

LIFE WORTH LIVING

Issues in Euthanasia and Assisted Suicide
Brief and Study Guide

Council on Faith and Life
Pamphlet Number 2



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Preface

In society and in the church a lively discussion is currently taking place on issues of euthanasia and assisted suicide. Society, through its government, is posing the question: Should Canadian law be changed to allow for assisted suicide? Churches are raising concerns about the care of the sick and the dying.

It is within the mandate of the Council on Faith and Life to resource the congregations of the Conference of Mennonites in Canada on topics vital to Christian life and witness. The matter of dying, and of living in community with those who are dying, belongs within this circle of concern. We commend this pamphlet as a resource for study in the churches.

Helmut Harder
General Secretary

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Introduction

Jesus's story of the Good Samaritan has motivated Christian groups throughout the centuries to help people in need. Mennonites, too, have become known for their expressions of kindness in the midst of suffering. This has included short-term outpourings of compassion in the midst of crises, as well as long-range responses such as the establishment of mental health institutions in the 1940s and 50s.

The current ferment surrounding issues of euthanasia and assisted suicide may provide renewed opportunity for Mennonites to respond to people in need. We have longstanding concerns about the treatment of the sick and the dying within our Christian communities and in society. With the gradual increase in the number of elderly persons in our midst, their situation is becoming of concern to us. How should we respond to the call of Christ to minister to the dying, which includes many elderly people, but also persons of all ages?

This pamphlet brings the current situation, with its many questions, to the attention of the church, so that together we may find ways of ministering in the name of Christ. People of faith need to address these issues, especially as government considers changes in policy, and as the church faces new challenges in caring for the terminally ill.

The pamphlet comes in two sections. The first section is the text of a brief entitled *Life Worth Living*. The brief was originally presented to the Special Senate Hearing Committee on Euthanasia and Assisted Suicide when the committee met in Winnipeg on September 30, 1994. The brief is an example of how we can speak to government.

The brief and the study guide are the joint effort of several groups: the Peace and Justice Committee of the Mennonite Conference of Eastern Canada, the Resources Commission of the Conference of Mennonites in Canada (CMC), and the CMC's Council on Faith and Life. The brief was presented to the Hearing Committee by Tym Elias, Doug Pritchard, Roma Quapp, Dr. Howard Zacharias, and Helmut Harder. Professor David Schroeder gave helpful advice on content.

Let us approach this study in a spirit of prayer and with dedication to a ministry that upholds "life worth living." We have a commitment to each member of the body of Christ (1 Cor 12)—the strong and the vulnerable in equal measure (Gal 5; James 2). How shall we extend care and love for one another in the name of Christ?

SECTION ONE

BRIEF: LIFE WORTH LIVING

**A Brief presented to the Special Senate Hearing Committee
on Euthanasia and Assisted Suicide
by a delegation from the Conference of Mennonites in Canada**

We are grateful for the opportunity to contribute to the discussion about euthanasia and assisted suicide in Canada.

1. WHO WE ARE; WHAT WE BELIEVE

The Conference of Mennonites in Canada is an assembly of 220 Mennonite congregations with 33,000 adult members in seven provinces, from New Brunswick to British Columbia. We do not come as technical experts in this field, although we have consulted with healthcare workers, theologians, lawyers, chaplains, pastors, and others who are members of our Conference.

Rather, we come as a people who seek to affirm life in obedience to Jesus' command to love our neighbours and our enemies. Therefore, we have always opposed state-sponsored killing, be it war or capital punishment. But now the state is considering the legalization of killing in certain situations as an act of mercy rather than one of vengeance.

Our submission identifies pain, isolation, and fear as the principal factors that might lead some persons to feel that life is no longer worth living. We believe that the state, rather than facilitating the early death of such persons, should be facilitating the control of physical and emotional pain within a caring, community setting, in an attempt to assist persons to achieve a good death. Then life will be worth living.

2. WHY SEEK DEATH?

Sue Rodriguez captured the respect and sympathy of many Canadians by her courage and determined efforts to legalize assisted suicide. Many other persons facing death have gained respect and sympathy by their courage and patient endurance to the end of their natural lives. But neither situation is a sufficient basis on which to form public policy.

Death by choice

In addressing this issue, we need to define our terms. 'Euthanasia' simply means 'good death.' However, in popular usage, euthanasia has come to mean an act with the primary intention of ending a person's life. We find it helpful to use instead the term 'death by choice.'¹ This moves us away from imprecise

terms such as ‘euthanasia’ or ‘dying with dignity,’ and away from emotive terms such as ‘mercy killing.’ Death may be the choice of a conscious patient (as in suicide or assisted suicide), or the choice of family or healthcare workers for a comatose patient (as in euthanasia).

Why would someone choose death?

The fear of unbearable pain

One reason to seek death is to stop unbearable pain. Most of us fear pain, both physical and emotional. This is particularly so in Canada today because medical science has greatly reduced our experience of physical pain and suffering in everyday life. Faced with pains or problems, we are tempted to seek a quick fix. Unbearable and unrelenting pain might make death seem attractive. However, modern pain-control techniques make the pain in dying manageable in all but the rarest cases.² We have also gained experience from other approaches to pain relief, such as those used in natural childbirth and in acupuncture. So the pain of dying need not be so fearsome.

Fear of causing pain to others

A second reason for seeking death is to spare loved ones the burden of witnessing the dying patient’s pain and decline. Family and friends often feel impotent, unsure of what to say or do, and may indeed see no alternative but an early death of the patient. However, ethicist George Webster responds to their pain as follows:

“Assisting in the suicide of those in our community who are dying eliminates tragedy and suffering by eliminating the sufferer. Rather than being an expression of mercy or respect for another, communal endorsement of assisted death is the ultimate abandonment of the person. If we are to truly honour and respect those among us who are dying or those whose hold on life is weakened by disease or suffering, then we must keep company with these people and respond in concrete ways that communicate faithfulness and attentiveness.”³

Fear of disability

A third, and more frequent, reason for seeking death is the fear of experiencing a diminished quality of life owing to physical or mental deterioration. Our society overvalues youth, beauty, and strength, and questions the right to live of the old, the ugly, and the unfit. As individuals, we dislike any imperfection in our bodies; we avoid suffering; and we deny our mortality. We fear the loss of dignity if we become disabled in certain ways.

In recent years certain elements of our society have shown increased sensitivity to people with disabilities and their needs, owing in large part to the

increasing outspokenness of people with disabilities and their demands to be treated equitably. However, advances made by any particular group often provoke a backlash by those other members of society who resent the breaking down of barriers between *us* and *them*, who continue to fear the unknown, and who fear ‘contamination’ by the presence of people with disabilities. Those who currently advocate death by choice echo the old societal attitudes, in effect saying “We will provide you with access ramps and employment equity, but we think living with disabilities may be unbearable. We, if we found ourselves in your position, might prefer to die, and we believe you may prefer to die, also.”

There is the added danger that the pressure to choose death will rise with increased strains on health care budgets and the depletion of personal finances.

Vulnerable persons need society to reinforce their value and not cast doubt over their already precarious sense of self-worth. Thus, in our opinion, if death by choice becomes prevalent, persons with disabilities, the ill, and the frail elderly will find it increasingly difficult to live with dignity.

Fear of isolation

A fourth reason for seeking death is to end the indignity of lying in a sterile hospital bed, hooked up to life support systems, isolated from family and friends. Modern medicine has prolonged life, but it has also prolonged dying. The emotional and physical cost of putting death on hold, when there is no hope of recovery, is high. It becomes intolerable when no one is with us, no one cares for us, and we are left alone in an alien, antiseptic world. Under such circumstances, one might long for the power to choose to put a quick end to the suffering. A caring and supportive community of family and friends can provide companionship and comfort, whether in hospital, or preferably in a hospice or home setting.

Fear of powerlessness

A fifth reason for seeking death, and the reason death by choice has gained such attention recently, is the desire to maintain control and assert our individual rights. Yet exercising this ‘right’ of the individual has wide societal ramifications. Life is a gift from God and is not ours alone. Death by choice denies this and compromises the calling of healthcare workers who must now assist with putting to death. It may terminate family and friendship ties prematurely. Death by choice distorts our attitude to the acceptance of people with disabilities and of disability itself. Suicide does not end the pain — it lays it on the shoulders of the survivors and places a skeleton in their closet for the rest of their lives.

There are better ways to address the fears of those seeking death.

3. WE ACCEPT THE CESSATION OF EXTRAORDINARY MEDICAL MEASURES

One of the miracles of living today is the increase in life expectancy brought about by modern medicine. Diagnostic, surgical, and pharmaceutical advances have allowed many to live far beyond the Biblical threescore and ten years.

Medical advances can be overused

However, these advances have also created the fear that at the end of life, our dying might be cruelly prolonged as we are kept alive in a vegetative state on life-support systems. Healthcare professionals are dedicated to healing and preserving life. They commit considerable resources to the treatment of the terminally ill, sometimes beyond what the patient desires. They also feel an increasing pressure to avoid costly lawsuits. Family members may agree to or demand aggressive treatment to reassure themselves that everything possible has been done. Meanwhile, many terminally ill people simply want to be allowed to die peacefully, without aggressive intervention.

The cessation of medical treatment for or the withholding of extraordinary measures from the terminally ill is not death by choice. Allowing to die is not the same as choosing to die or causing a person to die.

People may choose to refuse treatment

When any medical test or treatment is considered, the patient and doctor must weigh the costs and benefits in order to give informed consent. As the patient's condition deteriorates, and death approaches, the potential benefits of treatment decline, and the costs increase. There will always come a point where death is imminent and inevitable. Further treatment would be useless and burdensome. Refusing medical treatment or withdrawing life support systems at this point is not death by choice. The physical deterioration, not the patient or the attendant, causes death.

The refusal of treatment can be troubling. In Québec in February 1992, Nancy B. refused to continue receiving life support from a respirator. This, and the refusal of others to have a blood transfusion, chemotherapy, or a diagnostic test, may seem foolish. However, this is not killing. It is a refusal of treatment and acceptance of the consequences, even death.

4. THE DANGERS OF DEATH BY CHOICE

We believe there are many dangers in any attempt by the Government to legalize death by choice.

Abandonment of belief in the sanctity of human life

The first danger lies in abandoning respect for the sanctity of human life. Times of monstrous inhumanity do not come about all at once; we slip into them gradually.⁴ There is a ‘slippery slope’ in moral decision-making where the single step from the top of the slope to the bottom is unthinkable, but the individual steps starting at the top seem quite possible.

For example, if suicide is not a criminal offence, why should assisted suicide be illegal? That seems a very small step to take. If assisted suicide is legal, why not legalize the killing of those who wish to die but cannot commit suicide themselves even with assistance? Then, if a conscious person can choose death, perhaps an unconscious person should also be enabled to die if prospects for recovery are virtually non-existent. If the terminally ill can choose death, why not the chronically ill, or persons with disabilities, or those who have lost hope? As death by choice becomes more common, then the state-supported killing of old people, people with disabilities, the mentally ill, and the ‘undesirable’ becomes more thinkable.

Going back to the first step, suicide was decriminalized because of compassion for the individual, recognizing that where the individual, for whatever reason, decides to take his or her own life, concepts of criminal liability and punishment (e.g. individual and general deterrence and the possibility of rehabilitation) have become largely irrelevant. No extension of this policy reason supports assisted suicide or death by choice. Yet this distinction is ignored by proponents of assisted suicide as they advocate the first ‘small’ step down the slippery slope.

Pressures inherent in caregiver fatigue

Family and caregivers generally act in accordance with what they believe to be the best interests of the patient. But there are times when the best of intentions can be clouded by self interest and there are many inducements for attendants to consider an earlier death for the terminally ill. Attendants may wish to end their own anguish at seeing a loved one in distress. A dying that drags over weeks or months taxes everyone’s physical, emotional, and spiritual energy, whether the patient is cared for at home or in hospital. Even the most saintly caregiver may occasionally wish for an end to this burden.

Healthcare systems, and to some extent families, also feel the weight of ongoing financial costs, and the pressure to reduce costs is growing. Family systems are more complex than before — who now has the right to decide for the patient? In addition, family members are usually beneficiaries of the dying

one's will. A greater portion of the cost of health care is being shifted onto patients, and their estates will be depleted as the costs of care continue. This further clouds the family's ability to assess matters clearly.

These inducements to choose an early death may influence only a few people. Yet they add to the feelings of uselessness among the old and the infirm who are already sensitive to the burden they create for others. With legalized death by choice, people who are dying and people with disabilities would constantly have to justify why they want to live longer.

Confusion of purpose in the medical system

Another danger in legalizing death by choice is that such an action would confuse the role of healthcare workers, who would sometimes counsel and assist in living and at other times counsel and assist in putting to death. At present, the primary responsibility of healthcare workers is to maintain or improve their patients' physical and emotional well-being. Where this is not longer possible, they should at least mitigate pain and suffering. To include putting to death as part of their responsibilities conflicts with the responsibility to maintain well-being, and places an enormous burden on them. It also has the potential to undermine the patients' confidence that their caregivers seek only the patients' recovery.⁵

Difficulty of enforcing guidelines

Those advocating death by choice insist that strict guidelines are required to prevent a slip into unintended predicaments. We agree. However we fear that if death by choice is legalized, no guidelines will be able to prevent the slip into more and more disturbing situations. The clearest justification for this fear is the experience with death by choice in Holland over the past twenty years. The guidelines used in Holland say that those seeking death must be mentally competent adults, experiencing intolerable suffering with no prospect of improvement, and the patients must request assisted death voluntarily and repeatedly. Two physicians must be consulted and accurate records must be kept.

In 1991, A Dutch government commission reported that these strict guidelines have been ignored hundreds of times, and no action has been taken against the offending physicians.⁶ Lethal overdoses were administered without the patients' knowledge, with the patients' death, rather than relief of pain, as the main purpose. Incompetent patients were killed, often without the knowledge of their families. The requirement to consult a second physician was ignored. Deaths by choice were not recorded as such. The guideline that there be no prospect for improvement was dramatically disregarded in the recent case of a 50-year-old depressed woman who expressed a wish to die after several

personal tragedies, and her psychiatrist assisted her in doing so. The Netherlands Supreme Court ruled that even this assisted death was justified, regardless of the guidelines requiring that the patient be mentally competent, experience intolerable suffering, and have no hope of recovery.⁷

Who really supports death by choice?

We need to look more closely at who wants death by choice. In one survey of Dutch nursing homes, 93% of inhabitants were opposed to legalizing it, and 50–60% of these same inhabitants were fearful of involuntary termination.⁸ This same survey shows that families seek death for the dying patients much more frequently than do the patients themselves. Surveys following a California referendum on legalizing death by choice show that support for the proposition was lowest among women, the elderly, the minorities. It was highest among the young and those with post-graduate education and incomes over \$75,000.⁹ Who is in favour of death by choice for whom?

If the Canadian government were to decide to legalize death by choice, it would have to guard against the concerns and abuses cited above. We believe this would be extremely difficult, if not impossible.

We believe there is a better way to achieve a ‘good death,’ without legalizing death by choice.

5. LIFE WORTH LIVING

Life is a gift from God

We believe that life is a precious and good gift from God. Therefore, our life is not our own; rather, we are ‘stewards’ of this life on earth. Life is more than the merely physical--it also has spiritual dimensions. Jesus warns us that the death of the body is not to be feared, but rather the death of the soul.¹⁰ We believe that, for the followers of Jesus, death has been conquered; death is not the end of life, but a transition into a new life.

As God’s creatures, we are not autonomous beings. We are created to be in community both socially and spiritually. Therefore, if one member suffers, all suffer together; if one member is honoured, all rejoice together.¹¹ Sue Rodriguez was known to politicians, journalists, and many Canadians. She was also known and loved by her son and other family members. When she chose to die, we were all affected; we all felt a sense of loss.

God has given us rules for living in community. One such rule is “Do not kill.”¹² We are not to kill in vengeance, but neither are we to kill in mercy. We know that death is inevitable and believe that we must allow it. While biological life is good, it is not an absolute or even the highest good in

creation. Its loss (death) is not the greatest evil. The greatest good for the Christian is communion with God, and the greatest evil is alienation from God.¹³ Artificially prolonging physical life when the terminally ill are ready to die is a kind of idolatry, a worshipping of life itself.

There is a time to die

There is ‘a time to die’ for each of us, but that time is rarely clear to us. We acknowledge that the infirmity and suffering which may accompany death can seem senseless, but we believe the experience of God’s presence and the human community surrounding the dying person give meaning to suffering. This is a mystery with which we continually struggle as mortals. Yet dying and death are a holy process, and the coming together of family and friends in their care for a dying loved one makes that more so. Many who attend the dying speak of the God-given grandeur of this hour of final submission. While we may shrink from suffering and death, we believe God loves us, knows our hearts, and is present with us.

In our own love for all God’s people, we believe that every person has an equal claim upon us for those resources necessary to prolong life. No person is more ‘worthy’ than another. Therefore we must not allocate resources only to those deemed more useful or more attractive to us, but we must ensure that all people have access to what is needful for their living.

We strive to achieve a ‘good death’

We need to be more tender, more compassionate, and more caring for both the living and the dying.¹⁴ When death is inevitable, a ‘good death’ for most of us would be a peaceful and gentle death, free from uncontrollable pain, in our own home, surrounded by those we love.¹⁵ Sadly, too few Canadians today experience this kind of death.

However, a ‘good death’ is much more likely with the assistance of palliative or hospice care. Palliative care is defined as

“active, compassionate care of a person whose disease is no longer responsive to treatment aimed at cure. Palliative care seeks neither to hasten nor to postpone death. The relief of suffering—physical, emotional and spiritual—is the primary goal.”¹⁶

Palliative care provides effective management of pain and other symptoms associated with terminal disease. Once curing the disease is no longer possible, then caring for the dying patient and his or her family becomes central.

We can do more to support those in pain

Physical pain can be controlled in all but the rarest cases today. On occasion, pain medication may shorten life, but this is not the intention. More research is

still needed into better medical approaches and alternative approaches to the relief of pain or suffering in the few cases where they remain unmanageable.

The *emotional* pain of isolation and alienation can be addressed with the loving concern and care given at home or in a hospice-type setting. To facilitate this, dying patients need to be more involved in important decisions affecting their care and treatment. In case of incapacity, families need to be better informed of the options available. This should reduce suffering when attempts to cure have become futile. Also, nominating a ‘medical attorney’ or preparing a ‘living will’ are means by which the wishes of dying patients and their families are brought to bear in medical decision-making even if the patient becomes incapable.¹⁷ Such discussions, and constant contact with loving human beings in a home-like setting, help reduce emotional and spiritual pain since those facing death have a “profound wish to feel that they are still part of the world of the living, that they are listened to and appreciated for what they have to offer.”¹⁸

The presence of chaplains in hospitals and palliative care facilities can also assist dying patients to achieve a good death, since chaplains can help deal with the spiritual realm, to which many people’s thoughts turn when they or their loved ones are dying. Chaplains can also help healthcare professionals to deal with the questions and pain of watching someone die.

To ensure more good deaths, palliative care must be made much more widely available in Canada. Such care can be delivered at home or in hospices by professionals and trained lay people.¹⁹ This need not cost governments more, since expensive, acute care hospital beds occupied by the dying will be released, and useless attempts at medical treatment of the dying will become less frequent. If cases of overtreatment and unnecessary expenditure got as much publicity as the demand for death by choice, we believe Canadians would better appreciate the importance of alternatives such as those presented in this submission. Chaplaincy care should also be expanded.

We believe that the wider availability of palliative care is more necessary and more urgent than legislation to legalize death by choice.

6. RECOMMENDATIONS

Based on our submission we make the following recommendations to the government of Canada:

1. Do not introduce legislation to legalize death by choice, euthanasia, or assisted suicide.
2. Increase financial support for the provision of palliative care in homes and hospices, particularly in remote areas, and continue to explore the use and

development of alternative health care services.

3. Provide more financial support for research into medical and alternative techniques for the relief of pain and suffering.
4. Provide incentives for health care institutions to maintain or reinstate chaplaincy services, to serve patients, family, caregivers, and the attendant health professionals.
5. Hear the contribution that the Christian faith makes to the meaning of life and death for people throughout Canada.

NOTES

- ¹A. Voth, "Euthanasia—A Physician's Definitions and Critiques," paper presented at Regent College Bioethics Seminar, June 26, 1993.
- ²R. Salter, "Palliative care ideal alternative to MD-assisted suicide," *Medical Post*, March 29, 1994; J. Scott, "Lies and lamentation—a solid no to euthanasia," *J. of Palliative Care*, vol. 4, no. 1 & 2, 1988, pp. 119ff; W.W. Rosser, "Is there a role for euthanasia in family practice?" *Cdn. Family Physician*, vol. 40, Aug. 1994, pp. 1395–96.
- ³G. Webster, "Keeping faith with the dying," *Toronto Star*, May 21, 1993.
- ⁴F.A. Schaeffer and C.E. Koop, *Whatever Happened to the Human Race?* Marshall Morgan & Scott, London, 1982, p. 61.
- ⁵*A Matter of Life and Death*, discussion paper by the Social Action Commission, The Evangelical Fellowship of Canada, May 1994, p. 10; W.W. Rosser, *op. cit.*
- ⁶S. Genuis, "Decriminalizing assisted suicide: more than we bargained for?" *Medical Post*, April 5, 1994; "The Report of the Dutch Government Committee on Euthanasia," in *Issues in Law and Medicine*, vol. 7, 1991, pp. 339–44.
- ⁷S. Connor, "Euthanasia enters ominous new territory," *Toronto Star*, June 29, 1994.
- ⁸B.A. Bostrom, "Euthanasia in the Netherlands: A Model for the United States?" *Issues in Law and Medicine*, vol. 4, pp. 477ff, 1989; R. Fenigsen, "A Case Against Dutch Euthanasia," *Hastings Centre Report, Special Supplement*, pp. 26ff, 1989; quoted by A. Voth, *op. cit.*
- ⁹"Help for the Helping Hands in Death," *New York Times*, sec. 4, p. 1, February 14, 1993.
- ¹⁰*The Bible*, Matthew 11:28.
- ¹¹*The Bible*, 1 Corinthians 12:26.
- ¹²*The Bible*, Exodus 20:13; Matthew 5:21–26.
- ¹³C. Brunk, "Ethical Issues in the Prolongation of Life," paper presented at Mennonite Conference of Eastern Canada Fifth Annual Session, April 4, 1992.
- ¹⁴M. Gervais, President of the Canadian Council of Catholic Bishops, *Statement on Assisted Suicide and Euthanasia*, January 13, 1993.
- ¹⁵*Preparing Together for Death*, paper approved for discussion in the congregations by the Division of Mission in Canada Executive, The United Church of Canada, June 1994, p. 7.
- ¹⁶Canadian Palliative Care Association, Board Position on Euthanasia, September 19, 1993.
- ¹⁷P. Singer, *Living Will*, Centre for Bioethics, University of Toronto.
- ¹⁸E. Seravalli, "The Dying Patient, the Physician, and the Fear of Death," *New England J. of Medicine*, vol. 319, no. 26, December 29, 1988, p. 1729; quoted by The United Church of Canada, *op. cit.*
- ¹⁹B.M. Mount *et al.*, "Palliative Care—A Passing Fad? Understanding and Responding to the Signs of the Times," *J. of Palliative Care*, vol.10, pp. 5–7, January 1994.

SECTION TWO

A STUDY GUIDE

for four or more sessions

The study is designed as a process to guide a congregation in formulating a faithful response to the issue of euthanasia and assisted suicide—a response grounded on scripture, exercised in community, and commended to government. Three different facets of the question should be kept in mind as you pursue this study: societal issues, the role of the church, and personal faith. We ask that participants reflect on their own experiences and on the biblical narrative to discern a faithful response to both personal issues of death and dying and to issues in society around the values of life and death.

The study is divided into four sessions. Each section can be dealt with in one or more meetings. The facilitator and participants ought to exercise sensitivity and not rush the process. Since participants are encouraged to reflect on personal experiences, it may be helpful to have someone available for comfort should a participant need support.

The issues we address in this pamphlet are many and complex. They present unique challenges and opportunities in each of our lives and communities. We need to talk in our faith communities and in the public forum. We at the Conference of Mennonites in Canada would be delighted to receive reports of the results of your congregation's initiatives.

SESSION 1: CAN WE TALK ABOUT IT? CLARIFYING THE PROBLEM

Pain, suffering and death are experiences and subjects we generally would like to avoid, if not deny. The story of the death of Lazarus puts us in touch with the drama of suffering, death and grief. Read John 11.1–7 & 17–36. Jesus “is the resurrection and the life,” yet Jesus’s response connects with our human response to suffering and death.

1. Reflect upon a person you love who is near death or struggling with a terminal illness, or upon the death of someone dear to you. Share your experiences.
2. When someone we care about is suffering or dying we must deal with many issues. What are some of the situations in which you’ve experienced suffering and death? What did you see and hear from those who were dying? How did you respond? When you were dealing with your situation, how did others respond to you? Did anyone talk about or ask for their life to be terminated? How was the question interpreted? How was it dealt with?
3. Do we tend to avoid talking about death and dying? Why or why not? What are some of the things we do to cope with grief?

4. What impact would the permission to take life into our own hands have on the grief process?
5. Our attitudes towards illness and death vary in accordance with where we place our faith: God, medicine, institutions, ourselves.... How has your faith and the faith of our society been a support or an obstacle in responding to these critical situations?
6. At the hearings on euthanasia and assisted suicide one of the Conference of Mennonites in Canada panel members spoke along the following lines:
At scenes of crisis—pain, loss, death—body and spirit are embroiled in struggle. As medicine has its role, so does pastoral care. Pastoral care provides personal affirmation for the worth of the person as God’s creation. Pastoral care validates a person’s struggle, identifying concerns and worries that arise, and provides a bridge to the church community. It seeks to meet a patient’s spiritual and relational needs. Furthermore, pastoral care is a ministry of compassion that empowers those who are suffering—the patient, family, friends, and other care providers—to interpret and own struggle.

In this struggle, the patient’s voice must be heard and cultivated. The option of ‘death by choice’ betrays our unwillingness to hear this voice. Our unwillingness to face the full extent of human experience and to learn the hard lessons of our frailty reveals that we view suffering as devoid of worth.

Listening for this voice, especially from of a seriously ill person, may prove disquieting. At times we may feel assailed by competing emotions that we find difficult to express. Unless we are prepared, we often cut off this pained attempt to relate and seek rather to secure premature closure. In the process we protect ourselves and coerce the sufferer into submission to the inevitable. Death by choice then becomes the pathetic plea of a person denied community.

We bring our experiences and feelings about death and dying to the bedside. What is the danger of projecting our feelings onto the terminally ill? Are we aware of the way in which our attitudes can influence the attitudes of those who are ill and dying?

Preparation for Session 2

Clip articles from newspapers and magazines and take note of TV and radio clips on euthanasia, assisted suicide, and related issues. Evaluate them: Whose perspective do they portray? What do they say about life and death? What do they say about death by choice? How do they feed or reflect public sentiment, current values? How do you see them in light of scripture?

SESSION 2: WHY TALK ABOUT IT NOW? *ENGAGING THE ISSUE IN A SOCIAL CONTEXT*

The idea of ‘death by choice’ reflects a modern context where primary value is placed on freedom and technology—the right of the individual to determine what he or she wants to do and the right to follow through on those desires.

1. In the brief, the term ‘death by choice’+ is used to define what has come to be widely accepted as the meaning of euthanasia or assisted suicide. What are the contemporary values and issues that lead our society to struggle with death by choice?
2. In section 2 of *Life Worth Living*, the question is posed: “Why would someone choose death?” What are some of the problems that we would hope death by choice would save us from (both on the part of the patient and as far as we are concerned)?
3. *Life Worth Living* names a number of fears that may lead someone to consider death by choice. How can congregational and social dialogue on these issues help us get at the core of the problem? Is there a more profound answer to these fears than death by choice?
4. What do you think would be the impact if euthanasia and assisted suicide were accepted (legalized) in our society?

Here are some other facets of the question you might want to discuss in your sessions:

- How has socialized medicine influenced the way we think about this issue? How have medical advances affected our attitudes towards illness and dying?
- What should be the role of government in deciding our values and in providing health services?
- What responsibility should the church take in speaking to government about the way it makes policy, and in providing leadership in society on issues of health, life, and death.
- Section 3 of *Life Worth Living* asserts: “We accept the cessation of extraordinary medical measures.” How might ‘advance directives’ or a ‘living will’ help us or our loved ones cope with illness and dying?

Preparation for Session 3

Discuss the issue of death by choice with a friend or family member, focusing on your beliefs as a Christian. Record the conversation (with your friend’s permission). As you replay the tape, note how you come across. Did you say what you meant to say?

SESSION 3: HOW CAN WE TALK ABOUT IT IN THE CHURCH? INTRODUCING THE BIBLICAL PERSPECTIVE

The Bible tells many stories of persons who struggled with life and death.¹ Paul entertained something akin to the contemporary notion of ‘death by choice’ (Phil 1). Similar expressions of pain appear on the lips of other biblical characters: Jonah (Jon 4), Elijah (1 Kings 19), and Jeremiah (Jer 14). Compare also the stories of Saul (1 Sam 31) and of Ahithophel (2 Sam 17.23).

1. It may be a human reaction to concede to acute frustration when things do not work out. What are some of the reasons given in the above-noted texts why we should not just give up and want to die?
2. In section 5 of *Life Worth Living*, the biblical point is made that “we are ‘stewards’ of this life on earth.” What does it mean to be a ‘steward of life’ when we are called on to care for persons who desire to end their own life?
3. The words health, holistic, wholeness, and holy share the same root. The terms for being in good health and being holy are similar in many ancient traditions, including the Judeo-Christian tradition. Hence, suffering and death are understood to result from unholiness. The book of Job relates a profound struggle with suffering (see especially Job 3). The writings of Ecclesiastes reveal a struggle with death (Eccl 3.18–21; 6.12ff). How do Christians understand the theological aspects of death and suffering?
4. There is a popular conception that euthanasia is an act of mercy, a ‘compassionate’ thing to do. Mercy in scripture signifies God’s forbearance of people when they are wayward (see especially Deut 7.9 and Ps 25.6; compare Lk 6.36). Closely related ideas include compassion and faithfulness. Compassion literally means ‘to suffer with’ (Zech 7.9). God suffers with downtrodden people (Lam 3); God suffers with us through Jesus Christ, who lived among us and knew our struggles. What do passages such as these say about mercy killing? If we are to follow the example of Christ, how ought we to respond to the choice of death?
5. Paul uses the image of the temple to describe both our individual bodies and the community of the church (1 Cor 3:16–17; 6.19; 12.27; Eph 2.21–22). Does the decision to terminate one’s own life violate the ‘temple’ in these two contexts—personal and corporate? How might we build up the temple when dealing with the dilemma of suffering?
6. Section 5 of *Life Worth Living* states that we are accountable to God for our lives. Furthermore, the brief says that modern medicine has “artificially

¹ See Gerhard von Rad, *Biblical Theology*, in which he describes the inter-relatedness of life and death. See also Hans Walter Wolfe, *Anthropology of the Old Testament*, Kent Richards’ article “death” in the *New Anchor Bible Dictionary*, and Lloyd Bailey’s *Biblical Perspectives on Death*.

prolong[ed] physical life when the terminally ill are ready to die,” and that this “is a kind of idolatry, a worshipping of life itself” (see Matt 11.28; 16.24ff). Passages such as John 14.3, 1 Thessalonians 4.13–5.11, and 2 Timothy 4.6 provide us with the comfort of knowing that fellowship with Christ will be completed as we pass through death. What light can this biblical perspective shed on our response to death by choice?

7. The command to choose between “death and destruction” and “health and prosperity” is central to the challenge of being God’s people (see Deut 30.11–20). The call to repentance is a call to choose life. The invitation to discipleship (Matt 16.24–25; compare Gal 2.20) is an invitation to die to worldly things. What are the implications of this perspective for the church and its members in the face of euthanasia and assisted suicide?
8. There is a time to die! We hope for a good death as a fitting conclusion to a good life here on earth. In scripture, when elderly people died they frequently pronounced blessings on the next generation (Gen 49). What would a ‘good death’ mean for you? What blessing would you like to pass on?

Preparation for Session 4

Study the following biblical passages with a view to how they guide us in taking action:

- The story of the Good Samaritan (Lk 10) is a parable illustrating the effervescent love as the heart of a relationship with God.
- The story of the Sheep and the Goats (Mt 25.31) underscores the expectation to do good to others.
- Romans 12.9-21 speaks of Christian hospitality. How might we apply this passage to the issues of euthanasia and assisted suicide?
- Compare the compassion demonstrated by the disciples in Gethsemane (Mt 26.36-46) and the women at the cross (Mt 27.55-6).
- Reflect on how you, as an individual or as a congregation, can assist those who are ill or dying. Be prepared to share your thoughts.
- Should we attempt to help those who are dying resolve unfinished issues in their lives? Do we feel free to discuss where they are at spiritually? How can we be ministers of God’s grace, love and forgiveness in bringing spiritual healing and wholeness when a patient is no longer responding to medical treatment?
- How can we become agents of hope for people near death, helping them to realize the worth of their life?

- The question “who is my neighbour?” raises the question of community. Palliative care workers claim that the reported incidence of pain and degree of discomfort among their patients is less when the patient has a loving, supportive community of family and friends. How do we practice our church community?
- It is a Christian perspective that ‘We do not live unto ourselves, we do not die unto ourselves.’ If we understand our lives in relationship to God and to our communities, is the decision ‘death by choice’ ours to make?

SESSION 4: WHAT CAN WE DO ABOUT IT? *IDEAS FOR ACTION*

In 1 Corinthians we read “If Christ has not been raised, then our preaching is in vain and your faith is in vain” (1 Cor 15.14; see also 26–55).

In the brief to government we made recommendations in an effort to shape and focus attention on the issues in a way we believe will be more helpful to society. In conclusion to this study we want to encourage you to develop a course of action in several areas: to be proactive in caring for the dying in your community, and to use your voice in the public discussion addressing local organizations and government.

1. Formulate a position-statement to be shared with the congregation, the local or federal government, or with an appropriate group in your community (hospital ethics committees).
2. Write a covenant, to be shared with the entire congregation, that addresses your concerns and in which you agree to care for each other in sickness and death.
3. Invite an expert to address your study group in the area of ‘advance directives’ or ‘living wills.’
5. Invite someone who works in the area of palliative care services in your community to speak to your study group about their work and to share insights.
6. Invite a chaplain to speak to your group on the challenges of working with dying persons and on what church members can do to support those in their community who are ill and dying.
7. Write a letter to the Minister of Justice (since euthanasia and assisted suicide is a legal issue), the Minister of Health and Welfare, and/or your local Member of Parliament stating your concerns and views.
8. Write a letter to the editor or an article and send it to your local newspaper or church paper, expressing your concerns about the issue of euthanasia and assisted suicide.

9. Consider whether it is time for Mennonites to develop palliative care hospices as we once responded to the need for mental health institutions, or to devise alternative palliative care services enabling ill and dying people to receive care in their homes.
10. Debate the question of whether employed persons should be eligible for ‘palliative care leave’ in order to care for dying relatives, similar to current maternity/paternity leave and benefits that enable parents to care for newborn infants.

Suggestions for continuing action:

- Volunteer for palliative care services at your local hospital or nursing home.
- Seek chaplaincy training and opportunities to participate with chaplaincy services.
- Plan a worship service incorporating the insights of these study sessions.
- Discuss as a congregation whether you should become involved with opportunities to provide palliative care in your community, and how you can do so.

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Videos

See the CMC Resource Centre Catalogue.

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Additional copies of this pamphlet are available at \$1 each or 10 for \$7.50.