FAITH SEEKING UNDERSTANDING

MEDICAL ASSISTANCE IN DYING

REFLECTIONS BY CANADIAN ANGLICANS

Faith Seeking Understanding: Medical Assistance in Dying

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Compiled by The General Synod
of The Anglican Church of Canada

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Essays herein include perspectives of the individual contributors. This resource aims to promote respectful conversations around medical assistance in dying (MAiD); it is not intended to affirm or reject the MAiD program. Our prayer is for any ensuing discussions or debates to exemplify values of faithful openness, tolerance, and spiritual-theological hospitality.

Contents

Foreword

From the moment of baptism every Christian faces the question, *How then shall I live in light of the baptismal promises?* When we turn our lives to God through Jesus Christ, to live in right relationship with God and all of creation, then we begin a journey of continuous discernment of what is right and good to do and to be. That discernment takes on a particular urgency when the world around us begins to shift accepted norms in light of new possibilities. Medical assistance in dying, or MAiD, has brought that discernment forward with sharp poignancy as we wrestle with the possibilities now available.

Some accuse Anglicans of being "wishy-washy" and desire a strong, clearly articulated stance of opposition to MAiD or of wholehearted support. My experience of Anglican discernment is that we have strong convictions about the gift of our life in Christ with a corollary recognition of the difficult contexts of human life that defy unequivocal answers. When we have gifts of medical science that can prolong life—must they be used? When suffering places an extraordinary burden on an individual or family, may it be relieved or is it to be endured when needed supports are not available? Is quality of life a factor of importance? Who decides the quality of life? Is quantity of life an essential good? What level of suffering is intolerable and unacceptable? Who decides?

Moral issues such as MAiD bring us face to face with the implications of decisions for people we know and love and for the life of our communities. Discernment requires looking at the issue as through a prism, turning the prism to see all perspectives reflected. We listen to the voice of scripture, tradition, and experience; we listen to the wisdom of elders and other Christian partners; and ultimately we make a choice in the knowledge that we see only through a mirror dimly—and our choices are constrained by the frailty of our capacity and the failings of

our community life as a Christian community, and in the midst of a secular society whose values have shifted significantly.

Our hearts hold a vision for life that is lived fully and well, with its ending embedded in a loving community of family and friends, and Christian community who offer support and care until our last breath, assisted by the gifts of medical science to alleviate suffering where possible. For some this is possible; for others their ending comes in loneliness and isolation, with little support or community, or with extreme mental or physical suffering. When we fail to offer support, we collude with conditions that make MAiD a possible or even inevitable alternative.

This collection of essays is a "turning of the prism" to hear a variety of voices reflect on MAiD in light of experience, scripture, theology, and community. Though there are contradictory reflections among the essays, what is clear and consistent in them is that decisions around MAiD are serious, never to be taken lightly, and always within the framework of all life as a gift of God to be honoured with care and love. The role of the community—be it of family or wider society—is highlighted in its support and in reflection on its absence that both influence decisions about MAiD. Anglicans do not advocate unfettered access to or application of MAiD. Discernment is expected to embrace the complexity of personal, medical, and theological information in the midst of the limits of human capacity and in humility before God's grace and forgiveness.

It is my hope that the diversity of these voices will awaken further conversation that will challenge the ministry of the church in its pastoral commitment to all people and in its call to uphold the sanctity of life in responsive community.

The Most Reverend Linda Nicholls,
Archbishop and Primate of All Canada, 2023

Introduction

J. EILEEN SCULLY

Canadian Anglicans are among the few Anglicans worldwide living in a civil jurisdiction in which medically assisted dying, or medical assistance in dying (MAiD), is a legal option. And it is such an option in a widening set of life circumstances which may, now, be determined to include those that are not coincident with what we have to date understood to be normal "end of life" circumstances.

We need to talk together about what this changed reality means for our country, for us as Christians, for the vulnerable, for health care, for social justice, and for God's gift of life. We need to figure out some things about what this means within our baptismal calling to care for those who suffer.

It has been difficult across our church to figure out how to talk together, how to listen to each other. Some bishops have issued guidelines and directives for clergy aimed to help them discern how to offer pastoral care when individuals have chosen medical assistance to die; others have not yet done so; and most church leaders are looking for guidance in what to do, how to offer the best local leadership. We need to talk.

In the 1990s, public debate in Canada coalesced around several prominent cases that centred questions about "mercy killing" and euthanasia. By 1998, *Care in Dying*[1] was commended to the church to help us to think through a number of end-of-life issues.

Roughly fifteen years later, early discussions of what was then being called physician-assisted suicide, though informed by public discussions and government proposals, were still based on hypotheticals. We could

[1] Task Group of the Faith, Worship, and Ministry Committee, *Care in Dying: A Consideration of the Practices of Euthanasia and Physician Assisted Suicide* (Toronto: The General Synod of The Anglican Church of Canada, 1999), http://www.anglican.ca/wp-content/uploads/2010/10/care-in-dying-scanned.pdf. Commended by The General Synod 1998 for study across the church.

articulate some things with clarity: concern for the most vulnerable and any who might be manipulated into a MAiD decision, the certainty of the need for provision of pastoral care to all who are dying, and deep concerns about a growing idolatry of choice and notions of human dignity rooted in autonomy rather than in God's gifts to us in life itself. And we could press for universal access to health care and to palliative care.[2] But anything that we were saying even just those short years ago looks quite different from where we might start the conversation today.

Today we have narratives from close experience: It can be that my mother, father, brother, wife, daughter, neighbour, parishioner chose to request MAiD to end their life. Perhaps my parish isn't sure how to think about someone who has made it known that their death will be on a certain date in the near future. Maybe my client in social services is distraught, having been presented with MAiD as a possible "treatment" option. Could it be that my physician was just talking about MAiD when they spoke about the long-term prognosis of my disease and what "treatment" may be before me? The fact of legal option means that we all in Canada can be presumed at some point to need to consider what to do if or when we are faced with the question, ourselves, personally.

And the crises of suicides continue, especially among young Indigenous people. Radical inequities in health-care provision remain and sharpen. The fragility of both acute care and long-term care systems is reported across the country. Palliative care in hospice is to many considered an unattainable luxury. And why do the voices calling for better palliative and hospice care seem recently more quiet, or perhaps more drowned out?

We now have several years' experience—some of them lived through a global pandemic—of wrestling in faith not with abstracted possibilities looming on a horizon, but with lived realities of pastoral response. We need to grapple with the incarnate reality of these pastoral and familial situations in our own lives.

Canadian Anglicans have had a difficult time talking together about MAiD. We live within a culture that sanitizes death and does not want us to gaze upon its reality, and so we cover up the "nakedness" of death with all sorts of different clothing intended to make us more comfortable with someone's "passing."

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[2] Faith, Worship and Ministry Task Force on Physician Assisted Dying, *In Sure and Certain Hope: Resources to Assist Pastoral and Theological Approaches to Physician Assisted Dying* (Toronto: The General Synod of The Anglican Church of Canada, 2016), https://www.anglican.ca/resources/sure-certain-hope-resources-assist-pastoral-theological-approaches-physician-assisted-dying/). This resource was published in 2016, the same year that saw MAiD legislation enacted, but the work on it had begun two years prior.

In part, it's been quiet because there is fear in the room, and with good reason. This is fearful stuff of human life, which we say as Christians is about our life in God, our life within the very life of the Holy Trinity. It is fearful stuff to stand in the place of contemplating our *telos,* the end of this earthly life, which we claim is actually an end that is ultimately being-in-God's-own-embrace within the new creation, in sure and certain hope of the resurrection to eternal life in God. And we know that this new creation and resurrected life starts now, within this life.

Some Canadian Anglicans have expressed their desire to hear The Anglican Church of Canada nationally through its leadership—be it the General Synod, the House of Bishops, or particular leaders—speak with one voice either to condemn MAiD both in principle and in practice, or to offer clear pastoral guides to priests and deacons and lay pastoral visitors on precisely how they should exercise pastoral presence in ministry with the sick in situations where MAiD has been enacted. In order for there to be any discernment of what might be said together, across some fairly difficult divisions of theological and ethical positions, we need to hear at least some of those voices first-hand.

This collection in part aims to do that: to bring together a sampling of pastoral, ethical, and theological reflections on present experiences and challenges in how MAiD is being offered, decided upon, and enacted; what these experiences illuminate and bring to the Gospel; and how Scripture, Tradition, and reason may be brought to bear on the ethics and lived faith of Christians as we face suffering and death, our own and that of those whom we love and care for.

Each of the General Synod's previous offerings on the topic of medical intervention in the dying process has been commended to the church in the hopes of engaging local conversations among parishioners, pastors, bishops, and other church leaders. This present offering is no different in its aim, though the starting place as mentioned is somewhat different because Canada is somewhat different now, seven years on into our experiences of legal medically assisted dying.

About the Essays in This Volume

The authors who have contributed to this volume were identified through a process that involved reaching out to a number of groups. All bishops of The Anglican Church of Canada were asked for their recommendations of potential writers. Anglican theological colleges and religious orders were also approached. Word of mouth spread interest in the project, and in the end close to forty potential authors were

identified in January of 2023. By the deadline in late June of 2023, 22 submissions were received from individual writers, along with the statement by The Prayer Book Society of Canada.

This volume of essays by Canadian Anglicans and ecumenical and full communion partners came together as an attempt to lay the groundwork for further conversation and theologically focused exploration of the issues involved. This Introduction does not serve also as a "conclusion" as though providing a summary would tell us what Canadian Anglicans are thinking about MAiD; there is no scientific statistical representational meaning to be found here. What is present is, however, a certain snapshot of some thinking in "real time" in 2023, by those who were willing to do the work for this project.

A preliminary version of this project was published in September 2023 along with a public invitation to the church to send in more essays. This final version includes a submission from the Diocese of Calgary, along with excerpts from the General Synod's previous work in 2016, *In Sure and Certain Hope*. Also added is the full text of the 2019 resolution of the Evangelical Lutheran Church in Canada, and the letter sent by Archbishop Fred Hiltz, then primate, to the parliamentary Special Joint Committee on Physician-Assisted Dying in 2016.

All essays share a deep rootedness in faith in the crucified and risen Christ, a desire to live in baptismal faithfulness in compassion and care, and a sense of call to be living out relationally the dignity and new life we are called to in God. All raise concerns about the real and potential abuses that can take place under a MAiD protocol. Some argue that MAiD itself is abusive, is wrong, and should never be considered by a Christian, nor supported by pastoral prayer at the bedside. Others speak of the compelling call of their vocations as clergy to accompany and not to judge, even while holding concerns closely. Some speak of personal decisions in process or having been made to enact MAiD within their own context of faith, decisions which have been for them revealing of God's grace.

All carry a deep sense of our mutual belonging to each other, as we are grafted together onto Christ. For some this radical nature of Christian identity shapes a strong critique of the idolatry of individual choice and freedom, and notions of dignity as consisting in autonomy. For others the duty of pastoral accompaniment includes a duty to honour and to recognize as faithful Christian acts the decisions by persons to access medical assistance to end their lives. Our responsibilities one to another extend into these tender and fearsome places.

The voices in this collection are not fully representative of the diversity of race, socio-economic location, geography, culture, language, and other realities that shape all experiences, including experiences of MAiD. This speaks to the need for ongoing gathering up of reflections, if we are truly to listen to the church.

Summary of Contents

The first thing that you will see after this Introduction is the official outline of what constitutes the legal framework of medically assisted dying in Canada, from the Government of Canada at this point of publication, in early 2024.

This is followed by two items created under the auspices of the General Synod in 2016, before the above legal framework was developed. As mentioned above, *Care in Dying* had, in 1998, addressed the theological-ethical considerations of euthanasia, offering careful distinctions and definitions of what matters were at stake. In 2015 a task force including health-care chaplains, physicians, ethicists, and legal experts began work to encourage pastorally informed and ethically careful theological reflections. Excerpts from that work, *In Sure and Certain Hope,* are presented here: What do we make, theologically, of human suffering? Of life as a gift? Where is hope? What constitutes dignity? This chapter is a reprint of the first section of *In Sure and Certain Hope,* received by the General Synod in 2016.

Later that year, 2016, The Anglican Church of Canada was invited to make a submission to the parliamentary Special Joint Committee on Physician-Assisted Dying. The letter, sent under the signature of Archbishop Fred Hiltz, Primate of All Canada, is included in its entirety as a chapter here. Its tone is instructive to government about who Anglicans are, our experiences in pastoral care with the dying, and the roots of our concerns for the framing of legislation around assisted dying. The letter also poses a lot of questions to those who were charged with framing the legislation. At centre are questions relating to consultation on a nation-to-nation basis with Indigenous Peoples in Canada, as well as expressions of concern about possible coercion and about the importance of a robust health-care system including palliative and hospice care.

The next chapter is a reprint of a statement adopted by the National Convention of the Evangelical Lutheran Church in Canada in 2019. *The Call to Journey Faithfully with Those Who Are Dying* reflects several years of consultation across the church and input from Lutheran theologians, pastors, and ethicists. Core pastoral and theological

questions are explored in sections interspersed with biblical passages, "Dwelling in the Word," to guide reflections.

Most of the book consists of personal reflections by individual authors. Some of the essays are reflections on experiences of the death of loved ones or parishioners or persons receiving pastoral care in health-care settings. June Maffin weaves together her experiences of three deaths intimate to her and asks what is it to "let love speak" and to listen to its guiding voice. Cate McBurney, an ecumenical voice in the collection, asks this question as well, and in efforts to combat the stigma around MAiD invites us into sacred conversation about what is required "to acknowledge and enter compassionately into the actual illness journeys … [of] those who have chosen MAiD and their loved ones." Trish McCarthy offers thoughts from many years of clinical pastoral ministry and teaching to guide pastoral attentiveness, leaving space for God to have room to work while helping people and their families to deal with fear, changes to personal identity, and meaning-making. Bruce Wheatcroft with transparency lets us in to his own discernment process and the Theological Worlds he has been leaning on to make sense of suffering and life and his own nearing death, and to how the aesthetic world, beauty, brings him close to divine hope. Chris Salstrom, a spiritual care professional in long-term care, whose role is one of non-judgmental accompaniment, asks what are the best pastorally caring ways to exercise vocationally the presence of Christ in relation to the needs of patients, families, and staff. Don Shields, also a spiritual care provider, sees his role as affirming God's love, aware of the times when he experiences dissonance, but nevertheless affirming the potential for grace when MAiD is employed within the palliative spectrum of treatment. Bertrand Olivier recounts his relative unpreparedness to face being called to a death by MAiD, naming some of the societal values and expectations about death that make the necessary reflection rare and difficult. In the end he understands himself as "someone whose role means that I need to be where God's people are, even if it is in a place where I would rather not be."

What guidance is being given to parish clergy and lay pastoral leaders about the nature of pastoral care in contexts of medically assisted dying? At this time of writing, we are aware of a good number of dioceses in which conversations are evolving for learning and mutual support as clergy in particular wrestle with conscience, ethics, pastoral duty, and the call to presence. The Diocese of Calgary commissioned a study paper that led to the development of its own guidelines which serve as diocesan policy. Both of these documents, the study paper and the

policy document, are included here. In a diocese that has not at present articulated guidance, Marty Levesque looks to the baptismal covenant and diocesan codes of conduct that bind him as a priest to find the guidance he wants for how to be present as a priest of the church in a death by MAiD, and finds himself in a process of ongoing discernment.

Another group of authors work from personal pastoral experience to raise theological questions. In a reflection on the Beatitudes, Miranda Sutherland lifts up a counter-cultural set of values for an alternative Christian approach to suffering and to the option of MAiD, urging the church to adopt values of humility, poverty of spirit, compassion, and empathy against the seemingly all-powerful nature of medical technologies and agents that make MAiD possible. Sister Kathryn Tulip explores the complex interweaving of personal, social, and human evolutionary events that have brought us to this place, and asks how we stand against the commodification of medical treatment and even of death as we have over-managed too many of life's processes already. How to keep tending to the needs of soul, of spirit, of human beings? Paul Friesen asks "What's a life worth, anyways?" and points to God as the source of our human dignity, and to the measure of quality of life that can be found through our putting on of the Lord Jesus Christ and living from the fruits of the Spirit. Peter Armstrong points to Christ to guide a more faithful response to the challenge of MAiD and asks us to centre the suffering of Christ and the possibility of the redemptive power of our own suffering when we are open to the Holy Spirit to build stronger theological foundations for our consideration.

While many of the papers raise concerns about potential abuses of MAiD and share some stories of MAiD being offered as an alternative to medical treatment for vulnerable populations, two essays stand out for their authors' locations in deep ministry with people living in poverty, with disability, and in insecure housing. Maggie Helwig reminds us that the public "face" of MAiD has been one of privilege, with rhetoric around a "good death": "a rhetoric which centres around choice and control, as opposed to a rhetoric which acknowledges vulnerability, weakness, interdependence, and social solidarity, is most often employed by people who already have considerable privilege and do not wish to release it, and that it runs counter to some of our basic theological principles." Angie Hocking tells the story of a vulnerable woman, sick with cancer and living in poverty, and reflects on the atrocities and injustices of MAiD being presented to people "as a better option than a life of poverty" and illness. Centreing the experiences of the vulnerable, those living in poverty and with disability, for each of

these authors is an act of calling on the rest of us to a new way of being, a Gospel way of being, to be truly about liberation of the poor.

The Prayer Book Society of Canada released a statement on MAiD on June 20, 2023, which is reprinted here. Based on the doctrine found in the Book of Common Prayer (1962) it declares MAiD to be against the *consensus fidelium* of the universal Church, and calls on the church "to issue a clear public condemnation of MAiD" and on those who have offered prayers or sacramental ministry to MAiD patients to make an act of repentance. Chris Dow expands on these foundations and argues that in choosing quiet acceptance of MAiD, our church is committing self-murder, or "ecclesial euthanasia." In choosing death, blessing MAiD, and sacramentalizing it in violation of canon, he argues, we have handed over a quasi-sacramental power to MAiD-providing medical professionals, and that we need a shock like a defibrillator to jolt us back to life-affirming discipleship and witness. John Berkman, a Roman Catholic theological ethicist, explores the relationship between law and morality in the Canadian process of legalizing MAiD and presents an alternative Christian narrative, one that must reject the euphemism of "MAiD" in favour of naming the killing of the innocent for what it is.

Ben Crosby also critiques a society that devalues the lives of persons with disabilities and defines the good life in terms of choice, autonomy, independence, and lack of suffering. We belong to Christ, and therefore to each other, and our choices should lead us to embrace what helps us to cleave closer to Christ; we cannot end the life we have received as a gift. Ian Ritchie further unpacks the myth of progress that enshrines control and autonomy and the promises of yet greater freedom; simply put, though, the Scriptures do not promise us either control or autonomy, and our freedom is in Christ, whose suffering can inform how we speak prophetically about the dangers of MAiD. "What is choice, anyways?" is a question with which several authors wrestle. Jesse Zink describes our current context, which enshrines the importance of individual choice while it "also occlude[s] the power of major corporations to shape those choices." Choice and freedom so touted as virtues are revealed as illusory idols. Ought we not better to learn from Jesus, whose identity was shaped not by particular acts of deliberate choice but by his identity-in-God?

Ephraim Radner brings his own family's experience of tragic death by suicide into dialogue with the work of John Donne and with Anglican commentaries on the book of Job. The legal presence of MAiD in Canadian society gives to suicide the too-alluring power of seduction and opens up a dangerous threshold over which we ought not to peer

lest we lose ourselves to this powerful compulsion; our eyes need instead to be firmly set on what we know of God in Christ Jesus.

Christopher Brittain looks to the Pendeli Statement of the International Commission for Anglican-Orthodox Theological Dialogue, *Dying Well, Living Well,* and finds its theological foundations solid but poorly applied to the topic at hand. Noting parallels in arguments against assisted dying, he asks for a reality check against projections and assumptions that are not what we have in a well-guarded system that offers medically led assisted dying. He leaves us with implied questions even about this particular essay collection process: Are we being true to the realities we are trying to address? Are we being true to our theological foundations? Are we bringing these two truth-searches together responsibly?

Lizette Larson-Miller offers us a theology of what it is to "die in the Lord." In baptism we are grafted into Christ, the Holy Spirit working to quicken in us a unity of body and soul. "We have put on Christ, our life is not our own to take." The baptismal living that pours from this font is union with Christ, is divine indwelling in us; baptismal dying is a profound witness to our unity with Christ and one another as we pray for the dying to depart from one part of the communion of saints here on earth to another part of that living communion.

Using This Resource

You will not find all of the essays easily agreeing with each other. Some groupings of essays can be considered complementary, and others contradictory.

One could choose to read only those essays with which one might be likely to agree, based on the first paragraph or so. Please do not be tempted to skim read in that way. If Canadian Anglican Christians have had a difficult time talking together about MAiD, and there is little evidence to the contrary, our talking together should begin in listening to one another, engaging the skills and disciplines we have learned in listening to each other in other contexts. Ecumenical dialogues, for example, teach us to listen to the other for the gifts that they are offering, bits of treasure, and even glimmers of God's grace articulated afresh for us that we may be surprised to hear. Listening to Indigenous survivors of residential schools has taught dominant culture settler peoples the importance of listening to painful stories in order to be confronted by the sin that we need to be confronted with, finding grace along the way of metanoia. We need to be reminded from time to time that it really is worth listening to someone with whom we are inclined in advance to

disagree. It is our hope that readers of this work will indeed take in all of the voices in the collection, in a spirit of dialogue. Read as though *listening* in these dialogical ways.

Each author was invited to create "Questions for Reflection and Discussion." These may help to guide your own reading and thinking, and could be used in parishes, theological colleges, or other contexts for discussion purposes.

Any group discussions ought to be carefully bounded by care for process in conversation that underscores mutual respect, listening, and generosity with time and attentiveness, opened in, undergirded with, and finally offered up in prayer. Care is to be taken early in the process to have all participants contribute to a conversation that sets and agrees "ground rules" for behaviour and appropriate boundaries. The *Study Guide* created for *In Sure and Certain Hope* is once again commended for use as an accompaniment to this volume of essays (available at www.anglican.ca/faith/focus/ethics/pad).

The Reverend Dr. J. Eileen Scully *serves The General Synod of The Anglican Church of Canada as director of Faith, Worship, and Ministry. She holds a PhD in systematic theology from St. Michael's College, Toronto. In her role with General Synod she is responsible for liturgical development and serves several networks supporting local ministries. She lives in Waterloo, Ontario, and is an honorary assistant priest at the parish of St. John the Evangelist, Kitchener.*

Medical Assistance in Dying: An Overview

GOVERNMENT OF CANADA[1]

The legal framework for medical assistance in dying is in flux at the time of writing; however, it is important to look at current provisions and regulations. Below is some of the information available as at the end of December 2023.

Overview

Medical assistance in dying (MAID) is a process that allows someone who is found eligible to be able to receive assistance from a medical practitioner in ending their life. The *Criminal Code of Canada* permits this to take place only under very specific circumstances and rules. Anyone requesting this service must meet specific eligibility criteria to receive medical assistance in dying. Any medical practitioner who administers and assisted death to someone must satisfy certain safeguards first.

Only medical practitioners are permitted to conduct assessments and to provide medical assistance in dying. This can be a physician or a nurse practitioner, where provinces and territories allow.[2]

There are two methods of medical assistance in dying available in Canada.

Method 1: a physician or nurse practitioner directly administers a substance that causes death, such as an injection of a drug. This is sometimes called clinician-administered medical assistance in dying.

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[1] Excerpts from official Health Canada government website, Medical Assistance in Dying Overview. https://www.canada.ca/en/health-canada/services/health-services-benefits/medical-assistance-dying.html, accessed December 29, 2023.

[2] For more details regarding the development of legal frameworks, see https://www.canada.ca/en/health-canada/services/health-services-benefits/medical-assistance-dying/legislation-canada.html.

Method 2: a physician or nurse practitioner provides or prescribes a drug that the eligible person takes themselves, in order to bring about their own death. This is sometimes called self-administered medical assistance in dying.

Clinical guidelines and practices outline which drugs to use, and are established by provinces and territories, and by organizations that regulate the practice of medicine.

Many of the drugs commonly used for this procedure are already available in Canada. Health Care providers usually prescribe them at lower dosages for common purposes, such as nausea, pain control, anesthesia. As the regulator of drug products, Health Canada is working with partners to help support access to drugs for medical assistance in dying.

Eligibility

To be eligible for medical assistance in dying, you must meet **all** the following criteria. You **must:**

- be eligible for health services funded by a province or territory, or the federal government
    - You may also be eligible if you meet your province or territory's minimum period of residence or waiting period
- be at least 18 years old and mentally competent
    - This means being capable of making health care decisions for yourself
- have a grievous and irremediable medical condition
- make a voluntary request for medical assistance in dying
    - The request cannot be the result of outside pressure or influence
- give informed consent to receive medical assistance in dying

Grievous and irremediable medical condition

To be considered as having a grievous and irremediable medical condition, you must meet **all** of the following criteria. You must:

- have a serious illness, disease or disability
- be in a state of advanced decline that cannot be reversed
- experience unbearable physical or mental suffering from your illness, disease, disability or state of decline that cannot be relieved under conditions that you consider acceptable

You do **not** need to have a fatal or terminal condition to be eligible for medical assistance in dying.

If your medical condition is a mental illness, you are not eligible for medical assistance in dying until March 17, 2024.

If you have a mental illness along with other medical conditions, you may be eligible for medical assistance in dying.

Eligibility is always assessed on an individual basis and takes all relevant circumstances into account. However, you must meet **all** the criteria to be eligible.

Informed Consent

Informed consent is when you give permission to receive medical assistance in dying **after** you receive all of the information you need to make your decision. This includes:

- your medical diagnosis
- available forms of treatment
- available options to relieve suffering, including palliative care

You must be able to give informed consent both:

- at the time of your request
- immediately before receiving medical assistance in dying, unless special circumstances apply

You can withdraw your consent at any time and in any way.

Making a Request

Regardless of location, you can request medical assistance in dying if you're eligible.

If you're experiencing a lot of pain and suffering due to your medical situation, talk to your physician or nurse practitioner. You can discuss options related to your circumstances and your possible interest in medical assistance in dying.

How and where this service will be offered is determined by:

- medical institutions
- provinces and territories
- the organizations that regulate health professionals

You may have to meet other requirements. Your health care provider tell you more.

If you don't have a regular practitioner, your province or territory may have a central coordination service that can help you.

The role of provinces and territories

Policies and procedures may vary depending on where you live. Provinces and territories can create health-related laws or rules that may affect medical assistance in dying services. However, they cannot permit actions that are prohibited under the *Criminal Code*.

Rules that can affect medical assistance in dying can include:

- data and information collection
- the use of specific forms to fill out
- special medical training for providers of the service
- rules or requirements for either type of medical assistance in dying

If you have questions about the law and policies in your specific location, contact your province or territory.

Procedural safeguards

Before a medical practitioner administers medical assistance in dying, they must satisfy certain safeguards. These include making sure that you:

1. have two independent medical assessments
2. make a written request signed by an independent witness
3. know that you can withdraw your request at any time
4. provide final consent before receiving medical assistance in dying
5. give advance consent, if applicable

They must also meet extra safeguards in the event that your death is **not** naturally foreseeable.

Medical assessments

When you make your request for medical assistance in dying, two independent medical practitioners (physicians or nurse practitioners) must assess it.

Your medical practitioner must make sure that you meet all of the listed eligibility criteria. The second practitioner must also provide a written opinion confirming that you're eligible.

The medical practitioner providing the original assessment and the one giving the second opinion **must** be independent. This means they cannot:

- knowingly benefit from your death
- hold a position of authority over the other
- be connected to the other or to you in a way that could affect their objectivity

Making a written request

You must sign a written request that says you want to have a medically assisted death. The request **must** include your:

1. signature confirming your request for medical assistance in dying. If you can't write, another adult can sign the request on your behalf under your clear direction. This adult must:
   a) be at least 18 years of age
   b) understand what it means to request medical assistance in dying
   c) not benefit from your death (for example, they must not be an heir to your estate)
2. written request must be signed and dated before **one independent witness**, who must also sign and date the request

Some provinces and territories may have a specific request form for you to complete. You can get this form from your health care provider or your provincial or territorial government website.

Independent witness

The role of the independent witness is to confirm:

- the signing and dating of the request by the person requesting medical assistance in dying
- that the person requesting medical assistance in dying understands what they're signing

An independent witness:

- must be at least 18 years of age
- can be a paid professional personal or health care worker
- must understand what it means to request medical assistance in dying

To be considered independent means that the witness **cannot**:

- benefit from your death
- be an unpaid caregiver
- be an owner or operator of a health care facility where you live or are receiving care

Withdrawing your request

You must be informed of your right to withdraw your request for medical assistance in dying at **any** time and in **any** manner.

You do **not** have to proceed even if you're found eligible for the service.

Final consent

Immediately before receiving medical assistance in dying, you must:

- be given the opportunity to withdraw consent
- affirm your consent if you do not wish to withdraw it

An exception to this requirement is possible if you have a waiver of final consent. You can waive the requirement to provide consent just before you receive medical assistance in dying, **only if**:

- your natural death is reasonably foreseeable and
- while you had decision-making capacity:
    - you were assessed and approved to receive medical assistance in dying
    - your practitioner advised that you are at risk of losing capacity to provide final consent
    - you made a written arrangement with your practitioner to provide consent in advance on your chosen date, if you no longer have capacity to consent on that date

Any arrangement for the waiver of final consent will be considered **invalid** if, at the time that you are to receive medical assistance in dying, you:

- no longer have capacity **and**
- demonstrate refusal or resistance to the administration of MAID by words, sounds or gestures

Reflexes and other types of involuntary movements **do not** constitute refusal or resistance. Examples of involuntary movements include responses to touch or the insertion of a needle.

Advance consent in cases of self-administered medical assistance in dying

You can make a written arrangement with your practitioner so that they can administer medical assistance in dying in the event of failed self-administration.

This arrangement allows for clinician-administered medical assistance in dying if there are complications during self-administration that cause your loss of decision-making capacity but not your death. This means that your medical practitioner must be present at the time that you self-administer the medications.

Requests where your natural death is not reasonably foreseeable

If the medical practitioners assessing your request for MAID determine that your death is not reasonably foreseeable, there are extra safeguards that **must** be met before medical assistance in dying can be provided:

1. One of the 2 medical practitioners who provides an assessment must have expertise in the medical condition that is causing your unbearable suffering.
    a) If neither of them have this expertise, you **must** consult another practitioner with expertise in the medical condition during the assessment process.
2. You must be informed of available means to relieve your suffering, and offered consultations with professionals who provide services including, where appropriate:
    a) palliative care
    b) community services
    c) counselling services
    d) mental health and disability support services
3. You and your practitioners must have discussed reasonable and available means to relieve your suffering, and all agree that you have seriously considered those means.
4. Your eligibility assessment must take a minimum of 90 days, unless the assessments have been completed sooner and you are at immediate risk of losing your capacity to consent.
5. Immediately before you receive medical assistance in dying, the practitioner must:
    a) give you an opportunity to withdraw your request
    b) ensure that you give express consent to receive medical assistance in dying

Medical practitioners

Those who can conduct assessments and provide medical assistance in dying are:

- physicians
- nurse practitioners (in provinces where this is allowed)

Those who can **help** provide medical assistance in dying include:

- pharmacists, pharmacy technicians and assistants
- family members or other people that you ask to help
- health care providers who help physicians or nurse practitioners

These people can assist in the process without being charged under criminal law. However, physicians, nurse practitioners and other people who are directly involved must follow:

- the rules set out in the *Criminal Code*
- applicable provincial and territorial health-related laws, rules and policies

Provider's rights

Not all health care providers are comfortable with medical assistance in dying. Federal legislation does not force **anyone** to provide or help to provide medical assistance in dying.

Provincial and territorial governments are responsible for determining how and where to provide health care services. They may also make policies around where medical assistance in dying can take place. However, they cannot permit actions that are prohibited under the *Criminal Code*.

Supporting access

We understand that these provider rights could create challenges if you want to access medical assistance in dying. Contact your health care provider for questions about access. You can also contact your province or territory for information on the procedure and other care options.

If you're a health care provider, contact your provincial or territorial professional regulatory body for information about:

- your reporting obligations
- specific practice guidelines

Additional Resources provided by Health Canada

Support Resources

- https://www.canada.ca/en/health-canada/services/health-services-benefits/medical-assistance-dying/supports-resources.html

For Health Professionals and Regulators

- https://www.canada.ca/en/health-canada/services/health-services-benefits/medical-assistance-dying/health-professionals-regulators.html

From Justice Canada, on the legislation

- https://www.justice.gc.ca/eng/cj-jp/ad-am/index.html
- https://laws-lois.justice.gc.ca/eng/acts/C-46/section-241.2.html

Questions for Reflection and Discussion

1. Having read the Canadian federal government's own summary of the regulatory framework for medical assistance in dying, what question would you wish to ask the framers of the legislation?
2. What are the human values on which this framework is based?
3. How does Christian theology engage with those values?

In Sure and Certain Hope[1]: Theological Reflections

FAITH, WORSHIP AND MINISTRY TASK FORCE, 2016

In 1998, the General Synod commended the study document Care in Dying *to encourage discussions in dioceses and parishes about euthanasia and assisted suicide. In 2014, as Canada's legal system began to consider MAiD as a constitutionally permissible possibility for certain persons, a task force of General Synod's Faith, Worship, and Ministry committee deliberated the changing context of MAiD. The anticipated legal changes underscored the necessity for Christians, especially those in pastoral roles, to further consider the ethical and theological dimensions of MAiD. The following is a segment from the task force's work, published in 2016.*

Insights from Scripture and Tradition

The approach taken by *Care in Dying (1998)* was to dive directly into some of the most controverted issues with respect to biblical witness. The most difficult questions still remain with us: the issue of suicide, the notion of life as gift, and the meaning of suffering. In each of these areas, the concern of the task force at the time (1998) was to elucidate and differentiate between acceptable and non-acceptable theological approaches, setting up contrasting views. The key points, with further elucidation, follow.

Suicide

Care In Dying pointed out clearly that none of the biblical passages that seem to refer to suicide[2] can be applied to the question of assisted dying in the context of a life maintained by intensive and often dehumanizing

[1] *In Sure and Certain Hope* was created by a Task Force of the Faith, Worship, and Ministry Committee of General Synod and released in 2016. It can be found in its entirety here: https://www.anglican.ca/wp-content/uploads/In-Sure-and-Certain-Hope.pdf. Members of the task force were: Eric Beresford, Louisa Blair, Anne Doig, Douglas Graydon, Juliet Guichon, Ian Ritchie, Janet Storch, with staff support by Eileen Scully.

[2] Examples cited in *Care in Dying* include: 2 Samuel 17:23; 1 Kings 16:18–19; Matthew 27:3–5.

technological intervention, or in the face of unbearable pain and suffering. *Care in Dying* also acknowledged how the church's approach to the question of suicide has changed from one of a blanket condemnation of the act of suicide to one of compassion and pastoral care for the one driven to suicide and to their family and loved ones. This shift has been driven both by a fresh articulation of the implications of the call to live in ways that reflect the unbounded love and compassion of God and also by a more nuanced understanding of the situation, health, and motivating factors that might lead and individual to believe that the only viable option in front of them is to take their own lives.

The church no longer sees as acceptable interpretations of the motives for suicide cases in terms of lack of courage, unfaithfulness, or in terms of the rejection of God's will. We have also become increasingly skeptical of our capacity to understand and interpret the work of God in the life of another person. And though we have a long way to go, Christians have benefitted from advances in public awareness and professional education regarding mental illness. Pastoral care of those with suicidal ideation begins in the seeking of immediate qualified critical psychiatric care and appropriate medical intervention. Questions of situation and cause need to be assessed within the context of medical treatment wherein mental health diagnosis and treatment are involved.

Suffering

A distinction needs to be made between suffering for the sake of the Gospel, and suffering within the human condition. When St. Paul speaks of suffering, for example, it is a suffering for the Gospel that comes as a result of his living out of his faithful response to the call of God. This is one sort of suffering which has its own theological meaning.

That form and meaning of suffering must be differentiated from the pain and suffering that is experienced as part of the human condition with its vulnerability to mental illness and physical sickness, aging processes, injury, suffering, and death.

Care in Dying rejected the claim that such suffering might be simply viewed as "devoid of purpose, and thus without redemptive value,"[3] and strove to be more nuanced. The report acknowledged that suffering might be meaningful. However, it also noted that suffering might be devoid of redemptive value in and of itself. It still remains to be asked

[3] P. 21, discussing the report of the Episcopal Diocese of Newark from which this quote is taken.

for whom this suffering might be meaningful. How is this sense of meaning to be established, and by whom?

The book of Job has been upheld as a profound wisdom tradition about the nature of human suffering, and has itself suffered from its vulnerability to misinterpretation. Looking closely at the biblical story of Job, we see that Job and his comforters seek to ascribe meaning and purpose to the mounting catastrophes that Job experiences. The interventions of the comforters are particularly problematic, but even Job's own search for meaning in the end comes face to face with the utter and impenetrable mystery of the being of God. In the face of this, all attempted explanations of human experience function ideologically.

> "Job's proper ethical dignity resides in the way he persistently rejects the notion that his suffering can have any meaning, either punishment for his past sins or the trials of his faith, against the three theologians who bombarded him with possible meanings – and surprisingly, God takes his side at the end, claiming that every word that Job spoke was true, while every word of the three theologians was false."[4]

Compare this with biblical scholar Walter Brueggemann's observation that, "The friends are dismissed because they had settled for an ideological conclusion, without taking into account the problematic of lived experience. The response to the encounter with the mystery of human suffering is not mere silence." As Brueggeman further clarified, "Yahweh does not want ideology to crush experience. And that leaves only two parties to draw the most authentic of conclusions: Yahweh and Job, face to face."[5]

If this encounter of the individual sufferer with God in faith is indeed the place where the mystery of their seemingly incomprehensible suffering is addressed (we cannot simply say resolved) and meaning evoked, then we as the church need to be reticent about proposing generalizable solutions. Of course, we believe that there is meaning, but it is a meaning for which we listen in the encounter between God and the patient, not one which we interpose to frame that encounter and define it.

Life as Gift

The scriptures affirm that life is a gift. However, the notion that the choice for death represents a disrespectful abandoning of that gift is one

[4] Zizak, *The Puppet and the Dawrf*, MIT Press, 2003, p. 126
[5] Walter Brueggemann, Theology of the Old Testament, Augsburg Fortress, 2012, p. 391.

that comes from later periods in the Christian tradition. *Care in Dying* (1998) draws particular attention to the views of Augustine of Hippo and Thomas Aquinas. Augustine argued from natural law that suicide violates our love of self and our instincts to self-protection. He builds on this, theologically, to say that suicide offends God who has given us life, and hurts the human community of which one is a part.

Augustine and Aquinas, arguable, set the stage for the development of Western Christian theology, and so it is not strange to find their approaches to this matter sounding somewhat familiar.

However, in each case, these two heavyweights of theology were doing what theologians do: bringing the lens of the culture, scientific knowledge, and philosophy of their day to bear on the Christian story. And those philosophic presumptions were precisely of those times, the 5th and the 13th centuries respectively.

Given the shift in Anglican thinking about suicide, we may need to rethink the easy assumption that receiving life as gift means that we cannot faithfully decide that the gift is one that we must now let go. Already in the case of the withdrawal of treatment we recognize that life is not an end in itself, and that the approach of death need not be resisted by all available means.

If the chief purpose of life is to know God and to enjoy God for ever, is it possible to conceive of circumstances where a person might faithfully conclude that this purpose could no longer be furthered by the extension of their life and might choose, not merely to cease to resist the approach of death, but to actively embrace it?

To approach this question helpfully would require a more nuanced read of the tradition[6], including its minority voices, than we are able to offer here. It would require as well a more intentional listening to the experiences of those who see no way in which their continued living can contribute to the ends of the life for which the gift was received.

Care and Community

Understandings of care, and how those understandings shape and express community, lay at the heart of the reflections in *Care in Dying*. Indeed, the trajectory of the document was in many ways set by the way it answered the question of what constitutes care. In seeking to answer the question of whether a decision to participate in the ending of life could be construed as an act of care, the study was in some ways quite

[6] For example, a close reading of John Donne's *Biathanatos*, rather easily dismissed in *Care in Dying*, might prove provocative and rewarding.

tentative. In the end however, that question was answered in the negative. The decision that there were problems so construing the ending of life as care were linked to questions of intentionality.

> "Perhaps a more telling question at this point might be to do with how our actions may be construed as examples of care. While it is fairly obvious that palliation and pain relief are acts that show our continued care for a patient for whom we can offer no cure, killing is a much more ambiguous act."[7]

Killing is more ambiguous because it can more easily be construed as an act of abandonment, a decision that the patient's life is not worth living and therefore not worth our continued investment in care. If, as *Care in Dying* insists, intentionality is important, then surely the points to be looked at are not simply whether we intend death or pain relief but also why we intend death and whether that intention is rooted in the life and dignity and choices of the one whose death we intend.

In other words, the question is more complex than *Care in Dying* allowed. It is not simply that we need to only intend death as an unfortunate, but unwilled consequence of our attempt to provide care, but also, and crucially, that in both dying and living, our care is articulated in terms of our covenant of presence to the other. This covenant is binding in health and in suffering, in life and in death. This is so because it reflects and communicates the presence of God to the other in their suffering and in their dying, and in the difficult and demanding decisions that might surround these experiences.

More careful reflection on the nature and demands of care is now particularly necessary in light of the decision of the Supreme Court of Canada. That decision consistently reduced the concept of care to the provision of therapy, in terms of medical treatment. It did not pay attention to the broader experience of care in terms of social, emotional, psychological, basic physical, and spiritual care, for example. The meaning of care and the demands it lays upon us need to be broadened.

A broadened view of matters of care, community, and conscience give rise to a complex of questions. *Care in Dying* asked whether a decision for physician assisted dying might be a response to the suffering not only of the dying but also of those who accompany them on that process. What constitute healthy relationships amongst caregivers, patient and supportive community in the patient's process of discernment? How

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[7] *Care in Dying*, p. 28

does a refusal to provide assistance in dying represent a commitment to continue with care? What does care look like in this context? What happens when my conscience is in conflict, in either direction, with the decision of the patient? What needs to be done within this conflict? How do I tend to my conscience as well as to the patient in a situation of pastoral care in which I am uncomfortable with the patient's decision? These are the sorts of questions that will be dealt with later in this document.

Intentionality and Rationality

There have been many debates over recent years concerning the role of intentionality. What does it mean to intend to do something? In debates about physician assisted dying intentionality is primarily used to distinguish between acts all of which result in the death of the patient but in some of which that death was not the willed or desired outcome.

Yet, as *Care in Dying* noted, intentionality can, in this sense, be only one part of the picture. While it is true that a foreseen consequence of our actions may not be what we intend, that it is foreseen means that we have at least some level of responsibility for it as an outcome. Perhaps more helpful in our context is the recognition that intentionality is about rationality and about narrative.

One of the things that makes a human action an action and not merely a reflex is that it is intended. If I am struck on the knee, I do not intend to kick the person in front of me. It is simply a reflex action over which I have no control. For something to be an action, at least in the moral sense, it must be something that I intend, something that I choose either explicitly or at least implicitly. This has a number of consequences.

First, it means that actions, properly so called, are expressions of who I am as a person, they reflect my intentions and in order to do so those intentions must be related to the wider narrative of who I am. I cannot simply intend anything, but only those things that make sense of my character, wider purposes, values, and commitments.

This means that what I might be able to intend changes over time as my character is shaped and reshaped by my intended actions. It means that the rationality of moral actions is in the end a form of narrative rationality because it is about rooting those actions within the story of a life in the broadest sense.

Finally, this also means that the task of moral understanding is in the end an interpretive one. I do not simply analyze actions on the basis of preformed rules and commitments, I consider actions in terms of the shape of a life. From a Christian perspective this means that I am

attempting to understand how an individual life participates in and reflects the life of Christ into which my life has been incorporated at baptism.

Vulnerability and Justice

This life into which we are incorporated is never merely about our individual lives. It is not a life that is lived for myself but rather one that shares in self-offering for the other. Christians have, from our beginnings, been concerned therefore for the well-being of the marginalized, the outsider to society.

In the area of physician assisted dying there are still reasons to be concerned about the impact of this change on those in our society who are most vulnerable. This is the reason why most groups advocating on behalf of those who live with disabilities have not welcomed this change. While advocating against the change in the law would not at this time be a practical or useful activity for the churches it is important that we continue to express concern for those who might be adversely affected. This is not simply a slippery slope argument. It is rather based in the complexity of how constitutional protections work and the experience of other jurisdictions where the initially narrow grounds for physician assisted dying became widened out of legitimate concern that some who might benefit were excluded under the initial definitions.

In the Canadian context this is particularly telling, as the conditions under which physician assisted dying will be made available remain in so many ways vague at this time. The regulations to be adopted will be crucial in ensuring that individuals are not either actively or implicitly coerced and that those who are vulnerable and at risk receive particular protection.

Dignity and its Meaning

Central to the debates concerning physician assisted dying, on all sides, is the question of the dignity of the human person. Yet, while all agree on affirming the dignity of the human person, there is little agreement on what that means and little public reflection on the dangers or difficulties involved in various approaches to uphold such dignity. In our society dignity is most commonly linked to the capacity to be the author of ones own destiny. However, this is linked with understandings of human individuality and freedom that are difficult to maintain.

All of us wish to affirm the freedom of the individual, but as our discussion of intentionality made clear, this does not mean that individuals can simply do anything.

While we all understand that freedom as involving authorship of our own acts, the idea that this is done *ex nihilo* (out of nothing) is simply unsustainable. In truth, who we are, and therefore what we are free to choose and to do, is already to some degree shaped by our personal histories, our background, our education, our cultural and religious assumptions and many other factors. Any adequate and morally informative description of human freedom and its exercise needs to take into account the very real limitations involved in living out that freedom in real historical lives.

Further, the simple link of dignity with the capacity to be the author of our own lives rather prejudges the issue for those persons whose capacities in this regard are significantly, and perhaps permanently diminished.

Others would argue that dignity is linked to relationship and is a product of the demands of human community. The point here is not that relationships confer dignity but rather that it is in our experience of those relationships that we are empowered to recognize and give voice to our inherent worth. While this approach to human dignity has much to commend it the danger is that it might be seen as reducing the dignity of those whose capacity for ongoing and sustained relationships is compromised.

In both of these approaches the difficulty is that dignity is only construed on the basis of the possession of certain qualities and capacities and this once again may lead to a devaluing of those persons lacking those qualities. Perhaps the key point, however, is that the language of dignity is supposed to remind us that in decisions about the life of a person it is that persons life, inherent worth (however that is ascribed), values, hopes, aspirations, story, etc. that drive the decision-making process and not the imposition of interpretive frameworks from without, the imposition of what Zizak and Brueggemann would call ideology.

"You matter because you are you." These are the words of Dame Cicely Saunders, expressing the foundational values of the modern palliative care movement. To uphold the intrinsic worth of the human person is to protect the very vulnerable members of society—those who have (or appear to have) little if any extrinsic value, because they do not have the capacity for full authorship or autonomy, and are not able to have the same sorts of relationships that more "productive" members of society have. This value challenges the linkage of dignity and worth with autonomy and ability to be in control of all aspects of one's life.

Conscience

One of the matters that was touched upon in *Care in Dying* and which is increasingly important in our new context is that of the role of conscience. It will surprise some people that the principle that the conscience must always be followed (*conscientia semper sequenda*) is a key element of Catholic moral theology that has continued if not with greater importance in the churches of the reformation. The role of conscience grants to the individual believer the responsibility to be the author of his or her own decisions.

This responsibility cannot be ceded to another, even to the church. Having said that, individual Christians have a responsibility to educate their conscience and this means a responsibility to engage seriously with the teaching and traditions of the church. A decision to place oneself at odds with a longstanding and widely held teaching is not to be taken lightly. However, changing social context can lead to situations in which that tradition can seem misleading, unduly burdensome, or even simply destructive.

Christians are not of one mind as to whether changes in the context of our dying are sufficient to change or qualify traditional views regarding assisted dying. In this context, especially given the changed legal situation, effective pastoral care will need to be quite clear in its respect for the conscience of the person making decisions around their own dying. At the same time, this is not to be construed as pastoral indifference, or even abandonment. We can minister with respect and care even in situations that will unfold in ways that make us uncomfortable. Indeed, it is arguable that this is where our pastoral presence is most eloquent and important.

Hope

As Christians we are called to lives shaped by hope. Hope involves the commitment that, whatever our circumstances, God is at work for our good (Romans 8:28, cf. Matthew 7:11). It stands opposed to despair. At the same time hope is not to be confused with a passivity that is unresponsive to our circumstances. Hope requires that we cooperate with God in the purposes that God is working out in our lives. Under all circumstances this will involve seeking what God is doing in our lives. This is true even in adverse circumstances, and it is not contrary to the notion that hope might include the embrace of our death.

Paul, writing to the Philippian Church chooses life for the sake of the Philippian Christians, although he clearly indicates that his personal hope is to "depart and be with Christ" (Phil. 1:23). Further, the willing

embrace of death as an expression of hope in God's faithfulness lies at the heart of our faith in the work of Christ.

Neither of these examples can be seen as either the act of, or the willing of, suicide, because neither of them are acts of despair. They raise for us the challenging pastoral question of how we might assist those faced with decisions around the end of life to make whatever decision they chose in faith and hope and in the embrace of God's presence to them.

Providing Alternatives

Having said this, if indeed decisions are to be made out of the commitments of those about whom decisions are made, then there need to be genuine alternatives and this currently does not seem to be the case.

In *Care in Dying* the argument was made that to move towards physician assisted death at a time when there were health care cuts and utterly inadequate provision of palliative care might be seen as cynical rather than caring. While it is now clear that the provision of such alternatives cannot function as a bar to patients making decisions to seek assistance to end their lives we remain of the view that this change will not reflect the intended affirmation of the dignity of patients unless there are genuine alternatives amongst which they can discern real and significant choices.

Urgent attention therefore needs to be given to the provision of appropriate (we would say excellent) levels of palliative care, social support and pain management so that any decision to avail oneself of physician assisted dying will indeed be a reflection of what expresses the patient's dignity and not an act of desperation or fear.

Questions for Reflection and Discussion

1. In your lifetime, what have been the changes that you have seen with respect to the ways that our society faces illness, suffering, and death?
2. What is the root of human dignity?
3. What does it mean to face the challenges of medically assisted dying with a "sure and certain hope of the resurrection to eternal life through our Lord Jesus Christ"? (*Book of Alternative Services*, 587)

Submission to the Parliamentary Special Joint Committee on Physician-Assisted Dying

ANGLICAN CHURCH OF CANADA, FEBRUARY 2016

In 2016, the Parliament of Canada appointed a special joint committee to consult with Canadians, experts, and stakeholders; review relevant reports and studies; and make recommendations on the framework of a federal response on physician-assisted dying. Below is the official submission of The Anglican Church of Canada to the Special Joint Committee on Physician-Assisted Dying, received in February 2016.

Background

The Anglican Church of Canada includes approximately 700,000 people across Canada, including a strong indigenous membership, along with people who come from every continent. While we were once a church of dominantly anglo-celtic ethnicity, we are now a multi-ethnic church with a face that looks a lot like the face of Canada. We are also a church of diverse perspectives on almost any issue you can say. We are rooted, though, in a shared compassion and a shared conviction of the worth and dignity of human persons, a compassion and conviction we share with many Canadians.

We have chosen here to frame our submission based on questions that arise from extensive Anglican pastoral practice and reflected upon experience, along with insights from our moral and theological tradition. Regardless of their position with respect to the Supreme Court's Decision in the Carter Case, Anglicans across the country are deeply involved in thinking about and discussing the complexity of its implications. Our church leaders have been providing leadership in public forum discussions and in consultations with regulatory bodies.

We trust that the questions raised here will contribute to your deliberations as you work out a legislative framework following upon the

decision of the Supreme Court in the Carter case.[1] We recognize that Anglicans across the country hold, in differently nuanced ways, views on the rightness or wrongness of the Supreme Court decision. We also, though, share fundamental values, points of doctrine, and ways of moral discernment. At root, these values are not incompatible with those shared more widely in Canadian society.

Ours is a contribution that comes from the concrete experience of accompaniment with the sick and dying, their families and communities. It is shaped by our commitments to social, economic and racial justice, the dignity of the human person, and the practices of love, compassion, and care. We are learning continually what it is to walk in committed partnership with those who are different from our majority population, and know what it is to listen well. When we listen, on this matter, we hear very good questions.

The Anglican Church of Canada is not new to the consideration of tough ethical issues regarding death and dying. In the mid-1970s, a report was commissioned to offer guidance on end of life care. When issues relating to euthanasia rose to prominence in public discussion in the 1990s, our Church carefully conducted research and engaged public discussions. The result was *Care in Dying* (1998), a resource still much in use today. It has helped to educate our constituency, for example, on the distinctions between pain relief that has a secondary effect of hastening death, and passive and active euthanasia. Though not a statement of policy, it has served us well in raising issues of concern and questions for further deliberation.[2]

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[1] What follows is not a formal *statement* of The Anglican Church of Canada either for or against physician assisted dying. Such a statement would require a resolution of our highest decision making body, the General Synod, and would presume a will to action by that body on a matter that may well fall within the category shared by other issues held by us to reside within the sphere of conscience.

[2] "The General Synod in 1975… 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 … (but was put on hold) … In the fall of 1996, the Faith, Worship and Ministry Committee were approached by the Canadian Council of Churches… (who) asked whether a draft statement prepared by their Faith and Order Committee… was consonant with the policy of the Anglican Church of Canada. (We)… were unable to confirm that the statement was consonant with the church's policy because, at this time, we have no policy.… Further, (our)… conversation 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." From *Care in Dying*, 1998. The present stage of work in 2016 takes the same approach: raising issues and questions.

At present we have a dedicated task force working specifically to address the matter of physician assisted dying. Its members include health care and legal professionals, (with specialists in medical ethics, palliative care, health care law, family medicine, and nursing) pastors, ethicists and spiritual care providers. It is as such deeply inter-disciplinary, and involves highly-placed professionals.

Within our church, lay leaders and lay pastoral visitors, parish nurses, deacons, parish priests, and chaplains have long and deep experience in accompanying the sick and dying, along with their families and primary communities. We know what it is to walk with people who are in pain and suffering, and through difficult end of life decisions.

Spiritual care providers are often intimately involved within the wider framework of the health care team and the family of the patient. Though spiritual care involves prayer and sacrament, it is even more about sharing a journey, both with the patient and with the family, in which deep listening fosters reflective openness—emotionally, morally, spiritually and intellectually. Spiritual care is always about inviting and attending to the patient's own narrative and reflections, and always carries with it an element of conversational moral and ethical discernment. In all of this, we are called to walk together, listening and talking, without being prescriptive, but enabling patients and families to make the best decisions they can within the context in which they are living, and within the best possible support systems.

The Anglican Church of Canada Task Force on Physician Assisted Death has just completed a resource to support those who provide care and accompany the dying. The introductory chapter is headed with a verse from the Hebrew Scriptures (The Old Testament) that reads:

> *But seek the welfare of the city where I have sent you into exile,*
> *and pray to the Lord on its behalf, for in its welfare you will find your welfare.* –Jeremiah 29:7

This part of our Jewish and Christian story reminds us of several things, with respect not only to this particular issue in health care. We are part of 'the city', a wider community, nation or country in which not everyone is like us, nor should they be, nor do we expect that the wider community outside (in our case) The Anglican Church of Canada to have the same faith perspective, or any faith perspective, to bring in to moral discernment, debate or the creation of legislation.

And, in that context of 'the city,' we have a duty to care about, to pray for, to live in harmony with, and to act with respect to all others on the

basis of their inherent human dignity and worth. This extends to the ways in which Anglicans have consistently offered spiritual care to any who call upon us, and those whom we encounter in daily life (of any faith tradition or no faith tradition). Our understanding of the duty to care for all extends, truly, to all: persons of different or no faith tradition, and those who choose physician assisted death, and those who do not choose this way.

These experiences have nurtured in Anglican pastoral sensitivities a lived wisdom that has become quite good at asking questions, particularly when faced with what seem to be binary positions or options. One of the things that we therefore offer, in seeking "the welfare of the city" is a stance that looks squarely at these options, pays attention to wider contexts of persons-in-community, cultures, power and privilege issues and considerations of compassion and justice all around, and says "it's not that easy." From there, we begin to raise important questions.

In light of the Supreme Court decision, the following are questions and concerns that we offer with the request that the Joint Committee receive with a commitment to engage.

1. Dignity, Personhood, and Community

At the foundation of Christian faith is the assertion that all human beings are created by God, in the image and likeness of God. It is on the basis of our very creation that we are motivated to uphold the dignity and worth of every human life. At the roots of our faith is the assertion that human persons, being in the image and likeness of God, are the bearers of an inalienable dignity that calls us to treat each person not merely with respect for their personhood, but with love, care, and compassion.

From these assertions follow the high value placed on personal conscience. It is not in juxtaposition but in harmony that we also say that persons do not exist apart from relationships. The questions are not about individual versus community based decision making (either-or), but rather about the person within his or her relationships (both-and). Personal conscience must be honoured, conscience shaped in the context of non-coercive, healthy, and just relationships towards sound decision making. The right to individual self determination and personal freedom and choice, and the right not to be coerced, are themselves rights shaped in concrete relationships.

Noting that the Supreme Court decision in *Carter* presumes the person to be a fully autonomous being, we raise here several questions.

Many cultures and faith traditions within the Canadian context are of the view, shaped by lived experience, that every person is part of a community, wherein they participate in receiving and in shaping values

and responsibilities. Individual values and decisions are shaped by relationships, and individual choices and concomitant actions have an effect on the community. Personal conscience must be followed; and all personal conscience shaped within the complexity of real relationships.

Q *How might the legislative framework pay attention to key relationships around the patient, when looking at the causative elements in the patient's decision making in order to determine the freedom of a decision?*

It is said by some that from North Atlantic/Western culture has emerged a sense of selfhood and individual rights that is simply a matter of inevitable positive development. However, assertions of this sort are continually tested and found wanting, both in everyday interdependence of persons in communities and families, and at times of crisis. The Anglican Church of Canada knows deeply, and in ways that challenge our own structures and priorities and values, how colonialism has devastated the Indigenous peoples and the cultures of this land, enforcing more individualistic systems and destroying communal cultural ways.

Q *What do the Indigenous peoples of this Land, and others whose lives and decision making processes are more shaped by the high value placed on community, have to teach us? What will a legislative framework look like after having listened and learned to these experiences?*

To assert that each human being has inherent dignity is to talk about worth and value in the essence of the person. We wonder how it has become that the notion of dignity has come to be equated with the power to have authorship over one's own life. In this shift, dignity is construed on the basis of certain qualities and capacities—an ideological equation that implies that those without full power of self-determination and autonomy over their own lives (bodies and minds) have lesser dignity than others. Is this not a dangerous path, and contradictory to advances that have been made with respect to care for vulnerable populations and those who have had their self-determination stripped from them?

Q *When referring to dignity of the person or of the choice, what are the factors that determine dignity? Does someone without the capacity to opt for a choice not to ask for physician assisted death not have sufficient dignity? How will you treat the notion of dignity within the legislative framework without narrowing to a definition that excludes large segments of the population from being considered to possess dignity?*

Anglican tradition and practice uphold some core principles, namely that moral discernment be:

- Compassionate: rooted in love and empathy;
- Concrete: more concerned with faithfulness to the gospel and character of Jesus, than with abstract and generalized rules or principles;
- Communal: taking place within community;
- Conscientious: respecting and calling forth the conscience of a person within the reality that they face (conscience must be followed)

- Critical: not content with the simplistic totalizing responses of other sides.

Q *Will a framework for legislation foster a context in which the conversations called for by these principles will be encouraged, or be truncated?*

Our Canadian society reflects the conflict between our commitment to care for the vulnerable, and the pressures of a more competitive individualism. The health care system is perhaps the place wherein these conflicts are enacted the most, and where—in situations of extreme financial pressure—duty to care is vulnerable to an interpretation that defaults to a less expensive set of options.

Q *How can a legislative framework ensure that appropriate care does not suffer from economic restriction, either real or ideological?*

2. Nation to Nation Relationship

We rejoice in the commitments, made by our Federal Government under Prime Minister Justin Trudeau, to new and just relationship between the Federal Government and First Nations, Inuit, and Métis communities. These are being framed as "Nation to Nation" relationships. We have learned so much, and we have so much more to learn from conversation with First Peoples. The conversation starts from the stance of newcomer peoples and dominant cultures and powers first *listening*.

On the basis of longstanding commitments and actions towards healing, reconciliation, and justice in right relationships with the First Peoples, The Anglican Church of Canada is conscious of when and where Indigenous voices and perspectives are present and when and where they are not.

Q *What assurance can the Joint Committee provide that First Nations, Inuit, and Métis leaders, and those who provide health care in those communities, are being consulted fully, Nation to Nation?*

Q *How would a legislative framework include values and perspectives from Indigenous peoples not as a special case, but integrated in a fully Canadian piece of legislation?*

Our Task Force invited submissions from Anglicans across the country about the matter of Physician Assisted Dying. Amongst others, we heard from health care workers in northern and Indigenous communities wherein, as is commonly known, the rates of suicide especially amongst young people is highly disproportionate to those in the rest of the population. This extends beyond the north to Indigenous peoples living in urban centres. Those who wrote to us expressed bafflement that there could be decisive and swift action on provision of physician assisted suicide when a) the crisis in suicides has not been addressed in ways that have made a difference in their communities, and b) there is inadequate health care and social service provision in so many poorer parts of our nation—for primary, specialist, psychiatric and palliative care.

Our church has undertaken a major initiative in suicide prevention. For many years our leaders have been on public record urging change in the conditions of poverty, intergenerational healing from Residential Schools, and other major social and economic illnesses at the root of the crisis of suicide.

Amongst the *Calls to Action in the Final Report of the Truth and Reconciliation Commission* is to be found a large section on health care (Numbers 19-24 especially) and justice (Numbers 36-41). It is clear that these priority areas demand immediate action. Issues of the suicide of teenagers and the requests for physician assisted suicide are not unrelated when we look at them from the perspective of these vulnerable populations.

Q *What related initiatives will be recommended by the Special Joint Committee for equally immediate and decisive action?*

Q *How might the legislative framework under construction at present contribute towards a wider, coherent expression of values in health care for Canadian society?*

We acknowledge the difficulty of speaking into the context of legislation framing around physician assisted death—on such a very tight timeline—when so many of our Indigenous Anglican members,

and all Indigenous Peoples with whom we are walking in solidarity and partnership, have yet to see significant action on the health care aspects of the TRC.

3. Contexts of Care and Access: Grounds for Questions about Coercion and Decision

We note that the Supreme Court Decision in the *Carter* case uses the word "care" as synonymous with "treatment." Care is about more than active treatment, provision of medication or therapies. It is about the wider context of care for the whole person, whose whole being is involved in any decision making process. This extends to spiritual care, psychological care, economic care, physical care that is much wider than medical treatment, support, and social welfare. Views have been expressed that provision of spiritual care is an automatic form of coercion against a free and clear decision to request physician assisted death. This bias does not reflect the realities of many professional spiritual care providers. Furthermore, the provision of this form of care to someone who has made the choice to be assisted into death can be one of the most critically important ways of supporting the patient and family in the process of waiting, in dying, and in the immediate time of grieving in which complex emotions and thoughts will need careful tending.

Q *Will the framework for legislation make provision for and encourage access to spiritual care?*

Some ask: how to ensure universal access to physician assisted death? The very deep and wide gaps in provision of universal access to medical care broadly speaking, both primary and specialist, pain relief and particular treatments, let alone palliation and hospice care (about which we will speak more fully below) raise critical questions about the free nature of a decision. If there are no other options available—whether high quality active treatment of disease or good palliative care, can a choice be considered 'free?' Are there not contexts wherein the lack of options itself creates a context of coercion? There is a difference between having a right, and giving access to structures respecting full dignity in which to exercise that right.

Q *How can the legislative context itself provide a structure that supports healthy decision making, including assurance of quality palliative and hospice care within the issue of universality of access?*

This Canadian Supreme Court decision, unlike those of other countries, does not require the patient to be terminally ill, only a

"competent adult" who is "grievously and irremediably ill." Several questions come into sharp focus around this particular clause:

- The definition of an 'adult' is not provided. *What if a child is 'grievously and irremediably ill'? How can legislation aid in measuring maturity and competence, and deal with the complex matter of coercion of a young person?*
- Those in perpetual, excruciating pain are in a different world from those who are not. *How might the legislative framework provide guides to evaluating a patient whose pain, or pain relieving medication, may decrease mental clarity?*
- If suicidal ideation in someone who is mentally ill is treated as a symptom of the disease, how do you determine the difference between the causality of decisions, especially when in many cases the symptom of suicidal ideation is a first presenting public symptom of mental illness? *How is mental health – as a ground of competence and freedom from coercion – to be assessed? What are the implications for mental health care?*
- Coercion can take many forms: finances, a sense of family responsibility, putting the elderly into institutions, lack of knowledge, societal pressures, lack of access to medical treatment and pain management or the options of palliation. *Will the legislative framework identify possible forms and signs of coercion and how such will be assessed?*

4. Palliative Care and Hospice

> You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die, peacefully, but also to live until you die.
> –Dame Cicely Saunder (1918-2005),
> founder of the Palliative Care and Hospice movement

Palliative care and physician assisted suicide are not complete opposites. They have a complicated relationship. Palliation is a form of assisting a person in their dying. The Canadian Association of Palliative Care Physicians (CAPCP) has reported to this Special Joint Committee, palliative care is only accessible by approximately 30 per cent of Canadian citizens.

Anglican spiritual care providers—often serving as multifaith chaplains—have a great deal of experience in palliative and hospice care. One of our

Task Force members served to found spiritual care at Casey House in Toronto and accompanied patients with AIDS for close to two decades.

Where the provision is of high-quality care, the journey of dying is accompanied by care that extends well beyond that of medical therapy. Many of our leadership, it is safe to say, would support the initiatives of the CAPCP in their call for a National Secretariat in Palliative Care, as reported in their brief of January 27, 2016.

While it may not be something within the direct and narrow remit of those drafting legislation for physician assisted dying, *how might this Special Joint Committee raise into prominence the critical need for more, and better, palliative care as central to the priorities and values of our health care system?*

In Conclusion

Our reflections here, and the questions raised, are not an objection to the decision of the Supreme Court—that decision has been made by the court, and we welcome the opportunity to contribute to a carefully crafted legislative framework that serves the inherent dignity of each human being within their primary community of support.

We care for the most vulnerable in our society, and walk with them. We are committed upholding the importance of personal conscience, and wish to find ways to ensure that such is formed without coercion. We are concerned about limited access to high quality medical care, including palliative and mental health care, especially in northern and Indigenous communities, with whom we walk in partnership. And we will continue to equip and support our pastors in their compassionate and wise care of the dying.

Summary of Questions

1. How might the legislative framework pay attention to key relationships around the patient, when looking at the causative elements in the patient's decision making in order to determine the freedom of a decision?
2. What do the Indigenous peoples of this Land, and others whose lives and decision making processes are more shaped by the high value placed on community, have to teach us? What will a legislative framework look like after having listened and learned to these experiences?
3. When referring to dignity of the person or of the choice, what are the factors that determine dignity? Does someone without

the capacity to opt for a choice not to ask for physician assisted suicide not have sufficient dignity? How will you treat the notion of dignity within the legislative framework without narrowing to a definition that excludes large segments of the population from being considered to possess dignity?

4. Will a framework for legislation foster a context in which the conversations called for by these principles will be encouraged, or be truncated?
5. How can a legislative framework ensure that appropriate care does not suffer from economic restriction, either real or ideological?
6. What assurance can the Joint Committee provide that First Nations, Inuit, and Metis leaders, and those who provide health care in those communities, are being consulted fully, nation to nation?
7. How would a legislative framework include values and perspectives from Indigenous peoples not as a special case, but integrated in a fully Canadian piece of legislation?
8. What related initiatives will be recommended by the Special Joint Committee for equally immediate and decisive action?
9. How might the legislative framework under construction at present contribute towards a wider, coherent expression of values in health care for Canadian society?
10. Will the framework for legislation make provision for and encourage access to spiritual care?
11. How can the legislative context itself provide a structure that supports healthy decision making, including assurance of quality palliative and hospice care within the issue of universality of access?
12. The definition of an 'adult' is not provided. What if a child is 'grievously and irremediably ill'? How can legislation aid in measuring maturity and competence, and deal with the complex matter of coercion of a young person?
13. Those in perpetual, excruciating pain are in a different world from those who are not. How might the legislative framework provide guides to evaluating a patient whose pain, or pain relieving medication, may decrease mental clarity?
14. If suicidal ideation in someone who is mentally ill is treated as a symptom of the disease, how do you determine the difference between the causality of decisions, especially when in many cases the symptom of suicidal ideation is a first presenting public

symptom of mental illness? How is mental health—as a ground of competence and freedom from coercion—to be assessed? What are the implications for mental health care?

15. Coercion can take many forms: finances, a sense of family responsibility, putting the elderly into institutions, lack of knowledge, societal pressures, lack of access to medical treatment and pain management or the options of palliation. Will the legislative framework identify possible forms and signs of coercion and how such will be assessed?
16. How might this Special Joint Committee raise into prominence the critical need for more, and better, palliative care as central to the priorities and values of our health care system?

Questions for Reflection and Discussion

1. Which are the most important questions that this letter raises with Parliament?
2. This letter was written in 2016. What do you think were its strengths at the time? Its weaknesses, in hindsight?
3. What questions would you want The Anglican Church of Canada to ask Parliament now that the legislation has been created and revised and is likely to be revised again?

The Call to Faithfully Journey with Those Who Are Dying: An ELCIC Resolution

ADOPTED AT ELCIC NATIONAL CONVENTION, JULY 2019

The Call to Journey Faithfully with Those Who Are Dying *reflects several years of consultation across the Evangelical Lutheran Church in Canada (ELCIC) and input from theologians, pastors, and ethicists. The statement was adopted in 2019 by the ELCIC National Convention.*

On February 6, 2015, the Supreme Court of Canada ruled that sections of the *Criminal Code* that had prohibited physician-assisted death were no longer in force and that a medically-assisted death could be allowed, but under strict criteria of protection.

In the public square and in the church, this decision stimulated conversations about dying, death and how we make decisions together. This conversation has sometimes felt uncomfortable, sometimes been enriching and sometimes revealed a deep yearning to live faithfully in all of life's realities. New ethical questions continue to arise. In certain moments, it has felt like the context is changing faster than the church can keep up; at least faster than church conventions can keep up!

All of this has provided an opportunity to be in conversation on deeply important matters. The conversation needs to continue.

In 1997, the ELCIC National Convention adopted *An ELCIC Resolution on Decisions-at-the-End-of-Life*[1], which makes reference to a 1982 *Social Statement on Death and Dying*[2] from a predecessor church body. In 2015 the ELCIC National Convention passed a motion directing the National Church Council (NCC) to review the 1997 resolution. To that end, NCC established a Task Force to generate conversations across the church and to make recommendations

[1] www.elcic.ca/public-policy/documents/1997-AnELCICResolutiononDecisions.pdf
[2] www.elcic.ca/Public-Policy/documents/500.31982-ASocialStatementonDeathandDying.pdf

regarding the current policy. This Resolution is the result of the work of the Task Force and NCC.

What core theological values will guide us as we seek to faithfully respond to our current context? In identifying theological values, our perspectives become most real, and most challenged, when we encounter personal stories. Always, we begin with the person created in the image of a God. We may well have had the experience of feeling anxious and unsure of what to say or do. The circumstances of each person's death are unique, and the final journey of one affects many: family, friends, faith community, health-care professionals and institutions.

As we make life's journey, it is vitally important to use practices that open our hearts and minds to hearing God's voice. Along with our reflections, throughout this statement we offer words to encourage and challenge us as we make this journey. These have been titled *Dwelling in the Word*. They are not intended to be proof texts, but words of inspiration, guidance and redirection as we seek to prayerfully engage in conversation and action. We have felt called to include some words from hymns along with scripture.

DWELLING IN THE WORD

We do not live to ourselves, and we do not die to ourselves. If we live, we live to the Lord, and if we die, we die to the Lord; so then, whether we live or whether we die, we are the Lord's.
Romans 14:7–8

Baptismal Calling

In Baptism, we are called to be in relationship with God and with one another, in loving and supportive community. We regard life as a sacred gift from God. Through all of life's passages, we promise to support and pray for each other.

Our first calling as a supportive community is to be present. Whenever we enter into a context where death is near, we are standing on holy ground. Life is a sacred journey; both being born and dying are truly sacred times. Death is a mystery. Recognizing the uniqueness of each person's journey, we enter the presence of another with humility: seeking to minimize our judgements, being careful about our certainties and listening with as much grace as we can offer.

As much as we cling to the promises of God, we must also admit that there is much that we do not understand. When we are called to journey with a dying person, it is a ministry of accompaniment. We bring our

compassion, humility, mercy and grace. We bring our whole self: our experiences, our fears, our hopes, our hearts, our minds, our spirits and our faith.

DWELLING IN THE WORD

As many of you as were baptized into Christ have clothed yourselves with Christ.
Galatians 3:27

Pain and Suffering

Life's journey includes times of pain and suffering: physically, emotionally, socially and spiritually. We are called to comfort and support people in difficult times, but we are not able to alleviate all of life's pain.

The pain of death is distributed inequitably. Some people die in accidents and some die at the hands of violence. Which is to say, not everyone has the opportunity to make decisions at the end of life. Some people do die as the results of illness. At some point during treatment, a diagnosis may lead a person to choose palliative care as the primary focus of treatment. We have faith that God is with us in all circumstances: as the apostle Paul asserts, *For I am convinced that neither death, nor life, nor angels, nor rulers, nor things present, nor things to come, nor powers, nor height, nor depth, nor anything else in all creation, will be able to separate us from the love of God in Christ Jesus our Lord.* (Romans 8:38–39).

When accompanying someone who is dying, we recognize that each person's experience is unique, while drawing on our own experience to deepen our understanding, as best we can. Our primary calling as disciples is to say to a dying person, "We will support you and journey with you whatever you decide."

DWELLING IN THE WORD

When pain of the world surrounds us with darkness and despair, when searching just confounds us with false hopes everywhere, when lives are starved for meaning and destiny is bare, we are called to follow Jesus and let God's healing flow through us.
Evangelical Lutheran Worship, Hymn #704

Even though I walk through the valley of the shadow of death, I fear no evil; for you are with me; your rod and your staff—they comfort me.
Psalm 23

Compassionate God

Lutherans believe in a God of compassion, mercy and grace. The global Lutheran community commemorated the 500th Anniversary of the Reformation under the theme *Liberated by God's Grace*, along with three sub-themes: *Salvation—not for sale; Human Beings—not for sale; Creation—not for sale.* These words uphold the dignity of all peoples and each person.

We are called to imitate the compassionate God. Compassion, "to suffer with," is at the heart of our call to love our neighbour. It is a responsibility as a member of the body of Christ (the baptized) and requires our response—ability—remaining present to the needs of others that we might respond respectfully, non-judgmentally, valuing their experience. Compassion is driven by relationship. It is the feeling in the gut and the heart that sees the other in front of us as similar to us—and as Christians we would say as one of us and as one of God's. Our God is a God of Compassion.

Jesus once said, *Do not let your hearts be troubled. Believe in God, believe also in me. In my Father's house there are many dwelling places. If it were not so, would I have told you that I go to prepare a place for you?* (John 14:1-2). As hard as we work to faithfully journey with those who are dying, it is valuable to periodically be reminded that God is also preparing for the death of each of us.

DWELLING IN THE WORD

For surely I know the plans I have for you, says the LORD, plans for your welfare and not for harm, to give you a future with hope.
Jeremiah 29:11

Dignity

"This church upholds the dignity of all people. We recognize the image of Christ in every person and serve that person as Christ himself. In meeting diverse people, we begin with a core sense of respect for the value of each person as a unique child of God."[3]

We affirm that a good death is an essential element of upholding dignity. A good or a satisfactory death, whether it is protracted or sudden, involves living in ways that set us on the path to a good death. Who we are as a person, in all our many roles, is how we will deal with life threatening illness and impending death. It is important to do that

[3] 2011 *ELCIC Social Statement on Human Sexuality*. www.elcic.ca/Human-Sexuality/documents/APPROVEDELCICSocialStatementonHumanSexuality.pdf

work—including having open and forgiving relationships with those we love throughout our lives.

We affirm that individuals have the primary responsibility for making treatment choices for themselves. "Christians should not support any treatment given without the consent of a patient, or if that is not possible, without the witnessed consent of those who have been given authority to speak on behalf of the patient."[4]Liberated by God's grace, we can trust people to make these decisions. We will not all agree with each individual's choice. But we can respect their right to make their own decisions.

We also affirm that personal decisions benefit from support, conversation and prayer. Individuals will be most empowered to make wise decisions when they are surrounded by a caring community and have input from persons, often professionals, with expertise on specific relevant matters, including treatment decisions, pain control, putting financial matters in order, funeral planning and spiritual care.

DWELLING IN THE WORD

For we do not have a high priest who is unable to sympathize with our weaknesses, but we have one who in every respect has been tested as we are, yet without sin.
Hebrews 4:15

Cluster of Companions for the Journey

We do not journey through life alone. All our decisions impact a complex, diverse web of people around us; and we have a web of relationships, a system of health care and a community of spiritual care informing our decisions. Most of us want and need this support. One of life's realities is that those called to give support may or may not actually be helpful to a particular individual.

Without trying to create rigid categories, for the purposes of this resolution we are identifying three inter-related clusters of support:

Supportive Relationships: referring to family, friends and creation.

Professional Health Care: referring to health-care professionals, institutions and legal guidance.

Spiritual Care: referring to those who listen deeply, help one to reflect on meaning and inspire prayer.

[4] 1997 ELCIC Resolution on Decisions-at-the-End-of-Life.

DWELLING IN THE WORD

Therefore, since we are surrounded by so great a cloud of witnesses …
Hebrews 12:1–2

Supportive Relationships

Relationships refer to family, friends and creation. These companions are personal, relational and unique to each person.

Beyond an individual, the family is most impacted by a journey toward death. Family is the primary place most people look to support. Families need support as a loved one journeys toward death. Many times, part of the work done by a dying person is to help prepare their family for the coming reality of the person's pending death. When a dying person no longer has the capacity to communicate their own choices, decision making may fall to particular family members.

Friends also are part of a dying person's community. Some friends may be as close as family. Other friends may offer a smaller but vital role of providing additional support, in various ways, to both individuals and family members.

Creation also has the potential to be a supportive relationship in the dying process. In wrestling with the meaning of mortality, an individual may ponder their connections to the web of life in all creation. Comfort may be experienced through fresh air, sunlight, the song of birds and a favourite place to sit or walk. For some people, relationship with a pet may be a source of comfort, and may be one of the relationships that needs a careful, heart-felt goodbye. *Creation—not for sale* is a reminder that we are liberated by God's grace.

DWELLING IN THE WORD

If one member suffers, all suffer together with it; if one member is honored, all rejoice together with it. Now you are the body of Christ and individually members of it.
1 Corinthians 12:26–27

Spiritual Care

We affirm that offering spiritual care is a calling of the whole faith community. In offering spiritual care, we are the embodiment of God's comfort, love, grace and strength during the dying journey; and beyond as we begin to grieve and remember.

A primary principle of spiritual care is to be consistently asking, "is my response serving the needs of the patient or is it serving my own

needs?" Our diligence in asking this question is an offering to our neighbour. We only discover the capacity to act for our neighbour's need through God's grace. We affirm spiritual care which reflects those values upheld within a ministry of presence.[5]

We affirm that spiritual care offered by rostered leaders is a gift. Care received from leaders authorized by the church, may be of particular comfort to some people in some cases. When pastors, deacons, chaplains and spiritual-health practitioners are offering spiritual care they may have credibility to interact professionally with other members of the health-care system. We trust authorized leaders to uphold the dignity of individuals through conscientious ministerial care and with respect for the individual's role in decision making.

"God's love for us is abiding. It existed before creation, calling forth light and life from the waters of chaos. God's love called us forth into life. Through the waters of baptism, God calls us into eternal abiding relationship with both God and all the people of God, from every time and every place. We are called to serve one another, especially at our time of greatest need and distress. God's love finds us wherever we are in life, including all stages of death and dying. God's love does not insist that we bear suffering beyond our ability to endure for our whole remaining existence. We are always surrounded by the great cloud of witnesses, so we will never be alone. God's love will be awaiting us beyond death when we will join that great cloud of witnesses in a new and different way from our earthly existence. We look forward to the new creation—when we will experience God in new and intimate ways, as part of the new heaven and the new earth. Soli Deo Gloria."[6]

DWELLING IN THE WORD

…I was sick and you took care of me, I was in prison and you visited me.
…Truly I tell you, just as you did it to one of the least of these who are members of my family, you did it to me.
Matthew 25:31–40

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[5] Definitions of "ministry of presence" can be found in, for example, *Toward a Theology of the Ministry of Presence*, by Neil Holm, *International Journal of Christianity and Education*, Volume: os-52 issue: 1, pages: 7–22. http://journals.sagepub.com/doi/abs/10.1177/002196570905200103. See also *In Sure and Certain Hope*, Anglican Church of Canada, page 22–23.

[6] Rev. Dr. Peter Kuhnert MD M.Div. FCFP, theological submission to the ELCIC Task Force, page 7. www.elcic.ca

Palliative Care

Palliative care is a concept of care provided in any setting (hospital, home, long-term care, on the street[7], etc.) where a person is, or chooses, to die.[8] "Palliate" comes from a Latin word, *palliare*, meaning "to cloak" or protect from suffering. Suffering may not be limited to the physical but also spiritual, psychosocial, financial or systemic concerns. This care often includes a whole team of professionals working with the patient and family, including physicians, nurses, home-care support workers, pharmacists, social workers, physical and occupational therapists, volunteers, to name a few. It is a high level of care designed to alleviate all types of suffering and can include specific treatments that at one time were considered only for those receiving acute care.

We recognize that there is good basic palliative care that happens all the time as part of "regular" medical care. However, serious inequities exist in access to specialized palliative care. For example, there are differences between urban and rural settings, there are variations in care standards between provinces and there are ongoing challenges to providing health care for more remote Indigenous communities. The reality is these services are not available everywhere across the country and in many cases the demands for this care can exceed the resources available.

"We affirm that we support just access for all to dignified, quality palliative care. We see the provision of such care as an intrinsic human responsibility toward the suffering person because of the inestimable worth and dignity of every human being, created as we are in the image of God, and because of Jesus' command to care for the sick (Matthew 25:36)."[9]

DWELLING IN THE WORD

O Lord, support us all the day long of this troubled life, until the shadows lengthen and the evening comes and the busy world is hushed, the fever of life is over, and our work is done. Then, in your mercy, grant us a safe lodging, and a holy rest, and peace at the last, through Jesus Christ our Lord. Amen.
from Night Prayer (page 325) and Funeral (page 284),
in *Evangelical Lutheran Worship*

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[7] In some communities, there are programs seeking to provide palliative care for people who are homeless. For example, in Toronto: www.journeyhomehospice.ca/about-us/.

[8] For the World Health Organization (WHO) Definition of Palliative Care, see: http://www.who.int/cancer/palliative/definition/en/.

[9] Canadian Council of Churches, Commission on Faith and Witness, *Statement of Support for Universal Access to Palliative Care in Canada*, October, 2016. www.councilofchurches.ca/news/commission-on-faith-witness-releases-statement-of-support-for-universal-access-to-palliative-care/.

Medical Assistance in Dying

Medical Assistance in Dying, commonly abbreviated as MAiD or MAID, is now legally recognized as a medical treatment in Canada, but under strict criteria of protection. These strict criteria, are somewhat ambiguous and open to interpretation. The criteria will likely be clarified and change over time, as requests for assistance in dying become more common, and as the decision-making processes are reviewed and analyzed.

From one perspective, this change in the Canadian context came about suddenly as the result of a legal decision in 2015. From another perspective, this change was the result of a longer history of requests from individuals experiencing unremitting suffering who have sought help to die. For some people, withdrawing life-sustaining treatment will lead to a good death; but for others, suffering will continue for an extended period of time because there is no specific treatment to stop that will bring about their death. Individuals and families are impacted by the reality that "we live in a society that places great emphasis on the individual and on individual freedom. This individualism affects...our perceptions of self, family, society and authority."[10]

Health-care professionals have long sought to improve palliative care for dying persons by finding effective ways to address physical pain and to attend to needs of the whole person. But not all pain can be helped with palliative care. Many of us find that, over the course of a lifetime, our perceptions and attitudes about dying and death are modified. As disciples, we are life-long learners as we seek to faithfully follow Christ.

The church also has a long history of offering healing ministries. This includes hospitals and care homes, visitation by pastors and deacons, and the work of lay people with a vocational calling in professional health care. Informed by faith and a sense of vocation, the church's healing ministry seeks to offer a competent and comprehensive care, with a rich regard for the needs of the whole person: body, mind, heart, soul and community.

In the Canadian context, it is likely that medical assistance in dying will be an option for the foreseeable future. As opportunities for assistance in dying become more normative, both society and the church will continue to be presented with difficult, and sometimes uncomfortable, questions. Over the course of time, through experiences, conversations and on-going reflection, many of us will find that our perspectives and perceptions may be modified.

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[10] 2011 ELCIC Social Statement on Human Sexuality.

We affirm that people have a right to assistance in dying. This includes good medical care and good palliative care. Some sick people are going to die. And some people who are going to die are going to be interested and involved in medical assistance in dying. The primary role of the church is to journey with people as they make difficult decisions.

DWELLING IN THE WORD

For I am convinced that neither death, nor life, nor angels, nor rulers, nor things present, nor things to come, nor powers, nor height, nor depth, nor anything else in all creation, will be able to separate us from the love of God in Christ Jesus our Lord.
Romans 8:38–39

Safeguards to Limit Medically Assisted Death

The ELCIC affirms the importance of safeguards when recognizing that choosing an assisted death is a legitimate choice for some people.

In the current context in Canada there are strict criteria for who is eligible for an assisted death and there is a rigorous decision process when someone requests an assisted death. We recognize that there are elements in the current criteria that are ambiguous and open to interpretation. And, we recognize that many current and future ethical questions will emerge from how safeguards articulate the criteria and processes for determining eligibility; thus, there will be requests for amendments.

We affirm and support the safeguards already in place that lead to a robust process of reflection and decision making that helps the individual to make informed and holistic decisions. Such a process will offer options for accessing resources that address the various significant and pressing needs of the individual. The faithful contributions of those offering relational support, professional health care and spiritual care will all be essential to this process. We support current practice that ensures no one will be coerced to choose an assisted death; that requests for an assisted death will include exploring any unmet needs and all available treatment options of the individual requesting a medically assisted death; that ensures the individual is capable of consent and is aware of their right and ability to withdraw their request for medical assistance in dying just prior to the procedure being administered and thus continue their journey supported by other palliative treatments and care.

We affirm that a system for monitoring who requests assistance in dying, who receives assistance and how the system implements safeguards is an essential component in maintaining high quality and protective care in dying.

We recognize that the safeguards are, and will be, a significant part of the ongoing conversations regarding issues of assistance in dying.

DWELLING IN THE WORD

Let love be genuine; hate what is evil, hold fast to what is good; love one another with mutual affection; outdo one another in showing honor. Do not lag in zeal, be ardent in spirit, serve the Lord. Rejoice in hope, be patient in suffering, persevere in prayer. Contribute to the needs of the saints; extend hospitality to strangers.
Romans 12:9–13

Emerging Issues Surrounding Medical Assistance in Dying

With the intent of creating additional safeguards to the federal government's action to bring about medical assistance in dying, the authors of the amendment to the *Criminal Code* attached three provisions to restrict such assistance to: (a) only persons age 18 or older who are capable of making informed decisions, (b) only persons who are not mentally ill (because their ability to consent if mentally ill was of concern) and (c) only persons who are fully competent and able to give an informed consent *immediately* prior to a medical practitioner or nurse practitioner administering a substance to bring about their death or prescribing or providing such a substance to that individual.

These restrictions are the subject of much public debate and dissatisfaction. There is a strongly held belief that many young people below age 18 are capable of providing a fully informed consent to access medical help to die. There is also a concern that no recognition has been given to the deep suffering experienced by many mentally-ill people who are sidelined by a blanket exclusion. And finally, there is deep dismay felt by those persons who have made or want to make a request for medical assistance in dying in advance of their need for assisted death in case they become incompetent to do so. They would argue that if they can have a "do not resuscitate order," why can they not have an advance directive/request to have medical assistance to die in the event that they become confused and incapable of giving a truly informed consent at that time?

Fortunately, in the preamble to the medical assistance in dying legislation, the federal government made a commitment to develop measures to support end of life decisions for mature minors, for those making an advance request, and for those in situations where mental illness is the only underlying medical condition.

Another potential emerging issue is a concern about who will be allowed to be a provider of assistance in dying. The present legislation includes both physicians (MDs) and nurse practitioners (NPs) as the only providers. Since registered nurses and other health professionals are deeply involved in the care of the dying in general, and now assisting physicians and NPs, will other health professionals be involved in the future?

Given that Quebec is a distinct society, their national assembly was able to create their own legislation with respect to medical assistance in dying. In December 2015 their *Act Respecting End of Life Care* came into force. Of prime focus in this Act is attention to palliative care, and only after that section, is the focus on aiding a person to die. There is a more gentle tone in the Act because of its broader focus on care at the end of life.

"In a perfect world, we would neither need nor desire physician-assisted death. Since we still wait for the fullness of the kingdom of God on earth, we continue our struggle to cope with the imperfections of this one. These struggles are never encountered in isolation, although it may certainly seem that way, but are shared by the community into which we are baptized. The decisions we make have consequences for those around us. This applies equally to those who choose physician [medically]-assisted death as to those who would discourage others from making that choice. If we consider our lives to be a gift from God, it may be a gift to the entire community rather than solely to ourselves. We, as individuals, are called to be stewards of our lives, on behalf of the larger community and on behalf of God, but ultimately we alone are responsible for our own individual lives."[11]

DWELLING IN THE WORD

Here is my servant, whom I uphold, my chosen, in whom my soul delights; … This one will not cry or lift up one's voice, or make it heard in the street; a bruised reed this one will not break, and a dimly burning wick this one will not quench; this one will faithfully bring forth justice.
Isaiah 42:1–3

Love your neighbour

In the *Small Catechism*, Martin Luther deepened the meaning of the Fifth Commandment from a single act of violence to a life-long calling to care for our neighbour: "We are to fear and love God, so that we

[11] The Rev. Kayko Driedger Hesslein, PhD, theological submission to the ELCIC Task Force, page 8.

neither endanger nor harm the lives of our neighbour, but instead help and support them in all of life's needs."[12]

What does this mean? From one perspective, good palliative care can be regarded as one of *life's needs*: to have as much comfort, support, respect and dignity as possible during the dying process. When a person receives medical assistance in dying, the cause of death on the death certificate is listed as the disease; the same disease that made them eligible under the criteria for medical assistance in dying. From this perspective, assistance in dying is not murder and it is not suicide. It is one option among many, in a respectful treatment plan developed under difficult circumstances with the best interests and the desires of our neighbour in mind.

Words commonly heard when asking why people might request assistance in dying are "I'm done." Which is to say, under the circumstances, "I am tired of living. I am tired of suffering. I am tired of the dying journey and I do not know how I can go on." Some words reflect the desire, the right to control one's life—the right to make proactive decisions which reflect a celebration of a life lived. These words have an impact. They are not words that diminish the value or sacredness of life. Rather, they are an expression of personal experience. "To choose death at that time... is not a statement negative or positive about the sanctity of life."[13] Desiring death can be an expression of joy and thankfulness—can be the final act of choosing life in the sense that the dying person is embracing his or her sense of destiny.

We affirm the dignity and value of each person. We would not want anyone to rush into a decision to end their life, or to devalue life of any particular person or group of peoples. At the same time, we acknowledge the temptation for too quick a judgment of a person's motivation. The vast majority of people who request assistance in dying have given it careful consideration. This freedom to choose is the best possible starting point for offering good spiritual, professional and institutional care.

The call to journey faithfully with those who are dying is a holy calling. "The Spirit is shaping an effective and apostolic heart in all of us. Let us listen to that Spirit-Song well and learn its melody. This song is a song of presence, of being with the other without calculation. We are not slaves; we are not members of Christ based on hierarchies of status of greater or lesser rank. We are friends. Such friendship in Christ makes

[12] Martin Luther, The Small Catechism, in Evangelical Lutheran Worship, page 1161.
[13] Bishop Telmor Sartison, Retired, theological submission to the ELCIC Task Force, page 2.

us companions at the Lord's table. There is a scandal in this: it goes against the competition models we have learned. It brings us into a communion of people bonded together in affective ties because God chose us and loved us first. The friendship we share here is one we can bring to others. Such a mission is a joy. Such action indicates a fresh initiative of the Spirit. Such a task brings delightful merriment and creative hope for our world."[14]

DWELLING IN THE WORD

You shall love the Lord your God with all your heart, and with all your soul, and with all your strength, and with all your mind; and your neighbor as yourself.
Luke 10:27

Principles for Journeying with those who are Dying

We affirm that whenever we enter into a context where death is near, we are standing on holy ground. Life is a sacred journey; both being born and dying are truly sacred times. We enter onto holy ground with humility.

We affirm that everyone has the human right to assistance in dying. This includes good medical care and good palliative care. Some sick people are going to die. And some people who are going to die may request medical assistance in dying.

We affirm that we do not all have to agree on all matters. We recognize that we live in a time of difficult questions and challenging emerging issues.

We affirm the importance of trust as we make this journey. We trust in the God of compassion, mercy and grace. We trust people to know their experience; we hear many people say "Trust me to decide." Nurturing trust is foundational to supportive relationships. Trust helps us to have a good death.

We affirm the vital importance of faithful end of life care, including good palliative care and diligent support for those who are making difficult decisions.

We affirm the church's call to offer spiritual care. We acknowledge that we are tempted to question motives. We affirm that the only path to deeper understanding and trust is to listen.

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[14] John J. O'Brien, C.P., in *Homilies for the Christian People*, Gail Ramshaw, Editor, copyright Liturgical Press, 1988, pages 277–279.

We affirm that disciples and the church have a baptismal calling to offer spiritual care. Our primary calling as disciples is to say to a dying person, "We will support you and journey with you whatever you decide." We affirm spiritual care which reflects those values upheld within a ministry of presence.

We affirm the value of people being in conversation about dying and death, because when your family is able to discuss this in a non-critical situation, it will enable better decision making in crisis situations. Open conversation regarding our own wishes regarding dying will increase our chances of have a good death when the time comes.

We encourage all people to discuss advanced directives with their families and to be clear about your wishes for your own care. We encourage everyone to consider the options that might need to be considered as death nears: withdrawal of treatment, palliative care, medical assistance in dying and the elements of a good death that are personally most important to you.

We encourage congregations and faith communities across the ELCIC to offer safe space for conversation, to empower lay disciples and rostered leaders for spiritual care by developing skills for visiting, listening, prayer and self-awareness; and to identify and gather local resources.

We affirm that individuals have the primary responsibility for making treatment choices for themselves. Liberated by God's grace, we can trust people to make these decisions. We will not all agree with each individual's choice. But we can respect their right to make their own decisions.

We encourage all decisions to be made with the faithful support of a caring community, including personal relationships, professionals, institutions and providers of spiritual care.

We affirm that we support just access for all to dignified, quality palliative care. We recognize that inequities in access exist. We commit the ELCIC to advocating for universal access to palliative care across Canada.

We affirm the right of health-care professionals to decline to participate in medical assistance in dying. In such cases, we encourage professionals to follow an ethic of duty to make an effective referral so the dying persons may continue to access all treatment options. We encourage institutions to uphold the dignity of individuals through a high quality of service and with respect for the individual's role in decision making.

We affirm the value of a compassionate church following a compassionate God.

We affirm that God is with us through the sacred journey of life, including birth, dying and death.

DWELLING IN THE WORD

For I am convinced that neither death, nor life, nor angels, nor rulers, nor things present, nor things to come, nor powers, nor height, nor depth, nor anything else in all creation, will be able to separate us from the love of God in Christ Jesus our Lord.
Romans 8:38–39

Questions for Reflection and Discussion

1. This is an agreed statement by a full communion partner church to The Anglican Church of Canada. What in it can you support?
2. Choose one of the Scripture passages offered here. What is it calling on you to reflect on more deeply, with respect to MAiD? Repeat with additional passages if you wish.
3. What additional biblical passages come to mind when thinking about death and dying and our accompaniment of those who are dying? How do these speak in the context of a pastoral response to a decision to use MAiD?

Let Love Speak

JUNE MAFFIN

Medical assistance in dying (MAiD) became law in Canada in June, 2016 with a variety of responses. It has been welcomed, ignored, misunderstood, controversial, deemed to be anathema.

Five years ago, the request by a friend to sign as a witness on her MAiD document made me pause and reflect, once again, on life, on death, on compassion, on personal decision-making about one's own body, and more. I found myself going back decades ago and a conversation with my mother who wanted to have "the conversation" with me. Having serious health issues, she wanted me to know her thoughts on dying and her wishes. We had "the conversation" many times over the years.

The day in her doctor's office when he told us that Mom's kidneys had failed and she would have to go on dialysis immediately, she made it very clear that she would not do dialysis. The earlier conversations were brought into reality. Mom had often expressed a hope that the Canadian government would let people who had been diagnosed with a terminal illness make the decision as to the timing of when they would die for themselves in consultation with their doctor. Mom didn't get her wish. MAiD was not legal at that time.

Before my husband Hans and I married, we talked about our "final wishes," and MAiD emerged in conversations. Hans was born in the Netherlands where they had their own equivalent to MAiD. He had researched it and was a supporter, and when his first cancer diagnosis was pronounced, we revisited our early discussions. With his second cancer diagnosis, he wanted to formalize things with his doctor and let him to know that if the prognosis were terminal with extreme pain and incapacitation, he wanted to be a candidate when the law was passed in Canada.

With his third cancer (terminal esophageal) a few years later, he knew that the extreme pain he dealt with each moment would get worse as the cancer continued to spread. There was no quality of life for him at that time. He couldn't swallow; he couldn't speak above a whisper; he was exhausted and the pain was not being managed. The time had come. He reminded me that his wishes remained strong and steadfast and that if he couldn't be granted his request in Canada, he wanted to go to the Netherlands where his request would be granted.

He reminded me of our experience with Shandy, our rescue dog and beloved King Charles spaniel who had been in pain for too long. While the medications helped her somewhat, pain was her daily, ever-increasing experience. The morning we put her favourite cookie in her mouth and she didn't know what to do with it, we were at a complete loss. The vet diagnosed it as canine dementia and told us that her kidneys had now failed. He could offer no further remedial help.

Shandy had no quality of life. She wasn't eating. She was in emotional distress and constant physical pain. She was deaf and partially blind. The vet asked what we wanted to do. We asked ourselves, "Could we love her enough to let her go?"

It was Friday. An appointment was set for the procedure to happen the next morning. "Monday." I said. "How about we have her with us over the weekend and have the procedure done on Monday?" My wise husband let me talk and cry it out. He had had dogs all of his life and had walked this road with them in the past. Shandy was my first such experience. Hans and I talked and listened to one another in the silence as we held Shandy close to us. And then I heard myself say, *"Let love speak."*

By rescuing her from a terrible situation so very long ago, we had given her love and a life of freedom from the pain she had endured from a cruel owner. That was then. Could we give her love and a life of freedom from pain now—even if that meant we would no longer have her with us? As difficult as it was, we knew that it was our time to give Shandy the gift of unconditional love and *let love speak.*

I will never forget Shandy's eyes as she sat on my lap on the drive to the veterinarian's office the next morning. Usually, on the road and at the vet's, Shandy was agitated. Not this time. This time, she was quiet. She was at peace.

Love spoke. Under the gentle hands of the vet, Shandy gently left us.

Supporting Hans's decision for MAiD was personally difficult. But in remembering our experience with Shandy, I knew I had to *let love speak* and support my husband's decision.

When I sit in a doctor's office and am asked to sign MAiD papers for friends with whom I have spent a lot of time listening to and talking about "possibilities," I remember my mother. I remember Shandy. I remember Hans. And each time, as I sign the papers, I know that the motivation is clear … *Let love speak.*

While I pray that each person whose MAiD paper I sign will leave planet Earth gently, in their sleep, I am aware that death may not happen that way. If that doesn't happen, and they choose to invoke MAiD, I will *let love speak* and support them in any way I can.

And, should such a time come when I make such a decision for myself, I pray that others will *let love speak* and support me in my decision. May love speak.

The Reverend Dr. June Maffin *is founder of Soulistry: Artistry of the Soul and a retired Anglican priest, having served in the Dioceses of both New Westminster and British Columbia. A published author and Creative Spirituality Artist, she has served in a leadership capacity in many diocesan, provincial, national, and international bodies of the Anglican Church and served as consultant to the women's desk of the Episcopal Church of the US. The subtitle of her doctoral thesis, "Making Faithful Decisions," was "Christian Ethical Decision-Making around Euthanasia." Prior to ordination, she enjoyed careers in broadcasting, script writing, print journalism, and education.*

Questions for Reflection and Discussion

1. What can be learned from the Anglican tradition's four-legged stool of sources of authority (reason, Tradition, experience, Scripture) for making a decision about MAiD?
2. How would you explain the differences/similarities in animal euthanasia and MAiD to an Anglican? Jew? Muslim? non-churched person? literal interpreter of the Bible? other?
3. In the musical *My Fair Lady*, a song told the lover, "don't talk of love, *show me!*" When we *let love speak* and reflect on these words in a MAiD context, what does that love look like?

Medical Assistance in Dying? What Does Love Require of Us?

CATE MCBURNEY

In 2016, as a critical care nurse, I participated in the first instance of medical assistance in dying (MAiD) in a large Canadian hospital. Apart from the fact that it shaped one of the most peaceful deaths I had ever witnessed as a registered nurse and a former clinical ethicist, this death was also marked by overwhelming stigma, both for those of us on the MAiD team and for the solitary family member who had to witness this death alone because other family members disagreed with the patient's choice of MAiD. Stigma still surrounds MAiD because it is a contested practice here in Canada, even though public opinion and legislation overwhelmingly supports MAiD.

In keeping with the central thrust of *In Sure and Certain Hope*,[1] which was to foster sacred conversations as opposed to taking a stand for or against MAiD, I will in this paper promote sacred conversations on two different but interconnected levels: firstly, the provision of pastoral care for those already on the MAiD journey themselves, or endeavouring to support loved ones on that journey, and secondly, the role that Anglican parishes could play to facilitate broad-based public education and discernment regarding MAiD as a possible individual choice. Before discussing these conversations, I will present my personal context and within that context, some theological themes pertinent to MAiD, particularly the question of what love requires of us.

Standpoint

I enter this project as an ecumenical voice. I am a Quanglican, as "colloquially known—[one who holds] to both Quaker and Anglican

[1] Faith, Worship and Ministry Task Force on Physician Assisted Dying, *In Sure and Certain Hope: Resources to Assist Pastoral and Theological Approaches to Physician Assisted Dying* (Toronto: The General Synod of The Anglican Church of Canada, 2016), https://www.anglican.ca/wp-content/uploads/In-Sure-and-Certain-Hope.pdf.

traditions."[2] In my case, I embody a complex intermingling of Quaker faith and Anglican monasticism as an oblate of the Sisterhood of St. John the Divine. The importance of community and contemplative silence resides at the heart of both traditions, as does the practice of expectant waiting and prayerful discernment of the leading of the Spirit in our lives. Having neither creeds nor ordained clergy, Quakers believe in a direct, unmediated experience of God and, in parallel, the notion that there is "that of God" in each person (George Fox 1624–91). Not merely a notion, this belief is a "call to action": a call to live one's life in loving response to "that of God" in each person.[3] Action in this sense and over the years of Quaker history has elevated certain priorities, or what Quakers call testimonies: values/actions in simplicity, in peace, in integrity and truth, in community, with equality and justice, and in unity with creation.[4] Given this non-dogmatic reality of Quaker life with all its diversity, we would not expect to find a unified "stand" on MAiD anywhere in the Quaker world. However, in Britain, where MAiD is still illegal, a group of Quakers came to this conclusion in 2019 through their communal discernment process regarding assisted dying:

> Our understanding of that of God in each person enables us to consider what love requires in each individual circumstance rather than leading to a united response. … We do not necessarily expect to come to unity: a failure to unite is not a failure. There is a value and a beauty in being able to find neither for nor against; but what love requires—and to ask questions. Our explorations need to be respectful and loving, and we need to be aware that our position is often one of privilege.[5]

Similarly, within an earlier compilation of views in *Assisted Dying*, Harvey Gillman, a British Quaker educator, ends his chapter with these words:

> So we sit and wait. We open ourselves to the Light. We listen to each other in the silence. We reflect upon ourselves and our lives. We make sure that we are as informed as we can possibly be. We face the query: What does love require of thee? In one way or another that process lies behind the Quaker way of coming to decisions. For life and for death.[6]

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[2] Jemima Thackray, "Following the Quanglican Way," *Church Times* (October 7 2016).
[3] *Assisted Dying: A Quaker Exploration* (Leeds, UK: Leeds Area Quaker Meeting, 2016), 17.
[4] Canadian Yearly Meeting of the Religious Society of Friends, www.Quaker.ca.
[5] *Assisted Dying: An Exploration* (London: Britain Yearly Meeting, 2019), https://quaker.org.uk/documents/assisted-dying-an-exploration.
[6] *Assisted Dying: A Quaker Exploration*, 27.

What Does Love Require of Us?

To consider what love may require of us, or how the requirements of love may relate to MAiD discernments, we will lay the groundwork for sacred conversations by considering a biblical and a non-Biblical source: 1 Corinthians 13 (NRSV), and "David," the classic poem written in 1942 by the esteemed Canadian poet Earle Birney (1904–95).[7] It would be truly great if all discussions about MAiD were conducted using the requirements of love specified by Paul in the thirteenth chapter of his first letter to the Corinthians; for example, if conversation partners were always patient, kind, hopeful, relishing the truth, believing in everyone involved, action-focused, ready to "go the distance" necessary to resolve conflicts, and never resorting to envy, pretentious boasting, irritability, rudeness, arrogance, or the "my way or the highway" approach.

Although Paul's prioritization of agape love over all spiritual gifts, particularly the gift of speaking "in tongues" and the gift of prophecy, may be lost on contemporary readers, we have our own problematic issues to overcome, for example, the pervasive speaking in polarized "tongues" that "obfuscate the true complexity" of the MAiD experience,[8] and the over-reliance on unfounded prophesying about "slippery slopes" without keeping MAiD discussions sufficiently close to the actual data regarding MAiD cases and pertinent legislation.[9] Paul's emphasis on evolving maturity (i.e., "Now I know only in part; then I will know fully …" [v. 12]) regarding one's capacity for agape love is essential. Whether or not one finds Paul's Greek concept of agape love relevant today is not as crucial as the importance of recognizing his correct perception of the need to achieve enough detachment from one's ego to be able to love authentically, i.e., to see "that of God" in all persons. It is this primary ability that is absolutely necessary for sacred conversations about MAiD.

In the Canadian Quaker handbook *Faith and Practice*,[10] we read these words from the 1971 Canadian Yearly Meeting: "Death is not an event, but a process. … The key to the process of dying and growing is learning to submerge the ego, the pride that causes separateness. … We need to learn to let parts of us die. …"

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[7] Earle Birney, "David" in *David and Other Poems* (Ryerson Press, 1942).

[8] A. N. Frolic, M. Swinton, L. Murray, and A. Oliphant, "Double-Edged MAiD Death Family Legacy: A Qualitative Descriptive Study," *BMJ Supportive & Palliative Care* (December 2020), 1, http://dx.doi.org/10.1136/bmjspcare-2020-002648.

[9] J. Downie and U. Schuklenk, "Social Determinants of Health and Slippery Slopes in Assisted Dying Debates: Lessons from Canada" *Journal of Medical Ethics* 47, no. 10 (2021).

[10] Canadian Yearly Meeting of the Religious Society of Friends, *Faith and Practice* (Ottawa: The Lowe-Martin Group, 2011), 7.

Birney's poem "David" tells the story of the journey of two men, David and Bob, whose struggles can be viewed as an allegory of the illness journey and to an extent, the MAiD journey. It is another study of the evolution of personal maturity and the requirements of love amid life and eventual death. The story is located in the Canadian Rockies near Banff, Alberta; the timeframe is indeterminate, and the story's narrator is Bob, who tragically loses David near the end of the poem. The two men climb at least four mountains over time, and David is clearly Bob's teacher for all the climbs.

Not long after an upbeat beginning, the first peril appears to Bob: "That day we chanced on the skull and the splayed white ribs of a mountain goat … caught on a rock … And that was the first I knew that a goat could slip." Climbing another mountain, Bob discovers another sign of peril: "That day … we found a robin gyrating in grass, wing-broken. I caught it to tame but David took and killed it, and said, 'Could you teach it to fly?'" Clearly, David understands the robin's limits at this point, and addresses the futility of Bob's move with the key question for him to ponder.

Unfortunately, during another climb, Bob loses his footing for one foot and in attempting to steady Bob, David endures a total loss of his footing, falls fifty feet, and ends up clinging to a ledge overlooking "the final drop, six hundred feet sheer to the ice." After moving down close to David, Bob, frozen in shock, "mumbled stupidly, 'Best not to move.'" In response, David says, "I can't move … If only I felt some pain." As Bob weeps and curses himself, David says firstly, "No, Bobbie! Don't ever blame yourself. I didn't test my foothold," and then, "Bob, I want to go over!" Bob clearly understands what David is asking and he counters with what he knows is a futile option: "I'll be back here by midnight with ropes and men from the camp and we'll cradle you out." A few minutes later when Bob indicates to David that his bleeding will stop, David says, "Perhaps … For what? A wheelchair, Bob?"

As Bob remains in a daze close to David, David calls out: "For Christ's sake push me over! If I could move … or die …" and finally, "I'd do it for you, Bob." Bob somehow pushes David over, and the poem ends with these words: "he fell straight to the ice where they found him, … that day, the last of my youth, on the last of our mountains."

Clearly, this is not a case of a medically assisted death; nonetheless, it is an assisted death preceded, not by an illness journey, but by one bearing significant similarities to an illness journey. Bob and David's trek starts out upbeat, not unlike that of many patients who have received a diagnosis along with hopeful treatment options. Thankfully,

many patients experience a complete cure which ends their illness journey; others are not so lucky, and their journey continues with its inevitable "ups and downs," reminiscent of mountain climbing. Along the way for patients, various mentors will appear in the form of doctors, nurses, chaplains, social workers, other patients, friends, and family members. As time goes by, perils appear.

At first, not unlike Bob's reaction to the goat's demise, there is a dawning realization that treatment options may not always end well. Not unlike the robin on Bob and David's path, patients may lose a "wing" and realize that no amount of learning or rehabilitation will return the function that their "wing" once had. Not unlike David, some patients will end up clinging to life, but with significant injuries and a greatly reduced quality of life by their own definition. Not unlike Bob, family members and/or loved ones will often experience shock and the psychological paralysis that brings inaction. Like Bob, they may blame themselves for aspects of the patient's situation. Like Bob, they may also be unable to see the "bigger picture" and suggest that the "bleeding" will stop and/or that the patient is "a fighter." Facing life's end, it is not unusual for patients to view their situation as David did: "If I could move … or die …."

Near David's end, he addresses his relationship with Bob: "I'd do it for you, Bob." Although we are never told the details of the relationship between these two men, David is ultimately asking Bob to submerge his own ego, and to venture beyond his wishes and fears to help move David off the ledge. In the end, Bob did what compassion or love required in this situation, but in doing so, he tragically lost David and as he tells us, he lost his youth forever.

Pastoral Care: Supporting Grievers, before, during, and after MAiD

Psychologist J. Worden has suggested that healing through grief happens gradually as grievers pass back and forth through four main tasks: "[Accepting] the reality of the loss" throughout their whole being; "[processing] the pain of grief" as "experienced emotionally, cognitively, physically, and spiritually"; "[adjusting] to a world without the deceased"; and "[creating] a balance between remembering the person who died and living a full meaningful life."[11] In the Canadian Quaker handbook, we read these words: "Accepting the fact of death, we are freed to live more fully. In bereavement give yourself time to

[11] "Worden's Four Tasks of Mourning," Our House Grief Support Center, https://www.ourhouse-grief.org/grief-pages/grieving-adults/four-tasks-of-mourning/.

grieve."[12] In fact, given the complexity of MAiD timelines from initial assessments to deaths, and the actual speed of MAiD deaths in minutes, time may be a burden and/or a gift for grieving patients, families, and loved ones.[13] Quite unlike other types of death, the fact that there is an appointment day and time for MAiD often creates intense anticipatory grief; this "is the distress a person may feel in the days, months or even years before the death of a loved one or other impending loss."[14]

Moreover, since MAiD is a contested practice too often surrounded by secrecy and stigma, grievers, including professional caregivers, often face disenfranchised grief from "losses [that] are not openly acknowledged, socially sanctioned, or publicly shared."[15] The reality of disenfranchisement makes the achievement of Worden's grief tasks even more difficult than it would be otherwise. Even without stigma, real or perceived, a person's MAiD grief and its difficulties "can be proportional to the level of agreement with the decision to undergo MAiD."[16]

Yet again, the movement beyond one's ego that love requires can be extremely challenging in the MAiD context: on the one hand, for example, a person can support their spouse's decision for MAiD because they feel it is a loving aspect of supporting their spouse's autonomy; but on the other hand, a person can ambivalently feel forced to agree with their spouse's choice for MAiD because more pain and suffering is not what anyone wants.[17]

Perhaps this was Bob's situation, but it suggests a troubling question: if David had been a bedridden, terminally ill cancer patient who asked for MAiD, would Bob have lovingly supported David in his request? On the mountain, Bob felt compelled to witness David's stark suffering and his clear request to die. By contrast, if Bob had been David's bedside visitor and David's suffering had not been so starkly obvious, Bob could have gently walked away when he wanted to, which sometimes happens, until David's MAiD request became no longer clear and therefore, could not be fulfilled under any circumstances. Generally speaking, "there is less conflict from family/friends if MAiD seems to fit with longstanding values of the patient."[18]

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[12] Canadian Yearly Meeting, *Faith and Practice*, 185.
[13] Frolic et al., "Double-Edged MAiD," 3–4.
[14] Marissa Conrad, "Anticipatory Grief: What It Is and How to Cope," *Forbes Health* (September 29, 2023), www.forbes.com/health/mind/what-is-anticipatory-grief.
[15] K. Doka, *Grief Is a Journey: Finding Your Path through Loss* (New York: Atria Books, 2016), 183.
[16] H. Yan, J. Bytautas, S. R. Isenberg, A. Kaplan, N. Hashemi, M. Kornberg, and T. Hendrickson, "Grief and Bereavement of Family and Friends around Medical Assistance in Dying: Scoping Review," *BMJ Supportive & Palliative Care* (2022): 9.
[17] Frolic et al., "Double-Edged MAiD," 3.
[18] Yan et al., "Grief and Bereavement," 9.

Anticipatory Grief

Having an appointment with death sets into motion "a parade of lasts"[19] which can seem surreal to family members and friends. However, research has shown that insofar as MAiD can be enacted as a meaningful ritual or ceremony rather than a procedure, the sense of the clock ticking down can be transformed from a burden into a gift.[20] Having the most appropriate location for MAiD is important; discovering who patients wish to have present (i.e., people and pets) during their last days is also essential; keeping the focus on quality time spent between people gives the greatest opportunity for closure; and the inclusion of appropriate spiritual, religious, and/or cultural death rituals adds integrity to the whole endeavour.

All these elements can decrease some of the stress related to the myriad of losses and difficult tasks faced by patients and their loved ones in the days leading up to and including the appointed MAiD day. However, above and beyond all these elements, there is a need for all professionals involved to normalize MAiD as an acceptable end-of-life choice.[21] In marshalling all available psychological and spiritual supports towards this normalization, aims could include "[offering] ways for families [and loved ones] to engage in meaningful activities to enrich the MAiD reflection period … (i.e., such as legacy work, oral history, dignity therapy, etc.)."[22]

Disenfranchised Grief

Grief can be disenfranchised in three different ways: because of the stigmatized relationship involved with a person who died (e.g., the death of a same-sex partner who had AIDS); because of the stigma attached to a socially unacceptable death (e.g., a MAiD death or a suicide death); or because of stigmatized customs of grieving.[23] Unfortunately, "the ways we die influence not only the grief we experience but the support we have."[24] The stigmatization of MAiD has affected all those involved in MAiD from doctors and nurse practitioners willing to perform MAiD and interdisciplinary teams supporting their implementation (e.g., teams of nurses, ethicists, chaplains, social workers), to the pharmacists providing MAiD drugs, to patients seeking MAiD, to families and loved

[19] Yan et al., "Grief and Bereavement," 9.
[20] R. Beuthin, A. Bruce, M. Thompson, A. E. B. Andersen, and S. Lundy, "Experiences of Grief-Bereavement after a Medically Assisted Death in Canada: Bringing Death to Life," *Death Studies* 46, no. 8 (2022): 1986.
[21] Yan et al., "Grief and Bereavement," 13.
[22] Frolic et al., "Double-Edged MAiD," 5.
[23] Doka, *Grief Is a Journey*.
[24] Doka, *Grief Is a Journey*, 219.

ones supporting MAiD patients, and, finally, to families and loved ones seeking support for their grief. For patients, families, and loved ones in particular, stigmatization leads to fear of disclosure of MAiD and the resultant secrecy, and fear of being judged negatively by relatives, faith representatives, and society at large.[25]

To stop the stigmatization of MAiD and the accompanying disenfranchised grief, we need to return to the question of what love requires of us, and to the fact that the vast majority of us are likely in a position of privilege in relation to the reality of MAiD in Canada. For example, according to Health Canada's *Third Annual Report on Medical Assistance in Dying in Canada 2021*, "MAiD deaths accounted for 3.3% of all deaths [i.e., 10,064 MAiD deaths] in Canada in 2021."[26] Given that these deaths represent a very small percentage of Canada's population, most Canadians are probably privileged to have had little or no experience with the reality of MAiD. It would seem that love requires both an individual and an institutional capacity (i.e., in the case of faith communities) to acknowledge and enter compassionately into the actual illness journeys that are driving MAiD requests rather than stigmatizing those who have chosen MAiD and their loved ones. Stigma can be combatted by building trust among patients and their loved ones, and particularly by supporting people in their efforts to disclose their MAiD requests, and to marshal effective accompaniment (including pastoral and liturgical support as appropriate) on their MAiD journey, no matter how their journey ends.[27] In this way, we truly acknowledge and support "that of God" in each person.

Public Education and Discernment regarding MAiD

Although Anglican parishes may hesitate to implement broadly based public education efforts because of lack of human resources, all that is needed is effective communication and sufficient in-person and/or virtual gathering spaces. A call to a local hospital's MAiD/Ethics department with a request for speakers will likely be met with enthusiastic and successful interdisciplinary collaboration, either free of

[25] Yan et al., "Grief and Bereavement," 9.

[26] *Third Annual Report on Medical Assistance in Dying in Canada 2021* (Ottawa: Health Canada, 2022), 19, https://www.canada.ca/en/health-canada/services/medical-assistance-dying/annual-report-2021.html.

[27] S. J. W. Oczkowski, D. E. Crawshaw, P. Austin, D. Versluis, G. Kalles-Chan, M. Kekewich, D. Curran, P. Miller, M. Kelly, E. Wiebe, and A. Frolic, "How Can We Improve the Experiences of Patients and Families Who Request Medical Assistance in Dying? A Multi-Centre Qualitative Study," *BMC Palliative Care* 20, no. 1 (2021): 7.

charge or for a small stipend. A brief needs survey among parishioners will raise the most pertinent questions in each context.

Most frequently asked questions include these: What is MAiD and who is (and is not) eligible for it? What is the difference between the MAiD journeys of Track 1 MAiD patients (i.e., where natural death is reasonably foreseeable) and Track 2 MAiD patients (i.e., where natural death is not reasonably foreseeable)? Who has accessed MAiD in Canada thus far, and, for example, why are the vast majority cancer patients? Why do people request MAiD and what are the other options (e.g., palliative sedation)? Where can those eligible access MAiD? Parish discussion groups wishing to discuss these and/or other questions with or without invited speakers can find easily accessible answers in the *Third Annual Report on Medical Assistance in Dying in Canada 2021*. For parish book club enthusiasts, three of Canada's earliest and most experienced MAiD doctors provide extremely helpful discussions of real MAiD cases in their 2022 books, *This is Assisted Dying*[28] and *The Last Doctor*.[29]

For those on the parish level assisting people (e.g., via home or hospital visiting) to discern whether they should initiate a MAiD request, we recall the earlier finding that it is easier for loved ones to support a person seeking MAiD when the request is in keeping with the person's long-standing values and beliefs. Thus, every effort should be made to elicit those values and beliefs, to assist people to connect them meaningfully to their current situation, and to communicate with both their loved ones and the health-care team regarding their wishes. Values and beliefs (or leadings) can be recalled and elicited through contemplative silence, storytelling, reflection on scripture, poetry, or other sources, and/or via specific communal discernment processes (e.g., Ignatian or Quaker processes such as the Claremont Dialogue or the Clearness Committee).

In these sacred conversations, deep listening will be required to appreciate the "mountains" that have been "climbed" on the illness journey, the "perils" that have been faced, and the "ledge" to which the person now clings precariously. What love requires for each person will be unique to them and their situation. There will always be loved ones who cannot initially support the person's request for MAiD, perhaps because of inconsistencies inherent in the request, or because loved ones cannot move beyond their own ego/grief issues. As Paul proclaimed in 1 Corinthians and Bob discovered on the slopes, authentic loving is a painful process of evolving maturity. In the MAiD context, this process requires time and the

[28] S. Green, *This Is Assisted Dying* (New York: Scribner, 2022).
[29] Jean Marmoreo and Johanna Schneller, *The Last Doctor: Lessons in Living from the Front Lines of Medical Assistance in Dying* (Toronto: Viking, 2022).

capacity to work through anticipatory and, often, disenfranchised grief. MAiD is certainly not for everyone. But for those who choose this path, and regardless of whether MAiD transpires in the end, the MAiD journey can be a loving response to "that of God" in each person.

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Questions for Reflection and Discussion

1. What are your reflections on MAiD after reading the discussion of Birney's poem "David"?
2. How do you relate to someone close to you even though you may disagree with their moral choice(s)?
3. What questions do you now have regarding MAiD, and how will you seek answers to those questions?

Pastoral Reflections on Medical Assistance in Dying

TRISH MCCARTHY

From pastoral experience, what is most important for people considering and planning to have medical assistance in dying is not necessarily the date and time of their planned death but rather how they prepare spiritually, psychologically, and socially for the conclusion to their life on Earth.

Over the last forty years, Canadian Parliament has revisited several times the topic of medical assistance in dying (now referred to as MAiD), and in June 2016 Bill C-14 was promulgated and royal assent was given. This 2016 Bill addressed the situation in which someone can seek assistance in death when their natural death is considered to be within the foreseeable future. There have been further bills that have been passed relating to people whose death is not reasonably foreseeable. Further discussions are now taking place as to whether someone should be able to access MAiD whose underlying medical condition is a mental disorder.[1] This last question seems to be a slippery slope and may not find its way into Parliament rulings.

With people who ask me about MAiD, I suggest that there are some social, psychological, and spiritual dimensions of human life which could be considered when seeking this kind of medical intervention. I am referring to what spiritual caregivers may refer to as preparations for a "good" death.

During my thirty-plus years of full-time urban and rural parish ministry, I would often visit parishioners in local hospitals and I gained insight during my three clinical pastoral education units, victim service training and volunteer work, as well as during my doctoral studies focused on pastoral care. I have read about, gained some insights on,

[1] Expert Panel on MAiD and Mental Illness, "Final Report" (Ottawa: Health Canada, May 2022).

and made some observations around end-of-life care including palliative care. Over the years, I have offered spiritual care to people who are dying, those who wish to die, as well as those who feel that the productive part of their life is over. This article is not steeped in scientific language or formal research but is grounded in prayerful pastoral encounter. The unattributed anecdotes I share help to highlight values to consider and pray about when objectively considering or personally contemplating MAiD.

As I support people who consider MAiD, I share some insights that may make the journey more meaningful for the person deciding, for those tender-hearted dear ones enfolding them, and for people wishing to grapple with the very concept.

My First Pastoral Encounter with an End-of-Life Decision

While anecdotes that appear early in this reflection are not directly related to the MAiD experience, there are special points I wish to make with these true-to-life stories that could inform the approach a person might take while preparing for this end-of-life procedure.

As a theological student in my early twenties, I took a semester of a field education program out of a prominent hospital in Toronto. After a few classes with our instructor, the students were sent to various assigned units with the intent to offer pastoral care. To my surprise, on one of my very first visits, I was sent to visit with a woman in her eighties who had just sustained a massive stroke. Having done a battery of tests and used several diagnostic tools, the doctor could report few positive signs that this dear woman would gain much healing ground. This gentle woman lay there in the emergency room, unable to speak, but was clearly cognitive, pointing from her chest then in the direction of the ceiling while her two daughters interpreted this to mean that she was ready to "go." Sitting with the daughters in a quiet room a few minutes later, I listened to their deliberations as they concluded that their mother did not wish to have unrealistic or heroic medical treatments other than to keep her comfortable. In fact, upon further reflection on their mother's earlier-articulated wishes around her final days, they went on to conclude that their beloved mother would not wish to linger and that it would be fine if the doctor could hasten her death somehow.

In reviewing this real-life example, I wonder if the litigious approach that exists in some parts of society have slowed down legal deliberations around what doctors are allowed to do when an individual desires and their family supports a similar compassionate and caring end for their loved one.

Interdisciplinary Care over the Years

When I served as a paid on-call chaplain while taking an extended clinical pastoral education unit at another hospital in the Greater Toronto Area, there were some pastoral encounters that involved end-of-life decision-making. The following anecdotes highlight some additional points I want to raise for people to consider while seeking or preparing for MAiD.

The hospital I describe was a teaching hospital and a regional trauma centre. At the time, spiritual care providers and clinical pastoral education (CPE) students were invited to hospital rounds for patients in the units to which they were assigned, and my experience of this proved to be a very enlightening time for me concerning end-of-life issues. My boss and CPE supervisor talked very candidly about end-of-life decisions and helped me to better understand this area of spiritual caregiving. Often, at the request of the nurse or doctor or a family member, I would be present to offer some emotional and spiritual support in moments when the family received an initial and difficult diagnosis.

On the Edge of Death

There were times in the above health-care context when I would learn about a young person being airlifted from northern Ontario to the regional trauma centre after a devastating accident while driving or riding in a car, three- or four-wheeler vehicle, snowmobile, or motorbike. The anticipated outcome for the young person would be very uncertain. There were also young adults who had been vigorously thrown against the boards in a hockey game coming out with at the very least a back injury, and sometimes their cognition was permanently compromised. Trauma patients typically have multiple injuries, and some recover over time while others may die unexpectedly in the trauma urgent care room. My point here is that I learned from these contexts just how fragile life can be.

Health-care professionals conscientiously offer a path of assessment and care to persons with traumatic external or internal injuries. Doctors make informed diagnoses with up-to-date techniques and treatments and, with ongoing due diligence, wait and hope to see signs of recovery. It is amazing to get a glimpse of the gap in the horizon between the work of standard health care and the miracles the Creator works right in a hospital unit. Given the plasticity[2] of young tissues and organs, some children and teens recover very quickly, so prognoses are sometimes shared in tentative terms. In these kinds of circumstances, several doctors

[2] "Plasticity" in this case means flexible and quick to heal.

had acknowledged to me that they had "done all that they could," beyond the vigilant, ongoing care by nurses and other hospital personnel. A few doctors that I interacted with often stated that the outcome was "up to" God in what they fervently hoped would be a healing process.

So, if a profoundly life-changing and careful diagnosis and prognosis is given, there may still be surprisingly positive results in which a doctor or nurse will refer to a patient as a "walking miracle." While life is fragile, the human body has many functions that support healing even in the most bereft circumstances. From some conversations with hospital staff, it has been medically proven that some parts of people's brains have adapted to take over the function of other brain parts that have been severely damaged.

Over the years, I have walked with people who have experienced massive strokes, been shot, or had falls from heights that led to multiple bodily and head injuries. When serious injuries such as head or spinal injuries are involved, doctors will give current perceptions and documented assessments of possible future outcomes but may share only in tentative terms what the family could anticipate for their loved one's future. The highly technical and reliable diagnostic instruments inform physicians about how much brain activity there may be at any moment, if there is any. But they will grant some grace time for the family members to personally observe and perceive any visible movements towards decline or healing over days or weeks. Such a tentatively shared diagnosis helps the family to take in the news and begin to cope.

Life Is Tenuous and Fragile

I remember over the space of several months interacting with the family of one young man in his twenties who stepped off a curb and was run down by a car. Any progress in healing seemed very minimal over the following three weeks. A nurse explained to me privately, after my initial visit, that his feet starting to lie flat and turn inward and his hands cupping dramatically towards his wrists were signs of profound brain damage. These indications, accompanied by what was detected in the battery of tests and scans, suggested a prognosis of very low future functioning. After a whole month in the intensive care unit, this young man never regained consciousness and was transferred to a step-down unit with one nurse to two patients. He died about six months later in a standard room in the hospital ward having remained in the comatose state.

On the other hand, there is the story of a younger man who collapsed and became unconscious at work and was rushed by ambulance to the local hospital. Based on the assessment data, his official prognosis was

poor with a type of advanced brain cancer. Most of the cancer could be and was surgically removed, and residual cancer was handled with radiation. This young man learned over the next two years how to walk and talk again. His progress seemed to far exceed medical expectations. Early on, the family had to be forthright in conversations with doctors and other health-care people in advocating for more than minimal rehabilitation on his behalf. Without this advocacy, it appears to me that he may not have done so well.

As there are people whose recovery is more advanced than medical staff anticipate and some are dubbed as "walking miracles," there seem to be few hard lines in diagnosing, treating, and supporting people with devastating injuries or incurable disease, which can initially lead patients to consider medical assistance in dying. Over time, the progressive signs of healing can tell medical people a lot more. I have often heard intensive care nurses say, "the next twenty-four to forty-eight hours will tell us a lot." Long-time, skilled, and highly experienced health caregivers who walk day to day with patients and carefully chart their conditions are often able to accurately predict a person's trajectory of healing. They watch for and know key signs of progress or decline, and health caregivers qualify their experienced assessments with phrases like "we never really know what level of function someone may ultimately have, but this is what I have seen in other people's situations." These phrases seem to be most effective in caring for the families of trauma patients.

I share the preceding anecdotes and scenarios to highlight the fact that life is generally tenuous and that there is a lot of grey area to take into account.[3] This information alone may give us pause for thought when we are taking in the meaning of a serious diagnosis. Outcomes after diagnosis vary a lot, and people sometimes unexpectedly recover. In fact, people in the spiritual caregiver ministry have carefully documented that a person's positive and hopeful attitude indeed affects the healing outcome. If someone is brought into the emergency room comatose, it may not be possible early on to learn about pre-existing health conditions or risk factors. But in most cases, doctors can quickly access the person's health history in order to share a well-founded prognosis. While medicine is a highly technical science, there can be grey areas in prognoses, as I have suggested above.

[3] Theologian Bernard Lonergan (1904–84) considered that there are a lot of 'gray areas' in life with which we need to wrestle with in prayer as we earnestly seek God's guidance. Scripture does not give us outright answers to all contemporary questions while it does give us all the principles we need for decision-making. Weighing and praying basic tenets of our faith with what is happening in life is important.

Room for God to Work

There is always a far horizon of scientific knowledge beyond which professionals cannot always predict. But short-term progress into longer-term therapy gives additional insight to the medical community on each person's unique healing curve. In sharing wisdom and experience from years of observing people's healing progress, medical professionals can offer us solid information. There can be a high level of clarity and accuracy in predicting a patient's path of healing. Still, this "far horizon" in the Christian description is "in God's hands." In addition, many philosophers and theologians caution us against making decisions based on negotiations with God, superstitious beliefs, or feelings without rational foundation.

Resources

The serious issue of stewardship arises when there is no bed available onsite or in town for a new patient arriving at a hospital whose initial conditions have a high likelihood of improving with the intensive attention and expertise of health-care staff in an intensive care unit. While we cannot reduce our decision-making to numbers, people can experience disappointment when a family member who is a patient is transferred to a step-down unit, but these decisions are made with carefully drafted ethical guidelines and great compassion. We are not God, but I believe that God wishes us to make difficult decisions in love and equity.

Wishing to Die and a Crisis of Meaning

Unfortunately, over the time of my ministry so far, I have had direct contact with families whose loved one had completed suicide. While we don't like to talk about this phenomenon much, people who are contemplating MAiD could find here some valuable insight to take away.

Sometimes we humans can feel so overwhelmed by physical or emotional pain or fear that we think there is only one way out of it all. Have you ever had an experience in life in which you responded out of character? Perhaps you based the decision to act simply on emotion or impressions instead of solid facts. This can and does happen. There are folks who make an end of their lives through suicide who seem to complete it without weighing all aspects out carefully. In their tunnel vision, they could forget about the ongoing pain, sense of guilt, and regret that families and close friends may endure for years.

But one health-care professional, a relative of mine, has shared with me that it can be the converse as well. People who are considering

suicide can also have weighed and re-weighed the positives and negatives of their lives and still found they desire to conclude their lives.

If there is a pre-existing mental health diagnosis, the following suggestion may not apply. But sometimes the assiduous step-by-step consultation and counselling involved in assessing people for MAiD can be very meaningful for people whose approach appears to need more thought and more time to weigh things out.

There are some ideas that a prospective MAiD patient may want to consider that I highlight here. Some people find life and social interaction so painful that it feels to them that life is not worth living at all. Some have only a death wish with no plan, while others actually make plans to end their own lives.

I don't know how many elderly people at ripe ages have asked me over the years: "Why am I still here?" "Does God have another job for me?" Not having all the answers, I usually try to draw out what they think and prompt them to consider what God could still have in store for them. After a long life, it is something to hear a senior wonder about "why" they still live on into their nineties and hundreds.

I do not have the answers here, but it can be important to consider what psychotherapists and psychologists have to say to us about people and end-of-life decisions.

Healthy Cut-Offs

Some social contexts can actually be toxic for some otherwise healthy people and a such a person may decide to simply extricate themselves from a prejudiced or skewed context. This can actually give the long-term relief needed. However, not everyone under great stress can think about the toxicity of their life situation as compared to other contexts. In this kind of case, sometimes we cannot see the forest for the trees and we assume life in other contexts, that *seem* the same, will contain the same socially induced pain of ostracization or condescension. Before some conflicted contexts get too far along, it can be meaningful to consult a skilled mediator to help the person most affected to carry on by putting some boundaries around destructive group behaviour. When this can happen, feelings of defeat and compromised dignity may be avoided. For some people, simply exiting their current context can give life more meaning.

On the other hand, in contending with some perceived danger, we may make quick decisions based on two primal urges: to defend our ground or to flee. In these times, we may shift from engaging our higher brain function (and weighing all the odds) to our brain stem functioning, which leads us to fight or flee: to make a decision to

confront or get out of danger. Sometimes we just want to do the "stage left." End it all. But this may possibly be a simplistic response to a more complex local situation from which a person could remove the self and be more at ease. If a person so afflicted can avail themselves of a psychologist or social worker, precipitous[4] decisions can be avoided. If a person is interested, various counsellors can help them to keep in mind all aspects of a situation and, as needed, assist them to engage higher brain functions and make balanced decisions.

Engaging Family in the Process

Sometimes a person concluding life with medical intervention may not be inclined to involve in their final journey those closest to them. This may leave their dear ones with what may be unfounded regrets and unanswered questions in their hearts. So, a considered and family-engaged journey may feel loving and may actually honour the deciding person's own larger set of values.

Sometimes it is easy to let the ego[5] point out choices that are final in so many ways. But if someone can take a few days to consider and be reminded of the love of special dear ones, what has given joy in the past, what things they can look forward to, they may be glad they didn't make an end of it at that time. In times of illness, loss, or defeat, it can feel so much like there is nothing or no one left to live for. The proverbial tunnel vision can get the best of us.

In past volunteer work as a victim service advocate and also in my long-term capacity as an Anglican priest, I have helped to ensure that people who are suicidal are given some grace time and asked them to agree to a forty-eight- or seventy-two-hour supervision. In the case of young people, with the parent's agreement and in concert with professionals in other disciplines, I have requested the same for folks under eighteen years of age. In these particular cases there was no later attempt or much thought given to making an end to life. These circumstances tell me that after careful conversation and consideration, some people are able to find joy and meaning in life that successfully outweighs psychological pain or other burdens that may exist.

People who are considering or asking for medical intervention in ending their lives may very well find conversations with psychologists,

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[4] 'Precipitous' is the descriptor of an action done suddenly and without careful consideration, *Oxford Dictionary* Online.

[5] 'Ego' is a traditional psychological term that describes the part of us that inclines us to make decisions as if we were the centre of the world and does not usually give deference to other people's feelings or circumstances.

spiritual caregivers, and palliative care professionals pivotal to their decision-making. Whatever someone ultimately chooses, engaging in these kinds of consultations may give them more peace and less fear as they approach their death date.

The Wonder of Human Life

In preliminary thinking about MAiD, while feelings point to some truths, it is very good to weigh things out with a professional who can gently and skillfully challenge any possible unfounded hypotheses and conclusions. It is very special when a counsellor who listens and gently raises questions can take someone to a new horizon of understanding or appreciation and even excitement for life. The wonder of human life is that there is always something new to experience, to comprehend, or to feel, if we are open. It is remarkable what people who have profound physical inabilities can enjoy or even accomplish. In fulfilling items on a bucket list,[6] some people who have considered MAiD have temporarily or permanently delayed their planned death date having regained a sense of the joy in life and a renewed vitality.

In the work of crisis intervention, which may address someone's specific reasons for wanting to end it all, skilled counsellors can often bring a person back from a proverbial edge by truthfully witnessing to the individual's intrinsic value, skill, wisdom, and potential for new life even in the face of profound loss, psychological pain, or some real impending doom. Each day can truly be a gift. I have witnessed people nearing death demonstrate a positive attitude in their approach to each day. Having consulted and listened, the person considering MAiD is more prepared to make a well-informed decision, and their experience of life in their remaining days may be more meaningful.

Wisdom of "Elders"

As a person deliberates about MAiD for their own self, it can be possible to get caught in the gloom of the moment and forget to reflect on the long, full, and unique journey of life that preceded a few difficult weeks or months. In the last three decades of ministry, I have encountered a few special, sparkling gems in the human race. I speak of the unique privilege of seeing how some spiritually and emotionally well-adjusted people, often advanced in years, handle ultimate meaning and looming reality.

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[6] A 'bucket list' is what people put together when life prompts it or they have a near miss with death. It is a set of experiences that they want to have before they die.

One couple in their early seventies learned unexpectedly that the husband had advanced, inoperable cancer which could be managed but was considered too advanced for actual cure or even remission. In my first early visit with them after they got the cancer news, these two dear friends showed lots of courage and articulated gratefulness for all that they had enjoyed and experienced together in their fifty-some years of marriage. They laughed and cried and laughed again as they supported each other in thinking about the whole expanse of their life together. While it is a testament to a sense of trust in their pastoral caregiver at the time, how they expressed their expanse of feeling was a sign to me that they were going to be okay as they moved forward and endured life's ups and downs in the several months approaching his death.

Indeed, over the next three months as I visited with them both, this trend of being real with and truly present to each other helped them to still make new memories, to find a renewed connection with the Divine together, which in turn helped to prepare them for the roller coaster experience of the husband's terminal diagnosis. Grief counsellors will tell us that when people who have impending loss or face death themselves are able to experience a wide range of emotions,[7] they are more likely than those who do not to get through the difficult time ahead with some ease, openness, and a sense of peace. As signs of death approached, I noticed that the couple I shared about here would not have "traded" any one of the last few days and weeks of what they had remaining together. They had found an even deeper, shared meaning that sustained them through the shadow days.

The above anecdote speaks to me about how someone can see the "long run" of life more easily and take things in their stride when they have enjoyed a life of deep reflection and a journey of faith. These folks can be a real resource for those who may feel hopeless in times of crisis. While we may never really "get over" tragedies and losses, people who live reflectively through life's ups and downs can be real medicine for others facing hard times. In addition to consulting skilled professionals, it can be important for individuals committing to MAiD to bring into their inner circle people who have a balanced view of life and the ability to see the glass of life half full. My concern here is about the quality of a person's remaining days.

[7] It is an accepted fact in pastoral caregiving circles that, as we are able to acknowledge and even eventually accept losses, we can enter more deeply into the present. A later stage in grief is the almost imperceptible shift of emotional investment from the deceased loved one and a reinvestment into life and love with those who remain.

For Christians, the above reference to "an ongoing reflective life" can be found in Christian spiritual disciplines of Biblical reflection, Sacraments, daily personal prayer, spontaneous personalized prayer by caregivers and family, as well as communal worship. It is a documented fact that those who have some religious and spiritual grounding fare much better in the last few days and months before death than those who have not spent time reflecting on ultimate reality or contemplating the Divine.

Pain Management and the Driving Fear of Pain

There are several health-care professionals in my family who have spent at least ten years in the palliative care, end-of-life field. I gather that in most medical cases, pain for someone approaching death can be managed well for quality of life for a longer time than many people believe. If you are considering medical assistance in dying, you likely have more potential for quality of life longer than you may think you do. A substantial consultation with palliative health-care professionals can help you to make a good decision about a quality end of your life. In doing so, you will be less likely to make a decision based on false assumptions and non-scientific preconceptions. Such new information may affect your decision-making on whether or when to engage in MAiD.

Some nurses engaged in palliative care often sense that the fear of future pain propels those who seek MAiD to make decisions based on popular conceptions not necessarily based on fact. Pain management is a wide and ever-expanding area of medical science, and pain control today is not the same as it was years ago when a beloved relative may have died in excruciating pain right in the hospital.

We have modern medicine at our disposal and we can investigate new pain management strategies and new knowledge around pain control. Besides being from the sweat of the brow of past researchers and practitioners, these developments can also be seen as gifts from the Creator, borne out of the meticulous scientific work of human beings. Perhaps God has finally made available to us the humane option to plan the date of our death, to have a peaceful passing, and to ensure we have our loved ones surrounding us at the time of our death.

In my ministry, I have walked with people who found it difficult for various possible personal and historical reasons to allow others to see them at vulnerable moments and in certain compromised physical conditions. This can have a lot to do with a person's sense of identity: how we see ourselves. Many people cringe at receiving what can feel to them like empty sympathy or condescension from others. This aspect of diminished physical and mental ability and concern around the

perception of others can take some time to get your mind and heart around. This is an issue of grief and coping with various losses as we age and or lose physical or mental ground.

Many people who are dying are surrounded by dear ones including family, who put their lives on hold so as to enjoy some precious final days or weeks with their dear one who is facing death. Compared to early conceptions of their final days on Earth, folks may end up having a very special communal experience and may feel honoured and cherished in ways of which they have never even dreamed. In fact, when the social context is right, there can be deep conversation and the joyful recollection of special memories. Palliative care professionals, nurses, psychologists, and health-care chaplains know this well and make wonderful suggestions to people who are actively dying to increase the quality of their lives for the interim.

Future Eventualities

It is true that there may come a time when pain management and desired cognitive engagement with loved ones may conflict and choices between these two values are needing to be made. This is where you will need a power of attorney for health care[8] and to document in a "living will" your health-care wishes in the case you are ever unable to communicate. The changes to the MAiD law have provisions for those whose health has declined to the extent that they can no longer give the final consent but gave consent several times prior to the decline.

Struggle with Changed Sense of Personal Identity

I suggest that emotional pain can enter into a person's decision in not wanting to carry on in what can feel like a diminished way. I remember one beloved gentleman in his eighties who could not agree to be transported to and to enter church in a wheelchair. In his view, the loss of mobility was embarrassingly painful. While I saw this gentleman as strong, caring, and determined, it is possible that he allowed his physical challenges to influence his sense of identity.

Fear of Sharing Emotion

Another parishioner was unable to attend church after her husband's death for a long, long time because she feared she might cry as she would

[8] An ***ordinary*** power of attorney is only valid as long as the donor is capable of acting for him or herself. If the donor becomes mentally incompetent (loses capacity), the ordinary power of attorney ends. An ***enduring*** power of attorney remains valid even if the donor later becomes mentally incompetent. The donor must be competent at the time an enduring power of attorney is made. See www.lawdepot.ca.

miss seeing him fulfill his long-time role in church of lighting the altar candles before Eucharist and also hearing him sing with his deep, resonant voice. Yet in this person's life, the church community was central to much of what she said and did. It is quite possible that fear of expressing her own emotions and crying in church prevented her from receiving more of the tender support the faith community members so much wanted to give. This group of church community members had shared a very life-giving and deep spiritual journey with each other, and this could have been a greater and powerful resource in her journey of grief had she been prepared to let herself express her grief in the presence of others.

Our Perceived Core Identity

Another emotional pain that we often need to contend with is the loss of special roles and a change in how we see ourselves. It can be difficult for us to keep our egos[9] in check when we experience the loss of responsibility, decision-making power, social stature, or prestige. It seems that as we may slowly gain some sense of power, privilege, or social stature as we grow up, it can also be difficult for us to begin to hold these aspects of life more loosely or tentatively as we approach the end of life. We come into the world without these, and then later, as we age or even accidentally lose social tenure or esteem, it can be painful to relinquish a sense of responsibility and eventually slowly release their "need to be needed" or to be "in charge." We humans sometimes identify so much with our work roles that we feel lost and disoriented when we retire and find we have to give up these cherished roles.

A terminal diagnosis or unplanned retirement may bring a sudden end to a professional life that has accorded a person much meaning, as well as power and prestige. Whether we are facing a serious diagnosis or another reason for considering MAiD, it is good for any one of us, no matter our life situations, to consider how we perceive our own identity. We could ask ourselves how much stock we put into what we do as opposed to who we are.

In my pastoral experience, when people facing death are aware of and accept the Creator's presence and compassionate activity in their lives, know themselves as adult children of God, they often experience the last few days, weeks, and months in some peace. I sense that they find peace by seeking greater communion with God and others, with thankfulness

[9] While 'ego' may be a dated term, I refer to the human tendency to see the world as revolving around us as individuals. We also might operate on this premise without realizing it.

in their hearts. We are adult children of the Most High; God cares for us deeply more than the "birds of the air."[10]

Spiritual Gift of Reconciliation

While we can never say we have had no part in a conflict situation that has evolved, even years after the fact, it can be a balm to the soul for key people involved in conflict to have some form or level of reconciliation.

Early on in a female minister's work, a well-educated professional lady in the parish requested that she give an intricate account of her ministry, and the vestry agreed to it. It was arduous and it seemed unrealistic to woman minister to be asked to do this. We can never really know what is going on in someone's mind and how people handle their time and responsibilities unless there is some conversation about it. But years later, at a wider church event, the female minister was addressed by another woman, and she happened to be the person who seemed to make her life more difficult than it needed to be. The parishioner apologized for being unrealistic in her request. There were tears and a hug between the two. It seemed to the woman priest that both went away that day feeling less burdened and lighter in heart even though they were both choked up at the time.

When some of the above psychological and spiritual issues are pivotal in the decision-making of people who are considering MAiD, it is possible that they are foreshortening a lifetime trajectory of growing intimacy with God. While spiritual maturity is surely not the conscious ultimate goal for everyone, it is possible that the Divine One is calling us to enjoy and be enriched by a deeper and more spiritually intimate walk with those dear to us as we prepare for death: our own or someone else's.

The Drive for Meaning

According to psychologist Dr Saul Levine, "It's clear that human beings have a profound need for understanding their origins and their place in the cosmos, some meaning and rationale in their often frenetic lives."[11] This resonates with my own pastoral experience: we humans

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[10] See Matthew 6:25–30: "Therefore I tell you, do not worry about your life, what you will eat or what you will drink, or about your body, what you will wear. Is not life more than food, and the body more than clothing? [26]Look at the birds of the air; they neither sow nor reap nor gather into barns, and yet your heavenly Father feeds them. Are you not of more value than they? [27]And can any of you by worrying add a single hour to your span of life? [28]And why do you worry about clothing? Consider the lilies of the field, how they grow; they neither toil nor spin, [29]yet I tell you, even Solomon in all his glory was not clothed like one of these. [30]But if God so clothes the grass of the field, which is alive today and tomorrow is thrown into the oven, will he not much more clothe you—you of little faith?"

[11] Saul Levine, "The Search For Meaning," *Psychology Today*, November 4, 2015, https://www.psychologytoday.com/ca/blog/our-emotional-footprint/201511/the-search-meaning.

grapple to figure out "why" things happen. I have seen this search in the eyes of many parishioners. In one pastoral encounter, I could see this search for the "why" in the eyes of the parents of a young man who lost one of his legs as he rode a motorbike on a major highway. Because of the instability of the round wheels of his dirt bike on the highway's hard cement, he slipped under the wheels of a transport truck. The parents asked themselves, "Where did we go wrong?" While parents cannot forever refuse freedom to their growing children, I heard a pivotal question in the boy's parents' grieving process. At first, there is a tendency to blame someone or some incident and preface a thought with "If only." The boy's parents asked themselves: "What could we have done differently?" "How can we make sense of this terrible loss of limb?"

Personal Search for Meaning and Purpose

Cultivating a sense of purpose and setting new goals even while facing death can give us a renewed sense of hope and energy. MAiD counsellors encourage those preparing for such medical intervention to make "a bucket list" that helps the person intending to have MAiD to find some enjoyment in the interim and to take advantage of an opportunity to tie up any loose ends.

I have personally found that the penultimate source for meaning can be found in spirituality and religion. While pat answers are not my first recourse, I find meaning in Paul of Tarsus's statement that "all things work together for good for those who love God, who are called according to *God's* purpose."[12] If we are patient and listen quietly for God to guide us, with God's help there may emerge a beauty and grace about our lives that is only revealed in the end. As Christians unearth the pearls of great price from our biblical tradition, we may begin to notice, as Matthew asserts, that as we seek God's kingdom, everything else will be given to us as well.[13] As we walk faithfully with our Saviour and Friend Jesus Christ, we may discover the resources we need to do what we are feel drawn to do, and thereby find deeper meaning and purpose in life. The main point in this question is: "What am I doing on Earth for heaven's sake?"[14]

My first spiritual director likened the beauty and grace in a human life to the work of making a piece of tapestry. It is only when a tapestry is complete and we turn it over to the finished side that the beauty of the

[12] Romans 8:28 (NRSV).
[13] Matthew 6:33, (NRSV).
[14] In his faith-nurturing course called Alpha, English priest Rev. Nicky Gumbel raises some ultimate questions like this one.

tapestry becomes clear. Turn over to see the back of a handwoven carpet and you will see what I mean. Often you cannot tell the theme of the carpet until you actually see the front of it. As I go through life, I keep this tapestry image in mind as I experience, at times, what feels like a dangerous swamp. Nurturing our spiritual imagery and connection with God can renew our sense of hope and give us new life and meaning in the face of any inevitable suffering we may encounter. Engaging in conversation with all members of a palliative care team can enrich what time we may have left.

Legacy Work

When people face the end of their lives, and there happens to be the luxury of time, I have witnessed how some "spiritual legacy"[15] work can be special. What has been important to you in your life? What things have you accomplished? What special memories do you have? What may you have done differently, if you had to do it all over again? These and other questions can help you and people close to you to celebrate and grieve what needs to be honoured and also reflected on. As we journey in life and also look back on life, seeing how the Christian cross may figure into it can be very special and meaningful.

An Authentic Meaning of "the Cross"

While there is a plethora of explanations of the Christian cross that are not helpful, there are some views of Jesus's suffering and death that can give deep meaning and purpose to human life. Someone who entertains the process of or has signed up for MAiD for their own self could find some special inspiration in Jesus's own last days.

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[15] Spiritual Legacy Questions *[Found in a booklet for someone dying and adapted by Trish McCarthy, January 2022]*. What was the world like when you grew up? What is your earliest memory? What was it like being a teenager? What was the most significant event of your childhood? What were your family's greatest strengths? Describe your relationship with your parents and grandparents? What do you remember your parents teaching you? Who was your best friend when you were growing up? Who have been the most significant people in your life? What has been the happiest time in your life? (If you took post high school studies…) What was college/ university like for you? How did you meet your husband / wife? What discoveries did you make during this time? (If you had children,) How did having children affect you? How did that experience influence who you are today? What has affected you and your family most? In your view, what have been your greatest accomplishments in life? If you were to live your life over again, what would you do differently or change? What would you keep the same? Who were the significant people that came into your life at any time? How did they influence you? For what in life are you most thankful? What do you regret about your life? What does your Christian faith mean to you? What piece of wisdom would you have liked to have known sooner? Who brought you into a personal relationship with God? When and how did that happen? What wisdom would you / do you hope to have passed on to your children or future generations? In the last ten years, what has been the most significant change you see in yourself? Talk about your life philosophy. What values do you believe? How do you hope you will be remembered? During this time, what is of most importance to you?

As we reflect on the circumstances of Jesus's suffering and death, we may sense that Jesus likely had to let go of various aspects of his life on Earth. Jesus was always thinking of those who would remain. He asked his disciple John to care for his mother Mary.[16] When he entered his interrogation and sentencing by the public authorities, he likely needed to release a need to defend himself. His predicament had devolved too far beyond reasoning. It is possible that others were re-asserting their own importance and power at his expense which would ultimately end his earthly ministry. Or, they were defending age-old religious customs as if it was a threat to their individual existence. Jesus's enemies may have been engaged in "group think"[17] or had reverted to fight-or-flight responses. It appears that the level of tension and conflict in Jesus's "trial" had gotten past a reasonable exchange. One could say "the writing was on the wall."

Given what was likely an excruciating experience of social degradation and physical pain, death was not the end. Instead, the final and ultimate outcome was resurrection and new life. The Gospels report that the disciples had opened their eyes wide enough to encounter the risen Christ, and then Jesus became triumphant in ascending into heaven to be at the right hand of God the Father, the Creator. Similarly, as we undergo "crucible" experiences in our lives, our intentions are refined and the meaning in our lives may deepen. Painful experiences do not have to lack meaning. Our hearts may search to understand what happens in life. Sometimes we gain insight and corrective guidance. At other times, we accept inevitable pain to renew or to revitalize community life and meaning for others.

People who are making plans for MAiD can find inspiration and hope that endures beyond the grave in Jesus's suffering and death. Some find meditation on Jesus's trial and death gives them peace as they review their own lives.

In life it seems that we are called to abandon a sense of occupying "the centre." This is one way to describe the inner struggle to accord dignity and love for others while maintaining a sense of our own intrinsic value. Our ego or fear of poverty can blind us to the needs of others. But the Creator sets us up to love significant others and to be caregivers of the next generation, drawing us out of ourselves. Through this

[16] John 19:25–27 (NRSV): [25] Meanwhile, standing near the cross of Jesus were his mother, and his mother's sister, Mary the wife of Cleopas, and Mary Magdalene. [26] When Jesus saw his mother and the disciple whom he loved standing beside her, he said to his mother, "Woman, here is your son." [27] Then he said to the disciple, "Here is your mother." And from that hour the disciple took her into his own home.

[17] 'Group think' is a social phenomenon in the tendency for groups of people to think and act alike so as to help them feel safe and valued. This often happens when the group has to contend with a bully in their midst.

powerful experience of intimacy and caregiving, God gives us a wider vision outside of our own needs and wants. This caregiver dynamic is expressed when a young father gets up in the middle of the night to care for his young daughter who is sick, even though he knows he will have a long day of work the following day and will then be exhausted.

We can also witness examples of this de-centring process when parents yearn to "be there" for their adult children for their life milestones along the way. Caring about a surviving young person in the family often gives new meaning and purpose for people who have experienced the loss of a significant person in their lives through death or marriage separation. It seems to me that we broach some level of spiritual maturity when we care about those around us while holding in tension our own needs and even desires.

We see this remarkably strong drive surface to care tenderly for others when a parent who is dying will "hold on" until the last of the adult children arrives to say goodbye. It can pull on the heartstrings to see this sign of love and care in our seniors. This caring drive seems to be built into the human psyche by the Creator. Perhaps it is part of a Divine design we can find in the universe.

Someone preparing for MAiD could take time to check in with family members and close friends to see how they are doing around the upcoming planned death.

Unfinished Business

I remember one senior's lodge matron who would ask people who had received a tough diagnosis if they "had any unfinished business to deal with." I spent a lot of time in my prayer life at the time thinking about what she was actually talking about. People initially considering MAiD might want to think about this question.

Can you imagine the actual joy a person can have who has addressed mistakes they made at different points in their lives with those they harmed? Seeking reconciliation with people who have been inadvertently harmed in work decisions or when an idle conversation was overheard can also be spiritually freeing. This may be helpful as long as one does not get consumed or scrupulous about it.

In the well-known healing process called the Twelve Step program, a person is to "admit to God, to oneself and to another human being the exact nature of *their* wrongs."[18] Each of the steps has some spiritual value that can enrich a person's life however long or shortened it may be due to health.

[18] *Alcoholics Anonymous* [The Big Book] (New York: Alcoholics Anonymous World Services, 2001).

Someone preparing for death might benefit from considering a few past experiences similar to the above and pray about approaching people involved. Similarly, a person who has been harmed may address the experience with those involved to gain insight or receive apology. Levels of energy and personality types will inform just what action in this area, if any, would be appropriate. It may be life-giving for someone considering MAiD to seek justice even near the end of their earthly life, so as to leave the world a better place for those who follow. In my estimation, taking care of some unfinished personal business can give peace and possibly a renewed faith or trust in humanity.

Such self-examination, efforts at amendment where possible, and an effort to renew one's relationship with the Creator can indeed make a person's remaining days much more peaceful.

Hierarchy of Needs

In helping people to prepare for death in a meaningful way, it helps that we discuss and be cognitive of our basic human needs. Psychologist Erik Maslow outlined five basic human needs that build upon one another. The first in Maslow's scheme is the care of (1) *physiological needs* of eating, drinking, and cleanliness among other things. After this, the next step in his pyramid hierarchy is the need for (2) *safety and security.* Without feeling safe, a person cannot usually proceed to the next three levels of human need. The next level is (3) *feeling love and a sense of belonging.* Without a sense of feeling cared for, we cannot easily develop (4) *a sense of self-esteem.* At the crest of Maslow's hierarchy of human need is the ability to enjoy (5) *self-actualization.* To prepare for what professionals consider to be a "good" death, to take care of unfinished business, and to seek needed reconciliation, a person seeking MAiD is well served to have the above basic needs met.

Conclusion

An objective consideration of MAiD may challenge some of our basic perceptions and assumptions. To learn of someone who is making a choice for the MAiD procedure can be mind-shifting and upsetting when we know another person who wants to "be there" for their loved ones until the bitter and potentially painful end.

When we can make compassionate end-of-life choices for one of our beloved pets and not affirm the choice of someone close to us to have a peaceful, engaged, and dignified end of life, who might already be facing death within the next year or so, then we might wonder if there is something awry in the universe.

Ultimate Meaning

I can support people who make an ultimate choice about their lives, as a person does in choosing MAiD. I encourage people seeking MAiD to give themselves the gift of special, creative, open space, time for their own psychological and spiritual care by consulting professionals such as palliative care providers, psychological counsellors, and spiritual caregivers. Such people can walk with them in making a decision that is truly right for them in their circumstances and timeline, unburdened by some intrinsic fear or anger, or fear of the process or pain of death itself.

While tunnel vision and single-focus thinking can lead us to make short-sighted and inadequate decisions, talking with a psychologist, a spiritual caregiver, and a palliative care professional can give us a higher level of objectivity so that our actions resonate with the wider set of our own cherished values. As Christians, we believe that death is not the ultimate end but the beginning of new life with our Creator and Triune God: Father, Son, and Holy Spirit. Making a choice about *how* we will die, with dignity and surrounded by those closest to us, is likely pleasing and acceptable to God who "knows the numbers of our days."[19] Plumbing the depth of psychological, social, and spiritual meaning can give us a greater objectivity and clarity in our ultimate choices surrounding this human life that God has given to us.

The Reverend Dr. Trish McCarthy *has served as an Anglican priest for thirty years, in rural and urban settings. She has three clinical pastoral education units and her Doctorate of Ministry project is de facto a pastoral care curriculum. Throughout her parish ministry, Trish met with parishioners sometimes in hospital or other institutional settings. During the first ten years of her ministry, Rev. Trish learned a lot during her training and seven-year volunteer work as a victim service advocate both in Hanna, Alberta, and then in the Niagara region of Ontario. Since 2010, she has had the pleasure of sharing her wealth of pastoral experience and insight in her teaching as a professor at Emmanuel and St. Chad College (Seminary) in Saskatoon, Saskatchewan. During regional archdeacon work, Rev. Trish facilitated leadership and ministry workshops and retreats for lay and ordained folks and interfaced with people of several First Nation communities.*

[19] See Job 14:5–6, NRSV. According to scripture, **the number of our days on Earth is already known by God**. Job affirms in his writing that our "days are determined, and the number of our months is known" to God.

Questions for Reflection and Discussion

1. Has someone who has been close to you made a choice for MAiD and followed through? What was your emotional experience after the person died? What regrets might you have had? What impressions were you left with?
2. What impressions have you formulated about how God may see MAiD? Share some Scripture passages with others in a reflection group.
3. What experiences of personal reconciliation have you had? What did these encounters teach you?

Choices: A Personal Theological Reflection on the MAiD Protocol

BRUCE WHEATCROFT

Sure, I'm happy to say grace.

"… and so we ask you to bless this food to our use and us to your service and make us ever needful of the minds of others …"

This slip of the tongue did happen to me, as I'm sure it has happened to others. But it gave me much food for thought. Theology was far from my mind in those days, but when it slowly made its return into my life, it was calling me to think more responsibly and to go in a different and unexpected direction. It was a great serendipitous moment, a moment of awakening to new ideas, new directions, new thinking, new people, and new studies, all in the name of lifelong learning. So, after a good deal of back and forth, it was back to school to do a DMin in pastoral theology, from which I graduated in 2001. It was a fateful year, as you will soon learn.

In February 2023, I presented a lecture and facilitated a class at Emmanuel College, University of Toronto. It was my most challenging presentation yet, lasting a full three hours. Walking has become much more difficult over the past few years and I knew that this would be a good test of my stamina.[1] An overnight stay in Toronto with my youngest stepdaughter made it possible to be well rested and prepared for my day in class. As it happened, both of my stepdaughters asked if they might attend the lecture. They have been huge supporters of this and several other projects—listeners, proofreaders, "all round" caretakers of details, but most of all, family members whom I love deeply. I was so delighted to have them with me as they were warmly welcomed by students and others gathered for this lecture.

Embedded in the body of my lecture notes were short video clips that affirmed, explained, or demonstrated points or concepts being made or

[1] I have what I refer to as "a trinity of afflictions"; Parkinson's disease, scoliosis, and severe spinal stenosis.

raised up for dialogue. I was able to keep the demons away long enough to complete the morning with some very profound questions floated by the twenty-five or so participants.

Opening Remarks from the Lecture

> [*Deep breath*.] Good morning. My name is Bruce. My yearning for some time now has been to have control over my end-of-life decisions. I am dying …
>
> Regardless of any personal convictions we may have, I would ask us all to be conscious of the individual and unique value of every person in this place and space in real time, [or after the fact as a reader]. This is a difficult and enormously challenging topic. So, we offer remarks throughout the morning, each to the other and collectively, with a sense of grace and respect.
>
> I hope to have you experience my urgency, my determination, and some of the gravitas that accompanies me as I face my death in my way and on my terms. Some of my personal journal entries have led me to tears and others lifted me high, ultimately leading me to a place of peace. I want to have control over when and how I die; the day, the place, the time, with immediate family and a few close friends.
>
> Today, in this moment, it is not about right or wrong, good or evil, cowardice or striking out to be the champion of a cause, or trying to bring you onboard of the cause I promote. I hope that it will be an opportunity for you to understand more clearly life as I now live it, and through my lived experience perhaps be open to some new possibilities. Such possibilities may enable us to find our way into a solid, deep, and meaningful dialogue about the MAiD[2] protocol. Times of quiet (the stillness of our minds), times of listening (listening with intent to hear something new, or in a new way), perhaps even some discernment may begin to alert us and ask of us to review or renew a position we once thought fully known.
>
> Discernment encourages narratives that can meet medical assistance in dying on a more level playing field, offering non-threatening dialogue. Possibilities may reveal themselves so that they can be known before the ramparts of divide and conquer are carefully put in place. Such narratives, if any, will be yours to take away. Much of what you will [read or] hear from me was planted,

[2] The acronym MAiD stands for medical assistance in dying.

nurtured, and harvested through my personal lens. That will surely be true for you too, should you venture down this path of narratives in either your professional or personal lives; perhaps both.

Beyond the veil that often separates us from family and others we cherish when faced with difficult choices, the reality is that my family has been both disquieted and calm of disposition, the result, I think, of having been part of my MAiD journey from the start.

The lecture I delivered was important to me for two specific reasons. First, it was a marker of my journey in the MAiD protocol—my inevitable journey toward death. It also came as a request to share some of my experience in the MAiD protocol with some graduate students looking to be more engaged with dying, death, and the process of grief. As we all know, grief starts most often before the death of a loved one, frequently disguised as anger, blunt, breathtaking, and brutal, lashing out, refusing to accept the inevitable; in many other ways, it is individually nuanced. This lecture had been announced by invitational letters to academics and others with strong feelings about the MAiD program, or with ethical and moral issues within the program, encouraging them to attend. Few did.

It was also a regular class for eight students who were studying death and grieving. As future pastoral caregivers they will need to have some kind of skill set in place to help guide them through dying, then death, each one being uniquely different. Grieving rounds out the trilogy of "passage" or "skills" (a Trinitarian starting point for my own work on MAiD). Of the three, the first two were primarily for my own benefit. The third benefits clergy, myself, and others who will encounter grief in any number of ways on this journey:

1. by marking my own progress in the MAiD journey—(for SELF)
2. by making my participation in the main protocol, public information—(for SELF)
3. by narrating my personal journey. Skill sets or tool kits that will be required of professional pastoral caregivers which the title "grieving" rounds out nicely—(for SELF and OTHERS)

These things were a leap of faith for me, because I *trusted* the process, but it also offered authentic freedom and what I would call firm hope, supported by faith, beauty, and love.[3] I understand authentic freedom

[3] 1 Corinthians 1–13.

as a time when you lose yourself in the process of the journey, when you are no longer the focus of the process, and the process becomes its own focus. *That* is authentic freedom—*that* is when you are set free, for it surpasses all knowledge and understanding and *just is*. Your spirit soars! You have become your own theological source of inquiry because you are functioning as a theologian—functional theologians—that's what I shall call all of you readers, functional theologians![4]

Most of the thinking and writing I have done in what I think of, broadly speaking, as the field of theology has been phenomenological. No surprises, I'm sure. But the tools used to get at the "good stuff" are many and varied, so back to the task at hand because it will allow us to dig in right away and perhaps reveal something important. If not, then at least let it be entertainment, crossing the threshold into the realm of fantasy and the fantastic! Daydreams, as it happens, are at the leading edge of the creative imagination.

I have chosen a phenomenological approach to the research for all my theological projects (there are one or two minor exceptions) for two reasons:

1. Empirical research suits a statistician perfectly but has too many jagged edges with blunt breathtaking screeches to make it less than preferred for sensitive subject material such as the MAiD provision, which needs thoughtful one-on-one compassionate care and careful listening. "When we are truly heard by another person, we cannot be the same."[5]
2. I have always felt that phenomenological research gets to the heart of the matter slowly, often with mistakes en route, and often with an energy drain to match. I can't imagine anything that would consume our minds and spirits, as well as our sense of moral and ethical positioning, more than the MAiD provision that received royal assent on the March 17, 2021, and became the law in Canada.

I do have a concern surrounding track two.
"Just because we can do MAiD doesn't mean we should."[6]

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[4] As much as I should like to claim this as my own, the real creator of the term "functional theologian" belongs to the American theologian W. Paul Jones. For a more complete commentary of the man, his writings, and his teachings, see: W. Paul Jones, *Teaching the Dead Bird to Sing: Living the Hermit Life Without and Within* (Orleans, MA: Paraclete Press, 2002).

[5] Robert John Root, "A Venue for Wonder" (DMin diss., St. Stephen's College, University of Alberta, 1998), 187.

[6] Jean Marmoreo and Johanna Schneller, *The Last Doctor: Lessons in Living from the Front Lines of Medical Assistance in Dying* (Toronto: Viking, 2022), 233.

Theological Worlds

"There is meaning in every journey that is unknown to the traveler.[7]" My journey is deeply embedded in music. Music is such a big focus in my search for authentic truth and authentic freedom, not only in this writing, but in topics closely related and those far-flung. What does this have to do with *Theological Worlds*? When managed by a contemporary theologian of the stature of the American W. Paul Jones, the connections are many and rich.

American theologian W. Paul Jones developed the concept of *Theological Worlds*.[8] A rich inventory of examples from the arts enhances our understanding of our place as creative functional theologians in today's world. Participants learn of their comfort level in one or more of the *Worlds*. How they are positioned within the fluidity of the five established yet ever morphing *Worlds* is the contribution that *Theological Worlds* can and often does make to the process of identifying our individual theological stance. The anticipated significance and value for discernment as it pertains to the world of the MAiD protocol cannot yet be fully determined in the rapidly burgeoning world of MAiD. There is simply not enough experience, and answers don't come easily.

> *Sometimes I know there is no answer. The turmoil I feel over in particular patient decision is often my own. Did I do enough? Did we do enough? That's about my morals burden, my doubt. I've learned not to load that on my patients. I have to work that out on my own.*[9]

A *World* results from the interaction between two poles. The first is one's *obsessio*, that lived question, need, ache, or dilemma which has its teeth into us at the deepest level.

The second pole is one's *epiphania*, that which through one or more events, moments, and/or persons brings sufficient illumination, satisfaction, or healing to provide a lived answer worth wagering one's life upon. One's *epiphania* is what touches promisingly one's obsession either as fact or as hope.

There are, of course, as many Christian Worlds as there are Christians. But they also converge into communities, resulting in the five Christian variations on the themes of the universal *Theological Worlds*.[10]

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[7] Attributed to Dietrich Bonhoffer.
[8] W. Paul Jones, *Theological Worlds: Understanding the Alternative Rhythms of Christian Belief* (Nashville: Abingdon Press, 1989).
[9] Marmoreo and Schneller, *The Last Doctor,* 239.
[10] Jones, *Theological Worlds*, derived from workshop instructions and guidance materials.

Worlds 2, 3, 4, and 5 follow in a similar manner. There is a form of discernment within the context of each world's "feel," yet the worlds are often so far removed from the evidence of discernment that they appear to have vanished, or at least are relegated to unseen. If not unseen, then unrecognized. It remains important to remind oneself of the existence of all five *Worlds* on a regular basis. The evidence may be sparse, but at least the remnants of each *World* will be there in some form and in some place.

The format of the following pages serves to sketch the material that one might find in each *Theological World*. *World 1* is presented in a truncated point-form format. Subsequent *Worlds* placeholders contain the bare minimum of information. All of the *Worlds* deserve a complete read for those so disposed.

World 1: Separation and Reunion[11]

Obsessio:

- often a sense of abandonment
- we feel isolated, small, lonely, or orphaned
- our longing is to find our way home
- yearn for a harmony to all things
- sad thought that there may be nothing behind it all

Epiphania:

- Resolution, the promise of homecoming
- through experiencing our existence as gift
- can be touched with awe
- often comes in sacramental moments
- grasped in oneness with the Ground of our being
- as if a veil is lifted, if only for a moment
- we know that we truly do belong

World 2: Conflict and Vindication

Obsessio:

- history and its various institutions are tainted with self-interest

[11] Information regarding *Theological Worlds* from this heading to the end of the section are derived from Jones's *Theological Worlds* represented here in a reductionist style. Contact the author for further information about a *Theological Worlds* Inventory and other workshop materials.

Epiphania:

- God takes sides, being committed to the poor, the captive, the blind, and the oppressed, and so must we

World 3: Emptiness and Fulfillment

- Emptiness and fulfillment are realized when we feel accepted unconditionally by God and others. It is the world of acceptance in spite of the fact (agape).

World 4: Condemnation and Forgiveness
World 5: Suffering and Endurance

> *… a few years on, I might do it differently. I might say to her sons, "Do you really want me to do this? Or do you simply need to be here with her, sit with her, and let her death happen?" I worry that I took away something that those men should have had: time to be still with their dying mum.*[12]

Aestheticization: The Process of Aesthetics

I turn now to another grouping of tools with a five-part configuration which I would name *the process of aesthetics. That* title may already exist more broadly than will sit well with the process I have in mind. I have resolved to find another word that I can coin for my specific intent and use of the word *Aestheticization*.

The process of aesthetics deals with values, worth, beauty, faith, love, hope, and others that you will run into or that will run into you. Everything will tend to interact with everything else; the tools may be used individually or in concert. That's the nature of research and discernment of this sort. Trusting the process is a methodology of proven worth in the artistic side of endeavours of this classification, style, or description.

Aesthetics: Trusting the Process

I have identified five components of aesthetics that have helped me understand the aesthetic process. The first three of these are:

1. apperception
2. appraisal
3. appreciation

[12] Marmoreo and Schneller, *The Last Doctor,* 234.

I believe that the role of the aesthetic is primarily, if not dominantly,[13] cerebral and thus passive. But it goes beyond the cerebral and strikes at the very reason for the existence of aesthetic values, that is, giving some kind of meaning to "who" and "what" we are all about. This is addressed at some length in Frank Burch Brown's superb little tome entitled *Religious Aesthetics: A Theological Study of Making and Meaning*,[14] where he identifies our understanding of music in the context of Christian worship, in terms of three basic elements of aesthetic taste: *apperception*, *appraisal*, *appreciation*. The remaining two, *appropriation* and *the aesthetic of process*, I have added. The fifth and final component is mine alone and serves as a discernment tool.

A Very Short Theological Lexicon

Apperception is the mental process that brings impressions to our attention and orders them in such a way that they are a coherent imaginative and intellectual order—a distinct phenomenon.

Appraisal is a self-conscious attempt to assess the aesthetic excellence of a work or object. It goes far beyond personal likes and dislikes.

Appreciation is a personal evaluation and a private response to a work of art.

Appropriation means to take something for your own use, to make it your own.[15]

Aestheticization is the name I give to the aesthetic of process. Aesthetica takes the four categories aforementioned and creates the "doing" of aesthetics.

Another group is what I refer to as the *Group 3 Kit*, not wanting to put too fine a point on it! It comprises all of those items that inform the research question(s) this essay refers to. It is, in some ways, the perfect answer to the perfect storm, allowing the researcher to select as many or as few items as useful for the research at hand. Constraints that you, or an outside source, have put into place—time, funding, staff, even paper and supplies—inevitable will set parameters for the *process*.

A Group 3 Kit of Gathered Tools

Aesthetics, memory, beauty, hope, faith, love, past memory, courage, determination, daydreaming, the creative imagination, fantasy, future memory, discipline …

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[13] The subtle difference between "primarily" and "dominantly" is important, for they do mean different things. "Primarily" might be thought of as "mainly in this context," while "dominantly" emphasizes that it is always the case.

[14] Frank Burch Brown, *Religious Aesthetics: A Theological Study of Making and Meaning* (Princeton: Princeton University Press, 1989), 2.

[15] Kierkegaard is thought to be the first to name this aesthetic function as appropriation.

No worries, I'm not going to deal with them all! Accepting the aesthetically beautiful is much easier to do than accepting any human activity (the aesthetic of process) that has to do with creating the aesthetically beautiful. The first is a cerebral exercise, tinged with the emotion; the second, an emotional response, tinged with the cerebral, is rooted in our personal inventory of memory.[16]

I think this is where MAiD will be first experienced by the conscious mind and formulated into a cognitive concept. Memory (a future memory being built from a present trigger or memory), sets this into motion.[17] It may not be accurate (especially if past memory has anything to do with it); nonetheless, MAiD will begin to engage in a dialogue with consciousness leading to a uniquely generated narrative somewhere between reality and fantasy. For this reason many of these early narratives will want to be considered carefully for their content, value, or worth, then applied accordingly to a "best in class" determination—existential phenomenological research at its best. Does the content now reflect authentic truth and authentic freedom? Or is it "the devil in the details" trying to cheat authentic "process" *(Aestheticization)* out of a fair hearing?

The Junk Drawer

In my kitchen, there is a drawer designated "the junk drawer." Every kitchen has one. Its function is simply to be there and receive any important junk that I just *know* I will have a use for someday. As it happens, that is usually not true, well, perhaps partly true. Nonetheless it is a good example for me of *form* following *function*, where *form*, (a container, in this case the top left drawer in the kitchen counter nearest the back door) follows *function* (a key on a string which functions as a door opener, or a charger for a long-forgotten cell phone that I may find one day). This form follows function example is the beginning of the *Group 3 Kit* collection of things or concepts.

The third group is just that, a group, a gathering together, a collection of things, a handful of terms with specific diagnostic application. All of *Group 3 Kit* may provide guidance, offer information (inform), or suggest ways of approaching, measuring, wondering about how their application may inform the MAiD provision and protocol.

If looking for ways to evaluate MAiD seems complex and difficult, it is. That is in part the reason for so many tools. It helps one to look at each situation and evaluate it using other of the kit tools as a cross-check

[16] Robin Maconie, *The Science of Music* (Oxford: Clarendon Press, 1997), 218.
[17] A discussion of memory may be found in my dissertation:Bruce A. Wheatcroft, "Musical Reverberation in Contrasting Worship Spaces" (DMin diss., University of Alberta, 2001), 36.

and to offer some data confirmation and psychological affirmation. It seems to me that the task goes far beyond looking at the client's request alone to provide a provision, but rather approaches the evaluation from the client's perspective as authentic to start with, to be taken with the utmost seriousness and sincerity in that moment for the best outcome—the last best judgment.[18] But even the last best judgment can be seen as "hope" because it offers options—tough as they may be—for those like me in Track 2.

It has been my experience that many of the tools suggested in the groupings outlined will fit comfortably in more than one place. It is by conscious and intentional observation that one of these tools in the kit has appeared more often than most others. My disclaimer is that only time and experience will confirm or reject such a hypothesis, but I am leaning toward "hope" as an operative candidate for this designation and thus, for more intensive research than this essay allows. And the choir sings on …

As you read this hymn text, my "best guess" is that you may be reacting to more than one of the tools that have been set out to use in a process of discernment. Here it is clearly the word "hope" that is being massaged to see what it will give up for the process and what it will continue to hold as just too precious to let go of completely. Devilish! I have intentionally highlighted a number of words that stood out to me as modifiers or informers or words that would take me to one of the *Worlds* of W. Paul Jones or indeed words that I perceived (guessed) might be metaphorical.

All my *hope* on God is founded;
he doth still my ***trust*** renew.
Me through ***change*** and ***chance*** he ***guideth***,
only good and only ***true***.
God ***unknown***,
he alone
calls my heart to be his own.

Human ***pride*** and earthly glory,
sword and crown ***betray*** his ***trust***;
what ***with care*** and toil he buildeth,
tower and temple, fall to dust.
But God's power,
hour by hour,
is my temple and my tower.

[18] Marmoreo and Schneller, *The Last Doctor*, 254.

God's great ***goodness aye endureth,***
deep his wisdom, passing thought:
splendour, ***light***, and ***life*** attend him,
beauty springeth out of naught.
Evermore
from his store
new-born worlds rise and adore.

Daily doth th' Almighty giver
bounteous gifts on us ***bestow***;
his ***desire*** our ***soul*** delighteth,
pleasure ***leads us*** where we go.
Love doth stand
at his hand;
joy doth wait on his command.

Still from earth to God eternal
sacrifice of praise be done,
high above all praises praising
for the gift of Christ his Son.
Christ ***doth call***
one and all:
ye who follow ***shall not fall.***[19]

There is not even a "hope" of exploring all of these with the reader, but the goal here is to have you realize the many options that a simple hymn tune and its text can have on the experience of memory for one, and how this might easily become a process of *Aestheticization*. But before we leave this area of massage, research, and possible new findings or learnings, I want to leave you with a glimpse of how I might look at the word "hope."

Hope, Hopelessness, Aestheticization, and *Theological Worlds*

Hope is my singular tool from the *Group 3 Kit* for exploration in this essay. From it, I am anxious that the application to other tools in the kit, as well as the other major tools identified as *Aestheticization* and *Theological Worlds* be more clearly evident.

[19] Joachim Neander, "Meine Hoffnung stehet feste [All my hope on God is founded]" 1680, trans. Robert Bridges, 1899.

Hope has found me; I did not discover it or search for it. Hope has led me where many other words (tools) fear to tread. The hope that found me was in the gift of two amazing human beings, one from the realm of medicine and the other a brilliant theologian. One helped address the debilitating pain that I have suffered in the past few years and together we grabbed for even more hope in a surgery to unlock the palsy-ridden right hand and arm. Sadly the surgery did not succeed, although with great exertion I am able to open the fingers slightly. And the other? That was the man in my doctoral program who taught me to trust the process. Dr. William Close was my model and mentor; what joy I feel as his colleague in this moment. My thinking and wondering focused on his understanding of hope. The formation of my thoughts was broadened and enriched by his *feel* for this sphere and figured prominently in my consideration and review of hope.

Hope is an elusive and cunning player/partner in the MAiD protocol because of its ambiguity. This is an approach that incorporates stewardship as the theological foundation or pathway for hope's journey. Remember that stewardship is the careful responsible management of something—usually something that one does not personally own, but in this theological context, believes in and trusts.

> *The concept of hope retains certain elements that were embedded in its early usage. Among these elements are the following: a future state of goodness, if not bliss; a present state of persistent, and perhaps, incredibly dire circumstances; a longing to leave behind the latter by either overcoming or transcending the threatening features of the present experience …*
>
> *Of special interest, like the proverbial, saying that "nothing focusses your mind quite like the prospect of being hanged in the morning," is the way COVID-19 jolted our culture out of its complacency. … And that was but one indicator among many that we were "going to hell in a hand-basket." … Our global society has been oscillating between hope and despair for some time. Then, in a matter of a few weeks, a random mutation in a Chinese bat unleashed an apocalyptic experience that was "up close and personal."*[20]

Hope, in this theological context, will become more dense before the skies clear. It would seem from all things considered that hope cannot be passed off quietly in the night and left on its own. "Elusive" and "cunning" were words used a short while ago. Search here for the word

[20] William John Close, *Intimations … Hints of the Numinous in the Ordinary*, vol. 5 (Baldwin's Mills, QC: self-published, 2021), 5.

"hope" and you will, in all probability, have "courage," "faith," "despair," "hopelessness," "beauty," "love," "fear," "betrayed," and many other words join the parade. It is true that these are all modifiers used in one format or another, yet "hope" remains ambiguous, elusive, perhaps even a bit demonic, and, at the same time, the only choice we frequently seem to have.

> *This story adds three important dimensions to our understanding of the existential nature of any hope worth its name. First, hope that is existential partakes richly of both the darkness and the light of lived experience, indeed, without both neither is experienceable, neither in life, nor in art. Secondly, existential hope, containing both "life and death, blessing and curse" carries no guarantee in regard to a final fulfilment. It can go either way. Here such hope needs a little help from its cousin, courage; not, however, the courage for a "good death" sought by Stoics ancient and modern, but courage for the risk of faith*[21] *in "another world" of promised fulfilment. Thirdly, … for the last word, artistically and theologically. Existential hope's structure necessarily exhibits transcendent object, whether the current secular age recognizes it or not.*[22]

If hope does one thing, it bids you pause and take some rest. These are the tools that I would work with if I were sitting on "the other side" of this merciless fence. Because I am a MAiD client, I often wonder if it would be "good and proper" for me to "stay the course," hold fast to the claim that "it is well with my soul" and refrain from comments. More often than not, I go off the rails because a pain level as measured on the "1–10 chart" feels that it has long since passed "11" and is rising. But, if I were on the other side …

Every patient that has requested MAiD that I know of has had very strongly held reasons and motives for choosing MAiD and can argue very convincingly for the MAiD provision. Now sorted and organized in a vague and forgiving sort of way, the tools that have assisted me in my search for my own truths and authentic freedoms have been at the core of my MAiD journey. They have clearly marked the way, providing some structured guidance which brings me solace and peace. I am anticipating such peace to continue until the end of my days, nurtured and nourished by the beauty I now see with the numinous in the ordinary. I continually trust the process which is, for me, the principal

[21] Solid and strong similarity to leap of faith mentioned earlier in conjunction with "hope."
[22] Close, *Intimations*, 7–8.

product of the creative imagination, constantly interacting with beauty, hope, and love. And the greatest of these …

> *… she wasn't conscious. I knew I wasn't going to administer the drugs, she couldn't give consent.*
>
> *I sat down. I could feel her death coming. I am where I need to be, I thought. And there I stayed for an hour, watching her breathe. At some point, I took out the nasal prongs delivering oxygen. She was at peace. Her breathing slowed. Then stopped. That was a good death, too.*[23]

These early days of the narrative can hardly be seen in historical perspective. The chart in the following section ("A Brief History of MAiD in Canada") clearly shows the change over a mere five-year period. That said, the early narratives remain surprisingly powerful, pivotal, even seminal at times. The narratives that I have penned and put forward come largely from this early and first of the MAiD protocols. I make no apology for that; we must start somewhere. When utilized "in concert," these "tool sets" come to life, demonstrating theological function and form. They will become a blend which in time and in turn will bring us to some thoughtful place. Other means and mechanisms with an enormous capacity for empathy may be introduced to bring us to a place of "inter-personal peace" where ethical and moral considerations about MAiD may find some resolution that will satisfy most of those seeking help with MAiD's protocol and its provision. I have placed a strong emphasis on the role of the arts. A deeper and richer understanding of the *Theological Worlds* and the fluidity of the *Worlds* in our lives and the manner in which the *Worlds* inform MAiD will become particularly apparent early on.

> *The entire area of religious aesthetics has not been without its problems, coming into prominence within the past two hundred years at best, and not with any particular practical impact until even more recently. … In the Protestant Reformation, for example, negative theological assessments of the arts typically were rooted in appeals to history or authority rather than in anything like a close analysis of aesthetic factors.*[24]

[23] Marmoreo and Schneller, *The Last Doctor*, 247.
[24] Burch Brown, *Religious Aesthetics*, 2.

The Canadian Presence in MAiD

In the years ahead, I believe that MAiD will tend to dominate provincial, federal, and world thinking, both sacred and profane. MAiD will engage the finest theological minds, and will ensconce some of the finest minds in constructive, ethical, and moral debate, on a global stage. In some respects, Canada's current and incomplete paradigm of the MAiD protocol may be found and reflected in the legislative debates of the international community striving to make it their own. Canada has been forthright in following through with legislation, which may even suggest that there is every possibility that Canada will continue to lead the world in this field. Finding ourselves in such a leadership role will require us to be conversant as well as fluid and fluent in how we engage in a narrative that honours truth, respects belief systems, and is held up to a standard of understanding easily measured. Or perhaps it will be utilized to inform those held in passionate debate vis-à-vis ethical and moral questions from the religious right. I believe it must never be nefarious in any attempt to "gain the upper hand." That is a tall order—proceed with caution! So, it becomes for me, in all humility, both duty and delight, as the great musician and hymnologist Erik Routley would say, as I share what I have learned and what I have not yet learned.

A Brief History of MAiD in Canada Looking Back from 2023

The five points in this chart outline the history of the MAiD protocol in Canada:

1. First MAiD legislation
    a) An Act to amend the Criminal Code establishing eligibility criteria; safeguards for assessment and provision
    b) Royal assent on June 17, 2016
2. Second MAiD legislation
    a) Extended eligibility
    b) Significantly modified applicable safeguards
    c) Received royal assent on March 17, 2021
3. CAMAP
    a) Canadian Association of MAiD Assessors and Providers
    b) Voluntary association of professionals
    c) Primarily physicians and nurse practitioners
    d) Provide MAiD and assessors
4. Track 1: Death *is* "reasonably foreseeable"
    a) Original safeguards
    b) Some modifications

c) Illumination of ten-day reflection
d) One rather than two independent witnesses

5. Track 2: Death *is not* "reasonably foreseeable"
   a) Additional safeguards
   b) Minimum ninety-day assessment period
   c) Consult with practitioner with knowledge of condition if assessors lack that skill set
   d) Offer information on available means to alleviate suffering

Canada's New MAiD Law

From the introduction of the new government guidelines for MAiD we read:

> *On March 17, 2021, changes to Canada's new medical assistance in dying (MAiD) law came into force. This marks a significant milestone for Canada. The new law responds to feedback from over 300,000 Canadians, experts, practitioners, stakeholders, Indigenous groups, and provinces and territories, provided during the January and February 2020 consultations. The revised law is also informed by the testimony of over 120 expert witnesses heard throughout Bill C-7's study by the House of Commons and the Senate.*
>
> *These changes to the Criminal Code now allow MAiD for eligible persons who wish to pursue a medically assisted death, whether their natural death is reasonably foreseeable or not. The new law will reduce unnecessary suffering in Canada.*
>
> *It also supports greater autonomy and freedom of choice for eligible persons, and provides safeguards to protect those who may be vulnerable.*[25]

Paul, in his Letter to the Romans, amplifies the Stoic outlook of the time:

> *We rejoice in our hope of sharing the glory of God. More than that, we rejoice in our sufferings, knowing that suffering produces endurance, and endurance produces character, and character produces hope and hope does not disappoint us, because God's love has been poured into our hearts through the Holy Spirit which has been given to us.*[26]

Hard to find language more existential than that.[27]

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[25] Canada's new Medical Assistance in Dying Law, March 17, 2021.
[26] Romans 5:5f (RSV).
[27] Close, *Intimations*, 4–5.

Trusting the Process

Dietrich Bonhoeffer must have been a master of one-liners in the world(s) of theology. He once said, "Christianity preaches the infinite worth of that which is seemingly worthless and the infinite worthlessness of that which is seemingly so valued."[28] I have always enjoyed such quotes and revel in the punch they carry. Thus with gratitude I identify some of the diverse material that I have come upon, by accident, or by serious study and research, to be centred in these intense one-liners or short quotes.

During this pandemic we have shared intensely the challenges and deprivation of prolonged isolation and we have discovered together the deep pleasure of laughter at the craziest things; absurdity does not necessarily entail despair. Indeed, in our case (remember St. Paul's words in Romans 5:5?) we have found ourselves impelled into an experience of a joy that is both earth-ly (earth-y) and transcendent. Thus it was that, on Christmas Day, we photographed ourselves greeting (and saluting) a "brighter" age to come. "Celebrating the birth of the Saviour with an image that radiates 'faith, courage, and love,' we declared our lived experience of 'existential hope'—come what may!"[29]

The DMin program I entered was not the "end-goal" but rather the "kit" that fit me out with tools and a solid model for research. There was a promise of goodwill among all who entered this quest for understanding. I believe it fair to describe the experience as a reciprocal one. Trusting the process gave me permission to allow an answer to appear (grace). Trusting the process also gave permission to find a place of temporary rest so that I might find and face some of my demons (also grace). Music, what I think of as my first language, might also be thought of as the epitome of phenomenological experiences by the grace of God's hand. It follows then, that music can and does eclipse The Word. Heresy I hear! The Word is enveloped in relentless rhythmic and harmonic motion (the spirit), comes to rest in a completely fulfilling experience (existential hope) bringing with it "that peace that the world cannot bring." At its close, it is an all-knowing and all-understanding place (the soul). Now there's a dissertation topic and lifetime of study for someone!

My Journey with MAiD

I was attending a national convention of the American Guild of Organists in Dallas, Texas, in the summer of 1994. The priest who delivered the homily at our first worship service spoke to us as a

[28] Quoted in Eric Metaxas, *Bonhoeffer: Pastor, Martyr, Prophet, Spy* (Nashville, TN: Thomas Nelson, 2020), 85.
[29] Close, *Intimations*, 8.

colleague and pastoral caregiver. But for some reason I found myself riveted to her homily.

> *Whatever it is that you fear, whatever it is that means humility to you, open your door and let it enter. Don't let it chip away, making its own entrance, for it will. Embrace its ambiguity, its paradox, trust that it is a midwife, seeking to give you new birth, … May it be your heart's epiphany.*[30]

Just after that convention, we relocated to Montreal. I had been offered and accepted a post at a large downtown church. In October of 2001 we took a trip to Edmonton for formal public presentation of my work, and graduation. Two weeks after our return to Montreal I suffered a serious accident. Life changed suddenly; my world crumbled beneath my feet.

How could I possibly have known of the forces that would render up such deep, aggressive, gut-wrenching mental pain? It could not be assuaged. How could I possibly have known of spinal stenosis, scoliosis, and Parkinson's disease that were to be in my future? Those strangely prophetic words of Helen Betenbaugh's homily were as fresh in that moment as they had been years earlier, but this time the crescendo of relentless tides of depression, crashing onto an uncharted coastline, had been unleashed and so reached painful decibel levels of mental anguish and fear of physically drowning.

Once again Helen's fateful homily unwittingly gifted me some glimpses and understanding of what it means to be vilified, so that is where I turned. I need you to stop this pain. I was frantic to escape. There was just too much to cope with and I needed help. I begged for closure, another serendipitous moment to chase after, like a butterfly's unpredictable yet beautiful movements. "Closure" is a word that rolls easily off the tongue but it is not so easily accomplished. Helen gave voice to and named her closure because she was able to do so. She spoke eloquently of her last service as a church musician:

> *A beloved friend and I had together celebrated a worship service in Perkins Chapel just a few months ago. We gave thanks for my 33 years as a church musician, which I had to leave behind because of the inexorable advance of disease and its chipping away at me … At the end*

[30] Helen R. Betenbaugh, "A Sermon for the Episcopal Worship Service of the 42nd National Convention of the American Guild of Organists" (St. Luke's Episcopal Church, Dallas, TX: unpublished, July 13, 1994), 2.

of the service, after I'd played the postlude, I removed my Master's hood with its pink velvet border and handed it to my friend. I needed to honour liturgically this death, this transition, this crossroads in my life …[31]

I didn't have that kind of closure. Mine came liturgically in a most unlikely place, a patient sitting room of a hospital where, at my request, the Eucharist was celebrated. There was no music, only quiet words. There was no academic hood to give over symbolically, only hospital attire, an intravenous pole, countless tubes, machines ticking, and some quiet weeping. The room smelled of disinfectant, disease, helplessness, and hopelessness! This was the moment MAiD entered my mind and was pressing me to listen. It was 2004 and there was no such thing as "medical assistance in dying," at least not spoken of aloud. Yet it quickly became a friend, offering another choice.

I acknowledged, faced, and articulated my pain. That has been cathartic. Such scarring pain cannot be forgotten but it can be forgiven. "Forgiveness does not change the past, but it does enlarge the future."[32] But for me, darkness still covered the earth. I knew there was something wrong and it demanded my attention. It was alerting me to what lay ahead.

After years of suffering debilitating back pain, a diagnosis of spinal stenosis was made in 2021 following exhaustive testing. I can easily recall incident after incident related to the Parkinson's, the stenosis, and the scoliosis. Now I know what is coming. I'm not ready just yet for MAiD and that accounts for why I am in Track 2 of the MAiD protocol.

Not long ago I saw my provider who asked if I had a date. "No," was my reply, "I'm not ready yet, but as time marches on I feel certain that I will know when that time arrives."

"Yes," came the reply, "you will know."

If I were no longer able to qualify for "advance requests," I would be returned to the nightmare and debilitating terror of not being able to access MAiD in time to prevent my family from the anguish, suffering, and pain that has already been ours for too long. It was that vision of unnecessary continuing physical pain that was seminal in my decision to seek out advance request for my own end-of-life narrative. But there is another reason. While physical pain may be the most significant factor in my narrative, mental anguish does not take a second place to physical pain. Mental anguish is suffering of its own; of a different and sinister

[31] Betenbaugh, "A Sermon," 2.

[32] Attributed to Paul Boise, producer, director, actor, and filmmaker, who is well known for his films and their presentation of LGBTQIA issues.

kind. It is cruel, frightening, unfair, and unfailing in its bid to crush any human spirit in its path.

Knowing that there won't be simple, right and wrong choices with track two MAiD requests—only hard options—Kevin created the IDEA rubric to formulate a last best judgment.
"I" Identify the facts.
"D" Determine the principles in conflict.
"E" Explore available options in clinical, legal, ethical, and organizational terms, using the social determinants of health.
"A" Act on the best option.[33]

Protocol, Provision, and Peace

A few weeks ago my spiffy new polished and powered wheelchair arrived. If I am honest, I will tell you that I have not always welcomed that prospect, but now, today, I am ready. It is another step along my journey. Now I peruse the day laid out before me and do a simple triage. I have learned to identify the most important task and aim to complete that first. Outline the remaining tasks in some order of priority then tackle them in a similar fashion. Soon the daily workload of care and concern, dispensing a keen sense of ethical and moral values, principles and standards, if requested, is over and done. Give yourself time to be angry or upset, and an equal amount of time to recover. Give yourself daydreaming time; that's where much work can be done while you rest! Give yourself recreational time in the day to do something that you particularly enjoy. Give yourself time to eat, to wonder, to suggest to yourself and others possible solutions that might be undertaken. Get as much joy and happiness from each day as you can. I am learning. I'm not there yet, but I am learning. I have embraced my authentic self and seek to live out my authentic truth to my last day.

I am engaging the creative imagination in new and bold ways. I am my own functional theologian, checking in with others from time to time, just to see if we can truly make the claim that there is a journey unknown to each of us who travel on the path of this miraculous gift we name life. It is the wise in our midst who seek to know the authentic truth of that discerned message.

With dignity intact, they make of their life, which includes their death—the last act of living—often the most meaningful. That is MAiD's protocol, that is my challenge and that is my goal.

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[33] Marmoreo and Schneller, *The Last Doctor*, 254.

Places of peace are teaching me how urgent it is to forgive. In turn I yearn to be forgiven so that I might depart my body in death as I came to it in life—naked, without baggage, and at peace. I hear the cries of newborns as they start their journey—naked, without baggage, and with few concerns. My journey is slowly nearing an end. I will once again enter a place new to me—naked, without baggage. And I pray, at peace.

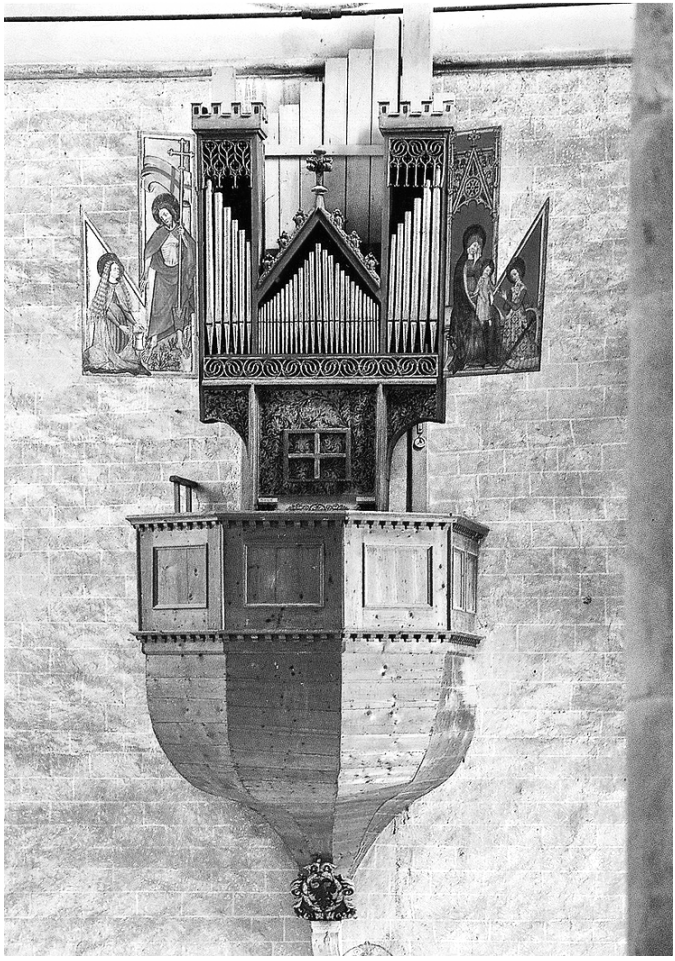
Times of quiet (the stillness of your mind), times of listening (listening with intent to hear with fresh ears, something new, transformed or transformative), is to experience the sacred, the Divine, in the ordinary.

Epilogue

In the world of music, fast and loud generally garners the applause. But I have consistently believed that the true mark of an artist who communicates a sense of awe and wonder and yet retains the mystery is the one who plays or sings something slow and simple with the same commitment to the same high standards of technique and musicianship. Listen to this short little piece in two parts as the two voices have what I have come to realize is a delicate existential musical narrative of love, informed by beauty—beauty of which I have spoken or written little.

Another time.
Amen.

Dr. Bruce Wheatcroft *is a retired church musician who served parishes in Calgary, Edmonton, and Montreal, and taught school and undergraduate and graduate students at the University of Alberta and at McGill University. An organist and conductor, he has broadcast extensively for the CBC and is known for his elegant performances as a recitalist in Canada and abroad. He holds degrees in performance, musicology, and theology. A serious accident in 2001 brought permanent disability, ending a distinguished career. Diagnosed with Parkinson's in 2014, in 2020 he suffered a pressure palsy paralyzing his right arm and was confirmed with severe spinal stenosis in 2021.*



Listen: "Duo para principiantes"
anglican.ca/wp-content/uploads/maid-essays-wheatcroft.mp3
(Antonio de Cabezon, 1510–66), played by Bruce Wheatcroft—live on the world's oldest playable organ (c.1425), in Sion, Switzerland. All original parts, except the keyboard, were replaced once, and white pedal pipes for short octave were added in the eighteenth century.

Questions for Reflection and Discussion

1. Whether you agree or disagree with the MAiD initiative, how do you first approach an individual case?
2. What tools for discernment would you suggest adding to the ones mentioned here?

MAiD in Long-Term Care in Manitoba: An Evolving Process

CHRIS SALSTROM

I have worked as an Anglican health-care chaplain (spiritual health practitioner or SHP) for over a decade, specializing in complex continuing care (chronic care), long-term, and dementia care. I have worked in faith-based and secular settings. I have always been expected to be non-denominational or multi-denominational in my roles. I have had the privilege of being the pastoral presence on a number of medical assistance in dying (MAiD) cases. Usually when I am called in, the client[1] or the family member is having an ethical, moral, or spiritual issue with the idea of MAiD provision. The staff therefore wish to have someone with expertise in this area to deal with the problem. This has led to referrals to visit with clients as we begin to navigate the new territory of MAiD in long-term care (LTC) in Manitoba.

The Three Issues around MAiD in Long-Term Care

From a pastoral perspective with respect to MAiD, there are three main issues that I have encountered in my practice. First, there is a reluctance in the LTC realm to comply with the resident's wishes to be in contact with the MAiD program. This occurs for different reasons. It may be because of the team's own feelings about the procedure or because of a discomfort of using the MAiD team in the LTC population. Second, I have noticed that there is a great deal of angst surrounding the decision to request MAiD in the LTC population that I serve. However, there are often positive outcomes in a number of ways. Third, the families and staff are often in need of pastoral and emotional care themselves when MAiD provisions are offered on LTC units as this is relatively new and out of character for traditional LTC populations in Manitoba.

[1] "Client" refers to a patient or resident in the long-term-care home population.

Reluctance to Comply with Resident Requests for MAiD

By law, in Manitoba, when a client asks, we are required to provide information so that the client may call the MAiD team if he or she desires. In one particular case, the client had asked about MAiD repeatedly without anyone providing any information. While the client did not have dementia, the team did not feel that she "meant" to ask for it. The issue was that the staff did not believe she understood the procedure for which she asked, despite her numerous requests. I believed she did understand, as she clearly described the overall process of MAiD to me. I did not perceive that the staff members were being unkind or dismissive, but I strongly suspected that the process of MAiD was consciously or unconsciously taking them outside their comfort zone. Therefore, they resisted complying with the client's request due to their own moral or ethical discomfort. I provided the information to the client. A family member later approached me and asked if I was the one who provided the MAiD information to his mother. I said yes and prepared myself inwardly to explain why I made the decision. He surprised me when he simply said, "thank you." His mother eventually decided against choosing to proceed with MAiD, but it was important to her dignity and well-being to be able to make this choice.

I believe everyone deserves to have a choice in their medical care. For many people MAiD *is* a matter of medical care and of dignity. Going through the process of death where a client feels that their dignity is robbed from them by disease, by caregivers, or by the pain itself can be torturous. It can be unbearable to some people. For others it is purely a matter of the pain or the disease process that is unbearable. Neither one nor the other is more important when considering personhood. All of it is critical to the end-of-life process and needs to be considered as a whole.

Numerous times when being referred by a staff member who is disturbed by the MAiD process, I am met by a defensive client upon entering their room. I introduce myself and my role and most often the first words I hear are, "I don't want to be talked out of this!" I then need to persuade the client that I am not here to talk them out of their choice, I am only there to be a supportive and non-judgmental presence, *if* they still choose to talk to me. I am able to have significant visits after that, often finding out their "why"; I learn what circumstances have led to their choice. Some have found great peace from deciding upon MAiD. The bottom line is, in order to preserve dignity, choice often is a critical part of it. End of life looks different now, because MAiD presents a choice for some people who meet the criteria. But truly, dignity in dying is just a part of dignity in living. No matter how one chooses to palliate,

it is important to have a non-judgmental presence in order to be able to talk about all choices, including MAiD. I believe that spiritual health practitioners are highly qualified for this role.

Angst around the Decision to Request MAiD

As noted, the prospect of a lengthy and painful death is unbearable for some. It is my anecdotal experience that the mere possibility of MAiD can bring so much relief to a client that a natural death can follow within hours or days of making the decision. In my practice, about 30 per cent of the clients I've journeyed with who have requested MAiD die naturally before the procedure is actually completed. This applied whether or not they had been approved by the panel.

One client agonized with me over the possibility of choosing MAiD for days. She and I discussed how she believed in God and how pivotal her faith had been to her entire life. She was tormented over how God would feel if she chose the procedure; she needed to reach a place of comfort that God would understand her choice. She wanted to be sure that this choice would not invalidate a lifetime of faithfulness and belief. At the end she decided that regardless of whether or not God would "damn" her, she could bear no more physical and emotional pain and asked to be connected with the MAiD team. Within three hours of making the decision she died naturally. Her family was shocked at the sudden loss, but at the same time they were relieved. They too had agonized over her choice to pursue MAiD and found it completely out of character for her. Despite the shock of her sudden death after the long months of suffering, they were relieved that it occurred outside of MAiD, as a natural death was more in line with their closely held values. However, I fully believe that it was being given choice that made a peaceful death possible for her.

My own mother had much the same experience at the end of her life. She was a devout Roman Catholic, but four years of cancer had brought her to the limits of her own pain tolerance. She had agonized over the decision for two years before she decided that when things got "bad enough" she would request MAiD. Even then, it was difficult for her to ask. Yet, one day, it happened. She had been hospitalized for a week, transferred twice, and told she now had been told she was going to personal care to die. Both the situation and the pain were a dual situation she could no longer bear. She asked me to call the MAiD team for her. Adding to the complexity of her situation, she had been transferred to a Roman Catholic hospital which did not permit the procedure, so the social worker could not assist us directly. It was over the weekend when

Mom made the request, so we could not speak to anyone directly, but I left a message with the MAiD team to contact us on Monday while Mom listened to the call. Mom had deteriorated so much that she could no longer make the call herself. Within twenty-four hours she died naturally and peacefully. This occurred before we could speak to anyone on the team. I suspect for her it was the relief of knowing that the pain was going to come to an end soon which allowed for her natural death.

Staff and Family Needs during MAiD Provisions in Long-Term Care

As noted, not all cases proceed through to provision. Yet, those that do often make a lasting impression. One MAiD procedure made a significant impression on me. I had followed this client through acute care to complex continuing care and through to his death. During his time in care, his body had continually declined. However, until the end, his mind was relatively sharp. We had deep conversations in both institutions. He challenged me intellectually, and we always had stimulating visits. He was interested in many things and he thought about things in ways that I couldn't even imagine. He participated in his care actively. He talked to the care team. In fact, he was quite endearing to all of us. I met his brother in the LTC facility during care team meetings but only met his extended family, his sisters, after his condition had deteriorated so significantly that he requested MAiD.

The staff were disturbed by his request and his family's compliance with the process. Many staff had objections to the procedure. Management called a meeting to allow staff to talk about their feelings. It was decided that any staff who objected on religious or moral grounds did not need to be involved with his care going forward. I supported both the staff and the client throughout. I also supported the family. The assessment was a two-week process. Family were convinced that this was the right choice for their brother. They could see the pain and suffering he was enduring.

I visited twice daily as the procedure neared. I also checked in on staff at those times. I could see the toll it was taking to wait for the approval and the date to be set. Meanwhile, the client continued to deteriorate, and he still had to consent on the day of the procedure. When all was set, I spent the entire morning on the unit. Some staff were crying and some prayed with me. I said a prayer with the client and family before the procedure. I was unable to be in the room, because his family were appropriately with him, but I stayed directly outside so I could provide support to staff, and afterwards say a prayer with the family and the

client, if they desired. They had appreciated prayer throughout and consented to it as soon as they saw me. I will never forget the words that one of the client's sisters said to me after I said the prayer, was saying my goodbyes, and offering after-care support. She said, "I will never forget you. You have no idea how much this meant to him, or to us. He's not in pain anymore. And you cared, you really cared. Thank you." I believe that for this client and family, this was a treatment, just the same as any other medical treatment. This procedure took away the pain in a way no other treatment could have done for him.

In LTC, MAiD requests and provisions are not a common occurrence at this time. Staff who are trained to prolong life or offer a peaceful, natural death are significantly disturbed by these requests. I often get requests from staff wanting me to "talk people out of requesting MAiD." I have to educate people about the pastoral role and how we don't talk people "into" or "out of" anything. We honour choices and help people come to their own self-awarenesses. Usually I end up talking to the staff about how they feel about MAiD and also find that the situation has triggered their own grief for the client or for someone else in their life. Religious, spiritual, moral, and ethical views run deep, and thus it can be difficult to navigate. While it might be the right thing for the client and family, the staff may be traumatized by the procedure a client chooses because they have come to care deeply for the client. Debriefs on all MAiD procedures are helpful if staff are allowed to share their feelings in a non-judgmental environment.

Despite all that has been done with MAiD in the palliative arena, MAiD is just beginning to spread into the LTC arena in my practice. It is still the exceptional case and it is shocking to staff and often to families. My mother had spoken to me about her desire for it in advance of being hospitalized or put into care, "just in case." She had worked in health care for over thirty-five years, she knew what death could look like, and she knew what she did and did not want to face. Most people don't have that knowledge until they are in the midst of it, so the reality of it can be shocking. It can also be shocking for health-care staff who have been trained to preserve and prolong life. It is sometimes unfathomable to LTC staff who are used to more natural deaths at end of life.

Going Forward

There is so much emotional and spiritual pain surrounding MAiD, both by those who are deciding whether to choose it and those around them, both staff and family. Religious belief is often at the centre of the dilemma. Will God "damn" us, as one of my residents asked? Will a

loving God punish one of God's own for choosing to end a pain that feels unbearable? That is the question that I frequently hear. The families often cannot understand their loved one, but they are not experiencing pain in the same way. Staff also are perplexed and torn. Are we expected to suffer as Christ did? What if the client feels that they cannot do so? Christ died to forgive us, so can he forgive this too? Is MAiD an act which actually needs forgiveness? These are questions that, of course, none of us can answer with certainty. We can only proceed with faith in a love that surpasses anything that we can imagine. Questions I think I can answer for myself are: Should I be deciding if the client should be willing to experience as much pain as Christ did? Should I be deciding for another whether or not this is their path to follow? For me these are "nos."

In my job, we are asked to leave judgments aside. In my role as clergy and as a follower of Christ I am asked us to accompany the sick and the bereaved and be a caregiver (Matthew 25:35–36). This is the role of non-judgmental companionship and the provision of dignity to God's own. I am in this role with those who are in physical, spiritual, and emotional pain. I strongly believe we are asked to *be* Christ to one another in these moments. Therefore, as we move forward, I see this being a role that that those in pastoral roles will be asked to fulfill in the LTC environment.

As MAiD becomes more common in the LTC area of health care, more education, resources, and support for staff need to be provided. This is not how it has "always been done." There also needs to be education on dignity for people who have the capacity to choose and also have the need to do so. I believe that dignity is an imperative at all times of our life, and death is no exception. People have the right to die with the same dignity with which they have lived, because after all, death is a natural and inevitable part of life. As people of God, I believe we shall need to answer to God regarding how we respond to people's choices. Were we Christ to the sick, the bereaved, and lonely? Were we Christ to the *least* of these (Matthew 25:45) and how do we know who are the least? Is it not best to refer to the "love everyone as I have loved you" law which Christ proclaimed took precedence over all other laws (John 13:34)? Theologically and pastorally it feels like loving one another is supporting those in their choices and allowing God to make God's own judgments. We are meant to be the bearers of the Holy Spirit in the world, to be the comforter. I believe that is my role in MAiD.

The Reverend Dr. Chris Salstrom *is an honorary assistant at St. Stephen and Bede, a Lutheran/Anglican parish in Winnipeg. She has been a chaplain for over a decade and is a passionate researcher and advocate for the profession. She is currently serving at Riverview Health Centre, specializing in care for both the complex continuing care and the special-needs dementia care populations. She came to her passion in ministry after a career in accounting.*

Questions for Reflection and Discussion

1. Is the LTC demographic well-suited to MAiD provision?
2. Who should accompany persons in LTC during MAiD?
3. Who should support staff during these times?

MAiD and One Chaplain's Reflections

DONALD SHIELDS

My first experience with death was my great-grandmother, who died at home in her bed at the age of ninety-eight. I must have been four or five, and can remember going into to her room wherein she lay with her face covered by a blanket, pulling back the sheet, and glancing at her still body. Nobody said I should be afraid and I wasn't.

As a chaplain, my first death I witnessed was of a patient, some twenty-seven years ago in an ICU unit in a downtown Toronto hospital. I stood at the end of the bed, prayers in hand, and watched the heartbeats displayed on the monitor above the bed slowly decrease to a solid line. The patient had died. It was not like what I experienced as a child; somehow death had become more mysterious, almost frightening, and my knees were shaking and I would have done anything to not be there.

Over the years death is something I have become comfortable with, having attended numerous bedsides where someone was dying or had died. I have memorized the prayers and the passages of comfort from sacred text and support loved ones and staff as a life comes to a conclusion.

My first experience of attending medical assistance in dying (MAiD) was venturing into the unknown. Familiar drugs used to sedate and operate on patients were now involved in ending life. I can rationalize why it has come to this. Some deaths are harsh and unpleasant. Secretions, difficulty breathing, pain, constipation, and backed-up bladders. Families struggle to stand vigil as the one who is dying struggles.

Palliative care is an option and works for many, many people who have access to it. And certainly hospice care. Yet, for some who consider life's end for themselves and their loved ones—how much dying is enough? How much pain is enough? How much surrender of simple things like toileting, bathing, and other activities of daily living need to go before a line has been crossed, dignity taken away?

At the bedside of a person who has chosen MAiD, goodbyes are said, laughs and tears shared, and a drug-induced sleep is administered that becomes deeper and deeper until no pulse is felt. It is a strange place, a land beyond the boundaries of what is familiar to us in Canada. As the medical staff announce that the patient has passed, those memorized prayers and sacred texts flow over my lips. They are comfort to those present and a final absolution for the one who has chosen to end their suffering.

In discussions with those who seek MAiD, I am asked what God thinks about all of this. Those asking are aware that some of their places of worship would not be supportive of their decision and the path they have chosen. I affirm that God is a God a love and charity. This I am certain of. Such an answer doesn't always dissuade the discomfort I am feeling, the dissonance that I feel. And perhaps this is good. One doctor whom I chatted with stated that to feel this discord is good. While MAiD addresses undue suffering and dying with dignity, it is a place beyond the known borders of care that we should be insecure with.

Kay Carter, whose court challenge led to the Supreme Court changing the laws around what then was called assisted suicide was asked how she felt when she heard of the decision. She responded that it was nice to now have the same rights as her cat.[1] Having witnessed two pets being euthanized, I know this was a compassionate move by our family to spare our beloved animal undue suffering and futile treatment. I know that the dying seek such compassion. I see MAiD as part of a continuum of care on the palliative spectrum that honours human dignity and mitigates undue suffering.

The Needle is chalky white
Saline flushes through a butterfly
As the needle is administered—eyes close, grimace fades, and body falls into pillow and mattress
A silent wait—the prescribed time, from life to Morpheus' realm
Stethoscope to chest, all waiting in hushed silence—"they have gone"
Tears, celebration, prayers, final goodbyes, and arrangements to make
What does it mean to not be?
There is no way we can leave our bodies, breathing in, breathing out
To contemplate our non-being
We can witness life stopping and death unfolding
Yet, it is a mystery, natural or assisted
We fear it, we deny it, and we shed tears when it happens
But truly, what is death?

[1] Interview with Mary (Kay Carter). CTV National News. CTV, September 2009.

The Reverend Donald Shields *is a priest in the Diocese of Toronto and has been a hospital chaplain for over twenty-five years. He is a registered psychotherapist in Ontario. Don is an honorary associate at St. Thomas Brooklin. He holds two master's degrees in theology. Don's hobbies are photography, music, and creative writing. Don facilitates mental health recovery groups as part of his chaplaincy work and also works with those who are grieving life losses. He enjoys mentoring colleagues in therapeutic techniques related to spiritual care and psychotherapy.*

Questions for Reflection and Discussion

1. How do you feel about to your own death and mortality?
2. Is it ethically and morally right to end a life that is ending?
3. What is a compassionate death?

MAiD: Crossing Too Soon? A Personal Pastoral Reflection

BERTRAND OLIVIER

A few years back, one morning, I had an unusual appointment in my diary. I knew it was coming because it had been the subject of discussion for a while, but I was feeling uncertain and slightly anxious about it despite having agreed to be there. That morning, for the first time in my ministry, I was going to be with one of our parishioners who had opted to receive medical assistance in dying (MAiD). They were at the end of a long road, and all that was ahead for them was the prospect of pain and loneliness in hospital for a few months before the inevitable. It felt deeply sad, and yet at the same time there was a dignity about making that decision, even if for some it would look like defeat.

I had not been that long in Montreal, only a couple of years, and that morning—as I was waiting for the bus to take me to the hospital—I saw something else I had never seen before. A woman crossed the street on the red, and a policewoman who was monitoring the crossing stopped her and gave her a ticket for jaywalking. I have been wondering a lot since then whether that was perhaps a metaphor for "crossing too soon," something to bear in mind in the context of MAiD. But, of course, the stakes were of a different order.

I have been a priest for over twenty-five years, having been ordained in the Church of England. There, I served in the Southwark and London dioceses. Like most clerics, I am no stranger to attending to the dying. Those that I remember specifically are the ones for which I arrived too late. Too late because the family or the hospital did not call in time, too late to be able to do anything meaningful for the person dying, though perhaps not too late for the family, not too late for providing pastoral care for those left behind. And of course, I have devised countless funerals in which to remember the dead and commend their soul to God: those who had died well after a long and slow relatively pain-free decline, but also

those who had died accidentally and far too young, those who had died at birth, those who had died alone, of the cold, on the street, unmourned. Death is never simple, and the ways of death in our global north cultures have changed beyond recognition in recent generations. Mostly, we do not really want to discuss it.

Overmedicalization of Health: Quality vs. Quantity of Life

Back before ordination, I worked in a different industry: I ran a communications and PR consultancy that specialized in pharmaceuticals. As such, most of our work advising some of the largest pharma companies was to promote the results of clinical trials that would help bring new drugs to the market, in therapeutic areas that were highly emotionally charged and in which there was a lot of research. We did a lot of work in cardiovascular drugs as well as in emerging cancer treatments, among others.

And there were significant breakthroughs that had the potential to transform the treatment of certain diseases, and did. And there were also new molecules that were shown to help add only a few weeks of life but with significant potential side effects to the patient and significant cost to the community.

This was the time when the questions of quality of life were starting to be raised routinely in assessing a potential treatment, and pharmaco-economics was looking at the cost benefit of specific drugs in very competitive markets. In an environment where many health-care systems were struggling financially, these were important questions which still to this day do not have a wholly satisfactory answer. Because who wants to take responsibility to prioritize the treatment of diseases over others?

Good Hospice Care as a Gold Standard

This was the period during which I was also responding to my call to ordination, and being trained in one of the part-time training schemes in the Church of England. During that time, I undertook the equivalent of clinical pastoral educator in a specialist cancer hospital in London, England, where I was confronted with the other side of the coin from my professional work: the reality of pain and suffering, fear and hope, and sometimes acute spiritual yearnings, and the ways in which the human soul can adapt to the certainty and proximity of death in the end. To this day, I remember spiritual conversations with young people with very little time left that showed a depth of spirit and trust in the divine that were breathtaking for me.

I found the experience so profound that I continued to serve as a volunteer in the hospital after my assignment was ended, and continued to have an interest in hospital visiting throughout my ministry. I revisited the experience later by volunteering a day a week in the day centre of Trinity Hospice in London, England—providing pastoral care but also perhaps continuing to learn to live with death for myself. Patients would attend once a week and take part in some art therapy activities as well as benefit from a range of other holistic support, as well as building community. As their disease progressed, they would become in-patients until, after an escalation in pain control, their time had come. In one sense, this is the best kind of holistic care that can be given to those for whom nothing more can be done medically. But it is not available everywhere.

And in the UK, when that level of care was not available, there was no legal option other than, for those who were still able and could afford it, to travel to Zürich where they could avail themselves of medically assisted suicide. A room with a lethal cocktail to end it all. A bleak journey.

First Encounter with MAiD

Shortly after I arrived at Christ Church Cathedral in Montreal, we heard a report that a former couple from the cathedral who had moved to Toronto had chosen to ask for MAiD and had both died together.[1]

They had been prepared for this by the then Dean of Toronto, who wrote about that experience. For us at Christ Church Cathedral, it was something we had not yet encountered as it was still a recent piece of legislation and there was uncertainty in the congregation, though overall there was also understanding. We organized an evening discussion with expert speakers to consider the current law in Quebec as well as the pastoral implications, with questions and answers at the end. It was in one sense a very Anglican evening. Anglican because—as we were grappling with something that was real and happening in the lives of faithful Anglicans—opinions were divided, though perhaps not as much as we might have expected.

After all, many people have experienced the death of a loved one, and in some cases the extreme pain and indignities that that occasioned. Not everyone is fortunate to be able to receive the best hospice care—I certainly witnessed a distressing example—which is not always easily available.

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[1] Kelly Grant, "Medically Assisted Death Allows Couple Married Almost 73 Years to Die Together," *The Globe and Mail*, April 1, 2018, https://www.theglobeandmail.com/canada/article-medically-assisted-death-allows-couple-married-almost-73-years-to-die.

No wonder that, for some—including people of faith—who find themselves at the end of their lives in a place where the only way forward is debilitating pain and loss of dignity, MAiD can be a way to control their final journey, in a not dissimilar way that we today take for granted that we can totally control birth, the journey into life, from induction to C-section.

Being There as a Pastor

Although it was inevitable, when the subject was broached with me for the first time by a parishioner at the end of their life, I was still not sure what I thought or felt. But I knew that despite the weight of their decision and the heavily medicalized context in which it was going to happen, God was going to be there with them and with their family, and with the attending staff. And so as a pastor, I had no hesitation in offering to be present in order to offer the sacraments of the church for the dying as well as a hopeful presence for the family, a human reminder of the love of God at that difficult and unusual time of transition.

I was fortunate that in that situation, I had plenty of time to meet the extended family in advance and therefore to earn trust of those who were not part of the Christian community, those who were not sure about Christian rituals and about Christian hope—even if they had residual memories of a priestly involvement at the point of death.

As I tried to consider how best to approach the day, I knew that I could not entirely rely on pastoral skills learned in many years of ministry, because the experience was going to be so different from that of a natural death. I was, to some extent, anxious at my possible reaction on the day and so wanted to be prepared and somehow bring some familiarity to an otherwise unknown environment. At that moment, that hospital room would be holy ground, and so I chose music to play, and I prepared—and printed—a short and simple liturgy using existing texts in which everyone could take part and which included anointing for the dying. The liturgy would help everyone focus and pray at the time of parting, and help me keep my professional stance at a stressful time.

Despite a slight delay in the arrival of the medical team, which meant there was an awkward hiatus in the process, it was an extraordinary peaceful moment of letting go—with deep sadness of course—but also with a real sense of the presence of God in the room surrounding us all. At the end, the doctor in charge commented on how the experience had been transformed by the presence of a priest in contrast to other such moments in which he had participated. Clearly, he and his team had experienced families in unresolved conflict and distress over the choice of a loved one.

The Question of Pain

It can be easy for those who do not suffer to find redemptive power in the suffering of others. And it is of course true that bearing pain when there is a prospect of recovery and continued life is what we all have to do at times, and it can build community and relationship. I am, however, finding it hard to subscribe to the idea that God sends us pain as a test in which meaning and growth are to be found, even if both can indeed be found with hindsight after a recovery.

We are blessed with wonderful and mysterious human bodies which, over time and through the wear and tear of life or through our bad decisions, are damaged and eventually fail without the possibility of repair. And this can sometimes cause excruciating and unbearable pain—physical and emotional—which only increases until death—even with modern pain control.

It is possible to argue that many who are choosing MAiD are people who, prior to that decision, have been in receipt of painful, invasive, and life-changing medical treatments without which they might have long before died, probably in great pain and distress. So in that sense, and administered in these conditions, MAiD is not a defeat before God, but instead it is the point at which we humbly acknowledge that there is no more to be done, that we have extended life as far as we could. Prolonging suffering for a diminishing life is, for some, not honouring the life in all its fullness that Jesus promises us. This is of course not to say that it is an easy or the right decision for everyone.

Concerns over Newer Developments

MAiD is not simple for our society and for people of faith. It is not simple theologically, pastorally, or legally, nor does it not affect those who surround those who choose it. Because it is not, and it does. While it is possible to rationalize the point to which we have come so far ethically and spiritually, there is much work to do yet as we consider developments under discussion.

Expanding the Scope of MAiD

The extension of MAiD to include categories of diseases for which a prognosis of physical death cannot be given is concerning. Up until proposed new changes, the will and dignity of the patient, without coercion, to be able to express their wish to die with dignity in this way was paramount, as well as the medical support for that decision.

In the cases in which I have been present, the patient has been asked to confirm this clearly and could have stopped the process until the end.

This seems ethically very different to the question of MAiD in the case of future mental health degradation, when the medical community would find themselves ending the life of people who by that stage may have no idea at all about what is happening to them. The recent Quebec film *Tu te souviendras de moi* (You will remember me) directed by Eric Tessier deals with the complexity for families of watching the mental life of a loved one disintegrate through dementia, and leaves the question open—at what point is a life no longer worth living?

Re-branding

More and more, MAiD is being presented or discussed as a treatment option, which is problematic and may create confusion in the mind of those who are trying to weigh different palliative pathways. Even if it takes place under medical supervision, MAiD is not a form of treatment as it is not curing a disease but instead it is stopping pain by killing its source, the human body.

Of course, it is now a legal option and therefore should be discussed between physician and patient if the question arises, not as a routine alternative to pain control, but instead, as a choice for the patient which needs to be pondered in a context wider than that of the doctor's office, and should hopefully involve family and/or loved ones all working holistically in the best interest of the patient.

There have already been reports of the current legislation falling short in the case of some patients with mental health issues, and where families were put in a *fait accompli* situation at the last hour when other outcomes might have been possible.

Death: Friend or Foe

As a society, we have in recent generations learned to fight death at all costs, and to then make it disappear. Few people have witnessed death, it most often occurs in hospital, and death rituals are accelerated—for cost reasons but also because of the lack of framework for most people in the face of death.

We expect the silver bullet of a miracle cure to always be there, available, regardless of the cost, and yet we are not willing to discuss openly the limitations of medical science and also the limits that have to be put around the treatments that can be provided, in an area where budgets are ever soaring.

Many people do not consider in time the advance medical directives that might obviate the need for later difficult decisions once their life was diminished without hope of recovery. Death is, after all, a natural

process which is part of life, and it is the unnecessary pushing of boundaries in order to maintain life which creates the ethical dilemmas which we face, for instance with MAiD.

Perhaps we need to relearn what a good life and a good death mean, and value again quality over quantity of life for ourselves, as well as for those we love whom we should be ready to let go when the time comes, for their sake. After all, our faith provides us with the hope that death is not the end, but only the beginning of the next stage of our journey with God.

Conclusion

I have not sought here to write an essay in ethics but rather to put down my thoughts as a pastor, someone whose role means that I need to be where God's people are, even if it is in a place where I would rather not be.

I am not sure whether I personally would or would not have the courage to ask for MAiD, and I certainly know that I would not want to be pushed into it. It is not an easy decision, one that requires courage in the weighing of one's life but, as I have witnessed, it is one that can be liberating because it provides the opportunity for dignity at the point of closure of a human life.

In the instances in which I have been involved, it has allowed for a coming together of families, for time for discussion and proper farewells, and the relief that this would not happen in a place of excruciating pain or diminishment, but instead at a point where the individuals were still themselves, sad to have to go from this world but ready for the next, and with no other alternative—sooner or later—to embracing this step into the eternal life promised by Jesus.

The Anglican Church has long changed its view on the place of those who end their lives in other circumstances, and we need to be pastorally present to those who, probably in increasing numbers, will be considering the option of MAiD.

The Very Reverend Bertrand Olivier *has been overseeing the work of Christ Church Cathedral in Montreal for over five years. He was previously incumbent of the parish All Hallows by the Tower in the Diocese of London, England, following two incumbencies in Southwark diocese. Prior to ordination, Bertrand headed a London-based international communications consultancy specializing in health care. Originally a French national, he has a particular interest in pastoral liturgy as well as issues of justice and peace. He is a member of the Iona Community.*

Questions for Reflection and Discussion

1. Have you had the experience of seeing someone you loved die after a painful illness? How did you feel? Where was God for you in that experience? If not, can you imagine what that would be like?
2. Within your family or friendship circle, has someone requested MAiD? If so, were you able to empathize with their decision and support them through this journey? Did you find this easy or did it require a lot of emotional strength? What was joyful and what was painful? What was your prayer during that time?
3. Proposed extension of the MAiD legislation in Canada would mean that it would be possible for people with degenerative diseases such as Alzheimer's to request MAiD for the time when they no longer recognize anyone from their previous life. Is it possible to separate body and mind in making that decision? Can we as a society ask doctors to end the life of healthy bodies with absent minds? How does this fit with Jesus's assurance of "life in all its fulness"?

Living in the Tension: Contradictions in Codes of Conduct

MARTY LEVESQUE

Ethics, broadly speaking, is the study of how we ought to act. Professionally, ethics map out best practices, virtues worth fostering, and standards of conduct. In short, ethics in the workplace refers to a "standard that governs the conduct of its professional members."[1] This differs from morals, which are better expressed as personal principles regarding right and wrong. Sometimes "ethics" and "morals" are used interchangeably, although this tends to lead to confusion about ethics in general; are they personal or professional?

For the purpose of this paper, I will be using the definition that ethics are indeed external to the self and are codified in a set of principles to govern the conduct of members of an organization. This definition helps distinguish between personal morals and professional ethics. This definition allows for tension between competing sets of ethics as well. For instance, the professional code of ethics surrounding the protection of vulnerable populations in the Diocese of Huron is captured in Canon 40, Screening in Faith.[2] This code of conduct surrounding vulnerable populations is a professional ethical standard that all clergy must adhere to while exercising ministry on behalf of the bishop. Yet this standard may come into conflict with other codes of ethics, namely the virtue ethics taught in scripture or natural law theory, also codified in scriptures.

It is this struggle between competing codes of ethics I wish to engage through the use of a case study of how the church, and a pastor, is to

[1] Gerald Corey et al., *Issues and Ethics in the Helping Professions*, 9th ed. (Australia: Brooks/Cole/Cengage Learning, 2015), 8.

[2] Diocese of Huron, "Canon 40: Screening in Faith," 2016, https://diohuron.org/resources/canons-and-constitution/pages/canons.

respond to the request for aid in assisted dying as part of the overall health team of a patient. This case study will open some interesting ethical challenges between protections of the vulnerable patient, the demands of scripture, and how the clergy can best respond to a request at the end of life.

Yet before proceeding with the case study, it would be best to frame the discussion with a brief description of Canon 40 and the policies and procedures of this diocese. With this groundwork in place, I will then proceed to outline the ethical issues surrounding assisted dying and how I am to respond as a member of the Diocese of Huron and The Anglican Church of Canada. During the discussion, I hope to bring forward paradoxes and tensions that must be held together as I seek to minister to individuals at the end of life.

Canon 40 of the Diocese of Huron sets out the legal framework for the policies that surround the protection of vulnerable populations. It creates a process by which clergy and volunteers are screened and determined if they are fit to work with vulnerable persons. This includes compliance with Diocesan policies; discerned level of risk; volunteer ministry description; recruitment process; application form; interview; reference checks; police records checks; orientation and training; supervision and evaluation; and participant follow-up. Diocesan policies are continually updated and are reflected in the *Sacred Trust* document.[3] Generally speaking, safe-church policies revolve around sexual misconduct but also have been expanded to include professional standards of conduct in relation to our baptismal covenant. Our baptismal covenant, our rule of life, frames the professional conduct standards of clergy in the Diocese of Huron and how we are to interact with others, both parishioners and others we serve.

In our baptismal covenant, we make five specific vows, the first of which is to continue in the apostles' teaching and fellowship, in the breaking of the bread and the prayers. This means we must acknowledge the "God-given value of every person, and to refuse to tolerate any vexatious or exploitative conduct or comment that might prevent a person from fully, safely, freely and joyfully participating in the regular learning, fellowship, worship, and prayer of the church."[4] The ability for us to gather cannot be impeded through bullying, degrading comments, or verbal, sexual, psychological, or physical abuse.

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[3] Diocese of Huron, *Safe Church Guidelines,* 17-6. PDF file. https://diohuron.org/safe-church/safe-church-manuals.

[4] Diocese of Huron, *Safe Church Guidelines*.

The second vow is to persevere in resisting evil and, whenever we fall into sin, repent and return to the Lord. The pastoral relationship is fraught with power imbalances. The church has a special responsibility to persevere in resisting any teaching or conduct which would abuse the sacred relationship between priest and parishioner. We are to avoid teachings that objectify individuals and rather see each person as uniquely made in the image and likeness of God.

The third vow is to proclaim by word and example the good news of God in Christ. Rather than the code of conduct entirely being prescriptive, it is also affirmative in our relationships and/or interactions with parishioners in all aspects of life. Integrity of being and the joyful life-giving expression are not held as opposites but live in tension and are to be found as healthy part of the life in Christ. Proper relationships with healthy boundaries have "the ability to reflect most beautifully the depth of love possible in relationship with God."[5] Healthy relationships in this manner become an example of the good news that is found in Jesus Christ and a tangible example of God's incarnational love in the world.

The fourth vow is to seek and serve Christ in all persons, loving your neighbour as yourself. At the core of this vow is to be faithful, loving each person and seeing within them the very image of the crucified God. It presupposes our connection in the sacred web and covenant and integrates us into the great body of Christ through time and space, the Church. Through the act of seeking and serving Christ in all persons, we affirm the divine in each person and hold them as sacred. As each person is sacred, our actions and conduct towards them should reflect the same reverence we hold for God as codified in the Two Greatest Commandments.[6] This is once again a positive statement of the conduct expected of clergy within the Diocese of Huron.

The final vow is to strive for justice and peace among all people and respect the dignity of every human being. It is incumbent to take very seriously any circumstances in which abuse is suspected or reported, whether in the church itself or the lives of those we minister too. It is "important for justice to be carried out with thoroughness, care, and expedience, to provide a foundation for restoration of peace and healing."[7] For justice to take root we must protect the vulnerable, especially where there is an imbalance in power. And when that imbalance leads to the code of conduct being violated and vulnerable

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5 Diocese of Huron, *Safe Church*, 17-7.
6 Matthew 22:34–40.
7 Diocese of Huron, *Safe Church*, 17-7.

populations abused, "we must work for the healing of victims, their families and congregations."[8]

The code of conduct being firmly grounded in the baptismal covenant clearly is an attempt to articulate that Canon 40 and the code of professional conduct is for all in the church, and not just the clergy. This code of conduct is meant to cover all volunteers, lay and ordained, as well as all employees. As a policy statement the Diocese of Huron "undertakes to ensure that our Churches be a safe and holy place for all whom ministry affects."[9] Further the policy states

> In relationships of trust, whether with children or adults, the greatest care must be exercised to avoid taking advantage of trust, or abusing the situation of responsibility and caring. Clergy and other church workers need to recognize the unique dynamics of these relationships and the potential for harm and abuse. Vulnerabilities are exposed, and the very strengths of these relationships, namely the expression of care and love, can easily take on inappropriate forms.[10]

These policies and code of conduct clearly articulate for me the role that discipleship and baptism play in our daily conduct. The code is not just about professional conduct but is a tool for how we ought to live as Christians, both professionally in how we ought to treat individuals but also personally and how we relate to the world around us. This blends the professional world of ethics and the personal dimension of morality. The baptismal covenant reaffirms our daily commitments to God and to neighbour. And unlike a simple code of ethics or policy, the covenant transcends human understanding and makes our agreement not just with those we minister to, but also makes that agreement with God.

The policies of conduct, therefore, are not only firmly grounded in our tradition, liturgies, and rites of initiation but also in scripture, best expressed in the Two Greatest Commandments: "You shall love the Lord your God with all your heart, and with all your soul, and with all your mind. This is the greatest and first commandment. And the second is like it: you shall love your neighbour as yourself. On these two commandments hang all the law and prophets."[11] The covenantal act secures that our treatment of God will also be the same treatment for those we minister to and our own personal care.

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[8] Diocese of Huron, *Safe Church*, 17-7.
[9] Diocese of Huron, *Safe Church*, 17-7.
[10] Diocese of Huron, *Safe Church*, 17-7.
[11] Matthew 22:37–40 (NRSV).

With this framework in mind, we are now able to turn to the question of assisted dying. The recent decision of the Supreme Court of Canada in February 2015 found that physician-assisted dying is constitutionally permissible and brought to conclusion the public debate concerning the legal ban on physician-assisted dying. The new legal framework that has been passed into law has caused a dynamic tension in the life of the church and how clergy are to aid and bring comfort at the end of life.

In 1990, the Doctrine and Worship Committee of The Anglican Church of Canada was asked to prepare a theological statement of euthanasia. The draft statement reads as follows:

> 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* [my emphasis]. The Christian vocation is to keep 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 and 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."[12]

This theological statement was never adopted but rather was built up in the *Care in Dying* document, which was prepared for The General Synod of The Anglican Church of Canada in 1998. In *Care in Dying* the same theological principles were restated, namely that we are made in

[12] The Ethics Group of the Doctrine Sub-committee, "Draft Statement on Assisted Suicide [1995]," Appendix A in Task Group of the Faith, Worship, and Ministry Committee, *Care in Dying: A Consideration of the Practices of Euthanasia and Physician Assisted Suicide* (Toronto: The General Synod of The Anglican Church of Canada, 1999), 39.

the image and likeness of God and "our life is to be seen as a gift entrusted to us by God."[13] Furthermore, the task group built upon Romans 14:7 in that we do not live to ourselves and we do not die to ourselves but are part of the body of Christ. The report continued to state that the church has "actively supported the development of palliative care facilities and practices, including pain management."[14] The report further captured the idea that "euthanasia could present special risk for those in our society who are already vulnerable."[15] As such, the report recommended,

> 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 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.[16]

It should be noted that the church's position on assisted dying and euthanasia rests on the intent of the treatment that is being offered. To help clarify the position of the church and therefore the role its clergy may play in end-of-life decisions, the report provided some helpful definitions. Brain death and removal of life support do not consist as assisted dying or euthanasia simply because death has already occurred when the "brain, including the brain stem, has irreversibly ceased to function."[17] As such, removal of life support cannot be construed as either euthanasia or assisted dying. Clergy are welcomed to perform last rites, administer communion, and offer prayers with the family.

Termination of treatment "refers to those situations where medical treatment is no longer indicated and all treatment except palliation (food, hydration, pain relief, etc.) is withdrawn."[18] Sometimes this is thought of as passive euthanasia, except it is better understood as an "expression of the common law right of patient, or their legally appointed proxy, to refuse treatment."[19] The intent here is not to cause

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[13] Task Group, *Care in Dying*, 3.
[14] Task Group, *Care in Dying*, 3.
[15] Task Group, *Care in Dying*, 4
[16] Task Group, *Care in Dying*, 4.
[17] Task Group, *Care in Dying*, 6.
[18] Task Group, *Care in Dying*, 6.
[19] Task Group, *Care in Dying*, 6.

death but rather recognizes that death can no longer be resisted and allows the patient to pursue a course of actively dying. As with the original statement first drafted in 1990, the clergy are encouraged to keep company with the patient, share communion, and provide the laying on of hands and anointing of the sick, known as unction.

It is the next three categories where the policies of the church limit the role of clergy. In passive euthanasia, "where the intention is to allow the patient to die," death is sought by a decision not to act. The result of choosing not act to effectively correct the condition leads directly to the death of the patient. This occurs when a decision is made to withhold treatment because the quality of life after the treatment would be deemed not to be of value. It is not that the treatment wouldn't save the life of the patient; the calculation is simply that the quality of life after the treatment does not justify the treatment. In this case, clergy are welcome to offer pastoral care, but not to counsel the patient or their proxy on the withholding of treatment. And since the patient or their proxy are entering into what the church would describe as a state of sin, the sacraments of the church are not offered.

Physician-assisted suicide refers to the "provision by a physician of the means by which a patient ends his or her own life."[20] In this case, the physician simply provides the means and the patient controls their fate. Once again, this shedding of one's life is seen to be in contradiction to the statement of the church in *Care in Dying*. In this situation, the clergy person is once again welcome to provide pastoral care but should counsel the patient that all life is sacred and that we are made in the image and likeness of God. Pastoral care may be offered, but the sacraments of the church, communion and last rites, would not be offered.

And finally, there is the situation of euthanasia where a caregiver "intervenes directly to bring about the death of the patient."[21] Pastoral care may also be offered, but the church's liturgies, last rites, unction, and communion are withheld. Direct action, even with informed consent, is still seen to be in contradiction with the gift of life from God and our role as image bearers of God.

While the church's position has been well articulated, it has sought to further nuance its position "that in both dying and living, our care is articulated in terms of our covenantal presence to the other."[22] While not willing to open itself completely, the church has made room for clergy to

[20] Task Group, *Care in Dying*, 8.
[21] Task Group, *Care in Dying*, 8.
[22] Task Group, *Care in Dying*, 8.

be present at the time of death, even in cases of assisted suicide or euthanasia. The question though, for individual clergy, is whether to adhere to the tenets of the church, providing good pastoral and palliative care as part of the end-of-life health team while simultaneously withholding the sacraments of the church? Is this truly the best the church has to offer?

Doherty makes an interesting observation in his work *Soul Searching*: "morality is a communal as well as a personal affair."[23] While he is speaking specifically to therapist, his insights do provide some clues into a pastoral response for individual clergy. Doherty asserts, "As therapists, we are moral consultants, not just psychosocial consultants."[24] I would extend Doherty's thinking into the realm of pastoral care provided by clergy. Our role at the end of life is not just pastoral, but also makes us part of civil society, and as part of civil society we must choose how best to provide pastoral care, even to those who choose death.[25] This may include violating the codes of conduct of the church and providing last rites, unction, and Holy Communion to a patient who is to receive assistance in dying.

As articulated in both the *Care in Dying* and the *In Sure and Certain Hope* documents, the role of the clergy is to be present with the other, even at the time of death and even if that death is freely chosen. The ministry of presence is grounded in our initiation rites, namely our common baptism. As stated previously, "our care is articulated in terms of our covenant of presence to the other."[26] The covenant, though, is not just between clergy and patient, but broadly speaking includes the baptized, the Church as a whole. It also includes God. The covenantal relationship always begins first in the grace and mercy of God as God moves first and we respond to that movement.

The role of the clergy to be present in the dying process, therefore, is a means by which we make the presence of God known to those who are to shed this mortal coil. As the church wrestles with whether they may liturgically participate in assisted suicides and euthanasia, I have always believed that it is not my role or place to mitigate God's grace. As clergy, we freely offer forgiveness to all who are repentant. We offer the bread of heaven in the Eucharist. We baptize all who seek God. We confirm those who make a commitment to God in their lives. We marry those who seek to live a life in Christ. And we provide the ministry of healing, unction, to all those who are ill and dying.

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[23] William J. Doherty, *Soul Searching: Why Psychotherapy Must Promote Moral Responsibility* (New York: Basic Books, 1995), 38.

[24] Doherty, *Soul Searching*, 33.

[25] For more on civil society, see Doherty, *Soul Searching*, 95.

[26] Task Group, *Care in Dying*, 11.

As first discussed, ethics is broadly speaking about a code of conduct and morality is about personal acts. Morality, or personal ethics as informed from scripture and tradition, seems to be in contradiction with the code of conduct of the church. There is no easy way to resolve this tension, other than to live in the tension itself. If we take seriously the commandments to love God and love neighbour, then we must always be willing to bring God in the form of the sacraments to our neighbours even when they make a choice that is contradictory to the teachings of the church.

The Christian life is one of hope, hope in the resurrection and hope in the forgiveness of our sins. This hope is grounded in Christ's sacrifice on the cross, affirming that every sin can be forgiven, and everyone has the opportunity to rejoin the community at the table to celebrate the heavenly banquet. Clearly, there is a paradox in our ministry of presence where we bring God's presence to those seeking assisted dying and withholding of the sacraments, which makes God's presence tangible. Can both positions be adhered to simultaneously? Clearly not. To overcome the paradox, clergy will need to make a choice whether to adhere the code of conduct as laid out by the church or choose to bring the sacraments and fulfill the covenantal ministry of presence. The paradoxical situation of competing ethics does not make matters easy, for it is not possible to fulfill one's duty without violating either the ministry of presence or the codes of conduct of the church. In both cases, clergy would still never counsel a patient towards accepting assisted dying or euthanasia. Instead they would hold out the hope to the dying in the forms of the prayers of the church and for some who chose to violate the code of conduct, the sacraments of God.

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Questions for Reflection and Discussion

1. Whether you belong to the clergy or laity, what are the various professional, vocational, community, or personal "codes of conduct" that bind you? Starting with the baptismal covenant, look at them all together and invite a conversation among them. Where do they say the same thing or point to the same values? Where do they challenge each other?
2. Do you experience any contradictions among the codes of conduct, baptismal and ordination vows, and Rule of Life to which you are bound?
3. How should the church—laity and clergy together as the community of the body of Christ—be present for someone who has requested MAiD? With pastoral prayer? Eucharist? Unction? What pastoral direction have you received from your bishop on this matter?

Position Paper on MAiD and Protocols on Pastoral Care for Those Choosing MAiD

GREG CLARK, CHRIS ROTH, OZ LORENTZEN, PILAR GATEMAN, GREG KERR-WILSON

There have been a number of clergy and other members of the Diocese of Calgary with questions and concerns on how to address medical assistance in dying. This document, completed in October 2023, is a response to those questions, offering a theological framework and pastoral direction for addressing medical assistance in dying within our current context.

Introduction

To address any social or ethical issue within our present context in a secular, democratic and pluralistic society requires that we begin with a simple recognition; the foundations, principles and goals with which we work, while at times touching or overlapping with those of secular society, will be other than those employed by governments and secular courts. The work of these bodies is to arbitrate between competing individual and social freedoms and demands, while seeking a balance between individual rights and social good that will be acceptable to the greater part of the population. For the Christian Church, our starting point is the revelation of God in Jesus Christ; our principles are those articulated within the teaching of Jesus as received and understood within the Church, and our goal is to "not be conformed to this world, but be transformed by the renewing of your (our) minds" (Romans 12:1-2); to "to let this mind be in you that was in Christ Jesus" (Philippians 2:5); to seek in Christ for God's will to be done, not our own. This is not to deny, of course, the role of reason in addressing questions before us, but to recognize that all reasoning begins with and rests upon a starting point and the particular data with which it is presented, (for us, the Gospel of Jesus Christ) and to understand that natural reason is perfected only by

the grace of God and the guidance of the Holy Spirit. Of course, this basic stance is one which is not meant to and cannot be imposed upon others, but is received when we turn to Christ in faith and allow it to grow in us as we grow in faith; it is, however, one which guides the life and practice of faith within the Church.

When we address issues relating to death, our starting point is an understanding of life. As Christians that means we begin with the received understanding that life arises from God's creative action. While our cultural context usually inclines us to think of life mechanistically (the product of naturally occurring processes), our faith affirms that life is both created and continuously sustained by the grace and love of God. God is inextricably involved in creation and never absent from any part of it. The gift of life is not once given, but continually being given by the source of all life; in a manner analogous to the sun being the source of light in our solar system. While we are culturally conditioned to think of "our" life as being a sort of "possession" (it is ours, it belongs to us and we have the right to do with what is ours as we might choose) our faith affirms that while life is indeed a gift, all life continues to belong to God. We do not possess it uniquely in the manner that we think about possession within the legal and material framework of the world. Certainly, we have rights with respect to "our life", both in conjunction with and over against the rights of others, but the political framework within which this is understood in western, secular society is, as hinted above, a way to adjudicate competing concerns between autonomous individuals, not how Christian faith understands our dependence on, our relationship with and our created duty to the source of all life.

The issue of suffering stands at the heart of this attempt to live with God, others and our-self.[1] The presuppositions of our culture (and increasingly our own) underlie and inform our understanding of suffering and the central role it plays in the dialog around death and dying. First, the person is defined irreducibly and almost exclusively as a Self: understood as an autonomous individual. Consequently, the rights of the individual become a focal point and ensuring individual rights the highest good. The state, further, exists to provide and safeguard these rights.

Current presuppositions about God, if they factor at all, seem to consign Him to the role of a doting and indulgent Grandparent who will, of course, want for us what we want for ourselves.

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[1] This discussion on suffering is indebted to Stanley Hauerwas, *Naming the Silence: God, Medicine, and the Problem of Suffering* (London: T&T Clark, 2001).

A third set of presuppositions includes community and our duty to others, which are relegated to a secondary or peripheral role. This accentuates both the current poverty of the church and the newly found "salvific" role of the state—as the guarantor of the individual's rights, the provider of the highest good.

The state has supplanted the church. Perhaps the church has become too weak to be a community which can "absorb suffering" and provide the narrative in which Christian people live, (including a narrative about suffering and death), and provide bonds deep enough to sustain people as they face suffering and death.

As a church, the fault may be our own, and science, medicine & the state merely stepped into this vacuum; the state, however, doesn't generate community. Increasingly it seems the state absolves and frees the individual from community: from responsibility to others. In effect this erodes community. The individual, the Self, is increasingly thrust upon itself and its own resources to determine its own good, to create meaning, to craft a narrative that grounds and orients it. The state dutifully responds by safeguarding and legitimating these various self-determinations, these "rights" of the individual.

These presuppositions and their outworking in our current context underlie the issue regarding the question of suffering (even posing suffering as a problem to be solved indicates the influence of these presuppositions) and they predetermine how one can respond to suffering. Suffering becomes a problem that the state offers to solve.

Our presuppositions from a faith perspective, however, lead to a different understanding and response. When we as Christians seek to understand most fully what it means to be fully human with respect to any aspect of life, including our relationship to death, we look to Jesus as the one who has fully shown us what it means to live our lives as God intends and as God created us to." Not my will, but yours" is the ground on which we stand in faith as we seek to address the question of the death of all human beings – including our own.

A Good Death

If we look to Jesus as the example of what it means to be fully human, to be fully alive, then, since death is the final act of being alive, it makes sense that we look at the death of Jesus to see what makes a "good death." There are three salient points coming from the death of Jesus.

First, what makes death "good," what allows for dignity for the person who is dying, is neither choice of the timing or means of death nor is it a product of the conditions under which death is experienced. Instead,

dignity is what the individual brings with them as they face death; it is a factor of how one approaches death.

Second, Jesus approached death by committing himself to God's will, plan and purpose, and by entrusting himself to God's care.

Third, when we step back from the actual details of the death of Jesus, we see that death is an occasion for God to work beyond our understanding and wildest expectations. At minimum, there is the response of the Centurion as he witnessed the dignity and personhood of Jesus dying on the cross.

These three points—1) dignity is found in the person, not in circumstances, 2) the meaning of death is determined by what transcends death (e.g. the will of God) and 3) death can serve a greater good—define a "good death." This description is in general agreement with a significant testimony of philosophical, theological and religious thought.

As we begin to think pastorally about death, we can add that the response of those who support and journey along side those who are dying is to offer the response of Jesus' companions at the cross—to find the courage to bear witness through our compassionate and engaged presence to the fundamental dignity of this child of God as they approach this significant threshold.

Pastoral Care

When it comes to pastoral care it is important to define what it is we are doing. For instance, while there is overlap between the care given by a Christian priest and a psychologist, it is important to note that the end goal of each encounter is not the same.

The Christian view of a fully healthy human being is a human being whose vision is so flooded with Jesus Christ that they reflect Jesus Christ from the deepest parts of their being. Pastoral care has this as its goal. We see this idea in St. Paul's words to the church in Galatia: "My little children, for whom I am again in the pain of childbirth until Christ is formed in you" (Galatians 4:19). This is stated in many different ways in scripture. For example, the death of the works of the flesh and the expression of the fruit of the Spirit (Galatians 5:16-26); The embodiment of love (1 Corinthians 13); The striving for the perfection of God (Matthew 5:48); etc.

From a Christian point of view, health looks like a human being continuously shaped into the image of Christ by being continuously drawn into our Lord's presence, teaching, and example. The practices of the church lead us in this direction as a part of the primary goal of the

church, which is to glorify God. We call on Christ to be Lord of our lives, whatever our circumstances—even when our circumstances are perplexing. As we provide pastoral care, we keep this goal in mind, even if it is not made explicit to the person we are caring for. Whatever help we offer people is to be in line with God's goal for the person. While God's will is not always clear in the details of one's life (e.g. should I become an engineer or a biologist), the overall biblical principles are much more easily discerned (e.g. our central motivations are love of God and neighbour).

There are times when God's desire to shape us into the image of Jesus will mean not immediately rescuing us from discomfort (see 2 Corinthians 12:7-10). Christ himself endured the cross following God's will. It surely seemed to be pointless suffering to observers—perhaps it even seemed to be suffering that glorified the power of the Roman Empire, but not God. Jesus is our model when it comes to suffering: Jesus wept (John 11:35); Jesus seems to have felt forsaken by God on the cross (Mark 15:34; Psalm 22); Jesus seems to have prayed an unanswered prayer to be saved from suffering (Mark 14:34-36). As hard as this is to hear in a society that is obsessed with immediate comfort and personal autonomy, God's primary goal in our lives is not our immediate comfort. God's goal for human beings is long-term joy in the presence of the Trinity and the saints, which is attained by being "in Christ". This does not mean that God is insensitive to our suffering, rather, God does not want to grant us immediate relief from discomfort if it means sacrificing a greater good (our being shaped into the image of Christ).

As the Christian pastor serves those who are suffering, their task is to help the Christian trust in Christ, who loves them, who suffered for them, and who is constantly interceding for them. As St. Paul says, "I consider that the sufferings of this present time are not worth comparing with the glory about to be revealed to us. …We know that all things work together for good for those who love God, who are called according to his purpose. For those whom he foreknew he also predestined to be conformed to the image of his Son, in order that he might be the firstborn within a large family" (Romans 8:18, 28-29). With the letter to the Colossians, we encourage followers of Christ, "if you have been raised with Christ, seek the things that are above, where Christ is seated at the right hand of God. Set your minds on things that are above, not on things that are on earth, for you have died, and your life is hidden with Christ in God" (Colossians 3:1-3).In order to respond pastorally to others, we have a great need to rediscover meaning in the midst of suffering.

Suffering is not, however an end in itself . So while it is not permitted for a Christian to engage in the purposeful killing of a human life (apart from situations of defense of self or others) we are able to help Christians advocate with the health system for improved palliative care, pain control, and withdrawal of active care. Many people are not aware of the range of options, or how to navigate the health system. Clergy are sometimes more aware of these matters due to their experience in these settings.

It may be the case that the use of a drug like morphine will shorten the life of someone who is suffering. This is not to be equated with killing. In just war theory, harm may be done to an attacker, but the motivation is to defend the vulnerable. In a similar sense, the use of drugs is motivated by the desire to control intense pain. A side-effect of the use of that drug may be the shortening of the life of the patient, but the death of the patient is not the primary intent.

It follows, theologically and pastorally, that should someone choose to die by the active involvement of the health system ("assisted suicide", "euthanasia", "MAiD", "mercy killing", or "legal medical homicide") we are not to cooperate with this decision. We must resist the temptation to create a liturgy around the moment of killing. It may be tempting for the individual and the priest to sacralize this event, to have the priest hold their hand and pray over them as they slip into eternity. It may be tempting for the individual to have this kind of control over the end of their life, or to romanticize the event. But, we must not lose sight of the fact that this is the active killing of a life—a temple of the Holy Spirit (1 Corinthians 6:19); a bearer of the image of God (Genesis 1:27). This does not mean we give up hope or give up care for the person. It is a delicate situation that requires the wisdom to care for the person without supporting their decision to be killed. This is likely to create a complicated pastoral situation with the person's family, and perhaps with health care workers as well.

Compassion means to "suffer with" someone. Job's friends "made an appointment together to come to show him sympathy and comfort him. And when they saw him from a distance, they did not recognize him. And they raised their voices and wept, and they tore their robes and sprinkled dust on their heads towards heaven. And they sat with him on the ground seven days and seven nights, and no one spoke a word to him, for they saw that his suffering was very great." (Job 2:11-13) This was the best thing Job's friends did. It is no small thing to be compassionately engaged and present to another who is suffering. Nor is it an easy thing, it requires incredible courage and humility. As pastoral caregivers we need to hold onto hope, and, to provide that hope

to others, who may be struggling with hope. God will not let suffering have the last word in His good creation. Life does not end with a cross. It ends with resurrection and new life.

Conclusion

Current cultural and societal values and assumptions about the nature of humanity, the purpose of life and the role of science and medicine have led to a widespread acceptance of Assisted Dying as one choice for those who are facing the end of life. Our biblical, historical and theological norms and values lead to a different conclusion. This brief overview of our Christian position, while not being exhaustive, clearly points to the response we, as Christ's vicars, must give to those who are seeking MAiD. We are grateful for all that clergy do to support and give pastoral care to those in many situations. We hope this guideline gives some parameters to the many who have requested them.

Medical Assistance in Death – PROTOCOL

Introduction

Christian pastoral care has always had ministry to the sick and dying as one core piece of its activity. Pastors have sat with the dying and their families, offering presence, counsel, and prayer as expressions of our faith and hope in Jesus Christ. We offer our ministry "in sure and certain hope of the resurrection to eternal life through our Lord Jesus Christ." (Committal, Funeral Rite, BAS p.587) We are present, not as judges, but as pastors. Love for God and for our brothers and sisters in Christ, while holding true to the faith that we have received, is the context for the following protocol, based on the above theological framework. Out of necessity, a protocol is general and meant to give guidance under usual circumstances. There are often "what if's, and perceived exceptions that might arise. However, exceptions are not a basis for establishing norms, and it is not wise to create a protocol that attempts to deal with every conceivable circumstance.

Parameters for clergy in the Anglican Diocese of Calgary

BEFORE the death

We fully expect for clergy to provide Pastoral Care before and after the death.

This would include visits to the patient, family or friends as is deemed appropriate by the clergy person. It includes a posture of listening and prayer, not judgment or criticism.

DURING the death

We will not provide liturgies during the event. We strongly advise that clergy not attend the event in order to avoid any confusion or assumption that clergy is blessing the event. Although clergy are not present at the moment of death; prayers said in advance of and after that moment are as appropriate and fulfill the pastoral call.

Not Permitted:

1. Providing a liturgical framework for the moment of death which in any way celebrates, honours or condones the taking of life or the choice to end life.
    a) This includes providing communion, anointing or prayers of blessing at the time of death. Please note: It is appropriate to provide pastoral care to the sick at earlier stages in this process. To avoid the appearance of sacralizing the act of killing, these formal acts of priestly ministration should be concluded at least 24 hours before the event of dying by MAiD
2. Commentary with family or patient which creates guilt or shame around the choice.

AFTER the death

We encourage clergy to be involved in pastoral care with the family after the death of the loved one. Providing ongoing spiritual counseling and conversation for both family and those involved in performing the Medically Assisted Death is appropriate. Alongside of the normal grief experienced at the death of a loved one, there also may be feelings of regret, shame or rejection among surviving family members which should be addressed pastorally. Providing a funeral for the deceased is also an appropriate pastoral act for the family.

Additional Resources Recommended

Guidelines for the Celebration of the Sacraments with Persons & Families Considering or Opting for Death by Assisted Suicide or Euthanasia. From the Catholic Church bishops of Alberta and the Northwest Territories.

Questions for Reflection and Discussion

1. As you think about your own death, what does it mean for you to contemplate "not be[ing] conformed to this world, but

be[ing] transformed by the renewing of your [our] minds" (Romans 12:1–2)?

2. The paper suggests that going by natural reason alone is bound to lead us astray, as people of faith. What does it mean to reason together in Christ, under the light of faith?
3. We live in a culture that both avoids the fact of death and is overly confident in its rationality. What does it mean to say "no" to both of these cultural currents in the context of MAiD?

Pastoral Reflections on Canadian Medical Assistance in Dying

A POLICY STATEMENT FROM THE DIOCESE OF CALGARY, OCTOBER 2023

Euthanasia[1] and assisted suicide[2] have been made legal in Canada. This has led many to ask about how to address the subject theologically and pastorally. The following document provides some guidance for parishioners and clergy in the Anglican Diocese of Calgary.

The Anglican Church maintains that life is a gift from God and has intrinsic sanctity, significance, and value. We have a leasehold on our lives; we are not outright owners. Human dignity comes from our being created in the image of God, and not from our abilities or accomplishments. We are, furthermore, stewards of time. Both life and time are held in trust to be used to work toward the restoration of all things.

Our vision is of God's completed redemption of all creation on the Day of Resurrection. Our lives are to be shaped by this vision of our end; our ethics come from our eschatology—a healed and redeemed community thriving in a new creation. Euthanasia and assisted suicide betray this sacred trust and are not compatible with the Christian faith.

Suffering and death are no argument against life. As Christians we take our lead concerning the thorny problem of suffering from Jesus, who shared our human nature. He lived and died as one of us, to reconcile us to God. Jesus did not flee from the pain and suffering that is our human lot; instead he transformed it by making it the path of salvation. So too, we believe that he can bring release to those who place their hope in him. Through patience with our human condition, we trust that by God's grace we will find grace sufficient to meet all our trials, even as Jesus through death overcame our mortality.

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[1] Euthanasia is intentionally bringing about the death of another who is terminally ill.
[2] Assisted suicide is assisting in the death of another either by direct action or by the preparation of the means for suicide.

Our Canadian Context

Medical assistance in dying became legal in Canada on June 17, 2016. Bill C-14[3] introduced legalized euthanasia for those whose natural death was reasonably foreseeable. No specific time frame was set, but those who had a "grievous and irredeemable medical condition" could apply for a doctor or nurse practitioner to bring about their death. Currently, four conditions need to be met to enact the powers set out in the medical assistance in dying legislation. A patient must:

1. have a severe and incurable illness, disease, or disability [4]
2. be in an advanced state of irrevocable decline in capability
3. have enduring, intolerable physical or psychological pain
4. have a natural death that is reasonably foreseeable.

As the law is written, intolerable psychological pain is assessed entirely subjectively by the patient. Consequently, what constitutes enduring, intolerable psychological pain can range from being afraid, to feeling isolated, to feeling like a burden on one's family, to not being able to do normal activities.[5]

On March 17, 2021 Bill C-7[6] was brought into effect, amending the 2016 MAiD legislation. A second stream of assisted suicide was introduced. It dropped the eligibility requirement that natural death be "reasonably foreseeable." The amended legislation also waived the requirement for final consent, allowing advanced consent to be made for both euthanasia and assisted suicide.

Our Pastoral Response

The dying process has the potential for personal and spiritual transformation, reconciliation, and healing for the dying person and for his or her loved ones. Even though they are difficult, it is important to have discussions in our families and parishes about the ultimate meaning and purpose of human life.

Clergy need to take account of their parishioners' personal and family situations when offering pastoral offices. The ministry of the sick is an extension of the Church's basic act of worship, the gathering around the word and sacrament. It places the sick person in his or her time of trial within the Christian hope of communal wholeness and wellbeing.

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[3] https://www.parl.ca/Content/Bills/421/Government/C-14/C-14_4/C-14_4.PDF
[4] Sadly the legislation includes "disability" as a condition warranting euthanasia.
[5] See the *First Annual Report of Medical Assistance in Dying*: https://www.canada.ca/en/health-canada/services/medical-assistance-dying-annual-report-2019.html
[6] https://parl.ca/Content/Bills/432/Government/C-7/C-7_4/C-7_4.PDF

Through pastoral care we commend the compassion of Christ to those confronting their mortal end and the challenges of illness, suffering, and diminished capacity. We work toward God's plan for wholeness by promoting healing, consolation, guidance, reconciliation, and nurturing.

We strongly endorse palliative and hospice care. They bring support and hope to the suffering person and to his or her family and friends. Palliative care is indispensable and should be made widely available. Quality medical care and dignity-preserving practices at all levels of health care would go a long way toward removing euthanasia and assisted suicide as desirable alternatives to life.

It may help to share with parishioners and family that to withhold, withdraw, or terminate excessive treatments or interventions is not euthanasia.[7] To withhold or withdraw excessive medical treatment or intervention may be appropriate where there is no reasonable prospect of recovery. Refusing or terminating medical treatment is a legitimate individual moral choice.

Moreover, when the primary intent is to relieve suffering and not to bring about death, to provide supportive care (e.g., analgesics) for the alleviation of intolerable physical pain may be appropriate, even if the side effect of that care is to hasten the dying process.

Although clergy support the sick and suffering, they should not promote euthanasia or assisted suicide. *The pastoral offices* ***should not be used*** *in such a way as to appear to sanctify life-terminating procedures,* if a parishioner has so chosen. **Neither special prayers nor special liturgies should be created for the practice of the taking of life by means of MAiD.**

Christian funeral liturgies stress the continuing dignity and value of a person after death. They are a powerful witness and provide needed comfort in the face of death. For the Lord has searched us out and known us, darkness is not dark to God, nor is death the end, and not one thing can separate us from the love of God.

Clergy and parishioners must continue to look for new ways to be present and supportive to the sick and the dying, and to their families. May the Holy Spirit grant us all wisdom and insight. With thankful hearts let us continue boldly to encourage the flame of life and keep the lamp of expectancy alight, so that our society, conversation, and even the fabric of our lives makes us fit for the kingdom and the coming of the Bridegroom.

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[7] For more on this and the following paragraph see Resolution 1.14 and the report on euthanasia in the 1998 Lambeth Conference.

Questions for Reflection and Discussion

1. "Suffering and death are no argument against life." What does this mean to you?
2. Do you think that your diocese could adopt this policy statement? If not, what would need to change and why?
3. "The ministry of the sick is an extension of the Church's basic act of worship, the gathering around the word and sacrament. It places the sick person in his or her time of trial within the Christian hope of communal wholeness and wellbeing." Ministry with the sick is usually something that takes place in a context of relative privacy: home, hospital room, etc. In a world that would like to keep religion as a private matter, and death as a hidden thing, how might worshipping communities build a better sense of unity between the church's public acts of worship and the more intimate experiences of pastoral ministry?

End-of-Life Decision: A Christian Perspective

MIRANDA SUTHERLAND

The aim of this paper is to provide prayerful pastoral, theological, and ethical exploration of medical assistance in dying (MAiD), from the perspective of Anglicans in The Anglican Church of Canada. MAiD, also known as euthanasia[1] (voluntary, involuntary, active, passive),[2] is a highly controversial and frequently debated topic that raises moral, legal, and religious concerns. Gushee and Stassen state that the term "euthanasia" is a component of bioethics,[3] which is "an act or practice of painlessly ending the life of people suffering from incurable conditions or disease."[4] The problem that the paper is addressing is the ethical dilemma surrounding MAiD or euthanasia from a Christian perspective. It explores the tension between the sanctity of life and the desire to alleviate suffering. From birth to death, in wholeness or in sickness, life should be treated with utmost dignity[5] and sacredness.[6]

This concept of "euthanasia," which often sends shivers down the spines of many, is not endorsed by those who are in support of allowing a person to live out their earthly lifespan in a dignified and sacred way. On the other hand, there are those who argue that the dignity and sacredness of life is also considered, even for an appropriate form of euthanasia.

The beginning of my discernment around this controversial topic started at Taylor Seminary, Edmonton, while studying a Christian ethics course. This Christian-based paper is building on the learning then and

[1] David P. Gushee and Glen H. Stassen, *Kingdom Ethics: Following Jesus in Contemporary Context*, 2nd ed. (Grand Rapids, MI: Eerdmans, 2016), 436–40.
[2] Gushee and Stassen, *Kingdom Ethics*, 437–39.
[3] Gushee and Stassen, *Kingdom Ethics*, 437–39.
[4] Gushee and Stassen, *Kingdom Ethics*, 437–39.
[5] Gushee and Stassen, *Kingdom Ethics*, 149–68.
[6] Gushee and Stassen, *Kingdom Ethics*, 149–68.

is being developed to support the Christian view of those who are not in favour of euthanasia. Scriptural evidence along with other credible sources will be provided as this position paper argues against permissibility for Christians to choose "end-of-life options" as this goes against the will of God. As this is not about universal law, the paper will be limited to include reference to the Canadian legal position,[7] thereby providing national background information to the reader. Information will also be provided from The Anglican Church of Canada's perspective.

Background—Canadian Government

The debate on MAiD in Canada can be traced back to the late twentieth century when it gained prominence, after the Supreme Court of Canada's role in significantly shaping the discourse. In 1993, there was a landmark ruling by the Supreme Court of Canada in the case of *Rodriguez v. British Columbia (Attorney General)*.[8] It ruled that the Criminal Code provisions prohibiting assisted suicide did not violate the Canadian Charter of Rights and Freedoms. Sue Rodriguez, who had amyotrophic lateral sclerosis, sought the right to physician-assisted suicide but was ultimately unsuccessful in her legal battle. The ruling opened the doors to further discussions and eventually led to the legalization of MAiD in 2016, with strict criteria and safeguards in place to protect vulnerable individuals.

The conversation continued and public opinion started to shift towards supporting access to medical assistance in dying. There was yet another ruling in 2015 by the Supreme Court of Canada.[9] It declared that the criminal prohibition on physician-assisted dying was unconstitutional for competent adults who have a grievous and irremediable medical condition that causes enduring suffering. It suspended its decision for one year to allow the government time to enact new legislation. The MAiD legislation received royal assent and came into effect on June 17, 2016. It included strict criteria and safeguards for access to medical assistance in dying, balancing the rights of patients with the need to protect vulnerable individuals.

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[7] Government of Canada, "Medical Assistance in Dying: Making a Request," accessed April 2, 2017, https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html#a3; "Medical Assistance in Dying: Overview," accessed February 13, 2023, https://www.canada.ca/en/health-canada/services/health-services-benefits/medical-assistance-dying.html.

[8] *Rodriguez v. British Columbia (Attorney General)*, https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/1054/index.do.

[9] *Carter v. Canada (Attorney General)*, https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do.

Response—Anglican Church of Canada

Among the discussant groups on this highly sensitive matter at that time were the churches, including The Anglican Church of Canada. In its 48-page response to the Supreme Court's 2015 ruling, The Anglican Church of Canada presented a balanced view, but also took a position. The church argued then that MAiD goes against the Christian understanding of the sanctity of life and the responsibility to care for the vulnerable, noting that life is a gift from God and is to be respected and protected from conception to natural death.

The following is an important extract from that report and necessary to be highlighted:

> While many may regret this change, the task force believes that our energy is best spent at this time ensuring that this practice is governed in ways that reflect, insofar as possible, a just expression of care for the dignity of every human being, whatever their circumstances. Theologically we continue to assert that human persons, being in the image of God, are the bearers of an inalienable dignity that calls us to treat each person not merely with respect, but with love, care, and compassion. This calling, being a reflection of God's free grace, is in no way qualified by the circumstances that an individual may face, no matter how tragic. Neither is that inherent dignity diminished nor heightened by the decisions they make in those circumstances, even if they differ from the decisions that pastors might in good conscience make or recommend. The judgment of the Supreme Court opens a new layer of difficult decisions, ones that will be difficult no matter what the initial preferences of the patient or their final decision. We also need to recognize the challenges faced by family, loved ones, and care providers in these difficult processes.[10]

Taken together, the resources from the Anglican Church of Canada in 1998 and 2016 reflect both that the church opposes euthanasia and assisted suicide and at the same time understands that there may be exceptional circumstances in which medical assistance in dying may be an appropriate way to care for people who are suffering.

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[10] Faith, Worship and Ministry Task Force on Physician Assisted Dying, *In Sure and Certain Hope: Resources to Assist Pastoral and Theological Approaches to Physician Assisted Dying* (Toronto: The General Synod of The Anglican Church of Canada, 2016), 5–6, https://www.anglican.ca/resources/sure-certain-hope-resources-assist-pastoral-theological-approaches-physician-assisted-dying.

Pro-euthanasia Christians

Christians who are pro-euthanasia present the contextualism[11] argument that certain terminal illnesses, long suffering, and unbearable pain are reasons to lovingly and caringly assist their loved ones to die more quickly and with dignity, avoiding the trauma they experience where this option is unavailable. While I am respectful of the positions taken by these families, and can also understand some of the emotional pains, from my own personal experiences in my family, I was never pushed with such anguish or personal comfort to desire an end-of-life option outside of the natural course of one's life span. My Christianity is imbedded in the belief that God is in charge of my life, and I trust him in health and illness, if it comes, until my life's end.

The research framework of this paper is limited to the given references, and I will argue my position accordingly. The expectation of the writer is that on completion of this paper, it will serve to at least narrow the current ethical ambiguity.[12]

Turning to the interpretation of scripture, Richard Hays, professor of New Testament at Duke Divinity School, uses a "four-task" approach[13] framework, which serves as a guide for understanding and applying the ethical teachings of the New Testament in contemporary context. All four tasks—historical, literary, theological, and contemporary—are applicable to this paper but focus will be on three of the four. The historical task involves examining the historical, social, and cultural contexts of the New Testament and an understanding of the perspectives and beliefs of the early Christian church, and their attitudes towards life, death, and suffering in the Greco-Roman world. For the next, Hays argues that the moral vision of the New Testament is inseparable from its theological convictions, particularly in Jesus as the Son of God and the embodiment of God's moral character. These theological foundations, he argues, shape the moral vision and help to uncover the underlying motivation and principles guiding the ethical teachings, found primarily in the teachings of the Beatitudes from the mount and on the plain. The last task involves applying the moral vision of the New Testament to present-day situations. Hays argues that, although the New Testament was written in a different cultural and historical context, its moral vision still holds relevance and can guide ethical decision-making today. These tasks help to provide direction to the moral vision conveyed in the scripture in relation to MAiD and enable readers to bridge the gap between the

[11] Gushee and Stassen, *Kingdom Ethics*, 74–76, 436–40.
[12] Gushee and Stassen, *Kingdom Ethics*, 83.
[13] Richard B. Hays, *The Moral Vision of The New Testament* (New York: HarperCollins, 1996).

ancient world and the modern, facilitating the application of the Bible's moral teachings to the complexities of contemporary life.

While Hays's approaches have provided some valuable insights into the New Testament's moral vision, without any definitive stance on MAiD, a closer look at some select scripture passages from both the Old and the New Testaments will aid for possible interpretation within a wider canonical perspective. Since this is a position paper, I will also be more subjective in my comments.

Euthanasia in Canonical Context

At the outset, I will state that the canonical text is silent on euthanasia. While the Bible does not explicitly address the issue of MAiD, there are scriptures that are applicable to allowing one to perform such a drastic and final act upon another.

Old Testament

Genesis 1:27 and 2:7 state that God created man in his own image and breathes into him the breath of life, and this is where the value and dignity of the human life was established. This was further reinforced throughout the Bible, particularly Exodus 20:13 among the Ten Commandments: "Thou shalt not kill." This is clearly a prohibition of the wilful taking of an innocent life. Scripture also shows that for the Christian, human dignity is advanced through struggle, even in the face of pain and suffering, and the Christian is encouraged not to be fearful, to be strong and courageous in the face of pain and suffering, knowing that the Lord is always there in every situation to protect. This will be borne out later.

Throughout my personal life and theological experiences, I have embraced the truths of these scriptures (Deuteronomy 31:6, 8; Psalm 23:4), and I am sustained and always have a hope for spiritual wholeness. In the book of Job is found the example of one whose fear of God allowed him to endure severe suffering and pain. He never yielded, even when family and friends encouraged him to give up, curse God, and die. Instead, he said with conviction, "The Lord gave, the Lord has taken away, blessed be the name of the Lord" (Job 1:20–22, 2:10). God later restored him to full health and possessions. Job's testimony shows that God will keep all his children who believe in him in his loving care and will restore them for his full glory.

New Testament—Euthanasia and the Jesus Paradigm

Jesus makes the paradigm shift when he called for the people to be neighbourly and virtuous, as recorded in the Sermon on the Mount

(Matthew 5:3–12),[14] commonly known as the Beatitudes.

His paradigmatic reasonings in these Beatitudes are calls to be neighbourly, and as such the matter of MAiD must be seriously explored to arrive at a deep spiritual contentment and differentiation. These Beatitudes are considered the cornerstone of Christian ethics and morality, and therefore, provide the framework for how Christians should live their lives to the very end.

Since the Beatitudes should provide a framework for understanding the Christian perspective on MAiD, such understanding should emphasize compassion, mercy, justice, a demarcation of intellectual and divine insufficiency, and above all, respect and upholding of the value of human dignity and the value of life. These values should not be in tension or contention with government legislation of MAiD, which is the intentional ending of a person's life. Further explanation on related Beatitudes will provide even greater clarity and reasons to uphold natural death.

The first Beatitude is *"Blessed are the poor in spirit, for theirs is the kingdom of heaven"* (Matthew 5:3). Embedded in this is the principle of humility and the importance of recognizing our own limitations as human beings. In the context of MAiD, this Beatitude highlights the importance of recognizing the limitations of medical technology. MAiD should never be viewed as a way to control death and suffering—no one has that authority. Neither should medicine be viewed as having the power to control death. The reality is, from an eschatological perspective, medicine is not always able to control death and suffering. The "poor in spirit" Christians should recognize these limitations and be able to accept the natural and physical process of death which leads on to eternal life.

The second Beatitude, *"Blessed are those who mourn, for they will be comforted"* (Matthew 5:4), is the extended hand, and expression of compassion and empathy. In this is the preparation and care and comfort that the Christian community is to carry out for those who are suffering. It is the drawing on the sources available in the church to come alongside those who suffer in various ways, including extreme physical suffering. Instead of ending a person's life, shouldn't the focus be on providing spiritual support and care to those who are in pain? This is often done through spiritual support in prayer and the ministry of presence, pain management, and emotional support in general.

"Blessed are the meek, for they will inherit the earth" (Matthew 5:5), is the third Beatitude—one of humility and gentleness. In the context of MAiD, this Beatitude emphasizes the importance of, again, recognizing

[14] Gushee and Stassen, *Kingdom Ethics*, 29, 31, 32.

the value of human life, which should not be undermined by the application of MAiD, because human beings are not merely disposable objects. Those who are meek recognize the value of human life and are gentle in their approach to journey to the end with end-of-life care.

"Blessed are those who hunger and thirst for righteousness": This Beatitude states that those who hunger and thirst for righteousness will be filled (Matthew 5:6). This Beatitude is not calling for the bargaining for one's life. The very state of the journey of the human being is toward a higher calling. In the context of this Beatitude, MAiD seeks to rob the kingdom of God of its teachings about what it means to glorify God. At every point in the human existence, God is teaching us, and for one to stop that process with MAiD is to stop short the glorification of God, and is "playing God."

Additionally, several other teachings are found in the Sermon on the Mount as recorded in the Gospel of Matthew and in Luke, the Sermon on the Plain, of how we are called to be neighbours to one another. Examples of these are found in Matthew 8:16–17, 9:35, and 15:30–31 and Luke 9:1–2, 10:8–9. The Christian understands what it means to be neighbourly, especially *to* those who are helpless, "going beyond conventional conceptions of duty to provide life-sustaining aid to those whom we might not have regarded as worthy of our compassion."[15]

The Christian community can also turn to the double-love command story of the Good Samaritan (Luke 10:25–37), to find another good example of this paradigmatic reasoning by Jesus. All parties involved have communal and neighbourly responsibility to each other, and if Jesus were here, he would be saying to those administering the drug, this is not the way of "deliverance from bondage of guilt."[16]

New Testament—Paul's Life and Endurance through Suffering

The Apostle Paul is a true example of how to make the paradigm shift to truly become "imitators of Christ" (Romans 15:1–7; 1 Corinthians 11:1; Galatians 6:2; Philippians 2:1–13). Any examination of MAiD should be with a view by the Christian community to perform the highest act of care for others, through *verstehen*—by standing in the shoes of Jesus. Christianity is a lived experience to the glory of God.

The Apostle Paul's life is a true example of honouring and glorifying God, even in suffering. The marriage vows in The Book of Common Prayer say something about our lives in Christ. Couples vow "to have and to hold from this day forward, for better for worse, for richer for poorer,

[15] Hays, *Moral Vision*, 451.
[16] Hays, *Moral Vision*, 32.

in sickness and in health, to love and to cherish, till death do us part, according to God's holy ordinance." It is not up to human beings to bring about untimely death. Paul was one who suffered much until death. The scripture is replete with his life story and how, through his own life experiences, Christians can take comfort in times of suffering and pain and hold on in spite of tribulations, distress, persecution, or the sword, because in the end "in all these things we are more than conquerors through him (Jesus Christ) who loves us" (Romans 8:35–37). In Philippians 3:10, he invites all believers into this suffering in order to "attain to the resurrection from the dead," knowing that within the physical body, rocked with suffering and pain, is something greater, as unto God (2 Corinthians 4:7).

I hold firm that the Christian is encouraged through scripture not to take matters of life and death into their own hands, but to trust the process of the sacred life, bearing and forbearing, recognizing full well that though our outer nature is wasting away, our inner man, the soul, is being renewed day by day (2 Corinthians 4:16–18). The Christian's hope in is Jesus Christ, who has the right report (not those ready to euthanize his people). The Christian is not allowed to choose life or death—life is sacred. Being baptized in Christ Jesus, this is where the equation changes. No longer is one living under their own jurisdiction but under the dictates of God. The Christian is now "united to the Lord and become one spirit with him," bought with a price and expected to glorify God (1 Corinthians 6:17; 1 Corinthians 3:16–17; 6:19–20).

The Christian knows that there is an appointed time for everything on this earth, even the death of someone (Ecclesiastes 3:1, 2), and should live with this knowledge for "precious in the sight of the Lord is the death of his faithful servants" and that God's eyes "saw my unformed body; all the days ordained for me were written in your book before one of them came to be." (Psalm 116:15 and Psalm 139:16). For these reasons, it is not allowable for a Christian to take their life, even if there is terminal illness or unbearable pain.

Euthanasia in the Symbolic World

Looking at this ethical issue through the symbolic world and from a paradigmatic standpoint, Hays' hermeneutical approaches to interpreting the scripture provide much clarity against euthanasia.[17] In the symbolic world, the Christian accepts that all things came into being by the word of God (John 1:3–5) and so "we are privileged to participate in the creative work of God, since as God's creatures, we are stewards who bear

[17] Hays, *Moral Vision*, 450.

life in trust."[18] With this understanding, to assist someone to terminate their life "is not only to commit an act of violence but also to assume responsibility for destroying a work of God, from whom are all things and for whom we exist. (1 Corinthians 8:6)"[19] Therefore euthanasia, which for me presumptuously assumes authority to dispose of a life that no human being can create, should be ruled as being wrong, due to its strong correlation with murder and suicide.

A Christian Call against Euthanasia

There can be no description of the mental stress that one undergoes to have a loved one ill for years, because each person has their own schema and their own emotional threshold. As I researched, I felt a surge of compassion for the parties on both sides of the fence. I listened to a video of Noreen Campbell[20] relating her pain over her mother's situation and I heard the stories of many, including one whose relative in their sixties was in a hospice for over fifteen years and could only speak like a toddler.

I have listened to clergy and laity and have read many articles on this subject. I have also solicited and have included personal articles from Father Art,[21] Father Simba,[22] and a member[23] of the laity who wishes to remain anonymous. I feel the pull on my heart for those who experience turmoil in everyday life and who openly express that they wish they were in the next life. And then, I sigh a sigh of relief when I recall the word of God to all Christians to cast all our cares upon him for he cares for us (Psalm 55:22; 1 Peter 5:5), because by his stripes we are healed (Isaiah 53:5; 1 Peter 2:25). Casting "all our cares." This is drawing on the faith as a mustard seed. This means a deep understanding of the power and work of the Holy Spirit in our lives and a call to divine trusting, not holding back anything from the Spirit, and refusing to make such decisions, like pro-euthanasia. God is the same yesterday, today, and forever (Hebrews 13:8).

What then can the church do in this moral ethical dilemma, in a post-Christian culture such as Canada? Return to the model of the Beatitudes from the Sermon on the Mount and on the Plain, taught and modelled by the incarnate one, Jesus Christ. He sat with the people. The church is reminded also of the three-authority model of Wells and Quash in the

[18] Hays, *Moral Vision*, 450.
[19] Hays, *Moral Vision*, 450.
[20] *Noreen Campbell Speaks Out about Her Choice*, (Dying with Dignity Canada, 2017), video, https://www.youtube.com/watch?v=74G_asBv66U.
[21] Art Turnbull. "The Voice of a Retired Priest on MAiD," Diocese of New Westminster, June 2023.
[22] Simbarache Basvi, "A Clergy Perspective," Diocese of New Westminster, June 2023.
[23] Anonymous, "A Member Perspective," Diocese of New Westminster.

interpretation of the scripture,[24] by first being neighbours in a community of faith, leaving them with one of love.

Hays argues that the Christian community does not have a definitive answer for shaping "its life in obedience to the witness of the New Testament" because "the community of faith continually confronts new circumstances that require us to work out our salvation with fear and trembling and forming fresh imaginative judgements."[25] For this reason, the church needs to make another paradigm shift to becoming, once again, a more "faith-learning community" formed by scripture, where all members of the community would see themselves as learning in the "faith school of life," then living out more of what it is to be truly Christian—the Jesus Way, consistently and effectually, with credibility and integrity, and anchoring our ethical teachings in theological thought.[26] The theological motif of eschatology and the new community in Christ would be better understood, and so I agree with Hay's affirmation that "When the community of God's people is living in responsive obedience to God's Word, we will find, again and again, such grace-filled homologies between the story of Scripture and its performance in our midst."[27]

Personal Story and Reference to John Wesley's Death

My mother, Florette Salmon, at sixty-three years old had lost her sight and was suffering from serious renal failure. I provided palliative care for her in my home. We knew that she was dying but we were praying for extended time. On March 2, 2005, my sister and I read the high priestly prayer, St. John 17 and sang with her, and then she asked that we pray with her. She died in my home that very night. We cared for her until her passing into glory. It was emotionally draining but we did the best for her by being by her bedside day and night. This reminds me of John Wesley who died on March 2, 1791, in his eighty-eighth year. As he lay dying, his friends gathered around him. Neither Mom nor Wesley were injected with anything. Mom gave her last breath naturally and went home to glory. As for Wesley, he grasped their hands and said repeatedly, "Farewell, farewell." At the end, summoning all his remaining strength, he cried out, "The best of all is, God is with us." He lifted his arms and raised his feeble voice again, repeating the words, "The best of all is, God is with us."[28]

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[24] Samuel Wells and Ben Quash, *Introducing Christian Ethics* (Malden, MA: Wiley-Blackwell, 2010), 3–6.
[25] Hays, *Moral Vision*, 133.
[26] Gushee, and Stassen, *Kingdom Ethics*, 41.
[27] Hays, *Moral Vision*, 460.
[28] "John Wesley and the Holy Club's 22 Questions," Hope · Faith · Prayer, accessed April 1, 2017, https://www.hopefaithprayer.com/john-wesley-holy-club-questions/.

The research for this paper has allowed me to appreciate the views expressed for those who are pro-euthanasia, but those views have not convinced me to have the audacity to hasten the hand of God to take me home before his time. Until then, I remain contented that Christians should not be allowed to choose to end their lives in the face of terminal illness or unbearable pain and neither should Christians entertain such requests from their family members. May God grant us the wisdom to choose life and allow him to choose death for us, so that when that time comes for him to take us home, we will all be welcomed as the prepared-for and expected guests into his kingdom where my mother, Miss Florette, theologian John Wesley, and the faithful saints of God have gone on before us.

Conclusion

Medical assistance in dying, MAiD, goes to the heart of every human being. There are reasons to be concerned about the impact that this legal decision has on everyone in our society and especially those who are most vulnerable. While the churches may not be able to change the law, they have the responsibility to discern and provide sound theological guidance.

While there is no direct biblical reference to be attributed to euthanasia and therefore the Bible does not provide substantial evidence for a normative judgment, inferential biblical sources and other authorities on tradition and reason provide a basis for Christians to avoid endorsing medically assisted death.

Scripture remains the foundation of ethical beliefs, and its teachings on healing, restoration, and the value of life should guide Christians in navigating the complexities of end-of-life decisions. The Holy Spirit of God will reveal himself to us when all tradition, reason, and experience are unable to provide the answers to human needs.

Further study, such as Professor Richard Hays's book *The Moral Vision of the New Testament*, is recommended, as this debate about MAiD is still very central in Christian discourses. It offers a comprehensive and thoughtful examination of the ethical teachings found in the New Testament, and it does provide the reader with a deeper understanding of the moral vision that underlies the Christian faith pertaining to end-of-life decisions.

The Reverend Miranda Sutherland *is Jamaican who started her ministry as a priest in Canada in the Diocese of Edmonton in 2015 and has been serving in the Diocese of New Westminster, British Columbia since 2017. She was called to the priesthood in 2011, after decades of working in the private and public sectors and national service in her homeland. In addition to her duties and responsibilities as a priest, Mother Miranda is the chaplain of the Anglican Church Women as well as a dismantling racism trainer in the Diocese of New Westminster. Her growing interest is now in the intentional interim ministry.*

Questions for Reflection and Discussion

1. The paper discusses the Beatitudes as a framework for understanding the Christian perspective on MAiD. How do these teachings, emphasizing compassion, mercy, and upholding human dignity, shape the ethical considerations around medical assistance in dying?
2. The author suggests a paradigm shift towards becoming a "faith-learning community" that continually seeks to align its life with the witness of the New Testament. How can the church navigate the challenges of a rapidly changing cultural context and apply the moral teachings of the Bible to contemporary ethical dilemmas like MAiD?
3. Personal stories, such as the author's experience with caring for a loved one at the end of life, can deeply influence perspectives on MAiD. How do personal narratives and emotional experiences shape our understanding of this complex issue, and how should they be considered in ethical discussions?

Dying in Grace and Compassion

SISTER KATHRYN TULIP

This article is based on personal belief and experience and does not reflect the collective beliefs of the Sisterhood of St John the Divine of whom I am a member.

My reflection will ponder the questions of what it means to choose when to die, what are some of the reasons we are at this point in society, what are the implications for caring in a society of increasing medical intervention and institutionalizing our personal health, and what is the impact of this on our spiritual self in relation to our human reality.

What does it mean to choose when to die? This was a question that surfaced for me decades ago when this emerging reality came into the public eye. I wondered what it meant to be a person suffering while navigating a myriad of institutions of medical science, ethics, and law. In my cultural past there was a sacredness towards a person's life, and we accepted that we were at the mercy of birth and death often beyond our human ability to intervene or manipulate. Now we have the power to orchestrate what is natural in birth, life, and death at an individual level. The sciences have given humanity advances in knowledge that have created an immense amount of good, and this power has also brought us many horrors and devastation, depending on how and when the knowledge is used. This reflection focuses on my thoughts on the dying informed by human, ethical, and social values that I believe must always be foundational to all sciences.

Choice, a powerful fate-filled moment in which we are given both freedom and responsibility of consequence. The freedom may be limited by circumstance and environment or even restricted to one direction, but the consequences are like a web of connections that can be life-giving or fatal. One of the foundations of my spiritual belief was the teaching of free will, the greatest gift and responsibility of being human. Another was the human reality of impermanence where all life has a trajectory of coming into being, living, experiencing entropy, and

dying. It is all around us, yet our awareness focuses most on living, in spite of its transience, and less on the entropy and death, yet it is all life in its immense wonder and mystery. Life can be for a moment or years, yet the peak of creation is no less immense in one than the other, so too the valley of dissolution. So let us for a moment dwell in this valley. What an experience it is to find our bodies and all we hold dear about ourselves, who we are, what we are, why we are, deteriorating, suffering, and diminishing beyond our ability to control.

This (often) rude awakening can trigger fear, anger, shame, and withdrawal, while for others it is a grounding to our deepest core self that cries out for a deeper intimacy with God and others. Personally, that is what makes it an intensely edifying and sacred time and space of immense clarity, purpose, beauty, and truth. We gradually cast off the outer layers of self, all the pretense, into a pure awareness that could not be more natural and organic in its progress. An experience of pain, suffering, grief, and sadness can be a moment of conversion, a moment of grace. An opportunity to face a moment of truth about life on our terms. This intimacy and choice can often be faced with a frantic intervention of this natural process, a fixing solution that we hand over to an institution that must have absolute control in order to promise hope of recovery.

We do not choose the disease, injury, or genetic fault, so we fight and flounder. Medicine has been a life-saving intervention for so many, giving years to our life, but the decision to intervene has also prolonged suffering, again that paradox. Where years ago we may have been resigned to accepting our frailty and menace of life, we are now faced with choices about death that I am not sure we are always able to make, that can outrage our sense of reason and confound our belief in God. These are final decisions that must be held in the deepest of respect, safety, and understanding. No one can feel your personal pain, no one knows the extent to which you suffer, no one knows the gravity by which you are making your choice. The important part being choice, it must be yours alone without coercion, influence, or resignation to circumstances that are being controlled by others.

What has brought us now to this stage where we are now taking this same life-giving medicine and using it to end life on our terms? I discovered that there is not one event but a complex interweaving of personal, social, and human evolutionary events that have brought us to this crossroad. There is the change in the nuclear family where we no longer have multi-generational households immersed and living together in the vitality of life from birth to death. There is the movement away from the sacred belief of higher powers of divine governance towards a self-governance and agency.

There is increasing knowledge from the sciences spanning from atoms to galaxies, life in all its diversity. There is a reality of decreasing sustainability of life on this planet due to food, water, and essential substances lost through exploitation and destruction. We now also commodify and exploit these changes to meet our desire for power, fiscal gain, and personal autonomy. There are many more and there are just as many reasons to promote these changes as to find fault in them.

What concerns me is the possible disequilibrium choosing an individual's death poses for the life of humanity—what are the unknown impacts this has on our future? We are all important in the cycle of life; no life is expendable or inconsequential. I struggle with concerns about safeguards being in place so that these services towards dying loved ones will not be marketed as any other commercial arrangement. Concerns that agencies that commit to end-of-life rights and services have the funding and support they need to conduct adequate education and support to individuals, families, and the clinicians involved. Concerns about how to ensure adequate government and public funding for the full spectrum of end-of-life to ensure services are available while navigating the barriers for those who are suffering.

How does this impact our personal lives? The most troubling aspect I see in my spiritual care is the desolation that takes away from the sacredness of life. It often feels we have institutionalized many aspects of our human life into a regulated, managed, quantified, and solution-based culture, one that decides on efficiency over human contact, a system of segregation over community, quantity over quality. We have so much to be grateful for in medical advances, we are blessed in this country by accessible services, even when they are stretched to intolerable limits, but we cannot expect them to do for us and our loved ones what we must do for ourselves. There is a sadness but also an honour in guiding others in the journey to death, one that gives opportunity to cherish the most about the person. Opportunity for conversation, shared memories, humour, intimacy, acceptance, and belonging.

Dying is not a sweet sentimental event and it is one of the greatest struggles everyone must face. But there are times when the dying need us as much as we have needed them. We can choose at these times to care in a loving and intimately giving way or create a tragedy amidst what is vital to our lives and those we love. When we as individuals cease to care whether we live or die, it can come from a place of deep frustration; fulfillment of our desires being eroded by our limitations to function, we are burdened with guilt and shame, withdrawal from family, friends, and community so that we no longer belong. A person has to want to live in order for the

energy of caring to be present. We are all born with caring as an essential part of being human, and although we all have the potential, this ability is not consistent or uniform. Our own experiences in being cared for and being able to express care influence our own ability to care. If we cannot care when someone is suffering, what does that say about us as individuals and communities? Let us avoid the tragedy of limited options for those faced with terminal disease, prolonged suffering, and imminent death. The decision must be one of mutual care and ensuring the inevitable nature of death be one in which we seek to understand, support, and companion those we love with both respect and compassion. How we personally approach death is important and can best be articulated and understood through advance care planning to ensure our voice is heard and honoured.

On pondering these many thoughts, I strongly advocate for a society with an open and available process of dying that supports and respects these decisions with a thorough range of available options, including hospice, palliative, home support and medical assistance in dying, in order to maintain the integrity of the person dying and their network of family and friends. A society that ensures the vulnerable, alienated, and marginalized will not be made victims of a dying process but one that gives them voice, listens, cares, and ensures that each life is worthy of respect. May we offer ourselves and others the same measure of God's grace in dying as we know and experience in living.

Sister Kathryn Tulip, SSJD *is a member of the Sisterhood of St. John the Divine in Toronto, Ontario, entering the religious life after a 38-year career in finance and administration. She has a devoted interest in pastoral care for the dying, chaplaincy, and ethics. Her various ministries have included work in hospice agencies as a board member and volunteer, and she presently provides spiritual care at St. John's Rehab Hospital.*

Questions for Reflection and Discussion

1. What expectations do you have with respect to your own end-of-life care?
2. Have you made plans to articulate these expectations in an advance care plan to ensure your wishes are known?
3. In what tangible ways can you or your community advocate for an inclusive, available, caring access to a full spectrum of end-of-life care options or specific services that you are able to support?

What's a Life Worth, Anyways?

PAUL H. FRIESEN

Whether one uses "anyway" or "anyways," one who hears the words must sift the possible meanings of these signs of grammatical transition. Here, in the midst of public and church arguments about medical assistance in dying, about MAiD, I want to offer a Christian "anyways" that for a few minutes walks us back from arguments about medical procedures and legislation, back from the journalistic dramas of particular cases of potentially or actually medically assisted dying, back from an atomized assumption about undefined "human rights" … back to what human life is worth to begin with, for surely we must start there. But when we turn to Christian Tradition and to its centre, the Scriptures, (as the church must do if it is to be the church), we find a swift and clear answer hard to come by.

What's a life worth, anyways? After the wars and genocides and assassinations recorded in our Scriptures, and featured widely in nationalist and imperial Christianity from the fourth century forward in Western Christendom? After the threats of hellfire and eternal human death keenly proclaimed? We can't sort these out in the course of a human life, let alone in volumes of studies, reflections, and meditations. As firmly grasped in hand as our Bibles may be, we walk through a world complicated beyond comprehension and are incapable of but a little understanding of how it all fits together. Yet we can set out in a certain direction on one question, toward the infinite value of a human life and en route consider where the church might go astray in relation to MAiD, and so consider making course corrections.

Of the reasons we hear today for MAiD, in the context of advocacy for increasingly unregulated MAiD in Canada, are two assumed show-stoppers; the avoidance of the loss of human "dignity" and a rescue from the loss of "quality of life." With these in mind, we need to ask the question of all those who are baptized into the church, and who are sustained by the sacraments and teachings of our Tradition. What's a life worth, anyways? Does its value hang on its "dignity" and "quality of life"? The answer is

actually "yes," but a "yes" not to be delivered as it often is. So what follows is a simple appeal to the foundations of Christian thought and practice.

"Dignity"; first things first? We may be tired of hearing this, but we must: "So God created humankind in his image, in the image of God he created them; male and female he created them" (Genesis 1:27).[1] In this first of the biblical accounts of creation, the image of God is related to, first, humankind's special responsibilities in relation to the rest of creation, and second, to human "fruitfulness"—most specifically the growth of the human race, that is the peopling the Earth with divine images whose responsibilities they were to bear. Dignity was not earned; it was divinely granted and could not be humanly effaced. The first murder, the first taking away of human life by another human life, was met with the Lord's pronouncement: "What have you done? Listen; your brother's blood is crying out to you from the ground!" And yet the murderer's life was itself spared (Genesis 4:10, 15). Dignity, both Cain's and Abel's, was divinely granted and could not be humanly effaced; taking a life could in no way erase the inherent dignity of anyone's life.

This ancient dignity was revisited in the depths of our Hebrew poetry. In the midst of the glorious splendour of a universe of heavenly bodies, the psalmist revisited creation and revisited humankind: "You made human beings a little lower than God, and crowned them with glory and honour." Their divine position within creation was ringingly recalled (Psalm 8:4–8). And in the midst of his insecurities and terrors the psalmist cried out again, "I praise you, for I am fearfully and wonderfully made. Wonderful are your works and that I know very well" (Psalm 139:14). Nothing could take away what was divinely granted. Neither should we let it, regardless of circumstance.

And nothing in our tradition grants more dignity to humankind than our confession of the divine incarnation, "the Word made flesh," the divine Word that dwelled as flesh among the flesh that we are made to be (John 1:14). And this dignity, says St. Paul, cannot be snatched away by "hardship, or distress, or persecution, or famine, or nakedness, or peril, or sword … neither death, nor life, nor angels, nor rulers, nor things present, nor things to come, nor powers, nor height, nor depth, nor anything else in all creation" (Romans 8:35–39). It was a human dignity afloat on the sea of divine love that ever upheld the divine images with which God had blessed the rest of his creation, however much they might have later failed in living out that dignity.

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[1] All biblical quotations are from the *New Revised Standard Version* (Washington, DC: National Council of Churches, 1989).

How much more is this confirmed by our never-failing creedal confession of the resurrection of the body, in the wake of the resurrection of the Word made flesh? Such affirmations of dignity are strong and deep and persistent in our tradition, attributed not earned.

And yet in our modern use of "dignity," Christian or not, there is so often a tragic flaw, the legacy of empires of shame and honour, fulsomely revived. Dignity, it seems assumed, can be lost by the most natural of things, such as aging; by the return of conditions that make an infant often charming, or at least excusable—the limitations of limbs and language, of gap-toothed grins, of obliviousness to food-stained clothing, of thin hair and uncooperative bowels, of endless medical appointments and embarrassing procedures. But beyond the dark comedy of the comparison, and of things far worse, lies the tragedy of the contemporary mind, untutored in biblical dignity, built on assumptions of decreasing value with increasing age or increasing incapacity. It is true that "dignity" can and should be attributed by the signs of gently mopping faces, of careful dressing and persistent attention. But the dignity underlying it all, granted by God, can only be recognized; it really can't be given or taking away by ourselves or by others. Permission for a premeditated, medically delivered, death date can't help preserve our dignity. Christian dignity is far too great for this. This is a Christian confession, anchored in a Christian conviction about our creation being divine and, hence, inalienable.

What's a life worth, anyways? We need to ask the question a second way. What of "quality of life"? Here we take notice of the Christian comprehension not only of divine creation, but of divine redemption too; needless to say, of redemption in the "image of Christ." The Apostle put it this way: "If anyone is in Christ, there is a new creation: everything old has passed away; see everything has become new" (2 Corinthians 5:17). This was not an appeal to a generic "fresh start," nor should the baptized confuse Christian redemption with a host of well-meaning and meaningful, but finally insufficient, phrases that elevate the affective, the emotional, and the one-off tropes about "giving your life to Jesus" at a time and date with or without the benefit of the font. A particular instance of biblical renewal is found in the prayer over adult converts, those confirmed immediately upon baptism: "Confirm and strengthen them, O Lord, with the Holy Spirit the Comforter, and daily increase in them thy manifold gifts of grace; the spirit of wisdom and understanding; the spirit of counsel and might; the spirit of knowledge and true godliness …."[2] It is a life-long journey of "quality" on which we set out.

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[2] The Book of Common Prayer (Toronto: Anglican Book Centre, 1962), 538.

We confess that the life of "quality" is the "virtuous life" of the baptized, daily developed through the faithful means of what might be called "holy habits," entering into the Christian redemption promised at baptism. The ancient measurements, when not dismissed, startle us as they should: "Religion that is pure and undefiled before God, the Father, is this: to care for the orphans and the widows in their distress, and to keep oneself unstained by the world" (James 1:27). But when it comes to the increasing boundaries of MAiD, there is that supposed trump card to justify it; an insufficient quantity of the "quality of life." To be sure our Scriptures, and our Tradition around them, are replete with affirmations of desired qualities of life, memorably listed by the beloved Apostle, beginning with the granted (and accumulating) dignity of the daily life of the baptized: "We boast in our hope of sharing the glory of God. And not only that, we boast in our sufferings, knowing that our suffering produces endurance, and endurance produces character, and character produces hope, and hope does not disappoint us, because love has been poured into our hearts through the Holy Spirit that has been given to us" (Romans 5:2–5).

The cultivated qualities of life, the Christian virtues, carved out of the divine grace of Christ's redemption, (a grace that infallibly falls on all the baptized in all circumstances), make for a "quality of life" that cannot fail, of which its possessors cannot be deprived. St. Paul wrote that the quality of Christian life was cultivated by the daily morning exercise of a truly spiritual dressing routine: "Put on the Lord Jesus Christ, and make no provision for the flesh, to gratify its desires" (Romans 13:14). Of course, he did not here mean, by "flesh," the physical body, but rather the unexamined human tendency to the vice of pride. The apostle describes it in a positive way too: "The fruit of the Spirit is love, joy, peace, patience, kindness, generosity, faithfulness, gentleness, and self-control. There is no law against such things" (Galatians 5:22). This is quite at odds of "qualities of life" as measured by various forms of "earned and deserved" human security, material luxury, and unneighbourly score settling.

It hardly needs to be said, does it? But then again, maybe it does, even among the baptized. The "quality of life" understood by Scripture, Tradition, and sanctified reason has been increasingly elbowed aside, or nudged into a shrinking "spiritual space" at the same time vaguer language about this diminished space is routinely used. The reduction of the life of the baptized to a "spiritual slot" disconnected from how one lives that life is not commended by the Gospels or Epistles; in fact it is routinely challenged. Needless to say "meaning" and "purpose," "goals"

in life, and personal "bucket lists" can be genuinely desirable, but never as much as the particulars of their quality; their connection, or lack of connection, to the intended life of the baptized who have entered into their Christian redemption. As the dignity of creation in the divine image is foundational when it comes to human dignity, so too the life of virtue is foundational when it comes to a life of Christian "quality."

Whatever show-stoppers there may be when it comes to the supposed benefits of MAiD, the mitigation of the loss of human "dignity" and a loss of "quality of life" cannot finally be among them, if the reasoning is that of the baptized. Of course this exercise in reflection on two tragic flaws in MAiD as a concept and a practice in relation to opting for a sure and certain death date (for this what MAiD offers), should not be confused with a problematic parallel. What might be called "MAiL," "medical assistance in living," or the purely technical and unwarranted prolongation of life without which death would certainly come on its own timely logic, is in fact not advised here. The baptized are not called to fear, or avoid, death and should not lack a courage that encounters the reality of death. They should freely confess their coming death—and their ultimate resurrection—as confidently as they confess Christ's, and along with it, the everlasting communion of the society of the saints. And so we have come full circle. What's a life worth, anyways? Everything. "The [Lord Jesus Christ] will transform the body of our humiliation that it may be conformed to the body of his glory …" (Philippians 3:21). What more "dignity" could the church grant the living and extend to her departed? What more "quality" could they possibly hope for than the daily cultivation of a life of Christian virtue?

The Reverend Canon Dr. Paul Friesen *is part of a household of five, whose two delightful adult daughters return from time to time to join their parents and the family Duck Toller in Halifax, Nova Scotia. His biological mother, stepmother, and father lived and died in the Christian faith. He has been most shaped by the Mennonite tradition and the classical Anglicanism which he entered in his twenties. His life has been enriched by roles as a labourer in construction and gardening, then as a probation officer, and finally as a professor and priest. He has served as a lay leader at Little Trinity, Toronto, as a curate at St. Mary Madgalene, Toronto, as a chaplain ad priest-in-charge at King's College Chapel, Halifax, and as the rector of St. Paul's, Halifax. He has taught or offered lectures at Tyndale University, Wilfrid Laurier University, Wycliffe College, the University of King's College, and the Atlantic School of Theology, where he still offers courses.*

Questions for Reflection and Discussion

1. As baptized Christians, what is distinctive about how we "value" life?
2. Can we distinguish between human "dignity" as attributed by our Tradition, and "dignity" as defined in popular culture?
3. What is "quality of life" as defined by our baptismal vows?

An Invitation to Further Reflection and Conversation regarding Medical Assistance in Dying

PETER ARMSTRONG

Anglican Identity and Ethical Issues

Throughout its modern history, the Anglican Communion has been in a process of self-reflection about our own identity: To what degree is our denomination *Catholic*, and to what degree is our denomination *Reformed* or *Protestant*? Those on the Catholic end of the Anglican spectrum rightly point to our threefold orders of ordained ministry, apostolic succession, our common liturgies, and our participation in the common rites and sacraments of the Western tradition. In contrast, others point to our local figures of authority, most Anglicans' unenthusiastic observation of the recognized saints of the Church, the historical emphasis of the sufficiency of Holy Scripture on matters of salvation, and a confidence of the individual's access to God through Jesus Christ. The answer to the question, then, is both—but this plays out in various ways in our common life.

Different denominations have different ways of engaging with moral questions: Roman Catholics are expected to defer to the Magisterium, the teaching authority of the Roman Catholic Church. Tradition trumps modern voices for our Eastern Orthodox brothers and sisters, which means that a conservative moral voice always dominates the position of that church. Lutherans may study the Augsburg Confession or Luther's Catechism; Presbyterians are likely to turn to the Westminster Confession. Evangelical denominations always go first to Scripture, and expect its voice to speak clearly and authoritatively on all modern moral issues.

Mainline Protestant denominations—by which we would include Methodist, Lutheran, Presbyterian, and United Church voices—turn to Scripture, but their interpretation of the voices within Scripture tends to be somewhat more nuanced. They acknowledge the role of tradition in the Church, but tend to be less bound by past voices. Mainline Protestant denominations tend to give a higher role to the voices of culture around us and contemporary experience. While all are tinged with sin, could it be that God the Holy Spirit is at work in a new way in the world around us? In what sense might a new moral question be prophetic—calling us to greater sensitivity and faithfulness?

Where do Anglicans collectively land, as we approach the moral questions of our generation? Our collective default is toward the mainline Protestant approach to moral questions—too fast for some; too cautious for others; but looking at the big trajectory—generally predictable. (This is neither a condemnation nor a triumph, but a matter of fact.) This is played out as the Canadian Anglican Church has sought to engage theologically and pastorally to the practice of medical assistance in dying (MAiD).[1] On the whole, the concern has been addressed as a pastoral issue—which it most certainly is.[2] Our theological reflection, though, has been somewhat weak. This collection of essays and reflections is meant to be something of a counterpoint.

Centrality of Christ

This shines a spotlight on a theological fact which should give us all pause: God's greatest triumph is understood to have been achieved through the self-suffering Lord. Radical suffering, it has been thought, is not to be avoided, but embraced. Among the many places in the Bible which attest to this, there is 1 Peter 2:24: "He himself bore our sins in his body on the cross, so that, free from sins, we might live for righteousness; by his wounds you have been healed."

This core current of Christian theological convictions has been universally upheld within Anglicanism. For example, Article 15 of the Anglican Thirty-nine Articles[3] includes this assertion: "(Christ) … came to be the Lamb without spot, who, by sacrifice of himself once made, should

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[1] See, for instance, *In Sure and Certain Hope*, the latest resource to address MAiD in The Anglican Church of Canada. Faith, Worship and Ministry Task Force on Physician Assisted Dying, *In Sure and Certain Hope: Resources to Assist Pastoral and Theological Approaches to Physician Assisted Dying* (Toronto: The General Synod of The Anglican Church of Canada, 2016), https://www.anglican.ca/faith/focus/ethics/pad.

[2] Sean Frankling, "Church Should Not Oppose MAID Law, Primate Says," *Anglican Journal*, September 20, 2022, https://anglicanjournal.com/church-should-not-oppose-maid-law-primate-says/.

[3] See The Book of Common Prayer (Toronto: Anglican Book Centre, 1962), 698ff.

take away the sins of the world."[4] During the Great Vigil of Easter, the deacon proclaims during the Exsultet, "For Christ has ransomed us with his blood, and paid for us the price of Adam's sin to our eternal Father."[5]

It is an ontological fact which is intended to offend and to disturb us: Our reconciliation with God is achieved *by means of* the crucifixion of Jesus of Nazareth, the Son of God. God's purposes for the created order is that the Son's suffering is the medium of salvation. We are invited to identify with what Christ did, through our own experiences of suffering. First Peter, again:

> For it is better to suffer for doing good, if suffering should be God's will, than to suffer for doing evil. For Christ also suffered for sins once for all, the righteous for the unrighteous, in order to bring you to God. (1 Peter 3:17–18a)

This is not to suggest that we seek suffering. Nor does it mean that we avoid taking reasonable steps to relieve the experiences of the sufferers. Christ's redemption does, however, challenge the narrative that the relief of suffering is to be pursued at all costs—including the costs of our own lives! We are also challenged to look beyond the multitudinous stories of stately suffering individuals. We are invited to consider carefully how *God* is at work within us and around us, through the experience of suffering.

The Church's Classical Interpretation of Christ's Suffering

This was the consistent approach by leaders and teachers in the Church's patristic era. For example, Ignatius of Antioch (d. 110) writes, "If I suffer, I shall become a freedman of Jesus Christ, and I shall arise free in him; and now I am learning, as one bound, to desire nothing."[6]

Most of us in the West view martyrdom with unease—even perhaps some dismay. However, martyrdom—the utter surrender of God's greatest gift, and the suffering associated with it—was a common theme among the early Christian teachers. Origen (d. 254) observes the link between Christ martyrs and self-identification with the suffering and risen Christ:

> Long ago, therefore, we ought to have denied ourselves and said, "It is no longer I who live" (Gal 2:20). Now let it be seen whether we have taken up our own crosses and followed Jesus; this happens if Christ lives in us. If we wish to save our soul in order to

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[4] Book of Common Prayer, 704.
[5] *The Book of Alternative Services* (Toronto: Anglican Book Centre, 1985), 323.
[6] William R. Schoedel, "Ignatius to the Romans, 2:2," in *Ignatius of Antioch: A Commentary on the Letters of Ignatius of Antioch*, ed. Helmut Koester (Philadelphia: Fortress, 1985), 175.

> get it back better than a soul, let us lose it by our martyrdom. For if we lose it for Christ's sake.[7]

Origen not only bonded our sufferings with the suffering of Jesus Christ. (In this period, the Church's articulation of the Holy Trinity was still being worked out.) Origen proposed that God the Father suffers:

> Moreover, does not the Father and God of the universe somehow experience emotion, since he is long-suffering and of great mercy. … The Father himself is not impassible. If he is asked, he takes pity and experiences grief, he suffers something of love and he comes to be in a situation in which, because of the greatness of his nature, he cannot be and for our sake he experiences human emotion ("*humanas sustinet passions*").[8]

For the anonymous author(s) of the *Didache*, a key pastoral and catechetical manual from the late first century, suffering is seen as an action from our gracious God: "Accept as blessings the casualties that befall you, assured that nothing happens without God."[9]

The conviction that suffering could always have a redemptive purpose is a doctrinal thread throughout the history of the Church. For example, in the thirteenth century, St. Anthony of Padua remarked, "God sends us afflictions for various reasons: First, to increase our merit; second, to preserve in us the grace of God; third, to punish us for our sins; and fourth, to show forth his glory and his other attributes."[10] Anglican Bishop Jeremy Taylor (d. 1667), in his treatise *Holy Dying*:

> No man (sic) wants cause of tears and a daily sorrow. Let every man consider what he feels, and acknowledge his misery; let him confess his sin, and chastise it; let him bear his cross patiently, and his persecutions nobly, and his repentances willingly and constantly; let him pity the evils of all the world, and bear his share of the calamities of his brother; let him long and sigh for the joys of heaven; let him tremble and fear, because he hath deserved the pains of hell; let him commute his eternal fear with a temporal suffering, preventing God's judgment by passing

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[7] Origen, "An Exhortation to Martyrdom, 12," in *An Exhortation to Martyrdom, Prayer, First Principles* Book IV, *Prologue to the Commentary on the Song of Songs, Homily XXVI on Numbers*, trans. Rowan A. Greer (New York: Paulist Press, 1979), 49–50.

[8] Origen, "Homily on Ezekiel, 6:6"; cited in Robert C. Grant, *The Early Christian Doctrine of God* (Charlottesville: University Press of Virginia, 1966), 30. Italics added.

[9] "The Didache, or The Teaching of the Twelve Apostles, 3.7," in *Ancient Christian Writers*, eds. Johannes Quasten and Joseph Plumpe, trans. James Kleist (Westminster, MD: Newman Press, 1948), 17. See also Shane Kapler, "Redemptive Suffering in the Early Church," Catholic Exchange, accessed June 28, 2023, https://catholicexchange.com/redemptive-suffering-in-the-early-church/.

[10] Kapler, "Redemptive Suffering."

> one of his own; let him groan for the labours of his pilgrimage and the dangers of his warfare; and by that time he hath summed up all these labours and duties and contingencies, all the proper causes, instruments, and acts of sorrow, he will find that for a secular joy and wantonness of spirit there are not left many void spaces of his life.[11]

Writing during the Second World War, Christian writer C. S. Lewis saw suffering as a means God uses to re-orient us (if we allow it) back to God: "We can ignore even pleasure. But pain insists upon being attended to. God whispers to us in our pleasures, speaks in our conscience, but shouts in our pains: it is his megaphone to rouse a deaf world."[12]

To be plain, no one *wants* suffering. Other contributions to this volume make this clear. Further, we have a moral and medical responsibility to *relieve* suffering in ourselves and in others. However, does this mean that we are to avoid suffering at all costs—even to the point of participating in MAiD? The classical Christian voice is clear: As difficult as it very often is, suffering can be a means of identifying with Christ; it can be a work of the Holy Spirit to draw us closer to God.

The atheist may be true to his or her convictions and choose MAiD. Christians are invited—even, challenged—to view the world through a different lens: Suffering can have a redemptive power. We can dare to have "a sure and certain hope."[13] Our default position ought to be to presume God's presence and grace, even in the midst of suffering.

A Contemporary Church Response

In light of the Christian position outlined above, why do some Christians choose to undertake MAiD in Canada? Studies indicate a number of motives for people to proceed with MAiD: Besides the desire to relieve suffering, some people fret that they might be a future burden to their family; they carry anxiety about the dying process; effective hospice and palliative care is uneven throughout Canadian health jurisdictions; even the cost of end-of-life care has been raised as a reason to choose MAiD.[14]

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[11] Jeremy Taylor, chapter 2 in *Holy Dying*, (1651), accessed June 16, 2023, https://www.ccel.org/ccel/t/taylor/holy_dying/cache/holy_dying.pdf.

[12] C. S. Lewis, *The Problem of Pain* (New York: Harper Collins, 1940).

[13] Book of Common Prayer, 602; *Book of Alternative Services*, 596.

[14] A. Nuhn, S. Holmes, M. Kelly, A. Just, J. Shaw, and E. Wiebe, "Experiences and Perspectives of People Who Pursued Medical Assistance in Dying," *Canadian Family Physician* 64, no. 9 (2018): e380–e386, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6135118/; M. Tran, K. Honarmand, R. Sibbald, F. Priestap, S. Oczkowski, and I. M. Ball, "Socioeconomic Status and Medical Assistance in Dying: A Regional Descriptive Study," *Journal of Palliative Care* 37, no. 3 (2022): 359–65, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9344489/; Riis L. Williams, "Low-Income Patients May Be Less Likely to Receive Medical Assistance in Dying," Princeton School of Public and International Affairs, July 1, 2021, https://spia.princeton.edu/news/low-income-patients-may-be-less-likely-receive-medical-assistance-dying.

Disquietingly, while research is still quite new and somewhat tentative, there is evidence showing that people who choose to participate in MAiD are more likely to be better off financially, independent, and to have more years of formal education. They are used to carrying out their own decisions. The decision to take charge of one's life, then, can even be extended to take charge of one's *death*. Jesus's challenge to die to ourselves in order to live for him is not easily received,[15] in any generation.

It is my conviction that the time to talk about MAiD, thoughtfully, prayerfully, and wisely, is not when death is imminent, nor when the current dose of narcotics does not sufficiently dull the pain. It is a conversation which needs to take place in parish councils and Bible studies; be explored thoughtfully and sensitively in sermons; be talked about around kitchen tables; be addressed in medical colleges. Please God, this online book can be used too, as a starting point for discussion—all for God's greater glory.

The Reverend Dr. Peter Armstrong *grew up in Nova Scotia. After completing his undergraduate degree in Halifax, he worked overseas as a labourer, during which time his sense of call was confirmed. Ordained in 1989, Peter has served in a rural parish, in an urban parish, and in a team ministry in the Diocese of Nova Scotia & Prince Edward Island. He completed a DMin in 2015. Peter currently serves at St. Brice's, North Bay, Ontario. He has had parishioners who have opted to participate in the MAiD process, and those who have not. Peter is married to his spouse Nancy. They have two adult daughters and a new grandson.*

Questions for Reflection and Discussion:

1. What are the most suitable resources for Anglicans to help us make wise moral decisions?
2. Do you believe that past theological reflection was adequate to understand God's best in the past or the present?
3. What do you feel would be the safest and most appropriate environment to talk about God's desires and MAiD?

[15] 2 Corinthians 5:16.

A Life More Human

MAGGIE HELWIG

We can only speak from our own place, so the first thing I need to do is to make my own place known to those of you reading. I have an adult child with a permanent severe disability. I have family members who have contemplated, in the depths of depression, ending their own lives. As a priest, I have attended at numerous deaths, including the deaths of infants, and of people whose dying process lasted for years. In my ministry context, I work much of the time with people who are extremely economically marginalized, many of whom suffer from chronic illness and disability, both physical and mental.

I have not, and I acknowledge this as a limitation in this context, attended directly at a medically assisted death, at least in the precise legal sense. But, of course, there are few clear lines, in this great mystery. There is a continuum of intervention in what we call "natural" death—cessation of treatment, withdrawal of nutrition, withdrawal of fluids, disconnecting artificial respiration, the administration of doses of pain relief which will inevitably also depress breathing. In the developed world, almost every death, except the most sudden, will involve at least one of these measures. Spiritual care providers know that the bare preservation of biological life for the longest possible time is not the goal. We will all die; nothing and no one can prevent that. The goal is the most dignified possible death, at the most appropriate possible time, and those who have that are—we suppose—as fortunate as mortal creatures can be. (We must grant that we do not, in fact, know anything at all about the actual experience of death, under any circumstances; we may, at most, know a very little about the experience of the time shortly before death.)

Medical assistance in dying (MAiD), in the first form it took in Canada, limited to those whose natural death is "reasonably foreseeable," could be seen as a part of this continuum. (It is a curious phrase, since any person's death is reasonably foreseeable from the

moment of their birth, and the legislation sets no specific time period, but there seems to be a general understanding that we are talking about death within a period of months to, perhaps, a few years.) Deaths by MAiD still form a relatively small percentage of deaths in Canada, although that number is growing each year. In 2022, roughly one in every twenty-five deaths involved MAiD, and if it were listed as a cause of death (it is not; the underlying condition is listed as the cause) it would now be about the fifth leading cause.[1] It is worth asking questions about what this does to our understanding of self, and how this relates to other social and theological issues, and I would like to sketch out a few questions briefly before looking at the much more complex and troubling expansions, and proposed expansions, of MAiD availability.

Our society values choice, control, and personal autonomy extremely highly, probably more highly than any other values. This is not very theologically supportable. A Christian anthropology begins with our radical dependence upon God's love and grace. We do not choose our lives or the conditions of our being; we understand them to be gratuitous gift. And the vision of our scriptures is consistently communitarian. We are not made by or for ourselves, but to be brought into the interdependent life of the Trinity, expressed in our membership in human community. We are all part of one body, and our health and salvation are entirely bound up in each other.

At the same time, each member of this body—like each part of creation—is infinitely known and infinitely valuable, each created as an expression of divine love; and we are *gratuitously* valuable, not for any achievement, not for any contribution beyond our being, not because we have exercised our autonomy for great ends, but because we are created, vulnerable, and beloved.

Of course, any member of a group which has been systematically denied choice and control can tell you that these values definitely have their place. It is an unmixed good, for instance, that women can attend school, that queer people can express their own identity in their bodies and relationships, that Black people can hold professional positions. The struggle of Indigenous peoples for autonomous control of their lands, their cultures, and their lives is deeply important and right. But it is hard to deny that a rhetoric which centres around choice and control, as opposed to a rhetoric which acknowledges vulnerability, weakness, interdependence, and social solidarity, is most often

[1] *Fourth Annual Report on Medical Assistance in Dying 2022* (Ottawa: Health Canada, 2023), section 3.2, https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2022.html.

employed by people who already have considerable privilege and do not wish to release it, and that it runs counter to some of our basic theological principles.

The Canadian government does not collect detailed demographic information on people who access MAiD, though they have expressed an intention to begin doing so. None of us, then, have any information beyond the anecdotal. But the public face of MAiD, the picture most often shown to us in media and public discourse, may be even more important; and that public face has, at least until recently, been one of privilege, of people who have had a high degree of control and autonomy in their lives exercising it also in their deaths. There has been an emphasis on what amounts to a personal curation of death, choosing important dates (often birthdays), arranging social gatherings in advance, ordering the environment in personally meaningful ways. Some deaths by MAiD are like this; some are not (about half of deaths by MAiD take place in a hospital or palliative facility, which automatically limits the possibilities for personal curation). But it is, or at least has been, the image of MAiD which is presented.

And, without criticizing any individual decision, we may need to ask what this image teaches us—in particular, that a good life, and a good death, involve the highest possible degree of individuality and personal choice. And, perhaps, that death may be a means of control, an assertion of a sort of victory over circumstance by the sovereign individual. We may even need to ask how this discourse and the associated practice form all persons and their understanding of their own humanity.

But the expansions, and proposed further expansions, of MAiD have added several more layers of concern. Since March 2021, MAiD has been available to anyone diagnosed with a "grievous and irremediable medical condition," even if this condition is not likely to cause their death. In 2021, deaths under this amendment accounted for less than 3 per cent of total MAiD deaths.[2] In 2022, it had increased to 3.5 per cent, remaining a small percentage of the total.[3] Nevertheless, it is since this expansion that we have begun to hear extremely disturbing stories.

Some of these involve people with disabilities, who have not expressed any wish to die, being offered MAiD as if it were something they might naturally be expected to desire. It is not really news that people who don't have much contact with disability assume that disabled lives aren't worth

[2] *Third Annual Report on Medical Assistance in Dying 2021* (Ottawa: Health Canada, 2022), section 4.5, https://www.canada.ca/en/health-canada/services/medical-assistance-dying/annual-report-2021.html.

[3] *Fourth Annual Report*, section 3.1.

living, and that all disabled people would probably rather die if they had the choice; it is unlikely that anyone in the disability community was surprised by this. It may be significant, in this connection, that when people who are seeking MAiD are asked about their reasons, by far the most often cited[4] are "inability to carry out meaningful activities" and "inability to carry out activities of daily living"—physical pain is a distant third, and the palliative pain management resources of modern medicine do mean that dying in active physical pain is an unlikely prospect for most (though management of chronic pain for those not near the end of life remains a greater problem). But nearly all the people who give these answers are people, usually terminally ill people, who have suffered a massive change in their conditions and abilities, who have lost many abilities previously available to them, and who can anticipate more and more loss, often at a rapid rate. Even the "ordinary" process of aging involves a surrender of capacities, one after another, and that surrender is often very hard to endure.

So there are reasons that it is common for the non-disabled to believe that a person whose abilities have always been different, and remain different, whose given constraints are not those of a (somewhat imaginary) "normal" life, is necessarily suffering because of that—or, indeed, even that all or most of those people whose abilities are dramatically changed must find in this a source of unbearable suffering, rather than a life which is simply other, with its own particular set of challenges and rewards. It is easy to assume that a life which involves a more obvious level of interdependence is a flawed life, when it may in some respects be a life more human, a life which can open us up to a fuller realization of what our created humanity means, and, indeed, a life which more closely reflects the nature of a Trinitarian, interdependent God.

Those whose stories have come to public attention—most notably Christine Gauthier, a veteran and Paralympic athlete—are people who have had the capacity, and the confidence, not only to refuse undesired offers of MAiD, but to take the issue to the media. But we need to ask—if these stories have come to the surface, have there been, or will there be, others? Have there been, or will there be, people less capable, more intimidated perhaps, people who have learned all their lives that it is safer to do what authority figures suggest? Or people who have been so deprived of self-determination that the image of a beautifully curated death may seem like their only available act of personal choice?

[4] *Fourth Annual Report*, section 4.3.

We have come to understand, at least in part, the complexities of consent in sexual relationships; we are aware of power imbalances which vitiate consent, and situations in which consent cannot be understood as genuine. Yet we have no real safeguards in place which consider the complexities of consent in an actual life-or-death decision, especially for people whose boundaries have been routinely violated, a sadly normal experience for those with disabilities.

This shades into the other, and larger, category of very disturbing stories, people with disabilities and chronic conditions who do not truly wish to die, but whose lives have been made intolerable, not by their conditions as such, but by the lack of social supports available to them.[5]

Consideration of this begins with the fact that we have, as a society, decided that disability payments should be set so punitively low, and be surrounded by so many regulations, that people whose disabilities mean they are unable to engage in economically productive labour will inevitably live in permanent deep poverty (not to mention the reluctance of employers to consider, or make adaptations for, qualified people with disabilities). We have also decided that many necessary medical interventions and adaptive devices should not be eligible for medicare. MAiD, however, is freely available. And while the legislative framework requires that those applying be informed of "reasonable and available" means of alleviating their suffering, that means little or nothing when, for instance, adequate income supports and appropriate housing are, due to deliberate government policies, simply *not available*.

All of this applies even more to people whose only qualifying condition is mental illness. There is no question that long-term mental illness can cause great suffering, suffering sometimes more difficult to manage even than intense physical pain. But it is also true that people with mental illness are even more likely than other disabled people to experience sustained poverty, extreme stigmatization and social exclusion, and frequent violations of personal boundaries by authority figures. At the time of writing, they may become eligible for MAiD in 2024.

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[5] For example, Brennan Leffler and Marianne Dimain, "How Poverty, Not Pain, Is Driving Canadians with Disabilities to Consider Medically-Assisted Death," *Global News*, October 8, 2022, https://globalnews.ca/news/9176485/poverty-canadians-disabilities-medically-assisted-death; Padraig Moran, "This Woman Is Considering Medical Assistance in Dying, Due to a Disability. But Poverty Is Also a Factor," *The Current*, December 16, 2022, https://www.cbc.ca/radio/thecurrent/maid-poverty-disability-1.6687453; Avis Favaro, "Woman with Disabilities Nears Medically Assisted Death after Futile Bid for Affordable Housing," *CTV News*, last updated May 4, 2022, https://www.ctvnews.ca/health/woman-with-disabilities-nears-medically-assisted-death-after-futile-bid-for-affordable-housing-1.5882202.

The report by the expert panel on MAiD and mental illness, commissioned by the government and released in May 2022, shows a good awareness of many of the problems and ambiguities, although it, like the whole process, is sorely lacking in input from people with lived experience. One of the most difficult questions they consider is distinguishing between a desire for MAiD and suicidality. The panel grants, finally, that it is simply not entirely possible, and that allowing an amendment similar to the policy which already exists in the Netherlands means that "society is making an ethical choice to enable certain people to receive MAiD on a case-by-case basis regardless of whether MAiD and suicide are considered to be distinct or not." The panel stops short of expressing an opinion on this ethical choice; though they do state the opinion that when an assessor is "not … able to form an opinion about eligibility for a given case because there is too much uncertainty or complexity whether it concerns incurability, irreversibility, capacity and/or suicidality … the practitioner cannot find the person eligible for MAiD."[6] In other words, that the burden of proof must be very high, and that if the possibility of change or effective treatment exists, even if it is not immediately available, the MAiD option should be ruled out.

It is probably usually the case that someone with adequate physical capacities, and a definite intention to end their own life, can find quicker and easier means than MAiD. (One family member has expressed this to me quite clearly.) The ethical problem is more subtle—that our legislation, and increasingly our medical system, is sending one more message, in a world filled with such messages, telling us all that life with a disability, and especially life with a mental illness, is a flawed life, a life which is very possibly just not worth living—that ending that life is a good and rational choice.

The expert panel is aware that people with mental illness often experience extreme insecurity of living conditions, and includes among its recommendations that persons considering MAiD on the grounds of mental illness alone should be offered housing and income supports as part of treatment/assessment; however, this assumes, as they grant, that housing and income supports will be *available*, which is commonly not the case. (The expert panel also notes that Indigenous peoples have never been systematically engaged in the MAiD discussion, an extremely serious, if not invalidating, omission.)

[6] *Final Report of the Expert Panel on MAiD and Mental Illness* (Ottawa: Health Canada, 2022), section 2.2, https://www.canada.ca/en/health-canada/corporate/about-health-canada/public-engagement/external-advisory-bodies/expert-panel-maid-mental-illness/final-report-expert-panel-maid-mental-illness.html.

The panel expressed, as well, concern about people living in "situations of involuntariness," by which they mean both long-term hospitalization or residential care, and incarceration. They note, accurately, that involuntariness may be related to mental illness, either as a contributing cause, or because such a situation tends to create or aggravate psychiatric conditions, and that "in such cases, the involuntary situation—rather than the medical condition—may be a primary motivating factor in requesting MAiD."[7] Senator Kim Pate, in an interview with APTN, has raised this same concern: "They're learning about (MAiD) … from staff members (correctional officers). … People are suffering. They feel that 'if I'm going to die in segregation, I'd rather (apply for MAiD and) see my family than die alone.'"[8]

The fact that few people who are not incarcerated would understand MAiD as potentially a unique route for family reunification speaks to how little "situations of involuntariness" are understood, but also points, with whatever overtones of dark irony, to our fundamentally relational nature, and to the ways in which that can be used, not always intentionally, to punish and manipulate through the denial of relationship, something well known to people with disabilities as well as to prisoners.

It may additionally be worth noting that at least one member of the expert panel has, since the report was released, branded its work an "utter failure," and has written a lengthy critique of what he sees as a uniquely Canadian "MAiD ideology" which presents medically assisted death as "a medically effective treatment option."[9] Another member of the panel resigned after five months, believing that it could not meaningfully protect people with mental illness, and that it had, despite some of the work in the report, failed to "engage seriously with complicated issues concerning decision-making, consent and capacity, privilege and vulnerability, and accountability and monitoring."[10] In any case, since the panel is purely advisory, none of their warnings or concerns need to be

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[7] *Final Report of the Expert Panel*, section 3.3.

[8] Kathleen Martens, "MAiD in Prison: Inmates Are 'Dying to Get Out' Says Senator," *APTN National News*, May 15, 2023, https://www.aptnnews.ca/national-news/maid-in-prison-inmates-are-dying-to-get-out/.

[9] Scott Kim, "In Canada, MAID Has Become a Matter of Ideology," *The Globe and Mail*, February 25, 2023, https://www.theglobeandmail.com/opinion/article-in-canada-maid-has-become-a-matter-of-ideology/.

[10] Ellen Cohen, "Why I Resigned from the Federal Expert Panel on Medical Assistance in Dying," *The Globe and Mail*, October 14, 2022, https://www.theglobeandmail.com/opinion/article-expert-panel-maid-mental-illness/.

taken into account when a final legislative decision is made, a decision which may been made by the time this piece is published.

To suppose that each person is a sovereign individual with untrammelled power to make personal decisions, that the person exists and decides outside of history and of a network of social forces, and, in particular, to suppose that there are not powers and principalities in this world which constantly restrict the decisions of those marginalized by disability, poverty, or both, and which constantly tell people that their lives are of lesser worth, is to deny a very present, and very dangerous, reality. It is not irrelevant to note that the expansions to MAiD have come about because of a court case (*Truchon v. Attorney General of Canada*), brought through a legal system which is built entirely around a belief in the sovereign, autonomous individual, and that most disability advocacy groups have opposed the expansions.[11]

And there is fear for what may come. Slippery slope arguments are problematic, and I hesitate to go in that direction. But my fears for my child's future are fears shared by most people in the disability community—and the last three years have made it obvious that our fears are reasonable. Despite a brief period of paying lip service to social solidarity, every country, every government, and a majority of citizens throughout the world cheerfully abandoned all public health precautions in the face of an ongoing pandemic, as soon as it came to be widely believed that only the elderly, the medically fragile, and the disabled were at risk. (Whether this is actually true or not is debatable, but it is certainly the general public belief.) It has become screamingly obvious that the vulnerable are, in fact, an acceptable sacrifice to "the economy" and "getting on with life," that the general public can easily live with a background hum of greatly increased mortality, and that,

[11] See an open letter to Members of Parliament signed by nearly 150 organizations (http://www.vps-npv.ca/stopc7)
statements by some important advocacy groups:
Council of Canadians with Disabilities (http://www.ccdonline.ca/en/humanrights/endoflife)
Disability Alliance BC (https://disabilityalliancebc.org/dabc-statement-on-medical-assistance-in-dying-maid-and-bill-c-7/)
No Options, No Choice (https://www.nooptionsnochoice.com/#About)
Inclusion Canada (https://inclusioncanada.ca/2020/02/28/medical-assistance-in-dying-bill-violates-equality-rights-of-people-with-disabilities-it-must-be-stopped/)
a few of many statements by disabled individuals:
Lorin MacDonald, "Expanding medical assistance in dying will have devastating effects on Canadians with disabilities," *Canadian Lawyer*, December 16, 2022, https://www.canadianlawyermag.com/news/opinion/expanding-medical-assistance-in-dying-will-have-devastating-effects-on-canadians-with-disabilities/372424
Tim Stainton, "Social Justice's Poor Cousin: Disability, MAiD and Social Work," School of Social Work, University of British Columbia, October 7, 2021, https://socialwork.ubc.ca/news/social-justices-poor-cousin-disability-maid-and-social-work/.

overall, few people care enough to take even small steps to protect others. Similarly, it is very evident that almost no one in power is going to do anything meaningful to create adequate housing, or even emergency shelter space, for the increasing number of people living in tents in cities and towns across Canada, and that the main organized efforts will be efforts to make these people go away, as if they could be made simply to not exist.

And maybe they could. Not, probably, at least in Canada, through openly coercive measures. But—in a collapsing economy, and with the considerable likelihood of COVID causing a significant increase in people with long-term disabilities—through a combination of an increasingly permissive MAiD structure, policies which create increasingly intolerable conditions of life, and, perhaps, more and more people willing to suggest, recommend, persuade, to others who are vulnerable, uncertain, afraid of authority, familiar with abuse, made to feel that they are of lesser value, or taught all their lives to do what they are told. People who may be offered no other dignity or beauty in their life, but are told that they can have a dignified and beautiful death. It is not the situation now. Maybe it will never be the situation. But those of us who live in the world of vulnerability know that it is not impossible, perhaps not even implausible.

Where, then, can the church be, in this complex situation? We cannot claim to speak with one voice, either on the existing legislation or on the proposed mental health expansion. While I believe that the 2021 disability expansion, and even more the mental health expansion, contain a large potential for grievous wrong, I know that there are Anglicans who, in all conscience, believe otherwise. My own hesitations about MAiD in its original form are probably not widely shared, and I acknowledge that it could have a legitimate place in the very profound and personal process which is end-of-life care.

Those of us who are clerics will, inevitably, counsel people who are approaching the end of life (as will some lay leaders in the church), and MAiD will inevitably be part of some of these discussions. We may also find ourselves having discussions with people whose end of life is not "reasonably foreseeable," but who are still considering MAiD. We can only do this by approaching every conversation openly and without judgment—in much the same way that most of us have, I think, learned to have conversations about the termination of pregnancy, whatever the personal convictions of the individual providing pastoral care may be. We must be prepared, if asked, to provide a theological framework for decision-making, or for families who are dealing with decisions which were made, and this will require us to be searching and careful in our own

thinking about what a "good death" could mean, knowing it does not always mean the death with the highest degree of personal control; and that finally, by whatever means, we will all fall helplessly into the hands of the God of love.

And it is my belief that we will also be able to do this more effectively if we are familiar and comfortable with an understanding of what it means to be disabled, physically, mentally, or both, how disability is socially constructed and inflected, and what the life of a disabled person means and is worth. This is a gap in most theological training, and one which is more and more important to remedy.

I think that the Anglican Church does speak with a single voice in some areas which could mitigate the potential for grievous harm. Though our influence in the public realm is much less than it used to be, we are still able to advocate, with whatever voice we do have, for far-reaching improvements in our social safety net, and in the other structures of our society which create intolerable conditions of life for people who are disabled, marginalized, or struggling in other ways. And, since we may have less and less to hope for from our governments in an increasingly difficult time, to use our own material resources to do whatever we can to ensure that no one finds themselves wishing to die because of remediable situations like a lack of income support or appropriate housing.

We should also—though we have perhaps not done this very well in practice—be able to speak to all those who are stigmatized or cast aside of their own unique value as members of the one body. I returned to the church, after some years away, because it was a theological framework which could fully honour the value of my daughter's life. We have that framework; potentially, at least, we have an understanding of humanity which does not depend on achievement, or economic productivity, or social success, which can hold difference and diversity, and comprehend the infinite reach of God's love. Living out that understanding actively may be another matter, but this is at least a place to start. We should be, and I hope we can become, a place where disabled people are not only full members, but where disabled lives can model for us the truth and value of all our mortal bodies; a place where people who are neurodivergent or mentally ill, people rejected nearly everywhere else, can find support and companionship; where radical difference does not mean insult or loneliness or an invalidation of full humanity.

Perhaps, a place which can defend people against a world which believes that their lives are improved by ending. A place where, even when the rest of the world might prefer that some people simply did not exist, all of God's people are safe.

The Reverend Canon Maggie Helwig *is a settler living on the land covered by the Dish With One Spoon wampum, and serves as the rector of the Church of St Stephen-in-the-Fields.*

Questions for Reflection and Discussion

1. How do we think about what constitutes as "good life"? Are our thoughts actually formed by a Christian understanding of what it means to be human? How does our conception of a "good life" affect how we imagine a "good death"?
2. How can the lived experience of people with profound disabilities enrich our conception of the value and meaning of a human life? What can our church do to support and protect people with profound disabilities?
3. How can we find ways to talk about the complexity of consent in areas other than sexuality, and especially in areas of life-or-death significance?

The Church Alive in the World: How Centring the Poor in Christian Communities Changes Everything

ANGIE HOCKING

Nancy[1] sat in my office a few months ago with tears in her eyes. "My doctor gently talked to me about MAiD as an option, I am going to look into it more. Because the housing worker said the only way I can get expedited housing is to say it's terminal. No chance of survival. I need to tell them in writing that I'm expiring soon."

Nancy had been trying to get out of an insecure living situation with a slumlord when she was diagnosed with cancer a few months prior. She was in treatment, but was missing some of the sessions because she couldn't sleep many nights due to loud and sometimes hostile strangers coming in and out of the house all night. As a single woman with all male housemates, she was feeling very unsafe there. She pushed her recliner in front of her door every night to feel more secure. When she would finally zonk out at 3 a.m. from sheer exhaustion, it would sometimes be too late to make appointments.

On other days, getting to treatment was extremely difficult for a host of other reasons. The hospital was clear across town, and the crowded and unpredictable transit system was the only option she could afford for travel. This posed many problems for her, especially since she was told to eat a healthy meal two to three hours before chemo treatment (as opposed to her normal routine of skipping breakfast), which meant travelling to a whole other part of town to an early morning food program. All of these ongoing hurdles she faced—her stressful housing

[1] Pseudonym.

situation, her lack of transit options, her food insecurity—ultimately, *her poverty*—meant she was missing more than half of her chemo treatments.

The doctor had met with her just days before she was sitting in my office, to tell her that the chemo wasn't working because of her intermittent treatment. At that same appointment, he mentioned medical assistance in dying (MAiD) as an option for her to consider, if things continued to progress unsuccessfully.

And now Nancy is sitting in front of me, desperate to find a new place to live to try to better her situation. She tells me that she was told she can't get into expedited rent-geared-to-income (RGI) housing unless she says she is dying. I must admit, my first reaction was laced with a bit of skepticism. I mean, she has cancer. *I am sure that counts for something!* There must be some faster option that can get her out of the situation she is in.

I dialed a housing worker colleague on speakerphone with Nancy beside me. I thought that this call would help us learn more about options she does have, and that we could dive in together, onto a more hopeful, improved path.

We posed her question to the housing worker, and my colleague on speakerphone sighed a long, tired sigh. "Unfortunately, you heard that right, Nancy," she said. "The program you are speaking about does fast-track people into RGI housing, but only if they are going to die in two years or less. And that is the only option for accelerated housing in your situation."

Nancy responded, "But I don't want to die yet, I'm only sixty! And I don't want to say, 'I'm dying!'"

"There is the regular RGI waitlist, but that takes about thirteen years," said the housing worker. I interjected, a bit shocked, "There is really nothing that can be done here, if she doesn't want to definitively say she's dying soon? Even with a diagnosis of Stage 4 cancer?"

"I know it's hard to believe, but no. Only terminally ill people who are near death can get fast-tracked. It is possible to work with the doctor on this, but she will have to be comfortable talking about this as a hospice situation."

We ended the call, and I looked at Nancy. This smart, brave, intuitive woman looked across the desk at me with a blank stare and said, "The system wants me to die one way or another, doesn't it? My existence is a burden."

All I could do was tell the truth. "I would feel the exact same way, Nancy," I said. Her poverty was, quite literally, setting her up to die.

The topic of MAiD is complicated, and I struggle with finding my footing within its murky waters. I do believe that people on all sides of the arguments have dignity and human rights at top of mind. And I really don't know enough about all the details of MAiD legislation, or current statistics, to get into those specifics myself.

One thing I know for certain, is that in my many years of working alongside folks who are homeless and poor, people very often have *zero good options*. Ultimately, this is the very definition of poverty: limited options and choices. And giving someone the option of MAiD while no other rights or life supported options are offered to them, seems undignified, cruel, and dare I say, evil. When someone is yearning to actually experience *life*—basic needs like dignity, safety, inclusion—we absolutely cannot stand by and participate in a system that says, "These livable options you seek cannot be offered to you; death however, will be a 'choice' we will offer."

So, what is our role in this, as Christian communities of believers?

What is the role of the church in the world?

The church is to be a radical embodiment of an upside-down kingdom, where the last are first. The church is to be a physical manifestation of Gods love. The church is to foster communities of people who follow the beat of a different drum, who value things differently. The church is to be a place where our land and assets are used not for typical worldly prosperity, but for kingdom work such as building deeply affordable housing, justice work, and reparations with Indigenous communities we have deeply harmed. All the things and the people that the rest of the world would rather ignore—the church is here to uphold and cherish.

Growing up as a North American Christian and, now, working in the church alongside the poor for many years, my observation is this: although we may say compassionate words in the church, and even do charity work in our community, we haven't figured out what it looks like to truly be in community with one another, outside of tight cliques and narrowly defined circles.

We are ok with "helping," but our comfort zone is to keep one another at arm's-length. Do our Christian communities actually make room for the poor *in our own systems*? Do we have people like Nancy sitting in our pews, preaching in the pulpit, participating on our church boards? Or, do we more often just quietly go along in full participation and like-mindedness with the society that, as Nancy realized, basically wants her dead? If Nancy (who shared with me that she has been a Christian since childhood, but doesn't have a home church) was deeply loved and

celebrated and fully accepted into a church community, might this struggle of hers look much different?

If my daughter were to get sick, my husband and I would become immediate experts on the subject. We would be learning as much as we could, absorbing anything the internet had to teach us about her diagnosis. We would be doing anything possible to connect to the best practitioners. My husband surely would be devouring every peer-reviewed study he could get his hands on. Our living room would turn into a research room, our bedroom into a place of nursing her back to health, our kitchen into a place of nourishing her body to support her thriving. Our desperation for her to be well would drive us. Because she is ours.

In many of our churches, the poor are—by and large—people we are disconnected from, whom we interact with mostly through charity programs or advocacy letters. Generally, they are not those we deeply love, and know, and belong to in mutuality and in love. The poor are *them*, and we are *us*. And when it is simply *them* who are experiencing an immeasurable injustice, or a complete lack of life-giving options, we just … aren't ever going to be able to really, truly, *get* it.

But what if it was *us* experiencing these injustices? What if the people we loved were being faced with poverty and horrible options that only lead to death? How then, might we operate? How, then, might the church become alive in this world?

I have personally known six different people now who are seriously pursuing MAiD as a direct result of their extreme poverty. They have no other options. So MAiD, then, feels as though it's a choice, the *only* choice, when no other real choices exist for full participation in life.

But if *they* were to be *us*, our sanctuaries would be places where the poor are included, listened to, valued, and loved.

If *they* were to be *us*, our church kitchens would be places of nourishment and food equity.

If *they* were to be *us*, our billions and billions of dollars of land wealth across the country would be used for building deeply affordable housing, community capacity building, and organizing.

If *they* were to be *us*, we would be fully invested in upside-down kingdom living, doing all we can to liberate *ourselves* from the ways of the world.

If *they* were to be *us*, we wouldn't stand for this kind of reality for our loved ones. We would demand our government be held accountable for the ongoing atrocities that face the poor. We would demand that life-giving options are offered alongside end-of-life options.

If *they* were to be *us*, poverty simply wouldn't be able to exist, let alone thrive, within Christian communities, because of the very way we choose to live, share, protect, and provide for each other. The early church in Acts was full of folks who experienced poverty and oppression. This is exactly why it was set up the way it was—to care for, to centre, to liberate.

The injustice of MAiD being presented to people as a better option than a life of poverty is ultimately a call to a new way of being for *us*, if we are willing to hear it that way. The future of a thriving and transformational church doesn't simply do charity or advocacy for the poor, it *centres and liberates* the poor. A truly inclusive church creates a new kind of community, one in which we cannot help but use every room, every resource, every advantage and privilege, for the liberation of the people we love. While the world tells Nancy to choose between "death now" or "death soon," a truly inclusive church creates and advocates for tangible, concrete options for her to experience life.

When people who are poor can fully exist as human beings in our communities where they are loved, cared for, and valued (both inside church doors and as neighbours), we will be operating from a place where end-of-life options can be contemplated from a place of dignity and alongside loving community. My hunch is that, if we strived to live into full communion with one another, it would birth new conversations for us, and ultimately, generate a very different reality for the poor who are facing the decisions of MAiD as a direct result of their poverty. And folks like Nancy could actually have the choices that they deserve.

When the church is truly alive in the world, we will see that life begets life. But it needs to be a life worth living for all. Are we willing to play our part?

The Reverend Angie Hocking *is a deacon in the Diocese of Toronto who has worked alongside folks experiencing homelessness in Toronto for sixteen years. Currently she is a Community Minister in Regent Park with the United Church of Canada, as well as a neighbourhood deacon for the diocese in the lower east side (All Saints Sherbourne, St. Peter and St. Simon, and St. Bartholomew). Both of these roles allow her regular opportunities to lead worship, community organize, engage with pastoral care and outreach, and capacity build. Prior to that, she served as the director of outreach at Church of the Redeemer (Anglican) for ten years. She has learned that none of us can be free until we are all free; our liberation is indeed bound up together.*

Questions for Reflection and Discussion

1. Are there spaces within your parish where the poor are currently excluded or devalued (even if that exclusion is accidental)? Consider aspects of your parish such as teaching, leadership and governance, future planning, community engagement, etc. that may be unintentionally elite.
2. What might *real* accessibility look like in your parish, for folks who are living with the daily burdens of poverty? What might church *need* to look like for those neighbours? (Tip: Don't guess on behalf of people you don't know! Engage with folks—ask them what a space of inclusion, value, dignity, and equity looks like to them!)
3. Consider the idea of choice within your own Christian community. Who experiences the luxury of having more options and autonomy at your parish and in church programming? Are there people who experience less, and if so, in what ways does this manifest? Lastly, what role does choice have in the alleviation of poverty?

Position Statement on Medical Assistance in Dying

THE PRAYER BOOK SOCIETY OF CANADA

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The Prayer Book Society of Canada (PBSC) is deeply concerned by the rapid expansion in our country of "Medical Assistance in Dying" (MAiD), which is one of the world's most permissive and fastest-growing euthanasia programs. The leadership of The Anglican Church of Canada has taken the position that attempts to oppose MAiD would be ineffective, and that the church should rather focus on pastoral care.[1] However, the pastoral care that is being put forward actually embraces complicity in MAiD, as we explain below.

As a Society, we look to the established doctrine and discipline of The Anglican Church of Canada as enshrined in the 1962 Book of Common Prayer (BCP) to determine a faithful Anglican response to those who are considering ending their own lives. The introductory rubric to the Order for the Burial of the Dead provides crucial guidance for Anglicans seeking to discern such a response. It states that the office "is not to be used for any that die … by their own wilful act while in a sound state of mind" (BCP, 591). (This is a softened and nuanced revision to the original 1662 rubric that forbade Christian burial in this form to any who "have laid violent hands upon themselves."[2]) The amended Canadian rubric is a pastorally sensitive acknowledgement that many who die by suicide are mentally ill, intoxicated or otherwise not "in a sound state of mind" when

[1] Sean Frankling, "Church should not oppose MAiD law, primate says", *Anglican Journal*, anglicanjournal.com, September 30, 2022. See also the article by PBSC member Benjamin Crosby, "Where Are the Churches in Canada's Euthanasia Experiment?", *Plough Quarterly*, Number 35, Spring 2023; plough.com, February 27, 2023.

[2] Jesse Billett, "Canada's Prayer Book", lecture given at St. Olave's Anglican Church, Toronto, prayerbook.ca, November 1, 2022.

they take their own lives. Yet the Prayer Book is clear: a "wilful" act of suicide while "in a sound state of mind" is condemned as sin – although not necessarily unforgiveable – in keeping with the *consensus fidelium* of the one, holy, catholic and apostolic Church.[3] According to this *consensus*, suicide is intrinsically immoral, since it is an egregious violation of the threefold command of love (love of God, love of self, love of neighbour).

With MAiD becoming so commonplace in Canada,[4] many people are doing precisely what the Prayer Book condemns: wilfully choosing, and being encouraged to choose, assisted suicide while "in a sound state of mind". As Anglicans bound by the teaching of the Prayer Book, we see this as a grievous evil. Often, this deliberate decision is celebrated as an act of individual autonomy and self-expression that enables death with dignity. This rhetoric, which connects one's dignity as a human being to one's self-actualization and independence, is contrary to the spirit and piety of the Prayer Book which teaches that we are not our own but belong to Christ and that our dignity in him is inviolable. For the Christian, death is not an opportunity for the final exercise of self-expression and autonomous choice, but rather for the dying person to be conformed to Christ in his or her death[5] and for loved ones to share the dying person's burden by prayer and acts of mercy. The pro-MAiD rhetoric is not only contrary to our faith, but is particularly death-dealing to disabled people, who are told that their need for care renders them lacking in dignity and

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[3] A further rubric to the 1962 burial office instructs that in cases where a person dies by suicide while in a sound state of mind, "the Priest may use Psalm 51 or 130, St Matthew 25:31–46", and other prayers as deemed appropriate. Thus, such a person may still receive a church funeral, but with a particular liturgy that emphasizes human sin and the just and merciful judgment of God. No definitive pronouncement on the eternal destiny of the deceased is made. The point of this rubric seems to be to underscore that the deceased has not glorified God by his or her death and that the mourners ought not to celebrate or follow such an example.

[4] According to Statistics Canada, in 2021 (the latest year for which complete statistics are available) more than 10,000 people died by MAiD, accounting for 3.3% of all deaths in Canada that year. This figure represents a 35% increase over 2020, when roughly 7,500 died by MAiD, and a tenfold increase since MAiD was legalized in 2016.

[5] Note the wording in the Burial of the Dead in the 1662 BCP, unchanged in the 1918/1922 Canadian BCP (bracketed words were deleted from the 1959/1962 revision): "Thou knowest, Lord, the secrets of our hearts; shut not thy merciful ears unto our prayer; but spare us, Lord most holy, O God most mighty, O holy and merciful Saviour, thou most worthy Judge eternal, [suffer us not, at our last hour, for any pains of death, to fall from thee.]" Also the wording in the 1662 Visitation of the Sick, unchanged in the 1918/1922 Canadian BCP (omitted in 1959/1962): "Dearly beloved, know this, that Almighty God is the Lord of life and death, and of all things to them pertaining, as youth, strength, health, age, weakness, and sickness. Wherefore, whatsoever your sickness is, know you certainly, that it is God's visitation. And for what cause soever this sickness is sent unto you; whether it be to try your patience, for the example of others, and that your faith may be found in the day of the Lord laudable, glorious, and honourable, to the increase of glory and endless felicity; or else it be sent unto you to correct and amend in you whatsoever doth offend the eyes of your heavenly Father; know you certainly, that if you truly repent you of your sins, and bear your sickness patiently, trusting in God's mercy for his dear Son Jesus Christ's sake, and render unto him humble thanks for his fatherly visitation, submitting yourself wholly unto his will, it shall turn to your profit, and help you forward in the right way that leadeth unto everlasting life."

who are offered death as a treatment option for long-term disability. This is not just an academic worry. We have seen the repeated fears of disability rights and religious groups realized, as Canadians who are disabled, experiencing non life-threatening ailments, or lacking housing and employment are now being pressured into choosing MAiD by the actions of medical professionals or by their perceived lack of other options.[6]

The argument is often made that MAiD is a means of avoiding unnecessary suffering. But suffering, though not good in itself, is nonetheless an opportunity for the redemptive power of Christ to be exercised in one's life (2 Corinthians 5:7-10; 1 Peter 4:1-2). Bodily suffering can be an occasion for the healing of the soul and a witness of Christ to others. Jesus himself is the paradigm for faithful suffering and dying. In the agony of Gethsemane, Christ's human will was brought into alignment with the divine, providential will of the Father by his humble submission and obedience unto death (Matthew 26:39; Hebrews 5:8). Thus, for the faithful Christian, suffering is to be humbly received, patiently endured, prayerfully engaged, alleviated when possible, but not to be avoided at all costs. Moreover, alleviating the suffering of others is a moral imperative and a duty of all Christians. Modern medicine has extremely effective treatments for bodily pain. In very many cases, MAiD is requested because of a fear of being alone or of being a burden to others. When the person is assured that others *want* to care for them, he or she almost always expresses great relief and does not pursue a MAiD request.

We are deeply dismayed by the examples of Canadian Anglican clergy who have blessed, liturgized and otherwise advocated for MAiD.[7] Their actions are rooted in a flawed understanding of pastoral care as non-judgmental accompaniment and positive affirmation of whatever choice a person wishes to make. By contrast, the Prayer Book teaches a truly Christian model of pastoral care which encourages the Christian person to be conformed to Jesus Christ – incarnate, crucified, risen, ascended and glorified – and to live and die in his light with faith, hope and love, rather than in a spirit of infidelity, despair and impatience. Because we uphold the classical Anglican principle of *lex orandi, lex credenda* (that is, the law of praying establishes the law of believing, i.e., liturgy is an expression of doctrine), we are adamantly opposed to any blessing, liturgy or prayer used to sanction a MAiD procedure. Any such liturgical

[6] This has been shown conclusively by, among others, the investigative reporting of Alexander Raikin. See his "No Other Options", The New Atlantis, Number 71, Winter 2023, pp. 3–24; TheNewAtlantis.com, December 16, 2022.

[7] Kelly Grant, "Medically assisted death allows couple married almost 73 years to die together", *The Globe and Mail*, theglobeandmail.com, April 1, 2018.

innovation is explicitly opposed to the doctrine and discipline of The Anglican Church of Canada, as enshrined in the BCP.

The PBSC also takes issue with the 2016 document entitled, "In Sure and Certain Hope: Resources to Assist Pastoral and Theological Approaches to Physician Assisted Dying", published by The Anglican Church of Canada's Faith, Worship and Ministry task force on the subject.[8] The title, "In Sure and Certain Hope" is ironically a quote from the graveside portion of the Prayer Book burial office (BCP, 602). This memorable phrase has been taken far out of context and used to validate a document which, precisely in shying away from taking a firm position on MAiD and calling instead for non-judgmental accompaniment, is functionally a pro-MAiD document which provides "Prayer Resources" that may be used at a MAiD procedure, in flagrant defiance of the official doctrine and discipline of The Anglican Church of Canada as found in the Prayer Book. Furthermore, any "hope" offered by this document is neither "sure" nor "certain", as it barely makes any mention of the Resurrection. The Prayer Book teaches that our only "sure and certain hope" is in "the Resurrection to eternal life, through our Lord Jesus Christ; who shall change our mortal body, that it may be like unto his glorious body, according to the mighty working, whereby he is able to subdue all things to himself." (BCP, 602)

In the hope of that Resurrection, we call upon the Primate, House of Bishops, and General Synod to issue a clear and public condemnation of Canada's MAiD law as incompatible with the teaching of the Church. We call upon all Anglicans to model a Christian approach to death and dying to a world in desperate need of the Gospel. We pray that insofar as The Anglican Church of Canada has acquiesced in MAiD either by explicit endorsement or by silence, it may repent of its canonical disobedience and be subdued unto Christ, that we may be a light to our nation by resisting this insidious culture of death.

ALMIGHTY God, who showest to them that be in error the light of thy truth, to the intent that they may return into the way of righteousness: Grant unto all them that are admitted into the fellowship of Christ's religion, that they may forsake those things that are contrary to their profession, and follow all such things as are agreeable to the same; through our Lord Jesus Christ. Amen.
—The Collect for the Third Sunday after Easter

[8] Faith, Worship and Ministry Task Force on Physician Assisted Dying, *In Sure and Certain Hope: Resources to Assist Pastoral and Theological Approaches to Physician Assisted Dying*, (The General Synod of The Anglican Church of Canada, 2018).

In Sure and Certain Hope of Death? A Declining Church Embraces Canada's Euthanasia Regime

CHRIS DOW

On March 9, 2022, a long-time member of Churchill Park United in Winnipeg died by lethal injection in its sanctuary, an event hailed as Manitoba's first medically assisted death in a church. Just ten years ago, this would have been an act of culpable homicide under the Criminal Code of Canada. But times have changed rapidly. Last year, not only was the event legally permissible, but it was celebrated by those in attendance as being "very touching and intimate" with a "sense of 'rightness'" and the "overwhelming presence of spirit."[1] (Precisely what "spirit" was not specified).[2] The procedure was enthusiastically welcomed by the church's ordained minister, who liturgized the event with a blessing and the laying on of hands.

Far be it from me to deny the love and good will expressed by those involved in this occasion. I wish only to make two observations: first, the abrupt change in euthanasia's legal status in our country, as well as our cultural thinking on this issue; and secondly, the undeniable fact that a lethal injection liturgy in a place of worship can only be considered, to put it mildly, unrecognizably Christian to the historic and universal Church.

Some Canadian Anglican clergy have also blessed medical assistance in dying (MAiD) procedures, though to my knowledge, not yet in a church.[3]

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[1] Emily Standfield, "Manitoba's First Medically Assisted Death in a Church Was an 'Intimate' Ceremony," *Broadview*, April 29, 2022, https://broadview.org/medically-assisted-death-church/.

[2] This essay will be an exercise in testing the spirits (1 John 4:1–7).

[3] Kelly Grant, "Medically Assisted Death Allows Couple Married Almost 73 Years to Die Together," *The Globe and Mail*, April 1, 2018, https://www.theglobeandmail.com/canada/article-medically-assisted-death-allows-couple-married-almost-73-years-to-die.

Others have pastorally accompanied parishioners who have opted for MAiD, gladly approving of their decision.[4] Such actions, while well-intentioned, are an indisputable departure from the universal Church's tradition of pastoral care. It is also my contention that they defy the official doctrine and discipline of The Anglican Church of Canada, as the Prayer Book Society of Canada has argued in its statement on MAiD.[5]

My thesis is that because euthanasia is clearly contrary to the *consensus fidelium* of the one holy, catholic, and apostolic Church, blessing MAiD amounts to ecclesial self-murder. In other words, to bless and liturgize the euthanasia of human persons is an outward and visible manifestation of a declining church's own inchoate desire to be euthanized. If this sounds too strong a claim, I believe it can be demonstrated by examining the words of our national church leadership on this issue, which bear resemblance to the Death of God theology of the 1960s. This movement was a call for the church to negate itself by dispensing with traditional theology and belief in the transcendent, to the end of dissolving into the wider culture of secular progressivism.

I submit that The Anglican Church of Canada has accepted its statistically projected terminal diagnosis in 2040 and by embracing MAiD is hastening its own demise.[6] As a case in point, consider this article from the *Anglican Journal* entitled "Church Should Not Oppose MAiD Law, Primate Says," particularly this paragraph:

> "It's been clear for some time that the mood in Canada [is] not … to consider what churches have to say about this," she says. "It's been seen as imposing Christian values—which I think is a little unfair, as I don't think all of the arguments have been based on a faith perspective." Meanwhile, the shrinking staff of the church's national office has limited capacity to take on a question of this size, she adds, especially as the law, in her view, is a "fait accompli."[7]

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[4] Eric Beresford, "Medical Assistance in Dying: An Informed Discussion," May 4, 2019, Anglican Diocese of Toronto, video, 39:30, https://www.youtube.com/live/lm7ppu_BOy4?feature=share&t=2372.

[5] Prayer Book Society of Canada, "Position Statement on Medical Assistance in Dying (MAiD)," June 2023, https://prayerbook.ca/position-statement-on-medical-assistance-in-dying-maid, and included in this book. Specifically, the rubric on p. 591 of the Book of Common Prayer implies that any pro-MAiD advocacy or pastoral care is a direct violation of General Synod Canon XVIII.3.vii: "All persons who are subject to ecclesiastical jurisdiction in the Church shall be liable to discipline for any of the following offences … (vii) teaching or advocating doctrines contrary to those accepted by The Anglican Church of Canada." This suggests that pro-MAiD advocacy or pastoral care by a cleric could be disciplined.

[6] Tali Folkins, "Gone by 2040?," *Anglican Journal*, January 6, 2020, https://anglicanjournal.com/gone-by-2040.

[7] Sean Frankling, "Church Should Not Oppose MAiD Law, Primate Says," *Anglican Journal*, September 30, 2022, https://anglicanjournal.com/church-should-not-oppose-maid-law-primate-says.

These are the words of a church that has lost its will to live. That the church should shy away from speaking publicly from a "faith perspective" on a controversial moral issue, afraid and ashamed of "imposing Christian values," conceding our marginalization, "limited capacity" and declining institutional health is, frankly, for the church to abandon its life's mission and embrace its own impending death. Rather than calling MAiD what it is—a sinister manifestation of "the last enemy to be destroyed" (1 Corinthians 15:26)—we have willingly capitulated to a state-sponsored program of death that is now eliminating the poor, disabled, desperate and vulnerable,[8] conceding that this is all a "fait accompli."[9] All that is left for the church to do is step aside, yield to the secular medical system, and give our blessing to MAiD on the way out.

MAiD as a Medical Ersatz Liturgy and Sacrament

It has become commonplace to say that we are living in a secular age and that Western medicine itself has been secularized because it is no longer primarily delivered by church-run hospitals or explicitly Christian in orientation. But in fact, both our society and modern medicine, though post-Christian, remain fundamentally religious because they have ultimate values and retain cultic elements of liturgy,[10] priesthood, purity, sacramental practice,[11] and sacrifice.

Arguments in favour of euthanasia "have religious dimensions because

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[8] This is well-documented by, among others, the investigative journalist Alexander Raikin. See his "No Other Options," *The New Atlantis* 71, Winter 2023, 3–24, https://www.thenewatlantis.com/publications/no-other-options. See also Benjamin Crosby, "Where Are the Churches in Canada's Euthanasia Experiment?," *Plough Quarterly* 35, Spring 2023, https://www.plough.com/en/topics/justice/culture-of-life/where-are-the-churches-in-canadas-euthanasia-experiment.

[9] The Primate subsequently said that she is "concerned" about the expansion of MAiD eligibility. This provides me with some small measure of encouragement, but then again, if all we can manage is a mild expression of concern, this only further proves my point. Archbishop Linda Nicholls, "The Dilemma of MAiD," *Anglican Journal*, February 1, 2023, https://anglicanjournal.com/the-dilemma-of-maid/.

[10] The word "liturgy" derives from the Greek leitourgia (lēitos "public" + -ergos "working"), meaning "public service," "work of the people," or "worship of the gods." Christian liturgy is an action formed by the risen and ascended Christ to incorporate the members of his mystical body in worship. It is not primarily a human religious endeavour. Not all liturgies are Christian. Other religions have liturgies, and so does the secular state. The latter includes civic rites and ceremonies offered in service of national ideals and values.

[11] The word "sacrament" derives from the Latin sacramentum, meaning "solemn oath" (from *sacrare* "to hallow," from *sacer* "sacred"), used in Christian Latin as a translation of the Greek *mustērion*, "mystery." Christian sacraments are rituals instituted by Christ and are a means of his grace. They are signs replete with biblical symbolism from both the Old and New Testaments and are thus mysteries that incorporate Christians into the biblical narrative of cosmic redemption. The word "sacrament" is not regularly used outside of a Christian context. However, I would argue that there is such a thing as a non-Christian or post-Christian sacrament—a ritual instituted by someone other than Christ and thus imparting a different grace.

they assume a view of the good life, which is radical autonomy[12] and freedom from pain and suffering."[13] But it is important to note that intolerable physical pain is not the main reason why people choose euthanasia, as modern palliative care is very capable of relieving physical suffering. The main reason why Canadians choose MAiD is the loss of ability to engage in activities making life "meaningful." Another major reason is the "loss of dignity."[14] Notice how these are not clinical conditions, but modern values, which express a vision of a "good life" and "good death."

In the service of this vision, Canada's MAiD physicians have assumed a priestly role by administering a kind of sacrament that offers deliverance from a "bad death." The theological ethicist and palliative care physician Kimbell Kornu argues that euthanasia is a "medical ersatz liturgy" in which the "physician-priest effectively administers the sacrament of *pharmakon*, which in Greek means both remedy and poison."[15]

The liturgical dimension of MAiD is seen in how "the physician-patient relationship … resembles a pastoral relationship of shepherding unto salvation from suffering and protection from an unpeaceful death that is considered 'harmful.'"[16]

This pseudo-sacrament administered by the physician-priest is an effective "instrument of death-giving grace."[17] Under MAiD in Canada, 99 per cent of all deaths are physician-administered lethal injection (voluntary active euthanasia), rather than physician-assisted suicide, the term used for cases in which a patient is prescribed barbiturate pills to self-administer.[18] Euthanasia is the more "efficacious" sacrament because it is more likely to result in a painless death and because the patient is affirmed in their decision and comforted by the pastoral presence of the physician-priest.

MAiD is also sacramental in that it is a "liturgy that works to normalize death as medical treatment through the cultivation of habits, practices, and

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[12] The word "autonomy," oft-employed in euthanasia discussions, derives from the Greek *autonomia* (*autos*, "self" + *nomos*, "law"), meaning "having its own laws." One who strives for autonomy wishes to be a law unto him or herself, living without reference to their Creator, and in rebellion to divine law. In the Bible, this is the very essence of sin.

[13] Kimbell Kornu, "The Sacrament of Pharmakon: Physician-Assisted Suicide as Medical Ersatz Liturgy" (unpublished manuscript, 2021). This forthcoming paper is an extension of Kornu's concept of medical ersatz liturgies first developed in his article "Medical *Ersatz* Liturgies of Death: Anatomical Dissection and Organ Donation as Biopolitical Practices," *The Heythrop Journal* 63, no. 2 (2020): 1–15.

[14] *Third Annual Report on Medical Assistance in Dying 2021* (Ottawa: Health Canada, 2022), https://www.canada.ca/en/health-canada/services/medical-assistance-dying/annual-report-2021.html

[15] Kornu, "The Sacrament of Pharmakon."

[16] Kornu, "The Sacrament of Pharmakon."

[17] Kornu, "The Sacrament of Pharmakon."

[18] Physician-assisted suicide is commonly practised in the US state of Oregon, where voluntary active euthanasia remains illegal.

desires."[19] The sacraments of the church, Baptism and the Eucharist, conform us to Christ Jesus, that we may walk in newness of life in the strength of his Resurrection, instilled with the virtues of faith, hope, and love, to be servants of God and one another. Conversely, the sacrament of MAiD insidiously instills in its adherents the vices of pride, lust for power, infidelity, despair, and impatience and calls them virtues. With MAiD, "the good life that is offered is radical autonomy over life and death, coupled with the view that death by suicide is a good solution to life problems. Such thinking that is ensconced in law shapes its citizens to consider radical autonomy and death as morally good."[20]

The formative socialization effects of MAiD can also be seen in how it shapes our language around the practice. "Medical assistance in dying" and especially its acronym "MAiD," "euthanasia" (literally meaning "good death"), and "physician-assisted dying" are all euphemisms which deliberately mask what is actually taking place, that being an intentional lethal injection of neuromuscular blockers to stop respiration. Such euphemisms also hide the inherent immorality of the fact that a living person is killed—often now without having had a prior terminal illness. As Kornu has observed, such "change of language works to medicalize suicide" and "medicalizing suicide works to a-moralize suicide."[21] To call it "lethal injection" is uncomfortably descriptive, and "suicide" sounds too judgmental, but call it "MAiD" and the procedure becomes nothing more than a treatment option, a service provided by physicians in their role as hand*MAiD*ens of the "good death."

Clearing away the fog of euphemisms, the bottom line is simply this: MAiD is a straightforward and undeniable violation of the sixth commandment, "Thou shalt not kill" (Exodus 20:13). In short, MAiD is murder: self-murder on the part of the patient and murder on the part of the physician. This is what the one, holy, catholic, and apostolic Church has always taught on the question of euthanasia. This is what Catholic, Evangelical, and Orthodox churches, as well as the Anglican Communion, continue to teach.[22] But tragically it is no longer what our leadership believes. It is very telling that the only other churches in Canada that

[19] Kornu, "The Sacrament of Pharmakon."
[20] Kornu, "The Sacrament of Pharmakon."
[21] Kornu, "The Sacrament of Pharmakon."
[22] See the ecumenical and interfaith statement "We Can and Must Do Much Better: Religious Leaders in Canada Oppose Bill C-7," https://www.cccb.ca/media-release/we-can-and-must-do-much-better-religious-leaders-in-canada-denounce-bill-c-7-an-act-to-amend-the-criminal-code-medical-assistance-in-dying; and the report of the International Commission for Anglican-Orthodox Theological Dialogue, *Dying Well, Living Well: Our Sure and Certain Hope* [The Pendeli Statement] (International Commission for Anglican-Orthodox Theological Dialogue, 2023), https://www.anglicancommunion.org/media/493487/ Dying-Well-Living-Well-final-text_ecumenical-orthodox_0123.pdf.

endorse MAiD—the Evangelical Lutheran Church in Canada and the United Church of Canada—are also liberal Protestant churches at a similar advanced stage of decline. As my colleague Ben Crosby writes,

> Churches that choose—in contradiction to the entire history of Christian pastoral care—to forgo any sort of strong moral judgment, failing to teach their people that some choices are right and others are wrong, end up simply parroting the messages of broader Canadian culture.[23]

Ecclesial Euthanasia

The revisionist thinking of our national church leadership on euthanasia can be seen in the 2016 document entitled *In Sure and Certain Hope: Resources to Assist Pastoral and Theological Approaches to Physician Assisted Dying*, published by The Anglican Church of Canada's Faith, Worship and Ministry task force on the subject. But it can be seen even more clearly in the subsequent public comments of one of its contributing authors, the Reverend Canon Eric Beresford.

In Sure and Certain Hope argues that because MAiD is legally permissible in Canada, the primary task of the church is not public opposition, but pastoral care, which it defines as non-judgmental accompaniment and unconditional positive affirmation of a person's decision for euthanasia, even if this violates the conscience of the pastoral caregiver. The authors claim that to disapprove of a parishioner's decision for MAiD—and to refuse to refer them to a cleric who does approve—is "harmful to the parishioner" and constitutes "abandonment," which it condemns as "an unprofessional and inhumane act."[24] The upshot of this is to shame and pressure the cleric into committing a kind of suicide of conscience. We should all be alarmed when conscientious objection is verboten.

The authors state plainly that traditional Christian "dogma" forbidding euthanasia "can seem misleading, unduly burdensome, or even simply destructive."[25] In its place, they offer a theological twist on the secular dogma of autonomy, defined in the glossary as "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."[26] While it is true that humanity's creation in the image and likeness of the Creator God means that we too are makers

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[23] Crosby, "Where Are the Churches?"

[24] Faith, Worship and Ministry Task Force on Physician Assisted Dying, *In Sure and Certain Hope: Resources to Assist Pastoral and Theological Approaches to Physician Assisted Dying* (Toronto: The General Synod of The Anglican Church of Canada, 2018), 20, 25.

[25] Faith, Worship and Ministry Task Force, *In Sure and Certain Hope*, 13.

[26] Faith, Worship and Ministry Task Force, *In Sure and Certain Hope*, 25.

(Genesis 1:27), this certainly does not mean that we may arrogate to ourselves the power to kill, or make the "free choice" to be "authors" of our own deaths as a form of creative self-expression. Adam and Eve were created to be co-creators with God, but they transgressed precisely in their deceived attempt to be autonomous lords and masters of their own destiny, having been tempted by the serpent's lie that they could "be like God, knowing good and evil" (Genesis 3:5). The consequence of this transgression was death, and the first sin committed by the subsequent generation was murder. Humanity's creative power became destructive, un-making the world, ourselves, and one another. God's words to Cain speak directly today to those complicit in our murderous self-MAiD calamity: "What have you done? Your brother's blood is crying to me from the ground" (Genesis 4:10).

In the words of the Anglican Bible scholar Alastair Roberts, commenting on the rapid expansion of MAiD in Canada and its well-documented victimization of the disabled and vulnerable, "when we seek god-like powers for ourselves, we should not be surprised when the liberties that we assume take liberty with us and … turn back upon persons in the cruellest form of tyranny."[27]

What is perhaps most remarkable about *In Sure and Certain Hope* is the fact that it offers no Christian hope whatsoever. As the Prayer Book Society of Canada has pointed out, the title *In Sure and Certain Hope* is taken without citation from the graveside portion of the The Order for the Burial of the Dead in the Book of Common Prayer[28]. The authors entirely omit the most important point of all, that the Christian hope is "the Resurrection to eternal life, through our Lord Jesus Christ; who shall change our mortal body, that it may be like unto his glorious body, according to the mighty working, whereby he is able to subdue all things to himself."[29] How can a purportedly Christian discussion of death possibly fail to offer any theological reflection on the Resurrection? I leave that as an open question for the authors to answer. But I would remind us that if Christians are without the hope of the Resurrection, "we are of all people most to be pitied" (1 Corinthians 15:19).

Both *In Sure and Certain Hope* and Beresford pay lip service to the Bible only then to set it aside. Beresford cites Article VI of the Thirty-nine Articles to argue that only what may be proven from Holy Scripture is required for belief, but then concludes, "in my experience, that's a pretty small playing field, and it certainly doesn't include issues like MAiD."[30]

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[27] Alastair Roberts, "MAiD in Canada," *Mere Fidelity*, podcast, 47:05, https://merefidelity.com/podcast/maid-in-canada/.
[28] Book of Common Prayer (Toronto: Anglican Book Centre, 1962), 591.
[29] Book of Common Prayer (Toronto: Anglican Book Centre, 1962), 602.
[30] Beresford, "Medical Assistance in Dying," 1:44:10, https://www.youtube.com/live/lm7ppu_BOy4?feature=share&t=6250.

He adds that "there are six references to suicide (which is a different issue [from MAiD] but a related issue) in the Bible and not one of them condemns the suicide."[31] Beresford glosses over these passages without exploring the stories or even providing chapter and verse references.[32] The result is highly misleading, failing to mention that the Bible presents at least five of the six figures as rebellious against the Lord. Their suicides are certainly not commended, and in the biblical narrative, all of them take place before the Resurrection of Jesus, God's great act to bring about cosmic healing, forgiveness, and hope for the living and the dead.

Beresford's argument is that the Bible must effectively remain a closed book in our reflection on MAiD. Furthermore, he insists that The Anglican Church of Canada does not have a "firm policy" on the subject (which again is highly debatable, as the Prayer Book Society of Canada has argued). If the Bible and church doctrine cannot be consulted on the matter, how then is the church to proceed? Beresford proposes that "what I think we have are a series of pastoral and liturgical resources to help the church to engage people who are engaging these issues."[33] His comments on this are worth quoting:

> The call of anyone in pastoral ministry is to care and that care is without limit and without boundaries. So, we're not just to care for people who are like us, we're not just to care for people who agree with us, we're not just to care for people whose decisions we approve of, we're called to a care that is sacramental of the unlimited love and self-offering of God. That's the call.[34]

As he does not mention any one of the church's actual sacraments, what does Beresford's vision of unlimited pastoral care and boundless sacramental ministry look like in practice? He states that

> care, it seems to me, has to be centered around the person we care for and has to be willing to stay in the room, to stay in the company,

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[31] Beresford, "Medical Assistance in Dying," 1:44:31, https://www.youtube.com/live/lm7ppu_BOy4?feature=share&t=6271.

[32] The six suicides in the Bible are as follows: (1) Abimelech, the mass murderer of his seventy brothers, who dies by assisted suicide (Judges 9:54); (2) Saul, the disobedient and deposed king; (3) Saul's armour bearer – the only person of the six arguably not portrayed altogether negatively (1 Samuel 31:3–6); (4) Ahithophel, the betrayer of David and failed counsellor of the conspirator Absalom (2 Samuel 17:23); (5) Zimri, another mass murder and usurper of the throne (1 Kings 16:18); and (6) Judas Iscariot, the betrayer of Christ (Matthew 27:5). While some of us may be able to relate to the human brokenness and trauma of these stories, these figures cannot be used in any way to condone suicide.

[33] Beresford, "Medical Assistance in Dying," 1:44:50, https://www.youtube.com/live/lm7ppu_BOy4?feature=share&t=6290.

[34] Beresford, "Medical Assistance in Dying," 2:34:58, https://www.youtube.com/live/lm7ppu_BOy4?feature=share&t=9298.

to stay on the journey, even if it's a journey we wouldn't choose.[35]

Does this mean that the priest should be willing to "stay in the room" at the bedside of the parishioner while the MAiD procedure takes place? At what point in the lethal injection liturgy is the intravenous inserted into the patient, and when does the fatal flow of drugs begin? What prayers are said, and at what point? If the priest is to depart before the lethal injection, handing over liturgical presidency to the state physician, when exactly does this occur and why? Would the priest's premature exit not constitute a partial "abandonment"? I ask Beresford to clarify his liturgical prescriptions.

The essence of Beresford's argument is this: the Bible has nothing to say about MAiD, and neither does Anglican Church doctrine, and because MAiD is a legal reality in our country, the role of the priest alongside someone choosing MAiD is positive affirmation of their decision and unconditional pastoral accompaniment, even—and especially—if this means violating the priest's own conscience. Finally, this pastoral care is somehow "sacramental." Just how is it sacramental? Beresford does not say, and he deserves the opportunity to clarify. But it seems to me that if it can be called sacramental at all, it is thus because it blesses the pseudo-sacrament of *pharmakon*, in which the elements of respiratory-depressing drugs are transubstantiated into a means of death-dealing grace.

If this, or anything approaching it, anything even permissive of MAiD, is the sacramental ministry and pastoral care the church offers, it amounts what I call ecclesial euthanasia. The church is incapacitated and can no longer speak *qua* church when we keep the Bible closed and our doctrine sidelined. One might even say that such a church has sadly lost its dignity. From our deathbed, with our last sedated breath, The Anglican Church of Canada can muster only a surrendered but willing "Amen" to a secular ersatz liturgy offered to the false god of Autonomy.

Ecclesial Euthanasia and the Death of God

In conclusion, I wish to outline in brief how the thinking of our leaders on MAiD and the direction of our church in general, which I term ecclesial euthanasia, is reminiscent of the Death of God theology of the 1960s. I do not mean that our leaders cite or are directly indebted to the writings of the Death of God theologians—the American liberal Protestants Paul van Buren, Thomas Altizer, and William Hamilton—who were not widely read in their day and are all but forgotten now. But

[35] Beresford, "Medical Assistance in Dying," 45:37, https://www.youtube.com/live/lm7ppu_BOy4?feature=share&t=2737.

despite having had little influence in theological academia, the Death of God theologians were harbingers and interpreters of our present age, strangely prophetic in their call for the church to dispense with traditional theology and dissolve itself into secularism. Whereas the Death of God theologians explicitly advocated for the self-negation of the church, the leadership of The Anglican Church of Canada is at this point only moving in this direction, perhaps unconsciously, but no less effectively.

In an extraordinary 2016 essay, Matthew Rose offers an insightful summary of the Death of God movement and its legacy, and I am indebted to his analysis. He begins with one of the movement's first publications, van Buren's *The Secular Meaning of the Gospel*, which argued that "traditional religious language no longer makes sense in modern societies," but that the concept of God can now function to "express our attitudes, preferences and feelings." Thus, "the essential ethical message of Christianity can be expressed without reference to the divine. One can be secular—living and believing without reference to a transcendent Supreme Being—and still be Christian."[36]

Altizer took this much further, arguing that not only has belief in God died in the modern world, but that God in Christ willed his own death on the cross, and that because the Resurrection is a fable, God remains dead. For Altizer "in Jesus, God empties himself so completely, so unreservedly, that he ceases to have a transcendent reality of his own." Therefore, following in Christ's footsteps, the church too must "will its own death." As Rose observes,

> the rhetoric is foreign in its blunt directness, but the demand is suspiciously familiar. We live in a culture in which Christian teachings are accused of being unchristian, Christians are expected to engage in unending criticism of themselves in the public square, and Christians are asked, in the name of Christian charity, to reject their claims to truth.[37]

Finally, Hamilton, in his 1961 book, *The New Essence of Christianity*, celebrated the death of God as "providential" and declared that "secularism was therefore a new spiritual epoch to be welcomed." Humanity may now mature beyond its former servility to coercive, authoritarian church dogmas and pursue the freedom "to cultivate moral autonomy."[38] As we have seen, this is the very argument of *In Sure and Certain Hope*.

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[36] Matthew Rose, "Death of God Fifty Years On," *First Things* August 2016, https://www.firstthings.com/article/2016/08/death-of-god-fifty-years-on.
[37] Rose, "Death of God."
[38] Rose, "Death of God."

The Death of God theologians correctly predicted what is now the central phenomenon of contemporary North American religion: "the institutional defeat and cultural victory of liberal Protestantism."[39] And does this not exactly describe the present state of The Anglican Church of Canada? Our membership has declined precipitously, our bishops are closing churches regularly, and the values and priorities of our leaders are indistinguishable from those which have prevailed in the wider culture. The Death of God theologians would celebrate this development and say that the time has now come for the church to be euthanized.

Conclusion

I have no doubt that this paper, should it be read and engaged, will provoke the strongest, most visceral negative reactions. If it helps, consider it as being like a shock from a defibrillator. My hope is that our weakened ecclesial "heart of stone" may become once again a "heart of flesh," enlivened by God's Spirit to walk in his statutes and careful once again to obey his rules (Ezekiel 36:26). May this be our hope for the church and its members, not euthanasia.

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Questions for Reflection and Discussion

1. Read the articles by Alexander Raikin and the Reverend Ben Crosby cited in this essay. What is your reaction to the fact that Canadians who are disabled, experiencing non–life-threatening ailments, and poverty are now being pressured into choosing MAiD by the actions of medical professionals or their perceived lack of other options? What, if anything, should the church do about this?
2. Why do you think *In Sure and Certain Hope* makes no mention of the Resurrection? Are you comfortable with this omission?
3. Discuss the author's use of the term "ecclesial euthanasia" to describe The Anglican Church of Canada's position on MAiD and the direction of the church in general. Do you find this term helpful and accurate? Do you find it shocking and offensive? Do you find it inaccurate? If shocking and offensive, why? If inaccurate, what specific objections would you raise to his argument?

[39] Rose, "Death of God."

Euthanasia and Christian Tradition: A Critique of 'MAiD'

JOHN BERKMAN

As could be and was predicted at the time, the 2016 Canadian Supreme Court law legalizing euthanasia in Canada, and the legislation that followed was simply the thin edge of the wedge. Ever since it was first enacted, the various restrictions on euthanasia have lessened, and in 2023 the plan is to expand euthanasia for all persons with mental illnesses. Furthermore, many of the currently existing laws regulating euthanasia are regularly flouted. As it has been the case in countries like the Netherlands and Belgium, the scope of persons who qualify for euthanasia in Canada will undoubtedly continue to increase. The cultural and political logic at play will continuously attack restrictions to the practice until Canada has euthanasia on demand, that is, anyone can choose to be killed by a physician at any time and for any reason.

This paper will proceed in five necessarily brief parts. First, I discuss how morality is understood in the Western tradition and the radical challenge to it in the twentieth century. Second, I examine various ways of understanding the relationship between law and morality, especially as it applies to the law legalizing euthanasia. Third, I examine how the Christian tradition historically has viewed suicide and euthanasia, and the continuing relevance of that history. Fourth, I present the dominant narrative about euthanasia that has been proffered by the Canadian Supreme Court, the Canadian government, and most of the mainstream Canadian media. Fifth, I develop an alternative narrative about euthanasia to the currently dominant one, and outline a variety of ways in which all concerned Canadians can address the issues more thoughtfully, that is, the various reasons why this current situation in Canada is profoundly morally problematic.

Part I—What Is Morality?

Morality (or ethics[1]) is concerned with free human actions, actions for which we can be assigned responsibility and for which we take responsibility, our free choices, our free actions. In terms of morality in a society, morality is typically governed first and foremost by the virtue of justice.[2]

In this justice-oriented conception of social morality, there are certain things that are required for any good or even tolerable society. Perhaps the most fundamental presupposition, basic to any society which upholds even the most limited conception of justice, is that innocent persons may not be killed.

"Thou shall not kill" is a fundamental divine command for all those who identify with the major monotheistic religions, namely Judaism, Christianity, or Islam. However, divine revelation is not required to recognize the fundamental wickedness of the killing of innocent persons.[3] For example, in the current war in Ukraine, peoples of any nation and faith tradition recognize that the intentional targeting of innocent civilians in bombing or the massacre of innocent civilians in various Ukrainian towns constitute war crimes, crimes against humanity. So we might say the injustice of killing innocent persons is a truth of natural law, a universal truth that all reasonable persons can recognize.

Thus it would seem that any society that wishes to function justly has to recognize this proscription against the killing of the innocent. Any society that does not protect the innocent from being killed is a fundamentally unjust society. So the heart of this command against killing is that it is always wrong, always a great injustice to kill an innocent human person.

"Innocent" here does not mean that such persons have never done anything wrong; it simply means that these individuals have not done anything to deserve to be killed. It doesn't have any greater meaning than that. That is also what is still currently the legal and moral definition of murder, namely to intentionally kill an innocent person.

This principle has been accepted by innumerable traditions and by philosophers and theologians throughout history. From Plato and Aristotle to Augustine, Aquinas, Maimonides, Avicenna, and on to Luther, Kant, and the utilitarians Bentham and Mill, all were agreed that killing innocent persons was always morally wrong.

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[1] I will use "morality" and "ethics" more or less interchangeably, since one comes to us from Latin and the other from Greek.

[2] It has also certainly been informed by other virtues, including the virtue of love, but for simplicity's sake I will focus on the virtue of justice.

[3] One might say that the authority of revelation gives us a greater certainty of the truth of the wrongfulness of the killing of the innocent.

A Shift in Western Morality

There is a fundamental shift in moral perspective in the West that begins in the late nineteenth century. As noted above, all of the great moralists in the Western tradition up to that time recognize that certain actions—for example, the killing of the innocent—are always wrong, regardless of the circumstances or the consequences.

It is the English philosopher Henry Sidgwick, in the late nineteenth century, who first argues that there is no action that is always and/or inherently wrong. Every kind of action that we can think of as wrong, whether murder, torture, rape, massacres, etc., might be justifiable under some particular circumstances. How so? According to Sidgwick, any action could potentially be morally justified in at least some circumstances if the total consequences worked out for the best.[4] During the first half of the twentieth century, Sidgwick's view would become increasingly influential, especially in the United Kingdom.

Elizabeth Anscombe's Critique of the Sidgwickian Shift

In the 1950s, a young female philosopher named Elizabeth Anscombe was the first to clearly recognize the nature of this new form of ethics that had become dominant in British moral philosophy since Henry Sidgwick.

What is fascinating about Anscombe is that when she first characterizes Sidgwick's viewpoint, she is NOT doing academic moral philosophy. Rather, Anscombe's objection to Sidgwick's view of morality arises in the midst of a public protest Anscombe leads at the University of Oxford. In May of 1956, Anscombe opposes a proposal put before the University to grant an honorary degree to Harry Truman, at the time a former president of the United States.

Anscombe objects to this honour for Truman because she considers him a mass murderer of innocent civilians. In ordering the atomic bombings of Hiroshima and Nagasaki, Truman rejects the fundamental moral tenet of Western morality, namely that justice requires that one never intend to kill innocent persons.

While the prohibition against killing the innocent was a natural law moral truth, it was also a divine command clear to all Jews, Christians, and Muslims. While it would have been bad enough for an irreligious

[4] Ironically, these moralists who took themselves to be "secular" thought of themselves in rather "God-like" terms. That is, these moralists claimed to be able to regularly and reliably predict the future, namely all the consequences of their actions. Ironically, these moralists, who tended to be secular moralists, seem to see themselves as somewhat God-like or as prophets, being able to know the future, namely what consequences would result from this or that action. Furthermore, in being able to know the future. and what the consequences, the total consequences could possibly be in the future of their actions.

person to have massacred countless innocent civilians, for Anscombe the fact that Truman himself claimed to be a Bible-believing Baptist made it all the more morally horrendous.

Anscombe's protest was overwhelmingly voted down, but Anscombe did not give up her protest. She privately published a pamphlet entitled "Mr. Truman's Degree." A BBC producer, intrigued by Anscombe's critique of the character of Oxford moral philosophy in her pamphlet, invited Anscombe to speak on the BBC about the Sidgwickian character of Oxford moral philosophy, which Anscombe saw as justifying Truman's actions.

That same year Anscombe wrote what would become one of the most famous articles in twentieth-century moral philosophy, entitled "Modern Moral Philosophy." This article argues that if a society does not maintain an absolute prohibition on certain kinds of heinous actions, its ethic and rule of law will begin to crumble. In her article Anscombe gives the example of a judicially sanctioned execution of an innocent person for ulterior ends. According to Anscombe, if a society could justify the judicial killing of the innocent, then it could justify practically any evil action. As she noted, once the notion of any absolute moral prohibitions is dispensed with, the powerful will always find ways to change their moral principles and/or to change the laws to fit what they want to do.

Despite Anscombe's objections, this new Sidgwickian understanding of morality, one that denies that any action, no matter how heinous, might be justifiable, continues to be influential in Canadian society, and particularly within the Canadian courts.[5]

Part II—The Relationship between Morality and Law

I wish to critique two contemporary views about the relationship between morality and law in a society. The first problematic view is the view that law and morality must be kept entirely separate. This is an extreme form of a view called legal positivism. The second problematic view of the relationship between law and morality is the view that law should always reflect a particular moral viewpoint, typically the most dominant one in a society. While there are excellent reasons for rejecting either of these views, a detailed critique of them is beyond the scope of this paper.[6]

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[5] For a more detailed discussion of Anscombe's discovery, see John Berkman, "Justice and Murder: The Backstory to Anscombe's 'Modern Moral Philosophy'," in *The Oxford Handbook of Elizabeth Anscombe*, ed. Roger Teichmann (Oxford: Oxford University Press, 2022), 225–270.

[6] The basic problem with the legal positivist view is that it allows for the possibility that serious injustices may be imposed on a society. The problem with the moralistic view of law is that attempts by the law to demand great virtue from the members of its society almost always backfire, producing greater social evils in trying to do so. For a discussion of these viewpoints, see Cathleen Raven, *Law's Virtues* (Washington DC: Georgetown University Press, 2010).

A more adequate view of the relationship between law and morality is the view that civil law can and does function as a moral teacher in a society. Civil laws convey both explicit and tacit messages to individuals about how they should live (or not live) their lives. For example, laws against discrimination not only benefit some individuals, but ingrain attitudes in the public more generally that serve the common good. On the other hand, removing laws against certain kinds of gambling benefits some individuals (those who make huge sums of money running e.g. casinos and sports "books"), they harm other individuals (e.g. those who are destroyed by gambling addictions) and their families and friends, and also the common good by the legitimating effects of gambling practices of such laws, and the huge social cost transferred to society to address these harms. Similarly, the decriminalization of euthanasia has not merely allowed murder, but has had the effect of promoting murder, such that in many hospitals euthanasia is spoken of as an alternative "treatment" option, along with, e.g., chemotherapy, radiation, or surgery.

Murder and Canadian Criminal Law

In light of what Anscombe argued about the fundamental wrongfulness of the intentional killing of innocent persons, it is instructive to examine the legal definition of murder in Canadian law. According to the Criminal Code of Canada, culpable homicide is to be considered murder where the person who causes the death of a human being means to cause his death.

Furthermore, what constitutes murder in the first degree, i.e., the most heinous form of murder, is that the homicide is "planned and deliberate." The code goes on to give an example of first-degree murder, namely a contracted murder, where one gets paid for killing somebody and so forth. This is the meaning of murder in the Criminal Code and remains the meaning of murder up to the present day.

However, after legislation was created and passed to legalize euthanasia in Canada, an exception had to be added to the statute on murder. What was added to the criminal statute on murder was an exemption for "medical assistance in dying." The exemption states that "no medical practitioner or nurse practitioner commits culpable homicide if they provide a person with medical assistance in dying." Why did they have to bring in this exemption? It is because under Canadian law (and the law of most nations) euthanasia—whatever people's views about it are—comes under the definition of murder.

So it is very interesting that in Canadian law there was not even an attempt to think about murder differently such that this would be acceptable. They simply added an exemption. In other words, killing a

patient by euthanasia or otherwise is still murder according to Canadian law, but in this situation it is okay to commit murder. While it may come as a surprise to most Canadians that in 2016 the Canadian Supreme Court legally authorized murder in certain circumstances, that is in fact what happened, in terms of how murder is defined in Canadian law and in the law of almost every other jurisdiction. Yet most Canadians fail to recognize the Supreme Court's legalization of 'MAiD' as the legalization of a variety of murder and the profound implications for Canadian society when its Supreme Court legalizes a form of murder.

Part III—Christian Tradition on Suicide and Euthanasia

Understanding Suicide Morally

The starting place for thinking adequately about euthanasia—killing those persons who request to be killed—is with the question of suicide. The paradigm case for thinking about the morality of suicide is when it is freely and deliberately chosen, as is supposed to be a requirement for a person to be euthanized in Canada.

Historically, the West rejected suicide as a wrong equivalent to murder. Only in the eighteenth century did the term "suicide" enter the English language. Prior to that, what in English is called "suicide" was known as "self-murder." This older term still functions in other languages, as in German, where the term is *selbstmord*. This traditional understanding of suicide still exists and is embodied in various legal jurisdictions.

Now, at the same time, contemporary understandings of suicide recognize that certain psychological, cultural, and/or social conditioning may lessen or remove any personal subjective moral responsibility for a person committing suicide. This is why suicide has generally come to be seen as a great tragedy, especially when we see it with young people, that for some unknown reason such persons feel a deep compulsion to kill themselves, seeming not to choose or act freely in doing so. If an act of suicide is not freely chosen, then it cannot be evaluated morally.

However, Canada's euthanasia law both presupposes and requires that a person freely choose suicide. As noted above, a freely chosen act of suicide has traditionally been seen as a form of murder. It is killing an innocent person, namely oneself. Leaving aside whatever other reasons suicide may be seen as morally reprehensible, Christianity and other moral traditions have viewed suicide as the ultimate form of ingratitude to God for the gift of one's life.

Canada Statistics on Suicide prior to 2016

Prior to 2016, Statistics Canada had highly developed statistics on suicides or attempted suicides in Canada. What those statistics showed was, first, that over 90 per cent of those who commit suicide are mentally ill; second, that for every successful suicide, there are twenty attempts; and third, that only about 10 per cent of those who attempt suicide actually commit suicide in the next ten years. These statistics are highly significant for thinking about individual thinking about suicide.

First, a basic requirement of the Canadian euthanasia law is that an individual freely consent to be euthanized. This requirement has not been a significant limiting factor for the practice of euthanasia in Canada. However, if Statistics Canada is correct, that the vast majority of those who attempt suicide have a mental illness, and if persons with a mental illness have a seriously diminished capacity for making moral choices, then it would follow that the vast majority of people requesting suicide do not have the moral capacity to consent to be euthanized, and thus are being euthanized illegally. So we may be confident that already many persons with mental illnesses have been euthanized. (As any competent psychiatrist knows, depression is not typically diagnosed in one meeting, which is the extent of the psychiatric evaluation a typical euthanasia candidate receives before being euthanized. The idea that a physician can determine mental competency for as momentous a decision as euthanasia from a single discussion is a fantasy.)

Second, according to Statistics Canada, for every successful suicide there are twenty attempts. That fact should give us pause in evaluating requests for euthanasia. Killing yourself, if you really want to, is not difficult. That is a sad fact, but true. Unless we think that Canadians are unusually incompetent when it comes to killing themselves, the obvious conclusion to draw is that *the vast majority of people who actually attempt suicide do not really want to kill themselves*. They are not wanting to die, but to send a message that they need help. These statistics show that people who say they want to commit suicide (or be euthanized) on one level do not in fact want to commit suicide (or be euthanized) at a deeper level. Otherwise, there could be no explanation for the extremely low success rate.

However, the Canadian euthanasia law is being implemented in a way that presumes that everybody who requests euthanasia actually wants it. In hospitals, as soon as you mention a possible desire to die, you are presented with the paperwork to start the process of ending your life.[7]

[7] Though illegal, in at least some part of Canada you can get "same-day service" with being euthanized. It is perhaps the only "procedure" that gets done so fast!

But the statistics on suicide tells us that we cannot and should not make this presumption. Again, the fact is that 85 to 90 per cent of those who attempt suicide do not actually kill themselves — at least not in the next ten years. This means that most people who at one point attempt suicide not only do not succeed but also then happily live out the rest of their lives. By contrast, Canada's euthanasia law ensures that all persons who at one point want to die are killed. As far as I know, physicians who practise euthanasia have a 100 per cent success rate.

Why Did Canadians Want Euthanasia Legalized?

How did such a large number of Canadians come to support the legalization of euthanasia? In a major Angus Reed poll around the time of the change in the law, there were only two situations in which the majority of Canadians favoured euthanasia; when someone is greatly suffering and/or is in the last six months of their life. Since that time support for euthanasia has broadened. Why? Two reasons.

The first reason has to do with a popular belief that is highly praised in contemporary culture, especially in films and other mass media. It is the desire for independence, or more specifically, for control. The philosophical term for individuals getting more control over their lives is "autonomy." The second reason typically given is a fear of or a repugnance towards the possibility of suffering, whatever that is taken to mean by various individuals. The notion of suffering is typically left vague and up to each individual to decide what constitutes suffering for them. It is worth analyzing both of these beliefs in more depth.

Autonomy

The notion of "autonomy" arose in the field of medical ethics, and originally highlighted the notion of respect for persons. It gradually became merged with modern individualism. This kind of individualism was very well described in the 1960s as a political phenomenon by the Canadian political philosopher C.B. McPherson, who in his work in political theory came up with the notion of "possessive individualism." According to this viewpoint, an individual comes to see himself (and the phenomenon is stronger in men than women) as the sole proprietor of his skills and abilities, and owes nothing to society for them. This person believes in rights for himself, but typically not in any duties he may have to his society. In the extreme, this is the person who fantasizes that he has pulled himself up by his own bootstraps. It doesn't occur to this person to consider the roads he drives on, the utilities he uses, and all kinds of other things that are provided for him without his assistance. Such a person lacks the

appropriate gratitude for what his forebears did for him, and typically does not feel he has any obligations to current or future society.

It turns out that this political philosophy of possessive individualism, this fantasy of control and independence, only tends to be believed by, relatively speaking, one subgroup in Canadian society. That subgroup, as you might guess, tends to be the wealthy and powerful, who through their wealth and power are actually able, to some extent anyway, to live out this fantasy of autonomy. And this has been shown by the first major cohort study of those who received euthanasia in Canada. The subgroup who most wanted euthanasia was this subgroup of wealthy and powerful Canadians. After all, those who have come to expect that they get to control everything in life should naturally want to control their dying.

However, this emphasis on autonomy ignores a fundamental empirical reality in life. And that is the reality of sin and evil in the world, which we are confronted with every day in our newspapers. The vast majority of people never make purely autonomous decisions. They are influenced by others and often influenced by others in wicked ways or with wicked intentions.

Furthermore, there is a great irony in the appeal to "autonomy" to receive euthanasia. If such persons really believe in autonomy, they should want to kill themselves, rather than have someone else do it for them. For the demand that someone else kill you, whatever else is wrong about it, is certainly not an expression of autonomy.

Response to Suffering

The notion of suffering is a very squishy notion. It is "squishy" in that, in a certain sense, everybody gets to decide for themselves about what constitutes suffering. You can never say to somebody: "No, you're not actually really suffering that much—get over it!"—right? If anybody says they are suffering greatly, you simply have to accept that they are therefore suffering greatly. How did we as a society get to the point where a major moral imperative—to relieve suffering—has become profoundly privatized and individualized?

The societal obligation to relieve suffering has been the mantra of modernity since the time of Francis Bacon in the seventeenth century, who influentially proposes that the purpose of society is to go about relieving suffering.

This—the relief of suffering—gradually comes to be seen as the main task of a truly liberal society. Since a liberal society professes to be agnostic about the goals for human life and/or human fulfillment, the best that a liberal society can agree upon is to try to reduce everybody's suffering.

Now, the great irony of this is that in twenty-first century Canada, we live in a society that more than any other in the history of humanity has minimized the need for a person to ever be in serious pain. And yet we are one of the first societies to think that ours is a society with so much pain and suffering that we should be able to end it by demanding that another individual should kill us to end our suffering. It is a telling fact about human nature that a society with comparatively little suffering becomes the most demanding about having that suffering eliminated.

Part IV—Developing an Alternative Narrative about Euthanasia

The misleading terminology of "MAiD"

If Christians are to resist the culture of euthanasia that has become entrenched in Canadian society, there will have to be a fundamental change in the narrative as to what is going on. Let us begin with the euphemistic phrase "medical aid in dying," or "medical assistance in dying." If there is one thing I would ask of my reader, it is to refuse to use the term "MAiD." It is a grotesque lie every time that phrase is used. In fact, it is three lies.

First, is there anything "medical" in "MAiD"? No, killing is not a part of the practice of medicine. For the last 2,500 years, from the time of the Hippocratic oath onwards, the ethos governing the practice of medicine has barred physicians from killing their patients. Killing patients has always been abhorrent to the profession of medicine. For thousands of years physicians have taken this oath, which prohibited any and all deliberate killing of their patients.

Second, is there any "aid" in "MAiD"? Should killing patients be understood to be "aiding" them? Is this supposed to be neutral language? No. "MAiD" is clearly intended to make killing a patient sound like a good thing. Only in a perverse world does one come to someone's aid by killing the person.

Third, is there any "dying" in "MAiD"? This is most perverse of the euphemisms. "MAiD" is not *at all* about dying. "MAiD" is about killing. The purpose of "MAiD" is to allow physicians to kill patients. While all humans will die, relatively few will be killed, and the killing of human beings is always at least a tragedy. The deliberate obfuscation of "killing" by calling it "dying" is an abomination, the product of deeply corrupt minds. Terminologically, you can call it "mercy killing," you can follow the Canadian Criminal Code and call it legalized "murder," or you can call it "euthanasia." Any of these terms can be considered accurate, but to pretend that "killing" is "dying" is not.

Human Dignity and Motivations for Requesting Euthanasia

Research in 1999 by Harvey Chochinov, one of the most prominent and preeminent palliative care physicians in the country and the Canda Council Research Chair in Palliative Care, found that among those who requested euthanasia, the desire to be euthanized was not stable.[8] One day the patient might want euthanasia, the next day the patient would not want to be euthanized. And thirdly, the medical literature reveals that those whose symptoms were treated typically no longer wanted euthanasia. Furthermore, Chochinov showed that when caregivers dealt with patients's symptoms and were attentive to patients' individualized and specific sense of dignity, their desire for euthanasia typically disappeared.

Developing an Alternative Narrative—The United Nations Perspective

In February 2021, the United Nations delivered a report on Canada's euthanasia laws. This report said that Canada was in violation of three charters that Canada had signed: the 1948 Universal Declaration of Human Rights, the 1966 International Covenant on Civil and Political Rights (which Canada signed on to in 1976), and the 2010 Convention on the Rights of Persons with Disabilities. The report noted that Canada was a signatory to all three of these UN declarations.

So now Canada is in some sense not in compliance with their own promises to the United Nations. And when we think of all the human rights abusers, those countries who are abusing human rights, it's not a pretty thing to think that now Canada should be included among them. And what kind of expectation can Canada have of other nations who don't respect human rights, particularly China, when now China can happily say back to Canada, "Well, you're also violating the very human rights principles that you signed on to protect." So if Canada is trying to be any kind of witness on the human rights front, it is completely undermining its credibility with these laws.

Alternative Narrative: Motivation for Requests

I've already discussed two motivations for euthanasia—suffering and autonomy. Suffering is a deep part of the human condition, and part of what it means to be human is both to (1) constructively deal with suffering and (2) aid others who are suffering. The reality is that when a person loves, and the more a person loves, the more a person can and

[8] See, e.g., H. M. Chochinov, D. Tataryn, J. J. Clinch, and D. Dudgeon, "Will to Live in the Terminally Ill," *The Lancet* 354, no. 9181 (1999): 816–19.

will suffer. In this life, the only way to avoid suffering is to not love anybody or anything. Then and only then can you avoid suffering. Suffering is an inevitable part of the human condition. Anybody who lives a serious life will have to address suffering.

Similarly, the notion of autonomy is never pure. People make choices not from an ideal list of what life could be but between the options they have available to them in their context. If someone is unable to access disability accommodations, mental health services, or palliative care, or even afford a place to live, euthanasia may seem like the best option. But a choice between multiple bad options is not a free choice. Refusing to substantively provide people with they need to live and offering euthanasia instead is a coerced choice.

As noted earlier, the United Nations has reported on Canada's violations of three UN charters. The report also said there was a great prejudice against persons with disabilities in these laws. In the context of clear prejudice, euthanasia diminished human autonomy rather than enhancing it.

A 2012 Angus Reid public opinion poll on physician-assisted suicide showed that 35 per cent of Canadians already thought that people with quadriplegia should be able to be killed.[9] In other words, these Canadians thought that the lives of persons with quadriplegia weren't worth living. In the same poll, 38 per cent of Canadians "would allow a parent to end the life of his or her child who suffers from a severe form of a conditions such as cerebral palsy." These are not examples of choosing for oneself, but choosing that someone else should be killed. There is a great push to allow parents to kill (euthanize) their children. It is only a matter of time before laws allowing the killing (euthanasia) of children will be proposed and passed, unless there is a profound change in the attitudes of Canadians towards euthanasia.

Physician Character and Conscience Clauses

Why is it that the 2016 law makes physicians or nurse practitioners do the killing? You would think that if there were to be one group of people that should not be killing patients, it would be physicians, who have taken an oath not to kill their patients. Canada's euthanasia laws have only confound physicians with regard to their professional calling. Is the physician's calling to cure and to heal? Or is it also at times to kill?

Does it benefit the health care of Canadians that their physicians are given the power to kill? Does that not require that a physician be able

[9] Angus Reid Public Opinion, "Canadians and Britons Would Allow Euthanasia under Some Conditions," PDF File. July 26, 2012. http://angusreidglobal.com/wp-content/uploads/2012/07/2012.07.26_Assisted.pdf

to conclude that some lives are not worth living? Once a physician is expected to be able to determine that some patients are better off dead, their unwavering commitment to seek their patient's health has been undermined. The physician is no longer steadfast as a healer.

Therefore, we do well to ask why the 2016 euthanasia law requires *physicians* to be the ones to kill patients? I submit that the euthanasia law trades on the credibility and prestige of the medical profession to give respectability to the practice of murdering patients. The typical Canadian thinks, "Well, if physicians are doing it, then it must be a good thing, since physicians are healers."

My position is that if Canada is committed to killing patients, then there ought to be a special group of people doing the killing. There could be a one-year community college course in "thanatology," where young people can be trained how to effectively, efficiently, *and painlessly kill innocent people*. After all, it is a huge waste of medical resources for highly paid physicians to be devoting their energies to something that does not require any medical expertise or judgment. If Canada is determined to euthanize people, there's no need for it to be done in the most expensive possible way, that is, in hospitals, by physicians, in private rooms.[10] In this context, the most important task for Christians is to show solidarity with those most likely to be the unwilling and/or unwitting victims of a culture of euthanasia, and to refuse to stop speaking the truth about euthanasia: that it is the killing of innocent people.[11]

One related concern is that Christians have perhaps overly focused on conscience clauses as a means of opting out of having to kill patients. While it is reassuring that most physicians refuse to engage in killing their patients, I argue that the more adequate response is that *this is not medicine and it should not be paid for with health-care dollars.*

What Kind of Society Shall Canada Be?

I want to conclude by saying that killing innocent persons cannot be part of a just legal system and cannot be a routine part of a good society. As we have seen, once a society decides that it can kill innocent people, the parameters for who can be killed and for what reasons will continuously expand, because the fundamental prohibition has been broken.

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[10] In 2023, if somebody wants euthanasia in a hospital in Toronto, they immediately get a private room, even though there are months-long waiting lists for such rooms. Euthanasia patients are moved to the top of the list, occupying beds needed for patients in need of medical care.

[11] My thanks to Michael Buttrey for his very helpful comments on a draft of this essay.

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Questions for Reflection and Discussion

1. Is "MAiD" an appropriate acronym for the legalized killing of individuals? Are there reasons why Christians might refuse to refer to legalized euthanasia as "MAiD"?
2. Since killing persons is relatively easy, why might the government insist that euthanasia be done by physicians?
3. Is Canada inevitably moving towards a situation where anyone can ask to be killed for any reason? What might prevent this situation from coming to be in Canada?

Recovering the Art of Dying: On the Church's Response to MAiD

BEN CROSBY

The theologian Stanley Hauerwas likes to say that the Christian life is about preparation for death. Now, this statement might strike many of us as provocative. Many of us mainline Anglicans are nervous about theologies which appear to diminish the goodness and importance of this life in favour of an overemphasis on the life of the world to come. However, as an Anglican priest who is also a church historian, my work helps me to understand that our very discomfort makes us, not Hauerwas, the odd ones.

In fact, how to die well has long been an emphasis in Christian teaching, devotional literature, and hagiographical writing, and Christians have long been encouraged to prepare themselves to die in a Christian manner. Christian martyr narratives going all the way back to the martyrdom of Stephen in Acts have patterned a good death on the imitation of Christ's own death. In the Reformation of the sixteenth century, the period I study, the development of Protestantism changed what counted as a good death but did not remove the deep concern with Christian dying. For example, duelling Roman Catholic and Protestant polemicists argued about whether Martin Luther died in fear and agony or in confident, serene hope as a way of justifying or condemning his life and work as a whole. Indeed, the growth of popular devotional literature on how to die well which began in the medieval era continued into the eighteenth and nineteenth centuries.

We Anglicans can claim one of the most important examples of this genre: Jeremy Taylor's *Holy Dying*[1]. This book provided hundreds of pages of prayers, exhortations, and meditations to help the dying person prepare for death and reconcile herself with God and her neighbour. We

[1] Taylor, Jeremy. *The Rules and Exercises of Holy Dying*, 1651.

can even find an echo of this tradition in our current liturgy here in Canada: in the (Great) Litany found in both our Book of Common Prayer and our *Book of Alternative Services*, we ask God that we not die suddenly and unprepared. The preparation the liturgy has in mind is not just about setting our affairs in order or even about saying farewell to loved ones—it is spiritual preparation for a Christian death.

But what does all this have to do with a Christian response to MAiD, with the question of how Canadian Anglicans ought to relate to our country's laws and practices around euthanasia? I worry that our church's tepid and confused response to Canada's MAiD practices is an expression of a deeper problem: we church leaders have given up a historically central part of Christian pastoral care, namely, helping Christians die in a Christian manner. We have failed to care for our people, to guide them as they face the reality of death. In refusing to take a clear position on MAiD, we have largely ceded the question of what constitutes a good death to an ideology that prioritizes autonomy, choice, and the elimination of suffering over all else, both in how we live and in how we die. This ideology is incompatible with the Gospel of Jesus Christ and is death-dealing to some of our most marginalized neighbours. I believe that The Anglican Church of Canada needs to recover a vision of the care of souls more robust than non-judgmental accompaniment and condemn MAiD as opposed to the Christian faith and deadly to disabled people. I pray that we will join with disability rights groups and other faith organizations in working to mitigate MAiD expansion and that we will recommit to teaching our congregations about what it means to die in a Christian manner.

Euthanasia and The Anglican Church of Canada: A Brief History

To look at the history of our church's engagement with euthanasia is to trace the abandonment of our duty to provide Christian pastoral care for our people as they come face to face with death. I will not go into great detail here about the evolution of euthanasia jurisprudence, legislation, and practice in Canada, but to understand our church's response I do need to provide some broader context (for more details, see my piece in *Plough Quarterly*, "Where Are the Churches in Canada's Euthanasia Experiment?"[2]). Euthanasia was legalized in Canada in 2016, in response to the 2015 *Carter v. Canada* decision, which found that there was a Charter right to the practice. Originally, euthanasia was allowed in a

[2] Benjamin Crosby, "Where Are the Churches in Canada's Euthanasia Experiment?," *Plough Quarterly* 35, Spring 2023, https://www.plough.com/en/topics/justice/culture-of-life/where-are-the-churches-in-canadas-euthanasia-experiment.

restricted set of circumstances. But in response to a 2019 Superior Court of Quebec decision, Parliament passed a new MAiD law in 2021 which allowed those not likely to die soon to pursue euthanasia. It also expanded the range of conditions eligible for MAiD to include those diagnosed with a mental illness alone, although [as of time of writing] this expansion has been delayed until March 2024. Further expansion to include so-called "mature minors" and MAiD via advance directive is being considered.

What has our church said throughout the development of Canada's euthanasia laws? Before the 2015 *Carter v. Canada* decision and 2016 legalization of euthanasia, The Anglican Church of Canada was willing to speak clearly about euthanasia. In 1998, The Anglican Church of Canada set up a task group which produced the statement *Care in Dying*, which General Synod commended for study. *Care in Dying* argued against legalization of euthanasia: "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."[3] The document further recommended "that the church urge its members not to seek recourse to euthanasia and assisted suicide."[4] That is, *Care in Dying* both advocated a legal approach to euthanasia for Canadians as a whole and offered specific ethical and pastoral guidance for Canadian Anglicans. However, in a sign of things to come, the document also stressed that it was "a pastoral guideline rather than a policy statement" and was not interested in "demanding obedience to closely defined teaching."[5]

Then came the 2015 *Carter v. Canada* (the Supreme Court's ruling that euthanasia was a Charter right), and everything changed. Our church's position on this issue of grave moral concern changed, not because of new Biblical, theological, or ethical insight, but because of decisions made by the Supreme Court and Parliament. Not only did we choose not to object to the Supreme Court decision, but we also abandoned definitive teaching about euthanasia for our people. This is made particularly clear in the 2018 document *In Sure and Certain Hope*. Like *Care in Dying*, this was produced under the auspices of Faith, Worship and Ministry and was commended for study (but not

[3] Task Group of the Faith, Worship, and Ministry Committee, *Care in Dying: A Consideration of the Practices of Euthanasia and Physician Assisted Suicide* (Toronto: The General Synod of The Anglican Church of Canada, 1999), 11, http://www.anglican.ca/wp-content/uploads/2010/10/care-in-dying-scanned.pdf.

[4] Task Group, *Care in Dying*, 33.

[5] Task Group, *Care in Dying*, 9.

specifically endorsed) by the larger church. In the very introduction to the report, its authors forswear offering determinative guidance:

> What is offered in the pages that follow is a framework for effective pastoral support for all concerned (patients, family, loved ones, care providers, and wider communities of support), whatever decisions particular patients ultimately believe themselves called to make.[6]

In an environment in which euthanasia is legal and (as the introduction also notes) "public opinion has moved clearly and decisively in favour of physician assisted dying,"[7] it is apparently the job of the church to provide effective pastoral support in "whatever decisions" people "believe themselves called to make." The report acknowledges that Anglicans hold "that all life is sacred" and that "support for assisted dying seems antithetical to this belief." But it makes clear that the church cannot definitively say that seeking euthanasia is actually in contradiction to this core Christian claim. It is no longer the church's job to offer pastoral support by instructing Christians to refuse or accept MAiD, or indeed to describe a good Christian death. Instead, the church is to accompany people in whatever choice they make. This move to non-judgmental accompaniment is grounded in a broader refusal of the church's teaching authority as it pertains to the life of Christians. The Anglican Church of Canada, according to the report, has "become increasingly skeptical of our capacity to understand and interpret the work of God in the life of another person."[8]

It is therefore small surprise that as the most recent expansion of Canada's MAiD law moved through Parliament, The Anglican Church of Canada has largely chosen silence. In October 2022, Archbishop Nicholls in an interview[9] with the *Anglican Journal* recommended against the church opposing MAiD expansion. In a February 2023 editorial[10] on MAiD in the same place, the primate expressed concern about MAiD expansion but neither endorsed nor condemned MAiD as

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[6] Faith, Worship and Ministry Task Force on Physician Assisted Dying, *In Sure and Certain Hope: Resources to Assist Pastoral and Theological Approaches to Physician Assisted Dying* (Toronto: The General Synod of The Anglican Church of Canada, 2016), 6. http://www.anglican.ca/wp-content/uploads/In-Sure-and-Certain-Hope.pdf.

[7] Faith, Worship and Ministry Task Force, *In Sure and Certain Hope*, 6.

[8] Faith, Worship and Ministry Task Force, *In Sure and Certain Hope*, 8.

[9] Sean Frankling, "Church Should Not Oppose MAiD Law, Primate Says," *Anglican Journal*, September 30, 2022, https://anglicanjournal.com/church-should-not-oppose-maid-law-primate-says.

[10] Archbishop Linda Nicholls, "The Dilemma of MAiD," *Anglican Journal*, February 1, 2023, https://anglicanjournal.com/the-dilemma-of-maid.

an option for Christians, stating that "the conscience and autonomy of the individual" must ultimately be respected. At our most recent General Synod in June 2023, a proposed resolution, which was not able to be discussed, took a similarly vague line: it resolved that General Synod "take note with concern" proposed expansion of MAiD but did not explicitly criticize the expansion or MAiD in general. The most it was willing to say was that palliative care is "a more appropriate response to human suffering,"[11] but it emphasized the importance of pastoral accompaniment whether or not a person chooses MAiD.

While neither General Synod nor the Council of General Synod have taken an official position on MAiD, this is our *de facto* one: we have moved from offering clear guidance to our people on euthanasia to making statements of concern over ever-expanding MAiD expansion while reducing pastoral care in the face of death to non-judgmental accompaniment of whatever decisions a person chooses to make.

MAiD Ideology and the Gospel of Jesus Christ

As we have seen in *In Sure and Certain Hope*, much of our church's refusal to make clear judgments on MAiD stems from a commitment to respecting the consciences of Christians and a recognition that whatever a clergyperson or theologian may say, some Canadian Anglicans will choose MAiD. Rather than setting inflexible rules that may cut people off from the church, the thought seems to be, it is better to respect people's discernment of how to best live out their Christian commitments and walk alongside them. I do not doubt that this refusal is motivated by good intentions. But nonetheless our refusal seems to me to make a basic and crucial error. When the church leaves questions of life and death instead up to individual choice, it is not ceding ground for individual Christians to make decisions on the basis of their theologically formed consciences so much as endorsing an account of what it means to be human that is death-dealing to disabled people and contrary to the Gospel of Jesus Christ. That is, our church's abandonment of teaching people what it means to die in a Christian way is functionally a capitulation to an anti-Gospel which teaches that what is important about being human is unconstrained choice, independence, and the absence of suffering. It is this anti-Gospel that undergirds the practice and ideology of MAiD in Canada, and so it is worth careful examination of this ideology in relationship to our faith.

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[11] General Synod 2023. "Resolution C002: Medical Assistance in Dying." July 2, 2023. https://assembly.anglicanlutheran.ca/acc/cc/resolutions/c002.

What is the content of this MAiD ideology which I call an anti-Gospel? You can find few clearer examples than a glossy ad by the Canadian retailer Simons in October 2022 celebrating the decision of a woman named Jennyfer to die by euthanasia. The ad tells the story of Jennyfer's preparation for death. Throughout the ad, euthanasia is not portrayed as an immoral action or even as a heartrending decision in the face of unimaginable suffering, but as the expression of a desire to die with beauty: euthanasia is cast as an empowering choice, complete with swelling music and soft-focus camera shots. A clothing retailer, of all things, thought it appropriate—indeed, thought it beneficial for its brand image—to celebrate being killed by your doctor as an expression of individual choice and agency. The central values of human life, the ad suggests, are independence, agency, autonomy, and self-actualization—and MAiD allows these values to be expressed in death as well as in life. This celebration of a woman being killed by her doctor was already grotesque, but it later came out that the ad did not tell the full story. After Jennyfer's death via MAiD, further reporting revealed that she had earlier been featured as an anonymous source for a CTV article where she discussed feeling forced into MAiD because of insufficient health-care provisions in British Columbia. She reported that receiving approval to be killed by her doctor was far easier than accessing the medical care she needed to live with Ehlers-Danlos Syndrome. None of this made it into the Simons ad.

The juxtaposition of this celebratory account of MAiD and the hidden story about Jennyfer's lack of health-care options shows one of the most pernicious aspects of this anti-Gospel: its devaluation of the life of disabled people. Disability rights groups have opposed both the original MAiD legislation and MAiD expansion with good reason. We have numerous reports of people with disabilities choosing death via MAiD for reasons similar to Jennyfer's: it was much easier to sign up to be killed by their doctors than to receive the appropriate health care to enable them to live and thrive. More broadly, pro-MAiD rhetoric privileges choice, autonomy, independence, and lack of suffering as the markers of a good life. We hear over and over again from MAiD advocates that the reason that it is important to have the option of euthanasia is that this enables you to die on your terms, in the manner that you choose, while you are still independent and capable. Implicitly or explicitly, this ideology says that the lives of disabled people are not worth as much as those of able-bodied people, insofar as the lives of many disabled people are marked by forms of unavoidable dependence or suffering. Indeed, by removing reasonably foreseeable natural death

as a criterion for seeking MAiD, the Canadian government has said that having certain disabilities is a good reason to end your life, even if natural death is nowhere near. Roxana Jahani Aval, chair of the Canadian Council on Disabilities, puts the stakes of MAiD expansion very bluntly: "This is a fight for our lives."[12]

The incompatibility of MAiD ideology with Christian faith comes into particularly sharp focus when we look at attempts by Christian bodies to provide prayers for those choosing MAiD. The United Church of Canada includes on its website some prayers co-written by a UCC minister and a Dying with Dignity executive for those who have chosen to die by MAiD.[13] These prayers, precisely in their attempt to provide Christian language for MAiD, reveal the anti-Gospel nature of MAiD ideology.

This prayer is for a person experiencing fear:

> I hope they [my family] will be proud of my decision and will understand that MAiD is consistent with the love and compassion of Jesus. I have such peace in knowing this is my choice.

Here MAiD is asserted as congruent with Jesus's love and compassion. But note that the person praying is taught by the words of the prayer itself to find peace in knowing that they have chosen to be killed by their doctor. That is, the source of consolation in this prayer of a person preparing for death is not Jesus but autonomous individual choice.

This second prayer, for deciding on the time and place of death, is even more disturbing:

> I do not want to linger in pain, waiting for death to come. I do not want my family and loved ones to watch me suffer to the bitter end. I do not want them to be haunted by memories of a slow, painful death. Daily my dignity is being eroded. I am ready to go through that final door. **I give thanks that I have still the ability to choose, but I realize this window of lucid opportunity may very soon be closed.** [emphasis original]

As we saw in the first prayer, there is a strong emphasis on the ability to choose the time and place of one's death. But the sentence that most

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[12] "CCD Disappointed by House of Commons Yes Vote on Bill C-7 (Medical Aid in Dying)." Council of Canadians with Disabilities, March 12, 2021. http://www.ccdonline.ca/en/humanrights/endoflife/Media-Release-Bill-C7-12March2021.

[13] "Death and Dying." United Church of Canada, January 7, 2020. https://united-church.ca/worship-theme/death-and-dying.

sticks out to me is this one: "Daily my dignity is being eroded." In this prayer, a Christian preparing to die is given words to pray which explicitly say that the experiences of suffering, of loss of independence and choice, erode one's dignity. This is, of course, exactly what disability justice activists have called our attention to: MAiD ideology teaches that the lives of disabled people are less dignified than those of able-bodied people. From a Christian perspective, I think this statement is blasphemous. Surely we must say that human dignity is found in our being made in the image of God, not independence or choice! Surely our Lord Jesus, crucified and dying on the cross, wholly without choice or autonomy, was not lacking in dignity! Yet this is exactly what is entailed by this prayer published by a Christian church. MAiD ideology and the Christian faith cannot ultimately be reconciled.

Many Christians in Canada have been admirably clear about this incompatibility. A broad coalition of Christian, Jewish, and Muslim groups together put out a statement called "We Can and Must Do *Much* Better"[14] opposing MAiD expansion, and the Roman Catholic Church and evangelical churches have led the way among Christians in standing alongside disability rights groups in opposing MAiD. I find the Presbyterian Church in Canada's 2017 statement on euthanasia particularly helpful in its diagnosis of the stakes of endorsing MAiD:

> We live in a culture enamoured with the closing lines of "Invictus" by William Ernest Henley: "I am the master of my fate: I am the captain of my soul." "Invictus" is a stirring work of literature, but it decries any trust by God. As Reformed Christians, we profess a different heritage, powerfully stirring to our souls, that proclaims a complete and utter trust in God.[15]

The statement goes on to quote the first question and answer of the Heidelberg Catechism:

Q. What is your only comfort in life and in death?

A. That I am not my own, but belong—body and soul, in life and in death—to my faithful Saviour, Jesus Christ.

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[14] "We Can and Must Do Much Better: Religious Leaders in Canada Oppose Bill C-7," https://www.cccb.ca/media-release/we-can-and-must-do-much-better-religious-leaders-in-canada-denounce-bill-c-7-an-act-to-amend-the-criminal-code-medical-assistance-in-dying.

[15] The acts and proceedings of the one hundred and forty-third General Assembly of The Presbyterian Church in Canada, Kingston, Ontario June 4-7, 2017, n.d., https://presbyterian.ca/wp-content/uploads/2017_gao_acts-and-proceedings.pdf, 243.

We Christians cannot agree with MAiD ideology that independence, autonomy, freedom of choice, and lack of suffering are what makes human life worthwhile. Indeed, to be a Christian is to acknowledge dependence as a gift to be embraced, freedom as something to put at the service of one's neighbour, and even suffering (although not a good in itself) as an opportunity to cleave closer to Christ. Against an ideology that says that we are free to determine our own fates—and that such freedom is so important that we could reasonably choose to die rather than live without it—we Christians say that we belong to Christ and to each other and so, even in situations of suffering, cannot choose to actively end the life we have received as a gift.

This is why The Anglican Church of Canada cannot simply embrace a model of non-judgmental accompaniment when it comes to MAiD. The Quebec College of Physicians or other similarly pro-MAiD organizations may say that MAiD "is not a moral, political, or religious issue. It is a medical one."[16] But we Christians cannot accept this dichotomy. Wilfully choosing to end one's life is not a morally or religiously neutral act. The ideology behind MAiD legalization and expansion is in opposition to core Christian commitments about what makes for a dignified human life. In refusing to speak clearly about MAiD, we are allowing our people to be led astray by an anti-Gospel. Worse, in refusing to speak clearly about MAiD on the grounds of the supreme value of individual choice and autonomy, we are even acquiescing to it. The position that the church cannot intervene in the face of "whatever decisions" people "believe themselves called to make,"[17] as *In Sure and Certain Hope* puts it, is fundamentally a surrender to this ideology which is deadly to disabled people and contrary to the Gospel.

Recovering Christian Pastoral Care for the Dying

What then are we to do? First and foremost, The Anglican Church of Canada must clearly condemn the practice of MAiD and the ideology undergirding it as incompatible with the Christian faith. The recent Prayer Book Society of Canada position statement on medical assistance in dying (which, full disclosure, I assisted in writing) provides a good example of what such condemnation might look like. But as the

[16] Collège des médecins du Québec (@CMQ_org), "#MAiD s not a moral, political or religious issue. It is a medical one. 0–1-year-olds & people with disabilities are also patients and are entitled to the. . .", Twitter, November 18, 2022, https://twitter.com/CMQ_org/status/1593646607278510080.

[17] Faith, Worship and Ministry Task Force, In Sure and Certain Hope, 6.

Prayer Book Society statement itself notes, it is not enough just to condemn MAiD. No, we need to recover a *theological* approach to pastoral care for the dying, one which draws upon the wisdom of the Christian past to comfort the dying and their loved ones today.

I fear that part of why our church has so quickly acquiesced to MAiD is because we have allowed the definition of what constitutes a good death to be determined entirely by nontheological concerns. We see this most clearly in MAiD ideology itself, of course, where a good death is a death carried out at the time and place of one's choosing as an expression of one's autonomy and independence. But even for those who do not choose MAiD, how often does our church provide opportunities to reflect on what a *Christian* good death looks like? How often do our practices around death and dying reflect the belief that dying is a significant Christian act? The Prayer Book Society statement is absolutely correct to say that "For the Christian, death is not an opportunity for the final exercise of self-expression and autonomous choice, but rather for the dying person to be conformed to Christ in his or her death and for loved ones to share the dying person's burden by prayer and acts of mercy."[18] One of our church's great contemporary challenges is to provide pastoral care and teaching that puts this into practice.

In the concluding paragraph of the Prayer Book Society statement, the Society "call[s] upon all Anglicans to model a Christian approach to death and dying to a world in desperate need of the Gospel."[19] This must be at the heart of our church's response to MAiD. Let me be clear: I believe that it is vitally important that we stand alongside disability rights groups in opposing MAiD expansion in the public sphere and that we provide clear teaching to all members of The Anglican Church of Canada rejecting the use of MAiD for Christians. But we have more to offer than condemnation: we can model a way of living that rejects the death-dealing lies of MAiD ideology and celebrates the dignity of all human life and the goodness of dependence upon God and each other. We can model a way of dying that proclaims this glorious truth: death cannot separate us from the love of God in Christ Jesus but has been defeated by Christ's cross and resurrection and turned into a means of fuller communion with God. I want to close where I began, with pre-modern devotional manuals for dying. We Christians used to spend a great deal of time thinking about how to die well. Perhaps our forebears

[18] Prayer Book Society of Canada, "Position Statement on Medical Assistance in Dying (MAiD)," June 2023, https://prayerbook.ca/position-statement-on-medical-assistance-in-dying-maid, and included in this book.
[19] Prayer Book Society of Canada, "Position Statement".

in faith have the wisdom we need to relearn how to die in Christ. It is my hope that in response to the crisis of MAiD, we might turn to them to recover the Christian art of dying, both for our own consolation and as a witness to the Gospel to our neighbours.

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Questions for Reflection and Discussion

1. What has your church community taught about the nature of a good death?
2. What role does the church have in instructing Christians about how to die well?
3. How can dying in a Christian manner be a means of proclaiming the Gospel?

The Normalization of MAiD: Reflection on MAiD Technology and the Human Desire for Control

IAN RITCHIE

Since the advent of the doctrine of inevitable human progress in the nineteenth century, the idea that humans inexorably progress to greater and greater levels of freedom and well-being has been a mainstay of Western culture.[1] It lies outside the scope of this essay to unpack the sources of that doctrine, or its variants on the right and on the left, but it is helpful for us to remember that it began in the eighteenth-century Enlightenment era, when European intellectuals were optimistic about the powers of rational thought to make the world a better place. In the process, they believed all disorderly or irrational thinking must be purged from our collective psyche, or else humans would be doomed to live in the dark ages forever. The main problem with this way of thinking was the marginalized at the periphery of European society were most often targeted as "irrational" and "disorderly"; and therefore, in the most need of being remade in the image of those at the centres of power, and "Progress." Thus, a contradiction arose: if the supposed direction of progress is inevitably towards greater freedom for everyone, then what if some resist the new way? What shall be done with them? Postmodernists, among others, have criticized the totalizing narrative of modernity[2] for the hypocrisy of forcing everyone into a single totalizing narrative, while at the same time claiming to do it all for the sake of greater "freedom."

[1] Historian J. B. Bury wrote one of the most thorough accounts of the rise of this doctrine in 1920: *The Idea of Progress: An Inquiry into Its Origin and Growth*, https://www.gutenberg.org/files/4557/4557-h/4557-h.htm.

[2] See the works of Emmanuel Levinas.

The doctrine of progress, in many variants, tells us that specific technologies have an inherently liberating quality to them, and are therefore both the product of greater freedom, and, at the same time, produce greater freedom. Yet while the advent of such technologies as the automobile has given rise to increased choice of travel options for the masses, that increased freedom came with a price. Vehicles powered by the internal combustion engine can just as easily be used for violent military conquest: battle tanks, Dreadnoughts, submarines. Apart from limits inherent in the design of the device itself, no technology can control the ways human beings use it.

Knowing this, we do well to exercise caution whenever we hear that greater freedom of choice is the main goal of using a specific technology: in this case the drugs used in medical assistance in dying (MAiD). That doctors should be very wary around this sort of technology was one of the reasons behind the development of the Hippocratic Oath, since doctors in ancient Greece were already aware that certain drugs could be used to hasten death. Hippocrates taught that this knowledge should never be used by a doctor for the purpose of taking life.

Mental Illness as a Cause for MAiD?

Mental illness following the COVID-19 pandemic has been increasingly prominent in the public eye. Social problems connected to it appear to be accelerating. Many people are falling between the cracks of our social safety net: recently in St. Catharines, Ontario, a man wanted to request MAiD, not because he wanted to die, but because with his pain, disability, and depression he feared impending homelessness more than death.[3]

We were shocked to discover, last December, that at least five members of Canada's military have been offered MAiD when all they were inquiring about was assistance to live. A former Paralympian and veteran asked for assistance getting a wheelchair ramp for her house, when she was offered the equipment for MAiD.[4] Four other veterans were offered the same. This is shocking to hear. The Veteran's Affairs staffer who made these insensitive suggestions was dismissed. But if pressure caused by financial constraints continue it is likely that we will hear of more such cases in the future.

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[3] "Ontario Man Applying for Medically-Assisted Death as Alternative to Being Homeless," *CityNews*, October 14, 2022, https://ottawa.citynews.ca/2022/10/14/ontario-man-applying-for-medically-assisted-death-as-alternative-to-being-homeless-5953116/.

[4] Retired Cpl. Christine Gauthier, interviewed in Tom Yun, "Paralympian Trying to Get Wheelchair Ramp Says Veterans Affairs Employee Offered Her Assisted Dying," *CTV National News*, December 2, 2022, https://www.ctvnews.ca/politics/paralympian-trying-to-get-wheelchair-ramp-says-veterans-affairs-employee-offered-her-assisted-dying-1.6179325.

The pressure brought about by the chronic underfunding of our health-care system and lack of social housing must now be addressed, because it has moral consequences, both for governments, and for us as a society.

As pressing as these questions are for society, however, our task here is to address what unique gifts and calling the church has, to live out our baptismal vows amid these realities, first with a reflection on the fifth baptismal vow, particularly as that vow's intended purpose may intersect with concerns surrounding MAiD for the mentally ill.

Reflection on Our Fifth Baptismal Promise

Our *Book of Alternative Services* (BAS) includes in the baptismal vows a fifth promise made by all the baptized and those speaking for infants being baptized; the vow to "strive for justice and peace among all people, and to respect the dignity of every human being."[5] This vow was written into the set of promises making up one part of the baptismal covenant, the 1985 BAS making more explicit what had long been implicit in the Book of Common Prayer.[6] This promise was added to the liturgy as a result of several decades of theological consultations and ecumenical discussions, stemming from a broad agreement that striving for social justice is inherently a part of what the Scriptures call us to. Social justice was so clearly a major priority for the prophets of the Old Testament that no Old Testament scholar would disagree. The baptized believe the Bible points to Jesus as the fulfillment of all that the Law and the prophets desired, who taught His church to pray and work for God's will to be done "on earth as it is in heaven."

Because the baptized are to alleviate suffering, our church's 2016 report on MAiD titled *In Sure and Certain Hope* has a helpful section on suffering.[7] There, Walter Brueggemann, one of the world's leading Old Testament scholars, commenting on the discourses of "Job's comforters" says: "Yahweh does not want ideology to crush experience. And that leaves only two parties to draw the most authentic of conclusions. Yahweh and Job, face to face."[8] A truly profound insight, from which we should learn much.

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[5] "The Celebration of Baptism," *The Book of Alternative Services* (Toronto: Anglican Book Centre, 1985), 159; also in the Great Vigil of Easter, "The Renewal of Baptismal Vows," 332.

[6] The Book of Common Prayer, under the heading "The Promises," had only three. It is held that the third promise "to keep God's holy will and commandments, and to walk in the same all the days of your life" states, implicitly, what the BAS Baptismal Covenant makes more explicit in six vows. The Book of Common Prayer (Toronto: Anglican Book Centre, 1962), 535.

[7] Faith, Worship and Ministry Task Force on Physician Assisted Dying, *In Sure and Certain Hope: Resources to Assist Pastoral and Theological Approaches to Physician Assisted Dying* (Toronto: The General Synod of The Anglican Church of Canada, 2016), 8.

[8] Walter Brueggemann, *Theology of the Old Testament: Testimony, Dispute, Advocacy* (Minneapolis: Fortress Press, 2012), 391. As cited in Faith, Worship and Ministry Task Force, *In Sure and Certain Hope*.

Yet, in a more recent (2021) piece, Brueggemann lists five "signs of the kairos."[9] His list is familiar, but MAiD is not on it. Most likely because it is much harder to see how a life-ending technology is part of the kairos moment than life-giving movements like those for social justice and for the integrity of God's Creation. In fact, Brueggemann's work elsewhere suggests that such a technology, when given without restriction to all who suffer from depression, would become part of the apparatus of the culture of death, which Brueggemann eloquently reminds us, the Bible's testimony condemns.

Medical ethicist Stanley Hauerwas, also writing on the book of Job, refers to the same dynamic, quotes Brueggemann, and comes to similar conclusions, though he prefers to use the word "explanations" rather than "ideology."[10] I have come to prefer that choice myself. The term "ideology," once a creative and helpful tool for communication, has become in recent decades a word that too often carries with it freight it was never designed to handle. When thinkers on one side of the current political divide(s) use the term "ideology" as a kind of shorthand to describe the thinking of all their opponents on the other side of that divide, then it (perhaps inadvertently) serves only to shut down true debate and silence one's opponents. That, ironically, ends up doing precisely what the process of critical thinking and "progress" was supposed to put an end to, the emotivism that silences all serious dialogue, and leaves everyone deeper and deeper down their own "rabbit holes," where no one can speak to anyone who disagrees with them.

If then, our "no" to "ideology" comes to be seen as a sword that cuts in only one direction, then its usefulness and true purpose has been reduced by at least half. For certainly "ideology" as a concatenation of ideas serving the interests of a particular class can be a sword that cuts both from the "right" and from the "left." For this reason, we may be better off to use Hauerwas's choice of words when discussing the suffering of Job: "explanations." God, when speaking out of the whirlwind, condemns all the explanations of Job's comforters, saying: "none of them has spoken rightly, as my servant Job has."

"To strive for justice and peace among all people …"

All of this becomes relevant to the discussion of MAiD in the light of the two phrases of the fifth baptismal promise. The social justice that the

[9] Walter Brueggemann, "Borne Away," Church Anew, February 23, 2021, https://churchanew.org/brueggemann/borne-away.

[10] Stanley Hauerwas, *God, Medicine, and Suffering* (Grand Rapids, MI: Wm. B. Eerdmans, 1990), 49.

prophets desired so strongly, and for which they paid such a high price, is foremost in the baptismal promise. If we seek justice for the poor and the marginalized, then where is this justice in the context of a health-care system that is chronically underfunded, with mental health care being seen as financially out of reach by many of those who need it the most? When a person sees no hope in life, and MAiD is suggested to them because other treatments are costly, then how is that justice being served?

Hauerwas offers helpful insight from the early church:

> For the early Christians, suffering and evil … did not have to be "explained." Rather, what was required was the means to go on even if the evil could not be "explained." Indeed, it was crucial that such suffering or evil not be "explained."—that is, it was important not to provide a theoretical account of why such evil needed to be in order that certain good results occur, since such an explanation would undercut the necessity of the community capable of absorbing the suffering.[11]

This brings us to the absolute value of the church; for the church thus becomes, in mysterious ways, the "answer" to the problem of suffering, though it is not an intellectual answer to a theoretical puzzle, but an active answer to personal problems. Rev. John Matheson was chaplain at Montreal's Douglas Hospital for several decades and is a United Church minister. His work speaks of the power of church as community. He says: "We have asked people: 'What's missing now that you're not in church?' The answer that comes most often is: 'the sense of community.'" And he adds: "When people say: 'my church is going to pray for you' we expect something to happen."[12]

"… and to respect the dignity of every human being"

The second part of the promise urges us to respect the dignity of every human being. Of course, dignity has many layers and contexts of meaning, more and more in need every day. Whenever we address people with whom we disagree, we must remind ourselves to respond in such a way as to respect and honour the dignity of the other, no matter how strongly we may disagree. The tone of discourse in society has descended to new lows, but this is a call to us to renew our commitment to see each other person as one created in God's image, and therefore

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[11] Hauerwas, *God, Medicine, and Suffering,* 49.

[12] Rev. John Matheson, personal interview by phone, July 1, 2023.

worthy of the respect that goes with being human. For years in my youth, I worked as an orderly in hospitals in three Canadian cities. It was often said that "dignity is what you lose when you get admitted." We would love to retain our dignity, but hospitalization will usually mean the loss of it, at least for a while. Yet when we suffer a life-threatening illness, this threatens us more than loss of dignity. Because you don't have dignity if you don't have life.

The Scriptures do not promise us control over our lives, or autonomy. This is not to say that suffering must always be seen as salvific, as some versions of Catholic theology have taught. But neither does it mean that all suffering is meaningless, ultimately.

The meaning of the word "dignity," then, takes on a different spin when it is applied in the context of MAiD, as its use in the phrase "dying with dignity," also a name taken up by a lobbying group, suggests. Is it true that the "messy stuff" that causes the loss of dignity at the end of life can be avoided through MAiD for the mentally ill? We may want to ask the patient whether they see their own life as a "mess" that could be made "tidy" through a doctor's injection? Death is always messy, in one way or another, but it is part of the process of life.

As we reflect on the meaning of this baptismal promise, we must understand it as a unified whole: for the intention of the first part of the pledge is clearly social, as is described by the words "all people." The phrase "dignity of every human being" allows for individual expression, but it cannot be seen in such a way as to contradict or undermine the intention of the first part of the vow. For if it did that, it would also undermine any sense of dignity a person should have as an individual in relation to any social group.

A Pastoral Response

The implications for pastors if MAiD criteria are expanded to include mental illness are even more difficult than under the current law. At ordination priests receive their "mandate for ministry," an irrevocable charge to "care for the sick and dying, old and young alike." Everything in the calling and training of a priest is geared towards sustaining life, helping those who are depressed, giving them hope and reason for living, finding creative ways to solve the problems that wear people down. This calling is to help people see reasons for continuing to live, to encourage the discouraged, giving them hope that God does indeed have a purpose for their life, a reason to live. We are a gospel people, a people of hope, and can never offer a counsel of despair.

When "care" means being a channel for God's hopefulness, then a dilemma emerges for priests asked to be present for a prayer service at a MAiD event, especially where death had not been imminent. To assist in an event that would have signified abandonment of care (until now) creates moral stress. Our nerve endings have grown and are trained to reach for the provision of hope, or practical help, e.g., housing support for those suffering from addiction, for which 16,000 wait in the city of Toronto alone.[13]

The pastoral calling is one that is also prophetic at times, as Brueggemann says, for the ministry of Jesus was focused on healing the sick, casting out demons, and speaking the good news. The casting out of "demons" is a part of our calling that we as Anglicans tend to avoid talking about, except for charismatics. Yet it is significant that much of modern psychiatry has taken up the very language of "driving out demons" to describe what is done in mental health therapy. Of course, what is meant by "demons" is very different in psychotherapy. In talk therapy, people are encouraged to deal with their "demons": those irrational fears and foibles that keep coming back to harm one, over and over. In my research on African traditional therapies, I found that where African traditional "psychotherapies" share a surprising convergence with the modern is: (1) they agree on the importance of dreams, and (2) both emphasize the importance of being with the patient, allowing them to tell their story, and asking questions about their social relations. This is also part of the pastoral calling.

It is tragic that anyone would request MAiD for financial reasons. Chilling in the present time of financial clawbacks, while greater and greater numbers are showing up at our church's food bank and drop-in centre in Tamworth, as they are across Canada.

In a December 2022 interview, psychiatric doctor John Maher said: "I had a patient who talked to me recently about MAiD who wants to die because of his belief no one will ever love him." Since the church is called to be a loving presence in the world, what does this say to our calling? Currently psychiatrists face a dilemma:

> There are cycles of illness. … Some of it's up and down. It might be years. And then there's a burst of illness and suffering that we

[13] In November 2022, *The Globe and Mail* reported: "Psychotherapy, a recommended treatment for most mental disorders, remains too expensive for many Canadians. In Toronto alone, an estimated 16,000 people are waiting for supportive housing for mental illness and addiction." Erin Anderssen, "Canada Will Soon Allow Medically Assisted Dying for Mental Illness. Has There Been Enough Time to Get It Right?," *The Globe and Mail*, November 11, 2022, https://www.theglobeandmail.com/canada/article-maid-canada-mental-health-law/.

then take care of, … you're assisting someone in the completion of their suicide. The doctor is the sanitized gun. … I'm not at all disagreeing that there are people who have an irremediable illness. What I defy you or any other person in the universe to prove to me is that it's this person in front of you.[14]

Pastors face similar dilemmas.

Returning to the book of Job, we note it was often read as a book that seeks to answer the problem of why humans suffer. But does it do that? Stanley Hauerwas says it refutes the whole idea that one can silence the sufferer with explanations.[15] Job's three friends started off well. When they first come to him after his disasters, they sit in silence for one week (Job 2:13). That is the right thing to do. Be with the one who suffers, and don't be afraid of silence, without judging them. But the friends just couldn't resist the temptation to start moralizing, so each in turn makes long speeches that try to explain Job's suffering to him; maybe he didn't serve the poor enough, maybe he had forgotten to worship God, maybe he this, maybe he that. None of these explanations helped Job, but only made his sufferings worse.

The gist of God's speech "from out of the whirlwind" is that no human can ultimately know the reasons why bad things happen to good people. Job can't, and ultimately his three friends can't either. It is their pretence that they *can* know that is so very wrong that in the end *they* are the ones who must repent, so that Job can pray for them. Which he does.

The hour of death is similarly unknowable. We read in Ecclesiastes:

> "Moreover, no one knows when their hour will come: As fish are caught in a cruel net, or birds are taken in a snare, so people are trapped by evil times that fall unexpectedly upon them."
> (Ecclesiastes 9:12 NIV)

In this message, we hear the Old Testament say what Jesus will also say whenever his disciples ask him questions about the times. They asked him: "Lord will you at this time restore the Kingdom to Israel?" He replies: "It is not for you to know the times and seasons which are appointed by my father" (Acts 1:7). He gives a similar answer when he is asked about the time of his second coming: "But about that day or hour no one knows, not even the angels in heaven, nor the Son, but only the Father"

[14] "The Death Debate: Why Some Welcome Canada's Move to Assisted Dying for Mental Illness and Others Fear It," *W5*, CTV, October 15, 2022, https://www.ctvnews.ca/w5/the-death-debate-why-some-welcome-canada-s-move-to-assisted-dying-for-mental-illness-and-others-fear-it-1.6109646.

[15] Hauerwas, *God, Medicine, and Suffering*, 49.

(Matthew 24:36). Jesus is saying there are certain things we cannot know, and in some of those cases it would not even be helpful to us if we did know.

Those in hospital chaplaincies who have spent far more time with the dying than I have report that it is not that common that anyone knows the actual time when someone else's death will occur.[16] But people want control, and the desire for control, or autonomy, is, according to many, the most common motivation behind the push to expand the criteria for which MAiD can be approved.

We need to ask the question: If society's unwillingness to pay for more adequate housing, and medical and psychiatric care has become the motivation that suggests MAiD to suffering individuals, then how much of the responsibility for that falls upon us as a society, rather than on the suffering individual, who must suffer from the abuse of so called "comforters" who can only recommend MAiD? But even more, it is a challenge to the church to discern its kairos moment. For those in anguish don't need someone offering a counsel of despair. What people want, usually, is some way to live, not to die, if life is offered.

In John 10:10 Jesus said: "The thief comes only to steal and kill and destroy. I came that they may have *life* and have it *abundantly.*" Jesus offers life! The church is to be the place where this good news is lived out and taught. May our lives be a cup of cold water to the thirsty, and our church be a community of care.

The Reverend Dr. Ian Ritchie *taught Bible in Nigeria (1980–85), and returned to Canada to do a PhD at McGill University, which he completed in 1993. He was Professor of Religion and Culture at Concord College, Winnipeg, Manitoba (1995–99). After moving back to Kingston, Ontario, in 2000, he was ordained in 2002, and has ministered at many churches in the Diocese of Ontario up to the present. He also has served as an adjunct professor at Queen's University School of Religion, and taught World Religions at St. Lawrence College. He served on the task force that produced* In Sure and Certain Hope *in 2016.*

[16] Phone interview with John Matheson, July 1, 2023. Head Chaplain at The Douglas Hospital (Montreal's English psychiatric hospital) for several decades, and an ordained United Church minister, he was present for at least one death per week for over thirty years. His wisdom and experience on this topic are exemplary. He says the desire to control both our lives and our death is at the heart of the matter. But it is beyond us to know. He worked very well in an interfaith context. To Christians he says: "If Jesus says to the disciples there are some things you cannot know" then who are we to presume? Just don't!" … "People who attempt to commit suicide often fail—it's easy to fail, and people make their life much worse for the rest of their lives. This explains why a person might want to use a more reliable method to end their life. But most people don't really want to die, most people want to live as long as possible, if certain things can be managed. The demand for MAiD has more to do with the desire to control life and death, more than people wanting death."

Questions for Reflection and Discussion

1. What does our fifth baptismal promise, "to strive for justice and peace among all people, and to respect the dignity of every human being" call us to remember, particularly where financial considerations are the main driver behind a MAiD decision?
2. If a pastor declines to preside at a MAiD death, would this constitute "abandonment"? see "References and Definitions" in *In Sure and Certain Hope*, page 25.
3. Are parish priests at less risk than hospital chaplains (on hospital salary) of moral dilemma, stress, and possible job loss if they are requested to be pastorally present at a MAiD death?

The Challenge of Choice: The Rhetoric of and Response to Medical Assistance in Dying in Canada

JESSE ZINK

One of the most beguiling words in the English language is "choice." I had this brought home for me shortly after the young Syrian refugee Alan Kurdi drowned when the boat he was on sunk in 2015. The picture of his body washed up on a beach was broadcast around the world. A few days after his death, several newspaper covers drew attention to the plight of the boy's distraught father, who was one of the few still living in his immediate family. As I looked at these headlines in a grocery store, I heard a woman next to me mutter to her teenage daughter: "It's not our fault. That father had a choice to get on that boat!" It made me wonder: when you are living in the middle of a civil war and want only for your children to be raised in safety and peace, what meaning does the word "choice" actually have? This woman and Alan Kurdi's father were equally free to choose not to get in a boat across the Aegean Sea but only one did. Why?

Some years later, I watched the movie *Sorry We Missed You*. It's set in the north of England with a focus on workers in the gig economy. The gig economy refers to those people who work jobs where they are not paid for the number of hours they work but the number of tasks—gigs—that they complete. The centrepiece of the movie is Ricky Turner and his family—Abbie, his wife, and his two children. Ricky has had some hard luck in life, especially since the 2008 financial crash, and has struggled to hold down a job. At the start of the movie, Ricky is interviewing with a no-nonsense supervisor named Maloney, who offers him a role as a delivery van driver. It is a role, not a job. Ricky has to

provide his own van, doesn't receive any benefits, doesn't receive minimum wage, and is paid only when he delivers packages. He is not an employee, but an independent contractor. Maloney presents this as a great improvement in life: "Remember," he tells Ricky, "everything you do in this role is your choice. What do you say? Master of your own destiny." In other words, if you choose to deliver more packages, you'll earn more money. If you choose to deliver fewer, you won't.

Without spoiling the movie, it's fair to say that this promise of choice is a false one. Ricky's choices are fundamentally constrained. First, he needs to provide the van, which requires selling his wife's car, which she needs for her own gig economy job as a home health-care worker. It then turns out that there are quite a lot of policies he needs to follow, including using a very expensive hand-held device to track packages. He can't bring others along in his own van, something he finds out when he brings his daughter along for a day to solve a child-care problem. By the end of the movie, when everything has fallen down around Ricky, his physical health is falling apart, his family life is at risk, and he's on the hook for several hundred pounds for a broken hand-held device, we still see him crawling into his van to deliver packages to pay off the debt he is in to the delivery company. It may be his choice to drive, but it's not an especially meaningful choice. There's nothing else for him to do but to continue to endanger his health and well-being.

The line from the woman looking at the newspapers—"he had a choice"—and the line from Maloney—"everything you do in this role is your own choice"—demonstrate just how powerful and evocative "choice" is in the English language. It describes an ideal to which many of us would, on the face of it, want to subscribe. People should be permitted to make their own choices—and then live with the consequences. Choice is closely related to another powerful word: freedom. So long as a person's choices don't harm or impair someone else's ability to make their own choices, then people should have the freedom to do what they choose.

Choice and freedom are also powerfully related to the economic structures that dominate the world in this first part of the twenty-first century. Often loosely described as neo-liberal capitalism, these economic structures claim to empower individuals to make their own choices even as they also occlude the power of major corporations to shape those choices. Individual freedom, choice, and responsibility are held up as cardinal virtues. Those who are successful are deemed to have made the right choices, while for those who are not, it is easy to blame them for making the wrong choices. The widespread and growing

disenchantment with global economic structures that is clear in so many parts of the world is a demonstration, in part, of the dissatisfaction with the rhetoric of choice and freedom that lies at its core.

Choice is misleading and ultimately unhelpful because it puts the onus of decision and responsibility on the individual and turns the focus away from the broader structural factors that condition the choice. The examples with which I began this essay illustrate the point. If we focus only on the choice of people who get into unseaworthy boats to make a dangerous crossing into the European Union, we fail to recognize the violence and danger which they are fleeing, the many causes of the civil war that creates that violence, and the outdated and unjust international legal system for migrants that lie behind that choice. If we focus only on the choice of a gig economy worker to spend the vast majority of his waking hours delivering packages, we fail to recognize the inadequate education systems, the lack of opportunity, and the unequal burden of a financial crisis that led to getting behind the wheel of that van. Choice matters, but so too does the structure and context in which that choice is made. That is what neo-liberal capitalism would have us ignore.

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In the Christian tradition, choice has an interesting and not always clear place. Jesus himself rarely used the word. On one occasion, he did tell a leper who asked to be healed, "I do choose," and healed him (Mark 1:41), but often Jesus's healing was not a result of an explicit or direct choice he made but a function of who he was and his ministry in the world. Rather than choice, Jesus often highlighted the importance of being in line with God's action in the world and then modelled precisely this in his own life. As he told the Pharisee Nicodemus, "The wind blows where it chooses, and you hear the sound of it, but you do not know where it comes from or where it goes. So it is with everyone who is born of the Spirit" (John 3:8). Part of the reason Nicodemus is so confused by this is it challenges the sense that he is control, that the outcomes in his life are determined by his choice. Instead Jesus is pointing him to a faith that lies beyond choice. Given the frailty of humanity, a faith that lies beyond our choice is good news. God acts out of love towards us, regardless of what we do or don't do. This is what St. Paul is writing about when he says, "I do not understand my own actions. For I do not do what I want, but I do the very thing I hate. … For I do not do the good I want, but the evil I do not want is what I do" (Romans 7:15, 19). Paul doesn't directly use the word "choice" here,

but the implication is clear: what he chooses doesn't get him to the life in Christ he desires. God's action does.

Perhaps the clearest Biblical statement about choice comes from Moses, in some of his final words shortly before he dies and the people he has led out of slavery in Egypt cross into the Promised Land. Moses recalls for them the law God has given them and in the great summation of his work says:

> See, I have set before you today life and prosperity, death and adversity. If you obey the commandments of the Lord your God that I am commanding you today … then you shall live and become numerous, and the Lord your God will bless you in the land you are entering to possess. But if your heart turns away and you do not hear … you shall not live long in the land that you are crossing the Jordan to enter and possess. I call heaven and earth to witness against you today that I have set before you life and death, blessings and curses. Choose life so that you and your descendants may live. (Deuteronomy 30:15–19)

In the face of such an offer, who could refuse? Why wouldn't God's people choose life in this situation? The witness of the Hebrew Scriptures is, however, somewhat different. God's people struggle to "choose" life. Eventually, God will put the matter of covenant beyond their choice. God repeats on several occasions some variation of these words from Jeremiah: "You shall be my people, and I will be your God" (Jeremiah 30:22)—whether you like it or not, seems to be unstated premise.

With this reading of Scripture in mind, I approach with suspicion any use of the word "choice." "Choice" conceals too much and steers us too far away from the witness of the Christian faith which claims that we live in a world that is created by God, who loves this creation, makes covenant with it, redeems it, sustains it, and will consummate all things at the last day—with little regard for our, or anyone's, choice in the matter. We should rightly be suspicious, I think, when conversations about ameliorating the impact of climate change turn on the importance of individual action and choice, such as the widespread emphasis on reducing one's so-called "carbon footprint" (a concept developed by fossil fuel companies). Rather, we should speak about and campaign for the necessary structural changes that will create a world in which our actions are more in line with stewardship of creation. Likewise, we should be equally suspicious when conversations about drug addiction turn on individual responsibility and choice, without focusing on the structural

conditions—profit-driven drug companies and inadequate medical care, for instance—that lead to the "choice" to become addicted to these drugs. And, I believe, we should be suspicious of the language of choice when it comes to medical assistance in dying, or MAiD.

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I will not rehearse all of the background to MAiD in Canada. Suffice to say that in response to court opinions and apparently in line with public opinion, starting in 2016 the federal government of Canada has legalized the right of people in certain circumstances to end their own lives and for medically trained professionals to assist in this process. (The process has unfolded in a slightly different fashion in Quebec but I will leave that aside for the purposes of this essay.) The initial legislation indicated MAiD was only available to those for whom death was "reasonably foreseeable," though this was later amended to include those who did not fall into this category. At the time of this writing, further expansions of this protocol are under consideration, including for minors, for those who have mental illness, and for MAiD as part of an advance medical directive. It is these proposed expansions and a general sense of uneasiness about the availability of MAiD in Canada that are the occasion for this collection of essays. Before turning to applying the ideas of choice to MAiD, I want to highlight several important points.

First, from the perspective of Christian ministry, the end of life—however it comes about—is a pastoral moment. Theology bears on pastoral ministry but broad claims like "let's be suspicious of choice" need to be carefully considered and nuanced in the pastoral moment. Second, the choice involved in MAiD is deeply personal: it is about one's own life, and the decision is meant to be made entirely of one's own volition. True, the person's death may cause grief for friends and family who mourn their loss, but the primary impact of this choice, perhaps more than any other choice, is on the individual who made it and no one else. That alone may give reason to temper the suspicion that I believe should naturally attend discussions of choice. Third, at least in its initial stages, the decision to legalize MAiD in Canada has been broadly popular, endorsed by and mandated by various branches of government, and attended by safeguards. Popularity does not mean it is the right decision but due regard for the opinion of others would suggest the need to take seriously the claims of those who support MAiD. Fourth, the provision of health care is full of situations in which the only choice is between bad options, and the proper action may be

to seek the least bad choice. Indeed, proponents of MAiD have often suggested precisely this in relation to MAiD, that ending a life now rather than continuing in suffering is the least bad outcome.

MAiD is rooted in the idea of choice. Indeed, Kay Carter, the woman at the centre of the 2015 Supreme Court of Canada case that led to the legalization of MAiD, wrote to her family before she died, "I have chosen to die with dignity, tomorrow. I and I alone made the choice to pursue this path." The logic is clear: if someone chooses to die and that choice is genuinely of their own free will—and much in the legislation is designed to ensure that it is—then the state should not forbid that action. If choice is the highest good, then MAiD is a natural result. The expansion of MAiD, however, has made it clear that some people are "choosing" to die in situations that are very worrisome: disabled people whose income is not sufficient to afford housing any longer, or who fear being a burden on their family, or who cannot find the proper health care for their ailments. These are not terminal conditions that cause irremediable suffering. And yet MAiD is now open to people in these situations and some are choosing to die in this way.

MAiD is the logical public policy result in a neo-liberal society that elevates choice to be the highest criterion of value. The expansion of MAiD to more and more people, particularly those in vulnerable positions, is the logical result of that policy in such a society. If assisted dying is the best that we can do, then it is, I believe, an indictment on ourselves and the society in which we live. The Christian tradition tells us that some things are and should be beyond the realm of choice: life is one of these and so too, I believe, is death. None of us chooses the nature or manner of our birth, the when, where, how, or to whom we are born. Neither should death be the result of our choice. When we make death a choice we will inevitably end up in the position—indeed, we are already there—in which some people will need to justify why they should stay alive. Although the plaintiffs in the MAiD lawsuits tended to be from more privileged positions, it will invariably be those in marginalized positions in society who will bear this burden most acutely. Moreover, the nature of the rhetoric of choice is such that by focusing on choice we will place even less focus than we already do on the structural conditions that led to these apparent decisions.

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I have spent a considerable portion of this essay outlining and challenging the rhetoric of choice because I believe its beguiling nature has given it a unique power in our society today. But the question

remains: if not choice, then what? I want to conclude by suggesting another word that describes Jesus's ministry and gives us guidance when thinking about end-of-life ministry when MAiD is an option.

Recall Moses' concluding words in Deuteronomy: "I have set before you life and death. Therefore choose life." When choice—for all its problems—is deliberately and explicitly invoked, the command is clear: choose life. I fail to see how in this context MAiD can be the result. But this answer, no matter how Biblical, still leaves us in the problematic terrain of choice. In the context of someone considering MAiD, it also leaves a person still suffering and with little apparent recourse apart from an exhortatory pat on the head—choose life! It is easy to see that this may not be the most appropriate pastoral response.

I return, then, to Jesus. Instead of choice, a word I associate with Jesus is identify. Jesus identifies himself with the God whom he called Father—"I and the Father are one," he says directly (John 10:30). Elsewhere he adds: "the Son can do nothing on his own, but only what he sees the Father doing; for whatever the Father does, the Son does likewise" (John 5:19). This God, the Scriptural tradition tells us, is the God who is gracious and merciful, slow to anger and abounding in steadfast love. God is faithful in all God's words and gracious in all God's deeds. In other words, when God sets before God's people life and death, prosperity and adversity, God is embodying the fullness of life and the abundance of prosperity that is on one side of the equation. This is what Jesus identified himself with. In the same way that God works for life and prosperity, Jesus did too. What I think is noteworthy is that Jesus did not choose to do one thing over another but let his life be wholly identified with God. Jesus let his being become an extension of God's being in the world. In that way, the same graciousness and faithfulness and compassion of God worked through him. Identifying fully with God, Jesus also identified fully with the suffering and the pain of the people he encountered, teaching, preaching, healing, casting out, and making new, and in so doing proclaiming that the kingdom had come near to them. Again, this identification with the suffering of the world is not a choice but a natural extension of Jesus's very being, a being that is line with—identified with—the gracious being of God.

This idea of identification helps me move beyond the impoverished logic of choice. When Christians are baptized, we are adopted into the same position that Jesus had in relationship to God. Our life as Christians is a working out of this baptism, of coming to identify ourselves with that same faithfulness and compassion of God and letting that graciousness work itself through us and into the world around us.

This means that our efforts to walk in the way of Jesus are not the result of conscious choice—I don't wake up every morning and say to myself that today is a day when I'll choose to follow Jesus—but rather the result of a decision to seek to align ourselves with Jesus's identity. Speaking for myself, I frequently fail. But by setting aside choice, I find myself instead focused on being and asking myself how my being can be an extension of the grace of God in the world. It is not about what I choose to do but who I am and what that being reflects to the world.

What does this look like for people who are suffering intolerably and approaching the end of their life? In large measure, this will be situational and determined by the particularities of each moment. But two broad suggestions might be made. The first is simply to allow oneself to be with and to share the suffering. Jesus himself provides the model. In his incarnation, he chose to walk alongside the pain and suffering of humanity and ultimately to take on this pain himself on the cross. The theologian Sam Well has described this as "being with" and argues that it is the dominant form of Jesus's ministry.[1] It is, however, immensely challenging and difficult. In my ministry, I have found myself alongside people who are close to death and felt hopelessly overwhelmed and insignificant. Nothing I could do in those moments would prevent the impending death. Yet I could hope that this encounter could be a moment in which God's grace is made known and that the moment testified to the truth that the life God gives transcends this mortal life. Those suffering at the end of life need to know the fullness of the presence of the Christian community alongside them. This will mean challenging taboos in our society about suffering and death and facing these realities honestly. MAiD is one part of the broader medicalization of death that has taken place in the Western world in the last generation, which has tended to occlude these realities. Seeking to identify with Jesus will also mean being with and remaining with those who have chosen MAiD to end their life. It is possible and pastorally appropriate for Christians to both oppose MAiD while also accompanying those who have chosen MAiD to the point of their death.

The second and closely related suggestion is the alleviation of suffering. While Jesus suffered on the cross, he did not condone suffering and did not wish it for his followers, though he could see that it was coming. Jesus alleviated the suffering of those he encountered. Such miraculous means may seem beyond our ability, but palliative care remains an important calling for Christians. Christians should be at the

[1] Samuel Wells, *A Nazareth Manifesto: Being with God* (London: Wiley-Blackwell, 2015).

forefront of movements to support hospices and other forms of palliation. This means particularly calling attention to the inequitable palliative care system in Canada in which rural and Indigenous people in particular are significantly disadvantaged. This country needs a more just palliative care system, and Christians should be at the forefront of advocating for and building such a system.

Part of the challenge of an essay of this nature is that I am writing about MAiD from the perspective of one who does not need it. I am healthy and well. I can propound principles that can seem untethered to actual realities, such as the true depths of suffering and pain which lead people to consider MAiD. Nonetheless, the Christian tradition is one that engages directly and concretely with the reality of pain and suffering in the world through the fact of an incarnate messiah who wholly identified himself with the graciousness of God and wholly identified himself with the suffering of the world. The result of this dual identification was his death on the cross, an act far beyond his choice. MAiD, as it is presently practised in Canada, demonstrates a capitulation of our social values to a debased logic of choice that has little place in the Christian tradition. As part of our pastoral response to the reality of MAiD in this country, Christians are, I believe, called equally to seek to identify ourselves with the graciousness of God and be with those who are suffering and see in that act a testimony to the strange and wonderful grace of God.

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Questions for Reflection and Discussion

1. This chapter understands "choice" to be a dominant feature of the value system of our time. Where do you see the language of "choice" used? Is it generally helpful or unhelpful? What does it reveal? What does it conceal?
2. This chapter identifies "identify" as an alternative word to "choice" for framing Christian witness. What do you make of this alternative? What other alternatives might be suitable?

O Death, Where Is Your Sting? The Pendeli Statement on Medically Assisted Dying

CHRISTOPHER BRITTAIN

Following the destruction of the second temple in Jerusalem by the Romans in 70 CE, the last remaining Jewish armed resistance (967 men, women, and children) fled to the hilltop fortress of Masada in the Judean desert. Following a long siege, as the Roman army prepared to break through the fortress walls, the rebels decided to commit suicide rather than subject themselves to the fury of the Roman conquerors. The scholar Josephus, who accompanied the army, described what the Romans found as they entered the fortress: they "could do [no] other than wonder at the courage of their [the rebels] resolution and the immovable contempt of death, which so great a number of them had shown."[1]

This is the only written record of this event. Jewish Rabbinic literature ignores the story of Masada. The Talmudic and Midrashic sources offer no mention of this act of suicide during the uprising against the Romans. In fact, there is no mention of it in Jewish religious literature for nearly two thousand years.[2] While this absence in the tradition has led some scholars to question whether the event really happened, most explain the avoidance of the topic in Jewish writing as the result of a deep discomfort with any acceptance of suicide. It was only in 1948, when the slogan "Masada shall not fall again" rose to prominence, that this Jewish resistance against the Romans became symbolic of the modern state of Israel.[3]

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[1] Josephus, *The Jewish Wars*, book 7, chapter 9, trans. William Whiston (Peabody, MA: Hendrickson, 1987), https://www.pbs.org/wgbh/pages/frontline/shows/religion/maps/primary/josephusmasada.html.

[2] Amir Mashiach, "The Ethos of Masada in Halakhic Literature," *The Review of Rabbinic Judaism* 19 (2016): 54–77.

[3] Jodi Magness, *Masada: From Jewish Revolt to Modern Myth* (Princeton: Princeton University Press, 2019).

Many religious traditions and communities adopt a similar silence about questions of self-inflicted death or "suicide."[4] Such discomfort in response to the topic is understandable, given the various tragic forms of suffering that sometimes give rise to suicide, or the agony of those whose loved ones have taken their own lives. Moreover, the terrible legacy of state-sponsored euthanasia programs that targeted people with disabilities is reason to remain vigilant against "assisted death" practices that exploit or dehumanize marginalized and vulnerable peoples.[5] Finally, the theological resistance against failures to honour and appreciate the gift of life that God has bestowed upon humanity is a deep spiritual reason to be uncomfortable over any consideration of self-inflicted death.

Despite these important considerations, this essay supports the legalization of some forms of assisted dying in Canada. While I am by no means "comfortable" with or an "advocate" for the practice, in some circumstances, I think assisting someone to die can be an act of Christian solidarity with one's neighbour, and a witness to the Christian conviction that death is not something to be feared and resisted at all costs. In what follows, I will discuss the concerns surrounding medically assisted dying and how they relate to the Agreed Statement of the International Commission for Anglican-Orthodox Theological Dialogue, *Dying Well, Living Well: Our Sure and Certain Hope* (The Pendeli Statement).[6] Prior to turning to the Pendeli Statement itself, however, it is instructive to first turn to a vigorous non-religious critic of assisted dying.

I. Houellebecq's 'Thought Experiments' against Assisted Dying

Amid debates in Europe over the legalization of assisted dying (in France and Portugal in particular), the most vivid critic I have encountered against the practice is the French novelist Michel Houellebecq. With sharp wit and caustic style, Houellebecq marshals an aggressive moral critique against legalizing assisted death. He writes, "We [Europeans] are demonstrating

[4] Alexander Murray, *Suicide in the Middle Ages*, vol. II, *The Curse on Self-Murder* (Oxford and New York: Oxford University Press, 2000); M. Therese Lysaught and Joseph J. Kotva, Jr., eds., *On Moral Medicine: Theological Perspectives on Medical Ethics*, 3rd ed. (Grand Rapids, MI: William B. Eerdmans, 2012), chapters 21–23.

[5] Eugenics programs are frequently associated exclusively with National Socialism in Germany, without recognition of their past prominence in North American policy debates. See Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885–1945* (Toronto: University of Toronto Press, 2014); Amy Laura Hall, *Conceiving Parenthood: American Protestantism and the Spirit of Reproduction* (Grand Rapids, MI: William B. Eerdmans, 2007).

[6] *Dying Well, Living Well: Our Sure and Certain Hope* [The Pendeli Statement] (International Commission for Anglican-Orthodox Theological Dialogue, 2023), https://www.anglicancommunion.org/media/493487/Dying-Well-Living-Well-final-text_ecumenical-orthodox_0123.pdf.

once again our feeble respect for individual liberty and an unhealthy appetite for micromanagement—a state of affairs we deceptively call welfare but is more accurately described as servitude."[7] Lest his audience not grasp what he really thinks, Houellebecq adds, "This mixture of extreme infantilization … and a petulant desire for 'ultimate liberty' is a combination that, quite frankly, disgusts me."

Houellebecq brushes aside an argument often made in defence of assisted dying—that it might relieve a dying person of unbearable pain—by generically suggesting that morphine is sufficient treatment. The main moral authority he invokes is the ancient Greek writer Hippocrates, whose words new doctors often quote to this day as a vocational oath: "Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course." This principle, Houellebecq argues, represents a core commitment to uphold all forms of human life and is central to any "civilized society."

Houellebecq supports this position with reference to what he calls "thought experiments." In one such exercise, he imagines he possesses a vial of pentobarbital, a painless, lethal poison. He then asks what he should do if a friend who is suffering asks him for the poison. Giving it to him, he suggests, might enhance the friend's "individual liberty," but "I believe that the purchase of poison for people with a history of mood swings, like me, should be discouraged." Subsequently, he asks, "How would I feel if my friend decided … to take the dose I had given him?"

Notice what is happening in this "experiment" and, equally significant, what isn't happening. First, Houellebecq makes a basic assumption about this friend's state of mind—he "has a history of mood swings, *like me*" [emphasis added]. This suggests that this imaginative exercise is telling the reader more about Houellebecq himself than about the condition of all people who may ask for medical assistance to die. Such a request, he presumes, is nothing but a "mood swing"; it will pass, given time.

Moreover, what horrifies Houellebecq in this example is how *he* will feel if his friend decides to end his life. As such, the discussion remains within the parameters of Houellebecq's own experience and priorities. He adds, "morphine has been enough to relieve my pain." While I am glad to know he has experienced such relief, has he considered that his own experience doesn't necessary fully define that of others? Moreover, one might ask, what is it like for some people to exist long term on

[7] Michel Houellebecq, "The European Way to Die," trans. Robyn Creswell, *Harper's Magazine*, February 2023, https://harpers.org/archive/2023/02/the-european-way-to-die-euthanasia-assisted-suicide-michel-houellebecq/.

morphine (or other powerful opioids)?[8] Can such a form of existence always be described as "living"? What is left out of Houellebecq's critique is any direct engagement with people who aren't merely having a bad mood swing or going through a difficult bout of depression, but those who are critically ill with a debilitating disease and who, after deliberation and consultation with others, continue to wish to bring an end to their agony rather than endure it until their body finally shuts down completely.

Instead of confronting such concrete and tangible realities, Houellebecq reduces the supporters of assisted dying to bureaucratic or entrepreneurial buffoons. He writes, "Dignity has become a meaningless word, a joke in poor taste" and "If you plan on going into the assisted-suicide business, I wouldn't recommend Switzerland. … it's a fairly crowded market." By the end of his essay, he equates medically assisted dying with nightmare scenarios from science fiction, in which, "old people are given regular competency tests that they must pass in order to avoid being put out of their misery."

Although there are indeed potential abuses of legalized assisted dying, Houellebecq's tone at this point is not moral argument but hyperbole. Moreover, his discussion is not an engagement with people of differing views, but rather the construction of stereotypes and fear-mongering. While I respect the moral intensity Houellebecq articulates out of concern to guard against the misuse of assisted dying, I am not convinced that permitting the practice under certain conditions will result in the abuses he rightly criticizes. Moreover, I think that the voices of people suffering with terminal and painful conditions deserved to be at least listened to with greater attention and seriousness that Houellebecq's tone allows for.

II. Dying Well, Living Well: Our Sure and Certain Hope (The Pendeli Statement)

I summarize Houellebecq's attitude toward assisted dying because I think it illustrates some of the weaknesses of the Pendeli Statement, produced by the International Commission for Anglican-Orthodox Theological Dialogue. This includes reducing the motivations for the practice to bureaucratization and profit, and contrasting the practice with an idealized vision for public health care that remains elusive in contemporary society. Both weaknesses, I argue, are the result of failing to attend to any concrete situations in which mature adults, in

[8] P. Daeninck B. Gagnon, R. Gallagher, J. D. Henderson, Y. Shir, C. Zimmermann, and B. Lapointe, "Canadian Recommendations for the Management of Breakthrough Cancer Pain," *Current Oncology* 23, no. 2 (April 2016): 96–108.

consultation with others, have arrived at the considered decision that medically assisted death is preferable to waiting for a chronic and painful illness to fully run its course.

Prior to taking up these points, a few clarifications are in order. First, it is noteworthy that I am in agreement with many of the theological affirmations made in the Pendeli Statement, such as those about death and dying (e.g., paragraphs 1, 16, 29, 31, 32), the saving work of Christ (e.g., 17, 18, 19), the nature of human beings as vulnerable and interrelated creatures (e.g., 26, 27), and the ways in which both Anglican and Orthodox spiritual traditions help train people to face hardship and suffering (e.g., 27). My argument is thus not with the general theological principles articulated in the document, but rather with how these are applied to the question of medically assisted dying. Second, I want to be clear that I am defending *legal access* to medically assisted dying—I am not advocating that Christians (or anyone else) *should* choose such an option. Like the authors of the Pendeli Statement, I think there are many other responses to suffering and impeding death that are preferable to assisted dying. However, I acknowledge that, in some circumstances, the choice of assisted dying may be both ethically defensible and spiritually faithful. Moreover, I do not believe that The Anglican Church of Canada should ultimately have the power to make this decision on behalf of informed adults. With these clarifications in mind, I turn to some specific points in response to the Pendeli Statement.

II.i A Polemical Attitude Towards the Practice of Assisted Dying

From the outset of the document, the authors of the Pendeli Statement do not take arguments in defence of medically assisted dying seriously. In the introductory paragraph (p. 2), the tone is immediately antagonist and cynical towards the practice, characterizing it as only being "supposed[ly]" in the interests of "compassion," while implying that the true motivations are rather more sinister. On the next page (p. 3, para. 4), the term "assisted dying" is referred to as a "euphemism," again implying that supporters of the practice are hiding their true motives from public debate. The tone, in other words, is not one of open debate, or in the spirit of Christian hospitality and charity; rather, this is a polemical rhetorical stance that stigmatizes from the outset those who disagree with the position being advocated.

This dynamic continues later in the statement when it alludes to motivations for medically assisted dying "that are primarily based on financial, technical, bureaucratic or legislative expediency" (p. 16, para. 41). Granted, the authors don't argue that all supporters of the practice are always motivated by such agendas; but neither do they seriously consider

any alternative arguments in defence of the practice. Instead, they caution that the idea that assisted dying can be in the service of "quality of life" is "sometimes" merely driven by economic considerations (p. 16, para. 39). If one grants that point, however, does that not also invite the possibility that "sometimes" supporters of the practice have different and more noble convictions? What these might be, however, is left unexplored, leaving the impression that the authors do not think there are really any legitimate motivations in support of assisted dying: "The ethical and social consequences of economic and legal thinking alone … are perilous, leading to a purely instrumentalist evaluation of human life" (p. 16, para. 41). The perspective of the authors is consistent and clear: "The classic triad of temptations: money (greed and financial concerns), power (bureaucratic expediency), and status (professionalization of life and death …, commodification) are ever present" (p. 27, para 68). The tone in these sections of the document can thus be characterized as "Houellebecqian."

II.ii Offering an Idealized Abstract Solution

While the document presents the possibility of medically assisted dying in the worst possible light, the alternative it proposes is presented in idealistic and abstract terms. In the first section of the document (p. 5, para. 7), the authors acknowledge the disruptive impact of the COVID-19 pandemic on care facilities, and lament that many people died "without the support and comfort of wider family and community." Yet, the Pendeli Statement invokes alternatives to assisted dying as if these failures in the health-care system are largely in the past, and that the option of palliative care is always and everywhere readily available (p. 18, para. 45). It is noteworthy that, in 2021–22, 58 per cent of Canadians who died in care received some form of palliative care.[9] While that is a significant increase from the previous decade, this still leaves out 42 per cent of those who died in hospital. It is also clear that some regions have considerably less access to palliative care, and that people suffering from some conditions (e.g., cancer) are offered palliative care more frequently than those suffering from other conditions.[10] While every effort should be made to improve and correct such limitations and failures within the health-care system, at the same time, these structural issues should not be ignored or papered over during debates over death and dying in Canada. While this concern is

[9] *Access to Palliative Care in Canada 2023* (Ottawa: Canadian Institute for Health Information, 2023), 13, https://www.cihi.ca/sites/default/files/document/access-to-palliative-care-in-canada-2023-report-en.pdf.
[10] *Access to Palliative Care*, 15.

not in itself an argument in defence of medically assisted dying, it should be noted that over-emphasizing the current availability and access to meaningful alternatives to assisted dying is misleading.

II.iii A One-Sided Approach to Modern Medicine

A notable feature of the statement is the way in which the theological argument against medically assisted dying is framed. At the outset of the document, it is suggested that "every human life is a God-given gift that is not for humankind to claim any right over" (p. 2). Yet, are medical interventions to sustain life, such as a liver transplant or triple-bypass surgery, not a "claim" over life by human beings? Moreover, are all life-extending interventions free from motivations driven by money, power, or status? While the document implies that all motivations for assisted dying are merely utilitarian, what guarantees that the position the document takes on medical treatments that "ensure the best possible life for every human person at every stage of life" is not itself interpreted in utilitarian terms (p. 4, para. 5)? If "the best possible life" includes extending life for as long as possible, whatever the form, and however uncomfortable (or even conscious) a human being might be, then such a position is reduced to the kind of outcomes-based reasoning that the document itself rejects. Might some attempts to extend life be driven by the interests of drug industry profits, or even an unhealthy fear of death, despite the Christian hope in the resurrection?

I raise such questions to illustrate that the theological arguments emphasized by the Pendeli Statement are frequently employed in a one-sided manner. The document depicts medically assisted death in the worst possible light, without treating the complications and complexities surrounding other forms of medical treatment with equally critical scrutiny. Here, my intention is not to call into question most forms of medical treatment, but rather to highlight how one-sided the ethical argument is in this document. Greater attention to nuance and complexity than is on display in the Pendeli Statement is called for in any ecclesial consideration of medical ethics.

II.iv Who Determines the Limits of the Other's Suffering?

The Pendeli Statement suggests that "the process of dying can be source of profound healing" (p. 4, para. 6). This is indeed a teaching of the church; a truth that is revealed by the death and resurrection of Jesus and modelled by the witness of the saints. But two key words in the statement above are "can be." While the process of dying "can be" a source of healing, is it always? Moreover, should people for whom such healing is elusive be forced to continue to await it, whatever the cost?

Should the church or the state have the power to make such a decision on behalf of all adult individuals suffering terminal illnesses?

The church has learned through unfortunate experiences that forced conversions violate faithful understanding of the free offer of God's grace. Might this be instructive for debates surrounding the delicate subject of advocating others to endure chronic suffering? To be sure, the church should teach and witness to the reality that forbearance amid suffering can be a source of healing and grace; but it is quite another matter to force people to endure suffering "for their own good." At a certain point, ultimately, the church must allow an adult, after they have received all possible support, to search their own conscience and motivations, and decide for themselves how much suffering they are willing to bear.

III. Towards a (Reluctant) Defence of Medically Assisted Dying

I have a degree of appreciation for Houellebecq's angry and sarcastic rejection of assisted dying, since there does exist the danger that the practice could be abused, and so rigorous debate and weighing of complex issues is called for. I find the contribution of the Pendeli Statement less challenging, and also less instructive as a resource. It claims to speak from the perspective of two rich and diverse Christian traditions, both with legacies of deep spiritual wisdom and attentiveness to pastoral complexity. Yet, in my view, the weaknesses in the document that I identify above limit the capacity of the statement to contribute adequately to the churches' processes of discernment over this painful issue. The statement's leap from theological principle to moral application is unclear and uneven, and its engagement with issues in medical ethics is one-sided. Such a view, of course, shifts the burden on me to offer some alternative arguments regarding medically assisted dying. Here, space allows for only a few short remarks.

Regarding the potential dangers for abuse of the practice: the fact that these are legitimate concerns cannot be denied, and the churches should be on guard against them. But it is one thing to identify a danger; it is rather something else to presume that all potential risks will come to pass. Safeguards and policy protections can be put in place and procedures regularly monitored and reviewed.

This is to say that the kind of legalized medically assisted dying I support is one that bears little resemblance to Houellebecq's "thought experiment." It would not be reduced to allowing someone spontaneously to demand to be helped to die immediately; instead, a process of seeking permission would be established, in which a conscious adult who is able to understand what he/she is asking for is asked to first work through a process of discernment

with others. This process would include discussion of alternatives to ease pain (palliative care, etc.), the impact of one's death on others (family and loved ones), and (where appropriate) spiritual contemplation of what God is calling the patient to do in their present situation. After walking with a suffering individual through this process, should that person decide that they continue to think that an assisted death would be less harmful to their emotional, spiritual, relational, and physical well-being, then I think the churches should not get in the way of such a decision.

There is a statement in the Pendeli Statement that I think is relevant here: "Spiritual death is to be feared more than physical death" (p. 13, para. 31). Yes, and Amen. Yet, in contrast to the statement's own position on assisted dying, I think legally requiring a terminal patient suffering severe pain to continue to endure this pain, regardless of her/his own preference, sometimes risks causing a spiritual death in the person, long before physical death arrives.

In advancing this position, it is important to distinguish it from what has become known as "Track 2" access to medical assistance in dying (MAiD) in Canada. Such eligibility extends access to individuals without a terminal illness, and which only requires a ninety-day waiting process. Disability and mental health activists are right to raise critical concerns about Track 2 access.[11] Moreover, if MAiD becomes a mere escape route for desperate people who cannot afford to live into old age, or who cannot access needed support services in Canada, then the churches must lobby for alternative solutions to these situations. In such circumstances, the cautions raised by Houellebecq and the Pendeli Statement need to be heeded. My argument in this discussion, however, is that these socio-economic issues should not fully define the debate over medically assisted dying.

What is the best or most faithful choice for an individual with a terminal illness suffering severe pain or debilitation? God only knows. Furthermore, it causes me no end of discomfort when I ask myself how I would feel if a loved one asked me to support their decision to seek medically assisted death. Yet, in the face of such complexity, I think it is faithful for the churches to support a form of medically assisted dying when it is linked to a clear and intentional process of spiritual discernment, accompanied by prayer for the guidance of the Holy Spirit. The churches are most true to the calling to love their neighbour and to honour the work of God in the other's lives when they permit a conscious adult with a chronic illness, after a process of discernment, to decide what they think is best for themselves. The rest, as

[11] Meagan Gilmore, "Too Easy to Die," *The Walrus*, June 2023, 40–47, https://thewalrus.ca/assisted-dying.

one says, must be left to God. Thus, should someone, after such a process request medically assisted dying, then the churches have reason to hope that this choice, too, can be redeemed through the saving work of Christ.

To conclude: while I agree that great care and oversight is required to prevent medically assisted dying from becoming a utilitarian mechanism that abuses marginalized peoples, I think it is a gross exaggeration to imply that assisted dying can be equated with euthanasia. Furthermore, I think many opponents of assisted dying are also motivated by a more general fear of death that understandably has deep roots in the human psyche. Such discomfort with death is certainly reason for great caution and careful discernment, but it cannot be decisive for the decisions of the churches. For, as the Pendeli Statement reminds us, Christians are called upon to have their hearts and minds led not by a fear of death but by their faith in the resurrection of Christ. As such, as we confront the questions surrounding medically assisted dying with both critical scrutiny and pastoral maturity, let us say confidently, with Paul, "Where, O death, is your victory? Where, O death, is your sting?" (1 Corinthians 15:55).

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Questions for Reflection and Discussion

1. Given that Christian confess that, in the hope of the resurrection, death is not the end of the human being, does it make sense to insist that human life must be extended at all costs, regardless of suffering?
2. What does love of neighbour mean in the context of long-term chronic illness and extreme pain?
3. Who should ultimately be able to decide whether to adopt medically assisted dying or not—the church? The state? Conscious adults, after a process of discernment?

Peering over the Threshold

EPHRAIM RADNER

When I was nineteen, my mother killed herself. I had left home for university, and the student chaplain called me to his office to give the news. He had invited an older woman to join us. I had met her once or twice at church, I think. She had had some experience with suicide, and was there simply to offer support. I don't remember what she said, except a bit of advice. "You will be tempted," she told me, "to figure this out. And that will draw you ever deeper into its grip. Do not peer across the threshold."

I failed to follow her counsel. My mother had made attempts on her life before. Years of deep depression on her part had sunk their filaments into my bones, though I had not realized it. I struggled; sorrowed; ruminated. A year after her death, I tried to kill myself, and almost managed it. There was no Google at the time, offering the world instructions on these matters, and my cocktail of pills proved too weak. Therapy, medication, indeed several hospitalizations and treatments too severe to mention, sapping and clouding energies, have followed me through the years. As did the widening grip of sorrow's fascination in my family. One of my sisters killed herself just at the cusp of a medical career. A child of ours has spent years of struggle, hospitals, near misses, and the rest, navigating this entangled landscape of deadly temptation. And, for all my efforts, I have never ceased from peering, like a curse; though, like a grace, staring across the threshold, I have at last been granted some flickering image of God's passage. As Robert Frost puts it, describing his gaze down into a deep well and, beneath the black surface below, a glimpse of "whiteness? Truth? A pebble of quartz? For once, then, something".[1] Part of the church's vocation is to train our gaze, simply, methodically, unsparingly.

[1] *The Poetry of Robert Frost*, ed. Edward Connery Latham (New York: Owl/Henry Holt, 1979), 225.

I. The Wide Net of Suicide

In what follows, I want to explore how the social permission of suicide, as a response to a person's suffering, undoes the responsibilities we owe one another to support the person who suffers. Permitted suicides unravel our responsibilities not only with respect to the suffering individual, however, but for the great tree of life that marks our human family, made up of our particular families. I will reflect on all this in several sections. First, I will ponder the reality of suicide's negative consequences across generational lines. Next, I will provide a brief review of Anglican canon law and related formal responses to suicide, which seem to be founded in part on this reality of social consequence. This leads to some particular theological reflections: first, the attitude of the Book of Common Prayer (BCP) to illness, and then a longer illustration of these attitudes as they pertain to suicide, in the figure of John Donne and the Anglican commentary on the book of Job. My conclusion returns to the question of social consequence, from the posture of a Christian believer. In all this, I wish only to underline the absolute need we have, as fragile creatures, to rely, in our most extreme circumstances, on what we know of God in Christ, and to avoid looking beyond this into the recesses of God's hidden character. Such looking, now made necessary by cultural projects like MAiD, functions as a curse, not a blessing.

The notion that families can be cursed with suicide is not new. Think of the philosopher Wittgenstein, his three dead brothers, and his ever-lingering thoughts, which tried to exhaust themselves in sorting out a world whose brute acceptance he sought to justify by ever more elaborate means. Modern psychiatry has speculated on biological genetics here, or even more importantly, on the shaping pressures and shoves of surrounding locales and cultures. The notion of "systemic" social phenomena is familiar in our day, and suicide rears up as one of these.[2] Already by the seventeenth century in Europe, some observers noted clusters of suicides in this place or that, triggered by this or that event; and by the eighteenth, these dark blooms began to be studied. The sociology of suicide—its corporate curse—is now an industry, though one that is founded on rather inescapable facts.

Just these facts—the fact that these facts exist—render from the start the whole venture of Canada's medical assistance in dying (MAiD) a social solvent, and thereby the enemy of faith. My personal remarks

[2] Alan Lee Berman, Morton M. Silverman, and Bruce Michael Bongar, eds., *Comprehensive Textbook of Suicidology* (New York/London: Guilford Press, 2000), although already out of date in some respects, has some useful historical articles on the front end and covers the kinds of social scientific interests stirred up by suicide with a broad sweep.

above are but an illustration of a single point: just as birth is filiated—bound to generations—so too is death filiated. Our existences spring from, are entwined with, and cross over to the generations of others, biologically presented and communally contoured. In a Christian perspective, this generational movement from birth to death constitutes our lives as creatures made by God, and in just this form our natural existence is offered us as a divine good. Suicide, in this perspective, is the unravelling of filiation, the destructiveness of whose dissolution does not rest in a single moment or single death, but seeps its way to the full extent of the generational web the covers time and space.

To be sure, attitudes to suicide had already begun to shift radically in the late twentieth century, decades before the 2015 Supreme Court decision in Canada set in motion the legislation on assisted suicide.[3] Criminal codes had been changed, penalties removed, and the attraction to and even accomplishment of self-murder were, by the 1990s, increasingly viewed as realities requiring compassion rather than crude censure. But, until MAiD and its earlier European cousins appeared on the scene, this compassion was almost always strenuously preventative: suicide hotlines, counselling services, treatments and medications, support staff in schools. Elderly women who would sit by teenagers and gently pull them back. Advocates of the new legislation, with its definitions and limitations, did not see the self-willed death of mentally "competent," "intolerably suffering" persons, victims of "grievous and irremediable" illness, whose death was "reasonably foreseeable," as in any way undercutting our society's wider embrace of life. That is less clear with the new revisions, in 2021, of Bill C-7, which allows mental illness, independent of "reasonably foreseeable" death, to be the basis for self-killing. (At time of writing, this permission is on hold until 2024.) What is patently crucial now, according to the legislation and its advocates, are the rights of (increasingly young) individuals to adjudge their own level of unacceptable pain, their own responsibility to others, their own measure of unworthy existence as a sufficient basis for life's discarding.

But what MAiD did, even in its earliest provisions, in injecting, and with much fanfare, the permission and apparatus of successful suicide into an otherwise discouraging social framework, was to set our culture against itself, to pry it apart into incoherent and conflicting commitments. The tensions are enormous: forestalling suicide vs. lifting it up in ever-expanding facilitation; the virtue of medical care vs. the virtue of medical killing; the

[3] Official documents and legislation can be found at https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html.

value of social cohesion vs. the autonomies of self-destruction. Central civic virtues, like "justice" as an ideal, were riven: on the one side, justice for the preservation and valuing of the ill, the elderly, the young, the mentally ill, or the disabled; and over against this, justice for those whose circumstances (age, mental status, tolerance of pain, perhaps even material resources) may limit "access" to their own demise. In the process, generations are set against each other, vying for equal "treatment," rather than mutual responsibility—the elderly for the young; the strong for the weak; the suffering for the confused; and vice-versa in each case. Mutuality devoured.

This is a new, disintegrated culture of attention, where the morally serious politician tells us that, when it comes to illness, to pain, to self-killing, these are "difficult decisions," to be "thought through" with "care" and sober compassion, taken up by reflective individuals and their families; but then, having done so, if the decision is made to be killed, we should treat it with the hushed honouring of one who stands on sacred ground. In other words, this new imperative—for individuals and families to engage their suicides attentively, for policies to be weighed in the now continuous consideration of new permissions, for "individual choice" to be ever more refined and deliberately applied—constitutes a new burden laid upon us all: peer in, peer in!

Given the simple, but wicked web, of my own family's entanglement of sorrow, my duty now must be—dare I say, our common duty—to unknot it. I can only do this, not by grasping the filaments' display and by their theatrical performance, but by rendering their clamour mute. I consider the obliteration of the now socially required and accumulating existential distinctions that are meant to define the positive value of our suicides to be a moral good. Today we are encouraged to identify levels of pain and to pursue personal judgments on probabilities, possibilities (or impossibilities), dismissals of responsibilities, assessments and witnesses, waiting periods, and the rest. Such distinctions deserve to be rendered irrelevant, because in fact their enumeration constitutes the sowing of dissolving discontent. Such dissolution inundates my family, my community and church, my commonwealth. Do not look into that room, and its dark fires, the blazing workshop wherein God orders his work of "killing and making alive" (Deuteronomy 32:29). Look elsewhere, to the one, the only one, whose emergence from this precinct, and return into its heart, is our only guide: this counsel, this command, lies at the heart of the Gospel.

II. Anglican Attitudes toward Suicide

I would argue, then, that the whole haphazard network of customs and laws that rendered suicide a "crime" in the Christian church over

the centuries is driven, and rightly so, by the stark service of turning us from this threshold of peering, that is, that is from the enticing exploration of suicidal possibility that MAiD now embodies. Christian criminality is definitionally tied up with crime as accusation, charge, and earlier simply as "judgment," a placement within the great assize of eternal fate before God. To call suicide a "crime" is to link it to the judgments of God—the realm that intimately pertains to divine truth, that God literally cares about, in the sense of touching his character, perhaps even "troubling" God. Not all misdeeds are crimes in this sense. It is not insignificant that the suffering of life, even unto death, in whatever form, was finally described in terms of the judicial-existential category of "trial"; not unrelated to the biblical linkage of Satan as the "accuser" before God—a reality that impresses itself upon our thinking on the matter of suicide in the case of Job in particular.

It turns out that understandings of suicide in the church, including the Anglican Church in particular, are richly textured, and certainly ambivalent, though also oriented in the particular direction of restraint against the eye's restless peering.[4] "Attitudes towards self-murder were complex and contingent throughout the early modern period," writes the historian R. A. Houston, "not simple and severe at one date and simple and benign at a later one."[5] Canon law had, since the early medieval period, certainly viewed suicide as a grievous sin, and had generally forbidden Christian burial for those who had killed themselves. Such canons continued in place after the English Reformation, and were finally ensconced in the Burial rubrics of the seventeenth-century Book of Common Prayer: "Here is to be noted, That the Office ensuing is not to be used for any that die unbaptized, or excommunicate, or have laid violent hands upon themselves." But in fact, the canons themselves, over the centuries, were sparse and unelaborated. And pastoral practice went its own way, often in various directions.

R. A. Houston's detailed study of the penalties against suicide in Scotland and England startlingly demonstrates how the strange ordering of judgment and mercy by civil and ecclesial leaders tended towards great flexibility and, finally, towards charity. The major aim of the loose legal process was to maintain the bonds of the local community's mutual affections and survival. Official penalties, like the forfeiture of the suicide's goods to the Crown,

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[4] I still consider Jennifer Michael Hecht's historical and reflective overview the most compelling volume on the European and Christian experience of suicide: *Stay: A History of Suicide the Philosophies against It* (New Haven, CT: Yale University Press, 2013). For some helpful and concise documentary details in the Church of England, see John Henry Blunt, *The Annotated Book of Common Prayer* (London: Rivingtons, 1867), 293–94.

[5] R. A. Houston, *Punishing the Dead? Suicide, Lordship, and Community in Britain* (Oxford: Oxford University Press, 2010), 210.

were imposed rarely, nor in a way that actually harmed the family involved. Indeed, the distinction between self-murder that was "wilful" and hence criminal, and "accidental" death or suicide in fits of madness ("unsound" mind) was often deliberately fudged, and the presumption of innocence maintained for the sake of Christian burial. The 1662 rubric itself did not make the distinction (although the Canadian BCP does), but it was present in the earliest canons, and presumed by most Anglican legal commentators.[6] Even suicides "by fault" were, in any case, usually buried on church grounds, if not accompanied by a liturgy. "Yet even canon law was not absolutely clear on handling suicides. None of the ecclesiastical statutes of the Middle Ages mentions the interment of self-murderers, and the church had nothing new to say on the subject between *c.* 1000 and 1662."[7]

In this, the early modern British experience seems to have been no different than earlier Christian practice more broadly. Augustine, among the first to engage the question of suicide theologically, had never spent much time on the matter, and was, in any case—as later Anglican commentators on Job themselves underlined—deeply sympathetic with the descriptive piling up of misery that many people endure. The *City of God* is, among many of his writings, filled with such litanies of existential woe. There was, built into the Augustinian outlook on human life, a thin line between legitimate and illegitimate "desire for death." And just because the line was thin, it was both to be avoided and, when crossed, to be noted with a reticent and ignorantly uncurious compassion. The motive of penalty—e.g., the corpses of suicides publicly displayed on a gibbet, or buried at the highway crossroads, a stake in their heart—even if not consistently or frequently imposed, was starkly clear: "for the terror of them that live" (1601, William Fulbecke), and "to terrife all passengers, by that so infamous and reproachfull a burial; not to make such their final passage out this present world" (1631).[8] It mattered, and mattered profoundly, that others not be drawn along a pathway that led into the dark place beyond desire for death into its self-willed embrace.

Though actual pastoral practice had changed radically by the 1960s if not before, the seventeenth-century BCP Burial rubric remained in effect in the Church of England until only 2017, several decades after the Catholic church had loosened its own strictures.[9] By this point, the

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[6] Charlotte Wright, "The English Canon Law Relating to Suicide Victims," *Ecclesiastical Law Journal* 19, no. 2 (May 2017): 193–211.
[7] Houston, *Punishing the Dead?*, 196.
[8] Houston, *Punishing the Dead?*, 191, 192.
[9] "Synod: Law on Suicide and Unbaptised Altered," *Church Times*, July 14, 2017, https://www.churchtimes.co.uk/articles/2017/14-july/news/uk/law-on-suicide-and-unbaptised-altered.

ordering of charity that judged suicide to be, almost universally, a matter of "unsound" mind had triumphed. And it triumphed, ironically, just as the opposing shift in moral evaluation was culturally established, one that now viewed wilful self-murder—"competently" chosen assisted death, e.g., MAiD in its various forms in Europe and now Canada—as a protected right and thus good. In this case, the Christian tradition has been left staring at its own self-contradiction. But the contradiction is only a recent phenomenon. For a long time, the threshold of suicide's enticement was properly guarded by the cherubim of judgment and mercy both, their flaming sword meant to keep away the straying eyes, while offering the promise of divine aid amid the trials of survival outside the Garden. The "paradox" of created life itself hung in the balance.

That paradox, as a positive Christian truth, is on full view in the BCP's Office for the Visitation of the Sick, whose classic versions have a peculiar focus that has struck contemporary readers as odd, though it was a fairly standard outlook for centuries. Here, illness, including terminal illness, is viewed as a "visitation from God." This is perhaps a deliberate usage that joins the pastoral visitation of the priest to a divine infliction. The suffering of disease itself constitutes somehow God's providential purposing for the sick person, bundled with a divine pedagogy in a world of sin and mortality. While revised modern liturgies for the ill are seemingly caught up in an almost charismatic expectation of divine miracle, the BCP offers no such anticipation. Recovery will come only "if it be [God's] will." The focus is instead on life with God *through* the course of mortal frailty, from birth and on to youth and old age, and finally to and through death.

> *Dearely beloved, know this, that Allmighty God is the Lord of life and death, and of all things to them perteining, as youth, strength, health, Age, weakeness, and sickness. Wherefore, whatsoever your sickness is, know you certeinly, that it is Gods visitation.*

Illness is a divine "given"; and the question is "how" one engages it as a gift from God. Every illness is bound to death—"in the midst of life we are in death," as the Burial anthem goes. Every illness is "terminal" in this sense and infused with a vocation of patient suffering caught up with confession, reparation, and joyful expectation. All illness is, at root, "irremediable"; all those who are sick foresee death as imminent; all suffering, even in its intolerability, is nonetheless woven into the full scope and meaning of life as a whole. Thus, "soundness" of mind and the intention of the "will" are aimed at receiving *this* life of inevitable

limit and difficulty as God's offering of a place for encounter and faith. Anything other than such a willing reception falls short of our creaturely calling in Christ, either in the form of rebellion, or as simple madness. When it comes to the Book of Common Prayer, nothing could stand in greater contradiction than the directive conditions for suicide found in C-14 and C-7.

III. The Anglican Job

It is important to stress how soundness of mind in the context of illness, according to the BCP, properly cohered with—in that a sound will did not reject it in any final way—a life of horrendous suffering, even one struggled against, lamented, undone by. One small window into this is the Anglican treatment of Job. James, in his Epistle, sets out the ideal: "Take, my brethren, the prophets, who have spoken in the name of the Lord, for an example of suffering affliction, and of patience. Behold, we count them happy which endure. Ye have heard of the patience of Job, and have seen the end of the Lord; that the Lord is very pitiful, and of tender mercy" (James 5:10–11, KJV). In fact, though, it was an ideal well understood as a burden often, a sorrowful perplexity, but no less a profound and salvific calling. The reality of suffering, furthermore, as a powerful motive to suicide was not unacknowledged, and in fact proved one of the subthemes for Anglican readings of Job.

John Donne (1572–1631) is the most famous Anglican writer on suicide. But his discussions must be read in the context of his culture's Christian attitudes, not through the lens of contemporary assumptions. In 1608, during a time of personal and professional turmoil, and several years before his ordination and entry into an ecclesial career, Donne wrote a work unique to his time (or really any other), that he called *Biathanatos* (death by violence).[10] The full title, as it appeared on the cover, explains the theme: *Βιαθανατος. A Declaration of that Paradoxe, or Thesis, That Self-homicide is not so naturally Sin, that it may never be otherwise*.[11] The essay, which he only showed privately to a few friends, was never published until after his death, and for obvious reasons. With

[10] John Donne, *Biathanatos. A Declaration of That Paradoxe, or Thesis, That Self-homicide Is Not So Naturally Sin, That It May Never Be Otherwise*, https://books.google.com/books?id=3_oCAAAAQAAJ.

[11] When the volume was actually published in the 1640s, it roused a certain public interest. See the modern-spelling edition, edited by Michael Rudick and M. Pabst Battin (New York: Garland, 1982). On some biographical details, see R. G. Siemens, "'I haue often such a sickly inclination': Biography and the Critical Interpretation of Donne's Suicide Tract, Biathanatos," special issue, *Early Modern Literary Studies* 7 (May 2001): 10.1–26. Also, more popularly, David Albert Jones, "Did Thomas More and John Donne Advocate Assisted Suicide?" *Church Life Journal*, June 2, 2021, https://churchlifejournal.nd.edu/articles/did-thomas-more-and-john-donne-advocate-assisted-suicide/.

a numb relentlessness, Donne plows through the scriptural examples and theological arguments about (and against) suicide, and attempts to argue for their traditional misconstrual and limited application.

Donne's treatment of Job 7:15–16 is an example of his insistence on taking seriously—and literally—the crushing weight of personal suffering: "So that my soul chooseth strangling, [and] death rather than my life. I loathe [it]; I would not live alway: let me alone; for my days [are] vanity." This is not a spiritual figure. Job really *is* talking about suicide, Donne argues, thinking about it, handling its harsh possibility.[12] Donne presses this straightforward interpretation for every other biblical verse or example where "self-homicide" seems either to be wished for or pursued. Though others might not agree with him, he admits, he cannot see the classic "mystical" interpretation of Gregory the Great on this matter—Job wishes to die only to the "fallen" life of sin—as remotely plausible. The literal sense, which is that sense of actual existence, is unavoidable. There it is: the righteous Job is thinking of killing himself, and the thought is proclaimed aloud, written in the Holy Book, and left for all to read. If uncensured in Scripture, why not among actual people?

We know that Donne himself was prone to suicidal thoughts. In the midst of his own painful confusions—familial disarray and death, religious conflict, financial desperation, personal failures—the possibility of ending it all, he tells us himself, was one he struggled with. All this, we think we understand (probably wrongly). But having exposed at serial length as real the self-destructive instinct of scriptural personages, what Donne actually explains of his purpose in writing *Biathanatos* turns out to be more traditional. In his conclusion to the essay, he tries to justify his reflections. In a preliminary way, he has wanted to show how the door to one's own self-murder is actually somewhat left ajar by the Bible. This small opening does not derive from some divine encouragement to the act. Rather, we are allowed to glimpse the churning space beyond the door because Scripture is honest, and therefore the Bible lays out the sometimes horror of existence that must inevitably kick at the gate. Nonetheless, in explicating this, Donne (he says) hopes only to teach people not to be afraid of death; to have "contempt" for this life in favour of another with God. Not only this, but having upset our complacency in this regard—people really *are* pushed to the brink—Donne insists that he could never think of offering specific advice about this or that situation—die here, kill yourself there, and because of this or that form of pain. For in fact, such questions, such particulars, are too "obscure and steepy and

[12] Donne, *Biathanatos*, 151.

slippery and narrow, and every error deadly."[13] However much one might approach it, there is a threshold, and one dare not explore beyond it.[14]

I consider *Biathanatos* a kind of self-therapy, and take Donne's final words of stepping back as genuine. Like many of his contemporaries, though perhaps more than some, Donne was fascinated by death, including his own. He wrote about the topic incessantly until his final hours of life. Somewhere around 1620, Donne preached on Psalm 38:2, and returned to Job. Now he is willing to characterize the suffering man's desire to be rid of his birth and life as an "inordinate expostulation." The feelings are understandable, he says, and were shared by Moses, Jeremiah, Elijah, and Jonah; but in the end, such affections are hardly commendable. Seemingly quoting Chrysostom, Donne explains:

> This is a naturall infirmity, which the strongest men, being but men, cannot devest, that if their purpose prosper not, they are weary of their industry, weary of their lifes; But this is Summa ingratitudo in Deum, malle non esse, quàm miserum esse: There cannot be a greater unthankfulnesse to God then to desire to be Nothing at all, rather then to be that, that God would have thee be; To desire to be out of the world, rather then to glorifie him, by thy patience in it.[15]

Much later, in "Death's Duel," the excruciating yet transcendent sermon he delivered to the king, dragging himself from the bed of his mortal illness to do so, Donne has left the plausibility of suicide's temptation completely behind.[16] That suicide allures because, in some situations it makes psychic sense, is obvious enough to any normal person. Donne continues to admit this. But he now openly *accepts* Gregory's mystical interpretation of "desire for death." In a way no different than the attitude of the BCP's Office of Visitation, Donne explains how the suffering of affliction rightly opens up—perhaps violently so, but

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[13] Donne, *Biathanatos*, p. 193.

[14] At about the same time as the writing of *Biathanatos*, we see Donne, in the midst of theological reflection, openly critiquing his own argument. Cf. a September, 1608 letter to Henry Goodyer, in the accessible early edition of Edmund Gosse, *the Life and Letters of John Donne*, vol. 1 (London: Heinemann, 1899), 191.

[15] In John Donne, *The Sermons of John Donne*, vol. 2, ed. George R. Potter and Evelyn M. Simpson (Berkeley: University of California Press, 1955), 53. Nathan Wall, at Wycliffe College, has a knowledge of Donne's exegesis that surpasses that of anyone I know. He has been a great help in identifying a range of texts where Donne subtly engages this topic.

[16] This sermon, delivered in February 25, 1631, barely a month before his death, has as its full title, "Death's Duel, or, a Consolation to the Soul against the Dying Life and Living Death of the Body." It can be easily found in John Donne, *Devotions Upon Emergent Occasions, Together with Death's Duel* (Ann Arbor: University of Michigan Press, 1959); the volume is prefaced with Isaak Walton's "The Life of Dr. John Donne" (see below). The whole is online at Project Gutenberg: https://www.gutenberg.org/files/23772/23772-h/23772-h.htm.

marvellously all the same—a vision of our life as God's creatures, bound by our weakness and sin to divine grace, forgiveness, and the promise of transfiguration through just the mortal passage existence affords. Bodily suffering is a divine figure of this movement from and into God. If Donne had changed his perspective from 1608, it was a shift meant to *include* his previous arguments in *Biathanatos*, not hide them: the desire for death is real, and has its grounds; but its "obscure, steepy, slippery, narrow, and deadly" pathways are gloriously overshadowed by the reality of God's own creative calling and by such engraced movement through a difficult life; that is, by the divine Pathway of the Son.

His early biographer, Izaak Walton, relates some of Donne's final words to a friend. They seem to hint at why Donne stepped back from his disorienting and long peering over time: his life *was* worth living, he says, for all its difficulties. He lists the reasons for this—caring for friends, family, troubled neighbours, and church people—given by God's mercy.

> I most humbly thank him, I have been enabled to requite most of those friends which showed me kindness when my fortune was very low, as God knows it was:—and, as it hath occasioned the expression of my gratitude—I thank God most of them have stood in need of my requital. I have lived to be useful and comfortable to my good Father-in-law, Sir George More, whose patience God hath been pleased to exercise with many temporal crosses; I have maintained my own Mother whom it hath pleased God, after a plentiful fortune in her younger days, to bring to great decay in her very old age. I have quieted the consciences of many, that have groaned under the burthen of a wounded spirit, whose prayers I hope are available for me. I cannot plead innocency of life, especially of my youth; but I am to be judged by a merciful God, who is not willing to see what I have done amiss. And though of myself I have nothing to present to him but sins and misery, yet I know he looks not upon me now as I am of myself, but as I am in my Saviour.[17]

There are those who can love you, and those you can love. The good life revels in such realities. Walton tells us that, during these last few days of his life, Donne, "as Job," patiently "waited for the appointed day of his dissolution," in prayer, penitence, thanks, and expectation. Patience as revelling, that is.

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[17] Walton, "The Life" in Donne, *Devotions*, xliii.

Most early modern Anglican treatments of Job fit within the reach of this longer arc of Donne's own experience. The whole duel with desiring death, with suicide itself, is enclosed here. As many contemporaries remarked, even in Donne's time and after, Job held a peculiar fascination for Anglican commentators.[18] A wealth of discussion on the book emerged through the eighteenth century. Calvin, in a massive and influential set of sermons (159 of them), had already identified chapters 2 and 3 as key texts in which suicide's character is rightly examined—Satan's bitter challenge of "skin for skin," Job's wife and her own sharp urging that her husband "curse" (or, sarcastically "bless") God and die, Job's long declaration of his existence's cruel pointlessness and his explicit longing to be dead, indeed, "never born." And Anglicans were at one with Calvin, as they dwelt upon these texts, in rejecting suicide as remotely acceptable, in Job's case or in anyone else's.[19]

Yet in doing so, like Donne before them, they approached the narrative with an often shocking realism, underlining the personal struggle of suffering, and entertaining a range of possibilities about Job's own state of mind. Did chapter 3 amount to genuine cursing or to some other feint or weakness? They often acknowledged the difficulty of pinning down the moral weight of this or that feeling or expression. Rather than dwell on the imperatives of individual suffering, however, commentators tended—as Calvin himself did—to focus on the duties of and to others that suffering elicits and entails. In one remarkable commentary in verse, entitled *The Grand Tryal*, the author, William Clark, explains how Job's wife was called to be aid of hope, not a discouragement in the midst of life's misery.[20] (I have been otherwise blessed than Job in this regard.[21]) Clark has no illusions, though, and provides a long and elaborate discussion, on Job 3, of these very miseries and the reasons why Job's wife's counsel must seem attractive. Just here is where the "friends" rightly enter the scene. For all their mistaken

[18] For a list of some of these commentators, see Maurice J. O'Sullivan, *The Books of Job* (Newcastle, UK: Cambridge Scholars Publishing, 2007), 224–39. More broadly, Mark Larrimore, "The Reception History of Job," in *Wiley-Blackwell Companion to Wisdom Literature Reception*, ed. S. L. Adams and M. Goff, (Chichester, UK: John Wiley & Sons, 2020), 447–63.

[19] Arthur Golding's translation from the original French of Calvin's *Sermons on Job* into English in 1574 proved highly influential for subsequent English commentary. For a modern English edition, see John Calvin, *Sermons n Job*, 3 vols., trans. and ed. Rob Roy McGregor (Edinburgh/Carlisle: Banner of Truth, 1993). I have consulted the 1611 French edition (Geneva: Matthieu Berjon).

[20] William Clark, *The Grand Tryal: Or, Poetical Exercitations Upon the Book of Job…* (Edinburgh: Andrew Anderson, 1685).

[21] The early Jewish writing *The Testament of Job* elaborates on Job's wife in much detail, presenting her as an almost superhuman support to her husband, and who, finally exhausted by her sorrow and her service, expires in an almost martyrial devotion. *Testament of Job*, ed. Robert A. Kraft (Missoula, MT: Scholars Press for the Society of Biblical Literature, 1974).

judgments, they do exactly what friends must do: they stand beside and hold back a companion from crossing the threshold.

This is Calvin's point as well (drawing on a long tradition Aquinas himself articulates[22]): we are "bound" to each other, to parents, children, spouses, and neighbours: our miseries are part of lives shaped by our filiated relations—that explains not only their difficulty but also the profound joys and transformative responsibilities, all springing from God's blessing. The despair described in Job 1–3 is truly intolerable. Calvin acknowledges the text's marking of true feeling and genuine experience, one even Jesus shares. Nonetheless, Job must be prevented from having such sorrow *possess* him (as it did not for Jesus), precisely because such possession is the ruination of the ties that mark divine blessing upon human life. The slope to "absolute desire for death" is indeed steepy and slippery. As one Puritan commentator emphasized:[23] the attempt to peer into the "secrets" of God—God's counsels, decrees, and hidden works that shape our lives in obscurity, all lodged on the far side of the threshold—is itself absolutely deadly. On this side, we live by the "consolations" that "trust" affords us, in and through others as much as in the faith they offer. The old speak to the young about the paradoxical life of transfiguration that is Job's, just as do the young speak to the old about such things. Their speech, as Donne's own summation of his life indicated, perhaps awaits its voicing over the years; but it is embodied in any case this side of the threshold. How could it be otherwise? Always this side.

IV. Compassion and Restraint: Peering at Jesus

The contemporary era, as Houston argued, did not invent compassion towards the suicide. But nor, conversely, did the vision that sustained Anglican thinking for centuries about life and its burdens fade away in modern times either. The Catholic Church's teaching and experience has tracked with Anglicanism fairly closely in all this, if not with the same liturgical and literary pointedness. Pastoral practice was flexible and largely pressed in the direction of local reticence. With the growing official extension of "unsoundness" to most suicides, canonical penalties were more recently sloughed off. The new canons of 1983 (1184) make no mention of withholding Christian burial for a suicide (vs. the older 1917 canons [1240]), and such burial is now permitted.[24] If the church's

[22] Thomas Aquinas' classic summary is found in the *Summa Theologiae* 2a 2ae, Q. 64, A.5.

[23] Joseph Caryl, *An Exposition with Practical Observations upon the Three First Chapters of the Book of Iob* (London, 1643). Caryl extended his commentary at enormous length in subsequent volumes; in some cases, he simply reproduced Calvin.

[24] Code of Canon Law: Table of Contents, https://www.vatican.va/archive/cod-iuris-canonici/cic_index_en.html; 1917 Code of Canon Law, https://www.jgray.org/codes/cic17lat.html.

energies are roused by suicide, they are ones of mercy. But the threshold of judgment remains beyond it. The Catholic Church continues to view suicide as a grave sin (Catechism of the Catholic Church [CCC] 2280–84), however open to divine forgiveness.[25] The reasoning here continues to follow Aquinas's traditional enumeration: to kill oneself contradicts the natural law (of self preservation), and hence of the second of the two Great Commandments; it "offends" against love of neighbour and destroys the bonds of family and society; and, above all, it opposes love of God, who is the Creator and owner of life.

The issue of example here is important: according to the revised 1983 canons, attempted suicide itself is an "irregularity" that constitutes an impediment to ordination (1041). For behind all of this lies the governing challenge of "scandal" that suicide provokes as a model, especially to the young (CCC 2283). It is one thing to have mercy on the despairing, the suffering, the exhausted in their condition, by encouraging hope in God for their souls, and by welcoming their memory into the midst of a grieving community. While new to official Catholic canon law, such mercy conforms to much pastoral practice of the past, including the intuitions of Anglicans as well: the spirits of most suicides have been weakened somehow by the destructive forces of their lives, their "soundness" beaten into "unsoundness." But the face of mercy shifts in regard to those who, in sound mind and wilfully, are there to help, to witness to both patience and to hope, but instead press on, or stand ready to press others on, across the threshold.

In light of this, how might we respond, not only to individuals, but to entire communities who have carefully, legally, medically, and now even religiously, built up an edifice of scandal, not only to the young, but to all of us? It would be—it *is*, I openly confess—difficult for me to forgive a church and its leaders who have acquiesced in, let alone encouraged, a civil culture that grants permission to my daughter, or my mother, or my sister, or myself to kill themselves. This is not simply a personal resentment. It wells up from a sense that my own church has acquiesced perhaps, even encouraged the one thing Job knows he cannot do, "contend with God." Whereas only God can "shake the pillars of the earth" (Job 9:6), here we strive after our own impossibilities, to rattle those pillars with our own hands, to gaze into the abysses beyond their true foundations, to peer into the unfathomable depths of God. I have watched the attempts; I have explored them. "You cannot see my face; no one has seen me and lived," the Lord says to Moses (Exodus 32:20).

[25] Catechism of the Catholic Church, https://www.vatican.va/archive/ENG0015/_INDEX.HTM.

When John takes up this truth (1:18), he proclaims the Son as the one who can explain God to us. "No one has ever seen God; the only Son, who is in the bosom of the Father, he has made him known" John 1:1, RSV). Though our lives—littered with the unruly, the unfinished, the harsh, the depleting—are "not yet subject" to him, yet "we see Jesus, who was made a little lower than the angels for the suffering of death, crowned with glory and honour; that he by the grace of God should taste death for every [one]" (Hebrews 2:9). Donne had himself struggled with the question. "Who sees God's face, that is self-life, must die," he wrote in a Good Friday poem.[26] By contrast, in Jesus, we can see God's own self-giving. It is to this alone that we dare force ourselves to look. And to this alone we dare join our deaths. "What a death were it then to see God die?" he wondered. Years later, half his children dead, along with his wife, his many friends, his own body dissolving in pain, in that final and agonized sermon given to the king, he names this vision, this one thing we are given, out of God's hidden treasures, to peer into: "that blessed dependency," he calls it. He defines it thus: "to hang upon him that hangs upon the cross."[27] Go no further. Look nowhere else. Stand here.[28]

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[26] John Donne, "Good Friday, 1613. Riding Westward"; see Poetry Foundation, https://www.poetryfoundation.org/poems/44103/good-friday-1613-riding-westward.

[27] Donne, "Death's Duel," in *Devotions*, 189.

[28] My thanks to Nathan Wall, at Wycliffe College, whose knowledge of Donne's exegesis surpasses that of anyone I know. He has been a great help in identifying a range of texts where Donne subtly engages this topic. I have written on the topic of suicide elsewhere, e.g., Ephraim Radner, *A Time To Keep: Theology, Mortality, and the Shape of a Human Life* (Waco, TX: Baylor University Press, 2016), and on assisted suicide in the preface to Ephraim Radner, *A Profound Ignorance: Modern Pneumatology and its Anti-modern Redemption* (Waco, TX: Baylor University Press, 2019).

Questions for Reflection and Discussion

1. What do we owe one another in Christ as creatures of God when it comes to suffering?
2. Does the Anglican tradition have anything to teach us about the nature of suicide?
3. What do we learn from the experience of Job?

In the Midst of Death We Are in Life

LIZETTE LARSON-MILLER

Often in our academic writing and reflections we find our domestic and pastoral lives weaving in and out of conversations, inviting us to intentionally bring together unbidden parts of our life and work with more academic projects. Academic conversations about dying, about suffering, about the needs of others and their need for us to be wholly present are difficult to separate from our own experiences with family and friends. Theology becomes imminent and personal—above all it matters even more deeply when we draw near to ultimate things—the death of family and friends, and the very present reminder of our own mortality. The ongoing questions surrounding MAiD (medical assistance in dying) in Canada is a fraught conversation for those of many religions, particularly for Christians. This essay briefly reviews the issues and then offers at its core an argument for palliative care and against assisted dying from the theological perspective of Christian baptism.

Documents of The Anglican Church of Canada regarding Assisted Dying

Two documents, written roughly eighteen years apart, reflect a shift in approach on euthanasia, or assisted suicide. First, from the 1998 document *Care in Dying (Statement on Euthanasia and Assisted Suicide)* we read this summary statement against assistance in dying:

> 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.[1]

But the 2016 document I*n Sure and Certain Hope: Resources to Assist Pastoral and Theological Approaches to Physician Assisted Dying* says this:

> Given the shift in Anglican thinking about suicide, we may need to rethink the easy assumption that receiving life as gift means that we cannot faithfully decide that the gift is one that we must now let go. Already in the case of the withdrawal of treatment we recognize that life is not an end in itself, and that the approach of death need not be resisted by all available means. If the chief purpose of life is to know God and to enjoy God for ever, is it possible to conceive of circumstances where a person might faithfully conclude that this purpose could no longer be furthered by the extension of their life and might choose, not merely to cease to resist the approach of death, but to actively embrace it?[2]

The first document, *Care in Dying,* makes an argument for palliative care and against a society, or "human community" that would resort to supporting assisted suicide. The second document, *In Sure and Certain Hope,* responding to the reality of the Supreme Court of Canada's decision to move to legal euthanasia (passed by Canada's Parliament in June of 2016), is a "new resource for The Anglican Church of Canada [ACC] that would provide updated perspectives in light of the new legal situation."[3] Replacing the term "assisted suicide" with "physician assisted dying," this second document no longer proposes a theological defence of assisted dying or a stance against it, but instead accepts the legal decision and presents resources (liturgical and pastoral) to help those involved in assisted dying. Since 2016, there have been additional governmental statements as well as reflections from within and beyond the ACC.

Care In Dying argues that expanding and supporting palliative care continues to be important, especially arguing that palliative care be

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[1] Task Group of the Faith, Worship, and Ministry Committee, *Care in Dying: A Consideration of the Practices of Euthanasia and Physician Assisted Suicide* (Toronto: The General Synod of The Anglican Church of Canada, 1999), 11, http://www.anglican.ca/wp-content/uploads/2010/10/care-in-dying-scanned.pdf.

[2] Faith, Worship and Ministry Task Force on Physician Assisted Dying, *In Sure and Certain Hope: Resources to Assist Pastoral and Theological Approaches to Physician Assisted Dying* (Toronto: The General Synod of The Anglican Church of Canada, 2016), http://www.anglican.ca/wp-content/uploads/In-Sure-and-Certain-Hope.pdf.

[3] Matt Gardner, "Resource Offers Pastoral Approaches to Physician Assisted Dying," *News*, The Anglican Church of Canada, June 9, 2016, http://www.anglican.ca/news/resource-offers-pastoral-approaches-physician-assisted-dying/30016156/.

available to more people in more places, particularly for the socially and economically disadvantaged. But *In Sure and Certain Hope* changes direction with regard to purpose and intent. The theological section is not only shorter (deliberately so as not to repeat all that was laid out in *Care in Dying*) but considerably weaker in its scriptural and theological bases. Where is the theology of baptism, and its grounding in the theology of the church, baptismal ecclesiology? What follows is a theological proposal that attempts to draw both of these into a theology of dying in the Lord—an essential indwelling of theology, discipleship, and ethics.

Baptismal Life as Living Christened

> Do you not know that all of us who have been baptized into Christ Jesus were baptized into his death? Therefore we have been buried with him by baptism into death, so that, just as Christ was raised from the dead by the glory of the Father, so we too might walk in newness of life. For if we have been united with him in a death like his, we will certainly be united with him in a resurrection like his. (Romans 6:3–5)
>
> I have been crucified with Christ, it is no longer I who live, but it is Christ who lives in me. And the life I now live in the flesh I live by faith in the Son of God, who loved me and gave himself for me. (Galatians 2:19b–20)

In many Western Christian churches, particularly Anglicanism, the Pauline dying and rising theology dominates in the baptismal liturgy and therefore in our baptismal theology. The baptismal liturgy of the Canadian *Book of Alternative Services* circles around the image and reality of dying and rising in several different ways. One example is the concluding prayer of the litany sung on the way to the font:

> Grant, O Lord, that all who are baptized into the death of Jesus Christ your Son may live in the power of his resurrection and look for him to come again in glory; who lives and reigns now and for ever[4]

Perhaps the Pauline imagery of dying to self and living in Christ is most apparent in the outward expressions of having been "Christed" in baptism—which is primarily at the chrismation, accompanied by the words "I sign you with the cross, and mark you as Christ's own for ever,"[5] as well as other non-optional ritual texts.

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[4] *The Book of Alternative Services*, (Toronto: The Anglican Book Centre, 1985), 156.
[5] *Book of Alternative Services*, 160.

Baptismal Life as Living Quickened

> So if anyone is in Christ there is a new creation: everything old has passed away; see, everything has become new.
> (2 Corinthians 5:17–18)

The church's embodiment of the scriptural identification of Christ with those newly baptized ("it is no longer I who live, but Christ who lives in me") grows from baptism through other sacramental encounters, all of which are first and foremost at the heart of who we are, to our essential being. They bring us to participation that engages our whole being, especially the physical which gives expression to the mental, the emotional, the spiritual, the social; in the flesh, embodied, incarnational. Just as our baptisms are embodied, we are baptized into Christ as whole persons, so at Holy Eucharist we draw deeper into Christ who dwells in us and we in him, not only as individuals but communally, as the body of Christ we have become—the church. And so we often pray:

> Recalling his death, proclaiming his resurrection, and looking for his coming again in glory, we offer you, Father, this bread and this cup. Send your Holy Spirit upon us and upon these gifts, that all who eat and drink at this table may be one body and one holy people, a living sacrifice in Jesus Christ, our Lord.[6]

One of the foremost Anglican theologians, Richard Hooker, in arguing the physicality of participation in God via sacramental participation, linked the incarnation, the enfleshing of God in Christ Jesus, to our material, spiritual, intellectual, emotional, and experiential unity with God. He asked: "does anyone really doubt that from the flesh of Christ our bodies receive that life that will make them glorious and that they are already part of His blessed body?"[7] This union with Christ is, in turn, union with the Triune God. Christians baptized in the name of "the Father, and of the Son, and of the Holy Spirit," are promised that the "spirit of him who raised Jesus from the dead dwells in you, [and the same God] who raised Christ from the dead will give life to your mortal bodies also through his Spirit that dwells in you" (Romans 8:9–11).

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[6] *Book of Alternative Services*, 195.
[7] Richard Hooker, *Of the Laws of Ecclesiastical Polity*, vol. 5, ed. and trans. Philip B. Secor, (London: SPCK, 2003), 213.

This Spirit, the Holy Spirit, acts as the "energy and grace" through which the human unity of body and soul is vivified, or quickened. If the Holy Trinity, in the tradition of early Eastern theology, is understood in "the dynamic and intimate relation of the persons of the Trinity … as attraction, interpenetration and mutuality," we come to the "relational dynamic … termed *perichoresis,*"[8] the unity of God with Godself and through our indwelling in God, our growing into that unity. When the Holy Spirit engages in the actions of union between God and humanity, sacramental participation is central. "Sacramental life gives us a new way of being who and what we are, not just with respect to ourselves but in relation to every other creature as well as to God,"[9] writes Catherine LaCugna, rooting this transformative power of sacramental participation in what she calls "an ontology of communion." LaCugna's interpretation of this is based in relationality: "given the principle that 'person' is more ultimate than nature or substance, an ontological change would be not a change in substance but a personal transformation and renewal, and a new capacity or relationship, so that our true nature may be more perfectly expressed."[10]

Scripturally and throughout historical tradition, this union with Christ—the ontology of communion that is our new capacity of relationship—has been evocatively expressed in different ways. In the New Testament there are many of these metaphorical images, but one of the most powerful is the agricultural practice of grafting, generally with regard to grapevines and olive trees. The grafting process in vineyards, where new varieties are grafted onto existing root stocks, is today done for many different reasons, including changing or combining the grape types, resisting destructive pests, or increasing yield. While any or all of these may have been reasons in the culture and time of the New Testament, the theological point is that Jesus is the root stock, we are grafted to that vine, the root stock, the necessary pruning is done by God the Father, and the proof of a good grafting is that the root stock and the branches unite and bear good fruit. John 15:1–11 approaches this in several ways, but at the heart of this discourse is verse 5: "I am the vine, you are the branches. Those who abide in me and I in them bear much fruit, because apart from me you can do nothing." The grafting of vines (or of olive trees in Romans 11:17–18) becomes the

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[8] Eugene C. McDowell and Meghan F. Froehlich, "An Incarnational Approach to Eucharistic Participation: Anglican Reflection on the Real Presence of Christ in the Eucharist" in *Contemporary Sacramental Contours of a God Incarnate,* ed. Lieven Boeve and Lambert Leussen (Leuven: Peeters, 2001), 221–2.

[9] Catherine LaCugna, *God for Us: The Trinity and Christian Life* (San Francisco: Harper, 1991), 404.

[10] LaCugna, *God for Us*, 404.

outward sign of the inward reality—Christ abiding in us and we in him.

Another scriptural image of divine indwelling sustained through liturgical practice is the image of clothing—putting on Christ as an outward sign of the indwelling of Christ. This imaginative visual of Christ dwelling in us and we in him is most apparent in the writings of the Apostle Paul, beginning with Galatians:

> For as many of you were baptized into Christ have put on Christ. There is neither Jew nor Greek, neither slave nor free, no male and female; for you are all one in Christ Jesus.
> (Galatians 3:27–28)

The new identity of the baptized in Galatians is outwardly signified by the action of being clothed, here covering the social differences that preceded baptism. As in all rites of initiation, baptism tied the initiated into a new society signified by the change of clothes. And while the clothing imagery is used in other ways throughout the epistles, it is interesting to see the connection between having put on Christ in baptism and the transferral of the clothing imagery to the end of life in the first letter to the Corinthians:

> For this perishable body must put on immortality. When this perishable body puts on imperishability, and this mortal body puts on immortality, then the saying that is written will be fulfilled: "Death has been swallowed up in victory …"
> (1 Corinthians 15:53–54)

In both of these images there is a lifelong dynamism, an ever-developing relationship that sacramentality presents—baptism is not a single event, but for Christians the beginning of a life in movement into God—a movement changed, but not ended, in physical death.

We have died to ourselves in baptism; our lives are not our own. We continue a baptismal journey into the heart of the Triune God throughout our lives, crystallized in sacramental participation in the body and blood of Christ, and practised in the act of *kenosis*, emptying ourselves of whatever allows our own desires to overshadow the indwelling of God, so that with the Apostle Paul we can say "the life I now live in the flesh I live by faith in the Son of God, who loved me and gave himself for me." We are quickened in baptism—made alive in Christ Jesus—and that transformed and ever-transforming relationship means that we die in the Lord as Christ's own too.

Baptismal Dying as Continued Life in Christ

> For to your faithful people, O Lord, life is changed, not ended; and when our mortal body lies in death there is prepared for us a dwelling place eternal in the heavens[11]

This proper preface of the Eucharistic prayer for funerals is a reminder that Christian faith sees physical death as a point of change but not of ending—life continues in ways never to be fully understood by those of us in this life. In addition to this continuity through change, the change of physical death, the continuity of our life in Christ is not ended either, "for if we have been united with him in a death like his, we will certainly be united with him in a resurrection like his." The baptismal unity of the Christian with Christ and the Trinity, and with the corporate body of Christ—the Church—leads to the central belief that our life belongs to God; if we are Christed, our life is not ours to take. The absence of this theological approach in the ACC documents mentioned above seems odd in light of the emphasis over the past thirty to forty years in the ACC and other Anglican member churches on baptismal ecclesiology.

So, what is baptismal ecclesiology and what has it to do with the death of a Christian? A theology of the church rooted in baptism has often been narrowly focused on the sacrament of baptism as full initiation,[12] or more popularly, on a shift to seeing all ministry as rooted in baptism. In the United States and elsewhere, this model was very much a correction to what was understood as a clerically centred church. It argued that by presenting baptism as the fundamental sacrament of discipleship and ministry, rather than ordination,[13] baptism would be restored as the basis for the church in solidarity across all ecclesial boundaries and as entry into the primary holy order, the "priesthood of all believers." This took shape in the baptismal covenant written as a supplement to the interrogative creed of baptism in the 1979 US prayer book, and then adopted into the 1985 *Book of Alternative Services* here in Canada. What has often been missing from these conversations, however, is the breadth of application of baptismal ecclesiology to other areas of theological, ritual, and ethical concern, including assisted dying.

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[11] The Book of Common Prayer [The Episcopal Church], (New York: Church Publishing, 1979), 382.

[12] The so-called BACSI controversy (baptism as complete sacramental initiation) based in the 1979 Episcopal (US) BCP. See Colin Podmore, "The Baptismal Revolution in the American Episcopal Church: Baptismal Ecclesiology and the Baptismal Covenant," *Ecclesiology* 6 (2010): 8–38.

[13] See Louis Weil, *Baptismal Ecclesiology: Uncovering a Paradigm* (Dublin: Columba Press, 2006), 27–28.

That is the heart of the question of connection in this essay, the theology of baptism as participation in Christ through the language of indwelling, or the image of putting on Christ, or the metaphysical language of ontology (in being or relationship) that is not shrugged off at death. But theology is not something other than living in faith; it is the ever-changing understanding of faith which is pure gift of God. Theology is therefore not opposed to practice, or practicality, or piety; it is not simply logic of God, but words and images of God, which are prayer and praise of God. It is in this trajectory that sacramental theology invites a re-imagining. Sacramentality at the root of this theology is a worldview, a perspective that (should) affect and guide all our relations and actions. John MacQuarrie saw in the sacramental principle "a human way of seeing God in all things, of making the things of this world so transparent that in them and through them we know God's presence and activity in our very midst, and so experience his grace."[14] How then does the perspective of life in Christ affect the question of dying?

Knowing God in the Dying of a Christian

One of the most important dimensions of the conversation around assisted suicide is the question of suffering—is it not "more Christian" to alleviate suffering than allow someone to continue in it, which is what physician-assisted dying strives to do? In the theology of baptism proposed as a counter to assisted dying, I have described the union between the baptized Christian and Christ in several different ways. To summarize part of the argument again, we have put on Christ; our life is not our own to take. But, more to the point in this final section, when we put on Christ we put on the whole Christ: his incarnation, his life, his suffering, his death, his resurrection, his ascension, and his glorification. This putting on of all aspects of Christ is transformative, and the nature of baptism is efficacious in changing us. It is in this Christ that "we live and move and have our being" (Acts 17:28), and in whom we die and live anew. Therefore, any defence of baptism against assisted dying must confront suffering and what it means for the Christian.

If God is all-powerful and all-good, why is there suffering in the world? Why especially do faithful Christians suffer? These are certainly not new questions; they have formed the core of religious reflection for as long as human beings have recorded their engagement with the questions of who God is and who we are in relation to God. On an individual level, the personal experience of pain, whether physical or

[14] John MacQuarrie, *A Guide to the Sacraments* (New York: Continuum, 1997), 1.

other, can be the defining moment of faith. But it is often only after the shock of experiencing an intimate and unwanted reality in a world accustomed to virtual detachment that the reality of pain sinks in.[15]

Limiting this conversation to the dimensions of suffering which impact individual Christians brings us first to the intersection of the health profession and theology. In spite of the tremendous strides in alleviating physical suffering through new and stronger medications and better surgical procedures, the health profession still remains challenged to eradicate all physical pain, which is a primary definition of suffering. For the health profession, pain is often understood differently from theological arguments—it is not seen as a moral evil, but often can be a positive in that it "can function as an alarm, a warning signal that we are somehow being threatened."[16] After this initial usefulness of pain, however, chronic pain is no longer necessary in signalling an alarm or in assisting in a medical diagnosis and can therefore be safely removed by some type of medical intervention. But when pain cannot be removed, in spite of the advanced technological skills of physicians and others, the limits of modern medicine become apparent to those involved. The challenge to the Church then is first to take a stand on suffering, to acknowledge it as something to be struggled against, and then, when it continues, to imbue it with meaning. "Pain demands a response, (Joseph Selling says) while suffering demands an interpretation."[17] It is in this Christian interpretation of suffering through the relationship between the suffering of Christ and that of the individual Christian that a primary link is made to the participatory ontology of baptism.

None of this is to say there is any validity in proposing that the Church somehow believes suffering is desirable; it does not. The paradox of suffering in Christian teaching is always that it is to be fought against strenuously, but when it is unavoidable it is to be interpreted as having distinctive Christian meanings. The primary focus of this interpretation is that Christ will join this suffering to his own suffering as the whole body of Christ strives toward union in the resurrection for the good of the whole world.

In the three dimensions of salvific effect that suffering can manifest (on the individual level, for the Church, and for the world) there is an eschatological reality[18] in which the suffering person can articulate for themselves and for others the contrast between the "already" and the "not

[15] See Lizette Larson-Miller, *The Sacrament of the Anointing of the Sick* (Collegeville, MN: The Liturgical Press, 2005), especially chapter 4, for a more fulsome treatment of suffering.
[16] Joseph A. Selling, "Moral Questioning and Human Suffering: In Search of a Credible Response to the Meaning of Suffering", in *God and Human Suffering* (Leuven, Belgium: Peeters Press, 1990), 157.
[17] Selling, "Moral Questioning," 164.
[18] Selling, "Moral Questioning," 168–75.

yet" of eschatological hope. The sick and dying minister to us as sign and symbol: what do we learn of God, of faith, and of ourselves from accompanying the sick and the dying in their migration into God? The conscious faith-response to the love and presence of God through pastoral and sacramental care is to unite one's suffering to Christ's for the sake of the Church and the world.

These are foreign and obscure ways of thinking for many in the twenty-first century, or at least the stuff of martyrs and clergy. But again, if we take baptismal ecclesiology seriously, baptism is a baptism into the whole Christ—not just his resurrection, but also a willingness to join with him in suffering and death as we hear proclaimed the welcome of the church:

> We receive you into the household of God.
> Confess the faith of Christ crucified,
> Proclaim his resurrection,
> And share with us in his eternal priesthood.[19]

If our tapestry of presence, prayer, support, rituals, and rites with the dying centres around the ancient triad of reconciliation (with God, with our communities, and with ourselves), anointing for healing—not to be confused with physical cure—but healing toward wholeness and strength for the journey continuing in the migration of the soul, and finally, the "food for the journey," "the medicine of immortality" that is one's last communion, what are the prayers joined to these before, between, and after? Central to this might be the family of prayers known as the *proficescere*, "Depart, O Christian Soul." This prayer helps us, the living, let go, and helps the dying through a verbal letting go of the emotional hold we often have on dying loved ones, while it also hands over the dying Christian from one part of the communion of saints to another:

> Depart, O Christian soul, out of this world; In the Name of God the Father Almighty who created you; In the Name of Jesus Christ who redeemed you; In the Name of the Holy Spirit who sanctifies you. May your rest be this day in peace, and your dwelling place in the Paradise of God.[20]

The other deeply important traditional prayer, the *commendatio*, summarizes one of the primary works of the body of Christ in commending the dying person to God, their creator and redeemer:

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[19] *Book of Alternative Services*, "Holy Baptism," 161.
[20] Book of Common Prayer [Episcopal], 464.

> Into your hands, O merciful Savior, we commend your servant *N*. Acknowledge, we humbly beseech you, a sheep of your own fold, a lamb of your own flock, a sinner of your own redeeming. Receive her into the arms of your mercy, into the blessed rest of everlasting peace, and into the glorious company of the saints in light.[21]

How do popular curated rituals, drawn from a variety of faith traditions (and none), help faithful Christians on their journey? The concerns over conflicting theologies found in internet-accessed rituals is also a concern for those who minister with the dying.

Conclusions

This essay has focused on a proposal to counter civil legislation legalizing physician-assisted dying by proposing that taking baptism and baptismal ecclesiology seriously means first engaging with the theological understanding that our lives are not our own. Our lives belong to Christ, they are in Christ, and we are not free to decide how and when death comes. The example of The Anglican Church of Canada raises the question that rather than accepting the civil reality of assisted dying and creating rituals to accompany it, might the church say first to its own membership and second to the state, what does life and death and baptism mean for us? If a church is going to claim a baptismal ecclesiology, then that theology and its implications must be present not only in the rites of initiation, but in ministry with the dying, in its other sacramental rites, in its teaching, and in its funeral rites.

The second challenge is the very reality of suffering—how does the church theologically understand suffering when it is inevitable? How is the church fighting for and supporting the expansion of palliative care instead of acquiescing to assisted suicide? The most recent statistics in Canada still reveal that a very uneven access to palliative care in the home or in hospital exists throughout the country, and the ongoing studies question the relationship between the lack of access to palliative care and pain management with assistance in dying.[22] But, especially for Anglicanism, under whose guidance the modern hospice movement was born, I want to

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[21] Book of Common Prayer [Episcopal], 465.

[22] The legalization of MAiD in Canada in 2016 provided new impetus for improving palliative care. This commitment to improvement included the development of a National Palliative Care Framework and Action Plan. The purpose of this study was to understand the progress made in palliative care since 2016 from the perspective of persons working and volunteering in palliative care. Barbara Pesut, Sally Thorne, Anne Huisken, David Kenneth Wright, Kenneth Chambaere, Carol Tishelman, and Sunita Ghosh, "Is Progress Being Made on Canada's Palliative Care Framework and Action Plan? A Survey of Stakeholder Perspectives," *BMC Palliative Care* 21, art. 182 (2022), https://bmcpalliatcare.biomedcentral.com/articles/10.1186/s12904-022-01074-4; Health Canada. "Action Plan on Palliative Care." Canada.ca, October 29, 2019. https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/palliative-care/action-plan-palliative-care.html.

continue to ask, where is the parish-based palliative care that would make sense of the tradition and the theology?

And finally, it is important to acknowledge that none of us is so naïve as to ignore the reality that extraordinary means of sustaining life are often not opposed to physician-assisted dying but rather on a spectrum with it. Dying in the Lord with the best that medical professionals can offer is often a matter of estimating what pain relief is sufficient or too much, or any number of other attempts to balance pain management. I believe that what is central to the theological argument is intention.

In the end, how will churches such as The Anglican Church of Canada continue to engage in the necessary ethics of conversation regarding living on Earth, remembering that we have already died in Christ, modelling and articulating what this means for the baptized, and continuing to define both living and dying and living in the Lord?

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Questions for Reflection and Discussion

1. If we have died to ourselves in Christ, how does that affect self-determination regarding how and when we will die?
2. What is your (personal and/or community) theology of suffering, and how is it related to the suffering of Christ?
3. How does effective palliative care express dying in Christ and in the body of Christ (the Church) in different ways than medically assisted dying?