A Response to Euthanasia in Australia

Christian Medical Dental Fellowship of Australia Inc.

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CMDFA Ethics: A Response to Euthanasia in Australia

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CMDFA RESPONSE TO EUTHANASIA IN AUSTRALIA

According to the Australian Medical Association," Euthanasia is the act of deliberately ending the life of a patient for the purpose of ending intolerable pain or suffering". Physician-assisted suicide (PAS) occurs "where the assistance of the medical practitioner is intentionally directed at enabling an individual to end his or her own life"[i] and usually this involves the provision of a prescription.

Moral opposition to both euthanasia and physician-assisted suicide has been a feature of both the Hippocratic and the Judeo-Christian tradition from earliest times. This is particularly striking in view of the commitment of both traditions to the relief of suffering and care of the dying. We acknowledge the power of the arguments for both practices based on compassion but believe that even more powerful counter-arguments lead us as Christians and doctors to continue to oppose their legalisation.

The first of these counter arguments is based on the creation of humankind in God's own image (Genesis 1: 26-27). Every human, no matter how physically or mentally impaired, bears the divine image and as such their life is not their own or anyone else's to take. Life giving and life taking are divine prerogatives. To take human life is both to attack God through his image bearer and to usurp God's authority. This is the underlying principle behind the sixth commandment: "You shall not murder". Although God delegates life taking to his covenant people under particular circumstances during the Old Testament period (capital punishment and holy war), there is no suggestion of a divine mandate for suicide or euthanasia.

The second counter argument is based on justice. Within a biblical worldview, justice is understood not primarily in terms of individual rights but in terms of restoration of right relationships and the common good. It is particularly concerned with protecting those who are disadvantaged- the poor, the disabled, the sick, the very young and the very old. The legalisation of euthanasia would grant to some people a claimed right, but at the cost of putting at risk the lives of many other, vulnerable people. Evidence from the Netherlands where euthanasia has been legalised is that many people are killed without a specific request. And, the criteria for euthanasia have expanded from severe physical suffering, terminal illness and competent adult patients to include psychological distress and children, even infants. The very existence of the possibility of legal euthanasia or physician-assisted suicide increases pressure on the sick and elderly, who already feel that they are a burden on their family or society, to request it. This pressure would be further exacerbated by inequities in the availability of palliative care.

But what about the obligation to relieve suffering?

As Christians and doctors, we acknowledge our obligation to show compassion and use all legitimate means to relieve pain and suffering. This includes the administration of appropriate analgesia and/or sedation at the end of life, as long as the intention is to relieve suffering and not to terminate life. There have been concerns in the past that such treatments may shorten the life of the patient, however, we note the opinion of palliative care specialists that there is no evidence that the skilled and appropriate delivery of palliative care measures shorten life[ii]. Pain and other symptoms may (but not always) be associated with terminal illness, and palliative care aims to control distressing symptoms so patients can do the important things they want to do before they die. The most common reason why palliative care services cannot help dying patients is because they are referred too late or not at all. The development of palliative care services has reduced calls for legalisation of euthanasia on the grounds of compassion.

However, even with good palliative care, some patients will continue to suffer. We need to recognise that, essentially, suffering is not a medical problem. It is an existential problem that extends beyond physical pain. It is influenced by psychological, cultural and spiritual factors, and made worse by the fact that we, as a society, have lost touch with the spiritual concerns surrounding death. Many people are unprepared for death and fearful as it approaches, and this fear is promoted by media accounts of the suffering experienced by the dying. Often the physical symptoms can be dealt with, but the suffering may well remain. It may be that the call for legalised euthanasia is motivated by a desire to avoid the dying process itself. In a world of instant gratification, there is a reluctance to endure any hardship, even when we are dying . If the suffering patients wish to avoid is related to metaphysical or spiritual concerns, then not only physical but also the social, psychological, relational, existential, cultural and spiritual concerns need to be addressed.

While Christians do not fully understand problems of evil and suffering (2 Thess 2:7), we know that suffering is inevitable in this life because we live in a fallen world. But we also know that life is not meaningless, death is not meaningless, and that we can have hope amidst the suffering, because death is the gateway to resurrection (1 Cor 15).The euthanasia debate is an expression of a community which is struggling to find meaning in life, and so finds no meaning in death (Romans 1:21). But the answer to suffering is not euthanasia. It lies in the good news that Jesus came to give us new life, and to finally eliminate suffering in the world to come (Revelation 21:4).

In the meantime, for those who do not share this hope, we support ongoing efforts to find ways to minimise pain and other symptoms for those at the end of life and to always treat the dying with compassion. While acknowledging the limitations of medical practice, our challenge as Christian doctors is to transform the way we act towards the suffering and the dying, to treat them as the image– bearers of God.

What about respect for autonomy?

In the clinical context, autonomy involves self-determination, freedom and independence of thought, decision and action. An emphasis on respect for patient autonomy is a relatively recent feature of medical ethics but is to be welcomed in that it promotes shared decision making with health professionals, provides an opportunity for patients to retain some control over their lives, and encourages them to be responsible for their choices and actions. Yet there are problems with the concept of autonomy in health care. In particular, it may be naive in relation to the significant knowledge imbalance between the general public and health professionals. Further, it assumes the capacity to think, decide and act independently. But biblically, individuals are not conceived as purely autonomous agents but as persons in a web of social interdependence. So, to speak of the right to individual choice in relation to an issue as complex as euthanasia is problematic.

The minimal, negative or "constraint" requirement of respect for patient autonomy is the obtaining of informed consent for treatment. The argument from autonomy for euthanasia assumes that a competent patient could give a valid, informed consent to euthanasia or physician-assisted suicide. Yet this fails to address the real complexity of end-of-life issues. A range of cultural, legislative, community and family pressures place significant limitations and boundaries on individual choice, and this is especially so during a period of severe illness, when a person is at their most vulnerable and least able to be fully independent. His or her self-worth, framed in terms of crude economic terms, is greatly diminished. If unduly influenced by this perspective, or indirectly influenced by others who hold it, this person is greatly vulnerable to a diminished sense of self- worth. The common good perspective recognises that persons can be valued even in states of illness, suffering and disability. Resource allocation must be done in a way that respects the vulnerable members of society as participants in the common good, who are called to a destiny that transcends human society.

We also note that respect for autonomy applies to health care workers as well as patients, and no doctor or nurse should be required to perform a procedure which violates their own moral commitments.

Is there really a difference between withholding or withdrawing life supporting treatments and euthanasia?

In continuity with medical tradition going back to the Hippocratic corpus, the Statements of almost all Medical Associations distinguish between the withholding or withdrawal of inappropriate, futile or unwanted life-prolonging medical treatment, on the one hand, and the administration of a lethal injection on request and physician-assisted suicide, on the other. The former may be morally permissible, even morally required under certain circumstances, while the latter is opposed. "Letting die" by the withholding or withdrawal of treatment (treatment abatement) is non-intervention

whereas euthanasia/PAS is an intervention in the course of nature. In "letting die", the illness causes death, whereas in euthanasia/PAS, it is the human agent.

The ability of modern medicine to prolong life by use of dialysis, respirators and artificial nutrition and hydration (ANH) raises the question of when it is morally permissible for doctors to withhold or withdraw such treatment. First, a competent informed patient may refuse potentially life-saving treatment, and a doctor must respect that refusal, since to treat without consent would be an infringement of the autonomy, dignity and moral responsibility of the patient for his or her own decisions.

But in other situations, the patient may not be in a position to refuse treatment (they may be incompetent or even unconscious) and treatment abatement is a medical decision (often in consultation with relatives). Even "life saving" or "life prolonging" treatment may be foregone if it is held to be futile or unjustifiably burdensome, or in order to respect the natural dying process at the end of life .

There is some debate about whether percutaneous endoscopic gastrostomy (PEG) feeding may be withdrawn from an incompetent patient on the grounds of futility or burdensomeness. While it is standard treatment to give ANH to brain injury patients in the early stages of illness when some hope of improvement still exists[iii], some Catholics (and some evangelical ethicists) oppose removing ANH from people in what used to be called a persistent vegetative state (PVS), now termed post-coma unresponsiveness, at any stage. They argue that it neither causes a great burden to the patient nor is useless, but rather is beneficial in keeping him or her alive. Further, nutrition and hydration which are "basic to human life" should be clearly distinguished from medical treatment and should always be provided to PVS patients. Others say that this position is vitalism, an elevation of mere physical existence above all other values. It is argued that, for a patient in PVS, the preservation of life in such a state is not a benefit, and when medical treatment can offer no hope of pursuing the spiritual goods of life, there is no duty to preserve life and the patient should be allowed to die.

Yet discerning when it is time for the patient to die, time to withhold or withdraw treatment, is not straightforward, and there is a tendency for doctors to over treat at the end of life, so that some people the fear that the process of dying may be prolonged unnecessarily. It is important that patients are aware of the rights they have to refuse any, even life-prolonging, treatment. Such an act is an ethical option for a competent patient. Instigation of advance planning in healthcare enables patients to retain control of healthcare decisions even after they become mentally incompetent and should be promoted.

Medicine has a mandate for its goals of preserving and prolonging life in both the dominion mandate of Genesis 1:26-28, and the redemption project of healing the sick (e.g. Matthew 10:8) as a sign that the Kingdom of God has broken into this world to begin to reverse the effects of sin. However , we know that medicine cannot break the power of sin, nor the power of death. Medicine is not the Saviour. Medicine does not give eternal life. And since we are mortal, death is both an enemy to be resisted and the gateway to resurrection life. So, there comes a time when death is no longer to be resisted but acknowledged.

What about "terminal sedation?"

The term "terminal sedation" is used in a number of different ways. It may be used to indicate sedation in the terminal phase (last few days) of an illness, in which case there is no evidence that it shortens life. But "terminal sedation" may also be used to indicate a quite different practice, where the patient need not be imminently dying. Sedation is sometimes used in order to render the patient unconscious so that they can avoid eating and drinking without discomfort., ANH is also withheld with the result that the patient dies, either through dehydration and/or through the effects of immobility and inhibition of coughing, producing sputum retention and hypostatic pneumonia. In such a case it is possible to establish a causal link between the sedation and death, and the intention is to hasten death. It is uncertain how commonly this "sedation towards death" occurs in this country, although there was a celebrated case involving Australian euthanasia activist Dr. Philip Nitschke[iv]. It is morally indistinguishable from euthanasia.

But there is a third category of "terminal sedation", somewhere between sedation in the imminently dying and "sedation towards death", where sedation is given to relieve uncontrolled suffering and most likely does shorten life, but at the same time, death is not the intended, merely foreseen result of treatment. This is the only category of terminal sedation where the Principle of Double Effect[v] needs to be considered and might arguably be invoked in order to provide a moral justification for the practice, although this remains controversial. Some authors argue that if heavy sedation is administered to any but the imminently dying, it ought to be accompanied at least by artificial hydration.

Conclusion

Moral opposition to both euthanasia and physician-assisted suicide has been a longstanding feature of both the medical and the Judeo-Christian tradition for good reasons. This does not mean that Christian doctors do not respond with compassion to those suffering at the end of life. We are best equipped to support patients with advanced disease by learning how to discern when a patient is indeed dying, and to give appropriate care, including referral when necessary. Provision of competent and compassionate care will do much to ease the suffering of dying patients and their loved ones, and we have a moral duty to

provide it. However, we continue to oppose the legalisation of euthanasia or physician assisted suicide.

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i Australian Medical Association. (2007) The Role of the Medical Practitioner in End of Life Care – 2007. http://ama.com.au/node/2803

ii Sykes N, Thorns A. The use of opioids and sedatives at the end of life. Lancet Oncology 2003; 4:312-318; Good P. P. D. Good , P. J. R. a. J. C. and N. M. M. H. (2005). "Effects of opioids and sedatives on survival in an Australian inpatient palliative care population." Intern Med J 35: 512-517.

iii NHMRC. Ethical guidelines for the care of people in post-coma unresponsiveness (vegetative state) or a minimally responsive state. (2008). Australian Government, p. 36-7.

iv Kissane, D. W., Street, A., & Nitschke, P. (1998). Seven Deaths in Darwin: Case Studies under the Rights of the Terminally Ill Act in Northern Territory, Australia. The Lancet, 352(9134), 1097-1102.

v The Principle of Double Effect (PDE) specifies that when an action has two possible effects, one good and one bad, it is morally permissible if the action:

1) is not in itself immoral

2) is undertaken only with the intention of achieving the possible good effect, without intending the possible bad effect although it may be foreseen

3) does not bring about the possible good effect by means of the possible bad effect, and

4) is undertaken for a proportionately grave reason (Sulmasy, D. P., & Pellegrino, E. D. (1999). The Rule of Double Effect. Clearing Up the Double Talk. Archives of Internal Medicine, 159(6), 545-550, p.545). In the medical context, PDE means that “it can be morally good to shorten a patient’s life as a foreseen and accepted but unintended side effect of an action undertaken for a good reason, even if it is agreed that intentionally killing the patient or shortening the patient’s life is wrong” (Boyle, J. (1997). Intentions, Christian Morality and Bioethics: Puzzles of Double Effect. Christian Bioethics, 3(2), 87-88.)

Written by the CMDFA Ethics Committee

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