THE DANGER OF PHYSICIAN ASSISTED SUICIDE TO INDIVIDUALS, THE LEGAL SYSTEM, AND CULTURE.

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TWO INITIAL CONSIDERATIONS

1. This is not “death with dignity.”
2. This is not about “dying in pain.”

(see references 1&2 on last page)
Three Fundamental Principles

1. New freedoms cannot give rise to onerous burdens.
   *Principle of Justice and Freedom*

2. Intrinsic dignity of the disabled and vulnerable.

3. Responsibility for a *culture* of life & dignity.
Principle #1: New Freedoms Cannot Give Rise to Onerous Burdens

1. The law of perverse unintended consequences.
2. The new pressure or duty to die.
   Family pressure -- the case of Kate Cheney (Ref. #4)
   insurance pressure -- case of Barbara Wagner (Ref. #5)
3. The vulnerable populations.
   Disabled, pressured, depressed, “suggestable” & poor
Principle #2:  
Intrinsic Dignity of the Disabled and Vulnerable

1. The shift in justification -- from pain to the indignity of serious illness (and social burden).
2. Assistance for the disabled is undignified.
3. The indignity of needing assistance justifies suicide (see reference #3 on last page).
4. Branding of and pressure on the disabled and vulnerable.
Principle #3
Responsibility for Culture of Life & Dignity

1. What becomes legal, becomes socially acceptable; then becomes “moral.”

2. Redefining quality of life.
   ego-comparative vs. contributive-transcendent

3. Holland and the culture of suicide.
   (see reference #6)
# Four Levels of Desire-Happiness

## 4. Transcendent

**Source:** Transcendental awareness of and desire for the sacred, and spiritual as well as perfect and unconditional truth, love, justice-goodness, beauty, & being-home.

**Satisfaction:** Openness to a transcendent power who is perfect and unconditional truth, love, justice-goodness, beauty, & being-home.

**Problem:** Not maintaining life of prayer and moral-spiritual connection.

## 3. Contributive-Empathetic

**Source:** Self-consciousness, as well as empathy, and conscience creating a desire to make an optimal positive difference to the world beyond myself.

**Satisfaction:** Contributing through actions and empathy to family, friends, organization, stake holders of organization, community, church, kingdom of God, culture, and society.

**Problem:** Does not deal with the five transcendental desires and the yearning for the sacred.

## 2. Ego-Comparative

**Source:** Self-consciousness – trying to bring the outer-world under the influence or dominion of the inner world (ego world)

**Satisfaction:** Comparative advantage in achievement, status, popularity, intelligence, perceived intelligence, power, control, and winning.

**Problem:** Does not address the contributive; a profound emptiness, and negative emotions of the comparison game.

## 1. External-Pleasure-Material

**Source:** Brain and sensory faculties

**Satisfaction:** Food, drink, shelter, affection, recreation, and material satisfaction – clothes, house, car, jewelry, and other material goods.

**Problem:** Superficial, profound emptiness, reduces self to the merely material.
Redefining Quality of Life

(Level 4)  TRANSCENDENT-FAITH Q of L

(Level 3)  Contributive-Love Q of L

(Level 2)  Ego-comparative Q of L

(Level 1)  Physical-material (YUM YUM) Q of L
FOUR CONSEQUENCES of Physician Assisted Suicide on QOL

1. Sickness and dependence greatly enhance Level 3 and Level 4 QoL in both patients and caregivers.
2. The logic of assisted suicide only makes sense if Level 1 & Level 2 are emphasized to the exclusion of Level 3 & Level 4.
3. Both individuals and the culture itself will become more base – and oriented toward individualism and death instead of love and life.
4. This will change the culture of healthcare, hospitals, and especially senior care facilities. A steady decline in interpersonal care replaced by “your life has limited worth – it’s time to go.”
The Culture of Suicide in Holland

1. Ever increasing percentage of death by assisted suicide (increase of 73% since 2003) – between 3 - 5% of total deaths.

2. Ever increasing number of involuntary termination of patient’s lives. Current statistic between 7-10% (physicians don’t always declare).


4. Suicide requests based on vague quality of life difficulties – no longer unbearable pain or disfigurement.
1. See the California Catholic Conference’s document on End of Life Decisions and Directories
http://www.cacatholic.org/index.php/component/content/article/77-linked-articles-and-directories/583-frequently-asked-questions-end-of-life


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

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