Assisted Dying

1. Introduction

1.1 Once, we were a society that discussed death, but never sex, or politics. Now, it seems, we talk about nothing but sex, while death is a less easy subject for us. With that reflection. a report on "Assisted Dying" was commended to the General Assembly of the United Reformed Church, meeting in Manchester in July 2007. It was the culmination of a year-long discussion conducted through the pages of *Reform, a*t local meetings, in response to questionnaires, and in small groups at Assembly itself.

1.2 Essentially, the Church decided to oppose Assisted Dying, saying it could not support a change in the law that would allow doctors to act in ways that deliberately sought to help end a patient's life. However, it recognised that some treatment to relieve pain for people who are terminally ill might hasten death, and said it believed that to be acceptable, as long as the *intention* of the treatment was pain relief. It also expressed the view that more resources were needed to provide more uniformly available, and high quality, palliative care.

1.3 An amendment was suggested to the first clause of the resolution to insert the words *"We acknowledge the wretchedness of those terminally ill people who cannot believe that their continued life is worthwhile".* The person suggesting it had indicated that he was in favour of Assisted Dying. The amendment was lost.

Resolution passed by Assembly

General Assembly affirms the report Assisted Dying, as encapsulated in the following statements:

It is God given and not ours to extinguish. We also accept that we are mortal, and have a finite life span on earth. We believe in life after death and the promise of eternal life. There is a sense in which death is the ultimate healing. We believe in living the Christian life in all its fullness within the limitations of our circumstances.

3.4 Some Christians hold the view that life should be preserved for as long as possible, because it is always possible that God will intervene and effect a miraculous recovery, beyond that which medical science can comprehend. Others feel that whilst it could never be acceptable to help end

4.3.1 Another domi

relieve their pain. Similarly, a society that became accustomed to the intentional killing of some of its terminally ill members might also gradually develop an altered moral character as a result (4).

4.5 *Consequences and slippery slopes*

Another important strand of public debate concerns the possible consequences, beneficial and harmful, of proposed legislation. Opponents of assisted dying sometimes argue that even if it could be morally justified in individual cases, the effect would be that the lives of many more innocent and vulnerable people would be placed at risk. A related claim is that even if legislation contained built-in safeguards, to permit assisted dying would set society on a 'slippery slope' which would lead eventually to widespread euthanasia, loss of respect for human life, and the loss of protection for the vulnerable. In a sense, these arguments are secondary to those already discussed. If Christians conclude on principle that it is morally unacceptable to legislate for assisted dying, the arguments about consequences and slippery slopes will be superfluous. However, they are not unimportant; the social consequences of legislation should be considered, and even if assisted dying were morally legitimate in some cases, it could still be the case that the likely harmful consequences were so great that it would be wrong to legalise it. This, however, is an argument that is likely to turn more on factual evidence than theological considerations.

5. Practical considerations – by Delia Bond

5.1 Advances in technology and medicine give us choices that were not available even a generation ago; choices about whether we prolong life at all costs, or recognise that there is a time to die. So many considerations come into the debate: the age of the patient, the quality of life, the cost and efficacy of treatment and the patient's wish and readiness to die. There will be as many views on this subject as there are individuals, each coming with their own beliefs, traditions and experiences; some will have been uplifting; others

those looking after me. What about the burden I will be to them? There are those who say: If ever I become a vegetable and can no longer speak or move or do anything for myself, then please do not artificially keep me alive. What most would wish for is a timely, gentle and peaceful death in a loving, caring situation.

5.7 It is difficult to observe – and/or endure - suffering. Where does suffering fit into the Christian perspective? We are all part of a fallen world – it is part of our human condition. There is evil, sickness, suffering and dis-ease; we cannot escape it whatever our piety and belief, none of us is immune. We are all caught up in it, until God's Kingdom comes, it will continue to be so. We believe God does not send suffering but promises to be with us in our suffering and works through channels here on earth. He works through those who are alongside, who strive to alleviate and prevent the suffering of others. The Church, God's body on earth – through prayer, pastoral care, befriending, listening and the healing ministry in its broadest sense can reach out to those who are suffering and dying. Through being part of, or in touch with, the caring professions – reaching out into the wider community and looking at wider world issues – the Church has a significant role in the alleviation and prevention of suffering. The developing concept of Parish Nursing may come to play a significant role. See Appendix C.

5.8 As Christians we believe in the sanctity of human life, life is God given and not ours to extinguish. Equally, we have to accept that the greatest healing is death and being brought into

incapacity to right these wrongs, and there is much guilt and self loathing. Some see this as unforgivable sin. Others with no belief, simply feel tortured. Yet they rarely find a sympathetic and safe listener to relieve this profound distress which I have called Biographical Pain.

6.5 So when we observe the landscape of contemporary death, it is not one of painfree transition, assisted to a comfortable end by palliative care. Such services are rationed - mostly to younger people with cancers. More to the point, the indications are that the great majority die in physical pain which goes untreated or unreached by medica

medical staff to intervene in ways which deliberately seek to assist a patient to die. However, we do support the right that terminally ill patients already have, to decline treatment that might prolong life.

11. References

1. United Reformed Church. The Basis of Union, Schedule D

2. Susan Frank Parsons, *Feminism and Christian Ethics*, Cambridge: Cambridge University Press, 1996, pp. 53-6, 137-41.

3. Karl Barth. *Church Dogmatics*, vol. 3, part4. Edinburgh: T & T Clark, 1961, pp. 397-470

4. Acts, omissions and double effect are helpfully dealt with by Nigel Biggar *Aiming to Kill: the ethics of suicide and euthanasia.* London: Darton, Longman & Todd. 2004

5. Donna Dickenson, Malcolm Johnson and Jeanne Knd eiv 0 3c3r0.78 -1.20.78 & Th, DyiAimide JeanB(11a Un9(e)

Methodist Church of Great Britain. *Written response to the House of Lords Select committee on the Assisted Dying for the Terminally Ill Bill.* 2004. *A*vailable at http://www.methodist.org.uk/index.

Suggested form for a living will

This is to record my wishes about my medical treatment, to take effect in the event of my being unable to communicate my preferences at a future date. This may be because of physical or mental deterioration in my health, which makes me unable to communicate my views, or because I am permanently unconscious. I understand that I may change my mind at any time, and I will aim to review this document regularly to check that I still agree with it. I understand that I cannot demand any particular treatment, ask for anything against the law (such as euthanasia or assisted suicide); refuse the offer of food and drink by mouth or refuse the use of measures solely designed to maintain my comfort and dignity such as appropriate pain relief, and basic nursing care essential to keep me comfortable such as washing, bathing and mouth care.

I am writing this Living Will as an Advance Directive, and declare that I understand its scope, and am mentally and physically capable of making the decisions contained in it. I have not been influenced or harassed by anyone else when preparing it. My wishes are set out below.

FULL NAME .....
Date of birth .....
Current address .....
.....
.....
Nat. Ins. number .....
Name and address .....
of GP .....
.....

Name and address of primary contact(s) **– health care proxy**(s) *(the person(s)you would like to be contacted to approve the decisions of medical personnel if required by your Living Will):*

Name .....
Contact address .....
.....
Telephone number .....

or
Name .....
Contact address .....
.....
Telephone number .....

My wishes are as follows: I do, however, accept palliative care, including medication, to relieve distressing symptoms such as restlessness or pain, and to retain my dignity as far as possible.
(Delete in each case the alternative **1)** *or* **2)** *which is not applicable)*

A) If I (a) have a severe physical illness and/or a severe mental illness and
(b) am unable to participate effectively in decisions about my medical care, and
(c) there is very little chance that I will recover in the opinion of two independent medical practitioners,
1) I do not wish to be kept alive by artificial means, or to have medical procedures to prolong my life
or
2) I do wish to be kept alive for as long as is reasonably possible using whatever form of medical treatment is available

B) If I become and remain unconscious for ..... months or more, and in the opinion of two independent medical practitioners am not likely to recover,
1) I do not wish to be kept alive by artificial means, or to have medical procedures to prolong my life
or
2) I do wish to be kept alive for as long as is reasonably possible using whatever form of medical treatment is available.

C) I have specific wishes in certain circumstances named below:
.....
.....
.....
.....

Your signature .....
(witnessed)
Date .....

For the witnesses:–
I declare that when the maker signed this document he/she understood what it meant and that, as far as I am aware, no pressure has been put on the maker and that he/she has made it by his/her own wish

Witness 1 *
Signature .....
Contact details .....
.....

Witness 2 *
Signature .....
Contact details .....
.....

** Witnesses must be 18 or over but not a partner, spouse, relative or anyone else who stands to benefit under the maker's ordinary will*

Review dates and signature:–

Notes
1) Living Wills are recognised as being legally enforceable by the British Medical Association, the Royal College of Nursing, the General Medical Council and the Law Society.
2) Your Living Will should be discussed if possible with your family, your Medical Practitioner and your 'advocate'. Copies should be deposited with each of them, and you should keep a copy in your papers. You may like to carry a card saying that you have a Living Will, and where it can be found.
3) This form applies to England and Wales only. In Scotland a similar procedure is known as 'A Welfare Power of Attorney', which must be granted by the Donor while he or she is mentally competent, and registered by the Donor at the Office of the Public Guardian. The above form could perhaps be adapted.
4) A new document is due to be introduced shortly for England and Wales called a Lasting Power of Attorney, but is not yet available.
5) The United Reformed Church does not accept liability for the use of this form.

16. Appendix C

Parish Nursing

The title Parish Nurse is widely used and recognised in North America where nurses operate across denominations and across faiths. In Britain, the term is less familiar. A Parish Nurse might operate within a local church context and provide a number of services that could be summarised as being

other problems. S/he will also provide health care advice for colleagues in ministry and leadership within the church.

3. Referral Agent

Where necessary the Parish Nurse will make referrals to GPs, dieticians, physiotherapists,
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- It encompasses and encourages the prayerful and practical support of the whole Christian community for individuals and families and communities experiencing sickness and suffering.
- In practical terms there is a very wide remit, for it embraces most aspects of life where there is brokenness and disease including physical illness, broken relationships, abuse, trauma and depression.
- There is a pastoral aspect, which co-operates with and recognises God working through the medical professions.
- Expression of God's love and compassion for all people and the recognition of his being present

Francis MacNutt, *Healing,* Hodder and Stoughton 1997. ISBN 0340661402
Francis MacNutt, *The Prayer that Heals,* Ave Maria Press. 2005. ISBN 1594710554
Agnes Sanford, *Healing Gifts of the Spirit,* Arthur James 1979. ISBN 0853052107
Randolf Vickers, *The Anointing to Heal,* Terra Nova Publications 2005. ISBN 1901949389
John Gunstone, *A Touching Place*, Canterbury Press 2005. ISBN 1853116319
Healed, Restored, Forgiven. Prayers and Liturgies, Canterbury Press 2004. ISBN 1853115878
R T Kendall, *Total Forgiveness,* Hodder and Stoughton 2001. ISBN 034075639X R T KeIan Cowi, Res

moral living, thinking and decision-making. This might help explain some of the thinking behind the more specific arguments.

The United Reformed Church ‘acknowledges the Word of God in the Old and New Testaments, discerned under the guidance of the Holy Spirit, as the supreme authority for the faith and conduct of all God’s people’ (1). This formula identifies a central role for our Scriptures in shaping our doctrine and ethics. It also, deliberately, admits of a wide range of interpretations of Scripture and understandings of the nature of its authority. It allows a role for other sources (usually summarised as tradition, reason and experience) in theological and ethical thinking, and allows for a certain amount of prayerful improvisation on the part of a believer, or believing community, faced with new situations and questions.

When ‘discerning the Word of God in Scripture’, we need to remember that the biblical writings come from very different historical and social contexts from ours, and might not directly address our questions and concerns. We will not find within the Bible any formula for addressing the hard questions of contemporary medical ethics. In addrer(New T033 TmodeTc 0 Tw 4.98 0 0 4.98 159.96 707.36469.44

3. SUFFERING, DYING AND FEARS ASSOCIATED WITH END OF LIFE ISSUES

Prayer

We give thanks Lord, that we have come together to think and talk about the great mysteries of suffering and death. We thank you that you have an everlasting love for us, and that you want us to love and care for others.
We are often afraid to talk about suffering and dying because we do not know the answers to these mysteries and we are fearful in case we upset others and unsettle ourselves. May your Holy Spirit guide us as we look at the scriptures and speak with one another. Help us to understand more of your love for us and for all people and give us insights into the mysteries of suffering and death and take away our fear. Help us in our discussions to be sensitive to one another's feelings and help us to know how we should act as individuals and as a church or group in respect of end of life issues.
Thank you that you died and suffered and rose again for us, so that we may know more about the mystery of death and life everlasting. In Jesus' name, Amen.

Bible Reading

Luke 10: 25-37. Mark 12: 28-34. Matthew 19: 16-19. James 5: 13-16. 2 Corinthians 12: 1-10

See particularly Sections 4 and 5. Also see case studies and Appendix D healing ministry.
This is not a subject that can be addressed in isolation for we live in communities, thus it relates to the whole of the report and the Appendices. However we will endeavour to focus on just a few aspects in this section to try to unravel our understanding of suffering and our response to it.

Our responses to these issues will be informed by our faith, the teaching we have received and our own experiences. By listening to one another you may come to a different understanding and to see things from a different perspective.

First, let us look at suffering from the theological perspective highlighted in Section 4.3 of the report which addresses suffering;-3( )4(s)41-7(o)uCcho]TJ0.00E3.007 0 Td[(ha)7(ve re)-2(e hir03 Tmffe(n)6(D4

5. If there is a serious problem with care for someone who is terminally ill, what should we do, if anything? If there is no space in the hospice, what then? What are the issues to be considered before intervening?

6. Hospices are often stretched. How can the church offer support?

7. Do you liaise with, value and support, your hospital chaplains in their special role?

8. How can the church and individuals best support the patient, family, carers, chaplains and friends?

5. Older people

Prayer

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2. How can our dignity be maintained if we become disabled, frail in mind, dependent? As God's people are all equal in his sight, created by him and, as Jesus taught, loved by him, do we have a special responsibility to care for older people?

3. What about Christian homes and nursing homes. Are there any in your area, and how are the churches involved? What worship services are held, and are special prayers and themes chosen?

4. How could we achieve the same standard of care for older people who are dying, as is available in the Hospice Movement? There is no way at the present time that all those who need hospice care can have it. 'It should be a target to match exit standards with entry (maternity) standards' (Section 8.2).

6. LIVING WILLS – ADVANCE DIRECTIVES

Prayer

We thank you that we are a part of your creation. There is much we do not understand about life, death and suffering and thus we are sometimes fearful and unsure how to best deal with the end of life issues, especially when there is suffering in body, mind or spirit or all three. Some may have experienced suffering in others or caring for a loved one and one is aware of the strain and anxieties cast upon the carers. In our discussions, may your Holy Spirit direct and guide us and bring us comfort as to the way forward for ourselves and others. As we discuss Living Wills, may we be honest with ourselves and each other, about our fears of losing control of our lives and having suffering over which we have little or no control. We want to value life with all its richness and possibilities, but also want to recognise the right time to let go and not prolong suffering. We thank you that you gave your life for us and overcame death, and showed us that death is not the end, but after death we have everlasting life with you still surrounded by your love. In Jesus' name, Amen.

See Section 7 of the report and the example of a Living Will (Apr(ng th)shpes cast uponehBto matc

doctors and nurses in making correct choices of treatment, with the written Living Will to guide them.

Questions

1. What is a suitable time to bring up the subject of living wills with family and friends? Do you know anyone who has made one? Do you have experience, first- or second-hand, of caring for someone so incapacitated that you were consulted on decisions that must be made for them on artificial prolongation of life? Were these decisions difficult to make? Was there a Living Will available and if so, was it helpful?

2. Are there dangers in persuading someone to fill in a form expressing their wishes? Might there be pressure on them to make a choice for the sake of others, which they did not really want? How can we explain that this is not euthanasia, (it is not helping the person to die), but accepting that it only applies if they would die if left without artificial aid, either medical or mechanical?

3. What has our Christian faith to say about our making life-or-death decisions for: a) ourselves? b) others? Is modern medicine always helpful as it enables people to be kept alive artificially, indefinitely? There are continuing advances in transplant surgery - heart, lung, liver, kidney, face. Is there a limit to ethical use of transplants to prolong our natural lifespan? Are we in danger of interfering with God’s created order?

4. If we believe in life after death why do we cling on to this mortal life in spite of sickness and suffering?

5. Does the fact of Jesus' miraculous healing affect our choice of artificially prolonging our life, in case we might undergo a miracle cure in the future? (Jairus’ daughter healed - St Mark’s Gospel chapter 5, the story of the raising of Lazarus - St John’s Gospel, chapter 11).

Anne, a retired doctor, was suffering from an incurable brain disease. She had seen her husband die from a closely related degenerative illness, four years before. She said she did not want the “long slow demise” that he had suffered. She travelled to Switzerland to take her life, by drinking barbiturates, with the help of the Dignitas clinic. Her son said: She was ready to go and that makes it all the easier for us. We respect her choice. We are very thankful that her suffering was over”. *Daily Telegraph. January 25 2006*

Superman actor Christopher Reeve was paralysed in a horse-riding accident in 1995; his spinal injury was so severe that his first lucid thought was that it might be better for everyone if he were to die. However, his passion for how he chose to live his life from then on, his courage, his determination and his generosity in spirit were an inspiration to all those he subsequently met. He died in October 2004. Christopher and Dana Reeve Foundation www.christopherreeve.org .

Our son **Danny** died a drawn-out, painful death from an incurable bowel disease. By the time he was 21 he had gone through over 300 operations. We pursued every possible hope until the top international specialists eventually conceded there was nothing more they could do. The best drugs often couldn’t alleviate his pain and so he spent the last year of his life asking the doctors for medical help to die. The doctors would not help him die and instead Danny practically had to starve himself to death. What he went through at the end