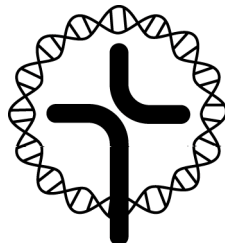


EUTHANASIA

Unethical Intervention or Death with
Dignity?

Interchurch Bioethics Council

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EUTHANASIA

INTRODUCTION

In New Zealand (and Australia) we are allowed to withdraw life saving or life prolonging treatment in circumstances where ongoing treatment is thought to be *futile* and the treatment is not providing *substantial benefit* to the patient. We generally think of a *substantial benefit* as an outcome which now or in the future the patient would regard as worthwhile. Notice that the relevant concept is patient centred and concerned with the all-in well being of the patient rather than narrowly considering the effect of interventions only in terms of the disease or condition being treated. Therefore, even if a resuscitation, for instance, is likely to “succeed” but leave the patient so damaged that they are what people often refer to as “a vegetable” that would not be a substantial benefit to the person.

Some doctors worry about depriving a person of *the necessities of life* which is a crime according to the Crimes Act. But this law is mainly to ensure that people who need it and are dependent on others, including doctors, get medical treatment which they genuinely need (or will offer them substantial benefit).

The latest court decisions imply that we can withdraw treatments which are life sustaining when:

- (a) any normal person would be likely to agree that the present life of the person is not worth living and therefore could legitimately refuse further life-saving treatment;
- (b) the opinion of suitably qualified specialists is that there will be no improvement;
- (c) the decision to let the patient die seems to be what that patient would have wanted if they could have foreseen what would happen.

Despite the fact that we can withdraw treatment in these circumstances there are some things we cannot do in end-of-life decision-making.

We are not allowed to assist suicide, give drugs to hasten death, or administer a lethal combination of drugs to bring about death.

However we can and do give drugs which may or even probably do hasten death provided that we do not give them for that purpose but only because we are forced to in order to make the person comfortable.

Some ethicist and doctors argue that it is worse to withdraw treatment than never start it in the first place because:

- (a) once you start treatment you have entered into an implicit commitment to the patient; and
- (b) you have to actively withdraw treatment once started so it is more like actively doing something to cause the patient’s death.

But in most hospitals part of the information which is shared about the potential recovery or

rescue of a severely ill patient is the possibility that things will not turn out well. What is more the patient's response treatment helps us to gauge how bad their illness is and therefore the withdrawal decision is on a sounder medical footing than a withholding decision.

The situation elsewhere in the world

Elsewhere in the world the challenge of euthanasia has proven difficult for the medical profession and legislators. The Netherlands is the situation where clear laws exist which allow a person to have a doctor help them die provided that the wish is settled, the disease is unbearable and the suffering unable to be relieved by any other means. Belgium has recently followed the Netherlands with very similar legislation. In the USA, Oregon has legalized physician-assisted suicide whereby a doctor can provide a patient with the means to end his or her own life.

Definitions

Euthanasia – literally “a harmonious death” or a death in keeping with a good human life, often translated as “a good death”.

Active euthanasia - an act whereby a doctor ends a patient's life for reasons of achieving a 'good death'.

Active voluntary euthanasia – active euthanasia at the request of the patient.

Withdrawing care – stopping life-saving treatment.

Withholding care – not starting life-saving treatment.

Passive euthanasia – a term sometimes used to refer to letting a person die where things could be done to keep that person alive.

Persistent vegetative State (PVS) – a state where the person's higher brain functions have been destroyed leaving the person unconscious but with some automatic and reflex functions sufficient to keep the body alive if they are fed.

Benefit – doing good for a patient.

- medical benefit – anything which improves the patient's medical condition.
- substantial benefit – an outcome which now or in the future the patient would regard as worthwhile.

Sanctity of life doctrine – the idea that life is sacrosanct and nothing should be done to end it.

Euthanasia: a conversation in a Hospital tea-room near you

Sophie (our philosophy student): I see that the politicians have got themselves into a discussion of euthanasia yet again.

Anne (a neurologist): I cannot understand why we do not just accept that there is a sanctity to human life and that it should be respected.

Brian (a cell biologist): But that is just the old religious line from when everybody believed in God and now most people don't so they should be allowed to have their own choice about the issue.

S: Well I guess, as per usual, you two have sketched out differing views on the topic and we need to spend some time sorting through the arguments to see which of them hold water. Brian seems to have latched on to the most widely held argument for euthanasia and Anne the most often quoted argument against. Brian, would you like to tell us more?

B: There's not a lot more to it, it seems to me, because the patient wants to die and should have the choice as they have about other major management decisions about their own medical care.

A: But that is just allowing people to commit suicide.

S: Not quite, it is allowing people to get an expert to help them commit suicide. So are we to take it that you are open to suicide decisions as well?

B: Well, not exactly. I think that there are cases, for instance a young person who tries to commit suicide when the person should be rescued and their problems should be attended to.

S: What is your reason for that position?

B: It seems obvious to me that some young people are just temporarily upset or totally fed up with life and that they impulsively try to kill themselves but that's not the same with a person suffering from cancer or something who has just had enough.

A: But I have read that really ill people can also get quite depressed and need help to cope with their illness; that seems to me to be a much better thing to do than just help them die.

S: Presumably because, like the youthful suicide victim the state which makes them wish to die might pass with treatment and not represent any clear-headed wish at all.

A: Well, I ask you, how can you actually want to end your life, it's not like agreeing to undergo a nasty experience or anything it is literally the end!

B: But there might be nothing left in that life except pain and distress or, even worse, loss of dignity.

S: So now we have a second argument aimed at the idea that no-one can rationally want their own death (which, incidentally was Immanuel Kant's argument against Suicide at the end of the Eighteenth century). The thought is that the wish to die is not in all circumstances irrational and that we can all understand a genuine and authentic choice not to go on living in a state that the person finds unbearably bad.

B: Precisely, just as we allow other people to make reasonable and understandable choices about their medical care, even if we would not make the same choices, we should allow them to make this one.

S: So here we are arguing that there are cases in which a kind death requires that we allow active euthanasia.

A: But what about the doctor's duty to save life and not to end it?

B: Surely a doctor has a duty to try and alleviate suffering and that may not be able to be done without ending the patient's life.

A: I don't agree, we can always give more treatment and make people comfortable without killing them.

S: But even if you are right in the vast majority of cases what about in that small number of cases where every day that the illness drags out is a day of suffering for the person and those that love them.

A: I think we can and a friend of mine who works in the hospice has told me that there is a lot that can be done nowadays that doctors may not always know about.

S: I'm sure that is true but there might be some really difficult situations in which the doctors have to more or less induce a stupor or coma, put the patient to sleep, as it were, until they die to keep them comfortable because every waking moment is agony.

B: And what's the difference between giving all those drugs to make the person less conscious, some of which depress their breathing and so on, and actually killing the person.

A: The difference is that you're not trying to kill the person.

S: In fact this is a very old and long-discussed argument called the doctrine of double effect whereby as long as you do not try to kill the person but you are only trying to relieve their suffering it is OK to run the risk of hastening their death.

B: Sounds like splitting hairs to me.

S: Not quite, because the idea of what you intended to do is a very important one in the law where it makes all the difference in the world if you kill a person by accident when you are trying to do something else, perhaps even to save them, and you deliberately attempt to kill them.

B: But the doses of the drugs may be exactly the same so we are already doing the same thing in the two cases.

S: Not according to the law or, we hear, in the minds of the doctors doing the end-of life care in these cases.

B: Hold it, hold it. Doctors sometimes stop ventilators and don't treat pneumonias and things like that so isn't that the same thing by different means?

S: Those things would be the same if you believe that there is no difference between killing and letting die but that is also a hotly debated topic.

A: I seem to recall that the Pope in a famous encyclical about life and death¹ said that there were situations in which a person should be allowed to die but that we should not actively kill our patients.

B: But is there really any difference?

A: It seems to me that there is and I think many other doctors also believe there is. I myself feel that there is a world of difference between supporting a person and making sure they are comfortable prior to their death and coming along to the bedside with an injection that is going to end it all there and then. The first alternative seems, I don't know, more natural and peaceful.

B: But the end result is just the same.

S: I agree but we have to think about means not just ends.

B: Do we?

S: Of course we do, think for instance of failing to donate to a third world children's charity with the result that three more children will die from disease or malnutrition in a given year – which may be the statistical outcome of the dollars you did not give. Surely this is not quite the same as going off to Africa or Bangladesh and shooting three children.:

B: Of course not, what kind of person would do that?

A: So this sounds like a genuine moral difference?

B: I suppose so.

S: But it is clearly only a difference of means as the result is the same although the death by gunshot may be more instant and less painful.

A: But a lot more costly unless you employed a local hit-man to do it.

S: I suppose you could hire a hit man in Africa for about \$30 a month, some teenage kid with an AK47 would do it.

B: Hold it, hold it, I don't accept the equivalence here.

S: So you do care about means and not just ends, process not just product, why next thing you know you will be a feminist moral philosopher.

B: Well I think you are overlooking the fact that most people would not see it that way and many people cannot see the moral difference between humane aid-in-dying and what you folk call "letting nature take its course".

S: But surely we are not going to let the fact that many people agree with active euthanasia foreclose the argument?

B: Why not?

A: Again, I think, parity of reasoning holds sway here. After all a majority of people in Germany in the late 1930s seemed to agree with the extermination of Jews as less than human.

B: Oh, you're not just running that old argument about euthanasia and the holocaust again. The situation is totally different as any reasonable historian or sociologist will tell you.

S: I agree but we are talking about a principle here and could equally well discuss eugenics in the early 1900s or slavery in the late 18th Century. The principle is that a majority opinion should not define the moral stand taken by a society.

B: But hold it that's against the principle of democracy.

S: I don't agree, rather it recognises that majorities are manipulated by the media and advertising and that something which seriously affects a range of legislation should be subject to rational debate by a responsible body of legislators who take suitable advice from the groups most likely to have thought about the issues.

B: Yes, I can see the reason for that; but who would be those groups for this question?

A: Well, doctors for one and lawyers and judges for another. The bodies that represent a wide range of doctors and lawyers would be expected to have an opinion and then you might ask ethics committees or some other bodies that look at related issues in medicine and bio-technology.

B: What if such bodies had a high representation of conservative people who might be a little old-fashioned or wedded to particular interest groups like the churches.

S: I don't see that as a great worry if the groups concerned are used to grappling with difficult moral problems unless they happen to be clearly dominated by extremists of one sort or another but I don't think that is a big worry in a country like ours.

B: Some groups have very black-and-white views like the idea that active euthanasia undermines the sanctity of life.

A: I guess death is a fairly black-and-white thing so it might be wise to put up reasonably robust barriers against any liberalisation in matters of life and death.

S: That might especially be so when something like active euthanasia is quite open to abuse and genuinely worrying cases could get lost in the midst of those that were truly compassionate.

A: Do you mean like Harold Shipman in England?

B: Oh, come on, that was an extreme example unlike most doctors involved in care of the dying. That just seems like scaremongering.

S: I think the point is that when we accept that doctors sometimes actively help their patients to die then a given case where it looks like that has happened might not be so carefully investigated as it is now.

B: That's possible but isn't the existence of clear legislation a safeguard against that kind of thing in just the same way as the abortion legislation changed backstreet abortions so that they became safer for woman already facing a terrible problem.

A: That may be true but let's remember that making abortion legal also took away a lot of the moral stigma attached and we now do far more of them for far less compelling reasons than we used.

S: Let's not get into that except to note that what is legal does have some influence on what we regard as morally acceptable.

A: There is also an argument that active euthanasia changes the nature of doctors.

B: I suspect that is like the arguments that always used to go around about Xrays, CT scans and so on taking away all our diagnostic acumen.

A: I'm not so sure they haven't. We are definitely more dependent upon the results of tests these days and more likely to be swayed by their findings than our own clinical judgement even when we know they are not 100% reliable.

S: What do you mean?

A: It's the technological bias. If there is a quick simple and easy way of answering a question then it tends to be used and heeded over against the more uncertain, soft, or subjective ways of looking at a clinical problem.

B: All to the good, I say. It's one thing for doctors to have a god-like status but quite another to rely on oracles.

A: It's not quite that, call it rather relying on human judgement and a fine sensibility to human feelings when situations are unclear, involve vulnerable and needy patients, and a great deal of judgement might be required to discern the truth. To me, if we allow killing and not just letting die, we do change the nature of the dying process and encourage doctors to be much more technological in managing dying.

S: We also change patients I would imagine because they suddenly have to make decisions where they used to be able to rest and let death come in its own time.

B: Which may not be a pleasant or peaceful coming!

A: True, but at least one source of worry and stress is removed.

S: I have also heard some doctors say that they think that active euthanasia is the beginning of a slippery slope.

B: That old argument is very similar to the bad holocaust arguments; the argument neglects the special social and cultural conditions in Germany in the 1930s. We have a very strong pro-life mentality in modern medicine and New Zealand society is very anti any type of discrimination or victimisation of the underprivileged and powerless.

S: Mind you, I have some misgivings about the climate of modern medicine.

A: So have I and I am thinking of the push for convenient and cost effective solutions to clinical problems, the conflicting climate for decisions about quality of life, resuscitation, the wishes of relatives and so on, and the confused feelings among doctors about their clinical responsibilities in the face of patient choices.

B: But surely none of these things means that doctors are willing to kill their patients.

A: I think that there are some dangers because if we lower our psychological barriers to killing patients then it may become easier and easier to do it perhaps for less and less compelling reasons and in more and more awkward and uncertain situations.

S: That sounds very unsettling for younger doctors trying to find their feet in the clinical world and really looking for firm guidelines.

B: But that is an argument for clear laws and transparent decision-making not a continued state of ambiguity.

S: So what are we actually allowed to do in New Zealand for patients who are dying?

B: In New Zealand we are allowed to withdraw life saving or life prolonging treatment where that is not likely to result in a benefit to the patient or be part of a meaningful recovery. The latest decisions in court seem to imply that we can do this when:

- (a) it seems that objectively there is a very poor quality of life;
- (b) the prognosis by suitably qualified specialists is for there to be no improvement;
- (c) the decision to let the patient die accords with an estimate of what that patient would have wanted based on the best evidence available.

S: Sounds like a set of lecture notes.

B: It is actually, but I have just had to get my thinking in order about this because of a recent case I was involved with. We are not allowed to assist suicide, give drugs to hasten death, or administer a lethal combination of drugs to bring about death. The doctrine of double effect applies in New Zealand law so that we can and do give drugs which may or even probably do hasten death provided that we do not give them for that purpose. It is probably right to say that as long as you do what you think best for the patient and consult with colleagues you cannot go far wrong.

A: As long as they understand the law.

B: True.

A: And at the moment the law says you cannot intentionally act to bring about the death of your patient although you can do what is needed to spare them unnecessary suffering and that is usually possible.

S: Well at least that is clear.

STUDY QUESTIONS

1. Is human life sacred? How do any beliefs you hold about the sanctity of human life affect your attitude to euthanasia?
2. What do you see as the difference between not giving a patient life-prolonging treatment, and actively intervening to end a patient's life?
3. Do we have a different attitude to a 16 year old attempting to commit suicide, and an 80 year old with cancer wanting to die?
4. What assumptions about suffering do pro-euthanasia advocates make?
5. What effect do you think agreeing to a parent's euthanasia might have on the family, short and long term?
6. What effect do you think it may have on a doctor if he/she actively assists a patient to die?
7. Who should have input into decisions about euthanasia laws?
8. Can you think of any biblical references which are relevant to the difficult question of euthanasia?

A BIBLICAL PERSPECTIVE

The issue of euthanasia is a complex one and as we approach the Bible to determine a Christian response, it is important to understand that there is no simple answer. There are however Biblical concepts which put together, point us toward a Biblical response to this issue. Often these biblical concepts must be held in tension with the values of our society, but it is in this tension that the Christian voice can be heard and a new way sought. This investigation into the issue of euthanasia will therefore cover four areas: The Sovereignty of God and Human Freedom; Social Responsibility and Individual Rights; Suffering; The Nature of Compassion. This study is not definitive, but will hopefully act as a starting point to allow you to ask the right questions and point the way to some of the Biblical answers.¹

The Sovereignty of God and Human Freedom

Bible References

Genesis 1:26-27, 2:7-9, 2:15-17; Job 1:21; Psalm 104:24-30, 139:1-18; Jeremiah 10:23-24; John 10:10; Acts 17:24-28; Romans 14:7-9; Philippians 1:20-22.

Questions

1. What metaphors might be used to describe the giving of human life by God? What value does the Bible ascribe to human life?
2. In terms of life and death, what role is ascribed to God and what role to humanity?
3. How does being made in God's image affect human freedom? In what ways are we free? In what ways are we limited?
4. Is it within human ability to control everything?
5. How should we respond to God in both life and death?

Social Responsibility and Individual Rights

Bible References

Genesis 9:5-6; Exodus 20:13; Matthew 5:21-22; Luke 10:27; John 13:34;
I Corinthians 8:9-13. 10:23-24. 10:31-11:1. (read these three references together).

Questions

6. In our individualistic society we often forget that the Bible, both Old and New Testaments, were written for communities, therefore individual freedom can not be separated from social responsibility. In this social context, what does the Bible say about the taking of human life?
7. Richard Gula suggests that Exodus 20:13 needs to be interpreted in the light of Exodus 20:12, where in the context of a nomadic lifestyle, the old and sick were often left behind to die.² How might this understanding impact on your view of euthanasia?
8. The moral teaching of Jesus extended the written law to include the attitude of our hearts. How might this be relevant to the issue of euthanasia?
9. How should we determine what is loving toward our neighbour? How would you determine when and how you wanted to die?
10. In 1 Corinthians(see above), Paul suggests that individual freedom has a lesser priority than social responsibility. How would you apply this to the issue of euthanasia?
11. What might be some of the social consequences of allowing euthanasia?

¹ All Bible references are taken from, Michael D. Coogan ed, *The New Oxford Annotated Bible, NRSV*, (New York: Oxford University Press, 2001, 3rd ed).

² Richard Gula as quoted in Margaret Whipp, *Euthanasia – a Good Death?*, Grove Ethics Series E117 (Cambridge: Grove Books Limited, 2000), 19.

Suffering

Bible References:

Psalm 10:14; Luke 22:63-24:53; John 18:1-20:31; Romans 8:18; 2 Corinthians 4:13-18; Hebrews 2:14-18, 4:14-16.

Questions

12. At the heart of the euthanasia debate is the issue of suffering. What image of suffering does Paul suggest in Romans and Corinthians?
13. In facing death, where does Paul's hope lie?
14. The death and resurrection of Jesus provides a powerful image of suffering and God's restorative action. As Luttenberger suggests, "Therefore, although suffering does exist and although God does not destroy the forces which perpetuate suffering, the Christian experience of the risen Lord and the belief in God's supreme act of "raising" Jesus from the dead clearly show that God does not leave persons to remain in pain and misery; much less does he desire or inflict the suffering itself. Rather, God supports persons in their suffering. ... Suffering may still evoke confusion and darkness, but a Christian understanding of suffering, in the light of Jesus' resurrection, will interpret it ultimately as an occasion in which one is not abandoned by God."³
How might suffering, and hence the relief of suffering through euthanasia, be viewed in this light?
15. What hope can we find in the suffering, death and resurrection of Jesus?

The Nature of Compassion

Bible References

Matthew 8: 5-13, 9:35-36, 15:32 and 20:29-34; Mark 1:40-42; Luke 4:18 and 7:11-15.

Questions

16. The Gospel image of Jesus proclaiming the Kingdom of God is one of boundless compassion and the restoration of brokenness. What was Jesus' answer to the suffering he witnessed?
17. The Christian life includes following the example of Jesus. What might our response then be to suffering? (Also see Matthew 10:8 and 25:35-40).
18. Can this image of Jesus be reconciled with the act of euthanasia? What might be an alternative response, rather than resorting to euthanasia?
19. Genesis 2:18a. God saw it was good that man was not alone. Does this have any relevance to the isolation of someone who is brain dead or in a coma?

³Gerald H., Luttenberger, *An Introduction to Christology in the Gospels and Early Church* (Mystic: Twenty-Third Publications, 1998), 257.

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* Highly recommended.