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Death on Demand? Wesley J. Smith Explains the Assisted Suicide Movement



American Thought Leaders

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[RUSH TRANSCRIPT BELOW] “When a country or a state legalizes assisted suicide or euthanasia, it can no longer call itself anti-suicide, because it specifically approves some suicides. ... It’s a very dangerous movement that is normalizing this kind of approach to dying as opposed to natural death.”

In this episode, I sit down with Wesley J. Smith, a lawyer, public speaker, award-winning author, and chair of the Discovery Institute Center on Human Exceptionalism.

“We’re seeing in Canada also the beginning of a situation where patients who have a tough time getting an oncologist because of such a long waiting list, ask to be killed because they can’t get quality medical care,” Smith says.

We dive into his work on bioethics and euthanasia, better known today as “medically-assisted suicide.”

“Assisted suicide and euthanasia is a symptom, not a cause, and there’s a deep nihilism that seems to have infected society on many levels,” Smith says.

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RUSH TRANSCRIPT

Jan Jekielek:

Wesley J. Smith, such a pleasure to have you on American Thought Leaders.

Wesley J. Smith:

Thank you.

Mr. Jekielek:

There’s been a lot of talk about MAID, or Medical Assistance in Dying. This has very quickly become commonplace in Canada. It’s a significant cause of death in Canada today. How did this happen?

Mr. Smith:

MAID is a euphemism for euthanasia or assisted suicide. In Canada, it’s lethal injection euthanasia. In other words, it’s homicide. It’s not murder because it’s legal, but it is homicide, one human being killing another human. In the United States, it’s so far assisted suicide where a doctor will prescribe poison, an overdose of opiates, to a patient to kill themselves with. MAID is something to try to deflect from the harsh darkness of that reality. It isn’t dying because they don’t use the term. They just say it’s MAID, in capital letters. What you’re talking about is mercy killing or assisted suicide or euthanasia.

The push for this began in earnest in the modern times in the late 80s. Back in 1990, there was only one jurisdiction in the world that had legalized assisted suicide, and that was Switzerland. Switzerland had done it in the 40s, and it wasn’t so much part of a right to die issue, because there wasn’t such a movement back in the 40s. In 1992, Oregon voters passed an assisted suicide law, 51 to 49 percent.

Since then, jurisdictions throughout the world have legalized either euthanasia or assisted suicide. It’s now legal in, I believe, 10 states in the United States, Canada, which you mentioned, Netherlands, Belgium, Luxembourg, Colombia,

often legal throughout most of Australia, and various places like Spain. So this has actually spread like a cancer.

And I use that term precisely because it is about death promotion. It is about suicide promotion. In fact, it seems to me that when a country or a state legalizes assisted suicide or euthanasia, it can no longer call itself anti-suicide because it specifically approves some suicides. And it's a very dangerous movement that is normalizing this kind of approach to dying as opposed to natural death.

Mr. Jekielek:

I want to look at it through the eyes of some of the people. They're in incredible pain, and they believe that this would be a compassionate way out, a painless way out, instead of promoting this suffering. That makes some sense, right?

Mr. Smith:

Only on the surface, because that's how it's sold. Euthanasia-assisted suicide is sold as a means of eliminating suffering when nothing else can accomplish that. A, that's mostly a misnomer. Suffering can be alleviated. And B, if you take a look, whether it's in the Netherlands, Canada, Oregon, and other jurisdictions, the reason people actually ask for euthanasia or assisted suicide isn't pain. It's existential issues such as fears of being a burden, fears of losing the ability to engage in enjoyable activities, fears of not having dignity. And these are important issues, but we can intervene and help people through those difficulties rather than kill them.

And the thing that strikes me is it's cruel, it's abandonment, even though that's not the intent. So somebody is going to jump off a bridge and we run up and say, no, no, don't jump off a bridge. And the person says, oh, but I have cancer. Oh, well, let us hold your coat. You're telling the person with cancer that their life isn't worth living. And even if that person doesn't believe it's worth living, when you affirm that for them, or when you actually start applauding them for that, you end up with a different culture than I think we would want to have.

Mr. Jekielek:

So, you know, I'm thinking about Germany, which I think, which is, essentially, if you wish to die, commit suicide, the medical system is to help you. Do I understand that right?

Mr. Smith:

That's not quite right. What Germany's highest court legalized was created a fundamental right to suicide. It didn't create a right for doctors to kill you, but it did say that you can commit suicide for any purpose as a fundamental right. It doesn't have to be related to health. That you have an ancillary right to assistance if that's what you want. And that anybody who wants to assist, if asked, has a fundamental constitutional right to do so. In essence, what the German high court, the constitutional court, legalized was death on demand.

And Jan, that's where this whole movement leads, even though that may not be the intent. Because once you say that killing is an acceptable and indeed a splendid answer to human suffering, how do you limit the, quote, suffering that would qualify for killing? Actually, you can't. And so if you take a look at jurisdictions where this has been legalized outside of Germany, which is mostly health-related or disability-related, what you find is that it's a continual process of expansion.

So let's look at Canada as just a good example, which I think is good for people in the United States because Canada is our closest cultural cousin. So in Canada, the reason euthanasia became legalized was a Supreme Court ruling that said that it was unconstitutional to outlaw. The parliament, the national parliament, then passed a legalization that said death had to be reasonably foreseeable. Now, that's a wide enough definition that you could drive a hearse through it.

Mr. Jekielek:

This is in the mid-2010s we're talking about.

Mr. Smith:

Now, this would be about 2015, 2016, 2017. I believe the Supreme Court ruling was in 2015. The parliament passed a law that said people can ask to be euthanized and doctors can lethally inject them, commit homicide, but legally, if death was reasonably foreseeable, which is a hugely open definition. Well, the euthanasia activists don't want it to be limited to people where death is reasonably foreseeable. Lawsuits were filed again.

Today in Canada, you can have euthanasia if you're terminally ill, if you're chronically ill, if you have a disability, if you're an elderly person who says they're suffering based on, let's say, debilitation, is such that you don't want to live. They were supposed to legalize it for the mentally ill. It's been put off till 2027, not because it's wrong, which it is, but because they need to prepare the psychiatric community to be able to do that.

And I would point out that in the Netherlands, mentally ill people are euthanized, as in Belgium. Then what happens is an instrumentalization of people, an objectification of people because once you're killable, then there's ways we can actually make good use of you. So in Belgium, in the Netherlands, and in Canada you now see euthanasia conjoined with organ harvesting.

In Ontario, Canada, if somebody goes to a doctor and says I want to be killed. The doctor says, okay, I'll kill you. Then the doctor contacts the organ procurement organization that will contact the patient and say, since you're going to die, can we have your liver? And I would point out that in this whole process, this patient is almost never given suicide prevention.

So what we've done is we have said, yes, you're killable. Oh, yes, we would like to make good use of your body parts. And there's been no real attempt made to try to keep that person, get them through the darkness that makes them want to die so that they can remain in life.

Mr. Jekielek:

You mentioned this term, right to die. Shouldn't we have that fundamental right as human beings?

Mr. Smith:

We have the power, but a right to die implies that the government will make it happen for you. And that's what I don't believe we have. And no government should be in the business of authorizing private killing.

Euthanasia is not the same thing as refusing unwanted medical treatment. That is a right. So if you get cancer and the doctor says, well, the only way we can keep you going is with an extreme chemotherapy that might cause you to be really sick, you can say, no, I don't want the chemotherapy.

If you are in an intensive care unit where you're hooked up to respirators and kidney dialysis, you can actually say, no, I don't want that, even though it's likely to cause your death. You can write an advance directive saying, in terms of if I'm ever incapacitated and can't make my own medical decisions, here's what I do want and here's what I don't want. Often, the right to refuse medical treatment is conflated with euthanasia. They're not the same thing at all.

I would point out that in the United States, there was actually a Supreme Court case called *Vacco v. Quill* back in 1997 where assisted suicide activists said, well, since a patient can refuse intensive care that will likely cause their deaths, that's no different than assisted suicide. And nine to zero, the Supreme Court said, no, that's not true, because one is a natural death, the other isn't. When you refuse unwanted medical treatment, the outcome is uncertain. You might be expected to die, but you don't necessarily die.

Mr. Jekielek:

And there's certainly plenty of examples.

Mr. Smith:

Absolutely. Art Buchwald, the humorist, was in a hospice because of kidney disease and in the United States to enter hospice, the rules are, I think they should be changed, but the rules are you have to have reasonably believe six months or less to live. Well, he was brought into hospice with kidney failure. And after a long time, he actually didn't die. And he left the hospice to write his last book. So you never know. It's never certain.

There have been people who have been given lethal prescriptions, for example, in Oregon, which has a six months to live requirement, who three years later died a natural death. We don't die by the numbers. Unless you're really close to death, you can't actually predict it with assurance. And again, we cannot have a system in which some people, oh, we want you in life, and other people, well, of course you should die. Because that leads to a two-tiered system of moral value, and I would say destroys human equality.

Mr. Jekielek:

This is this whole ideology of bioethics that you describe. It's sort of central to your book, *Culture of Death*, which I've been reading kind of with rapt fascination. You mentioned hospice, and you have an amazing story. Please recount it because I love this moment in the book. How did the concept of hospice come about in the first place?

Mr. Smith:

It was very interesting. The modern hospice movement was created by a tremendous medical humanitarian named Cicely Saunders from England. She's now Dame Cicely. She has since passed away. She was a medical nurse in World War II. And after World War II, she was caring for a Polish patient who had actually escaped the Holocaust and was Jewish, but was dying in the hospital in the UK. And she went to visit him every day, and she was asking him, what are you experiencing?

She said, I came up with a concept called total pain, that often people who are terminally ill will have physical issues, you know, symptoms, of course, but also existential issues, fear, often isolation. Too often we let people, you know, oh, I don't know what I'd say, and we let people be alone and isolated. And so she came up with this idea of becoming a doctor.

She was a nurse. She became a medical doctor back at the time when that wasn't done that often to promote this new idea of setting up hospices so that people could actually die with inclusion. In the 1960s, she created St. Christopher's Hospice in London.

I visited St. Christopher's. I had the great honor of interviewing Dame Cicely, who gave me a half hour of her time. One of the things Dame Cicely insisted on in creating modern hospice was that it would include suicide prevention because I asked her I said well you know there's this assisted suicide she said that destroys the equal dignity of my patients she became quite animated about that and the whole hospice philosophy was hospice is not about dying it's about living it's about helping people get the most out of life in the time they have remaining and a natural death.

She was once asked by the *New York Times*, how do you want to die? Amazingly, she said, I would like to die of cancer. And you go, what? And she said, the reason is because I know that my symptoms could be alleviated. I'd have the time to make, you know, say goodbye to my friends and so forth. And that's actually what happened.

Dame Cicely passed away in her own hospice, in peace and in dignity. And this whole idea that assisted suicide is death with dignity is really insulting because that means my father, who died with the care of hospice in 1984, didn't die with dignity. It means that my mother, who died of Alzheimer's disease in my home with my wife and I caring for her in hospice, didn't die in dignity. And we have to reject that idea out of hand.

Mr. Jekielek:

I'm not clear. Why would that be the logical conclusion?

Mr. Smith:

Because we're being told that death with dignity is assisted suicide.

Mr. Jekielek:

It's not the only death with dignity, is it?

Mr. Smith:

Of course not. In fact, I would say it's the opposite. But the implication is that dying with dignity means you've been given the pills or you've had a lethal injection.

Mr. Jekielek:

You've done it on your own terms.

Mr. Smith:

Right, exactly. So that people dying naturally, somehow that's not death with dignity? I reject that.

Mr. Jekielek:

What did she mean when she said that providing this assisted suicide would violate my patient's equal dignity? What does that mean exactly?

Mr. Smith:

Because we talked about this with the example I gave of the man on the bridge who wants to jump, and we say, no, no, no. Life is worth living. While I have cancer, oh, that's different. Let us hold your coat. She is saying that when you do not give suicide prevention to a suicidal terminally ill person, which often can make them not want to commit suicide, studies have shown that, that what you're saying is that their life doesn't have the same value as, we'll say, the veteran with PTSD who wants to commit suicide. No, no. What we have to do is try to prevent suicide not only in the patient with PTSD, which of course we do, but also the person with a serious illness because people can get through that darkness and be very happy to live.

I have an example. I was a hospice volunteer for a while and my last patient was a man named Bob Salamanca. The reason I can name him is because he wrote an article in the San Francisco Chronicle about how much he resented the assisted suicide movement because it was telling him his life wasn't worth living. Bob had Lou Gehrig's disease, ALS, which is a terrible, devastating diagnosis. And Bob told me that at that time, it was in the 90s, Jack Kevorkian, who used to commit assisted suicide in Michigan, was active.

And Bob, when he got this devastating diagnosis, was so shaken and so worried about being a burden to his family that he wanted to go to Kevorkian. His family said, absolutely not. We're not going to participate in that. And Bob put it this way. He said, after a while, the fog lifted. Those were his terms. And he was so glad to be alive. So because Bob was given the time to adjust to this very difficult circumstance, and I'm not saying his life was just peaches and keen thereafter.

It was a struggle often, but he was glad to be alive and he lived until he died a natural, peaceful death from Lou Gehrig's disease.

But if he had been taken to Kevorkian, or if at that time in California, which is where this happened, assisted suicide had been legal, which it wasn't at the time and it is now, I'm telling you, he would have taken those pills and he would have missed out what he said was some of the best time of his life. You know, you describe the sort of, just the logic of bioethics from many different perspectives in the book.

Mr. Jekielek:

Presumably in this sort of situation, people in hospice or people that might be in hospice, there are certain rules that these different bioethicists propose around who it is that you would offer it to..

Mr. Smith:

Yes, bioethics, which of course is a much larger issue than assisted suicide and euthanasia. Bioethics, the mainstream view, I mean, it's not a monolith. Somebody might have the name Catholic in front of bioethicists and wouldn't think this way, or might have pro-life or might have human rights, but if there is not a modifier in front of the term bioethicist, generally, what they believe is a utilitarian approach.

Mr. Jekielek:

Please explain that.

Mr. Smith:

That the purpose of health care should be to prevent suffering and to promote happiness. And if the suffering becomes greater than the happiness, then certain things can occur. We can take deadly action. Joseph Fletcher, who has been called by some of the historians of the bioethics movement, the patriarch of bioethics, was a rank utilitarian who did not value human life as human life. There was no intrinsic human dignity in his view. And in bioethics, there's no such thing as intrinsic human dignity. What matters is called the quality of life ethic.

Perhaps the most popular or famous proponent of that approach is Peter Singer, who is a moral philosopher and bioethicist who's now retiring from Princeton, who became famous for two reasons. One was a book called Animal Liberation, where he basically lifted the value of animals to that of people. But also, he was the prime promoter of infanticide as a moral enterprise, so that if the baby that is born does not suit the family, let's say because of a disability, it would be according to the total view, which is what he likes to talk about, okay to kill the baby.

And some of the examples he's used have been babies with Down syndrome, babies with hemophilia, this kind of thing. We don't have time to get into this, but what really motivates Peter Singer is that being human isn't what gives value, it's being a person. And a person has to have

certain cognitive capacities to be able to have the highest moral value, such as being self-aware over time or being able to value one's own life.

So in the Peter Singer view of things, there's such a thing as a human non-person and there's such a thing as a non-human person. So Peter Singer would say that higher mammals such as pigs or elephants are persons and that unborn children, babies, because they have not yet developed these capacities, or somebody like my mother when she had the last throes of Alzheimer's, are not persons. And that becomes very dangerous because you can use non-persons instrumentally. Well, in the euthanasia thing and in bioethics, there are four supposedly principles.

Beneficence, autonomy, non-maleficence, and social justice. And when we use these approaches, we're supposed to find what is right and just.

The problem, from my perspective, is that these four principles, quote, unquote, don't have an ultimate goal. It's not to preserve the intrinsic dignity of human life, which I think should be the fundamental purpose of bioethics. Because then, okay, how do we best protect the intrinsic dignity of human life? Which of these four principles do we apply that accomplishes that goal?

Mr. Jekielek:

Then it makes sense.

Mr. Smith:

Then it makes sense, yes, because you want to have ways to judge different approaches that get us to the goal that we have. But these four principles don't have an ultimate goal, so they become what I call outcome justifiers. So if I believe in euthanasia, and I'll say, well, then of course we have to apply the principle of autonomy because people should be able to do what they want.

But let's say there's a patient in an intensive care unit that wants that treatment to continue, but the doctor doesn't want to continue it, not because it doesn't work, but because it does work, and the doctor doesn't believe that the quality of the patient's life is worth living, or let's say the resources. Well, autonomy has its limits, and I've seen that actually written in bioethics literature. In this case, we have to apply social justice because that person is taking up undue resources. Or we have to take it with non-maleficence because that person's quality of life isn't worth living, and we have to make sure that that person does not suffer unduly.

And I will yell, but wait a minute, this is what the patient wants. Who are you to say that this patient is suffering unduly? If autonomy applies, but see, autonomy doesn't apply universally because these are outcome determinators or determiners, and it becomes a matter of, it's totally subjective, of what one's opinion is, what one's value system is, when it should be what the patient's value system is.

Mr. Jekielek:

As you're describing the purpose, a purpose could be maintaining the dignity of human life, right? Another purpose, as you're describing this, could be the greater societal good, for example.

Mr. Smith:

And if you do that, then you're going to end up with different results.

Mr. Jekielek:

Right, exactly. But I can't help but wonder, maybe some of the bioethicists do have a goal, which is the one that I just described.

Mr. Smith:

That's quite possible, but it's not stated, because they're also good politicians.

Mr. Jekielek:

So would that be problematic, I guess, is my question. Certainly, because you'd end up with a duty to die.

Mr. Smith:

Because if you're causing undue suffering, not only for yourself, but for your family, for the medical system or the medical team, it's very difficult to help people who are in extreme conditions. And for society, you could end up very easily with a duty to die. And actually, while a duty to die has not been implemented, it has certainly been discussed in bioethics literature. Right, because it's just better for everyone. It's better for the patient who's living a life that isn't worth living, better for the family that won't have to be burdened by the patient.

And remember, the reason people ask for euthanasia often is they're worried about being a burden on their family. And that's really frightening when you consider it. How have we created a society where people think they're a burden? We need to overcome that. Everybody needs to be welcomed in life as long as they have a natural life. Otherwise, we've lost the capacity to love as a people.

Mr. Jekielek:

This other term, quality of life, for most people is non-controversial, and that we should value that.

Mr. Smith:

Of course. I value quality of life. I have arthritic knees right now. The orthopedist has said maybe you should have surgery. And I have pondered whether the improvement in the quality of my life justifies the risk of knee replacement. So far I've said no. So that is always part of medical decision making. You know, what are the benefits I hope to receive? What are the potential risks? Will this improve my ability, my quality of life?

But quality of life cannot become a substitute for sanctity of life or intrinsic worth of life. That's the danger. Of course, quality of life, you know, I decide if I want to take a certain risk in doing a certain activity becomes part of all of our thinking, but it cannot be a substitute for value. That's the danger and that's where bioethics, I'm afraid, in the mainstream view, is moving us away from an intrinsic dignity of all human life, equality, to if somebody has a higher quality of life, they have actually greater value and moral worth than somebody with a lower quality of life.

And then we start telling people with the lower quality of life, well, your life really is less quality. Are you sure you want to live? And you're seeing that in Canada where doctors are now suggesting euthanasia to patients who haven't asked for it. Where you see, and I know one case where a social worker working with a veteran with PTSD because he was over in the wars in the Middle East, suggested to the veteran that he receive euthanasia.

We're seeing in Canada also the beginning of a situation where patients who have a tough time getting an oncologist because of such a long waiting list ask to be killed because they can't get quality medical care. So when you turn it from a value system of equal intrinsic dignity to your values based on quality, it becomes subjective and it becomes a real slippery slope leading to people being abandoned and exploited.

Mr. Jekielek:

With this concept of autonomy, you're suggesting in a similar way that this is being abused. But when the autonomy of the patient to decide is so critical and has so much value, it's actually elevated medicine substantially. But you're suggesting that this is being used against the patient?

Mr. Smith:

It's being used in a way that would enable the patient's worst fears to be implemented or to become the basis of medical action. Yes, we each have autonomy, but do we want to really destroy trust in the medical system by authoring doctors to kill patients? And that kind of strikes me as odd because you'll see a situation where a patient may not trust a doctor to properly care for them, to be able to alleviate their suffering and so forth, but will trust that same doctor to end their life. Autonomy, of course, is an important thing.

But if I decided that I wanted to take a knife and start stabbing myself, well, is that my autonomy? Or does there come a point where we have to protect people from themselves sometimes? That's what suicide prevention is. You are protecting people from themselves until they can get to the point where they don't need that protection. And I fear that if we abandon that approach, there will be a lot of people who will be dead, who, if they had been given the proper interventions, a few months later, maybe even longer than that, would be happy to be alive, like my friend Bob Salamanca, who I referenced earlier. He received the kind of interventions he needed from his family and from his church, and so didn't kill himself and was glad he didn't.

Even though he had one of the most difficult diseases that humans face, which is Lou Gehrig's disease, ALS.

Mr. Jekielek:

In a hospital setting there's a certain sort of utilitarianism that has to happen isn't there like you only have so much to spend on treatments you have to decide how to allocate that among patients.

Mr. Smith:

We are moving in that direction. And it's very ironic that if we're going to have that, we need to have an open and democratic debate. We can't let the experts decide whose life is worth living and whose isn't. And it's occurring at the same time where we're expanding medicine's jurisdiction from making sure that the person, let's say, with cancer gets proper care or that the person with a broken leg gets the bone healed. We're now moving into a world where we have to make sure that people's lifestyles are validated, that they can have their heart's desire through medical means.

And a lot of medical resources are actually going into issues that are not about healing and not about improving medicine, but making people have satisfaction in life. It's kind of an emerging technocracy where I think medicine is somewhat being deprofessionalized, and to the point that billions of dollars are spent on things that have nothing to do with life preservation or even actual physical wellness. And if we're going to do that, we're never going to have any ability to control medical costs.

But if we're going to have to have a certain limitation, then we have to decide what has to be covered and what doesn't. And I would say that the problem with that becomes that people without power end up not getting coverage and people with power get covered. And that's very difficult. But if we're going to have limitations on resources, it needs to be out in the open, not done surreptitiously based on somebody's subjective belief about somebody's quality of life.

Mr. Jekielek:

You use an example where someone deeply believed that they didn't want to have their arm.

Mr. Smith:

Yes, there's a disease called Body Identity Integrity Disorder [BIID], where the patient obsesses with becoming disabled. Their true selves may be as an amputee, or their true selves may be as somebody with a visual impairment, or being in a wheelchair. And there are actually, right now, it doesn't happen in mass, but there are some in bioethics beginning to say, well, the best way to treat that is to cut off their arm or to snip their spinal cord. And there have been a few cases.

In fact, there was a recent case in Canada where a patient was obsessed that his fingers did not belong in his hand and the, quote, treatment was to cut off those fingers. Well, what's going to

happen if his next obsession becomes, well, I shouldn't have my left arm? So this gets to that autonomy question you raised earlier.

There has to be a point where we do not harm people in the name of autonomy. BIID is a very difficult mental illness. People anguish. I've heard from people because I've written about BIID in my work. I hear from them, and our hearts go out to them. We have to try to care for them as best we can, but it seems to me you don't cross a line into giving in to somebody's self-destructive harm.

Let's say a young woman is anorexic and says, I'm fat, I'm fat, I'm fat. Well, bodily autonomy would have us put her on diuretics and purges so that she can get skinnier and skinnier, but that would cause her death ultimately and could end up being very harmful to her. So we don't say, yes, you're fat. We try to help that person with compassion and love. Because if you acquiesce in people's most urgent, self-destructive obsessions, then you really are causing a society, I think, that has no real compassion.

The meaning of compassion is to suffer with, to suffer with. That's what compassion means. When home health care workers help a person who's dying, they're suffering with that patient. If somebody comes in and gives them a lethal injection that they only met two weeks ago, that's not suffering with anybody. That's abandoning.

Mr. Jekielek:

It's the lack of an objective view of what someone being in a good state is. Because someone would argue that's different for everyone. So why not just help them achieve whatever that is for them? Isn't that the view?

Mr. Smith:

Yes, that is the view. But you're validating people's worst fears about themselves, the fear of being abandoned and the fear of being a burden, and so forth.

Mr. Jekielek:

Or their vision that they're actually one-armed instead of two.

Mr. Smith:

The greatest opponents of assisted suicide, the ones that have been the most effective, are not the pro-life people who have been very committed, they're not the medical doctors such as the American Medical Association which opposes legalizing assisted suicide, but the disability rights community. Why is the disability rights community, which tends to be politically liberal, tends to be very secular, I'm speaking generally, but tends to be very secular in their outlook, tends not to be pro-life on the abortion issue, but they have ridden like the cavalry coming to the rescue on the issue of assisted suicide because they see themselves as the victims.

They see that the assisted suicide movement denigrates people who do need help with life experiences and going through everyday living, independent living, and this kind of thing. You began to see a pushback that became effective in the 90s when a group called Not Dead Yet was formed, which is disability rights activists. Their first activity was to actually protest in front of Jack Kevorkian's house. They did a sit-in.

Mr. Jekielek:

I remember Jack Kevorkian, but there might be viewers who don't remember him.

Mr. Smith:

Jack Kevorkian was a pathologist who, after he retired, became obsessed with promoting assisted suicide. And he was operating out of Michigan and people would come and people would come to him and he would go over all this stuff and decide whether their life was worth living or not and if he thought their life wasn't worth living most of the people who went to Jack Kevorkian were not terminally ill. The media said they were but most weren't, most were disabled.

Then he would assist their suicides, usually with a carbon monoxide canister. So the question becomes is carbon monoxide a medical instrument or a medical substance? Of course not. He was brought to trial several times and he was defiant. We found out that society didn't have the strength to actually stop him until he lethally injected a man named Thomas Youk with Lou Gehrig's disease. He videotaped himself doing it and then brought it to 60 Minutes to Mike Wallace, who was a euthanasia booster. They played this killing on 60 Minutes.

I'll never forget Mike Wallace asking Kevorkian, is he dead yet? Then Kevorkian said, no, he's just unconscious. It was really awful. Finally, Kevorkian was convicted of, I believe it was second-degree murder, or it might have been voluntary manslaughter. He was jailed for 10 years. He said if he was jailed, he would commit assisted suicide. Of course, he didn't. Then he got out and he was making \$50,000 a speech, which kind of tells us something about our society. But that's who Jack Kevorkian was.

Mr. Jekielek:

So back to the Not Dead Yet group.

Mr. Smith:

Not Dead Yet saw Jack Kevorkian mostly helping disabled people become dead. The first demonstration was in front of Kevorkian's house. They then sat in the Hemlock Society's headquarters, which was then in Denver. The Hemlock Society was honestly named in those days. These days it's called Compassion and Choices because the death movement likes to use euphemisms, like MAID, which we talked about at the top of the interview.

And they became quite active, and because they're part of the liberal political coalition, in many what we call blue states, more liberal states, they've actually been instrumental in preventing

legalization in places like Connecticut, New York, Massachusetts, and some other places, Maryland, another example. They are the most effective anti-assisted suicide campaigners. In England, they set up a Not Dead Yet UK, and have been disability rights activists.

In fact, in England, there was an attempt several years ago, there's another attempt ongoing now to legalize assisted suicide, but I think it was in 2015 or something, there was a bill called the Joffe Bill from Lord Joffe, who was from the House of Lords. And there was this wonderful image of hundreds of people in wheelchairs demonstrating in front of the Parliament building, that wonderful building in London, against euthanasia, and they were able to stop it in its tracks.

Mr. Jekielek:

Compassion and Choices is an euthanasia advocacy organization. What about Canada? There doesn't seem to be a ton of pushback in Canada to,

I mean, what seems to be a rapid development of these policies, right? To the point, like you suggested, I'm also aware of numerous cases where people were offered it as a treatment of sorts.

Mr. Smith:

Yes. It's become a medical treatment in Canada and when something is a medical treatment there's no way you can deny it eventually. I've been fighting assisted suicide and euthanasia for 30 years and the reason was because a friend of mine committed suicide under the influence of Hemlock Society literature. They taught her how to do it, they gave her moral permission to do it, and they didn't even know her.

Her friends are trying to keep her in life and this literature from the Hemlock Society was called the Hemlock Quarterly. It's not published anymore. It helped push, Frances was her name, into euthanasia. In fact, I have an article on that that can be obtained on the internet called The Whispers of Strangers. It was my first anti-euthanasia piece in 1993. Just Google my name, it'll come up. And because of the hate mail I received from that piece is how I ended up getting into this issue.

But in Canada, in 2023, more than 15,000 people were euthanized. It's become one of the top causes of death in that country. And remember, in Canada, you don't have to be terminally ill. They have track one and track two. Track one is somebody who is reasonably believed to be terminal. Track two is somebody who's not believed to be terminal, and yet you can take, you can still be made dead by a doctor through a lethal injection.

Nothing has shocked me more in these 30 years of activism against this movement than Canada's smiling embrace of the culture of death. The Canadian people generally, of course not universally, have embraced this.

And so you're seeing an increasing number of Canadians wanting to do it. You don't have to be a doctor to commit euthanasia in Canada. You can be a certified nurse practitioner. You see a continual seeking to loosen the rules to allow more people to qualify.

As I said, in 2027, mentally ill people will qualify. You've seen organ harvesting conjoined. You've seen articles in the Canadian press saying, look at the many millions of dollars we've saved for the health care system because of euthanasia. Another example of objectifying people who want to be dead. And it's in and what really concerns me is not only what's happening in Canada but as I mentioned they're America's closest cultural cousins.

A lot of people in the United States, particularly the more liberal kind, look to Canada as our more enlightened cousins. Well our more enlightened cousins are abandoning an increasing number of people to killing, privatized killing. And in Canada, in Ontario anyway, doctors do not have the medical conscience right to refuse to kill. Because there was a court ruling that in Canada, if a doctor is asked for euthanasia, and that a patient qualifies legally for euthanasia, that doctor must either kill that patient or give what's called an effective referral, meaning they have to find another doctor or nurse practitioner who they know to be willing to kill.

And there was a lawsuit brought by Catholic doctors and other doctors saying, wait a second, the Canadian Charter specifically says that we have the right to freedom of conscience and religion, and killing patients violates our freedom of religion and it violates our freedom of conscience. And the court ruled, yes, you do have that, yes, this is a violation, but there's a more important right, which I would point out is not in the Charter, for every patient to have every legal available medical intervention that they want.

So the right to be made dead as a medical treatment was elevated by the court above freedom of religion and freedom of conscience, even though the first isn't in the Charter and the second is. And so doctors now face a conundrum that if they refuse to participate, if they refuse to be complicit in this maw of killing the weak and vulnerable, they could face medical discipline. And it's a real crisis.

You've had a hospice, I believe it was in British Columbia, shut down and removed from government funding precisely because it refused to allow assisted suicide on premises. So you have a real push, and to even now force Catholic hospitals, but this violates Catholic moral teaching, you know, through and through, to try to prevent Catholic hospitals from refusing euthanasia on premises. So what's happened is that euthanasia has become the preference of the ruling class, and those who wish to say no are not allowed to refuse to participate as a cost of being part of the medical licensing.

And of course, we're not yet to the place of a duty to die, but that's the direction in which I think things are drifting. There is a real attempt to prevent religious institutions that oppose euthanasia from not permitting it. Dame Cicely Saunders' hospices would be in real trouble in Canada because she would never allow assisted suicide in her hospices. And you're beginning to see some of that happening in the United States, not as much. Many of the states that legalized assisted suicide have already expanded and liberalized access.

And the media often treats, oh, well, don't worry, there's going to be strict guidelines to protect against abuse. And then within a year or so of that passing and the strict guidelines protecting against abuse being applied, they're now called obstacles and barriers to a chosen death. So the whole popular culture approach, the whole media approach is to push toward greater expansion of assisted suicide euthanasia once you've allowed the camel nose in the tent to use that cliché.

Mr. Jekielek:

Why all the zeal to do all this?

Mr. Smith:

This gets to a bigger issue, which is that assisted suicide and euthanasia is a symptom, not a cause. And there's a deep nihilism that seems to have infected society on many levels. And the cause of that goes well beyond fear of suffering. I think it goes to an existential darkness that has entered our society, which is why we have, ironically, public health officials calling suicide a public health crisis, which it is. I'm not talking about assisted suicide, they never mention assisted suicide as part of that.

And in fact, assisted suicides, because they've been redefined as not suicide, aren't even included in suicide statistics. And when you say, okay, we're going to fight suicide, but not all suicides, that's like saying, well, okay, please don't smoke. But if you do use a filter cigarette, you're not going to accomplish the goal.

Mr. Jekielek:

Something you've written and spoken a lot about is this idea of human exceptionalism, perhaps the opposite of what Peter Singer believes. Please explain how that fits into this whole discussion.

Mr. Smith:

Human exceptionalism is more than the sanctity of human life. Part of it is intrinsic human dignity, which is essential if we're going to have human rights, universal human rights. Because if you don't have rights based on human equality as an objective and intrinsic category for people, then you have to earn your rights. And at that point, that leads to oppression.

The first part of human exceptionalism is we are all equal and dignified in life. And it's based on being human. No subjective things such as quality of brain power or quality of life. The second aspect, and the reason it's not just called human dignity but human exceptionalism, is we are the only known species in the universe with moral duties. We know right from wrong. So we have duties to each other. We have duties to our posterity, people who we will never meet.

In fact, the founders of the United States talked often about their posterity. That's us. We have duties to treat animals humanely, as an example. We have duties to treat the environment in a proper way. So you've got the two aspects of human life, our rights, our values, and our duties and moral requirements. Another way to talk about the duties aspect, it seems to me, is that it's

about love, about loving each other. And sometimes love means you value somebody even more than they value themselves.

So in the context of assisted suicide and euthanasia, of course human exceptionalism goes way beyond this particular issue that we're discussing. We have to see the incredible worth of each and every patient even when they're at the point of death and to suffer with them which is what compassion means and to mitigate their suffering and let them know they're still us. There's no such thing as them, there is only us.

And if we can do that, and if we can find ways to renew our mutual cohesion as a society, I think a lot of this nihilism that we were discussing at the end of the interview here will begin to fade. It'll never go away completely because there's no such thing as a perfect society. But if we yield to our worst angels of our nature, to kind of borrow from Lincoln, then the kind of trauma we're seeing throughout society now will only get worse. And I don't know where the bottom is, if that's the way we go.

Mr. Jekielek:

Wesley J. Smith, it's such a pleasure to have you on the show.

Mr. Smith:

Thank you, Jan. I appreciate the opportunity.

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