

Care in Dying

A Consideration of the Practices of Euthanasia and Physician Assisted Suicide

as commended by the General Synod
for study in the Anglican Church of Canada

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

The Rev. Eric Beresford (Editor)¹

For further information, contact

Eileen Scully, Director of Faith, Worship and Ministry,
Anglican Church of Canada, 80 Hayden St., Toronto, ON M4Y 3G2

Tel: (416) 924-9199 Fax: (416) 924-0211

escully@national.anglican.ca

Contents

Draft Statement on Euthanasia and Assisted Suicide	p.2
Report of the Task Group on Euthanasia and Assisted Suicide	p.4
Appendix A: Draft Statement on Assisted Suicide (The Ethics Group of the Doctrine and Worship Committee, 1995)	p.38
Appendix B: Canadian Council of Churches Draft Joint Statement (Received by the Faith, Worship and Ministry Committee, October 1996)	p.39
Appendix C: Canadian Council of Churches Statement of Convergence on Euthanasia and Assisted Suicide.	p.40

Draft Statement on Euthanasia and Assisted Suicide
Euthanasia Task Group: Faith, Worship and Ministry
March 6, 1998

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 person's "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 commitment is expressed in the central role they have played in the development of hospices and palliative care institutions in many parts of the world. In Canada these programs involve health care professionals and volunteers from the church community in the 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 are reasons to believe that the legalization of euthanasia could present special risks for those in our society who are already vulnerable. Social and familial coercion, elder abuse, widespread undiagnosed depression, the pressures of materialism and greed, as well as medical convenience are all realities to be considered and which increase the vulnerability of the elderly and the disabled. 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 person's life. Our underlying commitment is that health care delivery as a whole should reflect the desire of Canadians to be a community which 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 discussions of public policy regarding euthanasia can be seen in the 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 Canadian context, what they have in common is that they are taking place in industrialized nations which have technologically advanced medical care systems, with their stress on large tertiary care centres for the treatment of critically ill patients. It will become clear in what follows that the discussions taking place 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 fuelled 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.

Although advances in medicine mean that we can often save the life of critically ill patients, sometimes they serve only to prolong the dying of those for whom little can be done to restore health.^A There is 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 these 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 their application. It is precisely

^A The distinction between, “saving life”, and, “extending the process of dying”, is introduced here. What do you understand by this distinction? How useful do you find this distinction in thinking about the sort of treatments patients receive at the end of their lives. If you are unsure what options might be available you might find it helpful to look at the case studies provided in the study guide.

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. They 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 such discussions might be conducted with greater clarity and greater charity.

In order to achieve this end we will first provide some definitions, and then offer an account of the Canadian context and of the events that have influenced it. Then we shall be ready to consider the issues which need to be raised in a theological discussion intended to support decision-making at the end of life.

Definitions^B

- 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 developed to determine that death had occurred in patients on life support systems which masked the occurrence of death, 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 as either euthanasia or the removal of life support.
- b) *Termination of Treatment*: This refers to those situations where medical treatment is no longer indicated and all treatment except palliation (food, hydration, pain relief, etc.) is withdrawn². 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

^B Remember we are just trying to offer definitions at this time. We are not trying to decide which types of action would be appropriate and which not. As you go through these definitions you might want to think of particular examples of the situations described. If you don't know any read the case studies and try and decide what sort of situation each case represents.

patients to refuse even life saving medical interventions was established in Canada by 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 concerns 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 to which no further resistance is offered, rather than as a result of withdrawing therapies *per se*.^C

We agree with the report of the task group established in the Episcopal diocese of Washington (*The Washington Report*), that it is confusing and unhelpful to refer to such withdrawal of treatment as passive euthanasia.³ Death, when it occurs is not intended, and 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 in 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.⁴

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.^D

^C Actually the American courts have been very suspicious of the distinction between killing and letting die. Do you think that we can really talk about different intentions here? Does it matter?

^D Some people have claimed that intention is too subjective a basis for public policy. Others say that it is an essential part of the moral life. What do you think about the way that intention is used in these discussions. You might also want to look at the discussion of withdrawal of treatment on pages 24-26, and especially the concerns about the use of intention expressed by Kenneth Kirk which appear on page 25.

Despite our agreement with the observations made by the Washington committee 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.

- c) *Passive Euthanasia*: Given the above definition, passive euthanasia occurs where the *intention* is to allow the patient to die. Perhaps the best example of this would be the decision not to treat a duodenal atresia, the blockage of the digestive tract that sometimes occurs in a Down's Infant.⁵ When this problem occurs it is easily correctable by a straightforward surgical procedure and does not result in a lower quality of life than that which might normally be expected for a given Down's patient. However, in some centres such patients were not treated because it was decided that their quality of life was too poor to justify treatment. In such cases we are not dealing with the recognition that death cannot be effectively resisted, nor are we addressing a situation where treatment has been declined by a competent adult. Instead, death is sought by a decision not to act to effectively correct the condition that, untreated, will result in death.
- d) *Physician Assisted Suicide*: This 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 his or her own life.
- e) *Euthanasia*: This 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.^E

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

^E Do you think there might be a moral difference between assisting someone to commit suicide and acting to end the life of a patient at their request?

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, *non-voluntary euthanasia* refers to a situation in which the patient does not have the capacity to consent either through age or immaturity⁶, unconsciousness, mental illness, or incompetence. Examples of such non-voluntary 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 such a case the use of this category presumes that there are reasons for believing that the patient would have consented had they been able to do so.^F

The Canadian Situation

In 1976 the Law Reform Commission undertook an extensive study in this area and in 1986 it 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 these restrictions. 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

^F Some people would say that all non-voluntary euthanasia is really murder. What do you think? And why? Can you think of an example of this type of action in Canada? Do you think we can really make a distinction between non-voluntary and involuntary euthanasia? What problems do you see here?

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.^G

In 1991 Chris Axworthy introduced a private member's 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 it 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. In a recent Gallup poll of 1029 adult Canadians, 70 per cent 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 per cent 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.^H 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.

^G How might the notion of intention, discussed above, be helpful here? What do you think the limitations of such a notion might be?

^H Public opinion is clearly important in any policy decision in a democracy, but Canadian politicians have continued to resist pressure for the return of the death penalty despite the evidence that a majority of Canadians would favour such a change. What role do you think claims about public opinion should play in a debate like this?

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 patient's projected desires are quite different from their actual desires when faced with serious illness.¹

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, they 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. Indeed, for many, the term "involuntary euthanasia" must appear to be a misnomer, since to take a patient's life without consent, whatever the motivation, is always an illicit killing of another person. These results raise a number of problems that could affect the development of public opinion because, as we shall show, the line between voluntary and involuntary euthanasia has already been blurred in the context of the North American discussion. Further, it appears that in the Dutch context it has proved difficult to maintain this distinction in practice, at least according to the figures provided by the Dutch government's own studies as published in 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 patient's 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

¹ Do you have any experience of this sort of difference between an anticipated decision and an actual decision in a time of crisis? How would you take account of this in making decisions on behalf of loved

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 exercise 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^J was that of Sue Rodriguez, a British Columbia woman suffering 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 her request 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 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 too long and he 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 ten year sentence. Despite this public support, the juries in both the original trial and in the retrial returned verdicts of guilty, although in the latter case the jury requested that the judge award a sentence below the minimum ten years. This request brought a storm of protest from groups representing the disabled who,

ones?

^J As you read these accounts of three of the high profile cases drawn from the Canadian context, you might reflect on what you see as the key similarities and differences between the three cases discussed. A different summary of these cases may be found in the study guide on page *.

deeply concerned about their own vulnerability, and risks to their rights and lives, 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. Although 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 could know that one acts only to end the child's pain, or adequately recognize the degree to which the need to end one's own suffering clouds this decision. The failure to recognize the problems posed by this lack of self transparency inevitably increases the fear of disabled people that any trivialization of Robert Latimer's actions must increase their vulnerability.^K

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 practised. Popular wisdom in Canada holds that it takes place rather frequently, 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 and/or what is called passive euthanasia. There is little evidence for widespread clandestine active euthanasia in Canada at this time.^L

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. 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

^K You will have a chance to think about these cases in more detail elsewhere. For now, just think of the differences between each of these situations and ask yourself which of those differences are important, and affect how you react to these cases.

^L We've all heard stories of people who were supposedly euthanised by doctors. Think carefully about some of these stories and try to decide what sort of "euthanasia" took place in the light of the definitions given at the beginning.

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 practised in the Netherlands, that association has rebuffed charges of abuse of the legal agreements under which physicians participating in these acts 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 counselling and consultation that must involve at least one other physician. Although euthanasia remains technically illegal, physicians who act within the guidelines drawn up by the Dutch Medical Association and the 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 practised and reported is monitored by the Dutch government, whose results are published in the two Rummelink Reports.

As a result of these reports several facts have come to light. In the first place Rummelink claimed that there was significant under-reporting of cases of euthanasia. The second report found that even after the provision of a policy under which euthanasia might be practised, only 59 per cent of doctors thought the requirement of a written report in cases of euthanasia was important, and it claims that around two thirds of physicians surveyed had issued death certificates stating that deaths brought about through euthanasia were from "natural causes."^M Given these realities, the number of cases of euthanasia is difficult to judge reliably. However, the Rummelink Report's own figures, which are generally viewed as conservative, estimate 2,300 deaths per year due to euthanasia, and 400 cases of physician assisted suicide. Given that the Dutch population is only around 14 million these figures are rather high. More disturbing still is the report of approximately 1,000 deaths per year from active involuntary euthanasia. The report concedes that in about 14 per cent 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 poor that it is judged by some 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 from voluntary to non-voluntary euthanasia that raises the question as to whether legal sanction of only voluntary euthanasia is a stable and sustainable position.^N 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”. The latter 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.^O

Despite these concerns, there appears to have been an increase in requests for euthanasia in the period from 1990 to 1995. However, despite the reports of fear amongst some elderly persons concerned that they not be euthanised against their will, there appears to be a marked shift of Dutch public opinion in support of voluntary active euthanasia.^P

Euthanasia: An Issue for the Churches?

There is 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

^M What reasons would you suggest for this reticence about providing correct information in a context where the practice of euthanasia has no legal sanction? What concerns would this give rise to about any proposal to legalize euthanasia in a Canadian context? How might such concerns be addressed?

^N Some people are very critical of slippery slope arguments. Can we really draw conclusions about what might happen in Canada from what appears to be happening in the Netherlands?

^O What is “substituted judgment” and why does it blur the line between voluntary and non-voluntary euthanasia?

^P We said earlier that it is not clear that cultural differences between Canada and the Netherlands mean that we should not assume that the Dutch experience could or would be duplicated here. Nonetheless, are there lessons from which you feel we could learn? What are they?

the subject.^Q Nonetheless, through 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 response to a motion passed at the General Synod in 1975, the primate established a task force on human life whose work resulted in the report, *Dying: Considerations Concerning the Passage from Life to Death*. This report did not give extended attention to issues of euthanasia and assisted suicide. In 1990, the Doctrine and Worship Committee 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 the fall of 1996, the Faith, Worship and Ministry Committee were approached by the Canadian Council of Churches (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. The Faith, Worship and Ministry committee were unable to confirm that the statement was consonant with the church's policy because, at this time, we have no policy. The committee did make some suggestions as to ways in which the CCC statement could be clarified and strengthened, and it committed itself to work further on this issue. As a result it was discovered that several of our partner churches were in the process of policy development. The Evangelical Lutheran Church in Canada (ELCIC) issued guidelines at its National Convention in Toronto in July 1997.

Further, the conversation in the committee suggested that, although there were clear differences of perspective, there were some common concerns. While they 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. They believed that the aim of the statement should not be primarily 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. The statement at the beginning of this book was offered as an attempt to provide pastoral guidance and support to those

^Q Through this section you might reflect on the question of what sort of statement might reflect this diversity and still give helpful guidance to members of the church community. How far does the proposed pastoral guideline at the beginning of this book go in providing that guidance?

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. In our view this needs to be done in a balanced and fair manner that reflects the range of issues and perspectives which 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. To quote from the report prepared by the Episcopal Diocese of Washington;

[Both] Christians who accept and those who reject assisted suicide and euthanasia begin with similar convictions. Both have a sense of the sovereignty of God. Both want to protect human dignity and to preserve the freedom of individual persons to choose how to confront human finitude and death. They both view life as a gift that is but not entirely at the disposal of humanity, Life is not another god, but a good in relationship to the broader purposes of life. These purposes, they agree, include bodily integrity, integrity of the spirit, sharing in human community, and honouring and nurturing goods beyond the self. They recognize that human life, especially in situations of death and dying, can confront us with a conflict of goods in which physical life clashes with other purposes or goods of life.... [Both] feel compassion toward those who suffer near death and desire to relieve their suffering in ways consonant with God's purposes. Both call on health caregivers and pastoral counselors to improve their treatment of pain and suffering... And both recognize that Christian principles of social justice call us to attempt to remedy a public policy that provides inadequate social support not only to the large numbers of persons who are poor and very sick, but also to those who are better off financially, yet lack medical and social support during critical illness..^{R7}

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 were simply not anticipated in earlier approaches to the problems

^R If you are studying this document in a group there are probably a range of points of view. Perhaps you could spend some time exploring, not your disagreements, but what you agree on!

raised. It has also been suggested that 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 practised 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.^S

Suicide Narratives in the Bible

Although the moral status of suicide is never the topic of any direct discussion in scripture, where it is mentioned is in accounts of the lives of those 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 adviser 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 advisers by his father David with disastrous consequences. The report of the task force 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, at least for the editor who produced the final version of this text, 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

^S What follows is a brief resume of those biblical passages which deal most explicitly with suicide or the provision of assistance in committing a suicide. Try reading through each of the texts discussed in this section before reading our comments. Ask yourself what relevance you think the texts might have.

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 it is the story of someone who has raised his hand against the individual 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.

Narratives Involving Assisted Suicide in the Scriptures

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 Abimelech's death is interpreted as a judgment against him 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. Although there is no specific condemnation of the suicide 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).

Taking all of these passages together, the condemnation of suicide that runs through them seems to be linked less to the somewhat later notion of the "sanctity of life" and 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. The suicides described thus reflect a quite different context from the suicide that is done, not as a result of some

moral or religious failing, but as a result of extreme illness and pain.^T It is important,

“[W]e 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 passages in the New Testament is an endorsement of the claim that suffering for the sake of the Gospel is a virtue and that an abundance of grace flows to those who experience such suffering. However, as the *Newark Report* points out, such endorsements are offered 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 which arises directly from the profession of our faith and therefore participates in the redemptive suffering of Jesus himself (cf. 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.⁸

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 as such is inevitable.^V 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. However, 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

^V This section is a rather brief account of the problems raised by suffering, but suffering is intensely personal. How can we listen more attentively to the voices of those who suffer? From your own experience how would you respond to the concerns of those who suffer? Can my response ever be normative for anybody else?

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 task does not belong to individuals Christians alone, but to the community, the Church, 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 with Paul we affirm 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. Even suffering that is devoid of purpo

especially clear when we raise the question of those 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.”⁹ 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.”¹⁰

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.¹¹ 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.¹² However, it might be suggested that the arguments of both Augustine and Aquinas reflect philosophical presuppositions current in the surrounding culture as much as they reflect the results of any biblical hermeneutic.^X Certainly biblical interpretation is not the primary focus of their discussion nor is it, in any explicit sense, the principle source of the values that inform the positions they take.

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. Within classical Anglicanism, Jeremy Taylor argues in *The Rule and*

^X While many Anglicans will regret the lack of clear references to the bible, we have appealed to tradition and reason as parallel if not equal sources of theological and moral insight. How do we weigh the insights of the tradition alongside a biblical witness that never directly addresses our questions concerning euthanasia and assisted suicide in the context of debilitating, painful, terminal illness?

Exercise of Holy Dying, that death must be prepared for, yet he insists that we should not seek to cause our own death.

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, in his *Utopia*, and John Donne in the *Biathanatos*. 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.¹³ 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 in *A Dialogue of Comfort: Against Tribulation*, against the option of taking ones own life. 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.

However, even if we accept that these examples remain within the general consensus that has existed up to the modern period, that consensus has now 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.^Y 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 whatever meaning and worth they have experienced in their lives.¹⁴ 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 1930s 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

^Y Do you think that Fletcher's account of love as the sole moral principal is convincing? Some have complained that Fletcher's concept of love is loaded and in fact covers an appeal to values which he never really makes explicit.

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.¹⁵

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.^Z Further, he suggests that 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 in 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.^{AA}

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 position is clearly reflected in the encyclical *Divino Afflante Spiritu* of Pius XII, (1953), which distinguished between ordinary and extraordinary treatments.^{BB} This distinction occurs again in Pius XII's well known addresses to the Italian Anaesthesiological society (1957)¹⁶, and in the Vatican declaration on Euthanasia (1980).¹⁷ 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

^Z Dean Inge's point sounds very compelling. How much of that is because of the terms he uses to express his point? Do you think he has been fair in the way he has defined the either or of "euthanasia" versus, "torture for the benefit of the sufferer?"

^{AA} Given that human suffering is hardly a new phenomenon, why do you think that the acceptance of suicide as a response to suffering appears so late in the history of Christian moral thought?

^{BB} How useful do you think the distinction between ordinary and extraordinary treatments might be in a practical context? You might want to look at some of the case studies in the study guide section of this book to become clear in your own mind about what is implied in this distinction.

by a number of Anglican reports too, which 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.¹⁸

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 intent to kill, rather it 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 to 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, and 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.^{CC}

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, 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.

^{CC} In your view, what sorts of interventions would constitute “treatment” and would be classed as care? Provision of pain relief would seem to be obviously care. Artificial nutrition and hydration may be a little more controversial. Where do we draw the line, and how?

There is a clear distinction between rendering someone unconscious at the risk of killing him and killing him in order to render him unconscious.¹⁹

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, and this remains true whether or not we intend those consequences.^{DD20} 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 price of choosing moral abandonment rather than the more costly process of providing palliation, and social, psychological, and pastoral support to accompany the patient in the process of his or her dying.^{EE}

Classical Arguments for and Against Euthanasia / Assisted Suicide

The classic arguments against assisted suicide and euthanasia have appealed to the language of gift and 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 to be something that 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

^{DD} Do you think Kirk's point is the same as those who would argue that talk of consequences only distracts us from the fact that the consequences of withdrawing therapy and administering a lethal dose are the same, namely that the patient dies? Can we really not distinguish between what we intend and the foreseen consequences of our action?

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. Although many Anglicans have rejected the latter, just war arguments are still frequently appealed to by Anglicans to justify killing in combat under certain circumstances.^{FF} Since there are already exceptions to the sixth commandment, it is suggested, 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?^{GG} 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 acknowledgement 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.

^{EE} This notion of care was an important one for the task group. It would be helpful to read some of the case studies in light of the question as to what actions would be expressions of care and what would become expressions of moral abandonment. What is at stake in this distinction?

^{FF} There are, of course, Anglican pacifists who would deny that there should be any exceptions to the prohibition against killing another person. However, even if there are exceptions, can one really draw conclusions across the three types of situation where exceptions have been suggested?

^{GG} We need to take very seriously the fact that people respond quite differently to severe pain and suffering. Think about the experiences of those known to you. How did they cope with their situation? Can we learn anything from the differences between the responses of individuals?

Another consideration has been suggested by the *Newark Report*. It urges 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 biologicistic neo-darwinian account of life that views it 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 assume that we can read moral obligations out of a purely descriptive account of the nature of the world, an example of the so called naturalistic fallacy.^{HH}

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 these persons to the mercy of God and provide whatever pastoral support is needed to those bereaved.^{II}

Critics have raised the question of whether a continued rejection of euthanasia / assisted suicide is 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

^{HH} The naturalistic fallacy is sometimes expressed in the claim that you cannot derive an ought from an is. You cannot derive a moral claim solely from a description of how things are.

^{II} The rubric in the *Book of Common Prayer* prohibits the use of the burial office for anyone who dies, “by their own willful act while in a sound state of mind.” This remains the norm for Anglican practice. However, in recent years Anglicans acted on one of two assumptions. In the absence of evidence to the contrary, anybody who seeks to destroy their own life must either be severely depressed, and therefore not of sound mind, or under such physical and / or emotional duress that their act could not in any usual sense be said to be an act of the persons own rational will. They have also supported the decriminalization of suicide on the grounds that the law is not a helpful instrument to deal with the aftermath of an attempted suicide. What are the significance of these changes for the discussion above? If they reflect a pastoral sensitivity to the situation of a suicide, and their loved ones, does this constitute an “acceptance” of suicide in a manner that would lead us to embrace euthanasia and physician assisted suicide as positive and appropriate options?

raised is whether it really is the same thing to commit suicide under severe duress as it is calmly and willingly to 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.^{JJ} 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.^{KK}

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

Autonomy

Although 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.^{LL}

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 autonomy cannot simply be expressed in terms of freedom from *all*

^{JJ} What moral differences do we have to consider when reflecting on the situation of someone who feels driven to commit suicide and that of someone who decides to assist a suicide?

^{KK} Do we have to change public policy to cope with these exceptions? If we do will we only open the door to exceptions?

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 are 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 to 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 approach is consistent with the virtues of self-reliance which are so profoundly embedded in our culture we need also to acknowledge the realities and even the goods of mutuality and dependency.^{MM} 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, to act in this way 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 becomes common practice in certain types of medical situation, the question is reversed and becomes, “why would you want to stay alive?” The burden of proof would now shift 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.^{NN} Of course, this need not 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 individuals and society around them. It does change the expectations within which they must decide. Many, perhaps especially the disabled, the elderly and the chronically sick, will find this shift deeply troubling.

Suffering and Compassion

^{LL} Of course, choice remains a value, just one of a number of values at stake in a given situation. How are such values to be ranked and related to each other? What considerations do we need to take into account in balancing choice with other goods?

^{MM} If autonomy does not simply mean that we can do anything, what does it mean? What elements would need to be part of an adequate description of the experience of being a free, responsible human person.

It is not difficult to imagine why euthanasia might be recognized and embraced as a compassionate act in the face of severe and intractable suffering. 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 relationship between the pressure to legalize assisted suicide and euthanasia and the absence of adequate palliative care facilities. At present such facilities in Canada are woefully underfunded. They 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 lacuna 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 used 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

^{NN} It seems that changes to benefit some may have a negative impact on others. How do we weigh these costs and benefits? Do Christians have particular perspectives to bring to such a debate?

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?^{OO}

Given the tension between these two central motivations, we should not be surprised that it has proven difficult in the Netherlands to hold the line at *voluntary* euthanasia. This experience suggests that we are dealing with a slippery slope argument which has 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 for those who suffer and would wish to avail themselves of the option of euthanasia, to allow such a resort even 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, 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. An approach which allows euthanasia and assisted suicide in certain circumstances might not be fully consistent, but since no one should expect it to be, there is no reason to anticipate an inevitable slide towards a complete loss of principled constraint. 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.^{PP}

The Fiduciary Obligations of Physicians

A final issue related to the standard arguments on euthanasia concerns 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

^{OO} The Dutch guidelines reflect both values, and any policy would have to attempt to balance these values against each other. The question is whether the tension between these two values does not make any such balance inherently unstable. Can we learn anything from the Dutch experience here?

^{PP} The task group are suggesting what might be called a precautionary principle. In an area where the consequences of change are severe, particularly for those members of a society who are already

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. Others fear that they will be denied access to treatment that may be helpful on the grounds that it is too expensive or its benefits not sufficiently certain. 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 physicians was to care for their patients. They were required first to do no harm (*primum non nocere*). They should provide what assistance they 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 development 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. There is a personal stake and commitment here which 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 requiring that choices 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 which 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

vulnerable, the burden of evidence should lie with those who are proposing a change to existing policies. Do you think such a principle is helpful? What are the benefits and / or dangers of such a principle?

maintained^{QQ}. This prospect perhaps explains 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 “classic” arguments for and against euthanasia and assisted suicide. There are other issues that 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, its failure 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 are kept at bay. Since the valorization of technique is widely shared in our society, patients and physicians are both caught up in the search for a “technical” solution to the failure of technique.^{RR} The irony is therefore not simply a product of modern medical practice, but also of the complex web of social expectations and values that form the social context within which physicians are trained and medicine is practised. If this description has any relation to our situation, then it would also mean that in the final analysis the move to euthanasia is both an expression of

^{QQ} We all work within contexts where we have to balance competing interests. What factors might justify the belief of the task group that the pressures placed upon physicians by the legalization of euthanasia and physician assisted suicide would be untenable? What other factors might need to be taken into account?

^{RR} A number of commentators, including Canada’s George Grant, have suggested that technology is not just about using tools. It is about how we analyze and respond to problems. It is also about what sorts of questions make sense to us, and what don’t. One theologian has suggested that as a result of our technological ways of looking at things we find it hard to understand a decision not to intervene as anything other than another type of act. How does this way of thinking affect the way we think about euthanasia?

hubris and at the same time profoundly a dehumanizing step 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 a higher percentage of the patients euthanized were women. 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. However, the two largest groups of patients requesting euthanasia at this time are AIDS patients and those in the terminal stages of cancer. Neither of these categories would explain the differences in the incidence of euthanasia between women and men. Alternatively, the difference 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.

Throughout the debates in Canada groups representing the disabled have voiced their concern that the legalization of euthanasia would leave them particularly vulnerable in a society which already systematically devalues them in a number of ways.^{SS} In the Netherlands the elderly have expressed some anxiety that they would experience pressure to resort to euthanasia rather than live with chronic illness. As Christians we are called to pay particular attention to the voices of the marginalized or of people who are in any way unusually vulnerable.

^{SS} Groups representing the disabled in Canada, and those representing senior citizens in the Netherlands have, in their different contexts been amongst the most vocal and vigorous opponents of the legalization of euthanasia. How should members of the Anglican church address themselves to the problems raised by these groups? What weight should we give to these particular voices and why?

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 difference 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, possibly 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 argued that the potential for serious social and moral ramifications arising from 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.^{TT} Instead we would recommend that the church urge its members not to seek recourse to euthanasia and assisted suicide. In view of this we would further recommend that the church both 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 than this report has done, 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

^{TT} Do you think that the approach of providing pastoral guidelines rather than policy statements provides the sort of balance that the task group was looking for? What alternative approaches might be considered?

time must be to continue to raise the questions that we all need to take seriously as we are called 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 those related to the burden of proof. We have sought to adopt this stance 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 on the part of both clergy and laity to 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 wrestle with these questions.

Select Bibliography

On Dying well: An Anglican Contribution to the Debate on Euthanasia, General Synod Board for Social Responsibility, Newport and London: Church Information Office, 1975.

Caring for the Dying: Choices and Decisions. A Paper Approved for Discussion in the Congregations of the United Church of Canada by the Division of Mission in Canada Executive, June 1994.

Report of the Task Force on Assisted Suicide to the 122nd convention of the Episcopal Diocese of Newark, Newark NJ, January 27, 1996.

Are Assisted Suicide and Euthanasia Morally Acceptable for Christians? Perspectives to Consider. Report of the Committee on Medical Ethics to the Diocesan Convention of the Episcopal Diocese of Washington, Washington DC, January 25, 1997.

“The ELCIC Provides Some Guidelines.” *The Canada Lutheran* October, 1997, 13-14.

Amundsen, D. W., “Suicide and Early Christian Values,” in Baruch A. Brody, *Suicide and Euthanasia*, Dordrecht: Kluwer, 1989: 77-153.

Brown, David, *Choices: Ethics and the Christian*, Oxford: Blackwell, 1983.

Callwood, June, *Twelve Weeks in Spring*, Toronto: Lester & Orpen Dennys, 1986.

Campbell, Courtney S. “Religious Ethics and Active Euthanasia in a Pluralistic Society,” *Kennedy Institute of Ethics Journal*, 2(1992): 253-77.

Chidwick, Paul, *Dying yet we Live: Our response to the spiritual needs of the dying*.
Toronto, Anglican Book Centre, 1988.

Childress, James F., "Life, Prolongation of," *Westminster Dictionary of Christian Ethics*,
James F. Childress and John Macquarrie, eds. Philadelphia: Westminster Press, 1986,
351-352.

Cohen, Cynthia B. "Christian Perspectives on Assisted Suicide and Euthanasia: The
Anglican Tradition." *Journal of Law, Medicine and Ethics*, 24(1996):369-79.

de Wachter, Maurice A. M. "Euthanasia in the Netherlands," *Hastings Center Report*,
22(2) 1992:23-30.

Fletcher, Joseph, *Morals and Medicine*, Princeton: Princeton U P, 1954.

---, *Situation Ethics*, Philadelphia, Westminster Press, 1966.

Gentles, Ian, ed., *Care for the Dying and the Bereaved*, Toronto, Anglican Book Centre,
1982.

---, *Euthanasia and Assisted Suicide: The Current Debate*, Toronto, Stoddart, 1995.

Gula, Richard M, *Euthanasia: Moral and Pastoral Perspectives*, New York: Paulist
Press, 1994.

Hall, Beverly, *Caring for the Dying: A guide for caregivers in home and hospital*,
Toronto, Anglican Book Centre, 1988.

Kirk, Kenneth, *Conscience and its Problems: An Introduction to Casuistry*, London:
Longmans Green, 1927.

Larue, Gerald A. *Euthanasia and Religion: A Survey of the Attitudes of World Religions to the Right-to-Die*. Los Angeles, Hemlock 1985.

Rudin, Rabbi A. James, *Statement Before the House Committee on Commerce, Subcommittee on Health and Environment*, New York, American Jewish Committee, March 6, 1997.

Smith, D. H. *Health and Medicine in the Anglican Tradition*. New York: Crossroad, 1986.

Smith, Margaret, Alter, Susan, and Harder, Sandra. *Euthanasia and the Cessation of Treatment*. Current Issue Review 91-9E, Library of Parliament Research Branch, Ottawa, 1993 .

Verhey, Allen "Choosing Death: The Ethics of Assisted Suicide," *Christian Century*, July 17-24, 1996, 716-719.

Whytehead, Lawrence and Paul Chidwick, eds. *Dying: Considerations on the passage from life to death*. Toronto: Anglican Book Centre, 1980.

Wood, Thomas, "Euthanasia," *Westminster Dictionary of Christian Ethics*, James F. Childress and John Macquarrie, eds. Philadelphia: Westminster Press, 1986, 349-50.

Endnotes

¹ The task group members would also like to thank Mr. Chris Ambidge, Dr. Walter Dellar, and the Rev. Linda Kealey for their assistance and advice.

² It should be noted that there is considerable debate about the withdrawal of so called “artificial” feeding and hydration. Many ethicists are now coming to the conclusion that such interventions are best seen as therapy rather than care. Given their invasive nature, they might therefore be classed in some cases as extraordinary treatment and therefore deemed to be unwarranted. Examples might include patients who are in Permanent Vegetative State.

³ *Assisted Suicide and Euthanasia: Christian Moral Perspectives*. Report of the Committee on Medical Ethics, Episcopal Diocese of Washington, Harrisburg, PA, Morehouse Publishing, 1997, p.19.

⁴ *ibid.* p.20.

⁵ We recognize that this practice is no longer accepted in many centers in Canada, even where such non intervention is requested by the parents.

⁶ The question of the age of consent is a complex one in Canada. The province of Quebec sets a minimum age for legal consent to medical intervention at 14. There is, strictly speaking, no legal age of consent in Ontario. Some other provinces rely on common law criteria which may vary on a case by case basis. Further, while euthanasia remains an offense under the criminal code in Canada any discussion of consent must be rather speculative. Presumably any act legalizing euthanasia and physician assisted suicide could include specific provisions for consent in such circumstances.

⁷ Washington Report, p.67, c.f. xii.

⁸ *Report of the Task Force on Assisted Suicide to the 122nd convention of the Episcopal Diocese of Newark*, Newark, NJ: January 27, 1996, p.7.

⁹ *Hilkot Rotzeah*, II, 7. C.f. the Talmudic text, *Yoreh Deah*, cccxxxix.

10

¹³ An extended discussion of both authors may be found in, Ferngren, Gary B., “Ethics of Suicide in Renaissance and Reformation,” in, Baruch A. Brody, ed., *Suicide and Euthanasia* (Dordrecht, Netherlands: Kluwer, 1989), pp.155-81.

¹⁴ Fletcher, Joseph, *Morals and Medicine*, Princeton, NJ: Princeton University Press, 1954, pp.172-210.

¹⁵ Inge, W. R., *Christian Ethics and Moral Problems*, New York: Putnam, 1930, p.397.

¹⁶ Address to Those Taking Part in the IXth. Conference of the Italian Anaesthesiological Society, 24th February, 1957.

¹⁷ In Larue, Gerald A., *Euthanasia and Religion: A Survey of the Attitudes of World Religions to the Right to Die*, Los Angeles, Hemlock, 1985, pp.35-43.

¹⁸ *On Dying Well*, p.61.

¹⁹ *On Dying Well*, p.9.

²⁰ *Conscience and its Problems: An Introduction to Casuistry*, p.8.

Appendix A

DRAFT STATEMENT ON ASSISTED SUICIDE

Our guiding principle is that we are made in the image and likeness of God (Genesis 1.26:27) and our life is a gift to us from God. God has created us for God’s self and the time of our living and our dying is not in our hands. 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 and important part of that body. The request for assistance in committing suicide is to be taken seriously as a failure of human community. The Christian vocation is to keep faith with and show respect for another by keeping company with them through the terminal stages of a disease or the life-span of a disability.

We, the Church, look with deep compassion on the suffering of all of God's children. We are called to promote the value and dignity of human life in the face of all forms of suffering by such measures as palliative care or good pain management.

The Christian response is always one of hope. This hope exists in the context of the physical, emotional, and spiritual support offered by the community and contradicts that chosen physical death for oneself or for another is the only solution.

The Ethics Group of the Doctrine Sub-Committee
Doctrine and Worship Committee, 1995
The Anglican Church of Canada

Chair: The Reverend Victoria Matthews

Appendix B

CCC Draft Joint Statement

Much discussion is being generated in both public and private forums on the changing of Canadian law and practice to accept so called "new" approaches to death and dying. The Commission on Faith and Witness of the Canadian Council of Churches has surveyed the ethical positions of its member churches and has discovered a remarkable Christian consensus on these issues.

Christian thought through the ages has always understood that life is entrusted to us by God. Similar to views reflected in other religious traditions life is seen as something larger than any person's "ownership" of it and, therefore, is not ours to discard. CCC member Churches do not accept the legalization of euthanasia or assisted suicide.

The Churches share in a long history of providing all forms of health care, healing and support of the suffering and dying. More recently they have evaluated and agreed to the provision of drug therapies and palliative care which attempt to alleviate pain and maintain dignity of life even at the moment of death. Christians are called by God to form caring communities which make God's love real for those who are suffering or facing death.

Christians believe they share with other members of society a concern for the protection and respect of life. To change law and practice to enable a person to take his or her own life, or the life of another, would undermine the ultimate respect for human life

itself. In all they do, people must affirm and revere the natural desire to live, both in themselves and in those they love most dearly. This commitment gives all members of society, especially the most vulnerable, the assurance that they will be supported in all circumstances of their lives.

The Faith and Witness Commission has used the following definitions. Euthanasia is deliberately killing someone by action or omission, with or without that person's consent, for compassionate reasons. Euthanasia does not include: withholding or withdrawing medical treatment when its burdens on the dying person outweigh its benefits; giving drugs to relieve pain, even if an unintended effect is to shorten life; respecting a person's refusal of treatment or request to discontinue treatment. Assisted suicide is the providing of information or the means to take a life.

**Faith and Witness Commission
of the
Canadian Council of Churches**

**Statement of Convergence on Euthanasia and Assisted Suicide
Christmas, 1996**

Much discussion is being generated in both public and private forums on the changing of Canadian law and practice to accept so called "new" approaches to death and dying. The **Commission on Faith and Witness** of the Canadian Council of Churches has surveyed the ethical positions of its member churches. While acknowledging the existence of a diversity of opinion both among and within our communities, we believe that we can detect a remarkable degree of convergence on these issues.

The Churches share in a long history of providing many forms of health care, healing and support of the suffering and dying. Churches actively supported the development of palliative care facilities, 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 form 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.

All of our member churches are very concerned about this issue, but are approaching it in a variety of ways. Some member churches, notably the British Methodist Episcopal Church, Christian Church-Disciples of Christ, and the United Church of Canada have urged their individual congregations to study the question, and see euthanasia not as a policy but a pastoral issue. The Society of Friends is continuing to study the issue but has not reached unity. Others, including the Anglican Church of Canada, the Evangelical Lutheran Church in Canada, and the Reformed Church in Canada are in a process of study and affirm the direction of the following convergence. Still others, including the Armenian Orthodox Church, Baptist Convention of Ontario and Quebec, Coptic Orthodox Church, Council of Christian Reformed Churches in Canada, Ethiopian Orthodox Tawehedo Church, Greek Orthodox Church, Orthodox Church in America, Presbyterian Church in Canada, Roman Catholic Church, Salvation Army, and the Ukrainian Orthodox Church, are prepared to speak with one voice on euthanasia and assisted suicide as follows: Much of the convergence in Christian thought follows from the conviction that life is entrusted to us by God. As in many other religious traditions, life is seen as something larger than any individual person's "ownership" of it and, therefore, is not ours to discard. Many member Churches believe that the move to legalize euthanasia or assisted suicide would run contrary to the wisdom expressed in this widely held religious vision. It would be destructive of both human dignity and community. These churches share with other members of society a concern for the protection and respect of life. To change current law and practice to enable a physician, family member, or any private citizen to take the life of another or assist in their suicide would undermine the ultimate respect for human life itself and create new victims in complex situations. The request for assistance in committing suicide, and the provision of such assistance has to be looked at as a failure of human community. While pain and despair are real, the solution should not be found in the termination of life. But 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 receive care and support in all circumstances of their lives, and not have dehumanizing medical interventions forced upon them.

The Faith and Witness Commission has used the following definitions:-*Euthanasia is an action or omission whose primary intention is to end a person's life, with or without that person's consent, for compassionate reasons-Euthanasia does **not** include *withholding or withdrawing medical treatment when its burdens on the dying person outweighs its benefits; *giving drugs to relieve pain, even if an unintended effect is to shorten life; *respecting a person's refusal of treatment or request to discontinue treatment-Assisted Suicide is the providing of information, assistance or the means for a person to take his or her own life.*

For further information: Eileen Scully, Associate Secretary, Faith and Witness, Canadian Council of Churches, (416) 921-7759, ex.23; or Donna Geernaert, Chair of the Commission on Faith and Witness, (613) 241-946

**Commission Foi et Témoignage
du Conseil canadien des Églises**

**Déclaration de convergence d'opinions sur l'euthanasie et l'aide au suicide
Noël 1996**

On discute abondamment, dans les forums publics et privés, des changements apportés à la loi et à la pratique canadiennes, et qui consistent à accepter des soi-disant «nouvelles» approches des derniers instants et de la mort. La Commission Foi et Témoignage du Conseil canadien des Églises a procédé à l'examen des positions éthiques de ses Églises membres. Tout en reconnaissant l'existence d'une diversité d'opinions, tant entre les communautés qu'à l'intérieur de chacune d'elles, nous croyons pouvoir déceler un remarquable degré de convergence d'opinions sur ces questions.

Depuis des siècles, les Églises assurent aux malades et aux mourants, sous des formes diverses, les soins et le soutien nécessaires. Elles ont activement encouragé le perfectionnement des soins palliatifs, dont le soulagement de la douleur. On sait le rôle central qu'elles ont joué dans l'établissement d'hospices et d'institutions de soins palliatifs dans maintes parties du globe. Ces programmes s'efforcent de soulager la douleur et de maintenir la dignité de la vie même au moment de la mort. Dieu appelle les chrétiens à former des communautés compatissantes qui rendent présent l'amour de Dieu auprès de ceux qui souffrent ou qui se trouvent face à la mort. Ces communautés nous permettent de témoigner de la possibilité, pour la vie humaine, de conserver sa dignité et d'avoir un sens, même dans la douleur, la souffrance et la mort.

Toutes nos Églises membres sont fortement préoccupées par ces questions, tout en les abordant de façons différentes. Quelques-unes d'entre elles, notamment l'Église épiscopale méthodique de Grande-Bretagne, l'Église chrétienne-Disciples du Christ et l'Église unie du Canada, ont pressé leurs communautés d'étudier la question en considérant l'euthanasie, non pas comme une politique, mais comme une question pastorale. La Société des Amis continue de se pencher sur la question, mais n'en est pas encore parvenue à l'unité. D'autres, dont l'Église anglicane du Canada, l'Église luthérienne évangélique du Canada et l'Église réformée du Canada, étudient encore la question, mais tout indique que leurs opinions concorderont avec celles qui sont exprimées ci-dessous. D'autres encore, dont l'Église orthodoxe arménienne, la Convention baptiste de l'Ontario et du Québec, l'Église orthodoxe copte, le Conseil des Églises réformées chrétiennes du Canada, l'Église Tawehedo orthodoxe éthiopienne, l'Église orthodoxe grecque, l'Église orthodoxe d'Amérique, l'Église presbytérienne au Canada, l'Église catholique, l'Armée du Salut et l'Église orthodoxe ukrainienne, sont prêtes à faire ensemble la déclaration suivante sur l'euthanasie et l'aide au suicide :

La convergence des opinions des chrétiens est issue de la conviction que la vie nous est confiée par Dieu. Comme dans de nombreuses autres traditions religieuses, elle représente une valeur dont l'individu n'a pas la "propriété" et à qui, par conséquent, il n'appartient pas de s'en défaire. Bien des Églises membres croient que la légalisation de l'euthanasie ou de l'aide au suicide irait à l'encontre de la sagesse qui s'exprime dans cette conviction religieuse largement partagée. Ce serait détruire à la fois la dignité et la communauté des humains. Ces Églises partagent avec d'autres membres de la société le souci de la protection et du respect de la vie. Changer la loi et la pratique actuelles pour permettre à un médecin, à un parent ou à tout autre citoyen de prendre la vie d'autrui ou d'aider à son suicide, ce serait miner le respect de la vie humaine elle-même et créer de

nouvelles victimes dans l'éventualité de situations complexes. On ne saurait voir, dans la demande d'aide au suicide et dans la prestation de cette aide, autre chose qu'un échec de la communauté humaine. La douleur et le désespoir sont certes réels, mais enlever la vie n'est pas la solution. La réponse chrétienne réside toujours dans l'espérance. C'est de l'espérance que naît l'engagement à donner à tous les membres de la société, et plus particulièrement aux plus vulnérables, l'assurance qu'ils recevront soins et soutien dans toutes les circonstances de leur vie, et ne seront pas soumis de force à des interventions médicales déshumanisantes.

La Commission Foi et Témoignage se base sur les définitions suivantes :

- L'euthanasie est un acte ou une omission dont l'intention première est de mettre un terme à la vie d'une personne, avec ou sans son consentement, pour des motifs de compassion.

*- On ne considère **pas** comme euthanasie :*

**retenir ou retirer un traitement médical lorsque, pour la personne mourante, les inconvénients l'emportent sur les avantages*

**donner de la médication pour soulager la douleur, même s'il a pour effet non intentionnel d'abrégier la vie*

**respecter le refus du traitement par la personne, ou sa demande de le cesser.*

- L'aide au suicide consiste à fournir à une personne l'information, l'aide ou les moyens qui lui permettrait de s'enlever la vie.

Pour renseignements complémentaires : Eileen Scully, secrétaire adjointe, Foi et Témoignage, Conseil canadien des Églises (416) 921 7759, poste 23, ou Donna Geernaert, Présidente, Commission Foi et Témoignage (613) 241-9461