Care in Dying

A Consideration of the Practices of Euthanasia and Physician Assisted Suicide

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Task Group of the Faith, Worship and Ministry Committee
Anglican Church of Canada

Task Group Members Who Drafted This Report
Dr. Arthur Kristofferson, (Chair)
The Rt. Rev. Victoria Matthews
Mary Rowell
Alison Williams
Rev. Eric Beresford (Staff)

For further information, contact Rev. Eric B. Beresford,
Anglican Church of Canada, 600 Jarvis St., Toronto, ON M4Y 2J6
Tel: (416) 924-9199 Fax: (416) 924-0211
eberesford@national.anglican.ca

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Christian thought through the ages has been guided by the principle that human persons are made in the image and likeness of God (Genesis 1:26-27) and our life is to be seen as a gift entrusted to us by God. Life is thus seen as something larger than any individual persons "ownership" of it, and is not simply ours to discard.

In Romans 14.7 St. Paul says that we do not live to ourselves and we do not die to ourselves. We are members of Christ's body, each member being an integral part of that body. While we recognize there is a diversity of opinion, both within the church and in society at large, this vision of human dignity and community gives rise to some profound misgivings with current proposals to legalize euthanasia in the form of physician assisted suicide.

The Anglican Church of Canada shares with other Christian communities in a long history of providing many forms of health care, healing and support of the suffering and dying. Churches have actively supported the development of palliative care facilities and practices, including pain management. This is expressed in the central role they have played in the development of hospices and palliative care institutions in many parts of the world. These programs attempt to alleviate pain and maintain dignity of life even at the moment of death. Christians are called by God to take part in caring communities which make God's love real for those who are suffering or facing death. It is through these communities that we bear witness to the possibility that human life can have dignity and meaning even in the context of the realities of pain suffering and death.

We believe we share with other members of society, on both sides of this issue, a concern for the protection of human persons and respect for their dignity and life. However, there is evidence that euthanasia is likely to have a different impact on different parts of society. We are concerned about the impact that making euthanasia available would have on the elderly and the disabled. We are also concerned that women may be more severely impacted than men. We would further urge that the attempt to change law and practice at a time when health services are being cut back and costs downloaded onto patients and their families is inappropriate. We believe that physician assisted suicide should only be discussed within the wider context of changes to the Canadian health care system.

In the light of these considerations we believe that respect for persons would not be well

served by a change in law and practice to enable a physician, family member, or any private citizen to take the life of another, or assist in their suicide. Both the request for assistance in committing suicide, and the provision of such assistance must be taken seriously as a failure of human community. The Christian response is always one of hope. From this hope there arises the commitment to give all members of society, especially the most vulnerable, the assurance that they will be supported in all circumstances of their lives, that they will not have dehumanizing medical interventions forced upon them, and that they will not be abandoned in their suffering.

Good medical practice sustains the commitment to care even when it is no longer possible to cure. Such care may involve the removal of therapies that are ineffective and / or intolerably burdensome, in favour of palliative measures. We do not support the idea that care can include an act or omission whose *primary* intention is to end a persons life. Our underlying commitment is that health care delivery as a whole should reflect the desire of Canadians to be a community that sustains the dignity and worth of all its members.

Care in Dying
Report of the Task Group on Assisted Suicide and Euthanasia

Introduction

Debates concerning the practices of euthanasia and physician assisted suicide have become commonplace in contemporary Canadian society. This trend has been underlined by several high profile cases. However, they are by no means unique to Canada. Significant debates concerning public policy regarding Euthanasia can be seen in USA, Britain, the Netherlands and Australia where the first law legalizing euthanasia was recently struck down by the courts. Although each of these debates has had an impact on the discussion here in Canada, such debates are common to industrialized nations with technologically advanced medical care systems, with their stress on large tertiary care centers for the treatment of critically ill patients. It will become clear in what follows that the debates in Canadian society are in part a product of the ambiguous benefits brought by advancing health care technologies. In part they reflect certain central values in our society that have fueled our pursuit of technological advancement. It is important to state at the outset that these values are to a large degree shared by advocates for both sides of the debate concerning the legalization of euthanasia and physician assisted suicide.

While advances in medicine mean that we can often save the life of critically ill patients, sometimes they serve only to prolong the dying of patients for whom little can be done to restore health. There is a widespread fear that such technologies may be used to subject us to an unnecessarily protracted death, or to a death surrounded by technology but isolated from the family and friends whose love and compassion can give comfort and support in our dying. The pursuit of such technologies was intended to reduce suffering and to increase personal choice. Yet it is these very values that seem to be affronted in some of the situations which result from the application of such technologies. It is precisely in order to enhance choice and to reduce suffering that people like Sue Rodriguez have sought to have the legal assistance of a physician in bringing about their death at the time of their own choosing.

The debates concerning euthanasia and physician assisted suicide have been intense and at times acrimonious. These debates take place inside the Churches as well as outside, and we cannot hope to resolve them in this short space. However, we do hope that we may be able to provide a framework in which those debates might be conducted with greater clarity and greater charity.

In order to achieve this end we will first offer some definitions, then offer an account of the Canadian context and of the events that have influenced it. Then we shall be ready to attempt a discussion of the issues which need to be raised in a theological discussion

intended to support decision making at the end of life.

Definitions

a) Brain Death and removal of "life support". While this is not an example of euthanasia, assisted suicide or the termination of treatment it is often confused with so called "passive euthanasia". The term brain death relates to the clinical criteria that were developed to determine that death had occurred in patients on life support systems that masked the occurrence of death if it was diagnosed according to the more traditional heart lung criteria. According to this definition death has occurred when the entire brain including the brain stem has irreversibly ceased to function. Since such patients are dead, the removal of "life support" cannot bring about death and such an action cannot be construed either as euthanasia or the removal of life support.

Termination of Treatment, refers to those situations where medical treatment is no longer indicated and all treatment except palliation (food, hydration, pain relief etc.) is withdrawn. Such a withdrawal of treatment is sometimes called passive euthanasia. However, it is better understood as an expression of the common law right of the patient or their legally appointed proxy to refuse treatment. The right of patients to refuse even life saving medical interventions was established in Canada in the case of Hopp v. Lepp (1980). Although there seem to be some ambiguities around the withdrawal of treatment the distinguishing mark of these cases lies in the question of intention. The intention is not to cause death, but rather to recognize that it can no longer be effectively resisted. The results intended by the provision of certain therapies can no longer be attained, so the treatment is deemed useless and withdrawn. In order to draw a sharp line between the withdrawal of treatment and provision of assistance in dying a number of thinkers have suggested that we understand death as resulting from the underlying disease that to which no further resistance is offered, rather than as a result of withdrawing therapies per se.

> Following the report of the task group established in the Episcopal diocese of Washington (*The Washington Report*), we agree that it is confusing and unhelpful to refer to such withdrawal of treatment as passive euthanasia. Death, when it occurs, is not intended and it is not the result of any act or omission of an act, but rather of the disease process itself. In fact, when life support is removed the patient may not die, as in the case of Karen Quinlan who lived for ten years following the removal of the ventilator that was believed to be keeping her alive.

The Washington document adds a further interesting illustration.

Consider a case in which a man slowly poisons his wife over a period of several years and she ends up an intensive care unit in hopeless condition. When the physician removes the respirator (sic) with permission from an appropriate surrogate, the physician does not kill the woman.

Yet without the distinction we are making between letting die and killing the implication

would be that the doctor had indeed ended the woman's life by his decision not to act, effectively absolving the husband of the most serious, and surely justified charge of murder.

In addition to the observations made by the Washington committee there is the additional consideration that there are some circumstances that appear to be quite different where the intention to end life is accomplished by the omission of an act. We would therefore suggest that the term, Passive Euthanasia be reserved for such circumstances.

Passive Euthanasia: Given the above definition passive euthanasia where the intention is to allow the patient to die. Perhaps the best example of this would be the decision not to treat duodenal atrasia in a Down's Infant. Such infants are often born with a blockage of the digestive tract. This blockage is easily correctable and does not result in a lower quality of life than that which might be expected for a Down's patient. However, in some centers such patients were not treated because it was decided that their quality of life was too low to justify treatment. In such cases we are not dealing with the recognition that death cannot be effectively resisted, nor are we dealing with a situation where treatment has been declined by a competent adult. Instead, we are dealing with a situation in which death is sought by a decision not to act to effectively correct the condition that, untreated, will result in death.

Physician Assisted Suicide, refers to the provision by a physician of the means by which a patient ends his or her own life, or the provision of information which a patient may use to obtain effective means to end their own life.

Euthanasia differs from physician assisted suicide in that the physician does not merely advise or provide the means for suicide but intervenes directly to bring about the death of the patient. Thus, the provision of sufficient barbiturates for suicide to a patient who is known to intend to use them for that purpose is a physician assisted suicide. To inject a patient with a lethal dose of morphine at their request would constitute active euthanasia.

At this point we might also distinguish three types of euthanasia which differ in the relationship of the act to the will of the patient. In *Voluntary Euthanasia* the act is carried out according to the wishes of an informed and competent patient who without coercion requests that his or her life be ended. *Involuntary Euthanasia* takes place when a person who is competent to consent but has not requested euthanasia is killed. It would include cases where consent is not sought because it is not deemed relevant, and situations where euthanasia is carried out because a care giver or family member is moved by the suffering of a patient and acts to alleviate pain and suffering without seeking or obtaining permission. By contrast, *nonvoluntary euthanasia* refers to a situation in which the patient does not have the capacity to consent either through age, the patient is too young to consent, unconsciousness, mental illness or incompetence. Examples of such nonvoluntary euthanasia might include appeal to substituted consent, where the consent of a parent, guardian or legal proxy is obtained prior to euthanasia but where there was no supporting evidence of the wishes of the patient. It might also include situations where consent is presumed. In this case it is argued that there are reasons for believing that the patient would have consented had they been able to do so.

The Canadian Situation

In 1976 the Law Reform Commission undertook an extensive study in this area and in 1986 finally tabled its recommendations. Despite the strong recommendation that there be greater clarity in this area the Canadian situation remains very confused. Active Euthanasia whether voluntary or involuntary, and Physician Assisted Suicide remain clearly illegal, although there is considerable pressure from right to die groups to change this. The distinction between passive euthanasia and withdrawal of treatment continues to be legally problematic. The usual situation is that an omission or failure to do something is not subject to legal sanction unless there is a breach of a prior duty of care. In Canada such a presumed duty of care exists in the requirement that those who provide health care services use reasonable knowledge, skill and care in doing so. Normally this would mean that those who provide treatment would be required to continue to do so if a failure to continue would be dangerous to life. However, legal commentators are divided on how rigorous this duty is.

In 1991 Chris Axworthy introduced a private members bill to the House of commons that would have legalized both active euthanasia and physician assisted suicide. The bill failed. Another bill (c-203), introduced by Robert Wenman, which would have protected doctors who administered palliative measures intended to provide comfort and relieve pain even where "such measures will or are likely to shorten the life expectancy of the person," would have provided some legal clarity around palliation and withdrawal of treatment issues but died in committee. Shortly before the last General Election, the Liberal Government promised an open debate and free vote on the issue in the House. It seems likely that some version of either the Wenman bill or the Chris Axworthy bill will be reintroduced to allow this to happen.

In all of this, despite internal debates, the Canadian Medical Association (CMA) has consistently opposed any move to allow physicians to administer euthanasia or assist at suicides. However, other public groups have taken quite different positions and there is a perception that the laws prohibiting euthanasia are maintained against strong public pressure to change the current legal climate. A recent Gallup pole of 1029 adult Canadians 70% of respondents indicated that they thought a physician ought to be allowed to end the life of a terminally ill patient whose disease causes great suffering. This represents an increase of 2% since 1986. However, it is not clear that this figure is as solid as it appears. It does seem to be based in part on widespread public fears concerning situations that are in fact rather less common than is often realized. Further, the support seems to be linked to misunderstandings about what constitutes euthanasia, and also concerning what actions are already legal in Canada. Many people are more concerned to preserve a right not to have treatment they do not want forced upon them. They are also concerned to ensure that unwanted treatments can be removed, even if a consequence of this is the death of the patient.

There also seems to be a gap between what people say they would want to happen to them in a medical emergency and what they and their family request when the time comes. Studies have repeatedly shown that patients projected desires are quite different than their actual desires when faced with serious illness.

Further evidence for how fluid public opinion might be in this area is suggested by recent experiences in the United States where propositions were placed on the ballot in California, Washington, and Oregon. Despite the fact that in all three states the propositions appeared to have a wide margin of support up to the date of the vote the propositions failed by substantial Margins in California and Washington and in Oregon, which had the most restrictive proposition on the ballot, the measure was passed only by a very slim majority. Returning to the Canadian context, it needs to be remembered that the support in the Gallup poll figures was based on *voluntary* euthanasia and an equal number of people rejected the possibility of involuntary euthanasia. This raises a number of problems that could affect the development of public opinion because, as we shall show, the gap between voluntary and involuntary euthanasia has already been blurred in the context of the North American discussion. It appears that the gap is regularly crossed in the Dutch context according to the figures provided by the Remmelink report.

In Canada a number of cases are relevant to our understanding of the current situation. In the case known as Nancy B. A woman from Quebec City went to court to have the ventilator that was keeping her alive removed. Her success in court was widely viewed as a victory for the pro-euthanasia position but it seems better to understand this judgment as an extension of the patients right of self determination, established in Hopp. v. Lepp, to include the refusal even of life saving therapy. The intention of the physicians in removing the ventilator was not the death of the patient but rather compliance with the wishes of the patient. This case was therefore argued in terms of the termination of treatment rather than passive euthanasia. The treatment was not going to lead to any improvement in the patient's condition or any change in the underlying disease. The patient wished to have the right to refuse treatment that did not bring about an acceptable resolution of her problems even if that meant accepting the inevitability of death as a result of her underlying condition.

The most high profile case in the Canadian context was that of Sue Rodriguez, a Vancouver woman who suffered from amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease) who sought to overturn those sections of the Criminal code that would prevent her from legally seeking the assistance of a physician in ending her life. Her case came before the Supreme Court where it was turned down by a slim majority. The majority found that the state's interest in protecting the vulnerable and preserving the principle of the "sanctity of life" was sufficient to ensure that a blanket prohibition against assisted suicide was neither arbitrary nor unfair and that any resulting deprivation of autonomy could not be deemed contrary to the principles of fundamental justice. After the Supreme Court Decision, Sue Rodriguez died at her home in Vancouver with the assistance of a physician who has never been charged and in the presence of the MP Svend Robinson who had supported her campaign.

Tracy Latimer was the daughter of a Saskatchewan farmer. Born with Cerebral Palsy, Tracy needed constant care and was apparently in great pain. Although doctors had decided to try a new procedure to alleviate Tracy's condition, her Father decided that she had suffered to long and took her life by Carbon Monoxide poisoning. The public reaction to the trial suggested a great deal of support for what he had done. At the very least many people expressed the view

that it was unjust that Latimer could only be tried for first degree murder with its mandatory 10 year sentence. Despite this public support the juries in both the original trial and in the retrial turned verdicts of guilty, although in the latter case the jury requested that the judge return a sentence below the minimum 10 years, a request that brought a storm of protest from groups representing the disabled who intervened in both the Latimer and Rodriguez cases.

One question that is raised quite sharply by the Latimer case concerns whose suffering is at stake. Clearly, Robert Latimer believes that he was acting in good faith and in a compassionate manner towards his daughter. While no member of the task group wished to question Mr. Latimer's intent we are driven to question whether his own suffering with and for Tracy does not put him in a situation where the capacity for self awareness would be severely strained for most people. It is difficult to see how one would know the degree to which one acts to end the child's pain and the degree to which the need to end ones own pain clouds this decision.

The Dutch Experience

Given the necessarily clandestine nature of euthanasia and assisted suicide in most jurisdictions it is very difficult to assess how widespread such a practice is, or to assess the manner in which it is practiced. The popular wisdom in Canada suggests that it takes place rather frequently here, but if we are careful to work with the distinctions outlined above the best available evidence suggests that what occurs frequently is the termination of treatment or what is called passive euthanasia. There is little evidence for widespread clandestine active euthanasia in Canada at this time.

The consequences of legalizing euthanasia in Canada are difficult to foresee with any degree of certainty. However, there is one context from which insights into how euthanasia could work as a publicly approved practice might be gained and that is the Dutch experience. However, even here, the significance of the Dutch experiment is subject to a wide variety of interpretations. Further, the social contexts of Canada and the Netherlands are quite different in a number of ways. The lessons of the Netherlands, whatever they are, may not be applicable in a simple way.

Although medical associations in other parts of the industrialized world have expressed their unhappiness at the participation of the Dutch Medical Association in drawing up and administering guidelines under which physician assisted suicide and active voluntary euthanasia are practiced in the Netherlands, the Dutch Medical Association has rebuffed charges of abuse of the legal agreements under which physicians participating in euthanasia and assisted suicide would be protected from prosecution.

Under the Dutch model a physician may assist in the euthanasia of a terminally ill patient who is experiencing unbearable pain and suffering after a process of counseling and consultation that must involve at least one other physician. While euthanasia remains technically illegal, physicians who act within the guidelines as drawn up by the Dutch Medical Association and Dutch Bar Association will not be prosecuted. To assess the situation a careful reporting of all cases of euthanasia is required and the manner in which euthanasia is practiced and reported is monitored by the Dutch Government whose results are published in

the two Remmelink Reports.
As a result of these reports several disturbing facts have come to light. In the first place Remmelink claimed that there was significant under-reporting of cases of euthanasia. The second Remmelink report found that even after the provision of a policy under which euthanasia might be practiced only 59% of doctors thought the requirement of a written report in cases of euthanasia was important and claims that around two thirds of physicians surveyed had issued death certificates stating that euthanasia deaths were from "natural causes." Given these realities, the number of cases of euthanasia is difficult to judge reliably. However, the Remmelink report's own figures, which are generally viewed as conservative, estimate 2300 deaths per year due to euthanasia and 400 cases of physician assisted suicide out of a population of 14 million. More disturbing is the report of approximately 1000 deaths per year from active involuntary euthanasia. The report concedes that in about 14% of these cases the patient was fully competent to make a decision but was not consulted. Recently there has been increased pressure to support the official sanction of non-voluntary euthanasia in the case of minors or non-competent adults on the grounds of compassion for persons who are not competent to make decisions concerning their treatment but who are in unbearable pain and suffering or whose quality of life is sufficiently low that it might appear to be in their best interests. One might note that these figures suggest that euthanasia is no longer an exceptional practice in the Netherlands. They also indicate a slide between voluntary and non-voluntary euthanasia that raises the question as to whether legal sanction of only voluntary euthanasia is a stable and sustainable position. In addition, it is important to note that the boundary between voluntary and non voluntary is made rather less clear by appeal to "substituted judgment". This is a situation where consent could not be obtained from the patient but is sought from the patient's guardian or a family member who can give assistance, preferably on the basis of earlier conversations, as to the patient's likely wishes.
Despite these concerns there appears to have been an increase in requests for euthanasia in the period from 1990 to 1995, Further, despite the reports of fear amongst some elderly persons concerned that they not be euthanized against their will, there appears to be marked shift of Dutch public opinion in support of voluntary active euthanasia.

Euthanasia: an Issue for the Churches?
There is a good reason to raise the question as to why euthanasia should be an issue to which the church should address itself. After all, there is a broad spectrum of opinion within the church as outside it, so we can hardly speak definitively or with one mind on the subject. Nonetheless, through its pastoral ministry and in the lives of church members Anglicans are facing the questions raised by public debates on euthanasia on a regular basis. In 1990 Doctrine and Worship was asked to formulate a theological statement on Euthanasia. A draft statement was produced by a working group in 1995 (Appendix A) but this statement was orphaned as a result of the reorganization that took place at General Synod that year. In fall of 1996 Faith Worship and Ministry were approached by the CCC. They asked whether a draft statement prepared by their Faith and Order Committee (Appendix B) was consonant with the policy of the Anglican Church of

Canada. We were unable to confirm that the statement was consonant with our policy because, at this time, we have no policy. We did make some suggestions as to ways in which the CCC statement could be clarified and strengthened, and committed ourselves to work further on this issue. As a result of this process we discovered that several of our partner churches were in the process of policy development. In the meantime, the Evangelical Lutheran Church in Canada (ELCIC) issued guidelines at its National Convention in Toronto in July of 1997.

Further, the conversation in the committee suggested that although there were clear differences of perspective there were some common concerns. While we recognized the need to think carefully about the status of any statement, the committee came to believe a statement whose primary intention was pastoral would be valuable. It is our view that the intention of the statement should not be to seek to dictate policy to lawmakers, but to raise issues which might be of concern to many Anglicans and other people of good will on both sides of the debate. We seek to provide pastoral guidance and support to those Anglicans who find themselves having to make response to requests for the termination of treatment, assistance in suicide or euthanasia.

In what follows we are attempting to summarize the theological and ethical issues that need to be considered in this area. It is our view that this needs to be done in a balanced and fair manner that reflects the range of issues and perspectives that shape the responses of Anglicans. The fact that we do not find some arguments compelling does not mean that they have no moral weight. We believe that it is important to remember what unites even those who profoundly disagree on what would constitute appropriate practice in this area. In the end many of our disagreements are rooted in our shared perception that the situations in which euthanasia is requested are almost always both complex and tragic.

[Both] Christians who accept and those who reject assisted suicide and euthanasia share certain convictions. Both have a sense of the sovereignty of God; both want to protect human dignity and individual freedom to choose how to confront human finitude and death; both view life as a good in relationship to the broader purposes of life; both recognize that human life, especially in situations of death and dying, can confront us with conflict between physical life and other purposes or goods of life; both feel compassion toward those who suffer at the end of life. Moreover, both recognize that Christian principles of social justice call us to remedy a public policy that provides inadequate social support to the poor and very sick, as well as to those who are better off financially, yet lack medical and social resources during illness.

Theological Issues

The Christian tradition has a long history of condemning suicide and euthanasia. For many this tradition has been fundamentally challenged by changes in our social, and medical contexts which are simply not anticipated in earlier approaches to the problems raised. The traditional position is further undermined by changes in Christian attitudes to suicide. To assess this claim we need some sense of the tradition and its sources beginning in the biblical materials and their appropriation by the tradition.

Biblical Views of Suicide

Clearly the bible does not address euthanasia or assisted suicide as it is understood and practiced in our context. The two examples of what might be called assisted suicide in the bible are both in the context of war and reflect that militaristic context. In addition to these narratives there are several discussions of suicide. It will be instructive to look at these and examine how they have shaped Christian reflection particularly in the light of recent changes away from the condemnation of those who committed suicide.

Although the moral status suicide is never the topic of any direct discussion in scripture where it is mentioned it is in accounts of lives whose actions have brought them to this final act of despair or who were attempting to avoid shame and dishonour. In 2 Samuel 17:23 Ahithophel a former advisor of King David who defects to the camp of his son Absalom hangs himself when Absalom chooses to follow the advice of Hushai, a prophet planted among his advisors by his father David with disastrous consequences. The report of the task group in the Episcopal diocese of Newark (*The Newark* Report), sees this narrative as "a panicked response of self protection," (p.14) but it seems likely that part of the issue for the redactor at least is the failure of a rebellion against God's anointed in the person of David.

In 1 Kings 16:18-19 we read how Zimri set a house on fire over his head, burning himself to death when he was about to be captured. Once again Zimri had killed the rightful heir to the throne which he had usurped. The narrative in its present form implies that Zimri's end is the inevitable consequence of his rebellion against God's anointed rulers.

In Matthew 27:3-5 We read of Judas' suicide after the betrayal of Jesus. Once again he has raised his hand against one who embodies God's purposes and the suicide finalizes the divine judgment on Judas who is excluded from any possibility of redemption and reconciliation. By contrast, in Acts 16:27-28 we find Paul preventing his jailer from committing suicide when it appears that he has lost the prisoners he is responsible for.

Two examples of assisted suicide are found in the Hebrew Scriptures. In Judges 9:50-66, Abimelech is mortally wounded in battle and orders his armour bearer to kill him to save him from public disgrace. But it is interpreted as a judgment against Abimelech for the murder of his brothers. In 1 Samuel 31:4-5, Saul asks his armour bearer to kill him, but the armour bearer is afraid to kill God's anointed so Saul falls on his own sword. Seeing this the armour bearer also commits suicide. While there is no specific condemnation in the passage the narrative context makes it clear that the reader is intended to see this as the inevitable consequence of the instability of Saul, his unfaithfulness to the divine call and the consequent withdrawal of the divine Charisma (1 Chronicles 10:13) . Further, when the story is taken up again in 2 Samuel it appears that Saul had not died from his self inflicted wound. He asks help of an Amalekite who delivers the death blow. When David hears this story he orders the death of the Amalekite because he, "killed the Lord's anointed." 2 Samuel 1:16.

The condemnation of suicide that runs through these passages seems to be linked less to the rather later notion of the sanctity of life and rather more to the horror of the spilling of blood which we see reflected in the story of Cain and Abel. It is also important to note that all of the stories relate to suicide done to avoid the consequences including

shame arising from wrongdoing. This is surely quite different from the suicide that is done as a result not of some moral or religious failing but as a result of extreme illness and pain. It is important therefore to turn our attention to what might be learned from the scriptures about our response to these realities.

The Bible and Human Suffering

This is not the point to enter into an extended discussion of biblical attitudes to pain and suffering. This is a complex issue that would take us well beyond the purposes of this report. However, it is important to briefly examine some of the ways biblical materials on suffering have been appealed to in the context of the euthanasia debate.

To begin with, it is important to point once again to a shared value. Participants on both sides of the debate concerning euthanasia and assisted suicide have reacted against attempts to valorize suffering as a good to be embraced for its own sake. To adopt such a position would make nonsense of the church's long-standing commitment to care for the sick and support of the process of healing and would undermine any credible theological assessment of the significance of the healing miracles of Jesus. Nonetheless there is a long history of drawing a connection between faith and human suffering that has its roots in the crucifixion narratives themselves and in the formative experiences of the early Christian community shaped, as it was, by persecutions that demanded that Christians articulate how faithfulness to the gospel could result in suffering and even death for God's beloved. How could faithfulness result in what was experienced as abandonment by God. From this comes the suggestion that the suffering that arises from faithful proclamation to the gospel is not a shame to be avoided but a blessing to be embraced.

"...we even exult in our present sufferings, because we know that suffering is a source of endurance, endurance of approval, and approval of hope. Such hope is no fantasy; through the holy spirit He has given us, God's love has flooded our hearts. Romans 5:3-5, c.f. 1 Peter 1:6-7, James 1:2-4

Repeated through these themes in the New Testament is an endorsement of the claim that suffering for the sake of the gospel is a virtue and that from it flows an abundance of grace to those who experience such suffering. However, as the Newark report points out, such endorsements are in the context of suffering *for the sake of the Gospel*. Such passages should not be taken as referring to suffering in general but to that suffering that arises directly from the profession of our faith and therefore participates in the redemptive suffering of Jesus himself (c.f. Hebrews 2:10-11). The Newark report concludes.

Unless an individual somehow understands suffering due to serious illness as a direct consequence of one's faithful response to the Gospel, endurance of such suffering cannot be seen as a mandate, either moral or theological on the basis of the scriptural witness. It is not a moral failing to view such suffering as devoid of purpose, and thus without redemptive value.

On this view euthanasia and assisted suicide might be seen as a means to alleviate non-redemptive pain and suffering for those who can get no medical relief and who do not choose to endure their suffering. Others will find this position insufficiently nuanced.

While it is true that we should be wary of imposing theological and moral mandates on those who suffer we need to acknowledge that some pain and suffering is a part of the human condition and is as such inevitable. Faith in God's love and goodness will not wholly eliminate the sense of isolation and loss that suffering brings. Grief, doubt, anger and fear are normal and appropriate human responses to such situations which call for pastoral support and care. But the question that scripture poses is not whether we should suffer but how. Suffering is a part of the human condition and to some degree it is inescapable. It is simply not true that meaningful suffering in the biblical materials, or even in the Pauline writings, is only suffering for the gospel. Any suffering may remind us of our limits and give us a clearer perspective on the meaning of our lives. Suffering need not be "for the gospel" to refine our faith and prevent it from collapsing into hubris, or to help produce perseverance and character. Part of the practice of Christian faith involves attempting to discern the signs of God's presence in the most unlikely of circumstances. This is not the task of individuals, but of the community, and it is a reminder to us of the central role of the community in supporting and caring for those who suffer that, through us, they might continue to know and experience the presence and love of God, and also that we through them may gain further insights into the depth and universal reach of the love of God. If Paul affirms that nothing can separate us from the love of God then even suffering that is not redemptive can be a place where we encounter the presence of God, and even suffering that is devoid of purpose need not be allowed to compromise the meaningfulness of our lives. Thus Paul is not apparently speaking of suffering "for the gospel" when he speaks of the thorn in the flesh from which he was to learn so much. Clearly, Paul sought release from this suffering, but in the absence of release he sought to discern the possibility of grace.

Three times I begged the Lord to rid me of [this suffering], but his answer was: "My grace is all you need; power is most fully seen in weakness." 2 Cor.12:9

This is not a theological mandate that demands that people suffer, "virtuously and without release." There is no simple either / or that connects such suffering with euthanasia and assisted suicide as the only viable alternatives. We are called to relieve suffering, and we are called to accompany people in the process of their dying. This involves a commitment to develop and support palliative care. It may involve a commitment to support people in their resistance to interventions that are futile and unduly burdensome, and to exert pressure to ensure that viable alternatives for care and support in the process of dying are available, both to the individual who is critically ill, and their loved ones. However, the suggestion that a rejection of physician assisted suicide and euthanasia "enslaves people" to some theologically driven mandate to suffer is not compelling. This is especially clear when we raise the question of the liberties that would be lost, as well as gained, by the legalization of physician assisted suicide and euthanasia.

Appropriating the Biblical Materials: The Tradition

Clearly we have shown that the biblical material on suicide reflects a quite different context than that of illness and suffering. Nonetheless, both Judaism and Christianity expanded the area of concern to reject all suicide, including

assisted suicide and euthanasia. Thus, Moses Maimonides claimed that "He who kills a healthy person and he who kills a sick person who is dying anyway, even if he is almost dead, all are guilty of murder." Jewish reflection has been extremely committed to preserving life to the extent that several Halachic authorities condemn acts that result in even marginal reductions in the length of life. According to Rabbi Caro (1488-1575) "We are not permitted to close the eyes of a person who is near death, lest we cut off even a fraction of life."

Amongst Christian thinkers we find Augustine in the *City of God* arguing that suicide is a cowardly way of escaping the pain and suffering of this life. Aquinas too objects to suicide which is prohibited on the grounds that it violates our natural self love and urge to self preservation, it offends the human community of which each individual is a part, and it offends God who offers life as a gift which must not be so disrespectfully abandoned. In both cases it might be suggested that their arguments reflect philosophical presuppositions current in the surrounding culture as much as they reflect the results of any biblical hermeneutic.

Amongst Protestant thinkers, neither Luther nor Calvin approved of suicide or euthanasia as a means of responding to the suffering of illness despite their own very real health problems, and within classical Anglicanism, Jeremy Taylor argues in *The Rule and Exercise of Holy Dying* that death must be prepared for, yet he insists that we should not seek to cause our own death.

Yet despite the continuity that can be traced in this area there are some authors who seem to offer alternative positions. The two most well known are Thomas More's *Utopia* and the *Biathanatos* of John Donne. More, a Roman Catholic, appears to depict Utopia as a place in which suicide and euthanasia were encouraged for those who suffered from incurable diseases and continuous suffering. However, a number of scholars have drawn attention to the satirical elements in More's work and suggest that his position is in fact ironic. This claim is supported by the fact that as he awaited his own execution he argued against the option of taking ones own life in his, *A Dialogue of Comfort: Against Tribulation*. Similarly, scholars have pointed to the difficulties involved in interpreting the *Biathanatos* and have suggested that Donne cannot be taken to defend suicide in the sense in which it is used in the debate concerning euthanasia and assisted suicide.

In the modern period, however, this consensus has been severely challenged. Perhaps the most vocal Anglican proponent of euthanasia and assisted suicide in our era has been Joseph Fletcher, author of *Situation Ethics*. For Fletcher the one overriding moral principle arises from our commitment to a love which is to be responsive to the particular and situational threats to the dignity and well being of others. Faced with the debilitating realities of pain, suffering, and dependency in terminal illness, Fletcher argues that euthanasia may be the morally most appropriate way of affirming the dignity and worth of another and of preventing the dehumanizing realities of terminal illness from robbing a patient of what meaning and worth they have experienced in their lives. Fletcher is not alone: influential Anglicans who have similarly criticized the mainstream Christian position on these issues have included Hastings Rashdall and W. R. Inge. In the early 1930's Inge stated:

I confess that in this instance I cannot resist the arguments for a modification of the

traditional Christian law, which absolutely prohibits suicide in all circumstances. I do not think that we can assume that God willed the prolongation of torture for the benefit of the soul of the sufferer.

Inge's point is that our human dignity is assaulted not only by physical pain but also by the depersonalization associated with the experience of prolonged serious illness and the medical treatments used to combat it. Further, it is suggested Christian theology need not and should not support the needless and cruel extension of such suffering where no moral or theological purpose is served. This position continues to be a minority one within the literature. However, the tradition as we have sought to articulate it is going to need some reformulation if it is to respond cogently to the realities of contemporary medical practice. We shall therefore examine the arguments that are currently most often appealed to in discussions of the withdrawal of treatment, euthanasia and assisted suicide.

Withdrawal of Treatment

There is a long tradition in Christian theology which allows for the removal of therapies that are useless or unduly burdensome on the grounds that these therapies serve to prolong the process of dying rather than to save life. In Roman Catholic moral reflection this is clearly reflected in the encyclical *Divine Aflante Spiritu* of Pius XII, (1953) which distinguished between ordinary and extraordinary treatments. This distinction occurs again in Pius XII's well known addresses to the Italian Anaesthesiological society (1957), and in the Vatican declaration on Euthanasia (1980). It can be seen in practice in the Roman Catholic Church's intervention in the case of Karen Ann Quinlan where Bishop Joseph Casey supported the request to have the ventilator removed on the grounds that this constituted an extraordinary treatment which was both ineffective and unduly burdensome. This distinction has been taken up by a number of Anglican reports too who have maintained a distinction between killing and letting die. Thus *On Dying Well* claims that:

Euthanasia implies killing, and it is misleading to extend it to cover decisions not to preserve life by artificial means when it would be better for the patient to be allowed to die. Such decisions, coupled with determination to give the patient as good a death as possible, may be quite legitimate.

In addition, Anglican reports have consistently supported the use of palliation and pain relief, even where it is acknowledged that the means of pain relief may sometimes risk hastening death. In both of these instances the question of intention is crucial, for it is argued that in neither scenario is the intention to kill, rather the intention is to care while acknowledging that the process of disease and its conclusion in death have now become irresistible. To continue to oppose death under such circumstances is to lose sight of the reality of the patient whose life we are called to respect. Further, resistance of the inevitable processes of death and dying at all costs, far from being an expression of respect for the gift of

life, is in fact a hubristic assertion of human control over life. At this point what is needed is not the pursuit of life at all costs, but the pursuit of a community in which the dying person is cared for, receives adequate and appropriate pain relief and comfort care and the support which makes it clear that the patient is not abandoned in their dying.

More recently there has been considerable criticism of the distinction between killing and letting a patient die, both from philosophical and legal sources, and in theological reflection. It is suggested that since the conclusion of both euthanasia / assisted suicide and the withdrawal of therapy is the same, then there is no significant moral distinction to be made between the two. Others maintain that intention is important. Further, in the withdrawal of treatment doctors do not kill patients but simply remove the barriers that they have erected to the process of their dying. There is a distinction to be made between what we intend and the foreseeable consequences of our actions. A doctor who administers chemotherapy is not trying to produce the many unpleasant side effects he knows will take place.

There is a clear distinction between rendering someone unconscious at the risk of killing him and killing him in order to render him unconscious.

Still, even if we can and must distinguish between what we intend and the foreseeable side effects of our actions such side effects are not morally irrelevant. As Kenneth Kirk, a noted Anglican bishop and moral theologian pointed out, “We are responsible for the foreseen consequences of our actions...” The relation of intention to consequence is thus only one part of the picture. Perhaps a more telling question at this point might be to do with how our actions may be construed as examples of care. Whilst it is fairly obvious that palliation and pain relief are acts which show our continued care for a patient for whom we can offer no cure, killing is a much more ambiguous act. Certainly it relieves the pain of the patient, but there is also a sense in which it puts an end to our pain too, since it reduces the need to acknowledge our failure and incapacity to act. It offers us a way of acting decisively to end the suffering of the patient, a technique of resolving the situation that has arisen due to the limitations and final failure of medical technique. But some would suggest that it is at the cost of choosing moral abandonment rather than the more costly process of providing palliation, social, psychological and pastoral support to accompany the patient in the process of his or her dying.

Classical Arguments for and Against Euthanasia / Assisted Suicide

The classic arguments against assisted suicide and euthanasia have appealed to the language of gift and to the language of the sanctity of life.

Life as Gift

In terms of the metaphor of gift, our life is seen not to be our own, but as something which comes to us as a gift from God which may not be discarded at will. Life is a sacred trust over which we are to exercise responsible stewardship, but our oversight does not legitimately extend to the right to take life. Yet proponents of euthanasia have pointed out that there are already a number of exceptions to the rule against taking life. Life is taken in time of war and sometimes in the context of capital punishment. While many

Anglicans have rejected the latter, just war arguments are still frequently appealed to by Anglicans. Since there are already exceptions to the sixth commandment, it is suggested, that we should entertain the possibility that there are good reasons to extend the exception to those who kill to alleviate pain and suffering near death. It might also be argued that the notion of gift is surely about the possibility of offering our lives in service to God and others, about human life as bearing dignity because it bears the image of God's creative will and purpose. If these are thwarted by severe illness and intractable, unbearable pain then in what sense are we actually continuing to experience our lives as gift rather than as burden and obligation? However, the language of gift does suggest that Christians need to be very careful of the rhetoric of "my life is my own to dispose of as I wish..." Whatever we are to mean by autonomy this idea of property in the self would seem to undercut the Christian acknowledgment that my life is not my own.

Sanctity of Life

There is a long-standing Christian commitment to the "sanctity of life." We have already pointed out that this position cannot strictly claim roots within the scriptures, although it is clear that scripture sees human life as valuable and precious since human persons are made in the image and likeness of God. But is it life itself that is valuable, or the quality of life that makes possible faith and a life lived in imitation of Christ? Some commentators would distinguish sharply between mere biological life *zoë*, and life which carries those human qualities that we particularly cherish, *bios*. Unfortunately, the Greek etymology appealed to here will not really support this distinction which in any case appears to be rather unhelpfully dualistic.

Another consideration has been suggested by the Newark report. They urge that creation reveals to us the inevitability of some destruction of life. "Life can only be sustained at the expense of other life." Of course, the difficulty with this position is that it seems to valorize a rather biologistic neo-darwinian account of life viewed as a struggle in which the strong survive by destroying the weak. This approach seems to leave little room for a more balanced Christian account of the goodness of creation, and tends to read moral obligations off from a descriptive account of the nature of the world, and example of the so called naturalistic fallacy.

Suicide, Assisted Suicide and Euthanasia

What is clear however, is that the traditional Christian prohibition against suicide has softened. This is largely due to a recognition that the majority of those who attempt suicide are not fully responsible for their act. If a person who commits suicide is depressed or under such severe emotional, physical, personal or financial pressures that they can no longer react rationally then it seems unduly harsh to see suicide as a deliberate turning away from God. Pity and compassion seem to be more appropriate responses than judgment and punitive measures such as the refusal to bury a person who has committed suicide in consecrated ground. It would seem better to entrust such persons to the mercy of God and provide whatever pastoral support is needed to those bereaved.

Critics have raised the question of whether or not a continued rejection of euthanasia / assisted suicide is not incompatible with this new-found pastoral sensitivity. If we no longer condemn suicide why do we condemn assisted suicide? And if we do not condemn assisted suicide is euthanasia really morally different? The question that needs to be

raised is whether it really is the same thing to commit suicide under severe duress as it is to calmly and willingly assist another in taking their own life. Those who oppose euthanasia would argue that the role of others is to provide comfort, support and reasonable alternatives to suicide, and they would urge that in the vast majority of cases this is possible. Some would admit that there might be exceptional cases where the suffering was extremely severe, and all other options for providing relief had been exhausted. but these should be seen as exceptions not as the general rule.

The classical arguments in favour of euthanasia and assisted suicide have rested on the recognition of autonomy and the need for compassion.

Autonomy

While autonomy is not a uniquely Christian concept Christians have some very particular reasons for taking the claims of autonomy seriously. An essential element of the image of God that we bear lies in our capacity to be the authors of our own actions, to make free choices and thus take up our role as co-creators with God. Advocates of the acceptability of euthanasia would thus argue that we have a right to choose to end our lives when we can no longer serve God or others by remaining alive in great pain and suffering.

Opponents might respond that such an understanding of freedom is in some ways problematic. It assumes first that choice is a good in itself irrespective of the ends served by choice. Yet surely choice is a good insofar as it serves the goods of individual human dignity and mature moral community. Choice abstracted from the demands of moral maturity and just community may be a far less appealing value.

The usual account of autonomy also assumes that a person can be abstracted from their fear and pain, and from their anxiety about the implications of their illness for others in order to make a detached rational decision that they have fulfilled their purposes and can say choose to exit. In fact, the context of severe illness, brings severe burdens, physically, spiritually, emotionally, socially and often financially. Our understanding of freedom cannot simply be expressed in terms of freedom from all constraint because we never in fact experience such freedom. Nor can it be adequately expressed in terms of making any decision we wish. This would not be freedom but irrationality. Rational decisions would be consistent with our character, our experience, our central values, our relationships and our sense of our obligations to those to whom we are related and our previous decisions.

In addition opponents of the above account of autonomy might suggest that it conceives of our relationship to God and others solely in terms of what we are able to give. While this is consistent with the virtues of self-reliance which are so profoundly embedded in our culture we need to also acknowledge the realities and even the goods of mutuality and dependency. We can enrich others by how we receive as well as by how we give and serve. Finally, we need to be aware that our support for autonomy can, in fact, become a sort of moral abandonment in which it really does not matter what a patient decides provided they decide. Clearly, this would be, in effect, the final abandonment of the goods of community, or any real commitment to the common life. Not only that, but the pursuit of autonomy for one can lead to the moral abandonment of others. Once euthanasia is legalized the burden of proof shifts. At present it is presumed, perhaps unhelpfully, that people normally want to prolong their lives. Once euthanasia is common practice in certain types of medical situation the question is reversed and the question

becomes, “why would you want to stay alive?” The burden of proof has now shifted to the sick or disabled person who, by implication, must explain why they wish to go on living with a quality of life that the majority in society would find unacceptable. This does not, of course, mean that there would be any actual pressure upon such people to be euthanized, but it does change the presuppositions through which they relate to society around them.

Suffering and Compassion

As a response to suffering it is not difficult to imagine why euthanasia might be recognized and embraced as a compassionate act. Yet it needs to be remembered that there is considerable evidence of under-use and inappropriate use of pain relief. Further, there is a clear parallel between the pressure to legalize assisted suicide and euthanasia and the absence of adequate palliative care facilities. At present palliative care facilities in Canada are woefully underfunded. Such facilities are still not available to all Canadians who could benefit from them. Too many Canadians are left to deal with severe illness or chronic and debilitating pain alone. In the case of Tracy Latimer, at least a part of the problem seems to have been the lack of assistance and support that the Latimers perceived to be available to them as they sought to deal with Tracy’s very severe handicap. It seems ironic to talk about compassion when so little is done to relieve the basic problems that underlie the sense that euthanasia is the only option. This is particularly important at a time when governments are seeking to reduce their health care spending to meet budgetary constraints. To seek to legalize euthanasia at a time when costs are being downloaded onto patients and their families, support systems are being cut, and an aging population is increasingly anxious about its future might seem to be more cynical than compassionate.

Autonomy and Compassion

A final issue related to autonomy and suffering arises from the relationship between the two. We have already pointed out that they are the key grounds to justify the acceptance of euthanasia and they are clearly reflected in the practices in the Netherlands. However, it quickly becomes evident that they stand in tension with each other. Put simply, if autonomy is the issue, why do we have to wait until a patient is terminally ill to comply with their request for euthanasia? Or, why must we wait until their pain and suffering is unbearable? If it is clear that their condition will be fatal, even if it cannot yet be described as terminal, or that their suffering is likely to be unbearable (for example a young man diagnosed as HIV positive), why wait for the inevitable? Is it not kinder, and more respectful of autonomy to act upon request and not demand that they wait until their suffering is unbearable and death immanent? On the other hand if suffering is the issue, is it not rather cruel to deny euthanasia to a child because they are not able to consent when we would gladly provide euthanasia to a competent adult under the same circumstances? Given the tension between these two central motivations it is hardly surprising that it has proven difficult in the Netherlands to hold the line at *voluntary* euthanasia. It might suggest that in this instance slippery slope arguments have logical rather than merely historical validity. Indeed, for many opponents of euthanasia such arguments are the most compelling. They would argue that while they have compassion on those who suffer and

would wish to avail themselves of the option of euthanasia, to allow this in restricted circumstances would open the door to more and more circumstances where euthanasia would be accepted. Without clearly defined stable limiting principles, they argue that it is inevitable that euthanasia will expand to the chronically ill, the incurable, the aged and infirm and the intellectually challenged. Once we cross the line, where do we stop? Where do we hit the bottom of the slippery slope? Of course, one response might be that all public policy is based on compromise and negotiation. It is not fully consistent but since no one should expect it to be there is no reason to expect an inevitable slide towards anomie. However, if there are particular reasons for thinking that proposed public policies in this area would be unstable, the stakes are sufficiently high to suggest that we err towards caution.

The Fiduciary Obligations of Physicians

A final issue related to the standard arguments on euthanasia relates to the trust extended to physicians, and the fear that if physicians are agents of death, as well as healing, their relationship with their patients will be irreparably damaged. It is perhaps as well to remember that there are already serious issues of trust between Canadian health care providers and the general public and that some of these are related to the fear that we may have unwanted and unhelpful care thrust upon us. Nonetheless there are some serious issues to be raised concerning the social location of physicians and their fiduciary relationships to their patients.

Prior to World War I, the primary task of the physician was to care for her patients. She was required first to do no harm (*primum non nocere*) She should provide what assistance she could to the healing process, but until the advent of widespread antibiotic use, adequate anaesthesia to make advanced surgery possible and improved diet and hygiene, there was relatively little that physicians could accomplish in terms of cure. With the advent of modern technological medicine, the situation has changed and cure has become the primary focus of medical practice, but this has left many care providers at a loss when their curative attempts fail, an eventuality for which physicians receive too little preparation. The emphasis on cure rather than care has contributed to the sense of loss that physicians inevitably experience when their best efforts fail to alter the course of illness. This means that physicians are not and cannot be purely disinterested parties, technicians who provide a service but have no particular interest in its outcome. Indeed, would we want this to be the outlook that shaped the relationship between physicians and their patients? The problem is exacerbated in modern medical practice because physicians already face a conflict between their fiduciary obligations to their patients and the need to act as gatekeepers, limiting the access of patients to scarce medical resources, especially when the benefits are likely to be marginal, and the costs high. They must work within strict budgets that require that choices will be made about who gets what. In this context to place the power to take life in the hands of physicians may appear to sharpen the conflict of interest that already exists in the roles of a physician to such a point that the levels of trust necessary for effective practice could no longer be maintained. This is perhaps why most medical associations have been resistant to calls to legalize euthanasia and assisted suicide.

Further Issues In Euthanasia

The above discussion has addressed the "classical" arguments for and against euthanasia and assisted suicide. There are other issues which are less frequently discussed but which are worthy of mention.

Impact of Technology

The first is the impact of technology on our attitudes to medical practice and our approach to problem solving. At one level it is precisely the advent of certain medical technologies that has given rise to the situations we fear: the prospect of being kept alive indefinitely in an intensive care ward hooked up to machines but separated from our family and friends. It has also affected how we think about the practice of medicine. Medicine is increasingly about technique. "How do I solve this problem?" is taken to mean, "what technique do I apply?" From this point of view euthanasia might be seen as a rather ironic gesture. Threatened by the products of technique and the failure of technique to deliver us from death we turn to technique to regain control of the situation. This time we do not remove the pathology, we remove the patient. Yet the illusion of control is maintained and chaos and the threat of dependence is kept at bay. Since the valorization of technique is a widely shared value in our society, patients and physicians are both caught up in the search for a "technical" solution to the failure of technique. The irony is therefore not simply a product of modern medical practice, but of the complex web of social expectations and values which form the social context within which physicians are trained and medicine is practiced. If this description has any relation to our situation then it would also mean that in the final analysis the move to euthanasia was both an expression of hubris and at the same time profoundly dehumanizing since it would devalue the relational and personal in favour of the practical and effective. Further, it would assert a preference for control that always tends to leave the weak and the vulnerable behind, or at best relate to them as objects to be cared for and acted upon for their good.

The Impact of Euthanasia on Particular Groups

A further problem that has attracted some recent attention in the area of euthanasia relates to the uneven spread of requests for euthanasia across populations. A disproportionate number of the high profile euthanasia cases seem to involve the euthanasia of women. In the Netherlands, where figures are available, the gap seems to be narrower than popular perception here might suggest. But still, Remmelink found that proportionally more women are euthanized than men. Of course, there may be a number of reasons for this. It may reflect the types of illness to which men and women are susceptible. Or it might reflect subtle social pressure on a group of people who have been socially defined in terms of the support they give to others at a time when they are no longer able to perform the roles that defined their lives and gave them meaning.

Conclusion

It is not the purpose of this document to suggest that either support for, or opposition to, euthanasia and assisted suicide is a natural and required consequence of Christian faith. We recognize that Christians of good will, after reasoned theological reflection disagree on the appropriate response at this time. In part this is due both to the complexity of the

issues and to the sense of tragedy that pervades those situations in which the appeal to euthanasia or assisted suicide appears attractive, possible compelling. If we cannot see the very real goods at stake on both sides of this debate then it seems inevitable that we will be insensitive either to the realities of people's lives or to the social ramifications of their decisions. In the end, moral theology cannot be separated from pastoral theology. Any policy adopted by the church needs to recognize that the choices we make are never free from cost or ambiguity. Nonetheless, we have suggested that the social and moral ramifications of a change in public policy would be great, and on balance the arguments we have employed tend to suggest that the Church should not support a change in public policy. Instead we would suggest that the Church urge its members not to seek recourse to euthanasia and assisted suicide. In view of this we would further urge the Church to press for and assist in the provision of such services and support networks, social, medical, pastoral and financial, as would make a decision not to seek euthanasia or physician assisted suicide humane and tenable. We believe that some of the reasons we have put forward are also grounds for the Church to oppose any shift in public policy leading to the legalization of euthanasia in our society at the present time. We recognize that in arriving at this position only some of our arguments were framed in a manner that might address itself to the wider community. However, to produce a document addressed specifically to the wider community is a separate task from the one set this task group. While we recognize that, even within the Church, some would balance and resolve the issues we have addressed somewhat differently. We would still argue that they and we seek to resolve these issues by appeal to values and commitments that are shared as part of our common heritage. A task for the church at this time must be to continue to raise the questions that we all need to take seriously as we are called to continue to wrestle with our position, whatever that might be in relation to this issue. We are called to listen to each other, and to those who must struggle very concretely with the issues that surround decisions at the end of life.

The Church must also take the role of critic, insisting that some questions cannot go unanswered, and offering advice on questions related to the burden of proof. We have sought to do this where we have raised questions related to the specific social, political and economic contexts within which the current debate concerning euthanasia is taking place.

We believe that the balance of evidence continues to support the church's traditional and often repeated prohibition against euthanasia. Too many questions have not been squarely faced and our current social and political situation offers new and particular problems for such a move. We would recommend that ongoing debate of issues of euthanasia and assisted suicide take place in the context of a renewed commitment to the support of palliative care initiatives and to the sensitive and constructive pastoral support of individuals and families facing end of life decisions. We would further recommend that the attached statement be treated as a summary of our current pastoral practice and a starting point for continued discussion and debate between members of our community as we continue to engage these questions.

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Endnotes