General Assembly 2018

A matter for study

May 2019

Dear presbyteries, Te Aka Puaho and church councils,

Back in December 2018 I wrote advising a number of decisions from the 2018 General Assembly and a matter for study. I noted a further matter for study would be sent in 2019.

End of Life Bill

Assembly declared it does not support provision for euthanasia and medically-assisted suicide as proposed in the End of Life Bill, on the grounds that any legally-sanctioned provision for doctors to actively end people's lives or assist them to die is ethically unacceptable and would in the long term be dangerous for public safety, especially for those who are seriously ill, depressed, disabled or very elderly.

It was also decided that General Assembly urge Parliament to respect the dignity and value of all human lives and General Assembly urge the Government to significantly increase the quality of and access to palliative care, hospice services, mental health services, care for the disabled and care of the elderly, including recognition for the need for spiritual care.

These resolutions have been communicated to the Church at large, to members of Parliament and to the media, along with a reaffirmation of the Presbyterian Church's commitment to care for the vulnerable and aged in our society.

The Doctrine Core Reference Group's report on the End of Life Choice Bill is now available to be referred , in revised form, to your church council and congregation for study, along with the decisions of the Assembly on this matter and also an accessible summary of the report. To assist – a series of questions has been included.

Earlier this year I wrote relating to proposed legislative changes with a request that you vote on those matters. I remind you of this and the opportunity you have and the deadline for replies of **10 December 2019**

In Christ,

Wayne Matheson

Assembly Executive Secretary

Doctrine Core Group

REPORT ON END OF LIFE CHOICE BILL AS PRESENTED TO GA18:[1]

A. Introductory comments

The Doctrine Core Group has considered issues around euthanasia, medically-assisted suicide, and the End of Life Choice Bill. Our views in this matter are generally consistent with those of the InterChurch Bioethics Council (www.interchurchbioethics.org.nz), as expressed in its public submission to the Justice Committee of the New Zealand Parliament (and appended to its report to GA18).

At the outset, to avoid all misunderstanding, we wish to emphasise that both the End of Life Choice Bill and our opposition to it have nothing to do with: (a) turning off life support systems so that natural death may take place (where patients are artificially being kept alive but have no realistic hope of survival), or (b) the administration of pain relief to terminally ill patients with the sole intention of relieving pain (but with the known side-effect that in some cases such pain relief medication may possibly accelerate the onset of death), or (3) patients declining life-prolonging surgery or medical treatment, or (4) patients declining food or hydration, or (5) "do not resuscitate" orders. All of those things are commonly practised in contemporary New Zealand, are ethically justified, are fully legal, and amount to our existing right to die in dignity without unnecessary or unwanted medical intervention. None of these practices are "euthanasia", nor are they in any way what the End of Life Choice Bill is about.

What the Bill is proposing (and we strongly recommend that people read the actual Bill) is that anyone aged 18 or over who fits certain criteria may request a doctor to actively end their life, either through an injection or infusion given by the doctor, or through a lethal "medication" set up by the doctor and then triggered by the person who wishes to die. The Bill conflates both of these under the euphemistic term "assisted dying"; but in the first case it should properly be called "euthanasia", and in the second case it should properly be called "medically-assisted suicide" or "physician-assisted suicide".

The proposed criteria for eligibility for euthanasia and medically-assisted suicide are very broad and subjective: they include not just terminal illness likely to cause death within six months, but "grievous" and "irremediable" conditions, "an advanced state of irreversible decline in capability", and "unbearable suffering that cannot be relieved in a manner that he or she considers tolerable".

Certainly there are specifically Christian and biblical-theological reasons for opposing euthanasia and medically-assisted suicide, such as the sixth commandment (which forbids

[1] Some minor revisions have been made in Section 9, with regard to the detail of the proposed safeguards.

murder), God's great love for human beings (which values and dignifies every human life and death), the call to compassion, God's heart for those who are weak and vulnerable, the rejection of selfish individualism, the belief in the common good, the sense that our lives are not ours to live or dispose of as we please, the realistic acceptance of some suffering, the conviction that our times are in God's hands, and the common Christian experience of "a good death". Such biblical values may add a distinctive flavour and depth to our concerns, but they also resonate with many of the wider and more general concerns in our society against euthanasia and medically-assisted suicide.

Supposed popular support for euthanasia, as captured in some polls, taps into most people's personal fears about pain, death, and dying, into the desire that we do not want to see loved ones unduly suffer, and into the societal value of being compassionate. We believe that support for euthanasia is predominately a *pakeha* phenomenon, reflecting contemporary western culture's pronounced individualism, its preoccupation with personal happiness (and its strong aversion to pain and suffering), and the illusion that our lives (and even our deaths) are something that we can control. By contrast, people of Māori, Pacific, and Asian cultures characteristically have a great respect for those who are aged, tend to be less individualistic in outlook, and may often be more accepting of the natural processes of frailty, dying and death; in such cultures, euthanasia usually has little appeal.

We note that many people in the media have adopted euthanasia as an enlightened and liberal cause, which we believe is highly incongruous in view of the realities that euthanasia involves State-sanctioned killing and suicide, and that in time it will inevitably lead to the devaluing of the lives of many vulnerable people and their premature deaths, as has happened in some overseas jurisdictions. We also note that thus far the level of public understanding and debate about this issue has not been particularly well-informed. The polls may also be somewhat inaccurate: 80% of the recent submissions to the Health Committee on "physician-assisted dying" were actually opposed to euthanasia; more than 60% of those submitting made no objection on any religious ground.

Ministers, and many others in the church, are often very familiar with the spiritual, personal, and pastoral implications of serious illness, dying, and death. We know very well the associated fears, distress, pain, and grief. But we also know that death by natural processes has its own timing and dignity, and can be very peaceful and relational, and can be an important part of the process for those who mourn. Many terminal patients, with appropriate support, good palliative care, and advancing illness, come to a place of peace about dying in nature's own timing. There is often a sacredness not just about life but around the end of life. To cut short that time through death by artificial means would be to miss out on something significant and precious both for those who are dying and for loved ones. The approach to death can also often be a time of spiritual healing, growth, and assurance for the person who is dying.

B. Our grounds for recommending that General Assembly declare its opposition to the End of Life Choice Bill are as follows …[2]

[2] Rather than write a whole new position paper on this matter, the Doctrine Core Group has extensively re-worked a paper prepared by the Convener for another context, and has added additional material.

1. *The Bill is inherently unethical and dangerous, because it involves State-sanctioned killing*

(a) For Christians, there is a foundational biblical principle that people should not kill one another.[3] We may understand that theologically (e.g. human life is in the image of God, derives from the breath of God, and is therefore sacred and of great value).[4] However, there are also very practical reasons why divine and human laws forbid killing people: such an ethical code helps to protect the safety of individuals, and therefore the wider wellbeing of society; wherever such a code is put aside evil outcomes will follow, in any society, but as especially demonstrated in war-torn societies where the rule of law has broken down, or in Germany when the State endorsement of euthanasia was followed by the "Final Solution" of the gas chambers.

(b) Deeply influenced by that Judaeo-Christian ethic, modern society, and its law assumes a deep respect for every human life. Public safety, our health system, and our protection of human rights, are all predicated on such an ethic. New Zealand law does not permit any person to kill anyone else (except in self-defence), whether by homicide, manslaughter, or culpable negligence. As an enlightened and ethical society we abolished the death penalty, and are increasingly reluctant to engage in warfare. Society must be extremely wary about relaxing that principle, as enshrined in current laws. This is a threshold we should not cross.

(c) The End of Life Choice Bill, if enacted, would grant legal authority to a very considerable number of persons in our society (all doctors) to actively end the lives of some others (those patients who meet certain criteria). We believe the ethical cost to our society of doctors (or anyone else) being allowed to kill people is simply too great. This is a critically dangerous line. To enact this bill would be an extremely significant change, and inherently imprudent.

(d) The language of the End of Life Choice Bill masks the wider ethical implications of what is proposed, by using euphemisms such as "assisted dying" and "administering medication". We feel this is less than candid. The same could be said for slogans such as "death with dignity".

2. *The enactment of the End of Life Choice Bill would have an erosive effect on the medical profession, on palliative care, and on doctor-patient trust*

(a) In giving doctors the legal right to actively end some patients' lives, the Bill deeply undermines the age-old vocation of those in the healing profession, who are trusted by

[3] This principle is primarily derived from the sixth commandment (Exod 20:13; Deut 5:17), usually translated, "You shall not murder"), and also from other Old Testament commands that attribute bloodguilt to deaths resulting from negligence (e.g. Deut 22:8) or that prescribe how to deal with unintentional killing (e.g. Num 35:10-12). Old Testament commands also specify exceptional circumstances in which persons were permitted to take the lives of other persons (e.g. legal execution of the death penalty by an avenger of blood (Num 35:21). The Old Testament condones killing in war and conquest, but – most important of all – the ethical teaching of Jesus in the New Testament strongly points towards loving your enemies, forgiveness, reconciliation, and putting away the sword.

[4] There is a separate section below on Old Testament principles relevant to the issue of euthanasia.

society to work for life, health, and well-being, and never actively to bring about death. Killing patients (even on request) is completely contrary to medical ethics. Any form of medical killing would fundamentally alter the relationship of medical professionals and those who are seriously ill or disabled. Doctors are committed to preserve life, and to heal. But if they are also permitted to kill some patients, or to help some to kill themselves, that would profoundly change the role of doctors and the trust in which they are held.

(b) The rights and obligations that this bill would confer upon doctors would be welcomed by some, for ideological or financial reasons, but would likely be felt as a heavy burden by many. Even referring patients on to a colleague willing to practise euthanasia would cause significant stress for many doctors.

(c) The practice of euthanasia could in time seriously erode public trust in hospitals and the medical professions. Hospital patients may worry that some medical or nursing staff may become less committed to their continuing palliative care, and that in busy hospital wards with too few beds and too few doctors, subtle pressure may be put upon patients to end their suffering by seeking or consenting to "assisted dying".

(d) There is nothing in the Bill to prevent doctors and other medical workers beginning to suggest euthanasia to some patients as a good option to consider. Such suggestions could be economically motivated: euthanasia would naturally be seen by some health officials as less expensive than on-going care, especially in a society where the numbers of elderly are growing and where there is increasing pressure on the health budget.

3. The Bill is medically unnecessary

(a) The "right to die" already exists. Terminally-ill patients may decline surgery or any life-prolonging treatment. Patients may stop eating. Patients may decline fluids, and death will follow within a few days.

(b) Terminal illness is always a difficult path, and almost always associated with some fear, pain, and distress. Because of excellent modern palliative care, however, very few terminally-ill people nowadays actually live or die in unbearable pain.

4. *The Bill is legally unnecessary*

(a) For the safety of terminally-ill patients generally, and others, it is crucially important that it remain illegal for anyone else to end someone's life or to assist them to end it.

(b) The current law works. Whenever the occasional case comes before a New Zealand court of some very distraught family member illegally ending a suffering loved one's life, or assisting them to end it themselves, judges have shown that they are able within the context of the existing law both to uphold that law and to exercise some compassion.

(c) The way the Bill is framed suggests that its primary aim is to give legal impunity to those doctors who wish to practise euthanasia.

5. The scope of the Bill is much wider than terminal illness

The Introduction to the Bill implies that it is only addressing a relatively few cases of extreme suffering among those with a terminal illness. But the Bill's criteria for eligibility are in fact much wider, and include any "grievous" and "irremediable" medical condition, any "advanced state of irreversible decline in capability", and "unbearable suffering that cannot be relieved in a manner that he or she considers tolerable". These criteria are both very broad, and very subjective. Inevitably, the threshold of "unbearable" suffering will become lower and lower. In the course of time, and mirroring trends already becoming apparent in such jurisdictions as Belgium and the Netherlands, such criteria would inevitably be applied to such conditions as depression, mental illness, dementia, disability, diabetes, incontinence, chronic arthritis, and just advanced old age and weariness with life.

6. *Provision for medically-assisted suicide would undermine New Zealand society's attempts to reduce suicide*

One of the two methods proposed in the Bill for "assisted dying" is where a doctor sets up an infusion of a lethal drug, which is then triggered by the person who wishes to die. This is medically-assisted suicide. The legalisation of medically-assisted suicide through this Bill would send a message to some people already contemplating suicide, that suicide has now become more acceptable. This could significantly undercut society's attempts to reduce New Zealand's tragic rate of suicide. It may be argued that most people would know how to distinguish between medically-assisted suicide and normal suicide; yes, but those considering suicide are not necessarily thinking very rationally. It remains highly inconsistent and problematical for society on the one hand to deplore suicide, and on the other hand to provide a legal mechanism for what is in effect State-approved, medically-administered suicide. Ideologically, this is an irresolvable contradiction.

7. *The risk to public safety, because of the inevitability of coercive pressures*

The Bill is dangerous in the long-term to public safety, especially for those people in society who are our most weak and defenceless. The Bill would inevitably lead to pressure (subtle or otherwise) on some vulnerable people – especially the very elderly, the very disabled, and the very sick – to "do the decent thing" and to request euthanasia. Old people commonly worry that they are a burden to their children, and to those who give them care, and many may feel they should opt for euthanasia. Some unscrupulous families may exert pressure, for financial reasons. The so-called "right to die" would for some people become "the pressure to die", even "the obligation to die". This proposal would open the way to the ultimate State-sanctioned abuse of both the elderly and the vulnerable.

So a key reason for objecting to this bill is that it threatens the lives of those in our society who are our most vulnerable. This is primarily a public safety issue, relevant to everyone in our society; but as a Christian church, we must be especially mindful of God's love for the weak and vulnerable, as evident in both the Old and New Testaments.

8. *The slide towards involuntary euthanasia*

Involuntary euthanasia is the ultimate breach of human rights. The introduction of voluntary euthanasia, in which it becomes legal and gradually more commonplace for some doctors to end the lives of certain patients, would inexorably change the climate of opinion and practice, especially in the health system, and would in time open the door to a growing acceptance and incidence of involuntary euthanasia. In the name of compassion – but with neither request nor consent – some hospital doctors may quietly end the lives of those patients whose lives they feel are no longer worth living. Such doctors may feel that even though they are doing something beyond what the law permits, they are doing so mercifully and even virtuously, that they relieving unnecessary pressures on the health system, and that they are doing society a favour. Over time, the practice of "assisted dying" would make such involuntary euthanasia seem more ethically acceptable. The absence of adequate reporting in the End of Life Choice Bill, and the absence of any criminal consequences for inappropriate deaths, would mean that there would be no effective legal barrier against such unauthorised medical killings. Such a trend is already evident in Belgium and the Netherlands (but is also under-reported).[5] While the majority of New Zealand doctors may want to have nothing to do with euthanasia either voluntary or involuntary, a minority may be very willing to practise it. The risk of being involuntarily euthanised would add another level of apprehension and stress to those who are in hospital or are very disabled, and would undermine trust of the medical professions and health system.

9. *The supposed "safeguards" in the Bill are extremely inadequate*

(a) The End of Life Choice Bill's "Explanatory Note" claims the "safeguards" in the Bill are "stringent". But in reality they appear very far from that. Most "safeguards" in the Bill appear to be designed to present a show of official process and primarily intended to protect not the public but the legal impunity of those doctors administering euthanasia or medically-assisted suicide, through providing a trail of signed authorisations.

(b) Some supposed "safeguards" in the Bill appear slightly farcical, such as the requirement to warn the persons of the "irreversible nature" and "anticipated impacts" of "assisted dying", Part (2), Section (2) (a) (ii)-(iii).

(c) Many "safeguards" in the Bill are very weak, such as:

(i) The "independent medical practitioner" who would be required to give a second opinion on the person's eligibility for "assisted dying" would presumably have to be someone already committed to "assisted dying", and listed as such, and as a result could hardly be seen as "independent".
(ii) There is a requirement to "encourage" discussion with the person's family, but such discussion is not mandatory.

(d) Many safeguards that would have been possible are missing:

i) There is no clause making it illegal for any medical person or family member to suggest assisted dying.

[5] We have chosen not to reference trends in overseas jurisdictions that have legalised euthanasia and/or medically-assisted suicide. Such trends are thoroughly documented in many other places, including the material of the Inter-Church Bio-Ethics Council.

ii) There is no mandatory requirement for a meeting with a palliative care specialist, to discuss enhanced palliative care options.
iii) There is no mandatory provision for independent psychological assessment.
iv) The independent physicians could have been required to be a panel of doctors not connected with any pro-euthanasia group.
v) While a doctor may decline involvement in any "assisted dying", a doctor is allowed no discretion to decline to refer the request to the SENZ group; the mandatory requirement to refer such a request would infringe the conscience of many doctors.
vi) There is no mandatory stand-down period.
vii) There are no safeguards against coercive pressures from family, or medical personnel, or health insurance companies.
viii) There is no provision for a mandatory check by an independent commissioner to check that no coercion has taken place.
ix) There is no provision for a system of supervision or of checking for full compliance with the law.
x) There is no provision that no doctor, medical facility, or other body should benefit financially from the provision for "assisted dying"; without such a safeguard, there will almost certainly be medical professionals and corporate bodies who would seek to profit commercially from any change in the law, and whose vested interests would help lead to the law being applied more and more liberally.
xi) There appear to be no penalties for breaching the law with regard to "assisted dying".
xii) There appear to be inadequate processes for monitoring, scrutiny, and the reduction of abuses.
xiii) There is no clause emphasising that involuntary euthanasia would remain a serious crime.

10. *CONCLUSION: Even with much more stringent safeguards, the End of Life Choice Bill would be ethically unacceptable and in the long term highly dangerous to public safety*

Because of all these issues, and above all because the enactment of the End of Life Choice Bill crosses two key ethical thresholds in proposing the legalisation of medical killing and medically-assisted suicide, we believe that no amount of amending or improving the Bill or inserting additional "safeguards" would make this bill either ethically acceptable or safe for society, long-term. While the often-stated intent of euthanasia is to relieve suffering, euthanasia is not necessary, and its introduction in New Zealand would be dangerous for vastly more people than it is supposed to assist. The risks are too high, especially for society's most vulnerable people (the very ill, the disabled, and the elderly), those whom the State should protect, and those for whom the church should raise its voice.

C. Old Testament principles relevant to the issue of euthanasia

(a) *God created humanity and grants life*

God created and breathed life into humanity. Thus, human life is not simply the possession of a particular human being,[6] but a gift from God (e.g. Gen 1:27; 2:7; Job 12:10; Eccl 5:18[MT 17]; 8:15).[7] Humans are not completely autonomous, nor in charge of their own destinies (e.g. 2 Kgs 20:4-6; Dan 5:23).[8] They are not authorised to dispose of their own lives or the lives of other humans, as and when they see fit (e.g. 2 Kgs 5:7).[9]

Implication: Those who administer euthanasia take autonomy and authority that God has not granted.

(b) *Human life* *has inherent and irreplaceable value***10**

God created human beings intricately, wonderfully, and in God's own image (e.g. Gen 1:26-27; Ps 139:13-16). Among other things, the Hebrew word *nphsh* can refer to that which makes a person a living being (e.g. Lev 17:11), the self (e.g. Isa 46:2), and an individual's life (e.g. 1 Sam 20:1), as well as the centre of a person's feelings, perceptions, and desires (e.g. Ps 42:2[MT 3]). The *nphsh* of any flesh is its blood (e.g. Gen 9:4-5; Lev 17:11, 14). Therefore, shedding innocent blood is not permitted and God requires a reckoning for human life (*nphsh*) (e.g. Gen 4:8-11; 9:5-6; 42:22; Deut 21:8-9; 27:25; 2 Kgs 24:3-4; Prov 6:16-19; Jer 7:5-7; 26:15).

Implication*:* Euthanasia intentionally terminates inherently valuable and irreplaceable human lives.

(c) *Suffering does not indicate that life is no longer worth living***11**

The reasons for suffering are not always obvious (e.g. Job 38-42). Sometimes there are positive outcomes from the suffering (e.g. Isa 53:4-6). There are also many examples of God's restoration of God's people, when they are suffering, near death, or even feeling they have had enough of life (e.g.1 Kgs 19; Pss 34:6[MT 7]; 56:13[MT 14]; 107:17-20; Isa 38). On the other hand, a young Amalekite man is punished for killing King Saul (the LORD's anointed), even though Saul, when he was near to death, had instructed the Amalekite to kill him (2 Sam 1:9-10, 14-15).

Implication: Euthanasia is not an appropriate response to suffering.

(d) *Goals for humanity include life and well-being, not death*

God's people are urged to seek and choose life (e.g. Deut 30:19; Prov 3:18, 21-22). Long life is considered a blessing (e.g. Gen 25:7-8; Deut 30:19-20; Job 42:12, 16-17; Pss 91:16; 128:6), and the Hebrew verb *khyh* relates to preserving and reviving life (e.g. Ps 119:25, 88).

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[6] Gilbert Meilaender, *Bioethics: A Primer for Christians* (Grand Rapids: Eerdmans, 1996), 58, 62.

[7] Ibid., 64. George Bryant, *Euthanasia*, Affirm Booklet 2 (Auckland: Affirm Publications, 1997), 14.

[8] Meilaender, *Bioethics*, 64. From a humanistic philosophical stance, "[t]he human being is in charge of his/her own destiny." Bryant, *Euthanasia*, 10.

[9] Meilaender, *Bioethics*, 62.

[10] Stephen Napier, "Why Are Religious Reasons Dismissed? Euthanasia, Basic Goods, and Gratuitous Evil," *Christian Bioethics* 22 (2016): 282, 290, 292, 293, 297.

[11] "[B]ad experiences do not entail … a life not worth living." Ibid., 282.

The Hebrew noun *shlvm* relates to general well-being as well as peace (e.g. Gen 43:27-28; Num 6:26). *Shlvm* is a blessing for God's people (e.g. Num 6:26; Pss 29:11; 128:6).

In contrast, God's people are not encouraged to choose the way that leads to death (e.g. Deut 30:15, 19; Prov 14:27; Jer 21:8-9). According to Gen 2:7, death came as a consequence of human disobedience. It became the penalty for some crimes and the outcome for those who had been devoted to destruction (e.g. Exod 21:15-17; 22:20[MT 19]; Lev 27:29; Num 35:31; Deut 13:14-15[MT 15-16]; 20:17-18).

Implication: The goal of medical intervention should be continued life and restored well-being, not death.

(e) *God's will for God's people is made explicit*

Ethics and values are primarily an outworking of covenant relationship with the LORD God and based on the standards prescribed in God's law (e.g. Exod 20:1-17; Deut 4:5-8; Ps 119:105; Eccl 12:13).

Implication: God's standards determine whether a decision is in a person's best interests or not.

(f) *Human freedom involves responsibilities*

People exist "in relation to God." Independence and satisfaction of one's own desires are not the ultimate objectives of life (e.g. Deut 6:5; Eccl 12:13).[12] An individual's decisions affect others, including members of his/her family and the wider community (e.g. Gen 44:30; 47:29-31; 50:4-7; 2 Sam 18:5; 19:4[MT 5]).[13] God's people are expected to love their neighbours as themselves (Lev 19:18).

Implication: The decision to euthanise affects not only the person who dies, but also his or her family members, the medical profession, the wider community, and God.

(g) *Community members are expected to care for others, especially the most vulnerable*

God looks after the "aliens," widows, orphans, needy, and other vulnerable individuals. God's people are expected to do the same (e.g. Deut 10:17-18; 14:29; 24:19; Ps 72:12-14; Isa 1:17; Jer 7:5-7). God's people are also expected to respect and care for the elderly (e.g. Gen 44:34; 47:29-30, cf. 50:4-14; Lev 19:32).

Implication: Caring for the most vulnerable members of society does not include providing options to conclude their lives prematurely.

(h) *Demonstrations of compassion do not cause harm to the recipients*

[12] Meilaender, *Bioethics*, 58, 60, 61, 62. Napier discusses the "desire-satisfaction account of goodness." "Why Are Religious Reasons Dismissed?" 290.
[13] Meilaender, *Bioethics*, 61.

Rkhvm is often translated "merciful/compassionate," *rkhm* is often translated "have compassion/mercy," and *rkhmym* is often translated "mercy/compassion," in English translations of Hebrew Bible texts. Based on the instances of these words,[14] it appears that demonstrations of compassion do not cause harm to the beneficiaries. God is the most frequent agent of compassion. Manifestations of God's compassion include relenting (e.g. Joel 2:13), pardoning or forgiving iniquity (e.g. Ps 78:38; Isa 55:7), wiping out transgressions (Ps 51:1[MT 3]), saving or delivering (Neh 9:27, 28), leading (Isa 49:10), gathering scattered people and returning them to their land (e.g. Deut 30:3; Isa 54:7; Jer 42:12), and multiplying (Deut 13:17[MT 18]), but not forsaking, abandoning, or destroying (e.g. Deut 4:31; Neh 9:17, 31). Other manifestations of compassion include keeping a child from being killed (1 Kgs 3:26).

Implication*:* The benefits of compassion do not include termination of life.

Conclusion

According to the Old Testament, God creates, grants, and determines the length of life. Every human life is intrinsically valuable, irreplaceable, and worth preserving, even during times of intense suffering. God determines that which serves the best interests of God's people. In turn, they have responsibilities toward other community members and toward God, including caring for (not killing) the most vulnerable. In contrast, those who administer euthanasia intentionally terminate lives, even though God has not granted them the autonomy or authority to do so. Euthanasia is not a compassionate or appropriate response to suffering. It does not serve the best interests of the person who dies, nor all those affected by that person's death. Medical intervention should be used to preserve life and restore well-being, not to hasten death.

D. New Testament principles relevant to life, death, and euthanasia

(a) The whole of the New Testament is in favour of life, not death

Death is a consequence of the Fall, whereby death and decay spread to all humanity and then to the world (Rom 5:12; 8:19–23). Death is our mortal and final enemy (1 Cor 15:26). The thrust of the New Testament is to undo death. Ultimately, as the Old Testament prophets said, death will be swallowed up and will lose its sting (1 Cor 15:54–56, cf. Isa 25:8; Hos 13:14). The mortal will be swallowed up by life, not life swallowed up by "euthanasia" (2 Cor 5:4). Through Jesus, the pangs of death are loosened (Acts 2:24, cf. 2 Tim 1:10), death will be irrevocably destroyed (Rev 20:14), and there shall be no more death in the new heavens and earth (Rev 21:4). The tree of life will be freely accessible as will the river of life (Rev 2:7; 21:6). Jesus is the resurrection and the life (John 11:25).

(b) Jesus showed God's love of life

[14] Instances of words from other Hebrew word families are also sometimes translated using "compassion".

Jesus repudiated death by healing people and saving them from death (e.g. Luke 7:1–10; John 4:47–54). Jesus never endorsed the idea of bringing the death of another person, in any situation. Jesus raised the dead three times (Mark 5:41–42; Luke 7:11–17; John 11:38–44). By doing this, Jesus gave a foretaste of the hope of the resurrection. Jesus' logic for ministry on the Sabbath was that the purpose of the Sabbath is to "save life", not to kill (Mark 3:4). This illustrated the essential nature of God's ideal of "Sabbath rest" – life and life eternal.

(c) The point of the gospel is not death or killing, but eternal life

The death of the sinless Jesus is the undoing of death as he goes to the cross and rises from the dead to save humanity from sins (1 Cor 15:3). Jesus rose to eternal life, a gift he conveys to believers (Rom 6:23). The trajectory of the story of God is from death to life, and never the cessation of human life by one's own agency or that of another person. This is especially prominent in John's Gospel whereby if anyone is faithful to God "he/she will never see death" (John 8:51) and "will never taste death" (John 8:52). Indeed, the gospel is "the words of this Life!" (Acts 5:20) or "the word of life" we are to hold forth to the world (Phil 2:16, cf. 1 John 1:1). It is the fragrance of God "from life to life" (2 Cor 2:16).

(d) We must all face death, and it is the gateway to eternity, but we should not seek to accelerate death

Just as Jesus died on the cross serving God utterly faithfully to death (Phil 2:8), death is part and parcel of the human life. The believer is to take on the mind-set of Christ (Phil 2:5) and give his or her life in the service of God "even to the point of death*"* (Rev 2:10). They are to take up their cross, and lose their life for Christ's sake, not at their own hands, nor to help another do the same (Mark 8:34–35). They are to be conformed to his death (Phil 3:10). For the writer of Hebrews, the death of Jesus destroyed the power of death and so we are not to fear death (Heb 2:14–15). When the time comes we are to embrace it as it is the gateway to eternal life. But there is no New Testament support for seeking our own death. Believers are baptised into Jesus' death and are to live their lives faithfully to the end when the time comes as the sovereign God oversees them rise to eternal life (Rom 6:3–5). Paul cries out in Rom 7:24, "who will deliver me from this body of death?" His answer is not suicide assisted or otherwise, or another taking his life, but Christ who defeated death (Rom 8:1–4).

(e) The New Testament does not condone suicide

There is no example in the New Testament which indicates one should take one's own life. It has been argued that in Philippians 1:19–26 Paul is considering suicide. However, that is clearly incorrect as Paul is joyful, chooses life and not death, and delights in fellowshipping in Jesus' suffering and being conformed to his death (Phil 3:10).[15] Paul spoke of his near-

[15] See the full discussion in Mark J. Keown, *Philippians*, Evangelical Exegetical Commentary (Bellingham, WA: Lexham Press, 2017), 1:251–53 who rejects this for these reasons: his joy in

death experiences often (e.g. 2 Cor 11:23), but there is no evidence he ever considered suicide. His words in Acts 20:24 show his attitude: "I do not account my *life* of any value nor as precious to myself, if only I may finish my course and the ministry I received from the Lord Jesus, to testify to the gospel of the grace of God." To his dying breath he served his God, knowing that God determines when this will be. He lived his life by faith in the Son of God, and would not contemplate taking it himself (Gal 2:20).

A New Testament example of suicide is Judas, who kills himself by his own hand, by hanging and falling into a field (Matt 27:5; Acts 1:18). His actions including his betrayal of Jesus to his death are seen as being inspired by Satan (Luke 22:3; John 13:2). According to Acts 1:25, Judas is now condemned to "his own place" which as Longenecker says, is likely a euphemism meaning "to go to hell".[16] We also see Paul act decisively when the Roman gaoler sought to kill himself to save himself from being put to death for allowing his prisoners to escape (Acts 16:27). Paul acted quickly to stop him from death by his own hand, so that he might live to find salvation and eternal life (Acts 16:28–34). Again, this is the trajectory of the gospel—a movement from death to life, and life eternal. Suicide is not a Christian option. Authentic Christian living is not accelerating one's own death through "euthanasia," nor actively helping another to die.

(f) Christ neither sought death, nor asked anyone else to kill him

Christ was prepared to allow himself to suffer and be violently killed, but he was far from eager as his Gethsemane prayer indicates (Matt 26:36-42). He did not request his death. But as an act of obedience to his Father, and for the good of humanity, he was prepared to let himself be tormented and killed, as the sacrificial lamb of God (John 1:29; Rom 5:8; 1 Pet 2:24, 3:18), in love "laying down" his life so that others may live (John 15:13; Phil 2:8-10). This act of infinite divine love, of God in Christ reconciling us to himself at great cost (2 Cor 5 10), embracing and accepting pain for the sake of others, is in no way the same as individualistic pain-avoiding acts of medically-assisted suicide.

(g) The New Testament builds on the Old Testament prohibition on murder

God is the giver of life (1 Tim 6:13). He gives life to the dead (Rom 4:17). His Spirit is the Spirit of life, not death (Rom 8:2, cf. 1 Cor 15:45), and the Spirit gives life (2 Cor 3:6). As Paul preached in Athens, "he himself gives to all humankind life and breath and everything" (Acts 17:25). God decides when we die, and it is not for us to decide by our own hand. Nor is it something that one person has the right to do to another.

Phil 1:18; his hope of deliverance/salvation in Phil 1:19; his hope not to be ashamed and to see Christ honoured; his control of his situation and certainty of release in Phil 1:22, 26; his statements "to live is Christ" and "fruitful labor for me" in Phil 1:21–22, and his positive view of suffering in Phil 3:10.

[16] Richard N. Longenecker, "Acts," in the *Expositor's Bible Commentary*, ed. Frank E. Gaebelein (Grand Rapids: Zondervan, 1981), 266.

Jesus endorsed the Old Testament prohibition on murder (Luke 18:20) and put out the challenge that even the thought of harming someone was the same as an act of murder (Matt 5:21, cf. Matt 19:18; Mark 10:19). Where a person conceives hate against another or murders them, they are in danger of hell (Matt 5:22). Hence, Jesus went further than the Old Testament and suggested that even to contemplate killing (murdering) another brings one into the danger of eternal destruction. Murderous thoughts are evil (Matt 15:19; Mark 7:21). Jesus considers murder Satanic (John 8:44). Killing is one of the features of the devil's basic instincts (John 10:10), whereas by contrast Jesus came to bring life in abundance. Paul endorsed this prohibition seeing murder as one of the hideous examples of fallen humanity's gross sin (Rom 1:29). To kill someone is a defiling of the central relational command in Scripture, to love one's neighbour as oneself (Rom 13:9). James, the brother of Jesus, endorsed this view (Jas 2:11; 4:2). Peter warned his readers not to murder (1 Pet 4:15). John repudiated the first murderer Cain (1 John 3:12) and agreed with Jesus that hatred is murder, let alone so-called euthanasia. Indeed, John writes "that no murderer has eternal life abiding in him" (1 John 3:15). Love means to lay down *our* lives for others in need (1 John 3:16–17). Jude repudiated "the way of Cain" (Jude 11).

(h) Biblical respect for the elderly

In ancient cultures, the elderly are cherished, not put to death. So, by the Spirit old men will dream dreams, speaking of their service to God to the end empowered by the Spirit (Acts 2:17). Even a very aged man like Abraham could be used by God to continue God's purposes (Rom 4:19). Joseph's death-bed speeches to his children set the course of their lives (e.g. Heb 11:22, cf. Gen 50).

(i) Biblical respect for the disabled

The disabled are to be cherished and cared for, not cast aside. Jesus' compassion for them was one of the features of his ministry. Those who are near the end of life and are increasingly dependent on others are to be cared for, and this is the heart of *agapē* love and compassion. We see this concern in the Great Banquet, when the disabled and infirm are invited to God's kingdom feast (Luke 14:13–14). When Paul was in prison, an old man and prisoner for Christ, his concern was not to end his suffering, but to travel to Philemon and enjoy his care (Phlm 9).

Conclusion

Under God, the appropriate biblical attitude is the love of life (1 Pet 3:10, cf. Ps 34:12), and life in its fullness is life from conception to the grave and it is God who decides the time when our lives shall come to an end. While there may be a time for just war and the taking or giving of a life to save others, Christians are to work to prolong life and help those who live to flourish in whatever situation they are in. To end a life or assist another in doing so is not

the way of God's people, it is a violation of the way of life, and evil, and the way to eternal death. Jesus is eternal life (1 John 1:2; 5:20), and it is inconceivable that his people who name him as Lord and cherish the Scriptures should consider active euthanasia as an option. Those whose names are in the book of life (Phil 4:3; Rev 3:5) are committed to enhancing the life of others, not taking it.

E. Additional material on old age, palliative care, and euthanasia

Discussion of euthanasia often involves unexamined assumptions and values regarding what constitutes a "worthwhile"" life.

The utilisation of palliative care has implications for the "character" of care institutions, the medical profession and the integrity of the social body. Euthanasia would have implications not only for those whose lives are drawing to completion but also for all those involved in palliative and elder-care.

For a thorough considerations by those at the coal face see the hospice movement's http://www.hospice.org.nz/about-hospice-nz/euthanasia-our-opinion. The *Hospice statement begins with a helpful definition of palliative care. It emphasises the need to direct Government attention and resources to improving and extending the end of life care that is available. It has been noted that there are some serious questions in New Zealand around whether palliative care is being made as widely accessible as it should be, whether many patients who would benefit are currently missing out, and whether enough medical personnel are being trained in palliative care.*

Note various resources:

- Jason Goroncy, "Euthanasia: Some theological considerations for living responsibly", *Pacifica: Australasian Theological Studies*, Vol. 29, Issue 3, 2016. pp. 221-243
- Thomas M. I. Noakes Duncan (University of Otago) "Voluntary Euthanasia in New Zealand: An Analysis of Compassion, Autonomy and Secularism in the Public Square" (available www.otago.ac.nz/ctpi/otago032509.pdf).
- Stanley Hauerwas and Richard Bondi, "Memory, Community and the Reasons for Living: Theological and Ethical Reflections on Suicide and Euthanasia" J*ournal of the American Academy of Religion* Vol. 44, No. 3 (Sep., 1976), pp. 439-452. This is a valuable article, despite its age.
- *The Other Journal* (Issue 14, 2009). This is a broad but constructive collection of articles within which euthanasia is considered and critiqued.
- For good examples of the complicated ethical balancing needed in the care of the elderly see the case studies in the United States National Center for Biotechnology Information: www.ncbi.nlm.nih.gov/pmc/articles/PMC5090095. These speak from the patients' side of the issue and of ethical demands that extended treatment options raise.

A final point is raised by a 2014 Dutch review of effects following the passing of their 2004 legislation. See Theo T. Boer "Euthanasia, Ethics and Theology: A Dutch Perspective", (www.pthu.nl/Over_PThU/Organisatie/Medewerkers/t.a.boer/downloads/boer-2014-res-euthanasia.pdf). It concludes by asking: once a euthanasia law has been passed, how likely is

a paradigm shift to happen from “euthanasia as a last resort in unbearable suffering” to “euthanasia as a right, based on autonomy”? On the basis of the Dutch experience, there are indications that such a shift would also occur in New Zealand.

Rev Dr Stuart Lange (Convener), with other Doctrine Core Group members: **Dr Judith Brown, Rev Dr Carolyn Kelly, Rev Dr Karen Nelson, Rev Dr Mark Keown, and Ross Sutherland**.

Doctrine Core Group: Presentation to GA18 (*This summarises part of the DCG report. The full DCG report also addresses biblical and theological aspects*)

The End of Life Choice Bill, currently before Parliament, is an issue with massive ethical and public safety implications for our society.

Behind these recommendations is the Doctrine Gore Group's comprehensive report, as included in the Assembly papers. Our approach is consistent with that of the InterChurch Bioethics Council.

Clearly, the campaign for euthanasia taps into ordinary human fears of suffering, pain and death. It reflects a secular worldview, a loss of belief in the sanctity of life, and western culture's preoccupation with happiness and personal choice, its aversion to suffering, and the illusion that our lives and deaths are something that we can control. People of Māori, Pacific, and Asian cultures, however, often have a greater respect for those who are old, and are more accepting of the natural processes of frailty, dying and death.

It must be emphasised that the End of Life Choice Bill has nothing to do with such existing measures as…

- turning off life support systems so that natural death may occur (where there is no hope of survival)
- or, the administration of pain relief to terminally ill patients with the sole intention of relieving pain (even though such pain relief may also sometimes have the side-effect of hastening death)
- or, "do not resuscitate" orders,
- or, patients declining life-prolonging surgery or medical treatment
- or patients declining food or hydration

All of those things are common, ethical, and perfectly legal, and part of our existing right to die. None of those practices are the same as "euthanasia" or "medically-assisted suicide".

What the End of Life Choice Bill is proposing is something completely different, that anyone aged 18 or over who meets certain criteria may request any doctor to actively end their life, either through an injection or infusion directly given by the doctor, or through a lethal "medication" set up by the doctor and then triggered by the person who wishes to die. In New Zealand, this is currently completely illegal.

As a church, we have many biblical and theological grounds for not supporting euthanasia and medically-assisted suicide, including the dignity and value and sanctity of every human life as created in God's own image, God's great love for everyone, and our sense that our lives are not ours to dispose of as we choose but are ultimately in the hands of God.

Ministers and others in the church are often very familiar with the spiritual, personal, and pastoral implications of illness and dying, and death…

- We know all about the fears, distress, pain, and grief.
- We also know that natural death has its own God-given timing and dignity, and it is an important part of the process for those who mourn.
- We know that many terminal patients, with appropriate support, good palliative care, and advancing illness, come to a place of peace about dying in nature's own timing.
- We know there is a sacredness not just about life but around the end of life. To cut that time short is to deny something that can be both healing and precious.

We summarise the reasons why we recommended that General Assembly declare its opposition to the End of Life Choice Bill…

1. *The Bill is inherently unethical and dangerous, because it involves State-sanctioned killing*

    - New Zealand law does not permit any person to kill anyone else, except in self-defence or war. But the End of Life Choice Bill, if enacted, would grant legal authority to a large number of persons in our society (that is, any doctor) to actively end the lives of any patient who requests that and meets the criteria). This inherently wrong, and dangerous, and is a threshold we should not cross.
    - The language of the End of Life Choice Bill masks the horror – and the wider ethical implications of what is being proposed – by using euphemisms such as "assisted dying" and "administering medication".

2. *The enactment of the End of Life Choice Bill would have an erosive effect on the medical profession, on palliative care, and on doctor-patient trust*

    - Euthanasia deeply undermines the age-old vocation of those in the healing profession, who are trusted by society to work for life, health, and well-being, and never actively to bring about death. Killing patients (even on request) is contrary to medical ethics.

- The obligations that this bill would impose upon doctors would be a heavy burden for many, in particular the fact that they would be legally compelled to refer patients on to a colleague willing to administer euthanasia (with up to a $100,000 penalty or 3 months in gaol if they refused).

- Hospital patients may rightly worry that some medical or nursing staff may become less committed to their continuing palliative care, and that in busy hospital wards with too few beds and too few doctors, subtle pressure may be put upon patients to end their suffering by consenting to "assisted dying". Such pressures could be economically motivated.

3. *The Bill is medically unnecessary*

- The "right to die" already fully exists. Terminally-ill patients may freely decline surgery or any treatment. Patients may decline fluids, and death will follow within days.
- Because of excellent modern palliative care, the reality nowadays is that very few terminally-ill people die in unbearable pain.

4. *The Bill is legally unnecessary*

- The current law works. Whenever the occasional case comes before a New Zealand court of some distraught family member ending a suffering loved one's life, judges have shown that they are able both to uphold the current law and to exercise compassion.

- The way the Bill is framed suggests that its primary aim is not compassion, but to give legal impunity to those few doctors who are eager to practise euthanasia.

5. *The scope of the Bill is much wider than terminal illness*

- The Introduction to the End of Life Choice Bill implies that it is only addressing a few exceptional cases of extreme suffering among those with a terminal illness
- In fact, the Bill's proposed criteria for eligibility for euthanasia and medically-assisted suicide include not just terminal illness likely to cause death within six months, but much broader and more subjective criteria, including any "grievous" and "irremediable" medical condition, any "advanced state of irreversible decline in capability", and "unbearable suffering that cannot be relieved in a manner that he or she considers tolerable".

- In the course of time, the interpretation of such subjective criteria as "unbearable" suffering will inevitably become lower and lower, and, as in Belgium and the Netherlands, such criteria could begin to be applied to such conditions as mental illness, depression, disability, dementia, and just advanced old age and frailty.

6. *Provision for medically-assisted suicide would undermine New Zealand society's attempts to reduce suicide*

    - One of the two methods proposed in the Bill for "assisted dying" is where a doctor sets up an infusion of a lethal drug, which is then triggered by the person who wishes to die. That is medically-assisted suicide.
    - The legalisation of such medically-assisted suicide through this Bill would send a message to some people already contemplating suicide, that suicide is now more acceptable, and would undercut society's attempts to reduce New Zealand's tragic rate of suicide.
    - It would be problematical for society on the one hand to deplore suicide, and on the other hand to provide a legal mechanism for what is in effect State-approved, medically-administered suicide.

7. *The risk to public safety, because of the inevitability of coercive pressures*

    - The Bill is dangerous in the long-term to public safety, especially for those people in society who are our most weak and defenceless.
    - The Bill would inevitably lead to pressure (subtle or otherwise) on some vulnerable people – especially the very elderly, the very disabled, and the very sick – to "do the decent thing" and to request euthanasia.
    - Unscrupulous families may exert pressure, for financial reasons.
    - The so-called "right to die" would for some vulnerable people become "the obligation to die".
    - This proposal would open the way to the ultimate form of the abuse of the elderly.
    - So a key reason for objecting to this bill is that it threatens the lives of those in our society who are our most vulnerable.
    - This is primarily a public safety issue; but as a Christian church, we must be especially mindful of God's love for the weak and vulnerable, and our obligation to help protect them.

8. *The slide towards involuntary euthanasia*

    - The introduction of voluntary euthanasia would inexorably change the climate of opinion and practice, and open the door to a growing acceptance and incidence of involuntary euthanasia.

- In the name of compassion – but with neither request nor consent – some hospital doctors will quietly end the lives of those patients whose lives they feel are no longer worth living.
- The absence of adequate reporting in the End of Life Choice Bill, and the absence of any criminal consequences for inappropriate deaths, would mean that there would be no effective legal barrier against such unauthorised medical killings.
- Such a trend is already evident in Belgium and the Netherlands.

9. *The supposed "safeguards" in the Bill are very inadequate*

- The End of Life Choice Bill's "Explanatory Note" claims the "safeguards" in the Bill are "stringent". But in reality they are anything but that.
- Most "safeguards" in the Bill appear spurious, and primarily designed not to protect the public but to protect the legal impunity of those doctors who wish to practise euthanasia.
- Some supposed "safeguards" in the Bill are farcical, such as the requirement to warn persons of the "anticipated impacts" of "assisted dying", and advising them of its "irreversible nature".

(e) Many "safeguards" in the Bill are missing, such as…

- The lack of truly independent 2nd opinions
- No mandatory discussion with families
- No barrier to doctors suggesting or urging euthanasia
- No requirement for a meeting with a palliative care specialist
- No mandatory provision for psychological assessment
- No discretion for a doctor to refuse to refer the request to another doctor
- No mandatory stand-down period
- No safeguards against pressure from family, doctors, or health insurance companies.
- No system of supervision or of checking for full compliance with the law.
- No penalties for breaching the law with regard to "assisted dying"

In conclusion,
It is the view of the Doctrine Core Group that no amount of amending the End of Life Bill would make it ethically acceptable, because it two key thresholds: (1) it would allow doctors to actively end people's lives, and (2) it would allow doctors to assist patients to commit suicide.

We consider the End of Life Choice Bill is neither necessary, nor safe. Its effect would be to endanger large numbers of people, especially society's most vulnerable

people (the very ill, the very disabled, and the very elderly): those whom the State should protect, those who may one day be us, and those for whom the church should now raise its voice.

STUDY QUESTIONS

We offer the following questions, which may assist church groups to study the report of the Doctrine Core Group Report on the End of Life Choice Bill. (These questions are keyed to the full report, but are also relevant to the summary)

Section A

1. What is the bill proposing, which is very different to those end of life medical practices which are currently legal and ethically well-accepted?
2. What misunderstandings are there in society about what is being proposed?
3. In your view, what philosophical assumptions and ordinary human fears lie behind whatever public support there is in New Zealand society for voluntary euthanasia and medically-assisted suicide?
4. How well do those views relate to a Christian/biblical world-view? (This is also addressed in Sections C and D)
5. How well does this proposal sit with non-western cultures?

Section B, 1-9

1. Briefly summarise and then discuss each sub-section.
2. Which of these objections (1-9) to euthanasia and medically-assisted suicide are the most compelling for you?
3. How many of the objections raised in 1-9 essentially reflect general human ethics and concerns for public safety? How many are distinctively Christian?
4. Some may wish to mention the journeying through suffering and death of people we have been close to, and how this applies to this issue.

Section C and D

1. Identify and discuss some of the biblical points (see italicised headings) which you find particularly applicable to the issues of euthanasia and medically-assisted suicide?
2. Do you feel there is a tenable Christian case for supporting euthanasia and medically-assisted suicide?

The resolutions of General Assembly

1. How can these best be implemented?
2. If communicating our concerns to our local MPs, what should characterise our manner and tone (1 Peter 3:15)? Which of our concerns are likely to be the most persuasive?