EUTHANASIA AND ASSISTED SUICIDE

SERIES: TAKING A STAND
EXPLORING THE ARMY'S INTERNATIONAL POSITIONAL STATEMENTS

Members of the International Moral and Social Issues Council (IMASIC) reflect on The Salvation Army's International Positional Statements.

STATEMENT OF POSITION

The Salvation Army 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.

Download the complete International Positional Statement on Euthanasia and Assisted Suicide at *salvationarmy.org/isjc/ips*

THE SALVATION Army's official statement of position on Euthanasia and Assisted Suicide is brief and unequivocal. At one time such a statement may have been unnecessary. There was a time when few people thought it was ever right to cause the death of an innocent person on purpose. But times have changed. In Europe, North America, Australia and New Zealand, laws protecting the sanctity of human life have been overturned or are on the verge of being overturned.

For example, the law in Switzerland permits assisted suicide but not euthanasia. That means that under certain conditions, it is legal for a person to help another person drink a drug that will end their lives, but not legal for anyone to put a needle in another person's arm and inject a killing dose. The same is true in several states in the USA. At present, Canada's law permits both assisted suicide and euthanasia so long as the person is mentally alert at the time, a Canadian resident and an adult. By contrast, the law permits patients as young as 12 years old to be euthanised in the Netherlands if the parents concur. And so on.

Legal differences aside, allowing for the acts of assisted suicide and euthanasia sends a message about the sanctity and dignity of human life. The International Positional Statement (IPS) says we must not judge anyone's life to be not worth living – even those who are suffering horribly or are in the final stages of an incurable disease. It says we must not value people differentially on the basis of their age, gender, social status or ability to be social contributors. Equal dignity and sanctity of all human life are for The Salvation Army bedrock biblical principles.

Yet, as we articulate strong moral principles that oppose euthanasia, we should not ignore the social histories that have led to the acceptance of what the positional statement says is wrong. Why, we should ask, do people in very affluent countries with excellent health services ask to have their lives ended? And, why do citizens in peaceful democratic countries find causing the death of fellow citizens appealing? What better alternative have we to offer?

Any 'no' we utter needs to be coupled with an equally principled, caring 'yes'. We need to show that The Salvation Army is not only *against* bad practices, but it is *for* good ones. When it comes to end-of-life matters, what are the individual and social positives we advocate?

The IPS includes several positive 'Practical Responses'. The first three are:

FOR REFLECTION

* How can we meet people in our institutions in an appropriate way when, contrary to our convictions, they decide to end their lives through euthanasia or assisted suicide?
* How can those who are vulnerable because of age, disability or illness be assured that they will not be abandoned?
* What is it that people are afraid of when they fear loss of dignity?
* How can we educate ourselves better about death and dying?

"Equal dignity and sanctity of all human life are for The Salvation Army bedrock biblical principles ..."

1. It is important to communicate by word and deed to the sick, the elderly and the dying that they remain worthy of respect, that they are loved and will not be abandoned to their suffering.

2. Respect for the dignity of human life demands quality care for all persons at the end of their lives. The Salvation Army therefore promotes access to palliative services that provide holistic care (physical, emotional, psychological, social and spiritual) when there is no longer medical hope for a cure. Optimal pain control and the overall comfort of the individual should be the primary goals of this care.

3. Human beings exist in social relationships; what happens to one person has a deep impact on others too. It is important that support is extended to meet the complex needs of family, direct care providers and the wider social community who will grieve the loss of their loved one and friend.

The IPS lists more ideas than these three, but what is called for is deeper understanding and then action, not just longer lists. The personal reflections that follow begin to show what that might mean. »

DEFINITIONS OF EUTHANASIA AND ASSISTED SUICIDE

The IPS on Euthanasia and Assisted Suicide states: 'It is important to start with definitions and distinctions, because discussions of euthanasia and assisted suicide often suffer from confusion about the meaning of key words:

'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.'

PALLIATIVE CARE

'Palliative care ... aims to lessen patients' suffering by helping to reduce their self- perception of uselessness, hopelessness and of being a burden ... In a case series of terminally ill inpatients and patients receiving home-based palliative care, pre- and post-intervention measures showed that 76 per cent of participants reported a heightened sense of dignity, 68 per cent an increased sense of purpose, 67 per cent a heightened sense of meaning, 47 per cent an increased will to live, while 81 per cent confirmed that the intervention had been or would be of help to their family ... Palliative interventions of this type, designed to help patients regain their dignity and to aid physicians in accepting full responsibility for those in their care, virtually eliminated requests for euthanasia in one palliative care unit [in France] where, over a period of six months, 13 (2.1 per cent) out of 611 patients had requested euthanasia' (*British Medical Journal*, bmj.com).

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» PERSONAL REFLECTION FROM CHRIS BREKKE

Gandhi is often credited with saying, 'The true measure of any society can be found in how it treats its most vulnerable members.' The elderly constitute one such group of vulnerable members in every society.[1]

Growing old may entail many challenges. For example, elderly persons may fear becoming an economic burden to their family. Faced with this fear, a society's legal and moral acceptance of euthanasia or assisted suicide could be interpreted as legitimising the conclusion that one's life has become more a burden than a blessing – and that it therefore serves society best if this life is ended. In this context, the way is open to exert a multitude of social pressures on already vulnerable people. Ultimately, the legality of euthanasia or assisted suicide could negatively affect the way society views the elderly, or other vulnerable groups.

A practical response to counter such developments is to 'communicate by word and deed to the sick, the elderly and the dying that they remain worthy of respect, that they are loved and will not be abandoned to their suffering'.[2]

Growing up, I lived many years in South Asia before moving 'home' to Norway. When my grandfather, well into his 80s, came to visit us in Bangladesh, I can remember the respect with which he was treated at every juncture, and the care that was taken to ensure he felt honoured and cared for. For me, this universal, sincere respect for one's elders is one of many things in Bangladeshi culture to admire and emulate. In this context, it's hard to imagine situations where it would be considered acceptable to intentionally end the life of an elder.

I don't mean to say that Bangladeshi society is better for the elderly than Norwegian society, or that Norwegians don't respect the elderly. But perhaps it's no coincidence that euthanasia and assisted suicide are firmly on the political agenda (although still illegal) in liberal, individualistic Norway, and far less so in the more family-oriented South Asian countries.

All the same, South Asia is not exempt from these debates. One recent example is the decision of India's Supreme Court to legalise so-called 'passive euthanasia' – defined as withholding potentially life-prolonging treatment. While this would not fall within the strict definition of euthanasia in our IPS, the court's emphasis on 'the right to die with dignity' when justifying its decision could be a sign of where the debate will move.

Rather than open a door that communicates to people that their life at some point may no longer be worth living, let us work to make our societies places where the elderly and other potentially vulnerable people feel unconditionally valued.

ENDNOTES

[1] The vulnerability of the elderly in ancient times may have necessitated the counterbalancing call to 'rise before the aged' and 'defer to the old' (Leviticus 19:32 *NRSV*).

[2] IPS on Euthanasia and Assisted Suicide, 2013, salvationarmy.org/isjc/ips

PERSONAL REFLECTION FROM DR JAMES E. READ

Since the middle of 2016 Canada has had laws that permit euthanasia and assisted suicide. In 2017, 1,961 Canadians made use of this law. Of these, only one was an assisted suicide and 95 per cent were voluntary euthanasia performed by physicians; the rest by nurse practitioners.

The law calls these actions 'medical assistance in dying' (MAiD). That's a name that troubles some of us quite a lot. Because it defines 'assistance' as euthanasia but does not include palliative care, providing genuine assistance to those who are nearing death. One reason The Salvation Army created hospices in Canada is the conviction that people who are in the process of dying need non-lethal assistance.

Death may be inevitable and curative treatment may be futile, but treatment aimed at symptoms is still possible. No physician should say to a patient with steadily-advancing illness, 'There is nothing more we can do.' Palliative care should be made available. Its aim, according to the World Health Organization, is to 'provide relief from pain and other distressing symptoms.' A serious commitment to palliative care has resulted in major advances in symptom management. But experience is showing that relief from physical suffering is not the key reason behind calls for MAiD. Felt threats to autonomy and dignity are more prominent.

In keeping with that, the person who receives MAiD is legally required to *ask* for it. Now, requiring an explicit, persistent request is important, but it disguises the complexity of what people are asking for when they ask

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for a hastened death. Some people have determined that they will control their dying long before the onset of their life-threatening illness (and evidence indicates they are the most likely to follow through with MAiD). Salvationist professionals working in the field have found that 'desire to die' statements are not uncommon from people living with advancing terminal illness. They vary over time and according to symptoms and felt worth. They range from unexpressed thoughts through expressed requests for hastened death; from hypotheticals ruminated upon to explicit plans. The desire to die can be held simultaneously with a wish for continued life-prolonging interventions. Laws cannot be vague, ambivalent or inconsistent – people often are.

The question is: who is going to attend to what real patients are *really* saying?

My wife Laurie helped create the Salvation Army Grace Hospice in Winnipeg. She has written about the sacred space where nurses and patients share 'mortal time'. 'It is a place of privilege, full of complexity and nuance, of discovery of both self and the marvels of the resiliency of the human spirit. ... It is a place for those who love to hear and be partners in the creations of life story.'[3]

PERSONAL REFLECTION FROM DR ROLAND STETTLER

'Australia's oldest scientist, David Goodall, has ended his own life at a clinic in Switzerland, surrounded by family and while listening to Beethoven's Ode to Joy. The British-born 104-year-old professor was forced to travel on a one-way ticket from his home in Western Australia to Switzerland where liberal assisted dying laws allowed him to end his life legally, in contrast to Australia where it remains forbidden.'[4]

Switzerland has one of the most liberal laws regarding assisted suicide and the case of David Goodall illustrates why Switzerland has become a country of 'suicide tourism'. Assisted suicide by Swiss citizens is on the rise too. In 2015 there were nearly 1,000 assisted suicides – 1.5 per cent of all deaths. This was a 30 per cent increase on 2014.

The Swiss Criminal Code outlaws 'incitement or assistance to suicide from selfish motives' (article 115). In plain English that means: anyone who helps someone to commit suicide, providing they are not acting out of selfish motives, cannot be punished. This liberal approach represents the opinion of the vast majority of the Swiss population. Even three quarters of all physicians support it.

Things are changing further. According to a new law in canton Neuchâtel, recognised charitable institutions must respect a patient's wish for assisted suicide on their premises. The Salvation Army filed a complaint against this, arguing it violated its religious beliefs and the organisation's freedom of conscience. The Federal Supreme Court of Switzerland ruled that, based on the right to self-determination, every individual is allowed to decide when and how they want to die. But, the judges said, a nursing home could avoid legal obligation by renouncing its charitable status. The problem is that it would lose government subsidies as a result. Without subsidies it is currently not possible to run a nursing home on a non-profit basis. The only alternative would be to close the home. This would cause many residents to lose their accommodation and so this solution was out of the question for The Salvation Army.

How then can we prevent people from following the path of assisted suicide? Respect for the dignity of human life demands quality care. The main cornerstone of quality care is compassion. I'd like to join Samuel Wells in writing: 'I hope to die with dignity. ... I hope to have people beside me who I can trust will never abandon me, however miserable I am or however much I suffer, people who, should I despair and wish to take my own life, will show by their love that there's something truer and deeper than suffering. That's what compassion is.'[5]

ENDNOTES
[3] L. R. Read, Sharing Mortal Time: Toward Evidence-based Understanding of the Role of Nursing in Transitional Cancer Care, Unpublished MN thesis, University of Manitoba, 2003

ENDNOTES
[4] The Guardian, 10 May 2018
[5] Samuel Wells, *How Then Shall We Live? Christian Engagement with Contemporary Issues*, Canterbury Press, 2016, 18