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A Discussion Paper on Euthanasia
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Introduction

Whenever euthanasia is discussed, its proponents claim that they are merely upholding the "right to die" and "death with dignity." Euthanasia is the conscious hastening of the death of a person, either by act or omission, on compassionate grounds. Euthanasia is most often considered for those who are in great pain or terminally ill or who face the prospect of long-term disability. The thesis of this paper is that such persons do not need "help" in dying; they need support to live in the face of suffering.

There are several factors which have contributed to the demand for euthanasia in our society. The first is the rise of individualism and personal autonomy with a resulting loss of community.

Increasingly, people believe that dying is a personal matter which should be left to individual choice. The community is no longer considered to have an interest in the individual or any rights in determining the time and ways of death.

With the loss of community and family ties comes increasing isolation. Health care has become professionalized and depersonalized. Many people no longer know who would care for them if they were to become disabled, nor would they necessarily feel any connection with a professional care-giver.

The individual's wish to determine when and how to die becomes acute in the face of the many technological advancements that can prolong life almost indefinitely. Much of the support for living wills, for instance, reflects the desire to retain control over life in a future situation where machines might "take over." Even without technology, there is a desire to have control over our lives, our bodies and our deaths.

The very technology which saves lives is also a contributing factor in the push for euthanasia. Technology is expensive: whatever other interests it serves, the concept of "mercy-killing" serves the interests of those who simply wish to ensure greater efficiency in the health care system. As concerns over the costs of health care increase, we should expect a corresponding push to legitimize euthanasia.

Advances in palliative care and pain control have diminished support for the argument that euthanasia is needed to end unbearable pain. Euthanasia is now most often seen as a form of compassion for those who are suffering from severe disability. We are told that persons lose their human dignity when they can no longer function in certain ways and that the compassionate thing to do in such a case is to effect a "mercy-killing."

This discussion paper is intended to explore some of the questions that arise in the context of the euthanasia debate. As the second section of the paper illustrates, there is often confusion over what does and does not constitute euthanasia. While we offer no definite answers that apply to every conceivable case, we offer some suggestions for a Christian response to euthanasia.

Christian Perspectives On Life and Death

The Scriptures provide Christians with a number of principles which they can bring to the euthanasia debate.

First, all humans are made in the image of God and therefore have inherent dignity and worth. Life is sacred and should be cherished. Christians must discourage the assumption that some lives are not worth living. We believe that there is no such thing as a "useless" life.

Despite the fact that our fall into sin has distorted God's reflection in us, we are assured that God places a high value on human beings. We read in Psalm 8:

> When I consider your heavens,
> the work of your fingers,
> the moon and the stars,
> which you have set in place,
> what is man that you are mindful of him,
> the son of man that you care for him?
> You made him a little lower than the heavenly beings
> and crowned him with glory and honour. (Psalm8:3-5)

The value and worth in our lives rests primarily in our relationship with a God who loves us. The idea that life can become useless implies that our worth is determined by what we can do, rather than by who we are in relation to God and to each other. As Christians, we assert that the primary issue is not our feeling about someone but the value of that person's life. Love and compassion, truly understood, do not eclipse the fact that all life is God's and that we must treasure it carefully.

Second, God is sovereign over our lives from the time we are conceived to the time that we die. Psalm 139 assures us that God holds our lives in his hands from the moment we are conceived:

> For you created my inmost being;
> you knit me together in my mother's womb.
> I praise you because I am fearfully and wonderfully made;
> your works are wonderful, I know that full well.
> My frame was not hidden from you
> when I was made in the secret place.
> When I was woven together in the depths of the earth,
> your eyes saw my unformed body.
> All the days ordained for me were written in your book
> before one of them came to be. (Psalm 139:13-16)

The human tendency is to attempt to ignore God's sovereignty in favour of human autonomy. Many readily proclaim, "It's my life and no one has the right to interfere with it." They may not have had a say in being born, but they will surely determine when and how they will die.

Third, death is not the end of life but a transition into a new life. Since Jesus Christ has walked the valley of death before us and claimed victory over it, a Christian need not view death as the ultimate enemy. Death cannot separate us from the love of God. Yet it is especially crucial at the time of transition from this life to the next that we humble ourselves to God's purposes. We cannot manipulate death, nor can we in any way tolerate the hastening of death - even for those committed Christians who may welcome death as the "doorway to heaven."

Fourth, the Christian message of hope in the midst of suffering leads us to assert that our concern is not whether disabled or terminally ill persons can die with dignity but whether they can live in the face of suffering.

When responding to the desire for easy access to death, we should point out that granting that desire will make it increasingly difficult for disabled or diseased persons to live with dignity. If deaths are readily hastened in our society then we will see disabled persons forced to "choose" early death rather than a fuller life. The pressure to reduce medical budgets may result in medical resources and attention being diverted away from palliative care and attempts to alleviate the suffering of disabled or dying persons.

Fifth, our compassion for those who suffer must be heard by those who find their lives to be so meaningless that they would rather die than live. Furthermore, we must be prepared to offer more than words in response to those who say that they have no hope in life and that they wish to die.

If we truly reflect Christ in our lives, then we will also take action to show that God suffers with the suffering and offers hope to those who despair. We must equip ourselves to minister to the disabled, the elderly and terminally ill both in informal ways and in more structured ways, especially as opportunities arise for participation in hospice care and other means of palliative care.

The Complexities of the Euthanasia Debate

The case studies presented in this part of our discussion paper illustrate several different contexts in which the euthanasia debate occurs. This discussion of euthanasia will take into consideration the issues of refusal of medical treatment, living wills, involuntary euthanasia and assisted suicide.

We acknowledge that real-life situations are always more difficult to determine than textbook case studies suggest. This underscores the need for the Christian community to develop an ethic concerning death and dying that can be truly useful to those who face real and very difficult decisions.

Refusal of Treatment
Nancy is suffering from a disease that makes her lungs unable to function on their own. She is therefore confined to a respirator that causes her lungs to breathe. She can live indefinitely on this machine but will die if it is turned off. The disease has not affected her mind and she is aware of all that is happening to her. She is a young woman who does not want to live like this indefinitely. Nancy therefore requests that the respirator be turned off and that she be permitted to die naturally.

In Canada, medical treatment cannot be given without the

consent of the individual. In law, medical treatment without the informed consent of the individual is regarded as an infringement on the person. Thus, a competent adult can refuse consent and no medical treatment can then be given. If an individual is too young or not competent to give consent, someone else, usually a family member, can consent on his or her behalf.

However, *Criminal Code* of Canada, section 14 states:

> No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.

Thus, there seems to be a conflict in the law in cases where medical treatment is required to keep a person alive. In a recent case of Nancy B., the Quebec Superior Court considered this conflict.

Nancy suffered from a condition that required her to be on life support systems indefinitely. She requested that the life support systems be removed. Her health care providers refused to turn off life support systems because they thought it might be a criminal offence and a breach of their professional and ethical guidelines. Nancy therefore applied to the courts to have the life support systems removed. The Court allowed the application and Nancy chose to end her treatment, which resulted in her death. The Court said that a person has the right to refuse medical treatment, even if it is life-sustaining.

Other people who had the same condition as Nancy B. felt very threatened by the court's decision. The choice of whether to continue treatment is not one they necessarily wish to be expected to make. Nancy received many letters and telegrams from fellow sufferers urging her to continue treatment because they believed that life has meaning despite severe disability.

Some commentators would say that this is passive euthanasia or euthanasia by omission since life-giving treatment is withdrawn. However, the distinction can be made that this is not killing but choosing to refuse treatment that is burdensome or medically useless and then accepting the consequences, even death.

Every person who has faced a medical procedure has had to weigh the benefits of the treatment against its possible negative effects, and then decide whether to proceed. Most medical procedures are potentially beneficial, but many are also burdensome.

The law allows the medical profession to override lack of consent in certain circumstances. One instance is attempted suicide. The medical profession assumes that a suicide attempt indicates a need for treatment. A person who takes an overdose of sleeping pills will be rushed to the hospital and will later be required to undergo psychological therapy or counselling.

The medical profession often overrides lack of consent or request in an accident situation. Many serious burn victims, for example, beg the doctors treating them to let them die because they are in severe pain, and feel that they do not want to live if they are disfigured. This is considered to be part of the emergency condition and many survivors are happy to be alive when they recover. This is not always the case, however. Some persons who have permanent injuries, such as paraplegia or quadriplegia, are not pleased to be alive.

In the case of patients who are incompetent to give informed consent to treatment, there must always be a presumption in favour of life, since the preservation of life is a fundamental value of our society. However, there are cases where such a presumption on behalf of an incompetent person may be inappropriate. For example, an unconscious person who is a Jehovah's Witness who has signed a card directing that blood transfusions may not be given on account of religious objections ought to have this wish respected, even if death will result without the transfusion.

Living Wills

Frank Smith is a widower. He has a family history of strokes. In fact, he has already had one serious blood clot. He has also had heart problems in the past, and is on medication to control his blood pressure. His doctor has told him that without the medication, he is very likely to have heart failure. He decides to give his sister, Martha, Power of Attorney over his person which is to be kept in his lawyer's office until the lawyer and Martha together determine that Frank is no longer competent to give consent to medical treatment. Frank tells Martha that if he has a stroke and becomes incompetent, he wants her to stop the medication so that he will die quickly.

Seven years later, Frank has remarried. He has a stroke. He is sometimes lucid but often does not recognize people. He always recognizes his new wife but often does not remember Martha. The doctors have determined that Frank is not competent to consent to medical treatment. What should Martha do?

The trend in Canada is to allow the individual full autonomy in making health decisions regarding his or her body. This

includes provisions allowing a person to decide about who should consent to treatment if he or she becomes incompetent to give or withhold consent.

Currently, when a person is incapable of giving or withholding consent to medical treatment, the next of kin can give or withhold it. Although the next of kin are generally motivated by what they believe to be the best interests of the incapacitated person, there are times (if they are beneficiaries under a will, for example) when the best of intentions are clouded by self-interest. It is also difficult for the next of kin to know what a person would choose if they had the choice to live in a coma or die.

Some individuals give Power of Attorney to a trusted person, which gives that person legal power to give or withhold consent to treatment when the individual is no longer competent to do so. The trusted person would be given some instructions as to the kind of medical treatment the individual desires under certain circumstances. However, such instructions are not currently binding on the person holding Power of Attorney.

Some people are advocating living wills. A person who is fully competent would stipulate in the living will the treatments to which he or she would or would not consent in a future illness. Currently these documents are not legally binding, but legislation has been proposed in several jurisdictions to allow legally binding living wills. In Ontario, legislation has been passed that permits persons to express a "wish" regarding future treatment. This wish requires compliance by whoever is authorized to consent to treatment on behalf of that person, if incompetent.

While they may have some merit, the difficulty with living wills or written expressions of a "wish" with respect to treatment is that people make them when they are not in the circumstance. It is not easy to anticipate how one will respond to a future, unknown situation.

Another difficulty with predetermining treatment is in interpreting exactly what is meant by a certain written expression. Some people use expressions like "no heroics" or "do not resuscitate." How should these expressions be interpreted if the person is choking on a chicken bone? Or if a person is a traffic accident victim?

Involuntary Euthanasia

Ravi Haraj is 68 years old and has just been found to have advanced Hodgkins Lymphoma. He currently has no symptoms of this disease. This type of cancer has a majority cure rate with aggressive chemotherapy. Ravi's doctor sees Ravi as a lonely old man with nothing to live for. His wife died last year and he is estranged from his only child. The doctor decides that it would be pointless to keep Ravi alive so he tells him only that he has inoperable cancer. The doctor does not indicate that there is any treatment available, but tells Ravi that he likely has less than one year to live. Has the doctor committed euthanasia?

This case brings us to the issue of involuntary euthanasia. Questionable situations occurring in Canada do not always constitute involuntary euthanasia; they range along a continuum from individuals removing life support systems from someone in a coma to doctors over-medicating to hasten death, with no consent from either the patient or any family member.

Given various advances in medical treatment, doctors often find themselves in difficult circumstances where they in effect have enormous control over the life and death of a patient. Over-medication or under-medication or no medication at all can equally hasten death. (It should be noted, however, that where the intent of medication is to control pain, it is done to enhance life, not to hasten death, even though the medication prescribed sometimes has that effect.)

Recently, when a doctor in Timmins, Ontario, admitted to deliberately killing a patient with the family's consent, the doctor was only mildly disciplined. He faced no criminal charges, nor was his licence to practice removed. It is frightening to know that this occurs in Canada. Deliberate over- or under-medicating to hasten death is, in fact, active euthanasia and is a crime under the *Criminal Code*.

A clearer situation exists where a doctor prescribes pills that are in fact suicide pills, with instructions to the patient to take one "when the pain gets too bad." If the patient is not given proper pain control, the pain from certain diseases, such as cancer, will likely become unbearable.

Provision of food and water should not be considered medical treatment. In addition, one does not need to consent to be fed under the legal requirements of consent to treatment. Where people are not able to feed themselves, provision of food and someone to feed the person should not be considered medical treatment. Yet there have been instances where food has been withdrawn under the guise of "cessation of medical treatment."

Many people look to The Netherlands, where assisted suicide is legal when certain guidelines are followed. Recent legislation restricted instances in which doctors can administer

lethal injections or other medication to hasten death. However, shortly after this legislation was passed, the justice department in The Netherlands announced that it was again considering allowing involuntary euthanasia through doctor-prescribed medication.

With the aged population growing and the costs of palliative care increasing, medical professionals face increasing pressure to reduce costs. Doctors may feel pressure to reduce treatment for elderly patients or others whom they determine to have a low "quality of life." Where involuntary euthanasia is tolerated or legalized, disabled, elderly or terminally ill patients are at risk.

There are alternatives to both expensive hospital care and euthanasia for terminally ill or frail elderly individuals. Canada has just begun to explore hospice or at-home care for such persons. These alternatives may be both lower in cost and higher in comfort than present approaches.

The medical profession itself is under an ethical obligation to save life. The question "What is life?" continues to be asked, however, under circumstances where technology can keep a body alive almost indefinitely. Is a life to be preserved at all costs? The medical profession grapples with such issues on a regular basis. Other questions also arise, such as "Who is to make the determination that another's life is not worth living? On what basis can one decide quality of life or meaning in life?"

Assisted Suicide

Sue Rodriguez has been diagnosed with ALS, a debilitating terminal disease. She knows that her central nervous system will deteriorate, leaving her unable to use her arms and legs, and eventually unable to speak. She is in the process of separating from her husband but he returns to her when she receives her diagnosis.

She does not wish to burden him or the rest of her family when she becomes unable to care for herself. She believes that she would like to have assistance to commit suicide when she becomes totally disabled. She is shocked when she discovers that this is illegal. She launches a campaign to be permitted to do this. Jim Hofsess, director of the Right to Die Society, works with Ms. Rodriguez on a media, political and legal campaign. The case goes to court and is eventually appealed to the Supreme Court of Canada.

The current law on assisted suicide is found in the *Criminal Code*, section 241:

Everyone who

a) counsels a person to commit suicide, or

b) aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable for a term of imprisonment not exceeding fourteen years.

Submissions have been made to a federal committee requesting that assisted suicide be decriminalized.

Assisted suicide is not a new concept. Ms. Rodriguez sought immunity from criminal prosecution for her doctor to assist her in committing suicide when she chose to do so. While assisted suicide is facilitating, rather than perpetrating, another person's death, the prospect of physicians being asked to assist suicide contravenes the physicians' obligation not to do harm and to abide by the ancient prohibition against killing. Physicians have long been considered healers. What will a change in role from healers to assisters in death do to our perception of the medical profession?

Allowing assisted suicide would change the very nature of the medical profession. Those who are licensed to preserve life would then also be licensed to kill. Assisted suicide would put physicians in a God-like role in determining the validity of a patient's own assessment that his or her life is no longer worth living. If a patient came to a doctor and requested an assisted suicide, the doctor would have to determine if the person needed treatment for depression and suicidal thoughts or whether a lethal injection was in order.

Ms. Rodriguez brought a court challenge to the above legislation under the Canadian *Charter of Rights and Freedoms*, arguing that section 7, which guarantees the right to life, also includes a right to die. She also used section 15 of the *Charter*, which guarantees equal treatment and benefit of the law without discrimination, to further her case. Since it is not a criminal offence to commit suicide, she argued, it is discriminatory to disallow the benefit of a physician to those who are too disabled to commit suicide without assistance.

The Supreme Court of Canada, in a 5-4 split decision, ruled against granting Ms. Rodriguez's request. The majority of the judges affirmed that the prohibition against physician-assisted suicide is rooted in the interest of the state to protect and maintain respect for human life. They went on to say that in order to effectively protect life and those who are vulnerable in society, a prohibition without exception on the giving of assistance to commit suicide is the best approach. The laws prohibiting assisted suicide were found to be for the protection of the disabled.

Those who are asking for assisted suicide do not need help dying: they need help living. One can point to many people who have contributed much despite disability, pain or debilitating illness. Of course, it is small comfort to point out heroes to those who are having trouble dealing with disability and death. Nevertheless, the heroes show that the problem is not the disease or impending death but how one lives the days that one has left.

Many disabled people are justifiably fearful of this "right to die" that society is offering them. With increased financial pressure in our health care system, not to mention the burden on family and loved ones, it is easy to imagine the pressure that some will feel to request assistance with suicide.

How terrible, to suffer from a debilitating disease and feel that one's family, neighbours, and doctor are questioning why one does not just choose to die. One can believe that in hard economic times physicians might be more inclined to encourage their disabled patients to simply make this "choice." A moment of depression might lead to the end of life.

Others question the limits of the "right to die." Would it be limited to terminally ill people? Would it allow anyone to end their lives to end "suffering"? A general "right to die" would allow anyone who is temporarily depressed to demand suicide by lethal injection from a doctor. The implications of this are frightening. Such a decision would generate many unanswered questions and leave many people at risk.

A Christian Response

The case studies discussed above illustrate the complexities of the euthanasia debate, as well as the importance of approaching each case on the basis of clearly articulated principles. We cannot presume to answer all of the questions raised in the previous section. Rather, we must apply Biblical principles to each case in which some would argue that euthanasia provides the best response to pain or suffering.

We must support Christian physicians and ethicists who struggle with the complexities of medical treatment in our society. What is needed is an "ethic" for healers, rather than a series of laws or rules for dealing with every medical issue. Laws and rules cannot be made fast enough or comprehensively enough to cover all circumstances.

An ethic on the other hand can, for example, establish helpful answers to questions surrounding comatose patients, such as: Which people are most likely to faithfully represent the patient's view? What outcome would be desirable? What outcome would be undesirable? How much should the next-of-kin's view be respected, in relation to the doctor's view? How one comes to a decision in such cases often shapes the type and quality of that decision, especially when the situation is complex.

We must also continue to develop our Christian understanding of suffering. The scriptures indicate that suffering is a normal part of life and that, at the same time, God's compassion (that is, "suffering with") is always at work to benefit those who suffer. We know that in some circumstances suffering has had a redeeming effect. It would therefore be sin to terminate a life which God redeems through suffering.

We must be willing to recognize that there is a point at which life need not be artificially prolonged. We should not argue for life at all costs and in all circumstances. The distinction may seem blurred when life-support systems are required to keep a person alive. The courts have said that people have a right to refuse these life-support systems. Even so, we should urge that counselling be given when a patient desires the withdrawal of medical treatment.

As indicated earlier, advances in palliative and hospice care offer viable alternatives to the depersonalization of hospital care. Wherever possible we should support efforts in this area and be ready to offer our own services to meet the needs of those who require palliative care, rather than simply opposing euthanasia.

When we are called to offer a political response to euthanasia we must begin by speaking against any law that legitimates suicide. Suicide was decriminalized because the government felt that it was not appropriate to punish those who were so troubled that they would attempt suicide. This did not mean that suicide was an acceptable response to such troubles. Thus, we should advocate that counselling someone to commit suicide or assisting suicide should continue to be crimes in Canada.

We must work to protect the vulnerable. How can anyone determine when a person's "quality of life" is so negligible that it is permissible to terminate their life? Everyone should be treated equally with respect to access to treatment and counselling. The law is opposed to discrimination; we cannot acquiesce to discrimination in the cases of terminally ill or disabled people. Nor can we support withdrawal of food and water to hasten death. A person may legally refuse medical treatment and even intravenous feeding, but where a person is able to receive these benefits and has not refused them, they should be provided.

In all we do we must act in ways that bring Christ's compassion and healing into the lives of suffering people. We cannot proclaim the truth of God's law without bringing Christ's compassion and love in a real way. We should be concerned when people feel that their lives are so meaningless that they would rather die than live. As Christians, we have a message of hope and compassion. There is room for fruitful ministry among the disabled and the terminally ill.

Conclusion

The presence of a movement to legalize euthanasia in Canada is symptomatic of the general tendency in our society to devalue human life. When God is no longer recognized as the source of life, then the measure of a life's worth will be narrowed down to uncertain, utilitarian terms. When God is no longer recognized as sovereign in the course of our living and dying, human beings are likely to claim their "right " to die.

On the other hand, when God is acknowledged as Life-giver, then all human life is recognized to have inherent worth and dignity. When God is acknowledged as sovereign in all matters of life and death, then life and death will be treated with great care and humility.

As Christ's agents in a world that often demonstrates extreme hopelessness we can approach human suffering with calls for life with dignity rather than easier access to death. As the euthanasia debate unfolds we must continue to witness to life, not death.