Deliberate Death: The Worst May be Yet to Come

STUDENTS OF WESTERN Wisdom Teachings may be familiar with the unenviable plight of the suicide, who, after taking his/her life must experience "the most excruciating torture" (*Questions and Answers,* Vol. 2, p. 34) "occasioned by the attempt of the archetypal body to draw physical material to itself" (*ibid*, p. 37). Some describe the pain as "a gnawing, throbbing toothache, with the difference that the pain is felt all over the body." And this distress continues until the time that the mental archetype for that person's life was destined by the Recording Angels to have naturally terminated.

While knowledge itself may not be a pain killer, it can fortify us to better endure present afflictions, whatever form they may take, rather than seeking to end it all. For all does not end.

Such knowledge may well act as a deterrent for those who contemplate suicide, either by reason of severe depression or due to what is conceived as unendurable pain. With respect to the latter, doctors may actually be performing a service when they mitigate extreme pain, especially in cases of presumed terminal illness, such as advanced metastatic cancer, by administering the anodyne morphine. However, many physicians are loathe to prescribe this substance, even if it is, as reported in *Time* (April 28, 1997), "more effective than most prescription-strength painkillers," some of which *are* routinely given and not infrequently *do* lead to addiction. (Fentanyl is a synthetic opiate that is 80 times more powerful than morphine.) This is stark irony. To deny palliative medication to patients with a terminal illness for fear of possible addiction is irrational, to say the least. Moreover, "the vast majority of patients today can take the drug [morphine] without becoming addicted."

Morphine is a narcotic. The word conjures a host of sinister and illicit associations, so that "those specialists in the treatment of pain who prescribe narcotics on a regular basis refer to the drugs as 'opiate medications,' as if calling them by a different name would counter their shady reputation" and thus clear the physician's conscience of personal scruples and allay potential public censure.

The *Time* article reports that there is "an ingrained prejudice within the medical community against using narcotics—even when they are indicated." In part this is due to the erroneous equation of dependence with addiction. Diabetics are dependent on insulin but they are not addicted to it. The main point, as described by Dr. Richard Patt of the M.D. Anderson Cancer Center of Houston, is that "when pain patients use drugs, they become more functional, much less isolated, and they move toward the mainstream." This is the crux of the matter. For when asked why they want to die, "most people who seek physician-assisted suicide [PAS] respond that it's because they can no

longer stand the pain. But when their pain is relieved, most would-be suicides suddenly find they are a lot more interested in living."

That's a practical and humane approach from this, the living side of the subject. There's no inherent virtue in suffering unmitigated pain. For, at the same time, we know that no one can avoid what it is their ripe destiny to experience. While knowledge itself may not be a pain killer, it can fortify us to better endure present afflictions, whatever form they may take, rather than seeking to end it all. For all does not end. This is what doctors should routinely prescribe for their depressed and life-challenged patients—information about the predicament of the suicide that Max Heindel sought to make generally known.

Not only may the pain a person seeks to escape by death be far exceeded by postmortem pain, but the Ego of the suicide in a subsequent embodiment may be subject to an obsessing spirit. "Investigation of their former lives shows that this affliction is usually the outcome of a desire to run away from life's experience; for those who are obsessed are often found to have been suicides in a previous existence. Then they had a body which they did not appreciate, and, as a consequence, in a later life the mentality became weakened either through an organic disease, a great shock, or by obsession." In any of these instances the spirit was ousted from its body and unable to reobtain possession.

"Sorrow and disappointment are usually the causes of suicide." The spirit that chooses this recourse must learn "the value of a body and of the links therewith, so that in the future no provocation will be sufficient to cause it to sever the silver cord. In fact, sometimes sorrows come to tempt a person who has given way in the past to do this very act; and when he resists, it shows he has become immune from the temptation" (*The Web of Destiny*, pp. 50-51).

This opportunity to prove one's moral mettle should not be short-circuited by well-meaning but ignorant and finally homicidal doctors who perform euthanasia as a putative act of mercy, for they are complicit in a pact that is both murder and suicide, however dire, hopeless, or heart-wrenching a specific case may *appear* to be.

Planet Art

Engraving (1514), 9 x 7 in, Albrecht Durer (1471-1528)

Melencolia

Even as the Renaissance celebrated the rich potential of living in the physical world, Durer suggests the cramping of spirit resulting from an exclusively materialistic perspective, here indicated by the strict geometric forms and instruments of quantitative measurement (balance, compass, hourglass). Human depression and the suicidal impulse can be effectively countered with knowledge of the superphysical dimensions.

Commenting on legalized PAS and euthanasia in Holland, Eric Chevlen, M.D., writes in a *First Things* (May, 1997) review of the book *Seduced by Death: Doctors, Patients, and the Dutch Cure* (Herbert Hendin, Norton), "One hardly knows which is more chilling, the widespread flouting of the scant and effectively toothless legal regulation of euthanasia in Holland, or the *sangfroid* with which it is defended by the Dutch practitioners.... When society gives the power of ending life to physicians, they will exercise it when they conclude that life is of no value. The physician

becomes the final arbiter of life's worth."

Traditionally, all physicians take the Hippocratic Oath, which formulates a set of ethics that should guide their practice. Part of the Oath's text reads, "I will give no deadly medicine to anyone if asked, nor suggest any such counsel." Flouting this resolve, the euthanasiasts seek to effectively increase the medicalization of death by diminishing patient autonomy turning the physician into an executioner.

A sick person who seeks suicide is fundamentally no different from a physically healthy person who does the same. The vast majority of such people are clinically depressed, although all too often their doctors fail to recognize it. (Fifty percent of suicides consult a doctor within a month before their death.) Many of those who seek PAS are in a state of terror. They are mortally fearful of debility, dependence, or even death. Some are so afraid of death that they would rather die than live in such fear. Assisting in such suicide does not, as PAS proponents allege, promote patient autonomy and dignity. Rather it reduces the patient to a victim of his fear and despair, and it guarantees that he will not work through his fear and find value in his life.

Proper palliative care, by contrast, starts with the recognition of the inestimable value of each individual life and seeks to maximize physical, emotional, and spiritual comfort. Among the spiritual comforts are scriptural promises, if the patient be open to them, such as St. Paul's assurance that God "will not suffer you to be tempted above that ye are able; but will with the temptation also make a way to escape, that ye may be able to bear it" (I Cor. 10:13).

Conditions on the other side of death may also be cited, as well as the repercussions of suicide in subsequent lives. Realistically, however, this information won't come from the orthodox doctor, and did it, it would find a frankly perplexed patient. Yet at what more critical or appropriate moment could such a life-saving message be delivered?

Should the prospect of possible obsession in the suicide's next life not give pause, there is also the possibility that the fear of death in that subsequent life is so great that when death does come, the spirit is frantic and "so anxious to get back to the physical world again that they frequently commit this crime of obsession in the most foolish and unthinking manner," including, if they are unable to find a negative human subject to obsess, ousting the real owner of an animal body and ensouling its vehicle; whereafter it is 'under the dreadful necessity of having to live an animal existence," and possible subjection to cruelty, vivisection, cosmetic and pharmacological experimentation, and being slaughtered for food.

Such occurrences must be rare, one thinks. On the contrary, states Max Heindel, "They happen very often, as a visit to some of the great American slaughter-houses has brought home to the writer in a most forcible manner" (*The Web of Destiny,* p. 52).

Grave as is the circumstance of one who is considering suicide, heinous is the mindset, trafficking as "strained mercy at best," which, when the patient is most in need of encouragement and validation, concludes that "he really ought to just hurry up and die." Harsh words? Dr. Chevlin writes in his aforementioned review that a Dutch government commission found that in about half of the 49,000 cases in which there was a medical decision at the end of life, the doctor chose a "treatment" whose primary or secondary purpose was to shorten the life of the patient—despite the fact that the patient had not been consulted in the matter.

Spurning the impulse to die will both prevent unimaginable suffering and transfigure the experience of living.

Suicide is one thing. That the proposed killing be expedited and delivered through the offices of the physician is a grotesque inversion of the oath of his profession. Life is not any human's to take. Whoever does will surely wish they had not. That is why it is incumbent on we who know more about the consequences of such action to be clear and outspoken in articulating our knowledge—that death does not end life and that spurning the impulse to die, by one's own hand or another's, will both prevent unimaginable suffering and transfigure the experience of living. ❒