The time has come once more for both the TIPS editor and the readership to bite the bitter fruit of deathmaking. If the readers' bite is bitter, the editor's is even more so, confronted with an 18-inch pile of clippings and related materials. One is almost paralyzed merely gazing at this pile, even after it has been sorted into about 20 subtopics.

Let's face it: if you can't live without good news, you might as well end it right now, or at least join the suicide cult, because good news is hard to come by these days.

Because we had fallen behind in putting TIPS out, readers are getting a special lagniappe of an issue that is long even for a double issue.

Deathmaking in History

Some people learn more readily about deathmaking by examining it safely from a historical distance than when it happens under their noses.

*Sloppy slopes and all that.* We often make the point that no perversion or atrocity—including that of systematic deathmaking—appears full-blown. Rather, they start small, almost always with positive-sounding rationales, and gradually enlarge. Those who oppose deathmaking have referred to this gradual enlargement as the “slippery slope,” meaning that once one accepts and practices a particular form of deathmaking, there are no firm footholds left which can stop one (or others) from rushing headlong down the slope to full-blown deathmaking, destruction, or perdition. While the "slippery slope" hypothesis is rejected out-of-hand by most proponents of deathmaking, it has proven to be true over and over again. The following is an example from a horror of the recent past that shows how racial hatred and persecution that eventually led to full-scale and overt genocide started small and increased only gradually and slowly. It is taken from Proctor (1988).

Between the time the Nazis came to power in April 1933, and the initiation of the plan to kill all Jews in September 1941, more than 250 laws, decrees and ordinances were issued that bit by bit chipped away at the rights of Jews. The earliest measures were not even specifically directed at Jews, but were "eugenic" in nature, and included the following.

7/1933 Law for the sterilization of carriers of hereditary disorders
9/1933 Law that only people of "German or related blood" may inherit farms
11/1933 Law permitting castration of sex offenders
Of the 250+ anti-Jewish measures, we list only a few landmarks, to capture the flavor of the progression.

9/1935 Outlawing of sexual relations between Jews & "Germans"
10/1935 Law requiring a medical certificate of health before marriage
11/1935 Law establishing "citizens" & "inhabitants"; Jews deprived of citizenship
1/1938 Law prohibiting change of names, & for Jews to assume "German names"
3/1938 All Jewish organizations must register
17/4/1938 Ordinance requires all Jews to have or assume a name from an official list of Jewish names
22/4/1938 Proclamation forbidding any effort to conceal Jewish ownership of businesses
26/4/1938 Jews must register all their property
7/1938 "Aryans" forbidden to give Jewish-sounding names to children
6/1938 Jews formally banned from most occupations
23/7/1938 Jews required to carry special passport, & show it without being asked
25/7/1938 Jewish physicians have licenses withdrawn
27/7/1938 All streets named after Jews required to change names
10/1938 Jewish physicians further restricted, & may practice only on Jews
11/11/1938 Progrom night; Jews physically assaulted nation-wide, their businesses & homes vandalized, synagogues & schools burned
12/11/1938 Jews required to pay for damages of Kristallnacht; Jews prohibited from participating in public events, entertainments, exhibitions, etc.; further restrictions on means of earning a living
15/11/1938 Jews barred from German schools
28/11/1938 Police authorized to restrict movement of Jews
1/9/1941 Jews must wear yellow star

*There may be something very symbolic in the fact that when the Nazis engaged in genocide, they often started killing the children first. When they decided to kill the handicapped, they first started killing handicapped children. When they decided to kill the Jews in the concentration camps, the children were the very first ones to be killed. Somehow it was as if the killers and the children could not co-exist under the same sky (A Journey of Faith), by Elie Wiesel, 1990, p. 64; source item from Ray Lemay). The contemporary deathmaking culture had its resurgence in the early 1970s with the legalization of abortion and the hospital killing of handicapped infants.

*Apparently, none of the researchers on the killing of the handicapped under the Third Reich ever found the word "kill" used in the voluminous Nazi documents on the killing. However, one euphemism that was used rather regularly by some of the actors was "disinfection." Thus, to kill was to "disinfect," and the people who had been killed were called "disinfected ones" (Source material from Peter Lindley). In some respects, "disinfection" was not far-fetched, since the gas that was widely used, Zyklon B, had previously been used as a pesticide, and many classes of people considered worth killing had been described by the same term used for insect pests.

**At last the order to get down came...The doctors, with their instruments, were lined up apart. It seemed rather reassuring. If doctors were present, it meant that people were cared for. The presence of four or five ambulances was also an encouraging sign. How were we to know that all this was staged in order to calm new arrivals and to keep order with a minimum of armed force, and that the ambulances were to transport the sick to the gas chambers? But it produced the desired result: maintaining hope and avoiding disorder...The goal of a doctor is to fight disease, to save human life and to alleviate pain...but at Auschwitz, medical science had only one purpose, to seek out those who were still capable of working. Its only official function was 'selection.'" (Aziz, 1976, Vol. 2, Doctors of Death, pp. 61-62).

*Dr. Werner Villinger was professor (in the disciplines of neurology and psychiatry) at the University of Hamburg, then chief physician of the famous Bethel institution for the handicapped, and then professor in Breslau. He was active in eugenics work from the beginning of the Nazi era,
and was one of the physicians who coded the case records of mentally handicapped people for death from the start of the "euthanasia" program in October 1939. He became professor at Marburg in 1946, in the first professorial chair in Germany for child and youth psychiatry. He participated as a board member of several major human service organizations between 1950-1961 and received numerous honors, including an honorary doctorate from the University of Hamburg. He visited American services for children and the handicapped, and was acknowledged as a leading youth psychiatrist both in Germany and abroad. In 1950, he was one of the persons who refounded the German Association for Youth Psychiatry, of which he served as president for the rest of his life. He was also president of the Association of German Neurologists and Psychiatrists between 1951-1961, and installed the first German version of the American child guidance clinics in Germany in 1951. He was also one of the prime promoters of the 1958 founding of the German association of parents of the mentally retarded, called Lebenshilfe. In 1961, he died skiing in the mountains of Austria. Lebenshilfe wrote him a glowing eulogy which said, among other things, that it will always be "profoundly grateful to him and we shall faithfully preserve his memory." A German 1984 text on the German "euthanasia" program raised the question of Villinger perhaps having committed suicide, particularly since the alleged accident occurred in early August (Sierck & Radtke, 1985, and other sources, including from Gunnar Dybwad).

In 5/87, two German physicians were tried for killing, or contributing rather directly to the killing, of about 15,000 mentally handicapped people in the early 1940s. Because these two perpetrators were already in their 70s, it is believed that this was probably the last "euthanasia" court case covering offenses during the Nazi era. They were both convicted, which is rather unusual, and received prison terms of 4 years. In the past, very few of the few people sentenced to prison served much of their sentence. The amazing thing is that one of the two accused said that he now perceived his moral failure, and in an almost unheard-of act begged forgiveness from the relatives of his murdered victims. Hardly any of the Nazi criminals, medical or otherwise, have ever repented, apologized or begged forgiveness. In our teaching, we always emphasize that when people make a profound commitment to evil, they hardly ever repent. (Source clipping from Gunnar Dybwad).

Lapon, L. (1986). Mass murderers in white coats: Psychiatric genocide in Nazi Germany and the United States. Springfield, MA: Psychiatric Genocide Research Institute. Lapon (1986) has probably provided the most extensive documentation of the presence of eugenic-thinking German physicians in American medicine after WWII, and especially psychiatry. Amazingly, one learns that a good number of them worked for at least some time in US institutions for the retarded, apparently while trying to establish themselves in the US.

Perhaps one of the most astonishing things about the German "euthanasia" program is that Jewish physicians who escaped the holocaust seemed to hold essentially the same eugenic attitudes as their German peers, and would probably have collaborated as much in the killing as their gentle peers if they themselves had not been persecuted. Lapon gives some verbatim telephone interviews with Jewish physicians who escaped to the US, and they seem to have no more come to grips with the German "euthanasia" episode than anybody else. They engaged in massive denial, revealed their own devaluing attitudes toward mentally handicapped people, and gave very contradictory testimony. Interviews often proceeded from denial that they knew anything to denying knowing anybody who had been engaged in the "euthanasia" program. Some even claimed that they learned nothing about the program even after the war. A few even denied that it happened at all, much as some people deny that the Holocaust happened.

*Sadly, the producer of "Shoah" asked in an interview at the end, "How did the first anti-Semitic measures of the Nazis in 1933 lead to Auschwitz?" He observed correctly that "once you are on the stairs of the death chambers it is too late." But he himself displayed total unawareness of the dynamics of evil. One of these dynamics that he was unaware of is how deception and violence always go hand in hand, deception commonly ending in violence in order to defend and justify the deception, and violence using deception as a cover-up. In the very same interview, he admitted freely that he had no compunction about lying to one of the informants that his testimony
would not be publicized or that his identity would not be revealed, or even that he was being filmed. Yet this is exactly how tiny little deceptions lead to bigger deceptions which eventually lead to violence; and indeed, upon the killing of the millions, nobody can remember or trace the progressions and origins in such very small and much earlier beginnings.

*Tasmania is a large island off the southeastern coast of Australia, and is one of the states of Australia. The Dutch captain Tasman was the first Westerner to land there in 1642, but did not encounter any people. The next Western visitors came on a French ship in 1772, and within a few hours of landing, the sailors had shot themselves several natives. Scattered settlements by seal hunters began in the mid-1790s, and then in 1803, the British began systematic long-term occupation by means of a convict colony. Within months, they began to massacre the natives with cannon, and a systematic genocide of the natives commenced that was largely completed in 1830, with a mere six remaining at large until 1842. The convicts and settlers would commonly buy or kidnap Tasmanian women for themselves, often killing the men. Some sealers and escaped convicts kept up to five native women for sex and slave labor, shooting them if they did not work well or tried to flee. Often, there were regular hunts of natives by settlers on horseback, poisoned food was set out for them, and steel traps set for them. Shepherds enjoyed cutting the genitals of aboriginal men and watching them run a few yards before dying. One party of police killed 70 Tasmanians in one hunt, dashing out the children’s brains. In 1828, the governor of the island permitted Europeans to shoot any aborigine found in settled areas. In 1830, a bounty of five pounds was established per Tasmanian adult, and two pounds per child. Finally, in 1830, a systematic hunt was conducted by a human chain from one end of the island to the other to get rid of the last Tasmanians, but only 300 could still be found.

No European was ever punished for ever murdering a Tasmanian.

Some authorities claim that about 4,000 people in Tasmania today, and possibly more, are of aboriginal descent, but many will not admit it or have never been told because it has been considered so shameful. Of course, virtually all of these are descendants of the native sex slaves to the sealers, convicts, and settlers (Diamond, 1993).


*It was not only the US army that sent smallpox-infected blankets to the Indians in order to wipe them out; Australians at one time had done the same thing to their "belligerent" natives (Discover, 10/92, p. 67).

*For several years now there has been an increasing trickle of reports and revelations that suggest that human subjects were used as guinea pigs in the British tests of nuclear weapons in Australia during the 1950s. According to some reports, mentally retarded people (probably those without relatives) were flown in from Britain and put in bunkers near the explosion site, and were never heard from again after the test. Much of this information is coming out in trickles from people who were involved, and who only in recent years have begun to talk about it. One pilot said that he flew retarded people to Australia from Britain and never heard of them being flown back. Apparently, aboriginals were also used as subjects on the results of radiation effects. Before his death, a warrant officer said that retarded people could be heard screaming in their bunkers, and then fell silent after two nuclear tests. He also told his wife, "one day all this will come out." (Clippings and information from Bob Jackson)

*In 1947, the British Medical Association submitted to the World Medical Association a statement condemning medical war crimes, and proposed that the World Medical Association incorporate into its charter a statement on medical ethics which, among other things, would say that "the greatest crime is cooperation in the destruction of life by murder, suicide and abortion." We have come a long way in a short period of time.

*Just how modernistic materialism leads logically to large-scale deathmaking is underlined by the fact--nowadays generally forgotten--that early in the 20th century, Marxism held that not only
entire social classes but also entire races would have to be exterminated. This tenet was formulated as early as 1849 by Engels, and later supported not only by Stalin but also by H. G. Wells and George Bernard Shaw. It was only because of the advent of Nazism with its atrocities that attention from this tenet of Marxism was diverted, and the Marxists themselves no longer explicitly stated it, although they continued to practice it, as evidenced by certain policies of the Soviet Union, both internally as well as externally (e.g., the latter exemplified in its wholesale slaughtering of ethnic groups and the Polish intellectual and leadership class), and as practiced more recently by the communist regime in Cambodia when it gained power in the late 1970s (Watson, 1992).

*When we closely examine the personal history of people who later became deeply involved in systematic—especially medical—deathmaking, we often discover that there has been a life-long pattern that in many instances started early in life. This is certainly true of the prominent German physician Hoche, the major medical philosopher of the killing of the handicapped that eventually took place under the Nazis, who developed a perverse fascination with death when he was still a young child. Similarly, Werner Catel, who not only was one of the big-time medical killers of the Nazi era but continued his deathmaking advocacy even after the war, admitted that he decided to become a doctor when, at age 16, he administered a lethal dose of opium to his ailing grandmother.

Miscellaneous High-Level Reflections on Deathmaking

*Since the early 1970s, I have persistently tried to draw parallels between the Holocaust and the killing of the handicapped in the Nazi era on the one hand, and deathmaking developments in our own day on the other. This has offended some people who see absolutely no connections, and tired others who thought that the parallel was simply overdrawn and wearing out. Yet in recent years, there has appeared some literature in Holocaust and Jewish studies that makes the point that the experience of the Holocaust can serve historically to either criticize or legitimize power. Of course, without the Holocaust, the Jewish state would never have come into being, but instead of using the Holocaust as a basis for critique, it is widely used as a legitimization (a) for the kind of power-wielding that we have seen in recent years by this state, (b) for its practice of cruelty, torture, denaturalization and dehumanization in its own territories against the residents thereof that are deeply devalued, and (c) the peculiar spectacle of its entering into close alliance with some of the world’s most repressive and killer regimes (South Africa, El Salvador, Guatemala, and many others). These critics underline once again that with power comes a hardening of heart, in contrast to the generosity that one often extends when one is the least secure. These issues not merely pose a decisive question for the future of Judaism in the world, but once again are intimately relevant to questions of deathmaking of other unwanted people. If much of Zionism has concluded that one of the biggest lessons of the Holocaust is to use power ruthlessly and mercilessly, is this not an intimate parallel to the rest of modernistic society concluding that the major lesson to be learned from the Nazi killing of the handicapped is how to do it in an even yet more subtle and legitimized way? It may not be long off when we will be told by the intellectualizers of deathmaking that the only thing wrong with the Nazi killings of the impaired was that it was illegal, and sometimes done cruelly.

*On the first day of the new school year, all the teachers in one private school received the following note from their principal. "Dear Teacher: I am a survivor of a concentration camp. My eyes saw what no man should witness: Gas chambers built by learned engineers. Children poisoned by educated physicians. Infants killed by trained nurses. Women and babies shot and burned by high school and college graduates. So, I am suspicious of education. My request is: Help your students become human. Your efforts must never produce learned monsters, skilled psychopaths, educated Eichmanns. Reading, writing, arithmetic are important only if they serve to make our children more humane." (Source from Michael Steer).
WHO’LL BE NEXT

Will it be you who cannot see,
Or you who cannot walk,
Or maybe your little brother,
Because he cannot talk.

You may even be Italian,
Irish or Polish too,
They just do not want you here,
So let’s do away with you.

It could be your mother or your dad,
Because they are too old,
They’ve become an inconvenience,
That’s what their kids were told.

That is what they started,
When they legalized their death,
They said they were not children,
Because they had not drawn a breath.

Will it be some little child
Who wasn’t made complete,
He must be done away with,
Because he hasn’t any feet.

It seems a foolish reason,
But the courts have all agreed,
That anyone can have it done,
Their right you can’t impede.

Or it may be because you’re black,
Perhaps yellow, maybe red,
Or because they do not like you,
And would rather see you dead.

But if this slaughter doesn’t end,
These things may all come true,
It may be a friend or relative,
And it even may be you.

Or it may be because you’re Catholic,
A Protestant or a Jew,
Or because you’re not religious,
Any reason will probably do.

(By Mike Cotrufo, 1984; In CRTI Report, 3&4/1991, p. 4)

Handicapped-rein? One of the things Doerner (1989) points out is that technical capabilities are now at hand to almost assure that we could have a "handicapped-free" society, at least as far as impairments are concerned that occur prior to, during or shortly after birth. While this language has not been widely used as yet, it may very well be so soon, and it would most certainly be very parallel to the Nazi expression "Juden-rein," which was the term to refer to a locality as being "clean of Jews."

An important point to keep in mind is that the presence of positive attitudes towards impaired people is not at all incompatible with a willingness or commitment to make them dead. After all, people nowadays set out to kill the very people who are closest to them out of perverted ideologies dealing with the nature of humanness, the value of the human and the nature of human suffering. A woman who has been a devoted and loving daughter all of her life may, in such a value context, start to refer to her demented father as "the man who used to be my dad," and advocate his mercy-killing. This point is so important to make because recently, when we warned of the increasing deathmaking of impaired people, we were told that the answer had to be working towards improved attitudes towards the handicapped person, which we obviously believe is not necessarily enough.

The issue of life and death as opposed, versus as complementary, entities. We have noticed that people sometimes try very hard to give to human death some positive cosmic, spiritual, or even what one might call mystified biological significance. Often, this is done as part of an objection to our proposition that there is both a unity of life and a connection among the things pertaining to death, and that these two are opposed to each other. Instead, some people say that "death is a part of life," or that "death serves a purpose in the continuing life-cycle of humanity and of the universe," and things along these lines. The idea that life and death are harmoniously complementary is particularly likely to be heard from people with a biological orientation. They point to the fact that the death of one organism sustains the life of another, even if the death of the one that sustains the
other seems gruesome to us.

We would certainly not deny that death is a part of the experience of life, as long as such a statement is understood to mean only that everything alive does, in fact, die, and that humans experience this reality as part of their lives. However, we would not agree that this means that on the moral and spiritual plane, the processes or forces of life and death are intertwined in a harmonious fashion, or are harmonious parts of each other. However, we realize that this is difficult to grant from a materialistic perspective.

Part of this idea that "death isn't really so bad" may derive from the fact that some people seem to have a somewhat romanticized or sanitized notion about death, and that so many people living these days have been spared by the conditions of modern life from the closer-up experiences of death that used to be normative. They may not have witnessed a death, or many of the horrors that often attend it. After all, in contrast to the way things used to be for thousands of years, there are fewer accidents, medicine has dramatically reduced the agonies that often precede death, and fewer people suffer their major diseases at home or die there. Instead, they are more apt to suffer and die in a hospital or nursing home, and this means that only trained medical personnel are apt to witness their death and much that precedes it. The rest--family and friends--are therefore likely to have an unrealistic notion of what death entails. Similarly, the deaths of people on the battlefield in war may be witnessed by some of their fellow soldiers or the enemy, and by civilians in remote and poorer parts of the world, but not by most people in developed countries. Only the police and the coroner may see the horrendous reality of death from street violence or traffic accidents. And so on.

For this reason, we thought it might be helpful to review just some of the gruesome realities about human death, so that people might be less likely to spout ignorant platitudes about it.

Take, for instance, the fact that in the world of nature (apart from humans), death tends to be normatively ugly: few creatures die what we would call a "natural" death from old age. Usually they are violently killed by other animals, or by humans, and almost always they get eaten. Often, they are eaten while they are still alive, which must be not only very painful but also incredibly horrifying.

Also, if human beings die "out in nature," i.e., apart from the care of other human beings, they too are highly likely to be gruesomely destroyed by other creatures, even if they were to die a "natural" death. Insects, birds, scavenging beasts and microorganisms will swarm on a dead human body just as quickly and indiscriminately as they do on a dead animal carcass.

Also, many, many human deaths are the result of either human violence, or the violence of nature which people are apt to call "accidents." And death by violence is apt to be at least two things: (a) painful, and (b) very ugly. A person may bleed to death internally or externally. The person may be torn literally limb from limb. The person's brains or guts may be spilled out. The person may be crushed or decapitated. As a result, in only a few seconds, a body may go from looking quite normal to most repugnant and repulsive. Some such violent deaths are very quick, but even they are not without pain or horror. And some violent deaths are very painful indeed.

Many people die in war, either as soldiers in battle, or as civilian casualties. Again, such deaths are usually dreadful. Bodies are often dismembered, sliced into pieces, or blown apart. War victims often bleed to death. Death in battle might be accompanied by terrifying noises, and the dying may witness the horrible deaths of others all around them. Historically, a huge proportion of the wounded used to die slowly from their wounds (e.g., by infection), or dehydrated to death. The dead may be so mutilated that they can never be identified (this happened to several hundred thousand soldiers of both sides in the WWI battles of Verdun), and they may be buried in mass graves--if buried at all. Some weapons used in war are intentionally designed to inflict the maximum mutilation and pain before a person dies. All in all, death in war is grisly, and not at all romantic as depicted in war songs.

In addition, even when a person dies what is called a "natural death" (by which is meant really a death not caused by relatively direct human or other violence), the death is often preceded by very nasty disease processes which ravage the body, and which are also usually very painful--unless controlled by artificial modern drugs. For instance, cancer often saps bodily strength, and results in physical deformities and even mental deterioration. Similarly, many degenerative diseases such as muscular dystrophy or Huntington's or Parkinson's gradually destroy the competence and
capacities of the body, and sometimes of the mind as well.

Regardless whether a death is "accidental" or "natural," the actual moment of death is often agonizing. For instance, it is not widely recognized that people who die a "natural death" expire because they suffocate slowly. Others undergo a frightening cessation of heart function. Even prior to the actual moment of death, there is often what is referred to as a "death struggle," i.e., a very real struggle between life and death. Some people take days or weeks to die, even when they are already very much reduced. They may be so reduced that it is very difficult for others to keep them clean and dry, e.g., they may no longer have control over bowel, bladder, or mouth and throat. Some parts of the body may decay even before death sets in, so that the dying person smells very bad even if kept clean.

At about the moment of death, bladder and bowel control are often lost, the contemplation of which is apt to be hard on the dying person who knows this, and the actuality of which is apt to be hard on anyone around the person. In some kinds of death, men ejaculate.

Then, within literally seconds of death, the body begins to decay, and microorganisms begin to eat it. Without preservation of the body (as via embalming), it begins to smell very unpleasant very soon after death.

We should also consider that even if one believes in life after death, the survivors who had affection for the deceased will grieve, and some will suffer most bitterly.

We hope that those who proclaim the harmony of life and death will give some thought to these realities.

Someone recently said that the unity of death these days is such that if children survive without getting aborted or killed in a war, they will surely turn around and kill their parents when they become aged.

Societal Resentment of Devalued People as the Vestibule of Deathmaking

In our teaching of Social Role Valorization, we point out that making people dead is the most extreme form of social devaluation, and a "final solution" to not wanting to be around the people one devalues. Therefore, (a) before we ever see deathmaking, we will see devaluation, and (b) when we see devaluation, we must begin to fear that it may progress to deathmaking. Sometimes, in early and/or milder forms of devaluation, people cannot imagine that the devaluation could escalate to deathmaking. In other cases, one can easily see that a devaluation phenomenon is only a step or two away from converting into deathmaking. We will look at some examples of mostly the latter kind.

* At least some of the branches of Islam define a category of people as moharebeen. In the eyes of Islam, these have low value and therefore can be struck down (Newsweek, 9 Dec. 91).

* After Baruch Goldstein mowed down 48 Arabs while they were praying in a mosque in Israel, a rabbi said (to the horror of Israel's chief rabbis) that even a million Arabs "are not worth a Jewish fingernail" (Syracuse Post-Standard, 28/2/94).

* The Walt Disney people and a commercial toy firm called Playmates got together and put out a 5" doll of "Steve the Tramp," who is a figure from the Disney film, "Dick Tracy." The tramp has a hideous face, and carries a bowie knife in one hand and a garbage lid in the other. The literature that comes with the tramp describes him as a "reeking piece of filth" who is a "public enemy" who will "use and abuse any young helpless prey he come across" (Time, 31/12/90). The toy came out just in time for Christmas.

* Moves are underfoot to require that shelters for the homeless require their residents to be fingerprinted. As we have pointed out since the early 1970s, registration, identification and person-tracking schemes have historically been the prelude to deathmaking of the affected groups if these were constituted of oppressed or devalued people.
*Newsweek* economic columnist Robert Samuelson claimed deceptively (11 Oct. 93) that US federal government support for older citizens is the "basic cause" of the federal deficit. With the same logic, one might just as well take the whole rest of the budget or any part that exceeds the deficit and call it the basic cause of the deficit. This kind of slanted interpretation is bound to add fuel to the currently growing resentment toward older people, and thus to deathmaking measures against them.

*Between a third and a half of young adults in a US survey perceived elderly people as a selfish voting block that benefits unfairly from government social programs, and as constituting a divisive influence in their communities (SHJ, 19/7/92). Reflecting these sentiments, a new anti-elderly organization has formed, deceptively acronymed AGE (Americans for Generational Equity), which contends that the older generation is getting more than its fair share of Social Security and other benefits, and that it is endangering the future benefits of the younger generation. In only 18 months of existence, it was able to get articles on its program into some of the most influential periodicals, such as *The Wall Street Journal*, *Readers' Digest*, *Washington Monthly*, *Atlantic Monthly* and *Esquire*, and its representatives have appeared on CBS, NBC, and the Public Broadcasting System. There is something thoroughly evil about this outfit, apparently not only because of its explicit goals, but also its deceptive name and acronym. Interestingly, the organization is made up of 51 business corporations rather than of individuals, and its board of directors is composed almost entirely of business people, including a senior vice president of Metropolitan Life and the chairman of the Hospital Corporation of America. Obviously, one of the real goals is to eliminate employer contributions to Social Security and the privatization thereof entirely. It also appears to attempt to deceptively enlist the support of the baby-boomers, or at least appear to represent them (Gray Panther Network, Summer 86).

*In one program in China, elderly employees who were retiring received coffins as retirement gifts (Philadelphia Inquirer, 5/86). As our friend Jack Pealer would say: "Not very subtle."

*Graffiti in men's toilets is usually sexual and obscene, or scatological. In May 1994, we ran across the first such graffiti of an ageist genocidal nature. It said, "Old men leave; go to hell."

*That some people value some lives distinctly less than others is underlined by the fact that people are vastly more disturbed when they hear about the suicide of a young person than that of an elderly person (AW, 12 June 93).

*Only partly tongue-in-cheek, Training and Evaluation for Change (TEC), an SRV and PASSING training group in South Australia, proposed that soon, people will be issued a "right to live license" at age 50. One can lose various amounts of points on one's license for such "offenses" against cultural values as losing one's good looks, becoming a burden to others, becoming unable to walk to the local stores, losing one's memory, etc. The government can revoke one's "license to live" at any time. The jokester(s) who conceived this scheme noted that this is not a game but reality for many elderly people. It is also eerily reminiscent of Fletcher's 15-point scale for "personhood," on which a person who does not accumulate enough points can be ruled to be not-a-person, and therefore legitimate to make dead.

*The TIPS editor has argued (e.g., in his 1987 monograph, *The New Genocide*) that much of the deathmaking of handicapped people is tied to the re-emergence of eugenics in a new form and under a new cover. Recently, Antonak, Mulick, and colleagues have developed a scale that measures people's eugenic attitudes towards retarded persons, and they have indeed confirmed that "the level of endorsement of eugenic principles in general samples of American society may have been underestimated."

*The TIPS editor remembers the days when parents of newborn children with Down's syndrome were told that the child would not survive infancy, and if it did, it would be profoundly retarded, and
that this was an urgent reason to institutionalize the child. When the untruth of these myths finally penetrated into the rank and file of medicine (which was 20-30 years after almost everyone in mental retardation knew better), a similar pronouncement began to be made about children born with spina bifida. Here, the truth still has not quite trickled down to front-line practitioners or even academicians. Then when the powers that be could no longer easily manage to separate families from their children with Down’s syndrome, another myth arose, and that was that adults with Down’s syndrome will invariably get "Alzheimer’s disease" in their 30s or 40s. We suspect that a phenomenon people have been observing is that people with Down’s syndrome who were severely deprived in their childhood and young adulthood because of earlier myths do, in fact, have a tendency to decline mentally earlier than others. However, we believe that normal rearing of children with Down’s syndrome, with at least a normative amount of intensive stimulation, will reveal the falsehood of this latest mythology as well. This was exemplified by a 54-year-old man with Down’s syndrome in St. Louis who sold newspapers at the Merchants Exchange and other valued spots until 1986, and who still did not have a gray hair (DSN, 4/86).

*In Germany, there has been an outbreak both of hostile verbal assaults on handicapped people in public, and of physical assaults on them. Some visibly impaired people have begun to be afraid to go out into public, especially without protectors.

*In 11/93, we first learned that people are speaking in terms of "taillight relatives," meaning relatives who are feeble, doing poorly, or are "circling the drain."

*Certain abnormal high plateau episodes in cardiograph curves are called "tombstones," because they vaguely resemble such. This is an unfortunate image juxtaposition because people with such patterns are usually at death’s door.

The Promotion of Suicide of Devalued People

Suicide isn’t what it used to be, because we now have suicide and "suicide," but both are being vigorously promoted. There is an entire cultus of encouraging people who are in chronic pain or unhappy with life to quit life; there are ever more manuals on "how to" do this; and glorification of people who have done it in the arts and news media.

However, intertwined with the above is the practice of killing someone, or helping someone to kill themselves, who expressed a desire to die, or who is merely interpreted as wanting to die. Here, too, more and more people are willing to participate as accomplices or even unilaterally, often called "suicide assistance." We have to be clear that when one facilitates the suicide of a person because the person is suffering, one commits "euthanasia." In German, an important distinction is made between Sterbenshilfe (helping someone die, close to suicide assistance) and Sterbebegleitung, i.e., accompaniment of someone who is dying. Because of the degradation of the term "suicide," it might almost be best to distinguish between sui-suicide (where it really is the person who (a) definitely wills his/her death and (b) kills him/herself), and allosuicide" (where someone else participates in the killing of a person to such a degree that the criteria for sui-suicide are not met, but where the dead person is interpreted to have committed "suicide").

First, we will cover the growing practice, and acceptance, of suicide; then we will cover the impersonal promotion and facilitation of it across distance (e.g., via manuals); then we cover the personal promotion of the suicide of a specific person without participating in it; and finally, we will cover direct assistance or participation.

The Growing Practice, & Acceptance, of "Real" Suicide

*The suicide rate in the US has been increasing steadily, having become the 8th leading cause of death by 1983, and 30% of Americans said that if they had a terminal disease, they would consider suicide (Time, 23/9/91). But not only are married women less likely than unmarried ones to commit suicide, but the more children they have, the less likely they are, which shows that contrary to what
is so often taught these days, people are capable of pulling themselves together if they see themselves as having serious responsibilities (Life at Risk, 6/93).

*A Syracuse man decided to run his head through the windshield of his automobile. When a policeman arrived to stop him, the man shouted, "See, it's my body and I can destroy it if I want and there is nothing that you can do about it," and continued with his demolition task. Even though his message sounded much the same as that of the abortion movement, the police officer arrested him for "violating the Mental Health Law" (SHI, 11 July 91).

*Some people can't take TIPS because it has too much bad news, so we here give good news. A woman wrote an article, taking up an entire page of Our Sunday Visitor (21/10/90), trying to make the point that one really should not commit suicide merely because one is afflicted. Now is that not wonderful? (Source item from Ann O'Connor)

*Suicide rates have also risen in all sorts of specific population groups. One of these is children and youths. The suicide rate of children has increased 800% in the 35 years between 1950-1983. By the late 1980s, suicide had become the 7th leading cause of death of children below the age of 15, and homicide 4th (AIDS Update, 8/89). Between 1961 and 1981, the suicide rate for people between ages 15 and 24 went from 5.1 to 12.8 per 100,000, an increase unmatched by any other age groups. A congressional panel found this "baffling," but one of the sensible explanations given by one of the testifying teenagers was that if an adult "messes up" by doing crazy things, drinking too much or using drugs, "it confuses us, especially if the adult is a parent." In other words, screwed-up adults must be expected to rear screwed-up children, and apparently it took the mouths of babes to tell our leaders that. The question now is whether they will believe it. The teenagers most likely to commit suicide are those who are using illicit drugs, those whose nuclear family has broken down, those with a history of mental problems, and those who are homosexual (IAETF, 8/90). The latter group's rate is triple that of other teenagers (Springfield Union, 18/1/90; source item from Michael Kendrick).

*Another affected population group is the elderly. In the US, their rate rose 25% just in the 1980s (USN&WR, 9 July 90) so that by the late 1980s, the 12% of the population that was elderly accounted for 25% of all suicides (19/11/89 CBS "60 Minutes"). Also on the increase is couples committing suicide together, or one killing the other and then committing--or trying to commit--suicide. Also, elderly people--even the women--are more likely to use gun shots. As we have reported many times before, when one spouse kills the other under such conditions, the survivor commonly gets off more or less free.

Modernism is such a powerful culture that it is rapidly replacing all other cultures across the world. This accounts for the fact that more and more, one sees the same developments in many other cultures. For instance, suicide among the elderly has also been increasing dramatically in Germany. Ironically, the answer offered by authorities is earlier referral for shrinkery of people at risk (AW, 10 Nov 90).

Even in institutions, the elderly manage to commit suicide or murder-suicide.

Bruno Bettelheim had survived the concentration camps, became a psychologist and child therapy guru, and wrote that meaning is the key to surviving experiences such as concentration camps. In his later life, he unfortunately joined the Hemlock Society. Someone at a dinner party in his honor in 1990 asked him how old he was. When he replied that he was 86, the guest immediately offered to introduce him to friends at the Society for the Right to Die or in the Hemlock Society. But Bettelheim had already belonged to the Hemlock Society, and committed suicide two weeks later by means of an overdose of sleeping pills and putting a plastic bag over his head, as recommended by the suicide manuals. While he had been living in a retirement home for 6 weeks, life conditions did not appear to have been all that bad for him, and certainly better than those of perhaps hundreds of thousands of others.

In 1992, there was what appears to have been the first case in the US where an aged man in a nursing home shot first his wife and then himself. Probably also new is people in pain smuggling
weapons into a hospital in order to kill themselves there, as a man did in Syracuse (SHJ, 8 March 94). He shot himself in a hospital toilet because he was in constant pain. If a doctor had done it with a needle or with "medicine" while the man was in a hospital bed, it might have been, or soon will be, perfectly legitimate or even legal.

What claims to be the first national study of suicidal behavior in US nursing homes reported in 1991 that about 20% of all residents have engaged in life-threatening behavior, but that this fact, as well as the suicide deaths that actually occur, are being kept a dark secret. A more detailed investigation of four nursing homes found that there had been between 40 and 50 suicides at each home over a 5-year period, but only 8 to 10 had been reported in each case. Suicide rates were lower in expensive facilities, those that provided individual counseling, church-affiliated ones, and those with a greater variety of activities. (Source clipping from Guy Caruso)

In 12/89, we reported on a quadriplegic man in an Alabama nursing home who won a court decision that he could turn off his own ventilator. Hearing of his desperate decision, a number of people in the area befriended him and told him that they would try to work toward something better than life in an institution. This gave the man hope, and he entered an employment training program run by a local United Cerebral Palsy unit (AP, 1/90 source item from Craig Dunnigan).

*Prison suicides have always been high. A somewhat unusual vignette is that of Joseph Kallinger who had committed numerous offenses, including murder, and was under court sentences from several states "too numerous to mention" which included several life terms. He ended up at Farview State Hospital, the maximum security forensic mental institution for the state of Pennsylvania, and long known to be a hell-hole. In 1990 he had a vision of Christ appearing to him in his toilet bowl telling him to join Him, and decided to starve himself to death. He somehow managed to get two lawyers, one to argue in favor of his right to die, and the other (appointed as guardian ad litem) to argue that his request should be denied. In 8/90, a Pennsylvania court ruled that a person in state custody has no right to commit suicide by starvation. (Source material from David Ferleger). In contrast, a prisoner in jail in Syracuse said he had a talk with the devil, and soon after hanged himself in his cell (SHJ, 22/1/90).

*Aside from the elderly, children and prisoners, a number of other groups have very high suicide rates, including physicians, pharmacists and police officers.

*The bad news is that there was also a 3-fold increase in suicides in the US "black" population, and particularly so in the 25-34 age range where it reached 19.1 per 100,000. The "good news" is that this is moving towards "equality" with suicide rates for Caucasians, which had been higher to begin with.

The Impersonal, Distantiated Promotion or Facilitation of Suicide

As mentioned, when we report on the promotion of suicide, the promoters usually are not only in favor of suiicide, but also allosuicide. Accordingly, most suicide manuals not only promote suicide but also "euthanasia."

Increasingly, suicide is now being called a "choice," and many people are arguing that it should be privatized. We are appalled at the application of the word "choice" here as if it were a matter of choosing between one or the other ice cream flavor. Once again, we believe that a much more accurate and traditional term would be "decision."

The suicide promoters have also come up with yet another euphemism for suicide, namely "auto-euthanasia," and also "client self-determination."

We also should be crystal-clear that the more legitimate suicide comes to be viewed, the more legitimate will also be viewed so-called "suicide assistance," and the more legitimized will become actually killing someone who asks for it.

*The first suicide manual (Euthanasia: The Aesthetics of Suicide) was actually written in 1894 by Baron Harden-Hickey, and published by the antireligious Truth Seeker Company. The author had
sampled 400 quotations allegedly from the world’s greatest figures, but most of the quotes turned out to be spurious, underlining once again the connection between deception and violence and deathmaking. Surprisingly, unlike most people who urge other people to kill themselves, the Baron did poison himself in 1898 (Felton & Fowler, 1975).

*Derek Humphry, suicide guru, & "how-to manuals.* In 1975, Derek Humphry encouraged his wife to commit suicide when it turned out that at age 42, she had breast cancer. He himself mixed the poison that she drank. Within a year he had married another woman, and with her, he founded the Hemlock Society that is dedicated to what they call "assisted suicide" and "self-deliverance." It is the most "radical" of the so-called "right-to-die" groups. Its suicide manual, Let Me Die Before I Wake, had sold 130,000 copies by late 1989. In 1989 alone, the Hemlock Society is said to have doubled in membership to 30,000 people in 51 chapters around the US.

The parents of the second Mrs. Humphry apparently had become convinced by the propaganda of their daughter and her husband, and committed suicide together. The daughter then wrote a fictionalized version of their deaths, Double Exit, published by the Hemlock Society. In early 1990, it became public that Humphry’s second wife had also developed breast cancer—upon which Humphry promptly left her three weeks after she had breast surgery. Many Hemlock members were shocked and surprised, but that merely illustrates how foolish they are. Sadly, she continued on the payroll of Hemlock herself (NY Times, 8 Feb. 90). Soon, she committed suicide, though embittered at being duped.

In recent years, there has been an explosion of suicide promotion literature and "how-to" manuals, and the most famous one, Final Exit, by Derek Humphry came out in 5/91. Early in Final Exit, Derek Humphry said, "if you consider God the master of your fate, then read no further." But within a few months, it had sold 520,000 copies in North America, became the top best-seller and has since made its author a millionaire. It tells people very explicitly how to kill themselves, help others kill themselves, or perhaps kill others for them.

One really has to ask what it means to a society when a manual on how to commit suicide becomes a best-seller, but one thing is certain: ever since Final Exit has come out, there has been a wave of suicides where the victims made use of the book and its recommended methods. The victims are often found with the book close at hand or even in their laps (IAETF Update, 11&12/91; Time, 15/11/93).

The vast majority of people who commit suicide in consequence of having consulted the suicide manual Final Exit are not terminally ill but merely elderly or depressed. Since in the US, more than half a million teenagers are said to attempt suicide each year, one can easily see that if one killed everybody who at one point said they did not want to live, one would commit societal suicide; soon there would be no young people left.

A disproportionate number of people who have been buying this book are elderly, health care workers and people with AIDS (Time, 19/8/91). In fact, the book is heavily aimed at the elderly, and boasts that it will solve the "problem" of "terminal old age."

Some high school classes use Final Exit as a text in their course on "death education" (IAETF Update, 11&12/92), and unfortunately, Humphry and his works have been promoted by frequent talk show guest Maggie Strong in her 1989 manual on taking care of a sick spouse (Mainstay).

One small bit of good news is that Australia banned the import of Final Exit on the grounds that it promotes "crime or violence" (IAETF Update, 3&4/92).

In Japan, a book entitled The Complete Manual of Suicide has also become a best-seller. Among other things, the book suggests good places to hang oneself or leap off buildings. Young women and college students are the most eager purchasers. The publisher claimed that the book inspires optimism by making people feel good about how to die if things got really bad (Newsweek, 27/9/73).

Pro-suicide propaganda, such as that sometimes found in the possession of people who have committed suicide, often has a religious flavor, comparable to the religious practice of "witnessing." There are also assurances to people contemplating suicide that this would be "empowering," and an uplifting experience (Newsweek, 28/6/93), perhaps especially if they hang themselves.

A leading American "gero-psychiatrist" complained that the recent rush of "how-to" books on suicide would seduce people with "treatable depression" into committing suicides. Presumably,
suicide is only okay for people with untreatable depression (SHJ, 17/2/92).

*The lesser of two evils? Liberal Columnist Ellen Goodman has complained about the medicalization of suicide, and says that people should resist this and keep suicide in the private nontechnical domain, facilitated by guidelines such as Final Exit (BR, 7/93).

*Pro-"suicide" societies claim hundreds of thousands of members. One of the biggies is Hemlock. It is rather amusing to contemplate that one of the arms of Hemlock is named Americans Against Human Suffering, and has chapters in many states. Insofar as humans will always suffer as long as there are any humans, the name could almost be equated with Americans Against Humans, or Americans Against Human Nature, or Americans Against the Human Condition. In British Columbia, there is a group called the Goodbye Society, which is similar to the Hemlock organization in the US (IAETF Update, 4/91).

*In 1990, a Canadian philosophy professor (Prado) published a book The Last Choice, that argues that suicide is sometimes the wisest course of action for ill older persons.

*The director of an "applied ethics" center in Australia has proposed that information on how to commit suicide be made widely available to medical patients. Fascinatingly, the article reporting this was placed right beneath an article warning physicians to refer to the people they treat as "patients" and not as "clients," which surely must tell us that one of the rights of being a patient would be to be helped to commit suicide (Age, 4 Feb. 91).

*The United Church of Christ became the first major Christian denomination in the US to assert the morality of suicide in 1991, in language that was couched in secular terms (as a "right") rather than in Christian terms (CRTI Report, Summer 92).

*Deathmaking promoters have begun to say that old age by itself is a sufficient reason to want to commit suicide in a rational fashion. In other words, one need not be sick or senile, but merely old, and contemplate that there are many increased risks to mind, health, prosperity and welfare, and kill oneself on these probabilistic grounds alone (e.g., Life at Risk, 7/92).

*One of the many fates worse than death. A Prudential securities advertisement in circa 1992 said perhaps "the one thing worse than dying is outliving your money" (Life at Risk, 6/93). This is a subtle way of promoting suicide by the elderly poor.

*In DesMoines, Iowa, the Meals on Wheels service occasionally encloses information pamphlets about nutrition for its clientele. The 2/1990 topic of these Nutrition Notes was—hemlock, and said that its "poisonous qualities have been exaggerated." The item signed off with the phrase "food for thought." We would say that this is a classical example of a repressed death wish toward dependent elderly people by those who serve them (The Rose Review, Fall 90; source item from John Morris).

*People with AIDS have not only become a major target group for the "euthanasia"/suicide lobby, but have in turn become gullible consumers of its propaganda, particularly since even homosexual men who are not HIV-positive have extremely high suicide rates. At an assisted suicide seminar (are they aware that this acronym means down to ASS?) in San Francisco, most of the 150 participants were homosexual men who had AIDS (IAETF Update, 7&8/93).

*Ever and ever more, when someone systematically plans and conducts a suicide, the media reports it in the most positive glowing terms.

*Child and teenage suicide. There have been steep increases in the suicide rates of children. In some teen population groups (e.g., Indians), one in six has attempted suicide (SHI, 25/3/92). It is now becoming apparent that death-and-dying units being taught in the schools are one of the
In some US schools, death education sequences start in 5th grade. Children learn the spelling of the terminology of death (corpse, morgue, embalm, etc.), the many ways to die, how to write their wills and epitaphs. They design their tombstones, have funeral directors lecture to them, and visit funeral homes. In some of these programs, children even climb into caskets. Teachers often encourage the pupils to contact pro-suicide groups for materials and "a balanced view" of "both sides of an issue" (IAETF Update, 7&8/93). On the one hand, all this may combat our cultural denial of death, but on the other hand, it may prepare children for both deathmaking and suicide. For instance, a number of students have committed suicide shortly after exposure to such death education modules (Source material from Ed Cohle). An article in the JAMA (26/12/90) also concluded that teen suicide prevention programs in schools may actually precipitate rather than prevent suicides, which would not surprise us in the least, and even mainline television (21/9/90, ABC TV "20/20") has taken a critical look at this development (IAETF Networker Update, 11/90). For instance, at a time of an unprecedentedly high suicide rate among teenagers, an English teacher in Melbourne, Australia, gave her students the assignment of writing a suicide note, which may in fact be a subtle way of further feeding the ongoing suicide craze (Adelaide Advertiser, 5/89; source item from Michael Rungie). The Long Island newspaper Newsday has recommended that grade school and high school students read the Hemlock Society's suicide manual, Final Exit (Life at Risk, 2&3/93). Researchers at Columbia University have also found that there were a whole series of TV movies on teenage suicide that portrayed the suicide-committing teenager so positively as to virtually set up teen suicide role modeling (Chicago Tribune, 29/10/90). Perhaps all this is an unconscious expression of this culture's hatred of children.

Children are taking in all these cues. After the devastating hurricane in Florida in Spring 1993, a dozen attempted suicide--something children in the midst of the worst scenarios of WWII in Europe never did. Today, death (one's own or someone else's) is just a convenient solution to trouble.

Among young people, there is apparently also such a thing as "suicide contagion," meaning that when young people learn that someone in their relatively proximate circle has committed suicide, they may then get the idea that they should commit suicide as well (IAETF Update, 7&8/93). An Arizona bar association sponsored an essay contest for grades six to nine on the legal issues of two pupils being trapped in a cave and surviving by killing a third one and eating him. Soon we may see "cannibalism contagion." At one time, parents were admonished to sit down with their children and talk of "shoes and ships and sealing wax and cabbages and kings," but today, advice columnists tell parents that it is time to sit down with their children and talk about--suicide (Advice column, Syracuse Herald Journal, 12 Feb. 93).

*A 1986 film sympathetic to suicide (shown on TV since) was called "Night, Mother," and concerned a woman (in her late 30s or early 40s) who had epilepsy, had been divorced, and lived with her mother. The daughter took care of almost everything around the house, to the point that the mother did not know where a lot of things were kept, nor how to order groceries. The daughter is so lonely and sad that she decides to kill herself, and to tell her mother beforehand what she is going to do and why. The mother, of course, objects, and says, "People don’t kill themselves unless they’re retarded or deranged." The two hours of the film are mostly a dialogue between the daughter and mother about their lives, revealing family secrets that are hurtful, etc. In the end, the daughter locks herself in the bedroom and shoots herself. While the viewer does feel a lot of sympathy for the daughter and her plight, she spouts totally modernistic, individualistic rationales for committing suicide, such as "It’s everything I wanted," "I’m just not havin’ a good time, and I have no reason to think it’s gonna get any better," and "I’m gonna say what happens to it, I’m gonna stop it."

**Personal Promotion of the Suicide of a Specific Person Without Participating in It**

Increasingly, people are suggesting that a specific person they know should commit suicide. For instance, ever more people are telling their ailing elderly parents that it is alright for them to commit suicide, or even that it is the best thing they could do (e.g., Life at Risk, 10/93; IAETF Update, 11&12/93). This is of course understood by the elderly parents to be a very strong suggestion that they should not become or remain a burden on their children. However, suggesting to others that
it is fine for them to commit suicide was called by columnist "Miss Manners" an "etiquette atrocity winner" (Ind. Star, 24/6/90; source clipping from Mike Morton).

*A woman committed suicide with a pistol, and her widower then sent the gun to his ailing 73-year-old aunt in New Jersey as a Christmas gift, together with a copy of the suicide manual Final Exit, and the message that "this will cause you no pain." The aunt took the suggestion and shot herself. The man was convicted of no more than failing to notify the mail carrier that the package he had sent contained a gun (CRTI Report, Summer 92).

*We reported above on a man in Georgia who wanted to be given the capacity to turn off his own respirator. We have learned that the State of Georgia was actually quite eager to speed this man to the cemetery because Georgia has had one of the worst provisions for funding home supports for people dependent on nursing or personal care. Accordingly, people who could live at home end up costing vast sums in hospitals or nursing homes. Unfortunately, people who have approved of the morality of the man's suicide plan, which apparently include the Georgia Medical Association, the State Attorney General and the Catholic archdiocese of Atlanta, have apparently failed to take the deficiency in state provisions into account. This is a classic example of a person being maneuvered into requesting "euthanasia" without anyone appearing to do the maneuvering (Atlanta Constitution, 10 Sept. 89).

*An ailing couple in Syracuse tried to commit suicide together in 1990, but failed. A neighbor said she was sad that they had not succeeded. This is the kind of sympathy for all forms of deathmaking that we see increasingly in Western society. However, due to the culture of externalism, this is an extremely imitative culture, and about 2 weeks after there was a big article in the paper about this couple, another local elderly man killed his wife and then committed suicide (SHJ, 29/8/90).

*There is a telephone hotline in the Netherlands that people can call for advice on how to commit suicide (Life At Risk, 12/93).

Direct Participation in the Killing of a Person Interpreted as Suicide

Direct participation in a suicide can take three forms. (a) One attends a person's suicide in a way that expresses approval or encourages it, and certainly without trying to stop it. In this case, one "aids and abets." (b) One actually takes an active part in the killing, e.g., by advice, or bringing and handling the means for the killing, in which case one is an accomplice. (c) One actually kills the person who says he/she wants to die (releasing the poison valve, suffocating, shooting, etc.), in which case one is a murderer in the first degree. However, many of these cases are described as suicide. The phrase "physician-assisted suicide" can refer to either (b) or (c).

*For every class and type of legitimized deathmaking, where thousands or even tens of thousands of actual deaths occur within that class, there occasionally pops up a singular case that in some way typifies its class, makes national or international news--and almost always contributes massively to a further legitimization of its type of deathmaking. An example of this is the revelation in 3/91 of a physician-assisted suicide of a wealthy woman in Rochester, NY, by Dr. Quill. Such cases evoke waves of sympathy and approval from big sectors of the public, which is encouraged thereby to henceforth both approve of more of the same deathmaking for others, and perhaps of some of it for themselves as well. It is only one part of the ugly underside of this that in actual life, wealthy and favored people will suffer much less from such systematized deathmaking than the poor and lowly. By the way, having gotten away with his complicity, Dr. Quill has since written a pro-"suicide" (actually, "euthanasia") book, Death and Dignity: Making Choices and Taking Charge. Quill is both an internist and psychiatrist.

*In 11/92, the New England Journal of Medicine published the first article in the US medical
literature that called for the establishment of criteria for "medically assisted suicide." The article did this in glowing positive terms such as that the request for suicide assistance can be "one of the most meaningful...requests a patient can make of a physician." Perhaps what makes it meaningful is that much of anything else that patients say to their physicians does not register or is not considered important. Another article in the same issue said that in order to keep physicians from "doing it badly," certain safeguards should be instituted. Thus, the debate has shifted from the question whether physicians should kill patients to how they should do it, and most people would not even notice that shift in address (IAETF Update, 2&3/93).

*Among the 145,000 members of the National Association of Social Workers, 64% believe that "assisted suicide" should be legal (and 81% said they would advocate for "aid-in-dying"), according to one survey, and almost all of these in the state of Washington thought so. Accordingly, the organization changed its ethics code so as to allow members to attend, or even assist at, the suicides of clients (IAETF Update, 2&3, 9&10, 1993; CRTI Report, Fall 93; source clipping from John O'Brien). In our opinion, this makes it morally impermissible to belong to this organization.

*The nation-wide newspaper USA Today editorialized in support of privatization of physician-assisted suicide (IAETF Update, 2&3/93).

*The major Syracuse newspaper ran a quarter-page-sized article by a family therapist entitled "Legalized Doctor-Aided Suicide: It's Time to Redefine 'Respect for Human Life'" (Syracuse Herald-Journal, 28/2/94). This is one of the innumerable ways in which the liberal media are promoting "euthanasia," much as they have long promoted abortion.

*Advice columnist Ann Landers has come out in favor of assisted suicide for the dependent elderly, calling it a "sane, sensible civilized alternative to existing in a nursing home, draining family resources and hoping the end will come soon. Too bad it is against the law" (St. Louis Post-Dispatch, 3 Oct. 93).

*In 5/94, the US Surgeon General, Dr. Joycelyn Elders, called for the legalization of suicide assistance.

*The film, "Last Wish" (co-starring Patty Duke), glorified suicide as virtually the only sensible choice for people suffering from a terminal illness. It is based on a newswoman's earlier account of how she helped her mother kill herself. The film trivialized hospice care, ridiculed pain control, and type-cast a character in the film who brought a religious perspective on the issue as air-headed.

*A "euthanasia" coalition, called the Oregon Right to Die Coalition, released a new physician-assisted suicide proposal in Oregon which one of its spokespersons called "a modest proposal" (Life at Risk, 12/93).

*In May 1994, a US District Court ruled that a Washington state law that impeded "physician-assisted suicide" was unconstitutional because it interfered with individual liberty, invoking as a relevant precedent earlier federal rulings in defense of unrestricted abortion.

*While an "assisted suicide" initiative in California was defeated in 1992, few people have taken note of how narrow the margin of defeat was. It would have taken a change of less than 5% to put it over the top. In our opinion, this makes it inevitable that such a law will soon be passed somewhere--and not just in one single jurisdiction.

*A 31-year old woman charged that her woman physician repeatedly helped her to attempt suicide, in ways such as advising and even persuading her on how to overdose, watching while she injected herself with morphine, and even spoon-feeding her lethal medicine doses (Time, 26/2/90). Apparently, some of this was supposed to be psychotherapy.
*Public hearings on an assisted suicide bill in Michigan have been disrupted by handicapped people protesting against "extermination without representation," and strongly opposed by "African-Americans" (Life at Risk, 3/94). Apparently, this has intimidated the death-leaning commission that had been set up to study the issue.

*According to a study in British Columbia, the rate of suicide and assisted suicide among people with AIDS is extremely high. Surprisingly, this has been used as an argument for legalizing assisted suicide because in so many of the above cases, the killing was done so inexpertly that it became a horror. For instance, people used pill dosages so inappropriately that "helpers" ended up putting plastic bags over their heads (Interim, 3/94).

*One study of "assisted suicide" in general found that half of them are "botched," and strangely enough, this is now being used as an argument in support of out-and-out "euthanasia" (Life at Risk, 6/94).

*In Spring 1993, two new pro-suicide groups were formed. The Patients' Rights Organization was formed as an ally of Hemlock. Its focus is on legislative and political action which Hemlock cannot do under its tax-exempt status. Within weeks after opening an office in Seattle, Compassion in Dying reportedly received phone calls from about a dozen people who said that they were ill and wanted help in killing themselves (New York Times, 13/6/93; source item from Joe Osburn).

*The Columbia Foundation dedicated to the "quality of life for residents in the Bay Area" (i.e., San Francisco area) awarded a major grant to the Hemlock of Northern California, i.e., an organization devoted to the promotion of suicide (IAETF Update, 1&2/1993, p. 5). In other words, dying, and helping people to kill themselves, is interpreted as improving their QOL!! Is there now even QOL after death?

*One active spokesperson and free-lance journalist on behalf of the lives of handicapped people is Ron Seigel in Detroit. He has noted that the recent efforts in the US courts and state legislatures to legalize so-called "assisted suicide"--i.e., physicians giving deadly medicine to patients who request it--is nothing but "legalizing participation in active killing under the pretext of assisted suicide." He also notes that it sends "chills up my spine to think" the term quality of life has been used to convey a judgment on the worth of people's lives. He also notes--in our opinion, quite correctly--that advocates of life these days are highly likely to be interpreted "as fanatics and extremists, who are dangerous because of their convictions." Such an interpretation is certainly fostered by the public media as well as by pro-death forces, and these messages have largely succeeded in brainwashing the public into believing it.

*One thing we can see is that these years of 1992-94 have been "breakthrough" years for the legitimization of "assisted suicide," i.e., allosuicide. There are now speculations that the "assisted suicide" business could become a $600 million "industry" (USA Today, 24/2/93).

*Jack Kevorkian: Dr. Death. So much about this Michigan serial killer (about 2 dozen victims so far) has been in the news that we do not feel it necessary to add much. Like so many deathmakers, Dr. K. has had a life-long love affair with death. Among other things, he had long advocated "harvesting" of organs of condemned prisoners, but wanted the organs taken out while the "donors" were still alive, since most methods of execution are bad on the victim's organs (IAETF Update, 11&12/91). Around 1990, his business card identified his "specialties" as "bio-ethics and obituary." His early self-drugging "suicide machines" (a pretentious term for some crude, rickety baling-wire contraption made with parts found at flea markets) had the name "Thanaton" (named after death), but then he detoxified it by renaming it "Mercitron."

Dr. Kevorkian has said that his advocacy and perpetration of assisted suicide boils down to one simple principle: "the right not to have to suffer" (Christianity Today, 15/8/94: source item from Darcy M. Elks). However, after first dispatching bodily suffering people, he quite logically also
began to kill merely depressed ones.

The Kevorkian affair is a classic example of the difference between killings being legal versus legitimate. Dr. Kevorkian participated in the suicide--sometimes giving a great deal of assistance--of one person after another over a series of years, with everybody declaring this to be illegal, laws being passed against it, and everyone wringing their hands or filing suits--but nothing really being done to stop him. We should note that the courts are now so pro-suicide assistance that the Mich. laws against it have proven unenforceable. Also, the state’s government seems to lack the resolve to nail Dr. K. This has been a great encouragement to pro-death circles.

One role that Dr. Kevorkian has certainly been playing is as a stalking horse for other deathmakers. For instance, a US Navy psychiatrist said that while he rejected Kevorkian’s suicide assistance model, he finds his proposals to be “thought provoking in the extreme,” and added that since veterinarians perform kindly euthanasia on animals, “should a physician do less?” The executive director of the American Journal of Forensic Psychiatry referred to Kevorkian as an “avant-garde thinker—a serious thinker.” Another psychiatrist interpreted the Kevorkian scheme as “well thought-out, thorough.” Other pro-death people have cynically denounced Dr. K. so that they could point to the “need” for “better” ways of helping people die.

Another thing that Dr. Kevorkian has done is to blur the distinction between suicide and murder in people’s minds. He himself has engaged in behavior which not too many years ago would clearly have been interpreted as murder, but is now dignified with the euphemism of “assisted suicide.” And, again and again, the media link Dr. K. with the “right to die” rather than the right to kill! As a result, public opinion has swung strongly in his favor. According to at least one survey, 83% of Americans said they would not convict Kevorkian of murder, and only 8% said they would (IAETF Update, 3&4/92).

We certainly hope that our readers get it out of their minds that there can be such a thing as a rationally controlled and properly safeguarded scheme of suicide assistance or “euthanasia.” Where things go almost overnight with such developments we have already seen in history, and continue to see over and over. An example is one of the cases of Dr. Kevorkian. He got a call from a woman who wanted to die, and all within hours, some of his accomplices had picked her up, she had an interview with Kevorkian, and was put to death (First Things, 3/93).

Seeing that Dr. K. was getting away with murder in Michigan, an elderly California couple took a trip there where the husband asphyxiated his ailing and dementing wife (on her request) in a motel room. He was acquitted (AP in SHJ, 11 May 91).

We saw a cartoon that made the painfully true observation that the only doctors these days who make house calls are the ones that come to kill, like Dr. Kevorkian.

Singer Mitch Snyder (whoever he is) was scheduled to sing at the Michigan State Fair. When officials did not let him sing an ode to Dr. Kevorkian, entitled “Mercy,” he refused to perform at all (AP 17/8/94, in Life at Risk, 7&8/94), but was not dispirited enough to commit suicide.

"Euthanasia" That Is Not Interpreted As Suicide

The foregoing should have made amply clear that from now on, one must differentiate "euthanasia" that is not disguised as suicide from the one that is. Unfortunately, not only is voluntary "euthanasia" now called suicide, but involuntary "euthanasia" is increasingly interpreted as voluntary. So if A becomes B, and C becomes B, then involuntary "euthanasia" is set equal to suicide. What’s next? The news that the 500,000 dead Rwandans really committed suicide? At this point, this issue of TIPS is getting outright depressing.

The barriers against "euthanasia" are continuing to fall one by one. Obviously, "euthanasia" will not be suddenly upon us without warning and in any kind of discontinuous fashion, but will creep up on us in a thousand little ways.

There have probably always been times when medical people did something deliberately that ended the life of a suffering person. For instance, we recently learned that among the poor people in the US South, there is a long tradition of referring to the administration of a killing substance (such as an excessive dose of morphine) to a suffering person via an injection as the "black needle." However, the difference is that in the olden days, everyone knew that there was something morally
us because it is merely one other facet of the growing support for "euthanasia" in medical practice generally (IAETF Update, 7&8/92).

*Dr. Ronald Cranford, the neurologist who was active in the Cruzan case and sought to starve and dehydrate Chrissy Busalacchi, suggested that persons diagnosed as being in a "persistent vegetative state," and possibly also persons in the late stages of Alzheimer's Disease, would fall beneath a meaningful life threshold. He called them "creatures of modern day medicine" who "lack personhood." He suggested that any discussion of the best interests of such patients is irrelevant since they have no interests in continued existence (IAETF Update, 4 Feb. 91).

*In 1/92, a US professor of medicine began to speak of the need to develop "a model" for the "role of terminator of life within the traditions of American medicine." Like Kevorkian, he has recommended that specialists—especially anesthesiologists—be certified to do the killing (New England Journal of Medicine, 16/1/92).

*The Michigan State Medical Society used to be opposed to all forms of "euthanasia," but voted in 1993 and 1994 to change its position to one of neutrality. Also in 1994, the Oregon Medical Association voted to remain neutral on the same issue (IAETF Update, 5&6/94). One can easily see a slippery slope from opposition to "euthanasia," to neutrality on it, to first endorsement under unusual, rare, or highly controlled circumstances, to eventual endorsement of unrestricted and unregulated "euthanasia," much like abortion.

*At a medical ethics conference in 1991, the TIPS editor heard a "bioethicist" talk who, ever so typically, said he did not want to give any answers but only raise questions. However, he made one most remarkable assertion, namely, that aborting the unborn because they are suspected to become retarded has not had a negative impact on how living retarded people were treated, as evidenced by the Special Olympics!

*One of the amazing reactions in some medical circles to the Supreme Court Cruzan decision (that one needs a very clear indication from persons before they become incapacitated that they did not wish to be kept on life supports) was that now, more patients might commit suicide out of fear of slipping into debilitation. The hypocrisy of the deathmaking circles is sometimes beyond all belief, though it should not be.

*It seems pretty obvious, but we had not reported on it before. Namely, when the powers that be in a hospital decide that it is time for somebody to die, they are extremely likely to put that person on a tranquilizer so as to increase the likelihood that the person will slip away quietly without making too much of a fuss. This practice is not exactly in the same category as using psychiatric drugs in a health-injurious or deathmaking fashion, since in most cases, the hospital patient would have died without the drugs anyway, but it is in the category of using drugs in collusion with deathmaking.

Support for Medical "Euthanasia" by the Media, Opinion Leaders, Intellectuals, Literati & Glitterati

Not only is one obstacle to "euthanasia" after another falling by the wayside, but with every day, more moral authorities are coming out in favor of it. Even a few church groups with official positions against it are being overtaken by the increasing sympathy for "euthanasia" among their membership.

*One thing we have noticed is that it is not just a question of occasional instances of support for deathmaking by any party or moral authority, but more importantly, whether there is a systematic pattern of such support. An example of the latter is the news media. Nowadays, they will print or broadcast not only an occasional item sympathetic to deathmaking, but entire series of articles or programs that are systematically slanted in favor of the deathmaking (and deathmakers), that ask questions that lead those being interviewed to sound sympathetic to deathmaking, etc. For instance,
the CBS news programs "60 Minutes" and "48 Hours" have each done several episodes over a period of years related to deathmaking, and the interviewers consistently ask questions in such a way as to imply that at least some deathmakings are justified, such as "but what about quality of life?" "do you ever wish the doctors had not done all they could for your child?" (who is now handicapped), and so on.

*An avalanche of deathmaking books have been coming out that are written by highly credentialed academics, which of course scientifiques and legitimizes deathmaking, and does so in a highly intellectualized manner that makes it look rational and moral.

*Last Rights: Death Control and the Elderly in America (1993) is a book about deathmaking of elderly people, with the term "death control" being meant to be a parallel to birth control, but meaning much the same as our term deathmaking. While claiming not to advocate death control, the book appears to be another thinly-veiled promotion of it.

*John David (by P. Milne, 1982), which appears to be autobiographical, is a novel sympathetic to letting a child with Down's syndrome die by withholding medical care. All characters in support of the child are depicted as offensive, and all in support of death as positive. Reviewers called the book "heartwarming," and "the best kind of contemporary novel." Hardly a book to recommend to parents of handicapped children!

*Bring back the grim Grimms! The same British author (Dahl) who wrote the children's book Charlie and the Chocolate Factory wrote a book first published in 1982 (George's Marvelous Medicine) in which a boy, with the help of his father, concocts a potion to kill his grandmother, and eventually succeeds in getting her to shrink away to nothing. The grandmother is described as an "old hag" with a mouth like "a dog's bottom." The boy's mother is at first distressed, but after a few hours allows that "it is all for the best, really. She was a bit of a nuisance around the house." The book can be found in many school libraries. In fairy tales of olden days, awful things would have happened to the killer boy, but nowadays he experiences glory. And the illuminati are trying to outlaw the Brothers Grimm!

*The CBS television series, "Picket Fences," must be aimed at the dredges of modernism. Among other abominable things, in an early 1993 episode, a singing serial killer nurse who is a nun committed "euthanasia" on a patient while humming "Killing Me Softly." This is another subtle way of deathmaking promotion while ridiculing religion.

*The media are extremely subtle in how they promote "euthanasia." In the movie "Aliens-3," an android or robot is damaged, is still able to function well, but is no longer "top of the line." So he asks to be "disconnected" because he would rather "not exist" than be below the "top of the line." The heroine obliges him (source item from Hank Bersani).

*US News & World Report of 25/4/94 ran a series of related articles (pp. 31-42) on "suicide assistance" and "euthanasia." The writers must have read some of Wolfensberger's works because they used the terms "deathmaking" and "devalued" people. However, the series was equivocal on the issues.

*Ann Landers and her sister Abigail VanBuren have been writing enormously influential advice columns for more than 30 years, shaping the attitudes of millions. In recent years, they have systematically thrown their support to many forms of deathmaking, including "euthanasia," and both have come out in support of death Dr. Kevorkian. Both have been members of "euthanasia" advocacy groups, and/or have received awards from them (IAETF Update, 11&12/93).

*It appears that in addition to Richard Lamm, former governor of Colorado, entertainer Art Linkletter, and former Boston University President John Silber (a recent candidate for the
governorship of Massachusetts) have all endorsed the idea that older people should get on with their dying so as not to become a burden to the younger generation.

*Viruses badly needed!* Interactive Software has produced "Dr. Ethics," which is a computer program "to analyze the ethical implications of case studies in clinical medicine," and which then recommends "resolutions" "as the starting point for ethical dialogue" (IAETF Update, 9&10/1991). Might this computer be kinder than "ethics committees"?

*Yet another example of blatant deathmaking propaganda occurred in a full-page story in the 6 April 1992 Time. The main headline was "When Love is Exhausted," followed by a secondary heading, "the abandonment of an elderly Alzheimer's patient highlights the pressures on those who care the most." These headlines referred to the incident reported around the world where a daughter took her aged father out of an Oregon nursing home and abandoned him at a race track in Idaho. The fact is that the daughter who did this was not the caretaker at all. One is absolutely amazed how the media can get away with such bald-faced lies. As we hammer on again and again: where there is violence or the desire for violence, there will also be deception.

*Financial columnist Jane Bryant Quinn used the expression that "Americans...are living too long" in a full page editorial in Newsweek (20/4/92). Formerly, one would have rejoiced about living longer and longer, rather than "too long." Most people will not catch the subtle deathmaking implication, but will nonetheless be influenced by it.

*A 1992 insurance advertisement was headlined "due to circumstances beyond your control, you may live too long" (source item from Susan Thomas).

Utilitarian Arguments for "Euthanasia"

Many arguments put forward on behalf of "euthanasia" that are couched in utilitarian terms are cynical, in that their promoters want what they want, and are merely using utilitarian arguments because they think that these will appeal to certain people. Some of these promoters would just as readily argue that God wants the deathmaking, if they thought that this appealed to an audience.

Not covered in this section are efforts to butcher people for their organs, since these cases do not involve "euthanasia" but other forms of killing.

*Everywhere we turn, we run across warnings that the increasing financial pressures on health services, which are beginning to run into serious funding constraints, will somehow or other feed into first "euthanasia" advocacy, and then actual "euthanasia." One scenario that is increasingly being mentioned is that "euthanasia" will begin to be transacted through a health service rationing construct such as is gradually emerging from the efforts of the Clinton administration. As we point out repeatedly, it is quite possible to institute some kind of rational rationing that is not of a "euthanasia" nature, but the present cultural and value context is not likely to achieve such separation of the two courses of action.

*There has also been a dramatic increase in the media of horror stories on how much sick, elderly, handicapped and dependent people cost, and this occurs regularly in the context of overt or covert promotion of deathmaking (e.g., IAETF, 8/90). One such writer with much influence, columnist David Wilson, proposed a form of medical Russian roulette. He proposed that a pill be developed that gives people a sense of euphoria, with one pill out of every 365 containing a fatal overdose. People contemplating death could take one such pill every evening at bedtime. The writer claimed that this will also help people to overcome religious scruples against suicide.

*A director of a critical care unit in San Francisco proposed that the crisis in health care would be solved by making dead those patients who are too elderly or too ill to "ever return to meaningful function." He also made the points that lives do not have equal value, and that the value of a life
is determined at least in part by how much it enriches or drains family and communities (IAETF Update, 7&8/94).

*Last Rights: Death Control and the Elderly in America (Free Press, 1993) underlines that the ability to choose when and how to die "promises substantial benefits to many Americans," as its advertising flyer put it. (Source item from Robert Flynn.)

*A guest editorial ("Let’s Get Moving") in the 3 Feb. 92 Time made nine proposals to save vast amounts of public expenditures in the US, and one of them was the passage of "right-to-die" laws.

*An Economic Planning Advisory Council to the Australian federal government recommended that "euthanasia" for the elderly should be considered as a means of curbing increasing health costs (Melbourne Age, 1 Feb 94; source item from John Annison).

*Cost-benefit type analyses of deathmaking issues can make remarkable reading. One may run across phrases such as "out-selection of those who offer the least benefit per unit of resource used." Not surprisingly, such analyses lean heavily on "quality of life"-type constructs. One such authority has defined 8 levels of disability and 4 of distress, yielding 29 separate "illness states."

The "Die Already" Cults

*One extremely subtle form of deathmaking has suddenly become a virtual craze in the death-and-dying culture. It consists of people telling very sick persons that it is alright for them to die, that they are free to "let go," and similar verbalizations which may be meant by some people to be reassuring and kind, but which also are bound to talk some people into dying who are really not ready to die, and who might otherwise still recover from at least their acute medical condition. We are inclined to call this the "die already" craze.

Closely related to, or part of, the "die already" cult seem to be books that glorify death, and as Time (8/8/94) put it, have titles that sound like cheery holiday brochures: The Trip of a Lifetime, Heading Toward Omega, Companion Through Darkness, Embraced by the Light, etc.

*Gram, R. L. (1985). An enemy disguised. Nashville: Thomas Nelson. This is a critique of the currently popular "death and dying" cult in American society, by a Christian pastor who ministers primarily to seriously and terminally ill people in hospitals. This cult purports to help people die well via such means as stripping away the mystery surrounding death, having people talk about their fears and worries, delineating "stages" in the dying process, and so on. But according to Gram (1985), these movements fall short of providing real peace to many of the dying and to their loved ones because they approach death from a purely secular perspective. Specifically, he critiques four contemporary dying cults: Kübler-Ross’s five stages of dying; the "near-death" experience, in which people who are very near death, or whose hearts actually stop beating, often report a sense of peace, comfort, and light awaiting them from "the other side"; the idea that one can conquer disease through mental processes; and the idea that medicine and scientific progress can eventually render humans immortal. According to Gram, some survivors have been so seduced by the contemporary claims that the mind and the will play a big role in disease that they blame the deceased for failing to overcome their fatal disease by force of will. Similarly, some people who are dying think there is something wrong with them if they do not progress through Kübler-Ross’s five stages of dying, and particularly if they do not finally accept the inevitability of their death.

Some other tidbits from the book: There is actually at least one mail-order bookstore in the US devoted exclusively to death (p. 32). The Threshold Research Center of Los Angeles sends "death and dying companions"--for a fee--to the home of a dying person, to discuss the positive aspects of the person’s imminent death (p. 40).
"Euthanasia" Governmental & Legislative Efforts

*"Euthanasia" is increasingly being pushed from the top down in China, which underlines how the values of modernism these days tend to override local values and traditions (Life at Risk, 6/91).

*Voluntary "euthanasia" bills were introduced into the British parliament in 1936, 1969, and 1976, and recently, attempts are in progress to try a fourth time (source clipping from Ruth Marchant.) However, to our surprise, a committee of the House of Lords in Britain has recommended against "euthanasia" legalization.

*A committee of the European Parliament in Strasbourg quietly adopted a resolution that physicians should be permitted to actively end the lives of competent patients who repeatedly request it. Full parliamentary debate on this issue is expected (NY Times, 12 May 91; source item from Rob Tebecio).

*In 3/91, a Commission For The Future (in Australia) proposed provisions for services for elderly people--and legislation allowing voluntary "euthanasia." This is an unhappy but probably not entirely coincidental juxtaposition (Source item from Ross Womersley).

*There are several legislative proposals underfoot in Canada that would permit physicians to kill their patients in order to end their suffering (IAETF Update, 11&12/91).

*Immediately after the Canadian Supreme Court ruled that laws against assisted suicide were constitutional, the province of British Columbia announced that it would not be aggressive in prosecuting cases of assisted suicide. In other words, we are going to see an instance of an extra-legal legitimization by government of "euthanasia"-types of assisted suicide (Life at Risk, 11/93).

*Every year, more US states are considering some kind of "euthanasia" legislation under the cover of "assisted suicide" or something similar. It cannot be too long before the first such bill passes, and that will open the floodgate to others. Virginia may win the race toward the legalization of involuntary "euthanasia" (NRLN, 25/2/92). Perhaps this is deeply symbolic in that the state cradles the District of Columbia. The "euthanasia" bills pending in various states would provide impaired people vastly fewer safeguards and protections against being made dead than are currently accorded to convicted murderers on death row.

*Full circle--& then some. In 1906, the Iowa legislature considered a bill "providing for the removal by the chloroform route...of certain individuals who are, by officials designated in the bill, found to be permanently and fatally diseased; and also...of certain ones that are permanently incapacitated owing to mental weakness." In 1989, under the direction of two professors, students at the University of Iowa College of Law drafted a "Model Aid in Dying Act," intended for consideration in all states. In summary, it proposed "euthanasia" for two groups of people: those who requested it and those who didn't. (Those who could request aid in dying were competent adults and children over the age of six. Surrogates could make requests for those who are incompetent or under the age of six.) For years now, there have been new proposals before the Iowa legislature to pass an "aid in dying" bill (IAETF Update, 1&2/92).

*A substantial guest article in the Chicago Tribune (3 Nov. 91) denied that a vote on behalf of "euthanasia" in the state of Washington would be a step on a slippery slope to other forms of deathmaking--totally oblivious to the fact that the vote itself is already an instance of a deep and fast slip on that very self-same slope.

*Apparently nearly all members of the Health Care Reform Task Force appointed by President Clinton and headed by his wife are in support of "euthanasia" in some form or another (IAETF
Update, 5&6/93), with the somewhat equivocal exception of perhaps two members.

*There are even efforts underfoot to pass laws which would compel physicians to kill their patients if they request it, or to hand their patients over to physicians who will do it if the attending physician will not (IAETF Update, 11&12/92).

Public Support for "Euthanasia"

*The "right to die" propaganda has been so effective that there has been a sudden and dramatic shift in American public opinion, within merely one year, that there is indeed such a thing as a right to "end one's life." From a minority opinion, this has become the opinion of a sizable majority. Not surprisingly, young people are even more likely to support a "right to die" than old ones since they see it as applying to mostly older people rather than themselves (USN&WR, 9 July 90). The gap in support for the legalization of "euthanasia" between young adults (79% in favor) and older Americans (53%) is 26%, but even the latter figure is rather high, and people should not be surprised when they end up reaping what they have sown (Life at Risk, 7/92). According to another survey, about two-thirds of elderly Americans are opposed to physician-assisted suicide while 80% of Americans in their 30s support it (Life at Risk, 4/94). Obviously, there is more at work here than a difference of opinion or even a generation gap, namely, wide-spread death-wishing of elderly people by younger ones. Support for "euthanasia" seems to be highest among college-educated younger women who in their minds see a parallel between it and "choice" (USN&WR, 25/4/94). The lowest rate of support is found among societally devalued classes who quite correctly see themselves as the most endangered ones.

*According to polls taken just prior to the 1991 Washington state "euthanasia" referendum, 64% of Americans favor both physician-assisted suicide and "euthanasia" for terminally ill patients who request it; and among adults under the age of 35, 79% support the idea. Apparently, attitudes towards such deathmaking correlate very strongly with attitudes towards abortion. Almost overnight, the public has also changed its mind and agreed that basic nourishment and liquid may be withheld as a means of ending someone's life. Obviously, what is happening is that the public has lost any sense of distinction between the termination of certain medical treatments, and people being willfully put to death. Catholics were highly in favor of the above measures, which also underlines that people's self-proclaimed religious beliefs or affiliations have hardly any ties left to their morality. Amazingly, only 14% of the sample said that they would never help anyone to commit suicide (Boston Sunday Globe, 3 Nov. 91; source item from Jack Yates). The referendum itself narrowly failed, 46:54%.

*Parties that combatted the California referendum on "physician-assisted dying" concluded that most voters no longer oppose "euthanasia" in principle, and that they therefore had to campaign against the referendum on the basis of its weak safeguards, rather than on it being medical killings (NC Register, 25/10/92). This of course is yet another of those gross incoherencies which abound in the "pro-life" movement.

*"Serial Killer" is a board game, which comes packaged in a body bag, marketed in the US, inspired by the real case of a man on death row who murdered 33 people. Players win plastic baby tokens by managing to "murder" people (AP, in SHJ, 22/2/93).

*It seems to be a sort of divine ironic joke that the generation that claimed to be able to conquer human affliction and death is now faced with rising rates of a death associated with dementia. This is more evidence of the eternal disfunctionality of the world, and of a new disfunctionality surfacing whenever another appears to be defeated. Also, a lot of people--many of them elderly themselves--are now trying to take care of demented relatives. Because they get so little help, many such caretakers slip into the temptation to approve of "euthanasia."
Death-Promoting Organizations

*It is perhaps not surprising that whenever there is a referendum on "euthanasia," as in Oregon and California, all the PC groups, most feminist groups, and homosexual groups come out in support of the pro-death position, together with all pro-suicide and pro-"euthanasia" groups, the American Civil Liberties Union and the Unitarian churches. We suspect that some of these groups do this not so much because they are actually in favor of "euthanasia" as they are against the traditional Judeo-Christian societal values to which they are so profoundly opposed for other reasons. Through the death initiative, they hope to strike a blow against them and thereby promote their other agendas. After all, some of the members of these groups themselves, such as people with AIDS, would be high on the list of "euthanasia" victimage.

*What do the Patients' Rights Organization, Citizens for Patient Self-Determination, and Compassion in Dying all have in common? They are all "euthanasia" and suicide groups (IAETF Update, 7&8/93).

*In California, a plebiscite (there called an "initiative") to legalize "euthanasia" is being promoted by a group called "Californians Against Human Suffering."

*The noble-sounding organization entitled Americans against Human Suffering was actually the political arm of the suicide/"euthanasia"-promoting Hemlock organization at the time when the latter merged with the Society for the Right To Die. The latter organization had first been known as Concern for Dying, then later as the Euthanasia Education Fund, and still later as the Euthanasia Education Council. In 1991 it changed its name again to Choice in Dying, forging yet another link among forms of deathmaking (specifically, abortion) via the positive-sounding term "choice" that so powerfully appeals to the individualistic modernistic mind (IAETF Update, 1&2/92).

*In Vancouver, an organization associated with Hemlock had the name Goodbye Society (IAETF Update, 1/2/92).

*The Center for Biomedical Ethics in Minneapolis is apparently a deathmaking advocate, associated with the prominent deathmaking neurologist Ronald Cranford who pops up in deathmaking lawsuits around the country testifying in support of death (DesMoines Register, 11 Dec. 92; source item from Rod Braun).

*The FHP International corporation is a for-profit firm that owns 58 related organizations. It is the major donor of funds to the FHP foundation, which in turn has been funding deathmaking conferences. (1992 Press release from Rod Braun).

Making Life-Support & Other Medical Decisions

*Even US News & World Report (25/4/94) admits that the withholding or withdrawing of life-sustaining medical technology is now a "common practice."

*In Florida, an elderly woman was declared dead, wrapped into plastic and her toe tagged. An hour later, her children arrived, and these lay people, without technology of any kind, established that she was still alive, especially since the woman soon said, "I'm not dead; I'm alive!" (Many 1&2/1992 clippings).

*Hilary Clinton told the Senate Finance Committee that under the Clinton health plan, people would know that they are not going to be denied treatment for any reason other than that it would "not enhance or save the quality of life" (NRLN News, 19/10/93).

*A good example of what we would consider to be an unwarranted high-technology escalation
is the transplantation of both a heart and a liver into a 6-year old child. Not surprisingly, the liver transplant had to be repeated, and the child eventually died.

*A committee of the British House of Lords stated that when people are in a "persistent vegetative state," then there is no longer an obligation to try to preserve their life by medical means (Guardian, 9 May 94; source item from Tony Wainwright). It now remains to be seen what legislative or administrative consequences this recommendation will have.

*A person who can take food by mouth is considered "ineligible" for being interpreted ("diagnosed") as being in a "persistent vegetative state" (PVS). So if one wants to have a dependent person made dead, and wants that person to be diagnosed as "having" or "being" PVS as a means of garnering legitimization for the deathmaking, one first has to take that person off oral food and install a naso-gastric tube, or even "better," a gastric one. This is apparently exactly what happened in the case of poor Christine Busalacchi, who was eventually starved/dehydrated to death in early 1993.

*A man in Britain had a motorcycle accident and was treated at Guy's Hospital in London, one of the most famous in the history of medicine. Physicians told his mother that he had severe irreversible brain damage and should have his life supports turned off. Upon this, the family had him transferred to another hospital that most people would never have heard of, where he recovered enough to be able to hold a conversation and read (London Times, 11 March 94; source item from Geoffrey Croot). A good lesson in this is to seriously consider transferring a patient away from a hospital or hospital unit where the patient is being talked dead.

*There is a hospital in London that has a "persistent vegetative state rehabilitation unit." Amazingly, over a five-year period, 22 of 43 consecutively-admitted patients were able to be discharged, and half of these have regained awareness after being on the unit for somewhere between 4 months and 3 years. One even had a complete mental recovery (British Medical Journal, 12/2/93; in Life at Risk, 7&8/93).

*Apparently, the ambiguity of the PVS "diagnosis" has led to a new descriptor, "vegetative pseudo-wakeful state" (IAETF Update, 3&4/93).

*All sorts of abuses of "advance directives" are beginning to become public. It appears that increasingly, health professionals will try to pressure or trick feeble people into signing "advance directives" that would bias future medical interventions toward death. Sometimes, they may try to do this even though the person already has some written arrangement in place. In such cases, the deathmakers can always claim that the more recent one supersedes the previous one. One kind of abuse is that when someone is being admitted to a hospital, they may be asked in the most casual fashion by a hospital admissions clerk, "Do you want to be a DNR?" This question may not be asked and recorded by anyone except a physician, and may not be asked casually or randomly. In some cases, the advance directives are outright ignored. In other cases, physicians withdraw treatment that patients would have wanted, but the physicians are twisting the advance directives in bias of non-treatment. In yet other cases, patients are receiving treatments that they had explicitly recorded that they did not want, whereas in yet others, they were denied life supports that they had explicitly requested. Furthermore, it has been found that when patients become incompetent and the legally legitimate surrogates step in, these tend to make decisions that have little concordance with what the patient had requested while competent. The question has also been raised whether nursing home residents specifically are being unduly influenced to record advance directives that are in the interest of the facility rather than expressive of the person's wishes.

*Nightmarish stories of how so-called "living wills" are being interpreted and misinterpreted by medical personnel are becoming more and more frequent (IAETF Update, 9&10/93). Here is one such "living will" nightmare that most people would certainly never think about. At the Good
Samaritan Health Care Center in the state of Washington, a woman was mistakenly given another resident's medication. This quickly began to have a lethal impact upon her. Even though the mistake was discovered within 30 minutes, she was not told what had happened or given any option for corrective measures. Instead, staff simply waited for her to die--all because she had signed an "advance directive" that she wanted no heroic measures to keep her alive (IAETF Update, 5&6/93).

Because of abuse of "living wills," one former advocate of such has changed his mind and now recommends that people do not sign any forms given to them by facilities that serve them, but instead make private arrangements as to who should represent their interests if they are not able to do so themselves. Furthermore, research has shown that people are very ambivalent about directives which they make in writing. In one survey, only 39% said that they wanted their physicians and surrogates to have "no leeway" in deviating from their instructions, while 61% allowed anywhere from "a little leeway" (19%) to "a lot" (11%) to "complete leeway" (31%). They also differed widely in the interpretation that they gave to factors such as pain, suffering, so-called "quality of life," etc. In other words, even if one follows a patient's "advance directive" to the letter, there is a very high probability that one is not actually doing what the patient would do or would have done (Life at Risk, 1/92).

*One state after another is allowing "terminally ill" patients to wear bracelets that request that no aggressive resuscitation be attempted on them outside a hospital. A physician's order is required to get such a bracelet, which is of plastic, resembling those placed on patients in hospitals, and which the patient or the family can cut off any time (Laconia Evening Citizen, 7/7/93; source item from Karen Barker).

*We advise readers never ever to tell anybody that they want to die under this or that condition, because years or decades later, a casual remark like this may be invoked by people who heard it--possibly even incorrectly--as a rationale for having one's life support withdrawn, or even for having active "euthanasia" committed on one. It was on the basis of evidence of one such casual remark years earlier that Nancy Beth Cruzan was starved and dehydrated to death.

*A very depressing study of the administration of CPR (resuscitation) showed that it assured survival only 58% of the time, and that subsequently, 95% of the survivors never left the hospital alive again, usually being hooked up to life support systems until they died--often soon after (Time, 29/3/93). Of course, this kind of research could very well be deathmaking propaganda, but if it could be verified and propaganda ruled out, it would provide powerful support for people to request that CPR not be performed on them when they are in otherwise already very precarious health.

*In at least two nursing homes in the Syracuse area, it was found that "do not resuscitate" orders had been attached to the charts of some residents by people who were not authorized to do so, and for people for whom there was no strong rationale for doing so. The nursing homes claimed that it was just an issue of sloppy paperwork; not only is this questionable, but even if it were true, it would certainly be an extremely life-endangering kind of sloppiness (SHJ, 8/6/90).

*A "do not resuscitate" (DNR) order is not necessarily the same as wishing a person dead, but often is exactly that de facto, or at least puts a person into the "already dead" role. This is underlined by a study that showed that when hospital patients were put on a DNR order, they began to receive less of all sorts of medical attention: fewer physical examinations, a drop-off in the taking of their vital signs, a drop-off in laboratory tests and x-rays, and so on. Amazingly, such patients even received less routine nursing care, whereas one would expect that this would be the very least that one would do well if one considered a person to be dying (IAETF Update, 7&8/94).

*The question has been raised whether the Heimlich maneuver to dislodge a piece of food from a windpipe is a "medical treatment," and/or an "extraordinary" measure. The question is crucial because if the procedure is ruled to be one of the above, then it can be withheld from people under all sorts of conditions, and perhaps even as part of a DNR order. However, a large proportion of
the ordinary population in developed countries knows about the Heimlich maneuver and is capable of performing it, and many people have in fact performed it around their dinner tables or in restaurants when somebody began to choke. It is thus roughly in the category of putting a band-aid on a person, or slapping them on the back if they have a hiccough fit.

*We increasingly hear of instances where elderly people with symptoms of dementia are being transferred from either their homes or nursing homes to hospitals, and are quickly put on a large dose of psychoactive drugs, and often even on several such drugs at once. At the same time, they are often put on a "do not resuscitate" order, but are not given much in the way of active or relevant treatment. The family may be told that the person needs to be in the hospital for several weeks, and his/her condition may be described in extremely pessimistic terms, including such things as "vegetable" language, or that the person "has no quality of life." Initiatives by the family to remove the person from the hospital are often vigorously combated. Families may even be given misinformation as to what rights they possess to take the person out of the hospital, or to resist the regimen imposed upon the patient. What we read in all of this is a very clear-cut effort to make demented elderly people dead as quickly as possible, but in ways that look entirely legitimate. We advise people to vigorously resist this particular deathmaking strategy.

*Unfortunately, but obviously, DNR often becomes not only "do not resuscitate," but also "do not treat."

*There are many problems too with substitute decision-making and guardianship. For instance, there have been cases before US courts where the question was whether the guardian of an impaired person can override the impaired person's present expression of desires to live, and can have that person made dead because at one time in the past when the person was more competent, the person gave an indication—or at least appeared to have given an indication—that he or she would not want to live under debilitated conditions (e.g., NRLN, 4 June 93).

*A Michigan man suffered brain injuries in a car accident that reduced his IQ to somewhere between 61-77, roughly equivalent to mild retardation. Even though he was neither terminally ill nor unconscious, but was on a feeding tube, his wife (who had become his guardian) sought a court order to starve and dehydrate him to death. His mother and sister opposed this, and there was evidence that the man had indicated through a computerized device that he wanted to live. Amazingly, one court had ruled that the man’s expressed wish to live was irrelevant because of his "impaired condition" (IAETF Update, 7&8/94). Those who wanted to make him dead have tried to interpret him as being "terminally ill," "severely demented," "totally dependent," "near PVS" (NRLN, 4 June 93). This is yet another case where any kind of expression in the past or at present by a patient to want to die is honored, while such expressions to want to live are increasingly not being honored. This is a reflection of great intellectual dishonesty and profound death-wishing toward debilitated people. It also makes virtually irrelevant any kind of "advance directive."

*An Ohio teenager had spent almost her entire life in foster homes. In 10/92, she was in a car accident. The physicians interpreted her as "noncognitive" but she did not need a ventilator or other machines, and contrary to news reports, she was not comatose. Suddenly, her alcoholic father stepped out of the woodwork, claimed his right as legal guardian over his daughter, and decreed that nourishment and liquid be withdrawn from her. The girl’s mother also came out of the woodwork and tried to prevent it, but eventually gave in to the father. Two families stepped forward offering to adopt the girl, the girl’s cousin tried to save her, but the absentee father prevailed and the girl died, age 14, from withdrawal of food and liquid (Life Advocate, 4/93). Again, it seems that courts mostly recognized that family member as a legitimate surrogate who opts for death.

Some people clothe their deathmaking of dependent individuals under a verbal blanket of positive-sounding rationales. A few are openly explicit. In this case, the father openly said to a judge, "I would like to have her life ended."
A 35-year old woman with Down’s syndrome had been living in a state institution in Mass. since she was 3. She had a degenerative kidney condition for which hemodialysis had been recommended. Her mother, who was her legal guardian, opposed this. Without it, the woman was expected to die in 1-3 years, but with it, in 20-30 years. The judge first agreed with the mother and said that the dialysis would be too burdensome and "not what the woman would have wanted if she were competent to make her wishes known." But the facts were that (a) no one had ever asked the woman what she wanted; (b) she had a demonstrated history of being cooperative with other medical regimens and restricted diets, and of having been able to bear the pain of past surgeries very well; (c) she showed some understanding of what would happen to her without the dialysis and had not indicated she did not want to undergo it; (d) the mother’s claim that dialysis for the daughter would be a burden to her (i.e., the mother) seemed to have little merit since it would be an institution staff member who would accompany the woman to the twice-weekly procedure. On appeal, the judge (in 1993) vacated the first decision against dialysis and ordered that it be started immediately, at least on a trial basis, which can be done and then terminated if it appears not to be helpful (Source material from Michael Kendrick).

A summer 1991 guardianship case in Mass. became a bit of a cause célèbre. A guardian ad litem was appointed to determine the best living situation for a debilitated man. Instead, the guardian recommended that the man’s life supports be withdrawn, which was not an issue in the guardian’s domain. This guardian was a nurse who had become a lawyer, and one wonders whether her specialty is to use her qualifications as a lawyer-angel-of-death.

Another cause célèbre occurred in Vermont—of all places, since it is otherwise one of the gooder states. Ronald Comeau, a Francophone man with a lot of problems, was arrested, hanged himself in his cell, and ended up severely brain damaged in a hospital. A guardian was appointed who tried to get him starved and dehydrated. A Christian minister active in anti-abortion intervened, and managed to bring the man’s long estranged father and uncle in from Maine. Then the man’s brothers and half-brothers in Massachusetts read about the case and rushed up. Though lowly people themselves, they assumed guardianship and had him moved to a rehab. center in Mass., and started keeping a 24-hour "guard" in his room to make sure no efforts were made to kill him. This is of course consistent with our own recommendations, as spelled out in our Training Institute publication on hospital safeguards. What makes the case otherwise interesting are the following facts. (a) There was great controversy over whether he was comatose ("slightly above a persistent vegetative state") or, indeed, quite communicative. The family, the brothers, claimed the latter, and appear to have some good evidence, though nurses and doctors claimed they could also be misreading mere reflexes. Also, the man got better when rescued. (b) The court-appointed guardian, who had not known the man before, based his decision on the assumption that he would not want to live because he seemed to be in pain. However, the guardian did—commendably—visit him every day. (c) None of this would have happened apparently if the state had moved him to a nursing/rehab. facility much earlier, which it apparently did not do for financial reasons—the same financial reasons that undoubtedly played a role in the decision of the hospital ethics committee to recommend cessation of liquids and food. (Many late 1993/early 1994 clippings.)

The role of guardianship corporations has become more complicated since such corporations began to be interpreted (since ca. 1990) to also have the power to give consent to the withdrawal of life supports for their wards. On the one hand, such a corporation may have an interest in having as many wards as possible. This would probably be a strong motive for not agreeing to anything that would abbreviate the life of a ward. One the other hand, in guardianship corporations, paid workers do the actual work, and given the realities of the current human service scene, it is unlikely that strong and enduring personal relationships would be formed between such workers and their wards, particularly since one worker would have to be responsible for a great many wards. A further problem along these lines is that when a person goes into an acute medical state, the defense of that person’s life can require round-the-clock attention—sometimes for months at a time—which an agency worker with many other wards is not likely to be able to provide, or provide very long.
Disguising Involuntary "Euthanasia" as Voluntary, & Arrogation of Ownership Over Human Life

Several vignettes in the previous section have already touched on this topic, and the drive towards "euthanasia" appears to derive at least as much energy from the need for control (both by people over their own lives and medicine over people's lives) as it does from mercy or fear of suffering.

*Doctors in general habitually grossly underestimate their patients' capability to endure discomfort, and their desire to live. For instance, when 600 ventilator-dependent adults with very debilitating conditions were asked whether they were "satisfied with their life as a whole," 82% responded positively, while at the same time, only 24% of the doctors and nurses on the scene predicted this response. Apparently believing that they would not want to live that way, they projected their own mindsets onto their patients (US News & World Report, 25/4/94).

*A consistent pattern of judicial decisions has been to uphold decisions to end a patient's life if there was reason to believe that this is what the patient wanted, and to overturn decisions to seek continued medical service and thus continued life even where there were strong indications that this is what the patient wanted. In other words, the judicial decisions have shown a strong pro-death bias.

*The executive editor of the New England Journal of Medicine said that when someone is in a "persistent vegetative state," the presumption should be that the person would not want to be kept alive, and that public opinion polls support this presumption. This attitude would reverse the presumption on the side of life to a presumption on the side of death. She also said that keeping such people alive is "demoralizing for care-givers" and "wasteful of valuable resources" (IAETF Update, 7&8/94).

*A it is very interesting to contemplate that all the "euthanasia" initiatives and legislation efforts in the US so far have restricted their proposals to patients who supposedly have six months or less to live. Yet the California Supreme Court ruled unanimously in 9/93 that population life expectancy statistics for people with various kinds of medical conditions have very little predictive value when applied to specific individuals, and that this was one reason why physicians would not be required to inform patients with terminal illness how long they can expect to live (IAETF Update, 11&12/93).

*A pediatrician in the Jewish ghetto in Warsaw during WWII fed fatal doses of morphine to children in order to "save them from suffering and death"--but lo and behold, she herself survived to a ripe old age of 75, dying in 1993 (SHL, 25/2/93). This illustrates one of many problems with killing people, namely, that one will never know in advance which of the ones one killed might otherwise have fared totally differently than one would have anticipated. Thus, by killing people, one literally plays God in more respects than one, including by assuming that one knows better than anyone else what the future will bring.

Language Manipulation & Other Deceptions about "Euthanasia"-Related Deathmaking

One of the most basic cosmic truths about the unity of life and the internal coherency of death is that violence is always attended by deception. These days, a major form of deception consists of language manipulations that (a) permit one to get away with violence, and (b) dupe others into compliance or collusion.

*Overall, the public is increasingly being led to believe that death is a very painful event, that suicide is an act of logic and courage, and that "euthanasia" is a civil right. Actually, even the very day before they die, only 31% of patients are using a pain medication.

*According to one study, when members of the public are asked questions related to "euthanasia," they respond in terms that are 6-10% more favorable to "euthanasia" when the
questions are framed in terms of euphemisms such as "medical procedure," "death with dignity," or "aid in dying," than when the questions are straightforward and talk about "euthanasia," "lethal injection," and "physician-aided suicide." Women fall much more readily for the euphemisms than men do (CHN Facts-Brief, 4&5/94).

*While speaking to a group at the Akron City Hospital last September, pro-death neurologist Dr. Ronald Cranford referred to severely brain-damaged patients as "neurologic creatures" (IAETF Update, 3&4/93).

*The International Bioethics Institute held a conference in San Francisco in April 1993 that had the ominous theme, "Beyond Autonomy: New International Perspectives for Bioethics." But aside from this title, one of its symposia was described as follows: "Infancy to Dependency, will focus on issues of autonomy and the individual within the healthcare system. Issues will range from perinatal dilemmas to Elder Ethics dementia. Do pre-persons and post-persons have rights and interests?" (IAETF Update, 3&4/93).

*Rod Braun brought to our attention that profoundly retarded people may now be interpreted to be in a "persistent vegetative state" (PVS), and that such interpreters are beginning to accuse others of interpreting people in a "PVS" as being "mentally disabled," being deceptive, or living in a pretense world. What these deathmakers are complaining about is that "the language of disability" is increasingly being applied to people in a "PVS," and how this disability language is being used in courtrooms "against families who want to stop treatment of the unconscious and let them die." The deathmakers want people said to be in "PVS" to be declared dead, and thus "beyond disability," and to have not a "reduced quality of life" but "no quality of life." Nationally syndicated columnist Ellen Goodman has begun to promote this kind of deathmaking propaganda (e.g., in DesMoines Register, 11 Dec. 92).

*We have all heard the expression "prolongation of life" (hence, prolonging life), but the deathmakers have now begun to coin the phrase "prolonging death," which is a most bizarre term because death is nearly instantaneous, and "dying" is a verbal construction of great slipperiness.

*It used to be that the phrase "kept alive" was used in a positive sense, e.g., that this or that "kept me/him/whoever alive." Recently, it has begun to be used with connotations that it is something awful, as in "being kept alive by machines," implying that the person should not be "kept alive."

*Editorials in major newspapers both contribute to opinions as well as reflect what opinion leaders believe. An editorial in the Syracuse Herald-Journal (29/3/93), headed "Are we getting our money's worth," said that we are "terrific at finding ways to keep 86-year-olds alive until they are 87, but we are terrible at keeping babies alive until their first birthday." This is yet another instance of setting people against the elderly, and perhaps even blaming them for the health care mess.

*A relatively new euphemism for active or passive "euthanasia" is the expression, "to let someone go on," as in phrases such as, "it is time for him to go on."

*Another new euphemism for deathmaking of older people is called "managing mortality." (Source item from Jan Doody)

*According to some deathmakers, the way to "restore dignity" to someone is to let them die or make them dead—even by withholding liquids and nourishment (IAETF Update, 1&2/93).

*One of the premier Australian newspapers, The Age (4 Aug. 90), gave us a dramatic example of how "euthanasia" and deathmaking are now viewed. In a headline, it proclaimed that "a stroke of a pen opens the way to a death with dignity." It almost sounds as if paperwork was all that stood
in the way of "euthanasia."

* A dispatching Dispatch. Another of the infinity of pro-death newspaper items described "Alzheimer's" as "an endless funeral" (St. Louis Post-Dispatch, 9 Aug. 92).

* As of early 1994, at least 34 court cases (!) seeking the withdrawal of life supports from a patient have cited the 1973 Roe v. Wade US Supreme Court decision as a relevant precedent, related to its establishment of the "right to privacy," which the abortion promoters have also labelled the "right to choose."

* Readers should keep in mind that the phrase "the right to die" is constantly being used when what is meant is someone’s "right" to make someone else dead.

* A remarkable instance of "dead-talking" took place in a town north of New York City. A baby was discovered at birth to have inhaled foreign matter while still in the womb, and was apparently not expected to survive. So the mother was told that the baby had died while the baby was transferred to another hospital. An obituary was published in the paper which, by coincidence, was seen by a physician in the second hospital. He then called the mother and told her that her baby was still alive. Eventually, after about a month, the baby did die. Interestingly, the incident was reported in the newspaper as a "hospital mix-up" (AP in SHJ, 10/7/90).

* A lawsuit in Florida is trying to have people’s death certificates pre-dated to the time at which they suffered the injury or disease from which they later died. The case involved a man who died about a year after suffering a heart attack, and the suit sought to fix his death date on the date of the heart attack. The more immediate motive was to cash in on a life insurance policy which expired sometime between the heart attack and the man’s death a year later, but of course the effect of such a ruling would be that people can be declared dead who are exceedingly live (IAETF, 1 May 89).

* At the emergency center of the St. Anthony Hospital in Michigan City, Ind., a physician declared a 66-year-old man dead--and then injected him with a lethal dose of morphine. When called on the carpet for this, her explanation was that she wanted to spare the widow the trauma of witnessing her husband’s reflexive last "agonal" breaths (Indianapolis Star, 25/2/93; source item from Joe Osburn).

* A new twist on the deathmaking rush is that court rulings and all accompanying transcripts having to do with continuing or discontinuing basic life supports may be sealed to the public. Thus, the public may never learn who the person at risk is, or whether the person ended up being made dead. One could make the point that cases of "euthanasia" should be a matter of public record (IAETF Networker Update, 11/90).

* Apparently it is common these days that when an invalid is deliberately starved to death in a hospital, the cause of death that gets listed is not that deliberate act, but the disease or injury that initially caused the invalidism (Interim, 9/93).

* One reason why so many abortion advocates have promoted the establishment of free-standing abortion clinics is that thereby, the killing action of abortion is clearly separated from the healing actions of general medicine. This removes many people’s objections to abortion. For instance, in general hospitals, there have always been medical and nursing people who had conscientious objection to abortions. In a free-standing abortion clinic, one can employ staff who unanimously and unreservedly will approve of, and perform, abortions.

For the very same reasons, it is now being proposed that free-standing "euthanasia" clinics should be established apart from hospitals and other medical settings, so as to help clear the path for medical "euthanasia" killings. However, there is also one additional motive here: namely, even people working in general medical settings who favor "euthanasia" would prefer not to have the
The public become afraid of generic medicine being the killing agent and site.

*The Serbs’ term, "ethnic cleansing," has begotten many other "cleansing" terms, some of them very useful, such as "medical cleansing" of chronic patients, as in long-stay medical wards, with legalized withdrawal of medical care (IAETF Update, 3&4/93).

**The Netherlands: A "Euthanasia" Free-Fire Zone**

We reported before that the Netherlands has earned the infamy of having become the world leader in deliberate medical killing of patients, that physicians are killing people with minimal afflictions, and without their, or their family’s, knowledge or consent. They are particularly apt to kill anyone seen as having what they consider to be a fatal illness, apparently thinking in terms of "they’re going to die anyway." The Dutch Pediatric Association has called for the "euthanasia" of handicapped newborns, and one pediatrician who killed such newborns said, "For these babies, life is a threat, not a perspective." Another physician acknowledged killing about six children a year because they have cancer (IAETF Update, 9&10/92).

*In order to educate the public on making "hard choices," the Dutch Ministry of Health co-financed a national TV series that is a remarkable parallel to the Nazi deathmaking propaganda practices. A younger and an older seriously ill patient presented themselves in the program pleading for expensive life-saving treatments. A studio TV audience then voted as to which of the two should get the treatment, and it voted 38 to 8 for the younger one (IAETF Update, 11&12/93). While the real decision was not actually determined by the vote, the program obviously was designed to condition the public to think ever more in "euthanasia" terms.

*On 23/3/93 and again on 25/2/94, US public television broadcast a documentary about so-called "euthanasia" in the Netherlands, and its implications for the US. The first broadcast, part of the "Health Quarterly" series, featured a 1-hour documentary film that was interspersed with panel and audience discussion. Panelists included three medical ethicists (two of them physicians), and another physician. The audience was apparently almost hand-picked, including as it did such people as the husband of the first woman killed by Dr. Kevorkian with his "suicide machine," one of the authors of a "euthanasia" initiative that failed to pass in California in 1992, and so on. Though the program purported to be a debate about "euthanasia," it was very strongly pro-"euthanasia," and the few voices raised against it only said something about the problems of controlling or restricting it, rather than that it was outright immoral. The second broadcast was part of the "Frontline" program, and showed the 1-hour documentary only. This documentary alone was one of the most unabashed pro-"euthanasia" polemics we have seen yet on American TV.

Below are a few points that relate to what we teach about sanctity of life issues.

The main arguments of those Dutch interviewees who argued for "euthanasia" were that (a) people should be in control of their lives, and (b) they should not have to endure what they called "needless" or "pointless" suffering. This illustrates one of the main dynamos behind so much deathmaking, namely, the absolute demand (it is nothing less) by modernistic people that they be in absolute and total control of all aspects of their lives. It also illustrates the horror of suffering in modernism, and the inability of materialism to find or project meaning in suffering--or to find a rationale for bearing with it even if one cannot find any meaning in it.

The fact that the key word heard throughout the program was "suffering," often qualified as "unbearable" or "for nothing," underlines once again how to modernists, suffering is the Great Devil, that people perceived as suffering without much hope for alleviation would be better off dead, and that it is very moral to kill them or help them kill themselves as long as it is done by physicians while a few safeguards are observed. What was called "mental suffering" is considered as much reason to kill somebody as bodily suffering.

The program illustrated dramatically how a materialized technologized medicine eventually must leave its practitioners with very little to offer patients, which is one of the reasons so many of them feel compelled--even against their own inclinations--to assist patients to end their lives. For instance,
both Dutch and US physicians spoke of "when you've done everything and there's nothing left to do," and saw their only options at that point as either abandonment of patients, or "euthanasia." They rejected abandonment, both because their patients resented and feared that, and because they thought that was wrong, particularly if they had had a long-term relationship with the patient. But they could not conceive of offering such things as presence, consolation, sharing the suffering, or even religious faith to the patient; only technological "tricks"—or killing. Thus, once more we see that in a service culture that is both materialistic, and that abhors suffering that cannot be alleviated, "euthanasia" and other deathmaking will appear as the only options—which indeed, to a rigorous materialism, they are. But to a non-materialistic, non-technologized medical or service culture or practitioner, technologies are only one very small part of what one has to offer a suffering person.

In turn, all this points once again to the necessity for those who would serve upon suffering people to themselves craft a moral stance on suffering, or else they will end up endorsing all sorts of deathmakings and other awful practices because these will supposedly end suffering.

Three of the 8 neonatal units in the Netherlands are said to kill their handicapped newborns, one of them reportedly killing 24 out of 500 seriously ill ones, which a physician called "rare," but which we calculated to be one in 20. One such clinic will kill children with Down's syndrome who have a blocked bowel because even though only a relatively minor operation would be required, such children would allegedly have no normal relations, not be able to raise their own family, be always dependent, have an unhappy life, and of course "be suffering." The program claimed that about 9,000 people are medically expedited to their deaths every year in the Netherlands, including 10-20% of all people with AIDS, though other estimates are much higher.

One of the killer physicians used high-sounding religious language to explain his practices, and said he always made sure to "take my white coat off" when he kills someone, and that as he is about to do so, there "often are some final jokes." Phrases such as "death with dignity" also abounded.

The program also illustrated that once the guideline for deathmaking is "what the person at issue wants," then there is in effect no guideline at all, because people will differ so dramatically in what they want, what they think they can or are willing to endure, etc. For instance, one man with AIDS was given poison by his doctor so that he could end his life, before he had even begun to show any debilitating symptoms of the disease!

What the program utterly failed to mention was that in the Netherlands, there had been a wholesale collapse of even the most elementary safeguards, and in fact not a single one of the many cases was mentioned where people were put to death without their knowledge, without their consent, without any waiting period, and after only mild medical complaints.

The film also illustrated the toll that engaging in deathmaking is taking on the medical profession. Several of the physicians who had "euthanized" some of their patients, or provided them with the drugs to take their own lives, spoke of how every time one did this, it "left a scar on the soul." Unfortunately, however, they did not seem to think that this was a reason to stop.

We were struck by the superficiality and even ignorance of the arguments on behalf of killing, which managed to stay away from high-order considerations. As deathmakers usually do, one of the physicians interviewed denied that there was any such thing as a slippery slope.

*In the Netherlands, when a patient requests of his or her doctor to be put to death, 13% of doctors will kill that patient within 24 hours. When the request to kill a patient is made by the family rather than the patient him/herself, physicians hardly ever obtain either a written request from the patient or a second opinion from another physician (First Things, 3/93). Obviously, Dutch medicine is extremely progressive.

*We have been told that in the Netherlands, if you want to kill yourself, the state will pay for the technical aids that you may need to do that. As mentioned, there is also a telephone hotline that people can call for advice on how to commit suicide.

*The Netherlands has actually subsidized one of its bioethics experts to travel across Canada and promote "euthanasia" (IAETF Update, 3&4/92).
A lot of deathmaking promoters claim that people need not worry about "euthanasia" and assisted suicide provisions, legalizations or mandates, because these would all be surrounded by virtually fool-proof safeguards. However, in the Netherlands, every single safeguard against such measures defined by the Royal Dutch Medical Society has been found to be frequently violated, and even involuntary "euthanasia" is frequently referred to as "good medical practice" (CHN Facts-Brief, 12/93).

A survey of older Dutch citizens asked questions of health care, and even though it did not mention "euthanasia," almost 10% of the respondents volunteered that they are afraid that if they went to a hospital, they would be put to death there. At the same time that more and more devalued people are being killed in the Netherlands, a Dutch foundation has established a retirement home for aging circus animals to save them from euthanasia (Life at Risk, 6/93).

A prominent " ethicist" in the Netherlands said that she disbelieves in the slippery slope argument, and does not believe that Dutch medicine is on such a slope in regards to "euthanasia." This is amazing considering that Dutch medicine is now near the bottom of the slope, after never having admitted being anywhere in-between (Life at Risk, 7&8/93).

The University of Florida College of Medicine has begun to organize guided tours for people to study "euthanasia" in the Netherlands. One such tour in July 1994 had the title, "The Netherlands' Practice of Euthanasia as a Model for the United States" (IAETF Update, 5&6/94).

Ironically, the Dutch physicians who have been committing "euthanasia" en masse for years denounced Kevorkian's "suicide machine" for not being "an expression of compassion, tenderness or care." Perhaps a more important element is unstated: it would surrender control of death from physicians to the victims themselves (AP, in Pittsburgh Post Gazette, 9 June 90).

A spokesperson for the Dutch Society for Voluntary Euthanasia said, "If we didn’t trust our doctors, euthanasia would be intolerable" (Life at Risk, 7&8/91). And people thought of the Dutch as humorless?

Rather hilariously, US News & World Report (25/4/94) bemoaned that the Dutch euthanasia practice "also" had a "dark side" to it, in that in more than half the time when euthanasia is committed, the doctors are killing the patients without their knowledge or consent, claiming that they are only doing what their patient or the patient’s family would surely have wanted, though in 45% of these cases, not even the family was consulted. The report noted that all of this was contributing to an immense increase of power by physicians.

After what appears to be a long period of paralysis, the Dutch Catholic bishops finally released a statement in 12/93 that condemned "euthanasia." Unfortunately, a significant portion of the statement addressed the pro-death government rather than their pro-death Catholic flock (NC Register, 9 Jan. 94).

In the Netherlands plain.
Whether rain or no rain,
It is quite plain
That of death a reign
Sweeps the Netherlands--how insane!

As a friend has put it, the Netherlands are finally earning their name as the low lands.

Forecasts About Deathmaking

Considering what a big business deathmaking has become in the form of abortions, speculation
has arisen that the deathmaking of medical "euthanasia" may also become a big and lucrative business.

*You Just Kill Me,* the title of an imaginary future handbook for professional obitiatrists, predicts that "euthanasia" will become so common that when one drives along on highways, one may see signs to killing clinics that will say either "right to die" or "left to die," depending on which side of the road the clinic is. "Dutch euthanasia" will refer to a plan under which couples are killed together but billed separately. "Voluntary euthanasia" refers to physicians volunteering to kill their patients, while "active euthanasia" involves chasing patients down who are trying to get away. Life will be referred to as either "prolonged dying" or "unbearable suffering" (source information from Christina Dunigan). A bypass procedure occurs when your patient has a blocked artery, and you bypass any treatment and immediately administer a lethal injection. If someone has food stuck in her windpipe, place your hands securely around her throat and squeeze tightly. This will prevent a prolonged dying process, and is called the Hemlock maneuver. Death with dignity is achieved when you place a trash bag over your patient's head and pull the drawstrings. Unbearable suffering means that the patient is still breathing, and imminent death means that someone is in your waiting room (ALL Legisletter, 3&4/92, reprinted in CRTI Report, Spring 1992).

*Hugh Gallagher, who wrote a book (By Trust Betrayed) on the medical killing under the Nazis, said that if in our society it should be decided to kill afflicted people, physicians should be forbidden to do the killing, and one might instead just as well set up a "termination bureau" with either veterinarians doing the killing, or vocationally retrained executioners (Habilitation, 7/92).

*Since we will soon see either legalized or at least legitimized second-party "mercy killing," we can also expect to see advertisements appearing in which people will advertise their preparedness and skill in putting somebody painlessly out of their misery.

*A cynic has come up with a new wedding vow: "Do you, so-and-so, take so-and-so for your lawfully wedded husband/wife, to love and to hold til euthanasia do you part?" (IAETF Update, 5&6/93).

**Opposition to "Euthanasia" & Suicide**

*Contemporary advocates of deathmaking often gleefully note the collapse of the Judeo-Christian basis that had underlain Western law since the Christianization of Europe, and call out that now is the time to kill rationally, and on the basis of an individualistic utilitarian ethic. They might do well to contemplate a ruling of a German court at Frankfurt which was subsequently used as a precedent in other "euthanasia" trials (Aziz, 1976, vol. 4, p. 135): "There is a law which is above the laws and which should serve as the ultimate measure of all formal laws. This is the law of nature which creates the final limits of the human concept of the law....The laws of Adolf Hitler on so-called 'euthanasia' are in flagrant contradiction to this fundamental principle of nature, for they hold in contempt the precept of the sanctity of human life and thus place themselves outside the law. They were in contradiction to all the bases of justice and morality and destroyed the foundations of human society because they designated one part for life and the other part for death. As a result, according to the eternal norms of natural law and because of their capacity of elementary injustice, they were unable to attain the authority of a law."

"Thus all regulations or laws concerning so-called 'euthanasia' are without legal value and have established no law."

*A German play that started in 1990 is called "Doktorspiele," which can be translated as "Doctor Games." It tries to acquaint people with the medical killings during the Nazi era, and to do so in a way where they can understand the ordinariness and ideologies of the physicians involved. After each performance, there is an audience discussion (The Economist, 5/90; source item from John O'Brien).
Klaus Dörner, a German psychiatrist who is in Germany what Peter Breggin is in the US, coined the term "tödendes Mitleid" ("killing compassion") for the kind of sentiment that holds that someone is suffering so much that he/she should be killed.

The German association founded by parents of retarded persons (Lebenshilfe) formulated (in 9/1990) a rather good position paper on the sanctity of life. It says that human life begins at conception; every human is a person; other life forms (e.g., animals) must not be equated with human life; all humans are of equal value; the right to life is "untouchable"; there can be no experimentation on human life and the interests of research must give way to the sanctity of life; efforts to depreciate the lives of some people or the right to life must be vigorously opposed; suffering is no reason to abbreviate life; no special laws in favor of handicapped people should be passed because generic laws already cover them (meaning that all that is needed is to apply the generic laws); and there is to be no "yes...but" arguing on these issues.

Apparently, these principles were drawn up in consequence of the Singer fiasco in Germany. Lebenshilfe had made the foolish mistake to invite this philosopher of deathmaking to speak, and had to go through an embarrassing disinvitation when handicapped people resolved not to allow a debate on their right to live.

We ran across (CRTI Report, 1&2/94) the following statement of 9 "life principles" that seemed to us to be concordant with a unity of life position.

"We hold these truths to be self-evident: That all human beings are created equal and are endowed by their Creator with certain inalienable rights, among which is the right to life; and therefore

- The right to life of each human being shall be preserved and protected by every human being in the society and by the society as a whole, and
- The life of each human being shall be preserved and protected from that human being's biological beginning when the father's sperm fertilizes the mother's ovum, and
- The life of each human being shall be preserved and protected from the biological beginning throughout the natural continuum of that human being's life by all available ordinary means and reasonable efforts, and
- The life of each human being shall be preserved and protected at each stage of the life continuum to the same extent as at each and every other stage regardless of state of health or condition of dependency, and
- The life of each human being shall be preserved and protected to the same extent as the life of each and every other human being regardless of state of health or condition of dependency, and
- When there is any doubt that there exists a human being's life to preserve and protect, such doubt shall be resolved in favor of the existence of a human being, and
- When two or more human beings are in a situation in which their lives are mutually endangered, all available ordinary means and reasonable efforts shall be used to preserve and protect the life of each and every human being so endangered."

An American hobo somehow managed to get to Frankfurt, Germany, when he was 83 years old. He was supported by German welfare for 5 years while efforts were made to deport him back to New York. However, it was decided that if he were dumped back to New York at age 88, it would be a death sentence to him, and thus efforts were made to let him live out his days in Frankfurt. It is fascinating to consider that the reality of the deathmaking of the homeless in the US was recognized and benevolently taken into account by a foreign government (AW, 8 Nov. 86).

Things have gone so far that efforts are now underfoot to pass legislation that will protect health care workers against job discrimination if they refuse to participate in "life-ending activities." One such bill was passed in 5/91 in Missouri (CRTI Report, Winter 92/93).

Surprisingly, the World Medical Association is still strongly opposed to "euthanasia" or suicide assistance, as is the Canadian Medical Association (Interim, 10/93), and the American Medical
Association has come out with an even stronger statement of opposition to "euthanasia" and physician-assisted suicide in 12/93 than its 1991 resolution, calling such actions "fundamentally inconsistent with the physician's professional role" (Life at Risk, 12/93). However, since these sentiments are apparently not those of the membership, little importance should be attached to them.

*In 1993, a group calling itself "Therapists for Life," with headquarters in Michigan, got formed. At first, we thought it was a bunch of shrinks offering to guarantee people "therapy until you die," but instead it is a group of physical therapists uniting themselves "in defense of the intrinsic value of all human life" (source item from Guy Caruso).

*According to one study, those who work closely with terminally-ill people are vastly more likely to be opposed to all active forms of "euthanasia" than health care workers who do not (Interim, 11/92).

Conclusion to "Euthanasia"

*Stunned by the atrocities of World War II, and the corruption of medicine in Germany under the Nazis, the British Medical Association issued a 4-page document in 1947 entitled War Crimes and Medicine. It contained the following passages.

"Whatever the causes such crimes must never be allowed to recur. Research in Medicine as well as its practice must never be separated from eternal moral values. Doctors must be quick to point out to their fellow members of society the likely consequences of policies that degrade or deny fundamental human rights. The profession must be vigilant to observe and to combat developments which might again ensnare its members and debase the high purpose of its ideals." "...The traditional medical ethic...maintains the value and sanctity of every individual human being. Although there have been many changes in Medicine, the spirit of the Hippocratic Oath cannot change and can be reaffirmed by the profession...the greatest crime being co-operation in the destruction of life by murder, suicide, and abortion. How totally medicine has rejected its most solemnly proclaimed "eternal values" in just a few short years (as history goes), and embraced the opposite!

*The so-called bioethics culture is truly amazing. It is exploding in size, and virtually anybody in any discipline may now be called a bioethicist, the only requirement usually being that they advocate or defend some kind of deathmaking, and that they have had lots of education. There are now even entire degree programs in bioethics, or even subspecialties such as fetal tissue transplantation from abortions. People can spend many years being students of such subject matters, and come up with no more than the same kind of deathmaking promotion as even stupid or uneducated people can.

In 6/94, the TIPS editor spoke on deathmaking in Berlin, Hamburg, and near Heidelberg. He was pleasantly surprised that everywhere, people spoke scornfully of "bioethicists," unlike anywhere else. The Germans seem to have "got their number."

*Gallows humor. Ronald Seigel, a Michigan journalist who writes on human service news, developed a very humorous pop "euthanasia" quiz. Below are some of the items.

1. Dr. Jack Kevorkian feels that questions of when a life is worth living should be decided by laws, but by the medical profession on the basis of situation ethics. In what situations is there a clear consensus that medical violence is unacceptable?
   A. When a patient is deprived of food and water (like the Nancy Cruzan Case).
   B. When the patient is not terminal (like Janet Adkins and Dr. Kevorkian's other patients).
   C. When there is no clear and convincing proof the patient wishes to die.
   D. When the patient could not have possibly expressed the desire to die (Baby Doe and Baby Jane Doe Cases, where the patients are infants)
   E. When the patients and their relatives both definitely want treatment to continue living (as with the Wanglie Case)
F. When patients file malpractice suits (since a recent article in the Journal of the AMA called medical malpractice suits a form of violence).

2. Dr. Susan Adelman, while director of the Michigan Branch of the American Medical Association, advocated reducing health costs by:
   A. Supporting national health insurance.
   B. Inducing doctors to lower their fees, forego luxuries and live in a more simple style.
   C. Increasing penalties for Medicaid fraud.
   D. Persuading doctors to report any colleagues who violate the law in violation of patient welfare.
   E. Adding to the number of doctors, either by providing more people the opportunity to go to school or restricting oppressive regulations restricting the number of doctors.
   F. Letting more patients die.

3. According to his friendly lawyer, Dr. Jack Kevorkian has a burning desire to ease human suffering. Dr. Kevorkian decided the most constructive way to do this was to:
   A. Start a free volunteer clinic in the inner city.
   B. Demand more federal funding for scientific research of fetal diseases.
   C. Donate his life savings to a muscular dystrophy fund.
   D. Lower his fees.
   E. Help patients die.

4. A local court ruled in the most recent Kevorkian case that there is no law in Michigan against participation in active killing under the guise of assisted suicide. What safeguards would then exist against the possibility that people could destroy patients who wanted to live and then could use the pretext of assisted suicide? Choose one of three answers depending on your religious convictions.
   A. (For Christians, Jews, and Muslims): God only knows.
   B. (For confirmed atheists): Nobody knows.
   C. (For Religious Agnostics): Who knows if anyone knows?

5. Leaders in the medical establishment want to take questions of life and death away from rule of law and put them in the hands of hospital-appointed ethical boards. What would be the difference between such US bioethical boards and South American death squads?
   Answer: The South American death squads speak Spanish.

*We salute one of the most honest things that has ever been done in an image-manipulating sector. A British firm has begun marketing a brand of cigarettes under the brand name Death, and the firm is quite up-front that it is "selling death." Every package has a skull and crossbones with a warning "if you don't smoke, don't start. If you smoke, quit." Quite a contrast to the cynical Joe Camel campaign. The sale of Death cigarettes is booming (SHJ, 25/2/92).

*Please note that in this section, we have not covered all sorts of deathmakings that range beyond a construct of "euthanasia," nor even all the material pertaining to "euthanasia." Unfortunately, we have almost as much copy on other deathmaking topics as we included in this issue.

Whatever readers may think about the deathmaking issues covered in this TIPS issue so far, they better get ready to be made dead whether they like it or not. And if you can help it, stay away from medical care people lest your presence lead them into temptation to kill you.

Health Care Issues

*The TI has had plenty to say about health care plans that may or may not work, namely, in its workshop entitled "The Implosion of Hospital Medicine Due to Its Humanly Unmanageable Complexity, & Some Implications for Vulnerable People & Their Allies." One very terse but almost certainly true comment we want to make here is that any scheme that is not based on a single-payer plan will not be sustainable very long. It will only postpone the day when other aspects of the root problem of modernistic health care collapse will have to be addressed, namely, humanly
unmanageable complexity. A single-payer plan reduces only administrative complexity, but other measures must be taken to delimit the technical and programmatic complexities of medical care.

One of many things wrong with the Clinton Health Plan is that it would pay for the abortion of an unborn child where tests indicated that the child would have a congenital impairment, while the very same plan would not pay for the same child’s long-term treatment if the mother refused to get an abortion. Mrs. Clinton has claimed that the plan would not deny treatment unless it is “not appropriate” and would “not enhance or save the quality of life” of the person.

*It is alarming to contemplate that the man hired not long ago by the University of Utah to lobby Congress for $25 million to pursue the university’s cold fusion fantasy was Ira Magaziner, more recently put in charge of Clinton’s health plan (FI, 5/94).

*In late 1993, the American Medical Association launched a $1.9 million ad campaign that implied that it had always supported universal health insurance whereas, in fact, the AMA has been the major obstacle to such without let-up since 1946. Obviously, where there is that much deception there must be much deathmaking (Consumer Reports, 2/94).

*Abraham, L. K. (1993). Mama might be better off dead: The failure of health care in urban America. Chicago, IL: University of Chicago. The title of this book tells it much as people think these days, though it is meant ironically. The author relates her story of a series of harrowing encounters with the US health care system when various members of her family had medical problems.

*As of 1991, Americans spent most on food and tobacco, followed closely by medical care, then more distantly by housing. However, they spent almost half as much on recreation and clothing respectively as on medical care (SHJ, 11 Feb. 94).

*At the same time as old and new infectious diseases are becoming a major new danger to all of the world, the US public health system has been in somewhat of a dismantling stage, and particularly so its infectious disease surveillance capacity, with many public health agencies having only a skeletal residual staff. Accordingly, many currently reportable diseases are significantly under-reported, which probably suits the empire just fine. Most people are still unaware that in 1993, there occurred the largest water-borne disease outbreak reported in US history in Milwaukee, which struck almost half a million people and brought about 10% of these to health facilities. Yet, the disease that caused all this was reportable in only two states, and there was no national surveillance for it. Accordingly, it is quite possible these days that there could be vast outbreaks of diseases from contaminated food or water without it being detected. Similarly, around the world, there have been outbreaks of epidemics that went undetected for a long time because the capacity for such detection did not--or no longer--exist (Science, 19/4/94).

Human Service News

*Fuchs, D., & Fuchs, L. (1994). Inclusive schools movement and the radicalization of special education reforms. Exceptional Children, 60(4), 294-309. In our opinion, everyone concerned with special education and/or "inclusion" or integration of handicapped children in the schools should read this article, and do so soon.

*Margaret Gould, 12 Fairview Street, Portland, Conn. 06480, has written a very clever paper on handicapped people on postage stamps from across the world, with an interpretive text accompanying pictures of these stamps. A fair proportion of these stamps deal with mental retardation.