



Euthanasia and Physician-Assisted Suicide

At a recent colloquium held by the Canadian Catholic Bioethics Institute (CCBI), Dr. Rory Fisher, a geriatrician at Sunnybrook and Women's College Health Science Centre, presented a paper on euthanasia and physician-assisted suicide. This was followed by a lively discussion out of which emerged important points and recommendations that the participants determined would be useful knowledge for society in general. Some of these points were strictly theological (dependent on faith) and others were derived from natural law as the result of observation and experience.

The dignity of the human person

Catholic teaching about the human person is firmly based on the concept of *imago dei*. We are made in God's image, and as such, every one of us has equal dignity before God. All that we have comes from God, and we recognize our privileged yet dependent status as creatures. We are gifted creatures, but inevitably limited in many varying ways.

Personal rights

Authentic civil rights, enshrined in just codes of law, stem from the inherent dignity of the person. Laws exist to serve and protect us as individuals, and also protect the common good and the good of order.

Patients' rights

Patients' rights are increasingly being mentioned, and exist in charters and bills in some jurisdictions. There is an international charter adopted by the World Medical Association called the "Declaration on the Rights of the Patient"¹. These rights are founded on the notion of autonomy, which currently dominates other moral principles in secular ethics. Our group agreed that the individual's consent to treatment is

paramount, and it is recognized that the person should be in control of decision making surrounding his or her treatment as far as possible. For good reasons, a person may decline treatment, even if doctors advise otherwise. So far in Canada autonomy does not extend to having a right to end one's life, or to having assistance to do so. Deliberate ending of life has never been seen as medical treatment, which by definition is meant to help and cure.

Misconceptions about a "right" to die

Death is something that happens inevitably to each of us, but that does not lead us to conclude that there is a "right to die". In fact, something that is inevitable cannot logically be seen as a right at all. Dying is a matter of fact.

Some people may feel for various reasons that they want to die, or perhaps feel in times of severe physical pain that they would rather die than continue to suffer. Physical pain and suffering can for the most part be treated, paradoxically to a degree greater than in any time in the past, but now some are demanding euthanasia as a relief not only from actual physical suffering, but also in anticipation of suffering and loss of control of one's body, e.g., in ALS (Lou Gehrig's disease). Dr. Fisher had pointed out that in the Netherlands and in Oregon, euthanasia and physician-assisted suicide is being requested by patients for other types of suffering, emotional or mental. We should also be aware that now people are being euthanized, not at their own request, but by others, who assess their suffering.

Yet what possibly could be the criteria for judging or measuring these highly subjective human feelings? Why do some claim that these feelings give rise to a "right" to die? Proponents of euthanasia use "rights" talk deliberately to make their

claims sound acceptable. But rights are not really the issue here. Through experience we can observe that many people feel this way at some low ebb in their lives, because of tragedy, depression, serious illness, acute suffering, loss, despair, and countless other reasons. These experiences, apparently random, demonstrate the limitations of the human condition and the overall lack of control over what happens to us.

This realization can be humbling. However, why do some claim that life is so pointless that death is the only answer?

RECOMMENDATION: *Society could and should act more positively to help people deal with feelings that life is no longer worth living, or is too burdensome, or to help bolster the moral fibre needed to continue.*

Survivors Stories

Many people have lived through intense periods of suffering, and still see value in life. The rebuilding that is taking place after the recent devastating events in New Orleans, Pakistan and India testify to the drive for life that exists in the human spirit. One of the participants remembers visiting the holocaust museum in Los Angeles, and related that an elderly, frail woman who was a holocaust survivor came in to the museum regularly to tell her story. She had lost all her immediate family at that time, yet she wasn't bitter, nor despondent, although she admitted to having been like that for many years. She found purpose in life in reminding people through her tragic stories how important and dignified every life is, and in urging society to ensure that the forces of death and destruction in our world do not prevail.

RECOMMENDATION: *Pay more attention to people whose lives have been dramatically altered by tragedy. (We could all benefit)*

Dying well

Pope John Paul II spent many years of his pontificate preaching the Gospel of Life, and encouraging us to spend our lives in solidarity with one another. He discussed rights frequently, saying, for example in *Evangelium Vitae*, that while now there is more awareness of human rights,

“On the other hand, these noble proclamations are unfortunately contradicted by a tragic repudiation of them in practice. This denial is

still more distressing, indeed more scandalous, precisely because it is occurring in a society which makes the affirmation and protection of human rights its primary objective and its boast. How can these repeated affirmations of principle be reconciled with the continual increase and widespread justification of attacks on human life? How can we reconcile these declarations with the refusal to accept those who are weak and needy, or elderly, or those who have just been conceived? These attacks go directly against respect for life and they represent a direct threat to the entire culture of human rights. It is a threat capable, in the end, of jeopardizing the very meaning of democratic coexistence: rather than societies of “people living together”, our cities risk becoming societies of people who are rejected, marginalized, uprooted and oppressed”.²

The sick person as “burden”

The modern concern for efficiency can generate the feeling in people that once they become incapacitated, they become burdens to their families and society. This tendency to feel useless and worthless must be resisted if people are to maintain a sense of their inherent dignity, which does not depend on what they do, or on how productive they are. All of us need to know that our families and our caregivers are our support and our strength, and are not simply counting the days until we die so that they can continue their own lives without the responsibility of looking after us. While recognizing that looking after sick and vulnerable people is onerous, we may still have to ask ourselves why we put so much emphasis on our own needs, plans and desires, thus seeing the person we are caring for as somehow preventing us from pursuing our own plans. Yet, when it is our turn to be in that same vulnerable state, what will we want, and what will we feel? Will our dignity be respected?

RECOMMENDATION: *Families be more engaged in discussing these ideas with their loved ones, and that this should be more encouraged in society*

The common good

Society is so fixated on individual rights that we forget that other people suffer consequences from actions we take. People who are left behind after another person's suicide testify to that. The fact that someone says that he/she really wants to die does not take into account

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anybody else's feelings on the matter. If we were truly a society of rugged individualists, perhaps that might not matter. But most of us have strong emotional ties to people, and losing someone does affect us under normal circumstances. One of the group noted that if her mother decided she wanted to hasten her demise from this world, she and her family would feel that somehow they had failed her – that they hadn't done enough to convince her of her worth and dignity. On the side of the person who desires death, assuming that there is no mental imbalance at work, isn't there a lack of consideration for anyone else? Isn't this a strange legacy to leave to our loved ones?

RECOMMENDATION: *We have to say loudly and clearly: there is **no** "right to die".*

Human needs and fears

Needs

In response to the possibility of the legalization of euthanasia and physician assisted suicide advocated by Bill C-407, and taking into account the recommendations made at the Colloquium, the CCBI issued a press release that included recommendations about deep human needs:

We do not NEED euthanasia and assisted suicide. Our hearts long for recognition, respect, friendship, community, a sense of worth, and a feeling of belonging. These are deep needs, built in to the very meaning of being human. Euthanasia and assisted suicide are not such needs. **Look after our real needs as people, and life will continue to have meaning, no matter what hardships and health problems befall us. Make sure the infirm, the vulnerable, and the poor receive good long term care in respectful and dignified surroundings. Make sure that they have adequate comfort care and end of life care. Make sure that they are never thought of as burdens to society.** If these things are in place, would we still think that euthanasia and assisted suicide are the only ways to end our problems? There is so much that can be done. Let's commit to doing it. Let's demand that our society and our politicians provide better community support. Euthanasia ends the life of the person with problems, but it does not solve the problems themselves.³

Relationships of trust

On this issue, the same press release said:

Quite the contrary. These practices breach long held convictions about the duty of care within families, about loving one's parents, about the physician-patient relationship built on trust. There is also the matter of giving control for decision making about one's very life to another. Surely these changes go against the way we have always structured relationships in our societies? Without those relationships of trust the vulnerable would be at the mercy of any person who thinks they may be better off dead. Further, without relationships of trust the fabric of society will breakdown.⁴

Fears about technology

It is strange that advances in medical technology which have brought about so much good have also resulted in the fear that people have of a perceived "tyranny of the machine". Many people do not relish the prospect of "being kept alive" by technology, as opposed to actively living. There is a common misperception that to discontinue use of one of these machines is tantamount to euthanasia. Although it may be difficult to work out the moral obligation in some cases, there is no obligation for a person to live out his or her life in a way that he/she experiences as overly burdensome.

RECOMMENDATION: *We remind people that the forgoing of what used to be called "extraordinary" means is a longstanding principle in Roman Catholic moral theology, which is more sensitive to deep subjective needs in its approach in some areas than many people recognize.*

Fears about the "medicalization" of dying

The colloquium group felt that there is too much focus on dying in dramatic circumstances in hospital, and that it is becoming overly medicalized. A colleague remarked that "dying is the most important thing we do", and that seems true. Therefore, shouldn't we be doing our utmost to make sure that we all die well? When Pope John Paul II returned to the Vatican from hospital to live out his last days, the way in which he did so serves as a reminder to us of what is possible. Of course he was given comfort care for his body, but his spiritual preparation for death was intense and moving. All those people praying with and for him, night and day! What a wonderful example to us of the way it could be done, and also what a wonderful

example of his own transition and gradual “letting go”, in peaceful surroundings. Although we cannot all have bishops and cardinals present, the same prayers can be said for us by our loved ones, ordinary people in the throes of the mystery of death, and the same peaceful atmosphere can be generated if the person dying and those who accompany him/her, “let go and let God”. Dying at home has a long history, and perhaps it is time to reclaim the practice. Perhaps through our own fear of death we have too readily given up the task of accompaniment of our loved ones to professionals, who, no matter how kind, are still strangers.

RECOMMENDATION: *Educate people about hospice care for a person's final days. This is, in fact, an old idea renewed, whereby people can come to terms with their mortality, and be given loving care as they prepare for death. This care should focus on spiritual care as well as comfort care, especially necessary at these final moments.*

Atheistic philosophy

During the colloquium, it was suggested that the lack of acknowledgment of God can lead us away from our reverence for every person's dignity to a consideration that life simply disappears with death, and, as such, *how* we die is not really that important. The materialistic view of the human, unrelated to any notion of God, can lead to that conclusion. If we ourselves do not see any future point to our lives, and think that when we die that is the end of everything, then we discount our lives even as we live them, and other people may be led to think the same way. Yet most mature people, especially those who acknowledge a spiritual component in their lives, come to appreciate that much of life remains mysterious, and that includes death and the hereafter.

RECOMMENDATION *We need to pay more attention to our deep seated reflections on the mysteries of life and death, and to our recognition that there are things we never fully know nor understand clearly – the Pauline “through a glass darkly”.*

Availability of palliative care and other resources

Knowledge of pain relief and adequate end of life care abounds: we only need the will to act. There are many palliative care facilities in Canada, but not accessibility in all areas. This is a major social justice concern, and we need to support people like Senator Sharon Carstairs who has worked for this cause for many years. Palliative and

good end of life care are important parts of health care in general, and we must demand them if they are not available. Funding is found for all sorts of other areas, and the end of life should not be an exception to this. Just because we all inevitably die does not mean society should abandon us in our final days. That approach can easily develop from the materialistic view of the person, where dignity is measured by competence and usefulness, and, when these are diminished, so too are our worth and importance to others.

RECOMMENDATION: *We must demand adequate end of life treatment.*

Otherwise, it could then be an easy step to move from euthanasia on request to non-voluntary euthanasia, and events in the Netherlands, such as the development of a protocol for euthanizing severely handicapped newborns “for their own good” (see Groningen Protocol, 2004) show us that this is already happening.

RECOMMENDATION: *Be concerned and watchful when such “compassion” is used to justify killing, and emphasize true compassion, supportive of life until its natural end.*

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Notes

- 1 World Medical Association, “Declaration on the Rights of the Patient” (www.wma.net/e/policy/I4.htm)
- 2 *Evangelium Vitae*, 1995. Chapter 1, Section 18.
- 3,4 Moira McQueen, “Death by Euthanasia or Assisted Suicide:

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