

MEDICAL ASSISTANCE IN DYING

Origin: Theology and Inter-Church Inter-Faith Committee

The Theology and Inter-Church Inter-Faith Committee proposes:

That the Executive of the General Council ...

- (1) receive the report of the Theology and Inter-Church Inter-Faith Committee on Medical Assistance in Dying
- (2) adopt the report as an official statement of the United Church on the subject of Medical Assistance in Dying.

Background

See the Medical Assistance in Dying report for a summary of how this issue has developed over the past two decades in Canadian governments, courts and the Church. With Medical Assistance in Dying now legal in Canada, people participating in United Church of Canada communities of faith are faced with their loved ones choosing such assistance in dying, or considering this option themselves, and with health care professionals in their communities who are discerning their response to this option. How can the church support people challenged with such a decision? How can the church prepare people for end-of-life decision-making? What context can the church provide for thinking about dying in general, and Medical Assistance in Dying in particular, from our theology and faith tradition? The report advocates community-focused and theologically robust discernment on a case-by-case basis that also ensures the protection and care of those potentially made vulnerable by this new law and others like it.

The Theology and Inter-Church Inter-Faith Committee has prepared this report on Medical Assistance in Dying in response to GCE: **TICIF4: Physician Assisted Dying, Motion: 2015-03-21-204:**

That the Executive of General Council enable the Church to be prepared to respond to a change in the laws of Canada that will provide a greater number of options in end of life decision making by:

- 1. Affirming the right and capability of individuals to engage with all of the issues making, the church affirms moral reasoning undertaken in relationship with family, loved ones, close friends and community and one's physician.*
- 2. Directing the Theology and Inter-Church Inter-Faith Committee to examine the theological implications of physician assisted dying and to offer guidance to the Executive on the development of a church statement on the issue.*
- 3. Encouraging congregations to deepen pastoral capacities to assist those who are facing end of life decisions, including a willingness to talk openly about death and dying.*

MEDICAL ASSISTANCE IN DYING

Outline

The United Church of Canada looks at the recent legal developments in regards to Medical Assistance in Dying with considerable interest. We are not opposed in principle to the legislation allowing assistance in dying and to such assistance being the informed, free choice of terminally ill patients. There are occasions where unrelenting suffering and what we know about the effect of pain on the human body can make Medical Assistance in Dying a preferable option. However, we urge a cautious approach by legislators and medical professionals implementing these laws, as well as by individuals, families and communities of faith who are considering making use of this new legislative option. To this end, we advocate community-focused and theologically robust discernment on a case-by-case basis that also ensures the protection and care of those potentially made vulnerable by this new law and others like it.

How We Got Here

In the past, The United Church of Canada has taken no formal position on assisted dying or euthanasia. A survey or poll of those attending a United Church worship service or event would likely find a range of views on this issue.

In 1995 the Division of Mission in Canada issued a study document entitled “Caring for the Dying: Choices and Decisions.” In summary, the document said:

We believe that it is appropriate to withdraw medical treatments that are not benefiting the patient and that are prolonging suffering and dying when the competent patient so decides, and when firm evidence of disease irreversibility exists. We believe that much can and should be done to facilitate the gentle, peaceful death that so many of us wish for, and the United Church should give leadership in this area. We do not believe, however, that the legalization of assisted suicide/euthanasia is justified, or will help make such a death possible.

This statement strongly supported the strengthening of palliative care options. As an alternative for those who have sought and received palliative care “and still believe that they want to end their lives, we believe that an acceptable alternative that does not require external assistance is to stop eating and drinking.”

No formal policy positions were brought forward as a result of the study document.

The positions outlined by the 1995 paper were consistent with the best prevailing social and medical opinions of the time. Since that time, there has been a shift in the legality and public acceptance of both passive and indirect euthanasia. Modern medicine is able to keep people alive much longer than had previously been possible. We have increased knowledge of the effect of pain on the human body in the process of dying. Many people will conclude that in some

circumstances, particularly those of grievous suffering at the end of life, preserving life may be a worse alternative than death. In light of these changes, we must respond.

In February 2015 the Supreme Court of Canada ruled unanimously in the *Carter vs. Canada* case to strike down the federal prohibition of doctor-assisted suicide as unconstitutionally infringing on the rights of individuals under the Canadian Charter of Rights and Freedoms. The court's decision applied to competent adults with enduring, intolerable suffering who clearly consented to ending their own lives. Federal and provincial governments were given a year to craft new laws. After a joint parliamentary committee (co-chaired by Member of Parliament and United Church of Canada minister Rob Oliphant) proposed a model for federal legislation, the federal government tabled, and Parliament passed, legislation allowing competent individuals aged 18 years and older with a grievous and irremediable medical condition to make a voluntary request for Medical Assistance in Dying.

With Medical Assistance in Dying now legal in Canada, people participating in United Church of Canada communities of faith are faced with their loved ones choosing such assistance in dying, or considering this option themselves. How can the church support people challenged with such a decision? How can the church prepare people for end-of-life decision-making? What context can the church provide for thinking about dying in general, and Medical Assistance in Dying in particular, from our theology and faith tradition?

Theological Convictions

Our latest statement of faith, *A Song of Faith* (2006), states that the Creator “made humans to live and move and have their being in God” and that “made in the image of God, we yearn for the fulfillment that is life in God.” The church affirms the image of God in every person. Each human being has an intrinsic dignity and infinite worth, qualities given by God. These understandings mean that the ending of any human life, regardless of apparent necessity, perceived propriety, or just cause, cannot be considered apart from this unique claim God has on each individual. Nor can any decision to end a human life be considered apart from its relation and potential contribution to the tragic dimension of the human condition (described in *A Song of Faith* as “brokenness in human life and community”). Medical Assistance in Dying, in this sense, is not something to be considered as morally or ethically neutral.

Holding these theological tensions is part of ethical discernment around medical assistance in dying. With these considerations in mind, there are certain instances where imperfect actions may be required in the face of worse alternatives. Christ's own ministry of healing and reconciliation made manifest the divine intent for the full flourishing of human life. In the case of some who are terminally ill, extreme, prolonged suffering and pain can diminish human flourishing to the point where assisting the process of death may be an act of compassion. We are made in the image of God, and a human life is not ultimately ours to take. At the same time, preserving human life is not an absolute in all circumstances.

Former Moderator, the Very Rev. Gary Paterson, wrote in this regard that the United Church's theological tradition is not to suggest that believing in the sanctity of life means that any attempt

to end life must be prevented: “For Christians, life is a sacred gift from God and needs to be valued and protected. But we also know that both life and death are part of the whole created order. Life itself isn’t absolute. Nor certainly is death. To speak of the sanctity of life is to affirm God’s desire for abundance of life for all of creation. God is love, and the Christian affirmation is that God’s love is the only absolute. ‘In life, in death, in life beyond death, God is with us,’ says our creed.” There are circumstances where concerns about undue suffering can outweigh the taking of an individual life and make Medical Assistance in Dying a preferable option. At the same time, we must ensure that societal notions about what constitutes “a good life,” or “a useful life” do not pressure individuals into seeking Medical Assistance in Dying. In the end, the mystery of death prevents it being seen as a problem to be solved with pat theological answers. We hold in tension God’s desire for full, abundant life with God’s promise to be faithful to us in death.

Cautions and Challenges

Medical Assistance in Dying is a multi-dimensional issue. The legislation emphasizes the role of the individual patient. The church, on the other hand, seeks to hold together individual moral agency and life in community. The church’s General Council Executive, in directing further study and dialogue on Medical Assistance in Dying, affirmed the right and capability of individuals to engage with all of the issues involved in end of life decisions, and stated that “in all of the complexity of end of life decision-making, the church affirms moral reasoning undertaken in relationship with family, loved ones, close friends and community and one’s physician as taking precedence over absolute statements.”

God’s people are called to embrace those struggling with these difficult decisions and to ensure that they are not alone. The choice of assisted death must be a free and informed decision by an individual who, with the support and accompaniment of others, sees this as one option among many in determining their future, and not as the only option that must be taken due to a lack of choice when facing terminal illness. Our communities of faith need to be safe places for discerning, thoughtful conversations about these options.

Medical Assistance in Dying must not be viewed as a way to curb health care costs or system burdens by terminating lives, or as a means to remove people from society because they are seen as a liability. In this sense, the church shares the valid concerns of people with disabilities and others about possible distortions and subtle abuses that may be used to pressure patients. The duress may be very subtle, even unconscious, exploiting the hopelessness that can result from the stigma and negative stereotypes of disability being irremediable and the guilt perpetuated by our society about people with disabilities being a burden or shameful. The lack of access to palliative and hospice care can lead people who otherwise might not choose to do so to seek Medical Assistance in Dying. All these factors jeopardize, sometimes even negate, the concept of informed consent to assisted death that is required under Canadian legislation.

It is also important to recognize that holding up the right to Medical Assistance in Dying for some patients may jeopardize others. Some people, particularly people with disabilities, are made more vulnerable in this regard because their agency has been diminished by society.

People with disabilities are often defined by society in terms of what they cannot do, what bodily parts or mental processes “do not work” in relation to what is “normal.” Sometimes they are not regarded as having the capacity to make free choices. In other cases their choices are constrained by societal pressure of what “a good life looks like” or “what is normal,” or the equation of a good life with being free from significant pain or from mental or physical constraint. In such situations, the “right to choose” can be subject to pressure—overt, hidden, or even sub-conscious. Affirming the image of God in each person means adopting a concept of interdependence, as opposed to our culture’s idea of the autonomous individual, the latter perspective a viewpoint that privileges some communities or sectors of society over others. As stated above, the church must hold together both individual agency and our covenant to each other in both living and dying.

To this end the church must call for full inclusion and attention to the concerns of vulnerable communities (e.g., people with disabilities, the frail elderly, those with mental illnesses, those without personal advocates) whose members may be coerced into choosing assisted death. The church must challenge society’s prejudice that equates a healthy life, often identified as “a life worth living,” with being able-bodied, and that defines happiness as the absence of suffering. It must also recognize the ways in which social power and economic privilege can affect the ability of people to make decisions about the end of their lives. Affirming well-being in a theological sense is a key contribution the church can make. Vulnerability is not abnormal – it is a sign of our interdependence as God’s children.

The church has a particular role to play in spiritual care by chaplains and spiritual care practitioners when suffering takes on a spiritual dimension as well as physical and psychological aspects. Despair at the end of life may manifest itself as loss of hope, meaning and self-worth, and may be articulated as a desire to die (which should not be interpreted simply as a request for assisted death).

What is more, those who face the challenge of the end of their lives should have the best of end-of-life care. The Canadian Council of Churches’ Commission on Faith and Witness has called for access for all to dignified, quality palliative care, in hospital, hospice, and home settings, and stated that:

We see the provision of such care as an intrinsic human responsibility toward the suffering person because of the inestimable worth and dignity of every human being, created as we are in the image of God, and because of Jesus' command to care for the sick (Matthew 25:36). All life is sacred, but all earthly life must end. When an illness cannot be cured or when natural life draws to a close, it is essential to offer relief of pain and suffering.

Palliative care is not universally available across Canada, and it is particularly lacking in regions with aging populations that lie outside major urban centres as well as in indigenous communities. Such care must be available across the country so that those facing the end of life are not forced into assisted death due to the fact that their personal needs cannot be met in their own region or community.

In addition to addressing concerns related to the patient, the church must also attend to the struggle of conscience faced by some health professionals (who may be part of United Church communities of faith). Physicians and other health professionals are expected by their training and commitment to save life. They can find it challenging and disturbing to be expected to provide Medical Assistance in Dying. While terminally ill patients need to have their decisions honoured, medical staff need to be able to have the right to decide if they will provide assistance in death. Patients must be able to choose freely; medical staff also should be able to be clear, and to be respected for their decisions, as to how they will live out their oath to preserve and maintain life. Health professionals should also expect that the church will provide an open and supportive pastoral presence as they wrestle with the issue.

It is important to engage communities of faith, and the broader community, in conversations about death and dying. Despite focusing in Holy Week and Easter each year on the story of a God who died on a cross, and being part of a faith fundamentally shaped by questions around the meaning of suffering and death, we have often been swept up in our society's death-denying culture and its general avoidance of conversations about death and dying. The stories and symbols of our faith tradition are a resource for supportive and pastoral conversations with those struggling with suffering (either their own or a loved one's) or struggling with making end of life decisions.

In our provision of pastoral care, we need to bear in mind that different cultures, including those represented in our membership, view death in varied ways. Those differences need to be respected even as they add complexity. For example, in a culture that views death in very negative terms, the desire of an individual to seek Medical Assistance in Dying can create a crisis for family members struggling to accept that decision.

Engaging different communities in ongoing, deep discussion well in advance of specific moments of decision-making can enable communities of faith to develop greater capacity to assist members who are facing end of life decisions and to support all of us to engage in moral reasoning in the midst of the complexities of the choices we are asked to make.

Those facing the end of their lives, and their families and friends, must feel that they will not be abandoned by the church at any point. This is an imperative for a church that, in the words of *A New Creed*, trusts in God and proclaims that in life, in death, in life beyond death, God is with us. We are not alone.

Conclusion

The issue of Medical Assistance in Dying is one that needs ongoing reflection and dialogue in communities of faith. It may be chosen as a faithful option in certain circumstances. At the same time, there are many challenges that have emerged since this option became available, challenges both spiritual and practical. While the right of terminally ill patients under the legislation needs to be honoured, affirmation of this legislation must be accompanied by protection and care of the most vulnerable in our society and by universal, equal access to palliative care. It must recognize

and respect the challenge Medical Assistance in Dying can pose for health care professionals. It must also be accompanied by an affirmation of the dignity and intrinsic worth of every life in relation to community.

Glossary

Euthanasia is the deliberate action undertaken by one person with the intention of ending the life of another person to relieve that person's suffering, where that act is the cause of death (*Special Senate Committee on Euthanasia and Assisted Suicide, 1995*). Euthanasia can be voluntary, involuntary, or non-voluntary, depending on the competence of the recipient, whether or not the act is consistent with his or her wishes (if known), and whether or not the recipient is aware that the act is being performed.

Medical Assistance in Dying is the provision, by a medical professional, of medication to a patient at the end of their life, at the patient's request, in order to relieve their suffering by hastening death (*Special Joint Committee on Physician-Assisted Dying, 2016*). Medical Assistance in Dying is the term used in federal legislation, and has been adopted by the Canadian health sector.

Physician-assisted suicide is the provision by a medical professional of a substance that a patient can self-administer to cause their own death. **Physician-assisted death, physician-assisted suicide, assisted dying, and assisted suicide** are terms for Medical Assistance in Dying that were commonly used prior to the 2016 federal legislation.

Palliative care is the type of care which aims to provide comfort and dignity for the person living with a terminal illness, as well as the best quality of life for both this person and his or her family. It meets the needs of the individual and his/her family in terms of physical, psychological, social, cultural, emotional and spiritual care while assisting individuals to live out their remaining time in comfort and dignity (*Canadian Hospice Palliative Care Association, 2016*).

Resources

Communities of faith need resources for study, sermon development, worship, personal contemplation, and conversation that face openly the challenges presented by end of life decisions from advance care planning to Medical Assistance in Dying. Such conversations will need to pay careful attention to including those who are most vulnerable in our communities, and to creating space where medical professionals can be part of conversations about death and dying. It is important that pastoral or spiritual care resources recognize the needs of all involved in end of life decisions: the individual, families and communities, medical personnel and other care-givers. Pastoral care that attends to the wholeness of the individual – mind, body, and spirit – and to the many dimensions of life in relationship creates a foundation for faith communities to accompany those facing difficult end of life decisions with compassion, respect, and confidence in our claim that God is present to us in life and in death, whatever those decisions may be. With the Apostle Paul we affirm that “If we live, we live to the Lord, and if we die, we die to the Lord;

so then, whether we live or whether we die, we are the Lord's" [Romans 14:8, NRSV translation].