



# living counter culturally

talk sheet

Euthanasia and  
Assisted Suicide

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## A step too far?

Human beings have always had a complicated relationship with pain. It seems to have the ability to both degrade and affirm our experience of life. No one seeks pain. It is tiring and debilitating and yet it is what gives words like 'courage' and 'empathy' meaning. The effective management of pain allows courage and empathy to flourish. Its elimination threatens to make those terms meaningless.

Take a few moments to consider the following statement:

**Never in human history has suffering been more readily relieved than today. And yet, paradoxically, we have never been more afraid of suffering.<sup>1</sup>**



The benefits of medical science have certainly resulted in us being exposed to less pain. Before effective anaesthesia, surgery was a horrific experience for the patient. 'Reminiscing in 1897 about pre-anaesthesia surgery, one elderly Boston physician could only compare it to the Spanish Inquisition. He recalled: '... yells and screams, most horrible in my memory now, after an interval of so many years.'<sup>2</sup> Today, patients are unconscious through surgery and doctors have a range of pain-relieving medication available to them to ease patient discomfort during post-operative recovery.

Of course, physical pain is not the only kind of pain that we experience. We suffer psychological pain and emotional pain too. Before the development of modern psychiatry and psychology, the experience of those with mental illness or emotional disorders was a sad and frightening life of poverty and discrimination in their community or isolation in an 'insane asylum'. Today, the right combination of therapy and medication can offer people a significantly improved quality of life and social interaction.

All this is not to say that the various types of pain can be entirely avoided, but it is true that we experience considerably less pain than our ancestors did. When medicine can ease a patient's experience of pain or discomfort, it is a good thing. But now a further step to avoid pain and suffering is being suggested. It is certainly a major step and we are being asked to consider whether it is a reasonable step or one that goes too far.

The suggested step is the legalised provision of euthanasia or assisted suicide.

## How did we get here?

It seems unusual that when pain management was at its least developed there was little call for legalised euthanasia and assisted suicide, yet at its most developed the call for legalisation is at its most insistent.

One of the possible reasons for this is suggested by bioethicist Yuval Levin in his 2008 book *Imagining the Future*: 'The worldview of modern science sees health not only as a foundation but also as a principal goal; not only as a beginning but also an end.

The Salvation Army's positional statement on euthanasia and assisted suicide states that it believes strongly that all people deserve compassion and care in their suffering and dying. Euthanasia and assisted suicide should not, however, be considered acceptable responses. They undermine human dignity and are morally wrong. The Salvation Army believes therefore that euthanasia and assisted suicide should be illegal.<sup>3</sup>

The statement offers the following definitions:

Euthanasia means killing someone else whose life is thought to be not worth living. Voluntary euthanasia is done at the request of the person who is to be killed or with his or her consent. Non-voluntary euthanasia is done without the request or consent of the one who is killed, because he or she is not capable of giving consent (for example, the killing of a patient with advanced Alzheimer's disease). Involuntary euthanasia is the killing of a person who is capable of consent, but has not given his or her consent to be killed.

Suicide is the direct and intentional killing of oneself. In assisted suicide someone else provides help to the person committing suicide (for example, instructions about how to commit suicide efficiently, or the means with which to do it) Where the assistance is given by a doctor, we speak of physician-assisted suicide.

Relief and preservation—from disease and pain, from misery and necessity—become the defining ends of human action, and therefore of human societies.'

What Yuval is suggesting is that society has moved from seeing pain management as a beneficial tool to regarding the avoidance of suffering as a primary goal in life. That would be a significant shift in the way we view the purpose of life and could explain why there are now calls for the legalisation of euthanasia and assisted suicide.

Society gives a person a certain level of autonomy to make their own choices about how they live their life, but no one is given

absolute autonomy. There are a range of choices society does not allow because those choices present an unacceptable risk to the person concerned or to other members of society.

Generally accepted primary goals of life have a significant influence on which choices a society will and will not allow. If a primary goal of life is to support people as they live their life to its natural end then it would not be surprising to see pain reduction as a beneficial tool and effective and universal palliative care as its most developed expression. If a primary goal of life is to avoid suffering at all costs then it would not be surprising to see society making euthanasia and assisted suicide legally available.

### **From a biblical perspective**

#### **What are the primary goals of life?**

We are part of God's creation and are to be good stewards of that creation (Gen 1:26–31). Our lives are given to us by God. We are caretakers of his creation and this includes caring for all other human beings.

We are created for fellowship and communion with God (John 14:23) and with each other in community (John 17:23). One of the reasons for living in community is that we can support (Gal 6:2) and encourage (Heb 10:24–25) one another. 2 Cor 1:3–4 says, 'Praise be to the God and Father of our Lord Jesus Christ, the Father of compassion and the God of all comfort, who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves receive from God.' See also The Parable of the Good Samaritan (Luke 10:27–37).

We are created in God's image (Gen 1:27) and we are to reflect that image (2 Cor 3:18; Eph 4:24). God is love and we reflect that love by loving others (1 John 4:7–12).

We are created for God's glory. Our purpose is to praise God, worship him, to proclaim his greatness, and to accomplish his will. This is what glorifies him. 1 Corinthians 10:31 says, 'So whether you eat or drink or whatever you do, do it all for the glory of God.'

#### **Questions for reflection:**

- (1) What do these biblical primary life goals say about how we should respond to suffering?
- (2) Are there any other biblical primary life goals we should take note of when thinking about euthanasia and assisted suicide?

#### **What other biblical accounts or principles may be relevant?**

What can we learn from the story of Job about human suffering and God's response? Consider Job 2:9-10, 3:11, 6:8-10, 13:15, 21:22, 37:23-24, 38:1–41:34 and 42:1-6.

The Bible witnesses to the sovereignty of God. Psalm 139:16 says that 'all the days ordained for me were written in your book before one of them came to be'. Jeremiah prays, 'Lord, I know that people's lives are not their own; it is not for them to direct their steps' (Jeremiah 10: 23).

**The Salvation Army accepts the principle that all people deserve to have their suffering minimised in every possible way consistent with respect for the sanctity of life. All human beings are made in the image of God, sacred and with an eternal destiny. Accordingly, all people have dignity and worth whatever their circumstances.**

#### **Also consider:**

- God the shepherd leading us through the valley of the shadow of death, Psalm 23.
- The incarnation of Jesus and his suffering death, Philippians 2: 5–11.
- Our bodies as temples of God, 1 Corinthians 6: 19–20.

### **Public attitudes to euthanasia and assisted suicide**

The Parliamentary Health Select Committee report on Petition 2014/18, released in August 2017, summarises people's attitudes in this area.<sup>4</sup> Some of those attitudes are further summarised here.

- *You may like to discuss which perspectives are most consistent with a biblical perspective.*

#### **Dignity**

Some people define 'dignity' as 'the ability to look after themselves and maintain their independence'. They are concerned that they will be a burden on others and the country's health system and that this will diminish their sense of self-worth. They gave examples which included requiring a wheelchair, needing assistance with toileting, being unable to fully communicate, and developing dementia.

Some people argued in their submissions to the Health Select Committee that this perspective undermines the idea of human dignity by equating an individual's worth with their ability to contribute to society. Such a view would be particularly concerning for disabled people because their lives might be seen as having less value, and for the elderly who might feel that they should seek an earlier death so as not to be a burden on family members.

#### **Pain and suffering**

In their submissions, some people recounted stories of family and friends who had died in pain over extended periods of time in hospital. They expressed regret about this suffering and felt it should not have happened and could have been avoided through the provision of euthanasia. People expressed the fear that they might experience pain and suffering in the future. To avoid this, they wanted the option of euthanasia. Some thought consideration of pain and suffering should not be confined to physical pain but also include mental and emotional suffering.

Amongst the submissions, medical and health practitioners said that no one should be dying in pain in New Zealand in the 21st century. Instances of this occurring indicated a failure in care and a deviation from the norm. It was also stated that many people misunderstand serious health issues and frequently misinterpret symptoms as indications of pain.

Several hospices made submissions on the nature of pain and suffering. They pointed out that not all pain is physical, and that in addition to treating physical discomfort, they also pursue the treatment of emotional, social and spiritual suffering. They argued that the very nature of hospice care and the underlying philosophy of neither hastening death nor prolonging life preclude the use of euthanasia and assisted suicide.

### Autonomy

Some people said an essential part of life in a liberal democracy and of medical ethics is individual autonomy. They placed a high value on their own autonomy and desired the right to end their life at the time of their choosing.

Other people argued that in a society, individual autonomy is frequently limited for the good of all members of that society. They illustrated their point by highlighting the need for traffic speed limits, and controls on guns and tobacco. Public safety was frequently cited as a reason why assisted dying could not be legalised. It was also noted that the individual's right to autonomy must be balanced against the effect that euthanasia and assisted suicide could have on others, such as patients' families and vulnerable members of society.

### Widening of scope: the 'slippery slope'

People making submissions, regardless of their views, were concerned about the 'slippery slope' effect—a tendency for assisted-dying laws to widen beyond the initial intentions. People cited the Netherlands and Belgium as examples of jurisdictions where the scope of legislation to assist dying has widened since it was introduced. Their laws were initially intended only for the terminally ill, but some submitters point to evidence of assisted suicide or euthanasia in cases of psychiatric conditions, dementia, depression and old age.

The initial Belgium law, passed in 2002, restricted euthanasia to those over the age of 18. However, in 2014 the scope was extended to people under the age of 18 in highly specific circumstances, including having a terminal condition and where a psychiatrist has deemed them competent. Some people expressed concern that the expansion of scope for assisted dying has seen an increase in the number of people ending their lives.

One of the more extreme examples offered by submitters was the increase that occurred in Belgium between 2002 and 2015. The number of people euthanized annually rose from 24 to 2,021. Other people argued that changes in scope are part of the democratic process, and that an increase in such deaths only demonstrates public awareness and acceptance over time.

### The role of medical professionals

The Health Select Committee heard from the New Zealand Medical Association (NZMA) that although patients have a right to autonomy in their health care choices, ethical and societal considerations inherently limit personal autonomy. Assisted dying or euthanasia does not only involve a patient's own personal autonomy, it necessarily also requires the involvement of a health practitioner. The NZMA believes assisting dying is incompatible with medical ethics. The World Medical Association holds the same view.

There are a few individual jurisdictions, like Belgium, where medical associations support or are neutral towards assisted dying or euthanasia, and where some individual doctors have expressed their support for euthanasia and assisted suicide in specific circumstances.

### 'Safeguards'

The Health Select Committee noted that most people making submissions identified effective safeguards as an important part of any assisted dying legislation, but that many of the safeguards proposed were actually simply eligibility criteria. Some people questioned whether formulating effective safeguards was actually possible, particularly given that none of those proposed 'safeguards' related to anyone other than the person wishing to end their life. How will other vulnerable

members of society such as the disabled and elderly be protected from the perceived value of their lives being eroded by the legalisation of euthanasia?

### Palliative Care

Modern palliative care is a comprehensive package of medical, social and spiritual care. The careful selection and application of the medical tools available to the specific needs of each person receiving care means that almost all physical pain can be relieved effectively.

**When people are supported emotionally, socially and spiritually, all types of pain and suffering can become more bearable.**

The World Health Organization (WHO) describes palliative care in the following way:

**An approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.**

Palliative care:

- provides relief from pain and other distressing symptoms
- affirms life and regards dying as a normal process
- intends neither to hasten or postpone death
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help the family cope during the patients' illness and in their own bereavement
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- will enhance quality of life, and may also positively influence the course of illness
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.<sup>5</sup>



**For discussion**

John is a 39-year-old father of teenage children who was diagnosed with muscular dystrophy four years ago. The disease has progressed rapidly, leaving him bedridden, barely able to move because of the loss of muscle tissue. He still has full mental capacity to make decisions about his life and wellbeing. John has expressed a desire to die, yet his family is opposed to the idea.

Jill is an 81-year-old widow. She was diagnosed with incurable stomach cancer 12 months ago. Her greatest fear is that she will die in intolerable pain. Jill's one surviving son is himself sick and they are both struggling financially. Recently, some of Jill's friends have been talking about euthanasia and she wonders if this would save her from being a burden on others.

Gary recently suffered a sports injury that has left him paralysed and wheelchair-bound. He needs help with all his bodily functions. His family are very supportive, but the injury has hit him hard psychologically and he is struggling to come to terms with it. He is wondering what he should do if euthanasia was a legally available option for him.

*Discuss each of these situations in light of the issues raised in this Talk Sheet:*

- What are the difficulties and challenges presented in each scenario?

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- Who are the immediate and wider parties involved? How might euthanasia affect these people?

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- What moral issues are presented?

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- How does a biblical perspective speak into the situation?

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**Further reading**

**The Salvation Army:** [www.salvationarmy.org.nz/euthanasia](http://www.salvationarmy.org.nz/euthanasia)

**Care Alliance:** The Salvation Army is a member of the Care Alliance, a diverse alliance of organisations and individuals who want to nurture better conversations about dying in Aotearoa New Zealand. Visit [www.carealliance.org.nz](http://www.carealliance.org.nz).

**The Life Resources Charitable Trust:** A New Zealand resource for life-related issues. Visit [www.life.org.nz](http://www.life.org.nz).

**16,000 Voices:** Publishing some of the diverse opposition to euthanasia and assisted suicide as presented to the 2016 Health Select Committee's investigation in response to the petition of Maryann Street and 8974 others. Visit [www.16000voices.org.nz](http://www.16000voices.org.nz).

**Endnotes**

- 1 <https://www.firstthings.com/web-exclusives/2012/08/our-neurotic-fear-of-suffering>, accessed 10/08/2017
- 2 <https://neurosurgery.mgh.harvard.edu/history/beforeth.htm>, accessed 10/08/2017
- 3 [https://s3.amazonaws.com/cache.salvationarmy.org/21df0850-f5a8-4440-affb-d5da46815142\\_Euthanasia+and+assisted+suicide.pdf](https://s3.amazonaws.com/cache.salvationarmy.org/21df0850-f5a8-4440-affb-d5da46815142_Euthanasia+and+assisted+suicide.pdf), accessed 17/08/2017
- 4 The full report is available at [https://www.parliament.nz/resource/en-NZ/SCR\\_74759/4d68a2f2e98ef91d75c1a179fe6dd1ec1b66cd24](https://www.parliament.nz/resource/en-NZ/SCR_74759/4d68a2f2e98ef91d75c1a179fe6dd1ec1b66cd24), accessed 24/08/2018
- 5 World Health Organisation 2017. [www.who.int/cancer/palliative/definition/en](http://www.who.int/cancer/palliative/definition/en), accessed 24/08/2017

**Talk Sheets on various topics are online at:**

[salvationarmy.org.nz/masic](http://salvationarmy.org.nz/masic)

**For more information, contact the Chair of the**

**Moral & Social Issues Council:**

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**Salvation Army Positional Statements:**

[salvationarmy.org.nz/positionalstatements](http://salvationarmy.org.nz/positionalstatements)