



NSW.ACT

Discussion Paper 1

*Euthanasia - Hearing the people in the situation,
understanding the dilemmas*

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Introduction

The wise person who gave us the book of Ecclesiastes reminds us:

For everything there is a season, and a time for every matter under heaven:

A time to be born, and a time to die;

a time to plant, and a time to pluck up what is planted;

a time to kill, and a time to heal;

a time to break down, and a time to build up;

a time to weep and a time to laugh;

a time to mourn, and a time to dance....

(Ecclesiastes 3: 1ff)

When is the time to die? Who decides that time? How do we distinguish God's time, from our time? How do we claim back God's time, when medicine has intervened to alter profoundly the times of living and dying?

I have two nightmares. One is that we accept euthanasia, without adequate safeguards. The other is that we reject euthanasia, forcing people to continue a life which offers them only further suffering.

Euthanasia, i.e., the artificially hastened death of an individual at their own request, is not a matter of simple logic about killing or not killing. It is part of a web of fundamental issues. We need to face some of the assumptions we make about life, death and medicine. Is death an event to be avoided at all costs, or is death part of the gift of life? Is God's gift of life meant to be limitless, or is the call for euthanasia to be heard as a call from some patients to reinstate death as part of life? Has society allowed doctors to continually defy and deny death, without looking adequately at the long-term consequences for the patient?

The redemption which Christ offers us does not take away physical death. Rather it takes away the fear of death - we know that in death we are in the hands of a God of love and mercy, and do not need to fear death. We believe that physical death is not the end, and therefore do not need to cling to this life when the time has come to die. To what extent have we allowed medical technology to distort the Gospel and undermine our acceptance of death?

Who are the stakeholders in the debate, ie who are the people in the situation?

In any ethical debate, there are a number of stakeholders - groups who participate in the debate for different reasons. It is important that we distinguish the various groups of stakeholders, and assess the validity and priority of their concerns.

In the following, the church is not listed as a stakeholder. The church's role in the public policy arena is not to serve an abstract belief system, but to serve the best interests of humankind. Christian belief may help us understand what those interests are, but in the end we only have credibility if what we say as churches makes sense as serving society, not ourselves. That is why in the Uniting Church, following the Anglican and ecumenical tradition, one of the most important strands of social ethics methodology has involved the development of policy principles (middle axioms) - principles which are consistent with Christian belief, but which are expressed in ways which makes sense in broader society. In the Catholic, Anglican and Uniting traditions, the human rights covenants provide one set of such principles which provide common ground with government and society in debate of policy matters.

However, we cannot assume that as churches we automatically serve the interests of humankind - we need a sense of self-suspicion, so that we test what we say and do. In more traditional theological terms, we need humility and a sense of confession, an awareness that we, like others, act from a mixture of motives.

Patients who want help in ending their suffering.

- Patients who call for euthanasia because they do not want life to be artificially prolonged by futile treatment.

The Department of Health's Dying with Dignity guidelines should satisfy these patients. However, there is some suggestion that the guidelines are not followed by all doctors in all hospitals, with some patients being artificially kept alive although good medical practice would end futile treatment. As long as people cannot trust the medical profession to follow the guidelines, people will be afraid of what will happen to them and will seek the right to euthanasia as an alternative to what appears to be officious medicine which refuses to accept that death is part of life. In this case, what is needed is not euthanasia, but clarification of the Dying with Dignity guidelines, including situations when they apply and the legal standing of the guidelines. They need to be understood, to be implemented in a consistent way, and to have legal standing. They need to be understood by both doctors, and the general public. Hospital staff need to be trained in their implications and proper implementation.

One of the confusions in the euthanasia debate has been that the term "passive

euthanasia" has sometimes been used to cover termination of futile treatment. This term (ie "passive euthanasia") is best avoided, since it confuses the debate.

- Patients who want euthanasia because they have not been offered effective palliative or other treatment which is available.

Not all doctors have an adequate understanding of the nature and availability of palliative care. This leads to some patients suffering unnecessarily, and raises community concern about painful death. For example, some doctors wait too long before referring patients.

Steps need to be taken to ensure that all doctors are trained to understand when patients should be referred to palliative care services, in the same way as doctors are expected to know when to refer patients to other specialists. Referring people to palliative care at the right time should be seen as a basic medical responsibility.

There also needs to be community education about palliative care, so that people know what it can accomplish and how to gain access to it.

- Patients who are terminally ill, and for whom palliative care does not work. That is, for whom palliative care does not relieve their pain, or results in such heavy sedation that they are unable to perform any function, or whose suffering is a matter of factors other than pain.

A particularly strong lobby group is people with HIV. AIDS is a terminal illness mainly affecting 20-50 year old males. For them the problem is not so much extreme pain, as debilitating suffering in other ways - chronic incontinence, diarrhoea, vomiting and paralysis (see attached summary of article by Darren Russell).

Workers in palliative care acknowledge that there are some patients (at least a small percentage) whose pain or suffering cannot be relieved through current palliative care methods.

- Patients who are chronically ill or disabled, and who find palliative care does not help them.

Some people with disabilities believe euthanasia should be an option. They argue that the life that they have as a result of medical efforts is not the life that they want - they feel that their bodies limit their life too severely.

These last two groups want euthanasia as an option of last resort. They emphasise that they also want affordable and accessible medical care, palliative care, support services, opportunity to participate in society and so on. They have a vested interest in not wanting to undermine the rights of people with illness or disability, but still want the option to exist. They stress that euthanasia is a voluntary matter (anything else is murder) and expect that only a small number of people would ever avail themselves of the option.

Doctors, nurses and other health professionals who have to respond to patients who want help to end their suffering.

Euthanasia should never be the result of inadequate access to palliative care. All doctors need to be trained in recognising when patients need to be referred to palliative care. However, while most patients choose palliative care, a small number consider it unacceptable and want the option of euthanasia.

Society has often left it to doctors to handle these situations without adequate training and backup. For example, it has been suggested that some doctors are afraid to follow Dying with Dignity guidelines because of fear of litigation from relatives, even though the patient's wishes are clear. Some arguments against legislation acknowledge doctors will have to make

choices about how they respond to patients' requests - and thereby leave individual doctors to bear responsibility on behalf of society, without any legal safeguards.

Some doctors also draw attention to the fact that while the Dying with dignity guidelines and the concept of voluntary euthanasia are clearly separated areas most of the time, there are some cases where the delineation between the two is not clear.

People who want voluntary euthanasia to be legalised but who appear to have no immediate personal stake in the issue.

There would again appear to be several categories:

- People responding to the situation of category (1) and (2).
- People who want a sense of control over life - who want euthanasia as an option for themselves at a future date, when they would come in category (1) or (4).
- People who do not have a clear distinction between voluntary and involuntary euthanasia, and who, in effect, think that it would be a good idea if someone else "chose" euthanasia, to end their suffering, or a life which others think is overly long. They would encourage euthanasia, rather than allowing it.

For anyone to encourage another person to end their life fails to respect their dignity as human persons, and their right to life. When a person says to a patient "You would be better off dead" or about a patient "X would be better off dead", the question must be asked - better for whom? Is it a statement based on the patient's own feelings and wishes, or on the wishes and feelings of the person making the statement. No one has the right to override a patient's desire and capacity to continue to live, by influencing them to artificially end their life.

The greatest problem in allowing euthanasia is in this area. The Northern Territory legislation prevents anyone who has signed the certificate requesting euthanasia from gaining any advantage as a result. But it is not clear how to draft legislation to prevent subtle pressure on patients.

People who are healthy, and who want society to allow them choosing their own time of death

The following concerns seem to be an undercurrent in some of the discussions.

- People who do not know about the Dying with Dignity guidelines, and who are afraid of their life being extended by futile treatment. People need to be informed about the guidelines, and need the medical profession to assure them that those guidelines will be followed.
- People who are afraid of a painful death. It is important that the nature and availability of palliative care and support services be publicised in the community, so people know that for most people the fear of a painful death is unnecessary. On the other hand, such publicity should be honest, recognising that there are some patients whom palliative care is not able to help.
- People who want to avoid going through the experience of growing old and frail. It is hard to see any way of ethically justifying such an approach. It seems to be a self centred approach which claims the right to determine individually when and for how long people will be part of society. It assumes that people have no responsibilities to others, but only to themselves.
- People who want to avoid "being a burden to others" as they grown old. It is ethically unacceptable for society to see euthanasia as a solution to this problem, since it is the responsibility of society to ensure that everyone is cared for - society cannot ethically acquiesce in the view that people who need help are "a burden" . To condone euthanasia for this reason would be an abrogation of society's responsibility - it would undermine the concepts of interdependence and human dignity.

- People whose long life now feels to them unbearably long - people whose bodies are slowly breaking down in their eighties, nineties or hundreds, and who in previous generations would have probably died but whose life has, in effect, been artificially extended through a whole range of relatively minor interventions, from flu vaccines and blood pressure pills through to operations. Medicine has raised their quality of life at various times through these interventions, but has also extended their life beyond their normal and natural capacity to the point where their life has now become wearisome by its very length. (It is the length of life medicine, rather than God, has given them).

The arguments in (c) and (d) could be applied in this case, but would appear to miss the dilemma their situation creates for society. The question is: if we allow interventions which artificially prolong life, are we entitled to refuse to hear people tell us that now life has gone on too long and they want an intervention to end it? If we say length of life is in God's hands, why do we not say this at every time and stage of life? Once we allow medical intervention to preserve life, how can we say length of life is not in human hands? There are obviously all sorts of dangers involved if we admit this reasoning, but if we deny it, we refuse to face the responsibility for the consequences of human intervention.

Patients who do not want euthanasia

These can be divided into two groups

- Patients who would see euthanasia as not an option for them, and who are able to resist any pressure to consider it.
- Patients who would see euthanasia as not an option for them, but who will feel under pressure from other people and find it hard to resist such pressure.

The comments under 3 (c) apply here. The most difficult task in drafting euthanasia legislation is probably this second group - is it possible to protect people from the subtle pressures of family and friends and to ensure that euthanasia only ever occurs as a result of the genuine initiative of the patient? How do we protect this vulnerable group? How do we expect doctors to ensure that the patient's expressed request for euthanasia is the patient's genuine desire, and not the result of pressure from other people?

Patients who are not competent to make a decision about treatment

- Those who are terminally ill
- Those who are chronically ill or severely disabled.

These patients may be adult or children.

These patients have a right to life which must be protected. This is the group for whom many opponents of euthanasia are concerned. The term euthanasia should not be applied to this situation, since it confuses the debate and introduces quite different issues.

With regard to (b), the Dying with Dignity guidelines covers the situation of a patient not being competent when treatment plans for the dying patient are being formulated.

Legislation concerning treatment of incompetent patients, and protection of their interests, already exists, and could presumably be amended if necessary to ensure their rights are not eroded.

On the other hand, there is some suggestion that staff of the Guardianship Board are sometimes unwilling to accept medical advice that treatment is futile and should be terminated. This contributes to the community not trusting that Dying with dignity guidelines will be followed.

There are also some situations involving children which raise questions. Logically, these questions are separate from those related to an adult patient requesting euthanasia. Opponents of euthanasia fear that the concept of artificially inducing death will be extended to

these patients. Is it possible to keep this as a separate issue - to distinguish voluntary requests of competent adults from any action related to incompetent patients?

Society as a whole

Society has a responsibility to listen particularly to the needs of people in groups (1) (5) and (6), that is, patients who are terminally or chronically ill and suffering and want euthanasia to be an option, patients who do not want it but may be put under pressure by other people to consider it, and patients who cannot make their own decisions.

Society also has a responsibility to ensure that human rights are upheld, and that members of society understand the meaning of those human rights as they apply to people's right to life, dignity and freedom from arbitrary interference.

However, society also has the responsibility to see the question of euthanasia in a broader context, and not to distort the discussion of euthanasia by oversimplifying the issues or making euthanasia carry responsibility for problems which already have roots elsewhere in the practice of medicine and the attitudes of society.

What does it mean to hear the people in the situation?

At the ecumenical meeting in June, some comments tried to reduce the concept of listening to people in the situation to "the pastoral dimension". This misses the point. The first step in ethical method is to understand the situation and to articulate the ethical issues which arise from the situation. The matter of euthanasia is not an abstract issue - it is a set of concrete issues which arise out of particular situations. We can only make sensible comment if we can name what people are really asking for, and the reasons they are asking for it.

From the Uniting Church's point of view, this is not simply a matter of intellectual acknowledgment of the issues. It is a matter of solidarity and empathy, ie of attempting to enter into and identify with the experience of those who are suffering and vulnerable. In this case, it involves hearing those who seek euthanasia, but also understanding the vulnerability of those who might be endangered by any legislation allowing euthanasia.

Solidarity is based on incarnational theology. In Christ, God entered into human life and shared in the worst that human life could offer. Christ himself knew the agony of human life, and the agony of pain through crucifixion. In the same way that God entered into the worst of human suffering, the church is called to solidarity, and to theological and ethical reflection which arises out of that experience.

The book of Job is the story of the harm which well meaning friends impose on those who suffer, when they ignore the reality of the situation and impose pre-conceived ideas. The friends, for claiming greater knowledge of what God required than the one who suffered, were judged not to have spoken of God appropriately. In the words, they were guilty of heresy. New situations of suffering require new theological thinking, based on encounter with the God who hears people's cries and comes to them to reveal himself in new ways. Medical intervention has vastly extended people's lives. When does that extension cease to be a gift and become a burden? When are people entitled to say it's time to trust God by choosing death, rather than being further dependent on the medical profession?

Solidarity means protecting the vulnerable from anyone taking away their life against their will. So-called "involuntary euthanasia" is not genuine "good death" and should be rejected. Current legislation already deals with such situations. But solidarity also means recognising the pain and other forms of suffering that people with terminal or serious chronic illness may experience, and the way that life appears to them. It means offering resources to those who suffer - palliative care, a supportive community, practical help, forms of prayer such as lament which allow them to bring their suffering to God - but not imposing these on people as if we can decide what is the appropriate solution to their problem.

Solidarity also means respecting as responsible moral decision-makers those who are suffering. It means not imposing on them decisions about morality made by those who are

outside the experience of suffering. If we do not have to bear the same burden as those who suffer, how can we tell them that they must bear those burdens?

Solidarity cannot be merely for patients in isolation - it must encompass others who are also in solidarity with them, who may be their lovers, friends and community, and their doctors and carers - all those who demonstrate a commitment to the welfare of the patient and respect for their human dignity. That is, we cannot ignore the dilemmas faced by the spouses, lovers, and doctors of those with illnesses such as HIV/AIDS. We must come to terms with the difficult dilemmas they face when the patient seeks euthanasia - dilemmas and decisions which are outside the experience of most, if not all, church theologians and ethicists.

Part of this solidarity is listening to the situation these people describe, and respecting them as moral decision-makers. Part of solidarity is also a healthy scepticism, which will take at least three forms, but which is fundamentally an awareness of human sin and frailty.

- A scepticism which probes below the surface to ensure that there is genuine solidarity and honesty about what is happening, how it is happening, and why it is happening. Not everyone who claims solidarity is in genuine solidarity.
- A scepticism about society which recognises that there are mixed motives in society for wanting euthanasia and that even if euthanasia begins out of solidarity with those who suffer, without adequate safeguards it would end up being a weapon used against people. Euthanasia can never be taken lightly.
- A scepticism about society which recognises that those who reject euthanasia may be fulfilling their own needs, such as an inability to cope with death or with the limits of medical treatment.

If we seek to make a credible and useful contribution to debate about euthanasia, we will need to find away of holding together these different aspects of taking seriously the people in the situation.

Intervention in life and death

Some arguments against euthanasia claim that we should leave matters of death to God. The fact is that we gave up doing that long ago.

Human interventions in life do not only occur at the beginning and end. Every day medicine makes an extraordinary number of interventions, most of them not spectacular but all of them significant for the length of human life.

People once died as the result of influenza, but now they are treated with antibiotics. People once died of asthma or diabetes, but now they are enabled to breathe by whole variety of treatments, ranging from the self-administered to sophisticated hospital treatments. People once died of shock and/or injuries following accidents, but now we have simple treatments for shock, can repair some severe injuries, and can keep people alive even when they suffer permanent major physical damage.

We prevent a number of diseases which once killed people in childhood, through immunisation. We have in various ways diminished the likelihood of a number of diseases which once wiped out large numbers of people through epidemics such as small pox.

We take blood banks and blood transfusions for granted, yet they have kept people alive who would otherwise die during surgery, or as a result of diseases such as haemophilia, or as the result of accidents.

We use a whole range of medical treatments to keep alive people who would once have died as a result of congenital diseases and disabilities such as diabetes and cystic fibrosis. Miscarriage and other problems during pregnancy no longer mean that a foetus automatically dies - artificial mechanisms are used to keep them alive until they attain the capacity for independent life.

We take for granted dialysis machines so that kidney failure does not result in death, and transplants of a number of vital organs (ie organs whose failure automatically means death) - kidney, liver, heart, lungs. We implant pacemakers.

We routinely use medication to reduce the risks of heart attack and stroke, and take for granted the use of cardiac massage, mouth to mouth resuscitation, and other mechanisms to restore to life people who are clinically dead through drowning, accident, heart attack, strokes or other events. We use surgery, chemical and ray therapy to deal with cancers which would otherwise kill people.

When we provide an antidote to a natural toxin or an synthetic poison, we intervene in the timing of death, sometimes cheating spider or snake of their natural role.

As a result of all this, we have raised the average length of life well beyond what was normally considered not the average, but the extreme, namely three score years and ten. The extreme end is now over a hundred, and while it is still unusual, it is no longer extraordinary.

In other words, the natural order, God's order, is that many people die in childhood, or through epidemics as adults, or through injury, or through degenerative diseases. We continually over-ride nature and cheat death. We allow human beings, not nature or God, to determine how many people live or die and when they live and die.

All of this suggests that we already accept technological and medical control of human life and death, and that as a society we value human life highly. What is natural is no longer accepted as God's time for birth or for death.

It is inconsistent to accept all this, and oppose euthanasia on the grounds that it is human intervention in a decision that rightly belongs to God. If the fundamental ethical principle is that the control of life and death belongs to God, then we must stop all those medical procedures which cheat death, and reduce medicine to palliative care and preventive health care in the form of encouraging exercise and good diet and a healthy living environment. Even immunisation and everyday antibiotics cheat death.

On any straightforward reasoning, we cannot pick and choose when to intervene to cheat death, and when to retire from the field and leave it to God. Having artificially prolonged life to the extent that we now take most such interventions for granted and do not see them in this light, the time has come when we must consider our responsibility for death as well. By what right do we assume that we can tell people that having artificially prolonged their life with medication and surgery we cannot assist them to die when they no longer want the life that medicine (not God in most cases) has given them.

Society has the responsibility to provide effective care for the sick, the elderly, and the disabled, not only because of the sanctity of life but also because we have artificially prolonged life for so many people and must carry through that responsibility.

For example, people with AIDS have increased vulnerability to infections and are at risk of death through diseases that it is simple to treat, such as influenza. We take for granted, quite rightly, that we will use antibiotics to treat them for flu, or pneumonia. Their life is artificially prolonged; the disease is cheated of its capacity to kill. But the argument is that when the disease gets worse, when the body breaks down and people do not want to live, we should not condone "artificially" hastening death that has already been "artificially" postponed. This is illogical, inconsistent, lacking in compassion and an abrogation of responsibility at the point where the patient is most vulnerable.

Similarly, we often artificially rescue people from death through the injuries received in an accident or fire. People often embrace life at the time, but are left with impairments which can make life difficult as they grow older. If people decide that they no longer want the pain and suffering of a life which was artificially prolonged in the first place, we surely have a responsibility to understand the implications for them of the original intervention, and not to turn the gift of life that medicine (not God) gave them into a souring and dehumanising burden.

The question of euthanasia therefore cannot be validly interpreted as an irresponsible question. It is intrinsic in the nature of medicine as it has been practised for the last hundred years or so. It is not a question of whether human beings should control life and death - we admitted doctors to that responsibility long ago. The question is, how does society define the responsible use of medicine's control over life and death? How do we as a society ensure that medicine is used for people and not against people? If we listen to the people seeking voluntary euthanasia, is what we hear a request for patients to take back control over life and death instead of being expected to accept the changes which medical professionals have imposed on their path through life towards death? This is not a question of God versus human beings, but a question of which human beings should determine times of death - which person's autonomy should be respected?

On what moral grounds do we allow doctors and their technology to determine when people live and die, rather than allowing patients to make the decision?

Intervention in pain and suffering

In the same way as we take for granted most of the ways in which medicine intervenes throughout life to postpone death, we also take for granted that medicine will relieve pain. Pain killers can be bought in supermarkets and over the counter at chemists. Electronic devices can be rented or bought from chemists or through mass distributed mail order catalogues.

Similarly, we take for granted medicines to deal with a wide variety of minor ailments, even though most of them are only temporary.

Doctors prescribe a wide variety of pain killers and other medication which is designed to relieve people of discomfort and suffering.

A whole medical specialisation has grown up to deal with physical pain, in the form of palliative care.

We assume the use of anaesthetics not only for major operations but for minor procedures by both doctors and dentists.

In other words, we do not believe that pain and physical discomfort are intrinsic to our humanity. We see them as matters that interfere with our enjoyment of the gift of life, and with our responsibilities in relationships and at work. While we would admit that there is misuse of medication by people who are abusing their bodies through bad diet, lack of exercise, unhealthy forms of stress and overwork, and so on, we generally also recognise that pain is inconvenient at best, and debilitating and dehumanising as it gets worse.

The biological role of pain and discomfort is to signal to us that something is wrong and that we need to take some form of action. Once we know what is wrong, there is no further point in that pain - it has no further intrinsic value.

Pain and suffering are alienating and isolating. That is why so much medical treatment aims to relieve it and most Christians avail ourselves of those treatments when necessary. In the Bible, Job's pain led him to scream out in anger at both his friends and at God. On the cross, pain led to even the Christ feeling God-forsaken and abandoned. The experience of many people who suffer severe pain or chronic physical suffering is the same - it debilitates one physically, emotionally, mentally and spiritually so that normal human activity becomes difficult, and in some cases impossible.

The problem of pain is not an intellectual conundrum. Suffering is a problem because it is an exhausting, horrifying, dehumanising experience which no one can really share with the sufferer. It is also a problem because those who have not experienced severe or chronic pain or suffering usually have no idea of what it is like for the sufferer. This lack of understanding by those who do not know the experience then becomes a secondary source of dehumanisation and alienation. In spite of the occasional anecdote to the contrary, most people find that involuntary suffering offers no opportunity to be noble - severe suffering

reduces us to quivering heaps who are totally self-centred because suffering allows little room to think about anything or anyone else.

We accept that when we can, we should cure illness and relieve pain and suffering. We assume that our own illness and our own suffering should be relieved if this is possible. It is an extraordinary contradiction, then, to say to people whose illness cannot be cured and whose suffering cannot be relieved that they should accept their suffering. Either suffering and pain will ennoble us all, so let's get rid of medicine, or they are not intrinsically ennobling to anyone, and we should get rid of romantic notions of the ennobling character of suffering and take seriously those who say they do not want to suffer longer.

Conclusion

This paper has shown that when we listen to the people in the situation, we have to face a number of dilemmas. The paper challenges some of the assumptions which the churches make in the debate about euthanasia. It is too simplistic to see medicine as an unquestionable good. Rather we must look at how medicine is changing the nature of life, and what that means for people's experience of life and death. How do we restore the proper place of death as part of life?

Questions raised in this paper

(The following is a list of the questions explicitly asked in the paper. There are many other questions implicit in the paper that readers may also wish to consider.)

1. Is death an event to be avoided at all costs, or is death part of the gift of life? Is God's gift of life meant to be limitless, or is the call for euthanasia to be heard as a call from some patients to reinstate death as part of life? Has society allowed doctors to continually defy and deny death, without looking adequately at the long-term consequences for the patient?
2. To what extent have we allowed medical technology to distort the Gospel and undermine our acceptance of death?
3. Who are the stakeholders in the situation?
4. How can legislation be drafted to prevent subtle pressure on patients?
5. If we allow interventions which artificially prolong life, are we entitled to refuse to hear people tell us that now life has gone on too long and they want an intervention to end it? If we say length of life is in God's hands, why do we not say this at every time and stage of life? Once we allow medical intervention to preserve life, how can we say length of life is not in human hands?
6. Is it possible to protect people from the subtle pressures of family and friends and to ensure that euthanasia only ever occurs as a result of the genuine initiative of the patient? How do we protect this vulnerable group? How do we expect doctors to ensure that the patient's expressed request for euthanasia is the patient's genuine desire, and not the result of pressure from other people?
7. Is it possible to keep this as a separate issue - to distinguish voluntary requests of competent adults from any action related to incompetent patients?
8. Medical intervention has vastly extended people's lives. When does that extension cease to be a gift and become a burden? When are people entitled to say it's time to trust God by choosing death, rather than being further dependent on the medical profession?
9. If we do not have to bear the same burden as those who suffer, how can we tell them that they must bear those burdens?

10. The question is, how does society define the responsible use of medicine's control over life and death? How do we as a society ensure that medicine is used for people and not against people? If we listen to the people seeking voluntary euthanasia, is what we hear a request for patients to take back control over life and death instead of being expected to accept the changes which medical professionals have imposed on their path through life towards death? This is not a question of God versus human beings, but a question of which human beings should determine times of death - which person's autonomy should be respected?

Recommendations:

(These are the implications of this paper. Most are uncontroversial, except 4 (d) and (e), which need to be further explored)

1. That the churches call for an immediate review of the Dying with Dignity guidelines, to determine
 - a) the extent to which the guidelines are understood and implemented in hospitals
 - b) what obstructions have prevented their full implementation by all staff in all hospitals;
 - c) the extent to which the public is aware of these guidelines, how they are intended to operate, and their rights as patient and family under the guidelines; any modifications to the guidelines, and any actions, such as placing the guidelines in
 - d) legislation or providing better training, which are necessary to ensure that the guidelines can be effectively implemented to enable the withdrawal of futile treatment which does not serve the patient's interests.
2. That the churches affirm the importance of palliative care, and call for better education of doctors and other health professionals as to when palliative care should be suggested, where it can be obtained, and what it offers the patient. The public also needs to be given more information about palliative care.
3. That the churches consult with the AIDS Council of New South Wales (and other relevant groups) about their proposed euthanasia legislation, with a view to understanding
 - a) what the legislation would entail
 - b) why it is felt to be necessary
 - c) what safeguards are provided, and
 - d) what amendments, if any, are necessary to ensure that euthanasia is always entirely voluntary, not the result of pressure or decisions by other people.
4. That the churches affirm
 - a) that all human beings have the right to life and to freedom from arbitrary interference; and that society should do all that lies within its resources to sustain, maintain and enhance the life of all its members;
 - b) that society has a responsibility to provide accessible and affordable high quality medical care, palliative care, and support services to all who need them, so that euthanasia is never a result of society's failure to provide adequate services;
 - c) the importance of the Department of Health's Dying with Dignity guidelines being fully implemented by the medical professions and widely understood in the community, so that people are not in fear of their proper time of death being postponed by futile treatment; and
 - d) that we live in a world where human beings have taken control of times of life and death, and that in that situation, adult competent patients have the right to accept or reject the life that doctors have given them; that is, that it is not appropriate that society prevent euthanasia from being an option for patients who find other options unsatisfactory.
 - d) that legislation allowing euthanasia would only be acceptable if:

- i) legislation ensured that euthanasia was an entirely voluntary decision made by competent, adult patients;
 - ii) there is a legislative commitment to providing patients with the option of palliative care and support services; and
 - iii) if adequate, workable safeguards are provided against patients being pressured into seeking euthanasia, and against the concept of euthanasia being applied to patients who are children or are not competent.
- f) That the churches explore the theological and ethical issues raised by the medical extension of life and relief of pain, including those raised in this paper, inter alia.

Appendix: Summary: Darren Russell: "Voluntary Euthanasia - a GP perspective"

New Doctor Winter 1995

Russell is a GP, one of seven doctors in Victoria who signed a letter admitting to euthanasia. The seven signatories come from different areas of medicine and were not all known to one another prior to signing the letter.

He works with HIV/AIDS patients, almost all of whom want the option of euthanasia available as a last resort, although few actually avail themselves of this option (currently available through informal networks).

He argues that palliative care doctors admit that for about 10% of patients, palliative care does not adequately control pain. PC is particularly likely to be ineffective in the case of pain of neural origin. It also does not deal with a range of other symptoms which cause suffering but not pain.

However, the suffering of HIV/AIDS patients is not only a matter of pain. Patients who have talked to him about the possibility of euthanasia have symptoms such as intractable weakness, nausea, diarrhoea (which may be watery, accompanied by nausea and abdominal cramps, and lead to dehydration requiring hospitalisation), incontinence of urine and/or faeces, paralysis, and failing vision. These symptoms cannot be controlled by current medical treatments.

He describes how he works with patients who desire euthanasia, as follows:

They usually talk about euthanasia with me for several months before reaching the point where they feel they can no longer go on.

For my part, I will always listen to a patient who enquires about euthanasia and will not dismiss their queries out of hand. I will endeavour to find out what symptoms they have, and what symptoms they fear, and do my best to assist in the control of these. Palliative care by specialist agencies is routinely arranged. However, it is the patient's legal and moral right to reject specialist palliative care, just as it is their right to reject any other treatment they do not want. Some patients will opt for suicide, but sometimes their nausea, vomiting, diarrhoea or paralysis are such that they are unable to take sufficient quantities of an agent to bring about the relief of suffering through death.

In such cases they must enlist the help of another. I generally do not like the idea of a relative, spouse or lover performing this duty for two reasons. First, it is not unknown for the helper to fail in the attempt, which can make matters worse and sometimes results in hospitalisation and subsequent difficulty in making a successful attempt. Secondly, I believe that it is a large burden for a loved one to shoulder for the rest of their lives. Feelings of uncertainty or guilt could arise, and could have harmful sequelae, especially in the grieving period. As a criminal act has been committed, they often feel unable to discuss their actions with anyone else.

Rather controversially, I believe it is the doctor's duty to assist someone with terminal illness to die (or to at least be informed of where they may obtain this service) provided that person is mentally competent, freely requests euthanasia and is suffering in a way which cannot be sufficiently palliated.

He argues that the present situation in law, which hinges on the intention of the doctor, rather than the outcome for the patient, "is patently absurd and cruel".

If the doctor's intention is to relieve pain, and death results, then this is entirely legal, and considered good medical practice. If, however, the doctor's intention is to hasten death (at the patient's request), then this is illegal, and considered to be heinous, contemptible medical practice. The result for the patient may be the same, with the exception that their suffering may actually be greater and more prolonged in the former case.

It is, of course, perfectly legal throughout Australia for a patient to commit suicide, and some terminally ill patients resort to jumping off buildings or in front of trains, or gas themselves in a car, or use a shotgun. These methods are all quite legal, yet cause further suffering to the patient, to their families and friends, and those who find the body...For me to give such a patient a lethal injection, and for them to quietly, painlessly and peacefully die, surrounded by those for whom they care, is murder and may be punishable by life imprisonment. It can be seen that the current laws are hypocritical and actually lead to increased suffering.

He sees the introduction of euthanasia laws in the next few years as inevitable, and comments:

...I am also convinced that in years to come we will look back and wonder how we could have been so cruel as to deny suffering, dying patients the right to exercise their autonomy and achieve a gentle, painless, assisted death.

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