Ken, bedridden and weak, was comforted by his sister Blanche. His story begins on page 14A.

Three lives, three journeys

At age 62, Ken secretly began starving himself to death. He had coped with a lifetime of cerebral palsy until a stroke left him a quadriplegic in a nursing home.

By Warren Wolfe
Staff Writer

Staff photos by
Stormi Greener

After Dr. Jack Kevorkian refused to help him, Ken decided to take control of his own death — in secret because the home said he'd have to leave if he stopped eating.

At age 47, Darrel Hildebrant is prepared to die. After eight years with AIDS, he won't end life the way his partner did. When Hildebrant dies, it will be physician-assisted suicide — illegal in Minnesota.

At 73, Bill Newman is dying of emphysema and heart disease. He wanted a doctor to help him die, but has changed his view of assisted suicide after a year in a hospice program.

Three men, three life journeys toward death, three examples of how the debate over assisted suicide and euthanasia affects Minnesotans.

Americans have a paradoxical view of modern medical technology. They expect the medical marines to save them by fighting off death and disability.

But they fear that the struggle could leave their bodies shrunken hostages to high-tech medicine, dying slowly in agonizing and humiliating pain and suffering.

Despite evidence that most Americans believe physicians should be allowed to help terminally ill patients die, it is illegal in every state.

That will change.

Sometime this decade — perhaps in Oregon or Washington or Michigan — voters will take control at the ballot box, and the first state will open the door to physician-assisted death.

Something very close to that already exists in Seattle, where Compassion in Dying helps terminally ill people consider their options, advises what drugs they might use and literally will hold their hands while they die.

But the issue is not simply a matter of individual rights, many physicians and ethicists say.

Most doctors do not practice good medicine with dying patients, they say. If patients received proper pain control and better comfort and emotional support, most requests for assisted suicide and euthanasia would disappear.

Ken/

A life, a death, a legacy

After being turned down by Dr. Jack Kevorkian and having his death wish alternately rejected and embraced by the nursing home where he lived, he took matters of life and death into his own hands

"It gets so frustrating," Ken said. "Why won't they just let me die?"

PO Box 261
Royal Oak, MI 48068-0261

10 January 1992

Dear Mr. Rice,

For the time being there is nothing I can do to help anybody, especially patients in other states.

I am not aware of any individual in your state who could help. Unfortunately, it is a felony in your state to do so, and that most likely will deter a sympathizer. Also, I do not give do-it-yourself advice for those who might try it alone. It can be dangerous and leave one worse off than before. Things are changing fast, and hopefully this long overdue and sorely medical service will soon be legalized and available to every suffering patient who wants and needs it--under professional medical guidance and control. It's too bad that your brother is caught in a period of transition; but I encourage him and all of you hold on until then.

Best wishes,

J. Kevorkian

Jack Kevorkian, MD

A year after his stroke, Ken decided he wanted to die.

"I'd rather have a doctor just give me a shot and put me to sleep. If I could move my arms I'd kill myself — pull a Russell Lund, you know, with a plastic bag over my head," the 62-year-old Twin Cities man said in a halting voice caused by a lifetime of cerebral palsy.

He took early retirement in 1987 to live in a northwoods cabin, one of three he built over the years.

"I always liked to use tools, build things," he said. "Sometimes people figured I couldn't do that stuff because I walked different and my arm sometimes twitched uncontrollably. That had nothing to do with building things. I got around pretty good."

Until a stroke five months after retirement left him a quadriplegic in a nursing home.

He contacted Dr. Jack Kevorkian twice, and was rejected for assisted suicide because it's illegal in Minnesota. Ken decided he had only one route left.

"I'm going to starve myself to death. It's the only thing I have any control over anymore — whether I eat," he said in an interview in September.

So he began to cut back on his food intake — but secretly. The head nurse had warned his sister that if Ken stopped eating, he would have to leave.

His act soon led to painful and protracted soul-searching by the nursing home. The questions rolled in like a winter storm.

Was Ken committing suicide? Should the home try to dissuade him? Had it done all it could to make his life meaningful? Would it break the law against assisted suicide by caring for him while he died? What was legal? What was right?

It was the sort of wrenching dilemma a family might face if a relative asked for support in dying because life was meaningless. Like most families, the nursing home was unprepared.

"We might have been kinder to Ken and his sisters if we hadn't changed our minds so often. What was it, four times?" the administrator said. "I'm sure they suffered from our indecision. We were suffering, too."

From the start, Ken was willing to use his full name for this article.

But nursing home officials — concerned that a public discussion of their struggle might hurt their reputation with regulators, professional colleagues and their residents — agreed to talk openly only if the home was not identified.

Ken, an engaging man with a quick smile, reacted with unusual sarcasm. Since identifying him might identify the home, he reluctantly asked that his name not be used "because I certainly wouldn't want those people to be made uncomfortable. After all, I only want to die. They want to examine their consciences."

Ken grew up in Minneapolis, attending Dowling School for Crippled Children and finally Dunwoody Institute to become an architectural draftsman. But he had trouble getting a job. Employers were put off by his difficult speech, the result of paralysis that affected his right side, especially his hand, leg and face.

"His fingers were permanently curled, so he had them broken and set straight so he could use it to hold paper," his brother-in law said. "I asked my boss to give Ken a chance as a mechanical draftsman."

He got the job at Johnston Manufacturing, which makes commercial ovens for industrial use, and stayed there for 37 years until he retired.

He lived in his parents' house until his stroke in November 1988. His father had died five years earlier. His mother died of a heart attack two weeks after Ken was hospitalized.

A lifetime of savings enabled Ken to finance his retirement — not as he had hoped at the cabin that took two years of weekends to build, but at a nursing home that last year cost him $47,000.

"Saving was easy. I was never much of a joiner anyway, but when you have cerebral palsy, you don't spend much time chasing girls or drinking with the guys," he said.

"The thing is, the money is all I have left. That and my two sisters. My cabin's gone, my movement is gone, my reading is gone unless somebody turns the pages for me. My body might as well be gone, too."

At the nursing home, he tried rehabilitation therapy for a while, "but it didn't seem to make much difference. Then they tried to get me to go to Courage Center to learn how to get along the way I am.

"I already know how to do that. They put me in my wheelchair in the morning, give me a bath, help me go to the toilet, feed me, give me my medicine for muscle spasms and put me to bed at night.

"That's how I get along. I get good care here but I can't do anything. I have acquaintances here, not friends. I don't belong in this place. I don't belong any place."

After Kevorkian turned him down, Ken considered going to the Netherlands, where assisted suicide is legal, until he found out that doctors there don't just kill people on demand — especially not patients who aren't terminally ill.

"I suppose I could drive my wheelchair in front of a bus, but somebody else might get hurt. And I'm not going to ask my sisters to kill me. They could go to jail."

Last summer he asked the doctor assigned to him whether starving to death would be difficult.

"He wouldn't even talk to me. He put in my chart that I should see the mental health nurse for depression. Everybody came in to see me, the chaplain, the social worker, the head nurse. They asked me if I wanted to talk about anything. I told them no, and they took it off the chart."

Weighing about 135 pounds, Ken developed his secretive strategy. He'd continue eating his breakfast of egg, toast and coffee, but his sisters would feed him lunch and supper, pushing his food around and giving him a bite or two if anyone paid too much attention.

By then, his sisters — never particularly close to Ken since childhood — had assumed new supportive roles.

Blanche, 67, became the nurturer. She came in at noon, playing the game with lunch, turning his newspaper pages, washing his face, brushing his teeth, combing his hair, caring for him almost as she once did for her children.

Grace, 69, an executive secretary who never married, retired to become Ken's defender. Already in charge of his finances, she took over supper duties, did his research, spoke up for him at the nursing home and began a search for a new home, one that would allow him to die.

Grace had been aware of his plans all along and approved. "We're a lot alike. We're both used to making our own decisions, running our own lives." At his request, she brought him a copy of "Final Exit," the book about suicide by a founder of the Hemlock Society that details ways to die. He read it twice.

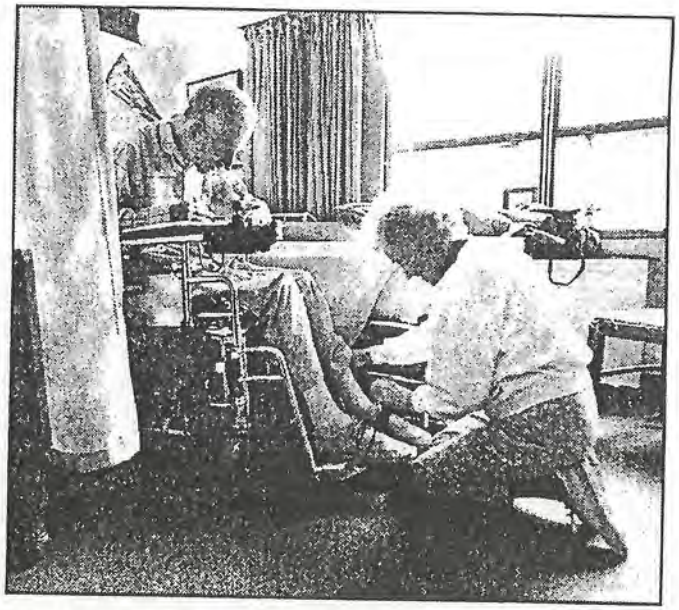
Blanche learned that Ken was considering suicide from the doctor, much to Ken's disgust. "I wanted to tell her first. I thought she'd be upset, but she supports me, too," he said.

On a referral from the Hemlock Society of the Upper Midwest in Edina, Grace found a doctor who would advise Ken about starvation.

Dr. Scott Strickland works mostly with AIDS patients, and discussions of suicide come up frequently. "I can't act because it's not legal," he said. "But I often have general conversations with people, and I could answer Ken's questions."

Ken took a Metro Mobility bus to Strickland's office and learned that any hunger probably would vanish after the first few days, he might develop abdominal pain treatable with morphine, and dying might take 14 to 60 days, depending on whether he stopped taking liquids. And if Ken had to move, Strickland would

A nursing home aide dried Ken's face after washing him. They sometimes watched televised baseball games together. "I get good care here, but I'm just taking up space," he said. "I can't do anything anymore, nothing that means anything."



His sister, Blanche, strapped Ken's feet down on his wheelchair foot rest. Despite medication, muscle spasms sometimes made his leg jerk. A motorized wheelchair allowed Ken to move through the nursing home wing unaided.

care for him at a nursing home where he has other patients.

Ken refined his strategy: "I'm getting a running start on killing myself," he said in early October. "If I lose enough weight before they notice, maybe I can go all the way before they can kick me out. If they do, I've got someplace to go."

But at an ethics forum at the nursing home, Grace asked the new medical director whether the home would eject a resident who decided to stop eating.

The new doctor seemed pretty certain: He could stay if his decision wasn't caused by depression or another problem for which he'd accept treatment. Residents have a right to refuse any care, including food, she said. They arranged to meet Nov. 2 with Ken, Blanche and the chaplain.

"I think she understands," Ken said after that meeting. "No promises, but now I have hope. I don't want to leave here. This has been my home for five years, and now I think they'll let me die in my home."

But nursing home officials were in turmoil.

They had three major concerns: What was legally right, what was morally right and what kind of public-relations fiasco could result?

Very old or frail residents sometimes stop eating. Some apparently decide it's time to die: some require no more nourishment because the body is shutting down in death. Their actions rarely are questioned. But Ken's case was different. He was not dying.

"Our business is to help frail people live as healthy and fulfilling a life as possible," the administrator said. "It's what we want, it's what regulators want, it's what our residents and their families expect."

The risk was too great, they decided. On Dec. 2 they told Ken they'd continue to look at the issue, but their preliminary decision was that he could not starve himself in their facility.

"I have a great deal of empathy for Ken," the medical director said. "I don't believe he is clinically depressed. He has a profound sadness about the way his life has worked out. But I had to ask myself, could I honor this request if it were my family member, and could I defend that decision to my colleagues? I decided I could not."

Ken was shaken. "I was so sure they understood. Why don't they just give me a piece of paper to sign that says I take full responsibility?"

But then he developed a new strategy. Grace had learned from the state nursing home ombudsman that the home had to give him 14 days' notice before evicting him.

Now down to 113 pounds, he would continue his diet until officials blew the whistle, then cut out everything. That might be enough time to die. Grace also found out that they could delay eviction by filing an appeal.

"It's so frustrating. I spend all my time worrying about this," Ken said. But then he noted with a smile, "At least it's better than TV."

His smile turned to hilarity a few minutes later when he saw a news account of Kevorkian starting a hunger strike after his arrest for violating Michigan's law against assisted suicide.

"This is crazy. There's Kevorkian forced to starve himself because he helps people die. And here's me, forced to starve myself because nobody will help me die."

Then his smile vanished. "I wish we had a Kevorkian in Minnesota."

Despite Ken's doubts, home officials really were rethinking their role. Their position shifted as they learned more.

A lawyer explored the legal grounds with regulators, never identifying the home. "They said they'll be a lot more concerned if we force Ken to leave than if we care for him while he dies," the administrator said.

But that didn't get them out of the woods.

"I can see a pro life group coming and picketing us if they find out we're helping Ken while he starves to death," the administrator said.

"But I also can see others picketing us if we tell him to leave. Either group could take us to court. Whatever happens, we lose. Nursing homes get bad enough press without something like that."

At the same time, some of Ken's nurses and aides started saying that it felt wrong to force him to leave. "They really like Ken. They said they feel almost like family, and that they want to care for him, no matter what," the administrator said.

"I couldn't sleep last night over this," he said. "I wish I could understand Ken's decision. Other people with severe disabilities seem to do pretty well. But if I were in his position, what would I want?"

It would be easier if Ken were older, or terminally ill, or demented, the administrator said, then laughed ruefully as he thought about that. "Is that discriminating on the basis of age or the basis of disability?

"It also would be easier if he'd gone ahead without telling us. We could have just ducked. But hard as it is, it's better for us to face it. This is the first request we've had like this, but it won't be the last."

Caught in a maelstrom of moral and ethical questions with no easy answers, "We did absolutely the smartest thing we could do. We brought in an ethics consultant," he said. "She didn't tell us what to do. She helped us think."

Karen Gervais heads the Minnesota Network for Institutional Ethics Committees. Recently she was named director of a new health care ethics center created by the College of St. Catherine in St. Paul, HealthEast and Fairview Riverside Medical Center in Minneapolis. It will open June 1.

"They were asking some questions they didn't need to ask," she said.

There were only two issues, she said: Was Ken's action legal, and should the nursing home continue to

Ken sat alone in the TV/dining room as he did every day, except when his sisters Blanche and Grace came to see him — twice a day, every day, seven days a week.

Ken needed help reading because his stroke left him unable to hold books or newspapers. One of his sister Blanche's daily duties was to turn the newspaper pages for him. "I used to read Sigurd Olson, Frederick Manfred, lots of books. Now I don't have anything."

offer care? The home already knew that Ken legally could starve himself.

"You don't need to decide whether Ken is morally justified. That's his problem, not yours," she said. "Your job is to decide if you can give him the kind of care you're trained to give."

Once Gervais came on the scene, "there was really no question about what we would do," the administrator said. "We would allow Ken to die in our care."

The administrator informed him Dec. 15 after breakfast. It was Ken's last meal.

But nursing home officials were still nervous.

"Maybe I'm paranoid, but a couple of the staff really object to what Ken is doing," the administrator said. "What if somebody calls the Health Department and says we're helping him commit suicide? We could find ourselves with a court order to stop while they sort things out. Could they order us to feed him? What if he refused?"

Gervais met again with the staff. She assured them it would be ethically appropriate if some felt that in good conscience they couldn't help Ken while he died. Some staff members argued over the morality of Ken's decision and the nursing home's response, but none sought a transfer.

"These are hard issues — especially hard in nursing homes. A lot of these topics are being dealt with somewhat by hospitals, but it's new ground for nursing homes," she said. "It's going to become more common."

Ken did not die quickly.

Ken began cutting back secretly on the amount of food he was eating after his sister was told that he would have to leave the nursing home if he stopped eating.

"I'm on the way," he said. "I didn't know how tense I was until they gave me the good news this morning. I just hope they don't change their minds again."

He cut back a little on liquids. His sisters stretched out their daily visits as he slowly lost weight. After two weeks, he was weaker and sometimes testy with aides and his sisters.

"I don't know why it's taking so long," he complained. A nurse from North Hospice in Robbinsdale joined his care staff early in January to help monitor his discomfort and prepare to treat pain.

Blanche's granddaughter was worried. Would Ken go to heaven? Blanche's family are devout Christians, and Ken hadn't gone to church for years.

"I couldn't ask Ken, but the hospice nurse did. She asked Ken if he believed in God, and he said yes. I was so grateful. I'd been afraid about that. Now I feel much more peaceful," Blanche said.

On Sunday, Jan. 9, Ken didn't get out of bed, and by evening his voice was a whisper.

"Help me, please. Help me, please," he kept telling his sisters. The hospice nurse authorized morphine and oxygen, and Ken relaxed. By morning he was in a coma.

His sisters started a 24-hour vigil, one always at his bed. Both of them stayed Monday night because they thought he would die soon. Several aides came in during the night.

"Goodbye, old friend," said a young man who used to watch baseball games with Ken. "I'll miss you."

By morning Ken seemed stronger, and Blanche went home for a nap.

At 2:30 p.m., Blanche was just walking into the nursing home as Grace sat beside Ken, holding his hand and napping with her head against his bed. As she awoke, Ken stopped breathing.

Formal cause of death: malnutrition/suicide.

"You know, Ken left us a powerful legacy," Gervais said.

"You can't develop a nice, clean policy that covers every ethical issue that will arise. That's the great story of what's unfolding in bioethics now — our greatly expanded medical and technological control over the body has far outpaced the ethical framework we've used to examine individual cases in the past.

"New issues come up — or in Ken's case, it's perhaps more of an old issue that in the past would automatically have been rejected.

"We're trying to shine the lamps of our values into dim corners we've never seen before, and we're struggling to understand the murky picture we're still seeing imperfectly."

Ken's sisters, their daily routine no longer built around his care and dying, are picking up the threads of their lives that had been put on hold for months. Grace is continuing to map the history of their ancestors, early settlers of both Massachusetts and Minnesota. Blanche visits old friends at the nursing home each Monday.

The nursing home is developing a policy for tackling new ethical issues, and Gervais would like to use Ken's story as a case history to help other nursing homes learn from the painful experience.

"It says a lot about the integrity of the nursing home officials that they were willing to stay in the middle of that murky picture, to stand there in the middle of their very great discomfort," she said. "True, one result was that the family and the staff may have felt jerked around. That's unfortunate, but that's the cost of being in new, not well-charted ethical territory."

Ken's legacy for the nursing home, she said, "was to open this territory, this gray area, and the nursing home really honored Ken by being willing to explore it.

"Ken's frustration through that process was another legacy, a sort of redemptive gift to some residents who will follow him with new, equally thorny ethical issues."

Because of his cerebral palsy and then a crippling stroke, Ken was not comfortable lying down or sitting up. Nurses would turn him every few hours during the night, making him more comfortable and preventing bed sores.

Ken's sister, Grace, held his hands as she kept vigil beside his bed. "It's hard to see Ken this way, but it was harder before, when he was conscious. He was so unhappy. We're a lot alike,

Shortly before he died, Ken had his sisters make funeral arrangements. The service was held at

Star Trib 7/20/94

She gave her life for right-to-die

Son is leading crusade for 'happy death'

Associated Press

Chicago, Ill.
She was a "little old lady in sneakers" who prized self-sufficiency and simple pleasures. Her son is a doctor who admired her spunk, her love of life and her decision to end it when her health failed.

In April, she committed suicide by refusing food and water.

Dr. David M. Eddy describes his mother's decision and death in a first-person account in a medical journal, saying the right-to-die debate has overlooked the option that gave his mother a painless "happy death."

"Without hoarding pills, without making me a criminal, without putting a bag over her head, and without huddling in a van with a carbon monoxide machine, she had found a way to bring her life gracefully to a close," he wrote in today's issue of The Journal of the American Medical Association.

In a hospital in her hometown of Middlebury, Vt., Virginia Eddy, 85, received morphine as needed to relieve any discomfort, said her physician, Dr. Timothy Cope. "It was less than I thought she'd need," he said in a telephone interview.

When the body stops getting fluids, life ends quickly, and dehydration seems to bring physical relief rather than pain, some researchers say. Virginia Eddy's death took less than a week.

Much of the right-to-die debate has centered on whether it is legal to pull feeding tubes from people unable to make such a decision for themselves, or whether mentally competent people should be able to end their lives with drugs or carbon monoxide, seeking help from others if necessary. One well-known how-to book, "Final Exit," doesn't even mention refusing food and fluids as an option, Eddy said.

His mother begged him to write about her experience, said Eddy, a resident of Jackson, Wyo., and a senior policy adviser to Kaiser Permanente of Southern California, a health maintenance organization.

"Tell others how well this worked for me," he quoted her as saying. "I'd like this to be my gift. Whether they are terminally ill, in intractable pain, or like me, just know that the right time has come for them, more people might want to know that this way exists.

"And maybe more physicians will help them find it."

Choice in Dying, which provides information to dying people and their families, said few people inquire about starvation as a way to bring about their deaths.

Yet, "the courts have generally said a competent person can refuse whatever they want to refuse," said Ann E. Fade, director of the legal and education program at the New York-based group.

Suicide is legal in all states, and doctors have been sued for battery for forcing treatment on patients without legal authorization, she said.

Some groups take a darker view of the choice to starve.

"On general principle: Is suicide moral? The answer is no," said Randall Terry, founder of Operation Rescue, an anti-abortion group that also opposes the right to die. "We cannot put ourselves in the place of God. Murder is against the Sixth Commandment, even self-murder."

CHOOSING DEATH
ASSISTED SUICIDE

'hen Darrel Hildebrant dies, the underlying cause of death will be complications caused / AIDS, but the instrument will be 2 grams of Demerol — physician-assisted suicide. He ıd a doctor friend who prescribed the drug emptied 20 capsules into this bowl before ıe photo was taken to ensure that even the brand name on capsules couldn't be identi-ed. "I'm a little paranoid about this. I have visions of somebody knocking on the door with a search warrant. That's why I don't keep the drugs in my apartment," Hildebrant said. Here with his dog Missy, Hildebrant commented, "I may want her to be someplace else when I die. I think she's going to be very upset. When Maurice [his partner] died, she just went nuts. She stayed under the bed and wouldn't come out."

Darrel/ Living with AIDS; prepared to die by his own desig

Darrel Hildebrant is prepared for his own death. When the time comes, the agent will be 20 Demerol capsules that he says were rescribed by a Minnesota physician and ıtained in another state.

wish [assisted suicide] were legal. I'd feel bet- r for the doctor. But I don't have any doubts ıout what I'm doing," said Hildebrant, 47, who as diagnosed with AIDS in 1985 and now works ll time for a Twin Cities AIDS organization.

ive years ago, he and his partner were living in ismarck, N.D., where Hildebrant was a librari- and puppeteer. Maurice was dying of AIDS at me, and Hildebrant tried to coax him into lking about it.

Maurice was in a lot of denial about his disease d about dying. I tried to get him to talk about but he wouldn't — not until the last month, ien it was too late," he said. "That's when he rted to talk about assisted suicide, but you n't arrange these things at the last minute.

le was 6 foot 2, but he was only 60 pounds ien he died. He had almost constant pain, rrhea, nausea and spells of dementia. It was lly awful."

ie home hospice nurse later confided that she d to restrain herself from smothering Maurice th a pillow to end his suffering.

ldebrant decided then that when his death proached, he would not force himself or his ends to endure that suffering.

ve seen too many friends die very bad deaths. never gets easier," he said. "I know what to ject. I know what I'll do."

moved to Minneapolis after Maurice died found a doctor who would help. He won't ntify the doctor to anyone. "I've never been patient, so there's nothing connecting us. 's risking a lot for a friend, and I won't put n in jeopardy."

e doctor didn't break Minnesota's law against ping another commit suicide when he pre- ibed the powerful narcotic pain medication,

> "I'm not despondent. I love life. But a few days or a week before AIDS kills me, I'll take the drugs with a glass of alcohol to speed the effect, and slip away."

even though he knew how Hildebrant intended to use it. The law will be broken when Hildebrant takes the drug and dies.

"I don't look on it as suicide," he said. "I know about suicide. That's what I tried to do twice," at the end of a 13-year marriage when he was struggling to understand that he was bisexual.

"I stood on a railroad bridge waiting for the train to hit me. Then I tried carbon monoxide in the garage. Both times somebody saw what I was doing and rescued me," he said.

"This will be different. I'm not despondent. I love life. But a few days or a week before AIDS kills me, I'll take the drugs with a glass of alcohol to speed the effect, and slip away."

He keeps the Demerol in a locked box outside his St. Paul apartment, safe from intruders — or an unlikely search warrant.

"I'm at peace emotionally and spiritually," he said. "I was really happy when my church [the United Church of Christ] decided that assisted suicide and euthanasia were matters of individual conscience."

Hildebrant isn't sure how he contracted AIDS. In the early 1980s he had unprotected sex with men before the risk of AIDS was fully understood. And in 1984 he had a blood transfusion in New York, then was told he should be tested for HIV, the virus that causes AIDS, because he received blood before it was routinely screened for the virus. He found he already had full-blown AIDS.

"Eight years with AIDS is a long time. At my age, I'm kind of the grandfather in the AIDS community. Most people die sooner and younger," he said. But he isn't sitting around waiting for death.

He spends up to 70 hours a week in public education, traveling across Minnesota and other states. Most of his salary is paid by the Centers for Disease Control and Prevention in Atlanta. Two years ago he was named Citizen of the Year by the National Association of Social Workers for organizing AIDS support groups in North Dakota.

"I don't talk about assisted suicide to most groups unless they bring it up," he said. "I do talk about it with doctors and nurses. They don't always agree, but they usually understand." But he doesn't suggest it for others.

"I'll help people explore their options, but I want them to know about hospice, about experimental drug programs like the one I'm in" at St. Paul Ramsey Medical Center, he said.

"Finding a doctor to prescribe lethal drugs is very difficult. There's no secret network of doctors in the AIDS community to go to. There's more talk about assisted suicide, but not many do it. I only know one other person who has her drug recipe ready to go."

There's a slim chance that he won't use the Demerol, he said.

"I'll see how it goes. Maybe if the pain is really controlled . . . but I'm pretty sure that when my body is disintegrating, before I'm too demented to act, I'll end it.

"I could live a couple more years, or I could get an infection and be gone in six months. Either way, it's OK. My affairs are in order. I'm ready.

The law in Minnesota

Minnesota law prohibits helping or advising someone to commit suicide.

The law:

Aiding suicide. Whoever intentionally advises, encourages or assists another in taking the other's life may be sentenced to prison for not more than 15 years or to payment of a fine of not more than $30,000, or both.(The penalty is equal to that for first-degree manslaughter).

Aiding attempted suicide. Whoever intentionally advises, encourages or assists another who attempts but fails to take his or her own life may be sentenced to imprisonment for not more than seven years or to payment of a fine of not more than $14,000, or both.

Acts or omissions not considered aiding suicide or aiding attempted suicide. A health care provider . . . who administers, prescribes or dispenses medications or procedures to relieve another person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death, does not violate this section unless the medications or procedures are knowingly administered, prescribed or dispensed to cause death.

A health care provider . . . who withholds or withdraws a life-sustaining procedure . . . in accordance with reasonable medical practice does not violate this section. . . .

Modern debate is rooted deep in history

Early thinkers generally accepted euthanasia and assisted suicide — if they were done for the right reasons

In some ways, the ethical, moral and theological debate over euthanasia and assisted suicide hasn't changed much since Aristotle and Plato reached different conclusions 2,400 years ago.

What has changed is the medical context. Modern medical practices — precise diagnosis and applications of technology, medicines and surgery — have given physicians and patients far greater control over the dying process.

Even the definition of death has changed, recognition that technicians can use machines to keep a human body "alive" after its internal life-support mechanisms have failed.

As they have from the beginning, physicians, philosophers and priests are struggling to define universal principles that can guide action in individual cases.

Early thinkers didn't draw moral distinctions between euthanasia and assisted suicide. Euthanasia, sometimes called mercy killing, is the act of painlessly ending the life of a suffering person; assisted suicide is the act of ending one's own life with drugs, instruments or instruction provided by someone else. (Modern thinkers often differentiate between "active euthanasia," a direct act to end life, and "passive euthanasia," withdrawing or forgoing medical treatment and allowing death to occur.)

Ancient Greeks and Romans generally accepted the notion of euthanasia among willing patients if it was done for the right reasons — for example, to end physical suffering during a terminal illness. Many believed that euthanasia helped a person into a "good death" — in a psychologically balanced state of mind, under composed circumstances, in a condition of self-control.

Euthanasia was not seen as suicide or murder, but one rational method of dying.

But not all agreed. In the fifth century B.C., the Pythagoreans believed that good and bad events of life were the result of one's past actions, that pain and an agonizing death were punishment by the gods. Suicide or euthanasia amounted to violating the lifespan ordered by the gods.

Plato sought to soften that view, arguing that euthanasia was reasonable in the face of an agonizing and debilitating illness when death was imminent. He rejected the notion that an individual owed his life to the gods, saying instead that a person's value was linked to his ability to act on behalf of society. Therefore, euthanasia was acceptable for incurably ill or severely disabled people whose lives were useless to themselves and others.

Aristotle disagreed with his former teacher. The dying or disabled person's duty to society required remaining productive for as long as possible, even in painful or debilitating circumstances, he argued. Dying courageously despite pain was a moral test for the virtuous person and an example to others.

The Romans generally were sympathetic toward voluntary euthanasia as a release from unendurable suffering. The Stoics, members of a Greek school of philosophy embracing virtue and reason over emotion, endorsed that option for those whose pain or physical abnormalities prevented them from fulfilling their individual needs. But it was not an acceptable escape from life's legitimate duties.

The role of Greek and Roman physicians in euthanasia or assisted suicide was accepted by many, including Socrates. But that issue, too, was controversial.

Although its authorship and purpose are debatable, the Hippocratic oath taken by physicians includes the promise that, in addition to not practicing abortion or surgery, "I will give no deadly medi-

History/ With medical advances came concern over treating diseases, not patients

Continued from previous page

Some scholars say that sentence was not a reflection of the medical ethics of the time but a statement of Pythagorean religious prohibitions against ending life. Others suggest it was an attempt to stop the occasional practice by physicians of murdering opponents of political patrons.

Whatever its origin, the prohibition, written sometime between the sixth and first centuries B.C., remains a guiding principle for physicians. Those who violate its terms generally argue that, on rare occasion, the physician accomplishes a greater good by speeding the dying process of a willing patient.

For early Christians, only God had the right to give and take life, and euthanasia was seen as usurping the role of God. The practice of euthanasia became rare after the second century of the Christian era.

By the fifth century, Augustine taught that life and suffering were ordained by God. Suffering came to be viewed as a source of rejoicing because God used it to produce spiritual maturity.

In the 13th century, Thomas Aquinas argued that ending one's life prematurely was sinful because it violated the commandment against killing, and because it left no time for repentance.

Achieving a "good death" meant accepting whatever pain or bodily failures accompanied death. The role of clergy, family and friends was to offer physical comfort, moral support and prayer.

Attitudes began to change with the humanism of the Renaissance and a revival of Greek and Roman ideas that accepted euthanasia and even glorified it. English writer and statesman Sir Thomas More, in his 1516 book "Utopia," envisioned an ideal society in which church and state officials would encourage suicide and voluntary euthanasia for those with agonizing diseases.

> In the 13th century, Thomas Aquinas argued that ending one's life prematurely was sinful because it violated the commandment against killing, and because it left no time for repentance.

The Protestant Reformation brought a storm of hostility against such humanistic beliefs, in some ways setting up a confrontation that has continued for centuries between extremes of conservative moral correctness and scientific humanism.

The humanists retained strong influences in medical science, and in the 17th century, philosopher and statesman Francis Bacon advocated use of science and medicine to lengthen life and, when indicated, to end it painlessly.

Increasing scientific control of the physical world led some physicians and philosophers such as Benjamin Franklin to predict that people might live for 1,000 years as disease was conquered and aging greatly slowed.

The 19th century ushered in the age of heroic medicine that set the stage for much of the current debate about euthanasia and assisted suicide. With the invention of the syringe and isolation of morphine in the mid-1800s, some physicians began using the combination not only to ease pain but to speed death. Even then, some practitioners were concerned that they were treating diseases rather than patients, extending the dying process and resulting in unnecessary suffering.

That concern has heightened in the past 30 years with the tremendous advances in medical technology. After years of using all means possible to extend life, medical science is being asked to reconsider appropriate application of medicine.

And more people — some citizen groups, some physicians, some ethicists — are raising the old questions about whether doctors should help their terminally ill patients who want out of life.

Suicide is not illegal, but helping someone else commit suicide is against the law in 32 states and has been prosecuted in some other states under manslaughter laws.

Since 1992, voters in Washington, Oregon and California have turned down referendums that would have legalized physician-assisted suicide. But the debate continues and proponents of change are gearing for new attempts to change the laws.

If that happens, the Pythagoreans and Aristotle will have lost and Plato won: The power to choose death and ask for professional help will rest with the individual, not the church or the state.

Questions for a patient considering physician-assisted suicide

This questionnaire is intended to help someone considering assisted suicide think through the issues. The questions will be most helpful if they are discussed with family, clergy, a doctor or other trusted people willing to talk openly about the topic.

Moral questions

- Is assisted suicide morally appropriate for me, given my present circumstances, suffering, responsibilities and values?
- Have I considered whether self-destruction may be immoral? Have I considered that not everything becomes moral simply because it results from my own free choice?
- Would another person in my circumstances be justified in choosing assisted suicide?
- Why do I want to involve a physician? If I cannot kill myself without help, why should I ask for assistance? Does professional endorsement of my decision ease my moral indecision? Am I concerned that I might botch my act without medical help?
- Should I deceive my physician and get unintentional help in committing suicide, or should I try only to get informed, voluntary help?

Family questions

- Do I want my family to know about my plans? If so, what role should they play in my decision-making process? Would my family accept my plans, however reluctantly? Would they try to change my mind or stop me?
- How might family and friends be hurt by my suicide? How can I minimize that harm? Is it important that they fully understand my decision?
- Do I want to die in privacy, possibly to protect my family, or do I want my family present?
- If I end my life, what lesson does that leave for my family and friends?

Religious questions

- Does my religious tradition regard suicide as always wrong?
- How can I conclude that killing myself is an acceptable act of stewardship over my life? Why would it not default on my other obligations to God?
- Might God punish me in some way for killing myself? Might God punish someone who helped me kill myself?
- Have I considered the moral and cultural costs to myself and my family of assisted suicide, given our general religious commitments? Have I adequately discussed these issues with a religious adviser?

Medical questions

- What specifically is my medical prognosis? What symptoms can I expect as my life progresses? What chance is there that this phase of pain or suffering will ease? Have I discussed this with my physician?
- Has my physician discussed my physical pain, emotional suffering, anxiety, medical condition, prognosis, options for treatment and how effective my comfort care would be at the end of life? If not, can I ask for that discussion? If that doctor refuses, can I ask to be referred to another doctor?
- If I have an incurable illness or condition, what do I believe is my doctor's function in treating me? What should be the goals of my medical care? Do I understand that physical pain usually can be medically controlled when I am terminally ill? Have I talked to a doctor or hospice nurse about that?
- Do I have a plan for assisted suicide? Do I have a good idea of what to expect physically if I act on that plan? Have I decided under what circumstances I would act? Am I open to discussing all of this?

Legal questions

- Because assisted suicide is illegal in Minnesota, do I know the possible legal consequences for my doctor or family if they help me end my life? Do I know the life-insurance ramifications?

Personal questions

- In what ways am I suffering? Why do I think my life is intolerable? Is my suffering more severe than that of other people who seem to be coping? Is there anything they can teach me?
- What control do I want over my dying and death? Must I have absolute control?
- Would asking for assisted suicide fit the way I have lived my life?
- Am I feeling pressured by others to end my life, or is this decision entirely my own choice?
- Have I explored all options for ending my suffering? Is there another way I can have a dignified and painless death? Have I considered hospice care? Who can I talk to about this?
- How much is my desire for assisted suicide an effort to exercise personal control over a process that seems to rob me of other choices?
- How much is it motivated by fear of future pain or degeneration? Have I explored those fears with my doctor or a counselor?
- Am I considering suicide as a way to protect others from potential emotional suffering as they see me in deterioration or great pain? Am I responsible for protecting them?

This questionnaire is based in part on a November 1993 report of the Task Force on Physician-Assisted Suicide for the Society of Health and Human Values, a national organization of physicians and other health care professionals, clergy, ethicists, teachers and others.

Common terms/

Here are some common definitions of terms used in the debate over assisted suicide and euthanasia.

The terms frequently are misused or misunderstood, and clear definitions are important as people think about the kind of medical care they consider appropriate for themselves, and about proposals to change laws regulating euthanasia and assisted suicide.

Suicide: Intentionally ending one's own life. It is legal in Minnesota and all other states.

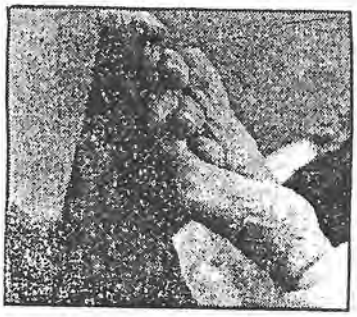
Assisted suicide: Helping another person end his or her life. Usually that involves intentionally providing the means, instruction or physical assistance to another person in committing suicide, or encouraging that person to do so. It is illegal.

Physician-assisted suicide: Providing or prescribing medication to someone, knowing that person intends to take a lethal dose of the medication, or advising someone how to commit suicide. It is illegal.

Active euthanasia: The act of putting a person to death painlessly. Usually a drug is administered intravenously to someone suffering from an incurable and painful disease or condition. The term often is used synonymously with mercy killing. It is legal in the Netherlands, but illegal in the United States except in the execution of criminals.

Passive euthanasia: An act or omission of medical care intended to allow the dying process to conclude, such as withdrawal of a feeding tube or a decision not to use antibiotics to fight a secondary disease such as pneumonia. The concept is legal and generally is accepted medical practice when a dying patient or the patient's legal decision-maker agrees.

Do not resuscitate (DNR) order: A written order in a patient's medical chart stating that no resuscitation attempt should be made in the event of cardiac arrest. In hospitals and nursing homes, doctors may make that judgment if resuscitation clearly would be futile or would merely extend the dying process, especially in the case of a patient who is dying, comatose or severely demented. The decision usually is made in consultation with the patient or family members, and with others caring for the patient. It is legal in all states.



Where to go to get help, more information

Help in dealing with issues surrounding death and dying is available from many clergy members, physicians, nurses, social workers, nursing homes, hospices, hospitals and disease-related organizations such as the Alzheimer's Association or American Cancer Society.

Experts advise patients to ask specific questions and press for answers. If you're not getting adequate answers, ask for a referral to someone else.

For further information:

- **Crisis Intervention Center,** suicide crisis line, 347-2222
- **Hemlock Society of the Upper Midwest,** P.O. Box 39691, Edina, MN. 55439-0691.
- **Minnesota AIDS Project,** 341-2060.
- **Minnesota Alliance for Health Care Consumers,** 866-4660.
- **Minnesota Cancer Pain Initiative,** which supports education and research. Paula Sallmen, coordinator. 863-4633.
- **Minnesota Hospice Organization,** 659-0423.
- **Minnesota Network for Institutional Ethics Committees,** 331-5571.
- **Minnesota Ombudsman for Older Minnesotans,** (800) 657-3591.
- **National Association of Social Workers,** Minnesota chapter, 293-1935.
- **Pathways,** which works with terminally ill people living at home, 822-9061.

By Warren Wolfe
Staff Writer

Staff Photos
By Stormi Greener

Several states attempting to legalize euthanasia, assisted suicide

Here's the status of state legislation affecting both active euthanasia and assisted suicide:

Attempts to legalize by voter initiative: California, defeated in 1992, 54 percent to 46 percent. Washington state, defeated in 1991, 54 percent to 46 percent. Oregon and Michigan, campaigns underway to introduce initiative on ballots in the fall.

Legislative bills to legalize: California, Iowa, Maine, Michigan, Oregon, Texas, Washington and Wisconsin. None has passed.

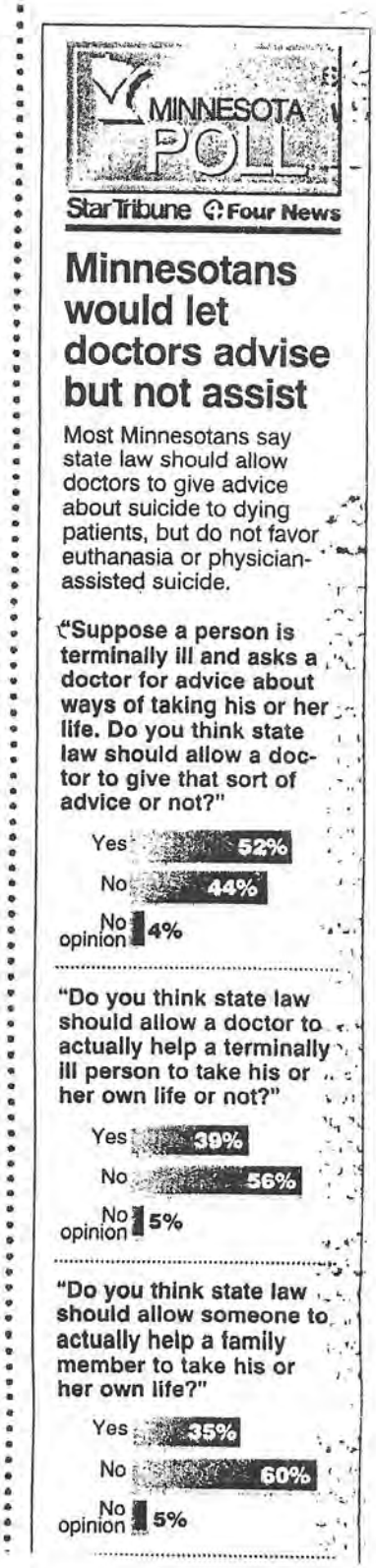
The Texas bill died in committee, and Wisconsin Rep. Frank Boyle, D-Superior, expects a similar fate for his bill. The bills are expected to be reintroduced in both states next year.

States with laws against assisted suicide: Thirty-two states, including Minnesota, Wisconsin, North Dakota and South Dakota.

Other states are Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Illinois, Indiana, Kansas, Maine, Michigan, Mississippi, Missouri, Montana, New Jersey, New Mexico, New York, Nebraska, New Hampshire, Oklahoma, Oregon, Pennsylvania, Tennessee, Texas and Washington.

Prosecutors in other states generally say it is possible to prosecute cases of assisted suicide under existing murder or manslaughter laws, although few people are charged because it can be difficult to prove. Active euthanasia, or mercy killing, is considered murder in all states.

States prohibiting suicide or attempted suicide: None.



From Buddhism to United Methodist, religious views on assisted suicide vary

Here are the views of some religion groups about assisted suicide or euthanasia:

Buddhism: To reach enlightenment through countless lives, a believer must live through suffering, illness and death — caused by negative karma, or bad past actions and delusion — and come to understand truth, justice and compassion. It is proper to relieve suffering with medication, sympathetic listening and counsel, but not to prematurely cause death.

Christian Science: Members are free to follow their consciences. However, belief in the power of God to heal any disease means most members would not advocate assisted suicide.

Eastern Orthodox: Greek and Russian Orthodox churches, the two largest Eastern Orthodox churches in the United States, have no formal position on euthanasia. But ethicists of both churches say that their traditions hold euthanasia to be murder.

Episcopal: There is no official position, although a 1952 non binding resolution by the General Convention expressed "complete opposition to the legalizing of the practice of euthanasia, under any circumstances whatsoever" because "as God gives life, so only through the operation of the laws of nature can life rightly be taken away from human beings."

Evangelical Lutheran Church in America: Church policy opposes assisted suicide, based on previous positions of the denominations that merged in 1988.

The Lutheran Church in America's 1982 statement on "Death and Dying" notes that "some might maintain that active euthanasia can represent an appropriate course of action if motivated by the desire to end suffering. . . . [But] meaning and hope are possible in all of life's situations, even those involving great suffering. . . . Performing active euthanasia, thereby deliberately destroying life created in the image of God, is contrary to Christian conscience."

The American Lutheran Church in 1977 noted that "Christianity has long taught that suffering can have meaning. . . . While direct intervention in many cases may appear 'humane,' deliberate injection of drugs or other means of terminating life are acts of intentional homicide."

Hinduism: Pain and suffering in terminal illness are the consequences of past actions. How one faces that will help determine the conditions of future lives. To cut short life by medical intervention interrupts this process, producing negative karma for the patient and

Islam: The Koran forbids suicide or the killing of others except as punishment for adultery, killing another unjustly or forsaking Islam. Every human life belongs to God, the creator of life, and no one may end it or ask another to take it.

Jehovah's Witness: "Active euthanasia is murder," according to the denomination's publication, Awake!, which reflects the thinking of its 18-member governing body. "Those desiring to conform their lives to Bible principles would never resort to positive euthanasia."

Judaism: No one may hasten death, either through suicide or assisted suicide. The Torah (the first five books of the Christian Bible) teaches that human life is "created in the image of God," and all human life must be treated with great reverence.

With no central bodies governing Jewish congregations, most teachings about modern health care issues are in published responses by individual rabbis to questions on social, religious and legal matters.

"The sanctity of human life prescribes that . . . [human life] may thus not be terminated or shortened because of considerations of the patient's convenience or usefulness, or even our sympathy with the suffering of the patient," says a 1984 collection of such thinking from the Reform, Orthodox, Conservative and Reconstructionist branches of Judaism. "In Judaism suicide and euthanasia are both forms of prohibited homicide."

Latter-day Saints (Mormon): "A person who participates in euthanasia — deliberately putting to death a person suffering from incurable conditions or diseases — violates the commandments of God," says Mormon policy, enunciated in its 1989 General Handbook of Instruction.

Mennonite: There is no formal position, but because Mennonites hold that human life is a sacred trust from God and thus formally oppose war and abortion, members would tend to oppose suicide or assisted suicide.

Missouri Synod Lutheran: "Euthanasia . . . is a synonym for mercy killing, which involves suicide and/or murder. It is, therefore, contrary to God's law," says a 1979 report on the topic by a church commission after resolutions at two conventions denounced euthanasia.

Presbyterian: A 1983 statement by the General Assembly affirms the value God places on life and respect Christians should have for it, but indicates that euthanasia might be consistent with respect for life:

less, too old, too weak, unproductive, sociopathic or a burden, thereby justifying some act of positive 'mercy killing,' " the statement says. However, the first appendix is a voluntary euthanasia form requesting "the administration of euthanasia" if the person has a terminal illness that is "expected to cause me severe distress or render me incapable of rational existence."

Roman Catholic: The church consistently has opposed the direct ending of human life.

"Nothing and no one can in any way permit the killing of an innocent human being, whether a fetus or . . . a person who is dying. Furthermore, no one is permitted to ask for this act of killing. . . . Nor can any authority legitimately recommend or permit such an action," says the Vatican's 1980 Declaration on Euthanasia, by the Sacred Congregation for the Doctrine of the Faith and approved by Pope John Paul.

That view was reaffirmed this month in a papal encyclical that enumerates "intrinsically evil" acts, including artificial contraception, suicide, euthanasia and abortion.

Southern Baptist: There is no official policy, but the church's Christian Life Commission in 1987 actively opposed euthanasia, "including efforts [to designate] food and/or water as 'extraordinary' medical care for some patients."

Unitarian Universalist Association: A 1988 General Assembly statement on "The Right to Die with Dignity" says that members "advocate the right to self-determination in dying, and the release from civil or criminal penalty of those who, under proper safeguards, act to honor the right of terminally ill patients to select the time of their own deaths."

United Church of Christ: The church in 1991 affirmed the "rights of dying persons and their families to make their own decisions on terminating medical treatment, including decisions regarding euthanasia and suicide. . . . While we may and do learn from suffering, we do not believe it to be the intentional will of God that persons must be so tested."

United Methodist: There is no formal position, but a 1986 joint position by a Methodist commission and a Catholic bishops' committee agreed that intense efforts to control pain among terminally ill patients is permissible, "even when they risk or shorten life."

However, the Catholics insisted that euthanasia "is objectively sinful in any and all circumstances," while some Methodist members said that under

ASSISTED SUICIDE

Seattle group helps patients end lives while operating on the edge of the law

Their first client for assisted suicide was a man in his 70s exhausted from "psychic pain" after fighting cancer for 12 years, the second a young woman whose body was disintegrating from a degenerative disease.

Poised at the edge of the law, a Seattle group helped both terminally ill people end their lives last year and now is working with about 10 new clients.

Compassion in Dying is the closest thing to legalized assisted suicide in the United States. Its founders regard it as a demonstration project that challenges state law without blatantly defying it.

"We do not promote suicide. We do not encourage, advocate, urge or tell anyone that we think it's a good idea," said the Rev. Ralph Mero, executive director.

"Compassion in Dying is the first organization to openly provide direct assistance to terminally ill patients, helping them consider how they want their life to end."

Mero sees Compassion as a template that others could copy. People from Florida, Arizona, Texas, California and Canada have contacted him, interested in forming similar groups.

A Unitarian minister for 30 years, Mero was an author of Initiative 119 and a leader of the unsuccessful effort in 1991 to pass the voter referendum that would have made assisted suicide and euthanasia legal in Washington state.

By choice, there is only a thin line between Compassion's "assistance with suicide" and the state law that sets a five-year prison term for anyone who "knowingly causes or aids another person to attempt suicide."

Some critics say it has crossed the line, although there have been no legal or legislative challenges to the group's work since it started last April, supported solely by donations.

"Some people argue that modern pain control makes assisted suicide unnecessary in most cases, but that's not addressing the fundamental issue," Mero said. "We hear over and over from patients that their suffering is not acute pain so much as exhaustion from wasting away, losing weight, chromic vomiting, diarrhea — the pattern of cancer and AIDS."

There is much that Mero and his staff of 25 volunteers, including doctors, nurses, social workers and other clergy, will do for clients and families.

They offer counseling about pain management, hospice care and other alternatives to suicide; spiritual and emotional counseling; advice on preparation for dying; advice on drug choice and lethal dosages and the presence of two Compassion members when a patient chooses to die.

They also promise not to divulge the name, date of death or other personal information about the client or the client's physician, "not to be secretive," Mero said, "but to protect the family against harassment and to encourage the participation of patients' doctors."

The patient must be in later stages of a terminal illness confirmed by a second physician; have severe, unrelenting and intolerable suffering; make three written or videotaped requests for help in dying and be able to take the drugs without help.

Close family members also must agree, and the request must not be motivated by depression, mental illness, inadequate access to hospice or medical care, lack of health insurance or other economic concerns.

But there are two things it won't do: supply or administer the lethal drugs — actions likely to be considered illegal.

Since it began work, Compassion has taken more than 200 calls from people, some merely interested, several dozen asking for help. It has turned down far more than it has accepted. Among those rejected were a profoundly depressed man dying of emphysema and two AIDS patients whose doctors would not prescribe lethal drugs.

Another man died of natural causes 36 hours before he was scheduled to end his own life, "and a number have decided, after exploring all their options, not to take their own lives. I feel very good about that," Mero said. "We have fulfilled our mission with them, too, helping them make a rational decision about how they wished to die."

Washington State Sen. Linda Smith, R-Vancouver, finds Mero's reasoning "obnoxious." An outspoken opponent of assisted suicide and euthanasia, she argues that Compassion members should be prosecuted for their work.

"Many elderly ill people have days when they despair. We should help them live, not help them die," she said. Her own mother lived for two years after doctors predicted her death from cancer, she said.

Other critics worry that Compassion's insistence on privacy for its clients prevents regulators from ensuring that the organization actually follows its guidelines.

"We realized that some would be concerned," Mero said. "Someday, we'll have a client who will be willing to go public. For now, we can only point out that we are not a doctor acting alone — the common practice for assisted suicide in the United States — but are 25 people from many disciplines who believe strongly in the right of individuals to set their own course for living and dying."

Should we unlock the door to death?

Sometime this decade, voters in several states will give physicians the legal authority to kill patients who want to die or help them commit suicide.

Like abortion, the issues of euthanasia and assisted suicide are wrapped in a complex and sometimes contradictory web of morality, theology, philosophy, psychology and personal experience.

At its core, the debate is about whether effective, humane medical care includes the right of patients to demand physician-assisted death as the ultimate release from suffering.

"It shouldn't happen, but it will," predicted Dr. Steven Miles, a Minneapolis ethicist and physician. Despite his opposition, he is helping two U.S. medical societies draft guidelines for doctors in preparation for the new laws.

But for many, the question is not just whether assisted suicide should be legal, but also whether the impetus for change has been caused by physicians who often do not give proper medical and emotional support to dying patients.

Too many physicians see death and dying as personal failures, Miles said. They end up giving inadequate pain control and little emotional support for their dying patients.

"Unfortunately, American voters are going to try to solve bad medicine with bad public policy," he said.

Modern science has greatly expanded medical and technological control over the body. For some, the result is full recovery from diseases that a generation ago would have killed them.

But for others, survival means lingering in the shadow of death for weeks or years, living with wracking pain from a disintegrating body, or with machines that do the work of failed lungs, hearts, stomachs, kidneys.

Requests for death most often arise among patients who are dying with cancer or AIDS. Even when pain is controlled, the ravages of both diseases often cause incontinence, severe weight loss, dementia, nausea and other symptoms that patients find exhausting and humiliating.

It's an issue as ancient as Hippocrates in Greece, and as modern as Kevorkian in Michigan. And after centuries of debate, physicians, ethicists and the general public remain deeply troubled about whether to unlock that door to death.

Most Minnesotans oppose changing the state law against assisted suicide, a Star Tribune/WCCO-TV Minnesota Poll conducted in September found.

Fifty-six percent of the 807 people polled said physicians should not be allowed to assist terminally ill patients in death, while 39 percent said the law should permit it.

National polls usually find that most Americans support legalized euthanasia and physician-assisted suicide. In a 1991 Gallup Poll, 66 percent said a doctor has the moral right to end a patient's life if the patient and family agree.

Euthanasia, often called mercy killing, is painlessly ending the life of a suffering person. Physician-assisted suicide is the act of ending one's own life with drugs and advice provided by a doctor. Most proposals to change state laws would require that a patient be terminally ill, make repeated requests for death in writing, be mentally competent at the time of death and be 18 or older.

The issue has been thrust forcefully into the public eye by Dr. Jack Kevorkian, a Michigan pathologist who has assisted at the deaths of 20 patients since 1990. Even critics say he has been effective in raising awareness of assisted suicide. But many trying to change the laws have been critical of his flamboyant style.

"He's the wrong man on the right side of the issues," said the Rev. Ralph Mero, who led an unsuccessful effort to change the law in Washington state. He blames the defeat partly on Kevorkian, who helped two disabled Michigan women die 10 days before the vote.

For many people, there is little to debate about assisted suicide.

"I want to be able to end my life in dignity, on my terms," said Don Anderson of Bloomington, president of the Hemlock Society of the Upper Midwest and a director of the national organization. "We should be able to tell the doctor, 'Help me die peacefully and painlessly now,' " he said.

That is a commonly held view.

"Whenever I speak to general audiences and ask how many support euthanasia, a lot of hands go up," said Arthur Caplan, director of the University of Minnesota's center on biomedical ethics. "Whenever it's an audience of seniors, almost every hand goes up."

Two recent incidents illustrate concern among older Minnesotans facing late life decisions.

Clarence Haskovec, 72, of Lewiston, was charged with assisted suicide in August after he survived a double-suicide attempt. His wife, Dorothy, 65, died after they ran their car's engine in their closed garage. He said she suffered from various illnesses, including diabetes, and wanted to die. In January he was placed on probation for 10 years.

Early this month, Ruth Gaustad, 76, shot and killed her husband and then herself in their Winona home. Notes at the scene indicated that Carland Gaustad, 79, was in failing health and the couple did not want to spend the rest of their lives in a nursing home. It was not clear who wrote the note.

Cases such as these leave physicians and social workers in a quandary, wishing they'd been able to talk with the families before they took action. But is assisted suicide the answer?

For most physicians and ethicists, the choice is not a simple yes or no.

"When patients talk about assisted suicide, they're really asking you to restore them to wholeness — if not here, then perhaps in the next life," said Dr. Eric Anderson, medical director at Abbott Northwestern Hospice in Minneapolis, which cares for dying patients.

"I understand the sentiment for physician-assisted suicide," he said. "It arises when a patient feels a terrible loss of control, often with fear about the future.

"Do we need to allow patients to kill themselves? We've all had patients who committed suicide. When I think back honestly, I think they were general failures of pain control, or some aspect of physical or emotional suffering. I don't disagree with what they did, but they resulted from our failures," he said.

"We know that 40 to 60 percent of cancer pain gets relieved, 90 to 95 percent with aggressive treatment," he said. "But we also know that about one-third of patients have pain that is intolerable, not controlled when it could be. Doctors typically are too timid in controlling pain."

They may fear legal retribution from families or regulators if controlling pain involves massive use of narcotics or leads to premature death, "but that's mostly a cop-out," he said.

> "There's a danger in trying to make physicians into prophet-priest-kings. We aren't . I can give a dying patient good pain control, but emotional suffering resides more in a person's psyche and spiritual realm."
>
> **Dr. Kathy Faber-Landendoen,** cancer specialist and ethicist, University of Minnesota

"That's why you talk in-depth with patients and families. Aggressive pain control is legal, appropriate and good medicine, and what families want most for dying patients is an end to the suffering."

But even some of the most skilled physicians must face that small percentage of patients for whom pain cannot be effectively controlled.

"So far I've been lucky," said Dr. Ron Cranford, a Minneapolis neurologist and national expert on end-of-life treatment. "I've always been able to end the pain." He assures dying patients that he will not let them suffer agonizing pain, and tells them how he'll do it.

"Nine times out of 10, I can still leave them conscious and in control," he said. "But I'll use whatever it takes to end the pain. In some cases that means putting the patient in a coma, even to the point of speeding their death."

That's where most pain-control legal experts draw the line: It's OK to give dying patients massive amounts of addictive drugs to ease pain, even if a secondary result is premature death. It is illegal to give the same dosage with the intent of causing death.

"So far I've never had to cross that line," Cranford said. "But if I were ever in a situation with my family where I couldn't control the pain, I definitely would do it. I would cross the line." And with another patient? "For a patient I knew well, same thing."

No one knows how many doctors illegally cause death. All medical associations oppose it, but some surveys indicate that between 3 percent and 37 percent of physicians would consider it if the law were changed.

In the Netherlands, where it is legal, about 2,700 cases of euthanasia and physician-assisted suicide are reported each year, 2.1 percent of all deaths. About 85 percent are cancer patients.

"I'm sure it's happening in every state, but I think it's fairly rare in Minnesota," Cranford said. "I speak to doctors all the time about this issue, and I don't know the name of a single Minnesota doctor who's doing it."

For many, the question is not just whether assisted suicide should be legal, but also whether the impetus for change has been caused by physicians who often do not give proper medical and emotional support to dying patients.

Dr. Scott Strickland is one who would consider it. The St. Louis Park physician treats mostly AIDS patients, and they frequently ask him about assisted suicide.

"I talk to my patients about everything, including suicide. I can't do much for them because it's illegal. But I certainly can tell them what not to do. A while ago I had a rash of patients who tried to kill themselves by drinking Drano. That's a horrible way to die. I should be able to give them an alternative."

Not so for Dr. Kathy Faber-Landendoen, a cancer specialist and ethicist at the University of Minnesota.

"The popular image is that people with cancer die painful deaths. In most cases that's not true," she said. "Most requests for assisted suicide result from unwarranted fears that pain will not be taken care of.

"I assure patients that I will give them whatever pain medications they need and will care for them to the end. For most patients, the request for death is dropped. They seem reassured, if not always happy."

That may not resolve a patient's emotional suffering, "but there is a question about how much one person can relieve suffering in another individual," she said. "There's a danger in trying to make physicians into prophet-priest-kings. We aren't. I can give a dying patient good pain control, but emotional suffering resides more in a person's psyche and spiritual realm."

But clergy, too, frequently fail to give adequate spiritual or emotional comfort to dying patients, said the Rev. Mel Kimble, director of the program on aging at Luther Northwestern Theological Seminary in St. Paul.

"Clergy reflect society. We don't do too well with death and dying," he said. "As a nation, we've lost the familiarity with death that we had when Grandma died in bed at home, nursed by the family. Now we're so uncomfortable with death that we've forgotten how to talk with dying people. Some individual clergy and individual doctors do very well, but most of us are in denial about our own death, so we can't very well help others face theirs.

"It's not so politically correct to say this these days, perhaps, but there can be tremendous value in suffering. You don't hear that from the pulpit very often. I am in awe of some friends who died with such grace despite suffering, allowing the suffering to teach them again the lesson of God's love and salvation."

But "God does not expect us to endure the unendurable," he said. "I don't make a moral judgment of those who choose assisted suicide as a way to escape. It is not my choice, but I cannot make your choice."

Physicians and ethicists find many gray areas in the debate, especially as they look at specific cases.

For instance, removing a feeding tube at a patient's request is considered passive euthanasia, a procedure that's legal. But is it suicide or passive euthanasia if a patient refuses to eat?

Proponents of assisted suicide and euthanasia typically would limit that choice to adults who are terminally ill. But how are those patients different from teenagers who are terminally ill and in great pain, or people suffering profound physical handicaps?

"That's part of the difficulty in framing a law that tries to spell out when assisted suicide is appropriate and when it is not," said Karen Gervais, coordinator of the Minnesota Network for Institutional Ethics Committees in Minneapolis.

"It is extremely important to remember that we are talking about people, and many individual cases don't fit neatly into the categories the proposed laws seek to define," she said. "You can't develop a nice, clean policy that covers every ethical issue that will arise."

Voters in Washington and California have rejected changes in the law that would legalize assisted suicide and euthanasia. But organizers in both states are trying to get it back on the ballot, and new efforts have begun in Oregon and Michigan.

"The first successful law probably will come in one of those states, where voters can initiate legislation," Caplan said.

"Minnesota physicians tend to practice better medicine here than in many other states. We do a better — though not terrific — job at controlling pain. We're a church-going state. The Lutheran and Catholic churches oppose changing the law, and they have a strong influence here.

"After a lot of other states approve euthanasia and assisted suicide, Minnesota will probably follow, somewhere in the middle of the pack well into the next century."

Bill

'I'm dying, but I feel more alive'

Tired, lonely and in pain, he saw assisted suicide as the best way out. But after his doctor got him into hospice care, he decided to give life a second chance.

A hospice worker swapped Newman's nearly empty oxygen tank for a full one. Dying from emphysema and heart disease, Newman always has oxygen at hand, including this portable tank that straps onto his wheelchair.

Bill Newman, 73, is dying slowly of heart disease and emphysema.

After seven heart attacks, he ives at home in Robbinsdale with constant ain, a continuous flow of oxygen into his nosrils, 32 different medications and his dog, Cricket.

wo years ago, after watching his wife, Marie, ie a slow and painful death from heart disease nd infection, he asked his doctor how he could nd his own struggle quickly — maybe with an verdose of morphine.

I was so tired. There just didn't seem any oint. I was alone, and nobody much cared," he id. "I wanted to make it like an accident so I ould be buried in the church."

e changed his mind after the doctor got him to hospice care at nearby North Memorial edical Center.

'm OK now. Well, I'm not OK," he said. "I t saw my doctor and he can't believe I'm still re. But I don't want to kill myself. I'm dying, t I feel more alive than I have for a long time. d it's the people at the hospice that made the ference."

wman's gratitude reflects stories that hospice rkers hear almost daily from patients and ir families.

e for the terminally ill at a hospice, usually homelike facility, frequently is cited as a er choice than assisted suicide for control of sical pain and emotional suffering in dying ple.

recent meeting at North Hospice, six nurs- nd social workers struggled to remember or three patients whose pain could not be rolled adequately.

not rare for a hospice patient to want h, to leave a body that no longer functions. etimes they ask why God is taking so long," Connie Holden, a nurse and manager of ospice until she took a similar job last h in Boulder, Colo.

"Cricket's my best friend, but she sure has a lot of energy," Newman said. Suffering from constant pain and loneliness after his wife died, Newman asked his doctor about assisted suicide. The doctor got him into North Hospice, which coordinates a number of medical and social services.

'But it's extremely rare for them to ask us to nake it happen quicker," she said. "Maybe hat's because they know we won't do it, but I hink it's mostly because we share the same goal: to help them live as well and as comfortably as possible until they die."

And while hospice workers talk of exceptional patients who remain serene despite open wounds, emaciation, incontinence or pain, it's difficult for some of them to close the door absolutely on assisted suicide or euthanasia.

It's a hard question," said Becky Olson, a ocial worker at North Hospice. "We can control pain in maybe 98, 99 percent of the cases. Ve have a ton of success stories. I worry that egalized assisted suicide could become too asy, that people would kill themselves out of ear or loneliness and not realize they have a hoice.

But should I deny it to the rare person who is agony that can't be controlled? Could I omeday want that for myself?"

he hospice movement began 30 years ago in ngland and is growing in the United States. here are 72 hospices in Minnesota and about 000 nationally serving 250,000 people a year, ostly cancer patients. But advocates say more ospices and more education are needed to elp dying people become aware of the service.

We often get patients too late to do all we uld," Olson said. "When you enter a hospice ogram, it's an admission that you're dying. ometimes that's hard for people, including octors."

ying people typically are more concerned out the dying process than about death itself, d often need someone to talk to, Holden said. at can be difficult for relatives without a ide to open the door.

Death is the great unknown, but we know mething about dying," she said. "What we ow can be very scary — friends who have d in pain or lived for years with dementia.

eople who are dying have a million questions. t often their friends and relatives — sometes even their doctors — are squeamish about cussing it. We don't do a very good job in this ntry talking about something that will happ to every one of us."

Looking back, Newman says, his request for assisted suicide was not caused by his failing body or the chronic pain he's lived with since a Japanese bomb sent fragments into his back at Pearl Harbor in 1941.

"It was loneliness. I can live with the pain, but it was the loneliness that made me want to die. After Marie passed away, my friends kind of left me. I was a district officer in the American Legion. I used to be a legion drum major. But I've never heard a word from them.

"My church used to send out visitors a few years back and that helped a little, but they stopped coming. No phone calls, no cards, no visitors. I just figured, well, I guess I'm not supposed to be here," he said.

He met with a psychologist and asked about assisted suicide. The psychologist called in a psychiatric nurse "because I guess he didn't want to talk about it. Most people are scared of death. I'm not. I'm ready. But I'm in no rush."

For more than a year, Newman has attended the North Hospice day program, recently increasing his visits from two to three a week so a nurse can monitor his medications more closely. Medicare covers his hospice costs, including most medications, because his doctor has judged that Newman will die within six months.

Through the hospice, he gets home health care, visitors, cleaning help, and "maybe best, a housemate." He rents a room to a young woman who works at a nursing home. They were matched through Lutheran Social Service's Share A Home program.

"I kind of feel like I'm useful now," he said. His presence helps support other hospice day clients, and recently he bought a recliner for the program after visiting a store three times to "test drive it. We can't just jump in and out of those things. You need the right height, the right support."

"I feel like I owe a lot to the hospice people. They kind of opened things up for me," he said. "They'll listen to you if you want to talk, and they'll shut up if you don't. It's real comforting.

"Assisted suicide? I used to think it ought to be legal. Since I learned more about dying, I've changed my mind."

Bill Newman loaded up his "traveling bag" of medicines before catching his Metro Mobility bus home from the North Hospice day program. "I think about dying, but I wouldn't consider taking my own life anymore. The hospice folks have helped me learn how to cope." he said. One pain-control technique he learned there: "New Age music. I don't know why, but I put on a tape and the pain starts to get better."