A Good Death? Euthanasia and Assisted Suicide

'Death like the sun should not be stared at'. Yet advances in medicine force us to do just that. If we are going to develop an authentic Christian response to the issues of euthanasia and medically assisted suicide, we need to stare at death with renewed intensity. We need to stare at its mystery and awful finality, at the questions and fears it raises, and at our own mortality.

'It's not that I'm afraid of death, its just that I don't want to be there when it happens'. The words of Woody Allen ring true. The problem is we have little choice in the matter. It is the drive for choice, for control, for personal autonomy which is at the heart of current moves towards the legalization of euthanasia which are taking place across the world.

Definitions

Words are slippery things, and in this debate, phrases such as the 'right to die', a 'merciful death', 'relief of suffering', and 'assisted dying' are often used loosely leading to confusion and misunderstanding. The phrase 'the right to die' sounds so reasonable and yet it can mean at least five different things to different people: (1) the right to refuse life-sustaining treatment which is burdensome and futile; (2) the right to refuse life-sustaining treatment for any reason; (3) the right to commit suicide for 'rational reasons'; (4) the right to obtain help in committing suicide; or (5) the right to be killed by a doctor at your request.

Of these the first is both legal and accepted as a basis of good medical care, the second and third are not illegal, whereas the last two are both illegal in most jurisdictions in the world. When we enter into the debate about euthanasia, we must challenge people to use words accurately and carefully. The term 'euthanasia' means literally 'a good death'. But here is a more precise definition: 'Euthanasia is the intentional killing by act or omission, of a person, whose life is thought not to be worth living'

This definition puts the emphasis on *intentional killing*, a deliberate and premeditated act to take life, to introduce death into a situation. Secondly it implies that euthanasia may be performed either positively by deliberate act, or negatively by omission. It is the *intention* to kill which is central to the definition. Euthanasia can be divided into *voluntary* euthanasia, killing carried out at the patient's explicit request, and *involuntary* euthanasia, where no

immediate or unambiguous request has been given, although a previous willingness to be killed may or may not have been expressed.

Under what situations has involuntary euthanasia been suggested? There is the malformed or brain damaged infant, whose life is considered to be worthless, or so limited due to disability that death is preferable to continued existence. There is the comatose or unresponsive patient, such as person in a persistent vegetative state. There is the confused or demented patient who many have previously expressed a wish to die, but is now incapable of understanding their current situation. Finally, there is the person with a severe untreatable psychiatric disease or personality disorder, who feels their life is worthless but is unable to give legal binding consent.

It is important to distinguish euthanasia from two other clinical practices: the withdrawal of life- sustaining medical treatment which is regarded as futile or burdensome, and the giving of symptom- relieving treatment in order to benefit the patient which may have the unintended side effect of shortening life. Both of these are an accepted part of normal medical practice.

Physician-assisted suicide

If euthanasia is defined as intentional mercy-killing, its close relation is physician assisted suicide (PAS) – the deliberate assistance by a physician in the suicide of a patient who intends to end his or her own life. It is intentional killing, but at one remove. Traditionally, both Euthanasia and assisted suicide were forbidden under almost every known code of law. The Hippocratic oath, which originated several centuries before Christ, specifically rules out both Euthanasia and PAS: 'I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them. I will not give poison to anyone though asked to do so, neither will I suggest such a plan.'

Now there is an international move to legalise both Euthanasia and PAS. As of March 2018, active human euthanasia is legal in the Netherlands, Belgium, Colombia, Luxembourg and Canada. Assisted suicide is legal in Switzerland, Germany, the Netherlands, and in the US States of Washington, Oregon, Colorado, Hawaii, Vermont, Montana, Washington DC, and California.

In 2006 the Voluntary Euthanasia Society changed its name to 'Dignity in Dying'. It seems that the sanitization of language is part of a strategy to make ethically controversial actions more acceptable. Killing sounds harsh, shocking. Finding a euphemism like 'assisted death', or 'death with dignity' makes the same action more acceptable. A senior Palliative care nurse responded to the use of the phrase 'assisted dying' for PAS. 'Midwives assist birth and palliative care nurses assist the dying with specialist palliative care. Assistance is not the same as killing. The use of the term "assisted dying" is offensive to those of us who are giving good care at the end of life. It is a deception to sanitise killing to make it more acceptable to the public. The implication is that you can only die with dignity if you are killed.'

Fear – the heart of the debate

Fear of Pain

By 'fear of pain' we mean much more than merely physical pain. We are referring to what palliative care specialists call *total pain*. This isn't easy to define. It is distress which has many components. Take an elderly person dying from cancer. He is in physical distress because the disease has spread to the bones, causing a continual grinding discomfort. He is in psychological distress because he is frightened at what the future may hold. He is in relational distress because the family is putting on a brave face and refusing to acknowledge the reality of what is happening. He is in spiritual distress because he is confronting the ultimate reality of death without any sense of meaning or purpose. What has his life been for? As a society we have lost the belief that suffering can have any positive value at all.

Fear of Indignity

These are the words of Ludovic Kennedy, "For many people the fear of being snuffed out before our time has been superseded by a greater fear, that of suffering a painful and lingering death when all possibility of revival has gone, being kept alive but deteriorating all the time. It is not death that people fear most, but undignified dying".

Fear of Dependence

These are the words of German philosopher Friederich Nietzsche: 'In a certain state it is indecent to live longer. To go on vegetating in cowardly dependence on physicians and machinations, after the meaning of life, the right to life, has

been lost, that ought to prompt a profound contempt in society…. I want to die proudly when it is no longer possible to live proudly.'

Ronald Dworkin argues that, even if we feel that our own human dignity is at stake if another person treats his own life as valueless, 'a true appreciation of dignity argues decisively in the opposite direction- for individual freedom, not coercion, for a regime of law and an attitude that encourages each of us to make moral decisions for himself. Freedom is the cardinal, absolute requirement of self -respect: no one treats his life as having any intrinsic objective importance unless he insists on leading that life himself, not being ushered along it by others.'

What are the dangerous consequences of permitting PAS? Surely one would be the subtle but highly significant change in the relation between doctor and patient. Currently the doctor is asked to cure when cure is possible; and regardless of whether cure is possible to continue to care. Thus, no cure should displace the duty to care; and no lack of cure should discourage or diminish that fundamental commitment to care. Assisted dying changes this relationship. Now the doctor's duty is to assist the patient in realising their desire to effect tangible change in their circumstances- and it change can't come about by cure, then change must be brought about by death. Medicine gradually ceases to be the practice of caring, even when one can't cure, and becomes the business of effecting change and executing the patient's wishes.

The second dangerous consequence of assisted dying is that a number of people who may have feared becoming a burden will almost certainly find their path to an earlier than natural death becomes hastened and difficult to inhibit. What started as the desire to assert the decision-making power of the suffering patient almost inevitably leads to creating convenience for the not so long suffering relative. If a person has signed an advance directive to suggest that they should be given a lethal dose should their health decline to a certain point, who is to intervene when their behaviour suggest they have changed their mind?

Sam Wells notes that the Christian doctrine of resurrection and everlasting life 'that precious benefit of Christ's passion that relativizes our anxiety about clinging to this present life and places our trust in Christ's promise of eternal life with God, curiously plays almost no role in the religious contribution to the public debate'

For Wells the most persuasive, most emotive and most troubling word among the arguments of those who advocate assisted dying is not choice, or dignity: it is compassion. Is it appropriate to call assisted dying an act of compassion?

Compassion is a wonderful word. It means to suffer with. Its what the Good Samaritan felt for the man who had been left half dead on the road to Jericho. Compassion is precisely what Jesus shows us, when like the Samaritan, he comes upon us in our troubled circumstances, makes our burdens his own, and through the Holy Spirit is present to us in our trials. The point of compassion is that it says. 'There's nothing you can go through that I will not face with you, there's no suffering you can reach that will scare me away, there's no pain you have to bear that will stop me walking beside you every step of the way. Compassion doesn't say, 'Of course there's no answer to this. Of course, you can't go on. Of course, you want to die.' Compassion persuades, encourages, reassures and supports and says, 'Together we can get through this.' For Wells a subtle thing compassion sets aside is the impulse to bring a solution. Bringing a solution isn't compassion (suffering with); its fixing, which is creating circumstances in which it isn't necessary to suffer with, because there's no more suffering to endure. Compassion is precisely being willing to accompany a person when there is no solution to their predicament.

Good Medicine knows its limits

For John Wyatt, the essence of being a good doctor is to know when 'enough is enough'. But how do we know when we should withdraw treatment, or withhold it? The most helpful way of addressing this issue is in each individual case, to try to balance the benefits against the burdens and risks of treatment. An obvious case is in advanced cancer. Is the burden of chemotherapy treatment, with all its unpleasantness, worth the benefit of maybe an extra three months survival? The answer is 'it all depends'. In some situations, those three extra months might enable all kinds of 'unfinished business' to be completed. In other situations, those three months may seem to bring little benefit compared to the burdens of invasive treatment.

Good medicine recognises the difference between intention and foresight

The pro-euthanasia lobby ridicules the difference between the traditional view that doctors may give a drug to relieve suffering that may incidentally shorten life, but may not deliberately give poison to end life. This is viewed as hypocrisy, as a deliberate attempt by doctors to cloak their life-terminating

activities in a charade of respectability. John Wyatt speaks of the 'widely disseminated propaganda to the effect that morphine is a highly dangerous and lethal poison, and that when doctors give morphine they are intending to kill but covering their tracks, to prevent prosecution. This is dangerous and misleading nonsense.' Wyatt states that when the euthanasia doctors want to kill they do not use morphine. The drugs used are barbiturates and muscle relaxants. These are the drugs of the anaesthetist, capable of inducing rapid-onset coma and muscle paralysis, not the drugs of palliative care.

Good medicine recognises the difference between intention and foresight. This is the so called 'principle of double effect'. Doctors treat cancers with toxic poisons knowing the likely effect- hair falls out, damage is caused to the bone marrow, the heart muscle and bowel lining- they carry a real risk of death. Does this mean that the actions are immoral? No, because the intention in administering these poisons was to heal. The doctor can foresee what the side effects might be, but they were not the intended goal.

In the same way in the treatment of the dying patient, the intention in withdrawing treatment such as intensive life support, or in giving opiates is to relieve suffering, to bring benefit to the patient. The doctor can foresee that the treatment decisions may shorten life, but that is not their intention.

Behind the principle of double effect lies a contrast between two ways of thinking about the actions of a moral agent. To many secular philosophers, human beings are totally responsible for the consequences of their actions, whether they are intended or not. Thus, if I perform action A and B results, I carry out full responsibility for B, even if I intended C. If I give a therapy intended to heal, but my patient dies as a result, I am as responsible for their death as though I had intentionally murdered them. My intentions are irrelevant.

But the orthodox Christian way of thinking views the stream of world history as ultimately under God's providential control, not as a product of human choices. My responsibility as a moral agent is to act *wisely.* It is as if I am called to toss into the continually moving stream of history wise and moral actions which are intended to do good. The eventual consequences of my actions 'downstream,' are outside my control and ultimately part of God's providential rule of the universe.

Ross