in "deserving cases," and the group created a separate organization for that purpose. As the first U.S. group to publicly admit to offering assistance in committing suicide, CID acknowledged involvement in 24 deaths during its first 13 months in operation. The group then refused to divulge its level of participation in those deaths. Mero and his group's activities even became a cover story in *The New York Times Magazine*.

Coverage of CID's activities caught the attention of Kathryn Tucker, an attorney with Perkins Coie, the largest law firm in the Pacific Northwest. Tucker, who had served as principal outside counsel to sponsors of the failed Washington "Death with Dignity Act," contacted Mero and suggested that, rather than exposing itself to possible prosecution, CID might be more successful if they were to challenge the constitutionality of Washington State's law prohibiting assisted suicide. That call launched two cases which would eventually reach the U.S. Supreme Court.

The commencement of CID's challenges to state laws banning assisted suicide coincided with an Oregon initiative campaign to legalize assisted suicide. The Hemlock Society's leadership had changed, and overtures were made to medical and legal associations as the organization sought to take on a mainstream image.

In November of 1994, Oregon voters approved the "Death with Dignity Act," making Oregon the first and only state to transform the crime of assisted suicide into a medical treatment. The law went into effect three years later. Since then, Oregon has been used as the "poster state" to make claims that assisted suicide is a personal choice that, when legal, is used infrequently and under carefully controlled guidelines. Right-to-die leaders were certain that other states would soon follow in Oregon's footsteps, but they were wrong. In state after state, ballot initiatives and legislative proposals went down in defeat. Meanwhile, both Hemlock and CID forged ahead with attempts to build public acceptance.

Hemlock Undergoes Another "Makeover"

By late 1996, the Hemlock Society had lost members and financial support. Rank-and-file Hemlock members had considered the leadership's approach to be too conservative. Faye Girsh, a long-time Hemlock Society activist, and a board member of ERGO, had taken over as Hemlock Society's executive director. With Girsh at the helm, gone were the days of waiting for Oregon-type laws to be adopted in other states. Hemlock had returned to its roots as an activist group, willing to push the envelope.

Under Girsh's leadership, Hemlock expressed admiration for Jack Kevorkian. (Girsh called Kevorkian's lethal injection killing of Thomas Youk "a courageous act of compassion," and Fred Richardson, when acting as chairman of Hemlock's board, said Kevorkian had been "practicing what we preached.") Once again, the Hemlock Society began to receive large gifts from longtime supporters, and the organization unveiled a new program called "Caring Friends."

Caring Friends Program

Hemlock Society leaders and members became outraged as court cases were lost and other states failed to adopt Oregon-style laws. Describing their frustration at a 2003 conference, Faye Girsh said, "Well, damn it, we had to do something. Gosh, you know, you go through all the channels and they don't help you…. So you just have

to take things into your own hands." The "something" that was done was the establishment of a new Hemlock Society program, euphemistically called "Caring Friends." According to Girsh, Caring Friends received its inspiration from what Ralph Mero had done when he established Compassion in Dying as a spin-off of the Hemlock Society in Washington State. Girsh said she and Derek Humphry "applauded the guts of Ralph Mero" because, at the time, he not only assisted suicides, but publicized what he was doing. Since CID had limited itself to implementing the Oregon assisted-suicide law, Caring Friends picked up the baton to assist in suicide deaths outside of Oregon.

An Arizona woman, who later killed herself, provided $40,000 seed money to begin training volunteers to facilitate deaths through Caring Friends. The first training was held in San Diego in November of 1998. By 2003, the program had more than 100 trained volunteers in various states, and was conducting additional sessions to increase that number.

Hemlock Society's New Name: End-of-Life Choices

In the fall of 2001, the Hemlock Society's Board embarked on a road intended to change and strengthen the organization. As part of the transformation, the Hemlock Society officially changed the name it had used for 23 years. In mid-2003 the Society took the new name "End-of-Life Choices" with the tag line "Dignity-Compassion-Control." Many Hemlock Society members were unhappy with the name change, but leaders described it as a necessity if the group wanted access to important places: "The name 'Hemlock' has a history and much of it is a history of earnest defiance but much of it is also 'baggage,' baggage that we can no longer afford to have weighing us down or interfering with our being able to partner with such important and powerful organizations as AARP."[37]

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[37] Jane Sanders, "Naming Update: A Rose is a Rose...Hemlock by Any Other Name," *EOL Choices,* Magazine of EOL Choices, vol. 2, no. 2 (Spring 2003), p. 11.

EOL Choices concentrated on what it called its "two pillars" – the Caring Friends Department (which it referred to as "client services") and the Government Relations Priorities (to promote laws permitting assisted suicide). At the same time, the organization launched its "National Advocacy Plan." Included in that plan was announcement of the intent to form groups with names like "Doctors for Death with Dignity," "Nurses for Death with Dignity," and "Clergy for Death with Dignity," so that "enemies of choice" would no longer be able to claim that all doctors, nurses and clergy are opposed to assisted suicide.

Meanwhile, EOL Choices and Compassion in Dying commenced serious talks to explore a merger between the two groups, and within a year, the merger was announced. The former Hemlock Society and its spinoff, Compassion in Dying, announced that they had merged, and would be known as "Compassion & Choices," which is the name they bear today.

Individual States

Despite their well-funded efforts, and despite many efforts in numerous states, to date only three states have successfully legalized doctor-prescribed suicide: Oregon, Washington and Montana.

Oregon

Oregon's "Death with Dignity" Act passed into law by voter referendum (51% to 49%) in 1994, but did not take effect until 1997. This law transformed the crime of assisted suicide into a medical treatment.

There is an annual reporting requirement for doctors who participate in prescribed suicides to report details to the State. However, Oregon officials in charge of formulating annual reports have conceded that "there is no way to know if additional deaths went unreported."[38] A lead author of several official reports said that information received

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[38] Linda Praeger, "Details Emerge on Oregon's First Assisted Suicides," *American Medical News* 07 Sept. 1998.

from doctors "is a self-report, if you will, of the physician involved."[39] Furthermore, there are no penalties for non-reporting.

As regards the reliability of the statistics coming out of the "Oregon Experiment," it is critical to remember that reporting is done (or not done) solely by doctors who, as participants, have a vested interest in suppressing information that could lead to the impression that the practice is problematic. When asked about a systematic way of discovering and recording complications, a state official said that none existed, "…other than asking physicians." Yet, even if they were inclined to report complications, physicians may not be aware of them since "after they write the prescription, the physician may not keep track of the patient."[40] According to the last official report, physicians who prescribed the drugs for assisted suicide were present at only 21.5% of reported deaths.[41] Therefore, any information provided by these "absent doctors" might necessarily come from secondhand accounts or may be based on guesswork.

Washington

Ballot Initiative 1000 (Washington Death with Dignity Act) passed on November 4, 2008, by a vote of 58% to 42%. The Washington law is virtually identical to Oregon's assisted-suicide law.

Montana

Baxter v. Montana; MT 449 (2009)

The Montana Supreme Court ruled that rights granted under the state's living will law, "The Rights of the Terminally Ill Act," form the

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[39] Dr. Melvin Kohn, Dec. 9, 2004, testifying before members of the British House of Lords.

[40] Dr. Katrina Hedberg, Dec. 9, 2004, HL, p. 259, question 567 given in Portland, Oregon, before a visiting committee from the British House of Lords. Committee proceedings were published in: House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, "Assisted Dying for the Terminally Ill Bill," Volume II:

Evidence. 4/ 4/05. Available at:

http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86ii.pdf

[41] http://www.internationaltaskforce.org/OR_WA_Reported_Deaths_04_10.pdf.

bases for permitting physician "aid in dying," and that there is no legal prohibition against doctor prescribed suicide. As a result of this ruling, the Montana legislature will be considering bills regarding legalization.

Since 1994, there have been legislative measures introduced in 24 states, and ballot measures in three additional states, that have failed to legalize doctor-prescribed suicide. Every year, particular states are targeted by the "right to die" movement in an attempt to have the crime of assisted suicide changed to a mere "medical treatment." So far, they have only succeeded in Oregon, Washington and Montana, but they are becoming more aggressive in their attempts.

The Holland Experiment

Although U.S. law is not dictated by what happens in other countries, it is worthwhile to take a brief look at Holland, since they have taken increasingly radical steps along the euthanasia path. It is particularly tragic that they have gone so far in this direction, since it was Dutch doctors who refused the euthanasia directives of the Third Reich in the 1940's. Unfortunately, their principled stand did not last, and Holland is now known for its practice of involuntary euthanasia and infanticide.

Euthanasia was practiced extensively for decades in Holland, prior to its formal legalization in April, 2002. Doctors who participated in the practice were simply not prosecuted, and the flouting of the law was so widespread that the Rotterdam Court, in 1981, issued guidelines for its practice. The 1991 publication of ***The Remmelink Report*** (the results of a government-commissioned study on the practice of euthanasia in the Netherlands) indicated that in 1990, 1,040 patients were killed by their doctors in cases of involuntary euthanasia. These were situations where doctors *killed their patients without the patients' knowledge or consent*. This practice has only increased in subsequent years.

In 2004, Eduard Verhagen, the medical director of the department of pediatrics at the University Medical Center Groningen (UMCG) in Groningen, Netherlands, issued what has become known as ***The Groningen Protocol***, which sets forth criteria for child euthanasia (the killing of infants). Obviously, infant children cannot choose suicide for themselves, so their parents and physician make the request for euthanasia on their behalf. The acceptance of this practice within mainstream medicine in the Netherlands is a stark reminder of how societal acceptance of something leads to abuses, and then to the gradual acceptance of far more than was originally contemplated.

Appendix II

Major Court Cases Dealing with Euthanasia or Assisted Suicide

There have been a few key court decisions, on both the state and federal levels, which have implicated the rights of the disabled over the "right to die" or the removal of life-sustaining treatment:

The Matter of {Karen Ann} Quinlan; 355 A. 2d, 647 (1974)

The New Jersey Supreme Court determined that the parents of a comatose[42] patient, who had authority to make medical decisions for their incapacitated daughter, were permitted to have the hospital remove her ventilator. The Court specifically differentiated between *allowing* a patient to die from natural causes (even if it involved removing life-sustaining medical treatment) and directly *making* a patient die by assisted suicide or euthanasia. In its opinion, the Court quoted extensively from an address given by Pope Pius XII to a group of anesthesiologists in 1957, which affirmed the principle that life-sustaining medical treatment that was deemed to be extraordinary could legitimately be refused by a patient and on their behalf by an agent.

Cruzan v. Director, Missouri Department of Health; 497 U.S. 261 (1990)

A Missouri state hospital refused to terminate the artificially-administered nutrition and hydration of Nancy Cruzan, a patient in a persistent vegetative state, despite the request of the patient's parents. After legal challenges on the state level, the U.S. Supreme Court held that the State of Missouri could require that evidence of an incompetent person's wishes as to the withdrawal of life-sustaining

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[42] Oregon Dept. of Human Services, "Ninth Annual Report on Oregon's Death with Dignity Act," 08 March 2007. http://www.internationaltaskforce.org/OR_WA_Reported_Deaths_04_10.pdf. The Annual Report states that the presence of the attending physician in 63 out of 191 reported deaths is 29%, however the calculation is mathematically inaccurate. The correct calculation is 21.5%.

treatment be proved by clear and convincing evidence, and that the Supreme Court of Missouri was not wrong in concluding that the evidence presented at trial did not amount to this "clear and convincing proof" of Cruzan's desire to have hydration and nutrition withdrawn. That Cruzan had once said that she did not want to live life as a "vegetable" was not sufficient evidence, nor did it necessarily reflect the wish for the withdrawal of medical treatment or of hydration and nutrition.

The *Cruzan* decision was important in a few ways:

- It articulated the common-law principle that there is a right to refuse treatment;

- It supported a state's right to impose a "clear and convincing" evidentiary standard on anyone trying to prove that a patient had expressed a desire for removal of his food and water in the event of incapacity;

- The court gave a good explanation of its position regarding the risk of error:

> *"The clear and convincing evidence standard also serves as a societal judgment about how the risk of error should be distributed between the litigants. Missouri may permissibly place the increased risk of an erroneous decision on those seeking to terminate life-sustaining treatment. An erroneous decision not to terminate results in a maintenance of the status quo, with at least the potential that a wrong decision will eventually be corrected or its impact mitigated by an event such as an advancement in medical science or the patient's unexpected death. However, an erroneous decision to withdraw such treatment is not susceptible of correction." – P. 1620*

Sadly, after the court decision, several people "remembered" additional statements Nancy had made that caused the case to be re-opened. As a result of this, Nancy was eventually starved to death.

Wendland v. Wendland; 26 Cal 4th 519 (2001)

As a result of a car accident, Robert Wendland suffered severe brain injury that left him conscious, but severely disabled, unable to speak and mentally retarded. His wife, who was his court-appointed conservator, attempted to have his feeding tube disconnected, but his mother and sister intervened and challenged her request.

The Supreme Court of California, relying in part on the U.S. Supreme Court in the *Cruzan* case, determined that "a conservator may not withhold artificial nutrition from a conscious conservatee who is not terminally ill, comatose, or in a persistent vegetative state, and who has not left instructions for health care or appointed an agent for health care decisions absent clear and convincing evidence that the conservator's decision is in accordance with either the conservatee's own wishes or best interest." A distinction was made between the authority of a court-appointed conservator and a patient-designated agent, with the court giving higher authority/discretion to the agent designated by the patient himself.

In Re. Michael Martin; 450 Mich. 204; 538 N.W.2d 399 (1995)

The Michigan Supreme Court ruled on August 22, 1995, that Mary Martin, wife and legal guardian of severely disabled Michael Martin, could not be permitted to cause Michael's death by having "life-sustaining treatment," namely his food and fluids, withheld. In a 6-1 decision, the Court found that the testimony and affidavit of Mary Martin, claiming that Michael had said several times prior to his injury that he would never want to live "like a vegetable," does not constitute clear and convincing evidence that he would not want to continue living in his present condition.

According to lower court testimony, Michael — who had suffered a closed head injury in a 1987 car/train accident — is not in a persistent vegetative state, nor is he terminally ill. He can carry out some voluntary motor commands, can recognize faces and can communicate with other people through head nods. There was also

testimony from various health care providers that Michael seemed happy with his environment, and that he was able to respond with a "no" head shake when asked if there were ever times when he did not want to go on living.

Yet, in spite of these facts, both a Michigan probate court and the Michigan Court of Appeals ruled that nutrition and hydration could be withheld from Michael. One judge held that Michael's response indicating that he wanted to go on living was irrelevant given his impaired condition. Michael's mother, Leeta Martin, and his sister, Patricia Major, in an attempt to save Michael's life, appealed the case to the state Supreme Court.[43]

Regarding Mary's contention that Michael's pre-accident statements prove that he would not want to continue living in his present state, the Michigan Supreme Court cited conflicting testimony from two of Michael's co-workers indicating that, before the accident, Michael expressed the wish not to be kept alive **if he was ever in a coma or in a vegetative state.** "[O]ur review of the record," the justices wrote, "reveals that virtually all the witnesses agreed that Mr. Martin is not in a vegetative state and is not suffering from the type of incapacitation referenced in his expression of a desire not to continue life-sustaining treatment."[44]

Vacco v. Quill, 521 U.S. 793 (1997)

In these companion cases, the U.S. Supreme Court determined in a unanimous opinion that there is no Constitutional right to assisted suicide. The Court drew a clear distinction between a patient's refusal of unwanted medical treatment and a request that a physician kill him.

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[43] Although at the time, Karen Quinlan was described as being "comatose", she was, from a medical point of view, in a persistent vegetative state: awake, but unaware of her surroundings.
[44] ITF *Update* Newsletter, Volume 8, Issue #3, July-August 1994.

In Re. Guardianship of Theresa Marie Schiavo, 780 So.2d 176 (Fla.Dis.Ct.App.2001)

The very public controversy of Terri Schindler Schiavo captured the nation's attention for months in 2004-2005. After suffering a cardiac arrest on February 25, 1990, loss of oxygen left Terri in a coma. Her condition improved somewhat over the next few years, upgrading to a "persistent vegetative state," and then improved even further to an ability to demonstrate some response to stimuli and to recognize her parents. Her husband, Michael, (who was her court-appointed guardian), sought removal of her feeding tube, but her parents opposed this and tried mightily to save their daughter's life. After numerous legal battles, Michael won the right to carry out Terri's starvation/dehydration, which he claimed was "what she wanted." Beginning on March 18, 2005, Terri was denied food and water. Her condition deteriorated over the next two weeks until her death on March 31, 2005.

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