

CARING FOR THE DYING:



CHOICES AND DECISIONS

R
726
C35
1995a
LARGE

R
726
C35
1995a
Large

*A Paper Approved for Discussion in the
Congregations of The United Church of Canada
by the Division of Mission in Canada Executive*

AWQ-1402

Prepared by a Task Group:

Chairperson: Rev. Anne L. Simmonds, Chaplain, Toronto

Dr. Faye Lindsey, Family Physician, Caledon, Ontario

Dr. John O. Godden, Physician, Toronto

Staff: Ruth Evans, Office of Christian Development, DMC

©The United Church of Canada
Division of Mission in Canada
All Rights Reserved
ISBN 0-88622-336-9
IM 06/95

United Church
Archives

TABLE OF CONTENTS

MANDATE OF THE COMMITTEE 4

Purpose of the Task Group
Task Group's approach

THEOLOGICAL FOUNDATIONS 5

INTRODUCTION 5

UNNECESSARY AND FUTILE TREATMENT; ALLOWING TO DIE 6

Case Study A
Case Study B

CREATING AN ENVIRONMENT FOR A PEACEFUL DEATH 8

Palliative care
Case Study C
Case Study D
Substitute decision-making

PHYSICIAN-ASSISTED SUICIDE AND EUTHANASIA 11

Assisted suicide or physician-assisted suicide
Euthanasia and mercy killing
Case Study E
Case Study F
Confusion in the assisted suicide/euthanasia debate
The case for assisted suicide/euthanasia
The case against assisted suicide/euthanasia
Additional reasons for resisting assisted suicide/euthanasia
Options for those wishing to die

SUMMARY 16

Appendix A: PETITION 62 17

Appendix B: TASK GROUP'S APPROACH 18

Appendix C: THEOLOGICAL FOUNDATIONS 19

Introduction
1. God is with us
2. Life is a gift from God: towards a Christian understanding of life and death
3. Created in God's image; called to be co-creators
4. Sin and suffering

Appendix D: SUBSTITUTE DECISION-MAKING: ADVANCE DIRECTIVES 23

Appendix E: GLOSSARY OF TERMS 24

FOR FURTHER READING/INFORMATION 25

DISCUSSION SESSIONS 26

VIDEO LISTING 35

FEEDBACK QUESTIONNAIRE 37

MANDATE OF THE COMMITTEE

The task group was asked to prepare a position statement¹ for the United Church on current issues that surround life-threatening illness, disability, and death, with a view to assisting church members and congregations faced with making difficult choices.

The need for such a statement was demonstrated by:

- Petition 62 from Muskoka Presbytery to the 34th General Council (see appendix A);
- requests from United Church members asking for materials containing such guidance;
- a report from the former Moderator, Walter Farquharson: in his travels across the country, he found that church members are dissatisfied with the church's apparent failure to address concerns such as the use of life support systems, living wills, and euthanasia;
- the urgency of avoiding futile prolongation of life for chronically or terminally ill patients, and avoiding painful decisions for their families during such prolongation.

Purpose of the Task Group

Our purpose is to assist members of the United Church to draw on their faith as a source of strength that will help them to make loving and responsible choices in life-and-death situations. By confronting in advance suffering and death and the pain, anxiety, and uncertainty they evoke, we hope to empower them to respond honestly to life-and-death issues, even though these will remain painful. By examining and reflecting on ethical dilemmas related to care of the dying, this report provides a framework within which to consider and assume responsibility for painful and perplexing moral challenges. We encourage UC members to prepare for their own "good death" as they continue to live life in all its fullness.

The task group was asked to address the theological and pastoral concerns regarding life-and-death choices and to provide guidance for those who make decisions for themselves or for those they love. We believed our principal task was to set out clearly the real and painful choices that people face, whatever stance they take concerning such complex and deeply emotional issues as physician-assisted suicide. In accepting this grave responsibility, we acknowledged that Christians, indeed all compassionate persons, can reach radically different conclusions on such issues and we wish to assure those who hold alternative views, that we have great respect for them.

Task Group's approach

The procedure by which the task group undertook its work is outlined in Appendix B.

¹ This position statement was presented to the Executive of the Division of Mission in Canada in June 1994, and approved as a paper for discussion in the congregations of The United Church of Canada.

THEOLOGICAL FOUNDATIONS

The theological foundations that underlie our report are outlined in Appendix C. They are reflected in a creed used widely in the United Church since 1968, and have their basis in our understanding of the Bible and how it informs us as we consider issues of life and death. We recognize, however, that our conclusions are not the only ones that can be derived from these theological foundations.

INTRODUCTION

Most of us want to live as long and fully as possible. As Christians, we believe that God intends us to live an abundant life in all its fullness. We also believe we are called to accept death as the culmination and last act of a person's life on Earth, and we trust that God's love endures through illness, disability, and death. We express our hope for that enduring love when we affirm that... "In life, in death, in life beyond death, God is with us. We are not alone."²

In the past, death was experienced differently from the way it is experienced today. Usually sudden or following a short illness, death was seen as part of life. People often died at home in the company of family and friends. However, in Western society today, in spite of Christian traditions, we shrink from aging and death and seek to postpone both by all possible means. Death has become a taboo subject, a fearful prospect, an admission of defeat. Denial of death sets the stage for much inappropriate behaviour, such as demanding or accepting unnecessary and non-beneficial treatment, and thereafter, confusion and conflict often develops about withdrawal of such treatment (allowing to die) and assisted suicide/euthanasia (directly causing to die).

The tendency to avoid facing death is reinforced by the way we use modern medical technology, which has changed the way we experience and think about death. Such use of technology and treatment make it possible to sustain physical life in ways not previously possible. In many cases, continued treatment prolongs the dying process and increases pain and suffering, even though it offers little or no real quality of living, or dying. Many times patients and families agree to treatments and procedures with little understanding of what to expect. When faced with a critical illness, many people want some form of aggressive medical treatment.³ At the same time, many frail elderly people want to be allowed to die peacefully without radical intervention.

2 A creed approved for use in the United Church in 1968.

3 Daniel Callahan *The Troubled Dream of Life*. New York: Simon and Schuster, 1993, pp. 48. COPYRIGHT © 1993 by Daniel Callahan. Reprinted by permission of Simon & Schuster, Inc.

We believe that this prolongation of life by means of aggressive medical treatment has increased the suffering associated with dying and strengthened the perception in our society that the only way to avoid terrible pain and suffering when dying is by means of assisted suicide or euthanasia.

The above summary outlines the problem that our task group was asked to address on behalf of the United Church. After meeting and deliberating with a wide range of consultants, we have concluded that the church faces two central issues: first, that dying is often prolonged through unnecessary and futile medical interventions; secondly, that the demand is increasing in our society for the legalization of assisted suicide and euthanasia. The first section of this report will discuss the issue of futile treatment and the prolongation of dying; the second part will examine the demand for the legalization of assisted suicide and euthanasia, which must be distinguished sharply from the first issue. Throughout, we affirm the goal of a peaceful death, in which the patient is free from avoidable pain and futile medical interventions and is surrounded by those who love them.

UNNECESSARY AND FUTILE TREATMENT; ALLOWING TO DIE

Medical and technological advances, although they have brought great benefits, have changed the nature of illness by increasing the degree and duration of sickness once contracted. The line between saving a life and extending a death has been made nearly invisible. Frequently, the results are: longer lives and worse health, longer illnesses and slower death, and longer aging and increased dementia.⁴ Technology has made it difficult to know when a person is dying, and has increased the frequency of futile treatment.

Futile is a term used to describe treatment which reasoning or experience suggests will not likely produce the desired outcome.⁵ A judgement of futility is both medical and moral: it is a calculation of the probability of medical outcome, and also it is a judgement about the morality of further treatment that has a low probability of success. We believe that physicians ought not to be required to perform procedures or provide treatments that they believe will do no good, and in fact may cause harm.

4 Ibid. Callahan pp. 46-7. COPYRIGHT © 1993 by Daniel Callahan. Reprinted by permission of Simon & Schuster, Inc.

5 Reproduced with permission, from Schneiderman LF, et al. Medical futility: Its meaning and ethical implications. *Ann Intern Med.* 1990;112:949-954.

See also Irwin Kleinman and Pamela Khan "Relative Treatment Futility," pp. 108. Reprinted from, by permission of the publisher, *Humane Medicine* 1994; Vol. 10(2).

Uncertainty about diagnosis, treatment, or outcome is inherent in clinical medicine, but is seldom acknowledged by either physician or patient. The unrealistic pursuit of certainty and control contributes to the overuse of medical technology, an escalation of health-care costs, and the declining satisfaction of both patients and physicians. Honest and thorough communication and careful decision-making can lead to more realistic expectations and make more tolerable the considerable uncertainty and risk that remain in illness.

Futile treatment may result in a technologically prolonged death, which can be marked by undue fear and uncertainty and by a lengthy illness and decline that can leave the patient isolated and degraded. Modern technology makes the course of such a death highly uncertain and alien to the normal cycle of life, removing the dying one from the life of the community.⁶ Our group heard disturbing evidence that this is an accurate depiction of many hospital deaths where radical medical intervention, often with the encouragement of the family, resulted in prolonged suffering before death. Families tend to push for the latest and the best, so that they can feel at the end that everything that could possibly be done was done. This scenario is illustrated in the following cases.

Case Study A

Fifty-year old Robert had told his adult son only a few days before his massive brain hemorrhage that he would never want to live like a "vegetable." For nearly two years he has been fed with a tube through his nose and shows no signs of intelligence, emotional response, or evidence of awareness. He lives in a ward with 25 other patients in a similar condition. It is getting increasingly difficult to get the tube through his nose and the doctor now wants to put a feeding tube directly into the stomach. The doctor will not consider stopping the artificial feeding, because he believes that would be equivalent to killing the patient. He also believes that death by starvation is extremely unpleasant and prolonged.

Case Study B

Michael was a 72-year old man who suffered from severe lung disease (chronic bronchitis and emphysema) and required supplemental oxygen to live. He developed pneumonia and came to the emergency department unable to breathe. He was admitted to the intensive care unit where he was put on a breathing machine (ventilator). Complications, such as heart failure, began to arise. Michael had expressed a wish to die and his wife had agreed with him. However he was kept in the intensive care unit on a ventilator for over two weeks before hospital staff would allow him to die.

6 Ibid. Callahan, pp. 26. COPYRIGHT © 1993 by Daniel Callahan. Reprinted by permission of Simon & Schuster, Inc.

The experiences of these and many other persons illustrate our conviction that there is no value in merely prolonging physical life and suffering when there is little or no hope of reversing the illness or providing significant benefit for the patient. We believe that life is to be cherished and respected, but that there is more to being alive than physical survival. Social, emotional, spiritual, and intellectual capacities are equally important. We do not believe that life-prolonging interventions are warranted when someone with irreversible illness and no potential for dimensions of life that make for wholeness is being kept alive by medically administered food and water,⁷ or on a breathing machine, or with other medical interventions.⁸ Prolonging physical life when relational and inner life appear to have failed forever, or when a terminally ill person is ready to die, does not show respect for the life that God has given us. Such actions are a kind of biological idolatry. We believe that we must make critical end-of-life decisions on the basis of valuing and respecting the dignity of the whole person.

Technology has blurred the line between living and dying, and between curing and caring. The medical "miracles" that technology seems to offer can tantalize patients, families, and caregivers with false hope, making the decision to withhold or withdraw treatment even harder. Where there are still unresolved personal conflicts, the decision can be even more difficult. The pastoral role in such situations is to help the family accept the medical judgement that further treatment (except comfort care) is likely futile and will prolong the patient's suffering. From this acceptance onward, the path of love is to accept the reality of what is; to support and comfort each other; and to find hope by helping all concerned become reconciled to their loss. Family conferences with the medical staff, the chaplain, and other caregivers have a vital role to play in this transition. We are challenged to turn technology around and focus it, not on the prolongation of life and defiance of death at all costs, but rather on providing palliation and peaceful death. The church can play a part in bringing about this change in attitude.

CREATING AN ENVIRONMENT FOR A PEACEFUL DEATH

Many people fear the process of dying more than death itself. When death is inevitable most people want to maintain their dignity, have their pain relieved, and to be cared for and die in their own homes. As Christians, we can help create an environment where attention is paid to the wishes of the dying person. A peaceful death is one that is tolerable, expected, and accepted without crippling fear, and one that affirms the bonds of community and social solidarity.⁹

7 Feeding tubes may impose a significant burden to patients with severe irreversible illness. However, physicians often persist with tube feedings even though it adds to the patient's discomfort and is against the family's judgement about relative benefit. This persistence has been explained on the basis of the symbolic value of providing food as an expression of basic care; the fact that professionals are socialized to intervene in human illness and are unfamiliar with the literature on starvation; and finally that caregivers and families interpret the withdrawal of food and water as starving and abandoning the patient. See footnote 48 for an article on "Accepting Death without Artificial Nutrition and Hydration."

8 Some would argue that to withdraw such treatments is to kill the patient. In such instances, we believe that it is the disease that kills the person, not withdrawal of medical intervention as the Court concluded in the case of Nancy B. in February 1992.

9 Ibid. Callahan, pp. 26. COPYRIGHT © 1993 by Daniel Callahan. Reprinted by permission of Simon & Schuster, Inc.

Such an end is possible when we acknowledge death as a part of life and seek to accept God's loving presence even in the shock and the heartbreak. Death can then be seen as the inevitable endpoint of medical care, and caring for the dying patient becomes as important as curing. The goals of medicine should be reoriented from an unbalanced effort towards cure and the reduction of mortality toward a renewed emphasis on the original aim of care and comfort.¹⁰

As those created in God's image and called to be co-creators, we can create a community of care around the dying, bringing God's compassion and healing power to situations of pain and grief. As we accompany the dying we can learn to give and receive, and discover that not all is death when the dying are sustained by the power of community. We should not only be willing to care for others; we should also allow them to care for us if and when this becomes necessary.¹¹ In the same way that the beginning of this life is a significant event, so can be its end. Paradoxically, providing comfort care to a dying person can lead to a heightened awareness of God's presence and love. Such care is known as palliative or hospice care.

Palliative care

Palliative care is 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.¹²

Palliative care provides effective management of the pain and other symptoms associated with terminal disease. Its purpose is to improve quality of life for the dying and to support patients and families as they incur multiple losses.¹³ Palliative care provides a natural death which comes when the disease process overwhelms the body and life is no longer sustainable.

Case Study C

Mary was a person of deep faith who had lived a rich life with her large family and friends. At 92 her mind was still clear and while blind, she was able to get around her own apartment where she lived with her daughter. Shortly before Christmas she had two falls while getting out of bed at night to go to the bathroom. She was bruised and sore, but nothing was broken so she stayed at home, mostly in bed with additional help. One day the visiting nurse noticed that her breathing was laboured and her pulse and respiration elevated. The doctor made a house call and determined that Mary was in congestive heart failure. Prior to this, Mary had made it clear to her doctor and family that she did not want "heroics" when her time came and

10 Ibid. Callahan, pp. 209. COPYRIGHT © 1993 by Daniel Callahan. Reprinted by permission of Simon & Schuster, Inc.

11 Ibid. Callahan, pp. 218. COPYRIGHT © 1993 by Daniel Callahan. Reprinted by permission of Simon & Schuster, Inc.

12 Canadian Palliative Care Association, Board Position on Euthanasia, September 19, 1993. Used by permission of the CPCA.

13 Elizabeth Latimer and Heather Dawson "Palliative Care: Principles and Practice," *Canadian Medical Association Journal* 148, no. 6 (15 March 1993), pp. 933. Reprinted from, by permission of the publisher, CMAJ 1993; 148(6).

that she wanted to die in her own home. The doctor explained to Mary and her family that if she stayed at home now she would most certainly die. If that was their wish, he would do everything to keep her physically comfortable. Mary insisted that she did not want to go to hospital. Over the next few days, family members came to visit. Mary assured them that she was ready to die and that this would be her last Christmas. On Boxing Day she died peacefully in her own bed surrounded by her family members.

Case Study D

Marion was transferred from the hospital where she had been treated for cancer of the breast with secondaries to the bone to a palliative care unit. There she was treated for symptoms of pain, nausea, and vomiting. She told her physician that she believed in euthanasia because she did not believe in suffering either for herself or others. When asked if she wanted it now, if that were possible, she responded that she did not consider her suffering that bad yet. When her symptoms were under control she was able to return home for several weeks with the assurance that a bed would be available to her when she or her family could no longer cope at home. When the pain became more severe she returned to the palliative care unit. The fear of excruciating pain on being moved made her pain even more severe. The doctor increased her pain medication and asked her again if she would want euthanasia now if it were possible. She quickly responded, "No, it's in God's hands now." When her physical pain was controlled she became less apprehensive and died peacefully several days later with her husband and son by her side.

In Canada, palliative care and its specialized knowledge is made available to a limited number of dying patients.¹⁴ **Many patients who could benefit do not receive good palliative care and their suffering is increased by the health care provider's lack of knowledge about modern techniques for pain and symptom control. As this report was being prepared, we were saddened by the death of Dr. Dorothy Ley, a pioneer of palliative care in Canada. As she died of cancer, she lamented that she was unable herself to get the kind of care that she had spent her life fighting for. In a US survey of physicians and nurses who treat dying patients, 80 per cent indicated that "the most common form of narcotic abuse in the care of the dying is undertreatment of pain."¹⁵ We believe that the church should support and work toward greater availability of palliative care. We believe this need is more urgent than, and would in fact reduce the perceived need for, legalization of assisted suicide/euthanasia.**

Substitute decision-making

An option for those wishing to avoid unnecessary prolongation of their dying is to complete a living will and form for durable power of attorney. For more information on these, see Appendix D.

14 For the urgency of funding palliative care and making it more widely available in Canada, see Mount BM, Scott JF, Bruera E, Cummings I, Dudgeon D, MacDonald N. Palliative Care—A passing fad? Understanding and responding to the signs of the times. *J Palliat Care* 1994; 10(1): 5-7. Reprinted by permission of the *Journal of Palliative Care*.

15 Mildred Solomon et al. "Decisions Near the end of life—Professional views on life-sustaining treatment," *American Journal of Public Health* (January 1993), pp. 14-23. COPYRIGHT © The American Public Health Association (APHA). Used by permission.

PHYSICIAN-ASSISTED SUICIDE AND EUTHANASIA

The appeal to the Supreme Court of Canada for physician-assisted suicide by Sue Rodriguez¹⁶ has put this issue squarely into public consciousness. On Sept 30, 1993, the court narrowly decided that the Criminal Code offence of assisting suicide does not violate the Charter of Rights and Freedoms.¹⁷ Thus, anyone assisting another person to end his or her life is still liable to criminal charges. In discussing this issue, we will define our terms, offer two public cases as examples, discuss the case for and against, and give our reasons for not supporting the legalization of assisted suicide.

Assisted suicide or physician-assisted suicide

Assisted suicide is the "provision of information and/or the means to enable a patient to take his or her own life."¹⁸ "Physician-assisted suicide" means the provision by a physician of information and/or means, such as prescribed medication which, taken in sufficient quantity, would cause death. This paper will use the term "assisted suicide," to include both.

Euthanasia and mercy killing

The word "euthanasia" comes from a Greek root meaning "good death." However, in public and professional literature, euthanasia has come to mean a medical act that directly causes death. In popular usage the terms euthanasia¹⁹ and mercy killing mean the same thing, that is, the deliberate administration of a lethal drug to a sufferer.²⁰ This is how it will be used in this document.²¹

Case Study E

Sue Rodriguez, 42, was suffering from amyotrophic lateral sclerosis (ALS), a degenerative and fatal neurological disease. As she deteriorated, she declared publicly that when she was no longer physically capable of taking her own life, she wanted to choose the time and circumstances of her death with the assistance of a physician. Although her appeal to the Supreme Court of Canada for this assistance was denied, she allegedly died (in late February, 1994) as a result of a lethal injection given by a physician.

16 Description of case follows in Case Study E.

17 Sack Goldblatt Mitchell "The Supreme Court Rules on Physician-Assisted Suicide," *Ontario Medical Review* (October 93), pp. 57. This article first appeared in the October 1993 issue of the *Ontario Medical Review* and is reprinted with the permission of the Ontario Medical Association and Sack Goldblatt Mitchell.

18 Bioethics Information Retrieval Project. *Bioethics Thesaurus, 1994 Edition*. Washington, DC: Kennedy Institute of Ethics, Georgetown University, 1994.

19 Previously the terms "active" and "passive" have been applied to euthanasia. However since this is not used in the public literature, we will use the term "allowed death" rather than "passive euthanasia."

20 A. Jonsen, M. Siegler and W. Winslade *Clinical Ethics*. New York: McGraw-Hill Inc., 1982, pp. 125. Reproduced with permission of McGraw-Hill, Inc.

21 The terms "voluntary" and "involuntary" may also be used to describe euthanasia. At the moment the public discussion focuses primarily around voluntary euthanasia, that is, at the request of the patient. However, there is a concern that euthanasia could become involuntary, that is, because someone else thinks it is best for a patient.

Case Study F

Timothy Quill, an American physician, reported in the *New England Journal of Medicine* that one of his patients, a 43-year old woman who was terminally ill with leukemia, had requested a prescription for barbiturates that she might use to kill herself. Knowing this, he prescribed the medication. When her immediate future held what she feared the most, increasing discomfort and dependence, she called up her friends and the doctor to say that she would be leaving soon and to say good-bye. Two days later her husband called the doctor to say that that morning she had said her final goodbyes to himself and her son and asked them to leave her alone for an hour. When they returned, she was dead.²²

Confusion in the assisted suicide/euthanasia debate

Sue Rodriguez died by euthanasia, Quill's patient by assisted suicide. However, many who argue for assisted suicide/euthanasia use, as an illustration of their position, cases that constitute allowed death.²³ To choose to stop active or aggressive treatment and request to be kept comfortable with adequate narcotics is not a request for euthanasia. It is a request to allow the person to "finish their dying."²⁴ Margaret Somerville suggests that some persons lump situations such as these with euthanasia to manipulate public opinion and to force individuals to vote for a package that contains both allowed death and assisted suicide/euthanasia.²⁵ We believe that there is a significant moral distinction between allowing someone to die, and actually hastening their death with assisted suicide/euthanasia.²⁶ This distinction is supported both by law and medical practice.²⁷

After lengthy consultation and much soul searching the majority of our task group has concluded that the case against decriminalizing assisted-suicide/euthanasia is more persuasive than the case that supports it.²⁸ The major ethical arguments for and against assisted suicide/euthanasia are set out on the following pages with some further considerations of our own.

22 Excerpted from information appearing in *NEJM*—Timothy Quill "Death and dignity—a case of individualized decision making," *The New England Journal of Medicine* 324, (1991), pp. 691-4. Used by permission.

23 From Fletcher, Joseph, *Humanhood: Essays in Biomedical Ethics* (Buffalo, NY: Prometheus Books). Copyright 1979 by Joseph Fletcher.

24 Roy, D. "Death, Meaning and Ethics Late in the 20th Century." Paper read at the King's College Conference on Death, Dying and Bereavement, May 17-19 1993, at the University of Western Ontario, London, Ontario. Used by permission of the author.

25 Margaret Somerville "Euthanasia: Seeking insights from the Edge," Paper presented at the King's College International Conference on Ethical Issues in the Care of the Aged, the Dying, and the Bereaved, London, Ontario, May 17-19 1993. Used by permission of the author. See also, Somerville: "The Song of Death: The Lyrics of Euthanasia," (1993) 9 *Journal of Contemporary Health Law Policy*, 1-76. "Death Talk in Canada: The Rodriguez Case," (1994) *McGill Law Journal* (3) 602-617. *Book Review*, "A Gentle Death," Marilynne Seguin, *Key Porter Books, Toronto, 1994, 249 pp.* (1994) LXXIV *The Canadian forum*, (835) 36-39. "Death Talk in Canada," (1995) *Humane Medicine* (11) 1 10-15.

26 While there is a practical difference between assisted suicide and euthanasia, we believe that there is no significant moral difference between them and thus we will refer to them together through the remainder of the document.

27 OMA Committee on Medical Bioethics "Exploring ethical aspects of physician-assisted suicide and euthanasia," *Ontario Medical Review*, pp. 15-17. This article first appeared in the March 1994 issue of the *Ontario Medical Review* and is reprinted with the permission of the Ontario Medical Association.

28 One member of our group believes that Parliament should explore the feasibility of a law that could provide a mechanism for the review of individual applications for assisted-suicide/euthanasia; but which would provide legal safeguards against the abuses reported from Holland.

The case for assisted suicide/euthanasia

Those who argue in favour of assisted suicide/euthanasia believe that patients whose illnesses cause them unbearable suffering should have the assistance of a physician to die at the time of their choosing. Also they believe that the patient has a right to control their own treatment that includes the right to request and receive assisted suicide/euthanasia.²⁹

Some who argue for assisted suicide/euthanasia believe there is no moral difference between allowing someone to die and intervening to end their life. For example, James Rachels asserts that because the "intention" in allowing someone to die is their death, this is no different from giving a lethal injection when death is desired.³⁰ For our part, we insist on the moral significance of the difference between knowing a patient will die and causing their death. Others acknowledge the distinction, but stress the individual's right to choose when and how to die. Some believe that compassion for the individual and their wishes takes precedence over every other consideration.

The case against assisted suicide/euthanasia

Until recently, active intervention, including that of a physician, to end life, has faced strong moral prohibition in our culture. Throughout the ages major world religions have placed a high value on human life.³¹ Christianity in particular teaches that it is wrong to kill. Equally strong is the secular ethic that views every life as valuable and sees it as wrong to kill in ordinary circumstances.³² "The claim of a right to be killed by a physician must be balanced against the legal, political, and religious prohibitions against killing that have always existed in society generally and in medicine particularly."³³ We believe that our society should uphold this moral principle.

While allowing death and securing active termination may have the same result, we believe that society should maintain a distinction based on intention. The intention in allowing someone to die is to acknowledge that death is imminent and inevitable and to minimize suffering. Narcotics given in adequate doses to relieve pain are not given with the intention of ending life. It has long been asserted, based on the principle of double effect, that there is a significant difference between intended wrongs and wrongs foreseen but not intended. This position holds "that

29 Excerpted from information appearing in *NEJM*—Peter Singer and Mark Siegler "Euthanasia—A Critique," *The New England Journal of Medicine* 322, No. 26 (June 28, 1990), pp. 1881. Used by permission. Note that these authors are opposed to the practice of euthanasia.

30 ETHICAL ISSUES IN DEATH AND DYING edited by Robert Weir. Copyright © 1986 by Columbia University Press. Reprinted with permission of the publisher.

31 Here we use the word life to refer to the whole person rather than to biological existence alone.

32 Peter Singer "Value of Life," in *Encyclopedia of Bioethics*, W.T. Reich, Ed. in Chief (New York: MacMillan/The Free Press, 1978), Vol. 2, p. 823. Used by permission of the publisher.

33 Ibid. (Footnote 29) Singer and Siegler, pp. 1882. Used by permission.

there are times when we require a moral distinction between two situations in which identical results, equally foreseen, have been achieved with very different intentions.”³⁴

Fundamental to medical practice is the relationship of trust between the physician and patient. Patients expect physicians to promote their welfare and not to harm them. The availability of euthanasia as a “treatment” would weaken this relationship and promote suspicion and fear rather than confidence.³⁵

Most literature that supports assisted suicide/euthanasia states that it would be necessary only in a limited number of cases. Palliative care has demonstrated that pain and other symptoms of advanced disease can in most cases be controlled,³⁶ and that, when this is provided, patients achieve the maximum available quality of life and do not ask for early termination.

Also patients must be able to trust the entire health care system. Once we remove the distinction between allowed death and euthanasia, we remove some important barriers to killing; we make it easier to remove other barriers and by such shifts gradually weaken and erode respect for life.³⁷ This “slippery slope” argument contends that public approval of the practice of active termination of life might lead to this and other unacceptable consequences.³⁸ The next step might be to bring the “comfort of death to some who do not so clearly request it,”³⁹ then to others who “would really be better off dead,” and finally to “classes of undesirable persons.”⁴⁰ “In the current era of cost containment, social injustice, and ethical relativism, this risk is one our society should not accept.”⁴¹

Additional reasons for resisting assisted suicide/euthanasia

The physical suffering in the terminal stages of an illness may be compounded by psychological and spiritual suffering. In accepting a plea for death without exploring the concerns that

34 Sissela Bok “Death and Dying: Euthanasia and Sustaining life: Ethical views,” in *Encyclopedia of Bioethics*, W.T. Reich, Ed. in Chief (New York: MacMillan/The Free Press, 1978), Vol. 1, p. 273. Used by permission of the publisher.

35 ETHICAL ISSUES IN DEATH AND DYING edited by Robert Weir. Copyright © 1986 by Columbia University Press. Reprinted with permission of the publisher.

36 Scott JF. Lies and lamentation—A solid No to euthanasia. *J Palliat Care* 1988; 4(1&2): 119. Reprinted by permission of the *Journal of Palliative Care*.

37 ETHICAL ISSUES IN DEATH AND DYING edited by Robert Weir. Copyright © 1986 by Columbia University Press. Reprinted with permission of the publisher.

38 “The Report of the Dutch Governmental Committee on Euthanasia,” in *Issues in Law and Medicine*, pp. 339-344. This report demonstrates that active involuntary euthanasia (deliberate action to terminate life without the patient’s request) is practised in Holland, involving both competent and demented patients. Physicians described about 1,000 cases annually in these terms. Reprinted by permission of the Publisher, *Issues in Law & Medicine*, Vol. 7, no. 3, Winter 1991. Copyright © 1991 by the National Legal Center for the Medically Dependent & Disabled, Inc.

39 Ibid. Reprinted by permission of the Publisher.

40 Ibid. Jonsen, pp. 126-7. Reproduced with permission of McGraw-Hill, Inc.

41 Ibid. (Footnote 29) Singer and Siegler, pp. 1883. Used by permission.

underlie it, we are in danger of prematurely ending a life. We may also miss an opportunity to heal broken relationships and inner wounds.

The debate and focus on the need for assisted suicide and euthanasia diverts attention from the real issues in the care of the dying, that is, improved pain control, better communication between doctor and patient, heightened respect for the patient's right to choose whether to accept life-sustaining treatment, and improved management of the dying process, as in hospice care.⁴² We believe that if such care were available, there would be much less perceived need for assisted suicide/euthanasia.

Legalizing assisted death/euthanasia in a climate of limited resources may put pressure on patients to perform or ask for this act even before aggressive comfort measures have become necessary or been tried.

We seem to believe that if we can "control" death, we can remove its physical and psychological "sting," and move how we die from chance to choice.⁴³ However, in spite of all attempts to control death and no matter how it happens, every death will involve suffering for some.

The distinction between caring for someone while they die and killing them with a lethal injection is very different on an emotional level. Physicians in Holland, who practise assisted suicide/euthanasia, acknowledge that it can be "deeply upsetting" and "emotionally burdensome."⁴⁴

Pieter Admiraal, a physician and leader in the euthanasia movement in the Netherlands, has outlined what constitutes "unbearable suffering" and thus what, he believes, warrants "justifiable euthanasia." In his view euthanasia is not medically justified by physical pain alone as it can be "adequately controlled in most cases." The psychological causes that he outlines include: anxieties about pain and suffering, deformation, dependency; grief and related feelings about impending losses of family and possessions.⁴⁵ These and other psychological justifications that he describes are a part of a normal grief reaction to one's impending death and most are relieved as much as possible by good palliative care.

As we read his list of justifications, we ask, whose fears and suffering is he talking about? The discomfort may belong to the caregiver who does not have "answers" and feels helpless in light of such spiritual and emotional pain. Egilde Seravalli recounts her experience when her

42 Ibid. (Footnote 29) Singer and Siegler, pp. 1883. Used by permission.

43 Ibid. Somerville. Used by permission of the author.

44 Ludovic Kennedy *Euthanasia: The Good Death*. London: Chatto and Windus, 1990, pp. 45. Used by permission of the publisher.

45 From Admiraal, Pieter, *Free Inquiry* 9 (No. 1, Winter 1988-89). Copyright © 1988 by Pieter Admiraal.

father was dying. As his condition worsened, the warm friendly visits of the doctor became rare, brief, detached, and almost angry.⁴⁶ Such stories are not new. As we noted earlier, many of us, including physicians and other health care providers, are uncomfortable with death.

As is well known in pastoral care, spiritual and psychological pain recedes when a person is given an opportunity to express their distress and suffering to another. 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 can offer."⁴⁷

It appears that the public's major concern, and it is a valid one, is increased suffering at the hands of modern medical technology. However, failure to distinguish between interventions that are burdensome, that cause suffering, and should be stopped, and those that actively terminate life, only arouses fear in the public mind and makes people more willing to accept legalization of assisted death/euthanasia.

Options for those wishing to die

For those who have sought and received palliative care and still believe that they want to end their lives, we believe that an acceptable alternative that does not require external assistance is to stop eating and drinking. An extensive literature review suggests that voluntary starvation does not cause pain or discomfort except for dryness of the mouth, which can be easily alleviated; indeed, such withdrawal may decrease the pain of terminal disease.⁴⁸ Experience with dieting and hunger cause many to believe that starving to death is painful. In reality, when a person fasts, the feeling of hunger leaves quickly and they are not uncomfortable again. As well, most terminal patients gradually eat less and less as the disease progresses.

SUMMARY

We believe that it is appropriate to withdraw medical treatments that are not benefiting the patient and that are prolonging suffering and dying when the competent patient so decides, and when firm evidence of disease irreversibility exists. We believe that much can and should be done to facilitate the gentle, peaceful death that so many of us wish for, and that the United Church should give leadership in this area. We do not believe, however, that the legalization of assisted suicide/euthanasia is justified, or will help make such a death possible.

46 Excerpted from information appearing in *NEJM*—Egilde Seravalli "The Dying Patient, the Physician, and the Fear of Death," *The New England Journal of Medicine* 319, No. 26 (Dec. 29, 1988), pp. 1729. Used by permission.

47 Ibid. Seravalli, pp. 1728. Used by permission.

48 With Permission...Robert J. Sullivan "Accepting Death without Artificial Nutrition and Hydration," *Journal of General Internal Medicine* 8, (April 1993), pp. 221-2...Philadelphia.

Appendix A: PETITION 62

Title: Pastoral Guidelines for Care of the Dying
Submitted by: Toronto Conference
Presbytery action: Concurrence
Conference action: Concurrence
Original source: Muskoka Presbytery
Financial implications: Dependent on travel needs of those who are to prepare the materials
Source of funds: Reassignment of already existing budget
Staffing implications: Yes

Rationale and Faith Base:

WHEREAS in the scriptures it is clear that life is a gift from God (Genesis 2, 7; Psalms 36:9; John 1:4 etc.); and

WHEREAS we are to treasure the lives of one another (Exodus 20:13; Matthew 5:21); and

WHEREAS we believe that God has promised us eternal life and Jesus has shown us by his life, death, and resurrection that life continues beyond the grave; and

WHEREAS science has already made it possible for life to be maintained when death would otherwise occur, thus placing into the hands of human beings awesome choices; and

WHEREAS daily decisions are being made concerning the care of the elderly and disabled, the terminally ill, and living wills; and

WHEREAS for people of faith these decisions are always spiritual as well as practical; and

WHEREAS many of the questions are new and not always clear cut;

It would seem appropriate for the church to address the spiritual and pastoral concerns of those who are in the painful situation of making life and death choices for themselves and for those they love;

THEREFORE BE IT RESOLVED that Muskoka Presbytery through Toronto Conference petition the 34th General Council to:

1. initiate studies on the ethical, moral, spiritual, and pastoral implications for the life and death choices which new technologies and new legal realities are presenting to the people of faith; and
2. provide guidelines for those who must make choices concerning either their own lives or the lives of others.

Appendix B: TASK GROUP'S APPROACH

The task group first met in May 1992. Originally, it consisted of five members. Robert Lindsay resigned in October 1992, but agreed to act as a legal consultant.

Rather than recruit new or additional members, the group decided to consult widely and move slowly as it deliberated the issues.⁴⁹ We consulted with the individuals listed below who each met with us at one of our meetings through 1993. We consulted with Roger Hutchinson throughout the writing process. In April 1994, when our document was nearing completion these individuals were asked to comment on our draft report. Their comments have been incorporated into the final document.

The consultants were:

Bill Harvey, Ph.D., Professor of Philosophy, Victoria College, University of Toronto, Ont.

Rev. John Hoffman, Ph.D., Th.D., Principal of Emmanuel College, Toronto, Ont.

Roger Hutchinson, Th.D., Professor of Church and Society, Emmanuel College, Toronto, Ont.

John Krauser, Associate Director, Dept. of Health Policy, Ontario Medical Association

Barbara LeBlanc, Manager, Health Policy, Ontario Medical Association

Robert Lindsay, Q.C., Osler, Hoskin and Harcourt, Toronto, Ont.

Cathy Lord, Clinical Nurse Specialist in Gerontology at Woman's College Hospital, Toronto, Ont.

Rev. Sue Manning, Lake of Bays Pastoral Charge, Muskoka Presbytery, Toronto Conference

Dr. John Senn, Oncologist and Associate of the Toronto Centre for Bioethics

As well, a written submission was received from the Rev. John Wesley Oldham, Donnelly United Church, Winnipeg.

In addition, all the above consultants, plus those listed below, reviewed the report and some of their feedback has been incorporated.

John R. Williams, Director, Ethics and Legal Affairs, The Canadian Medical Association

Rev. John Wesley Oldham, Universalist-United Church Minister, Donnelly United Church, Winnipeg, Man.

Dr. Peter Newberry, Director, United Church Health Services, Wrinch Memorial Hospital, Hazelton, B.C.

The Very Rev. Walter Farquharson and Joan Farquharson, Saltcoats-Bredenbury-Churchbridge Pastoral Charge, Saltcoats, Sask.

Dr. Abbyann Lynch, Bioethics Department, The Hospital for Sick Children, Toronto, Ont.

⁴⁹ Due to limited budget, we chose to meet only with people from the Toronto area.

Appendix C: THEOLOGICAL FOUNDATIONS

Introduction

In life, in death, in life beyond death,
God is with us,
We are not alone.

The heart of the faith as expressed in this United Church creed sustains us as we struggle with the issues of life and death and our fears of death, abandonment, and loss. It forms the starting point for our theological assumptions.

In this section we outline the basic convictions on which we ground our recommendations. All United Church members may not share our conclusions regarding withdrawal of treatment and assisted suicide/euthanasia, but we offer it as a starting point to clarify where we stand when faced with difficult decisions for ourselves or the ones we love.

“End-of-life” decisions usually are made with family, nursing, and medical personnel whose faith perspectives may be different and based on other values and convictions. We can learn with and from them, and we hope that this report will stimulate discussion of differences in a climate of mutual respect. Nevertheless, the mandate we have been given is to provide theological, ethical, and pastoral guidance for United Church members. If others find challenge, comfort, or insight here, that is an additional blessing.

1. God is with us

We affirm the central biblical message that we belong to God and that God is with us “in life, in death, and life beyond death.” The God of the Hebrew scriptures, who entered into a covenant with Abraham and the people of Israel, was experienced by their prophets and psalmists as a God whose “steadfast love endures forever.”⁵⁰ God, as revealed in Jesus Christ, is above all a God of love, portrayed in the persistent love of the widow who swept the house until she found the lost coin, of the father who welcomed his prodigal son, and the shepherd who went out to seek the lost lamb. The gospels record how Jesus assured people that God knows their needs⁵¹ and that, as Jesus forgives, heals, and feeds them, he is acting out God’s caring for them. Christians believe that Jesus’ life and teaching show us the love of God: “Whoever has seen me has seen (God)... (God) who dwells in me does (God’s) works.”⁵²

50 Psalm 136 from the New Revised Standard Version of the Bible, copyright 1989 by the Division of Christian Education of the National Council of the Churches of Christ in the USA. All rights reserved. Used by permission.

51 Matthew 6:32 from the New Revised Standard Version of the Bible, copyright 1989 by the Division of Christian Education of the National Council of the Churches of Christ in the USA. All rights reserved. Used by permission.

52 John 14:9-10 from the New Revised Standard Version of the Bible, copyright 1989 by the Division of Christian Education of the National Council of the Churches of Christ in the USA. All rights reserved. Used by permission.

2. *Life is a gift from God: towards a Christian understanding of life and death*

At the heart of our faith is our belief that God is the creator and sustainer of life. In the Old Testament tradition, life is understood to include not simply physical life, but also spiritual and social, that is, the unity of the person in community with others and God.⁵³ There is a strong emphasis on God's intention that relationship will be a source of wellbeing in human life.

Death in the Hebrew scriptures often means more than biological death. It is used as a metaphor for things that detract from the fullness of life as God intended it, as a value judgement on the quality of life, and as a failure to walk in God's way. The psalmists and Isaiah lament the pain and dread of death principally because it cuts us off from God and God's community.⁵⁴

In the synoptic gospels, Jesus says that the destruction of the body is not the worst thing to be feared, but rather the destruction of the soul.⁵⁵ He comforts us with the reassurance that not a single sparrow falls to the ground without God's knowledge: "So do not be afraid, you are of more value than many sparrows."⁵⁶ Jesus was moved with compassion for people who had lost the ones they loved. He charged his disciples to confront death as part of proclaiming the good news that the reign of God was at hand: "Cure the sick, raise the dead, cleanse the lepers, cast out devils."⁵⁷ Thus the gospel message has called Christians to combat sickness and suffering and to believe that the love of God endures even in life beyond death.

3. *Created in God's image; called to be co-creators*

We believe in God: who has created and is creating, who has come in Jesus, the Word made flesh...who works in us and others by the Spirit.⁵⁸

We believe that we are created in God's image. How one understands this traditional Christian doctrine depends on a person's theology and their experience of God in their life. Two United Church theologians express it this way:

53 Robert J. Nelson *Human Life: a Biblical Perspective for Bioethics*. Fortress Press, 1984, pp. 69. Reprinted from HUMAN LIFE by Robert J. Nelson, copyright © 1984 Fortress Press. Used by permission of Augsburg Fortress.

54 Lloyd Baillie *Biblical Perspectives on Death*. Fortress Press, pp. 55. Reprinted from BIBLICAL PERSPECTIVES ON DEATH by Lloyd Baillie, copyright © 1979 Fortress Press. Used by permission of Augsburg Fortress.

55 Matthew 10:28 from the New Revised Standard Version of the Bible, copyright 1989 by the Division of Christian Education of the National Council of the Churches of Christ in the USA. All rights reserved. Used by permission.

56 Matthew 10:31 from the New Revised Standard Version of the Bible, copyright 1989 by the Division of Christian Education of the National Council of the Churches of Christ in the USA. All rights reserved. Used by permission.

57 Matthew 10:8 from the New Revised Standard Version of the Bible, copyright 1989 by the Division of Christian Education of the National Council of the Churches of Christ in the USA. All rights reserved. Used by permission.

58 A United Church creed

To be created in the image of God, therefore, is to be created...for relationship in love, as the very being and character God displays. Authentic humanity means being in relationship with God, with one another, and with other-than-human creation.⁵⁹

“We image God in our loving,” that is, we are created for loving relationships. This is our “very essence and vocation as creatures of the God who is love.”⁶⁰

Discipleship is our response to God’s call to live in relationships of love and thereby build community in every aspect of our lives: “I give you a new commandment, that you love one another. Just as I have loved you, you also should love one another. By this everyone will know that you are my disciples, if you have love for one another.”⁶¹

The 1968 United Church creed states that God is at work in us. Theologian Dorothee Soelle derives hope from the experience of God in relationship. She states:

...life means involvement, living in relationships, living by and for relationships. I could even say that the more the relationship, the more the reality; the less the relationship, the more death there is.⁶²

Soelle believes that we are expected to bring life to situations of death; in a sense, to do miracles:

Just as he [Jesus] did miracles, so he accepted that his disciples, too, could do miracles (Mark 16:17; Matthew 10:7f.). In just the same way he sends us out to do miracles, to feed the hungry, clothe the naked, call the dead to life. Really to believe in miracles means to do miracles oneself. Luther said “One must draw Christ into the flesh.” Unless you “draw him into the flesh,”...you fail him. You may perhaps admire him, but you will not be following him.⁶³

So we believe that we are called to image and partner with God in caring for the dying.

59 Terry Anderson *Walking the Way: Christian Ethics as a Guide*; 1993, Toronto: United Church Publishing House, 1993, pp. 163. Used by permission of The United Church Publishing House.

60 Douglas Hall *Imaging God* Grand Rapids: W.B. Eerdmans, Friendship Press, 1986, pp. 132. *Permission to re-print granted by the Ecumenical Center for Stewardship Studies, Indianapolis, IN.*

61 John 13: 34-5 from the New Revised Standard Version of the Bible, copyright 1989 by the Division of Christian Education of the National Council of the Churches of Christ in the USA. All rights reserved. Used by permission.

62 Dorothee Soelle *Thinking About God*. London: SCM Press, Valley Forge, PA: Trinity Press International, 1990, pp. 117. Used by permission of the publisher.

63 *Ibid.* Soelle. Used by permission of the publisher.

4. Sin and suffering

The reality of human suffering is a difficult theological problem. We cannot answer the questions of why and how a loving God can permit or endure human pain and grief. This is an intractable mystery with which every faith community wrestles while encountering life's tragedies.

We do not believe that suffering is God's punishment for sin, or that suffering is ever intended by God. Our calling is to ease and relieve suffering in every way possible short of intentionally causing the person to die. Some suffering in life can be transformative; however, we reject any theological perspective that claims suffering is intended by God for redemptive purposes. We believe that the loving God revealed in Jesus Christ wills healing, wholeness, and relief of pain throughout the whole of creation.

Appendix D: SUBSTITUTE DECISION-MAKING: ADVANCE DIRECTIVES

Competent persons anticipating possible future incompetence should consider three areas: the reality of modern technological medicine, the circumstances that make interventions such as assisted breathing necessary, and the beliefs and values that they as individuals hold about life and its purpose. In the past few decades in North America, ethicists and their colleagues in medicine and law have developed legal instruments known as advance directives or living wills and durable powers of attorney to permit individuals while they are still mentally competent, to indicate to their families and to the authorities what level of care they wish if they become incompetent. Of the great number of these instruments now available, we recommend two: Dr. D.W. Molloy and V. Mepham *Let Me Decide*⁶⁴ and Peter Singer *Living Will*.⁶⁵

US law now requires that all hospitals receiving federal funding inform each patient, at the time of admission, of the existence of these instruments, and several Canadian provinces have passed legislation to give these documents legal standing.⁶⁶ In addition, Molloy and others have "tested" the living will in nursing-home populations and other groups of the elderly. Despite this activity, it remains to be seen whether the use of living wills will ensure patient autonomy, reliably and consistently, in the bewildering variety of situations in which life-and-death decisions are made in modern health care.⁶⁷ However, it seems clear that for many individuals, their families, and their physicians and lawyers the process of confronting the questions contained in a living will has great potential benefit: the consideration and the discussion of the various options described therein enables the patient and family to make some important decisions, which though provisional, may be of immense value to the family and its medical and legal advisors if subsequently the individual is rendered incompetent by accident or illness.

64 Dr. D.W. Molloy and V. Mepham *Let Me Decide*. Toronto: Penguin Books, 1992.

65 Peter Singer *Living Will*. Centre for Bioethics, University of Toronto. Order from The Centre for Bioethics, 88 College St, Toronto, ON M5G 1L4, 1-416-978-2709. Fax 1-416-978-1911.

66 Since this is a time of rapid change in the development of these instruments, we recommend that you consult the Attorney General of your province to find out the current legal status of substitute decision-making.

67 Peter Singer and the University of Toronto Bioethics Group "Advance Directives: Are They An Advance?", *Canadian Medical Association Journal* 146 (1992) pp.127-134. Reprinted from, by permission of the publisher, CMAJ 1992; 146 (2).

Appendix E: GLOSSARY OF TERMS

Allowing to die—the withdrawal or withholding of life-prolonging treatment.⁶⁸

Palliative care—Palliative care is active, compassionate care of a person whose disease is no longer responsive to treatment aimed at cure. The relief of physical, emotional, and spiritual suffering is the primary goal.⁶⁹

Assisted suicide—the provision of information and/or the means to enable a patient to take his or her own life.⁷⁰

Physician-assisted suicide—the physician provides both information and means to allow a patient to take his or her own life.

Euthanasia and mercy killing—an act with the primary intention of ending the life of the patient.⁷¹

Voluntary euthanasia—is the killing of a patient who is suffering or is afflicted with an incurable disease or condition, for reasons of mercy, at that person's request, or with his or her consent.⁷²

Involuntary euthanasia—is an act taken to end a person's life without his or her consent.

68 Bioethics Information Retrieval Project, *Bioethics Thesaurus, 1994 Edition*. Washington, DC: Kennedy Institute of Ethics, Georgetown University, 1994. Definition used by permission.

69 Canadian Palliative Care Association, Board Position on Euthanasia, September 19, 1993. Used by permission of the CPCA.

70 Bioethics Information Retrieval Project, *Bioethics Thesaurus, 1994 Edition*. Washington, DC: Kennedy Institute of Ethics, Georgetown University, 1994. Definition used by permission.

71 D. Sawyer, J. Williams and F. Lowy *Canadian Medical Association Journal*, 148, no 9, (May 1, 1993), pp. 1463. Reprinted from, by permission of the publisher, CMAJ 1993; 148(9).

72 Bioethics Information Retrieval Project, *Bioethics Thesaurus, 1994 Edition*. Washington, DC: Kennedy Institute of Ethics, Georgetown University, 1994. Definition used by permission.

FOR FURTHER READING/INFORMATION

Daniel Callahan *The Troubled Dream of Life*. New York: Simon and Schuster, 1993.

Joseph Fletcher *Humanhood: Essays in Biomedical Ethics*. Buffalo, NY: Prometheus Books, 1979.

Ethical Issues in Death and Dying, ed. Robert Weir. New York: Columbia University Press, 1986.

Euthanasia, the Moral Issues, ed. Robert Baird and Stuart Rosenbaum. Buffalo, NY: Prometheus Books, 1989, pp.126-127.

Dr. D.W. Molloy and V. Mephram *Let Me Decide*. Toronto: Penguin Books, 1992. (Available from the United Church Publishing House.)

Ludovic Kennedy *Euthanasia: The Good Death*. London: Chatto and Windus, 1990, pp.45.

Marilynne Seguin, RN *A Gentle Death*. Toronto: Key Porter Books, 1994. (Available from the United Church Publishing House.)

Lisa Hobbs Birnie and Sue Rodriguez *Uncommon Will: The Life and Death of Sue Rodriguez*. Toronto: MacMillan Canada, 1994. (Available from the United Church Publishing House.)

D. W. Molloy *Vital Choices*. Toronto: Penguin Books, 1993.

Issues of the Proceedings of the Senate Special Committee on Euthanasia and Assisted Suicide. Order from Canada Communication Group Publishing, Ottawa, ON K1A 0S9.

Canadian Palliative Care Association
5 Blackburn Avenue
Ottawa, ON
K1N 8A2
Phone: 1-800-668-2785 (in Canada)
(613) 230-3343
FAX: (613) 230-4376

Newfoundland and Labrador
Palliative Care Association
(709) 368-0380

New Brunswick Palliative Care Association
(506) 452-5321

The Island Hospice Association (P.E.I.)
(902) 368-4498/5632

Nova Scotia Hospice/Palliative Care Association
(902) 562-2322 ext. 129

Quebec Palliative Care Association
(514) 527-2194

The Community Hospice Association of Ontario
(for hospice programmes)
(416) 510-3880

The Ontario Palliative Care Association
(for individuals)
(905) 436-0145

The Manitoba Hospice Foundation
(204) 889-8525

The Saskatchewan Palliative Care Association
(306) 359-7484

The Palliative Care Association of Alberta
(403) 887-2241

British Columbia Hospice/Palliative Care Association
1060 West 8th Ave.,
Vancouver, BC V6H 1C4

DISCUSSION SESSIONS FOR CARING FOR THE DYING: CHOICES AND DECISIONS

Introduction

The aim of these hour-long discussion sessions is to help congregations talk together about caring for the dying and about the choices that new medical technology and new legal provisions are presenting to us. The sessions are intended to prepare us for the critical decisions we may have to make towards the end of a terminal illness, our own or that of someone we love. They are also intended to help us clarify our own beliefs and test whether we agree with the conclusions of the discussion paper or not. If congregational feedback indicates that some of these conclusions are not shared by significant numbers of United Church members, the paper will need to be revised.

As preparation read the Mandate of the task group that prepared the report (pp.4) and the petition that gave rise to it (Appendix A, pp.17) for a full account of the pastoral and ethical concerns the discussion paper was designed to address.

The purpose of the first session **Fears and Hopes about Dying** is to provide an opportunity for us to start voicing our fears and hopes about dying and to tell some of the stories that have most deeply affected us. These form the experiential grounding for our convictions about the issues raised by this discussion paper. The first session may also enable us to say what we truly believe, or question, about life beyond death, so we can discuss how our beliefs may affect our end-of-life decisions.

The purpose of the second session, **Faithful Responses to Choices in Caring for the Dying**, is to explore how we should be responding to the decisions that can confront us when we are dealing with a life-threatening crisis towards the end of life. Concerns will be raised about the inappropriate use of aggressive medical technology, and palliative care will be explained as a medical specialty of immense value for the terminally ill.

The purpose of the third session **Voluntary Euthanasia and Assisted Suicide** is to wrestle as a Christian community with the ethical dilemma of voluntary euthanasia and assisted suicide. Can the decision to end life before death would otherwise occur ever be a faithful one for those who believe that God is the giver of life? For those who would answer no, why not? For those who might answer yes, in what circumstances? How could this be a legal option for a very few without putting many at risk? The assumption underlying this session is that in any United Church congregation we might disagree vehemently on our answers to these questions, even though we start from very similar faith positions; but that we need to discuss them together for our personal clarification and to help us speak to our convictions in the political arena.

As a church we also need to find out whether there are some areas of broad consensus on which we can take a public stand. This is the purpose of the form for feedback to the Division of Mission in Canada that you are asked to complete at the end of your study (pp.37).

Resources for a fourth session are suggested for those who want to know more about **Advance Health Care Directives**. You will need to order some of the resources at least a month in advance.

Participants' Preparation

Participants will be able to contribute more effectively to the discussion sessions if they have read the discussion paper *Caring for the Dying: Choices and Decisions*, and also the article "Choosing a Faithful Exit" in the *United Church Observer*, January 1995. Distribute copies of these resources at least a week before the first session. Some people may come unprepared, so the sessions are designed to explain all that they need to know in order to be included. Since the sessions will build on each other, so that the experiential and knowledge base developed in Sessions 1 and 2 provides the context for a constructive discussion of the ethical issues in Session 3, encourage people to plan to attend all three sessions.

Timing

Each session is designed to take one hour; so the sessions could be used in a study hour preceding Sunday morning worship or a weekday meeting. (Stand-alone two-hour study sessions are no longer a possibility for many adults, particularly working parents.) Remember, completing each session in an hour will require fairly tight control of the time for discussion, especially if you have a group of 20 or more that subdivides into more than four or five small groups. When tested in a study session prior to Sunday morning worship, many participants said they would have loved longer to talk. If your time permits, and particularly if you are working with a group of seniors who may be able to spend longer and have thought much about these issues, you could well allow an hour and a half. If you are working with a small number of participants where there is no need to subdivide, one hour is sufficient.

Session 1 Fears and Hopes about Dying

Introduction

1. Welcome the group.
2. Explain the purpose of the discussion series:
 - To become comfortable with discussing death and dying, and our hopes and fears about dying
 - To face ahead of time the kind of critical decisions we may have to make when we or someone we love has a life-threatening crisis towards the end of life
 - To learn more about palliative care and the distinction between "allowed death" and "euthanasia"
 - To clarify our convictions about the ethics of voluntary euthanasia and assisted suicide
 - To learn about advance health care directives (if a fourth session is offered).

Purpose of Session 1

1. Explain the purpose of today's session:
 - To share some of our thoughts and feelings about life beyond death
 - To provide an opportunity to start talking about our fears and hopes about dying
 - To tell some of the stories about dying that have most deeply affected us

- To identify the values we believe should guide care for the dying.

2. Acknowledge that we seldom talk about dying these days, and that in our society it is almost a forbidden topic. But for many of us, particularly as we grow older, how we are going to die is a matter of deep concern, and it would be a great relief to be able to express our wishes and anxieties to our friends and families. We will not be able to do this, or help others do it, unless we first learn to name our hopes and fears around dying.

Our hope: God is with us

Some participants may be struggling with recent bereavement; others may be reluctant to think of separation from those they love. Lead into the first small group discussion by raising up some of the central affirmations of our faith as outlined in the study paper Introduction (pp.5):

We believe that God wants us to have life, and to live it abundantly. Our natural wish to live as long and fully as possible is part of God's intention for us. But we know that eventually each one of us will die, and we may dread what we imagine is involved. In the 1968 creed we affirm that... "In life, in death, in life beyond death, God is with us. We are not alone."

Ask: *What do you feel when you say that part of this creed?*

Invite people to move into small groups of two or three for discussion. Write the question on the flipchart. Call the groups back together after 15 minutes and invite any who wish to share their group's insights. Let people share as long as they want (as time permits), because this lays the faith foundation for the whole series. If no one is ready to share, that's fine too.

Hopes and fears about dying

Focusing on our hopes and fears about dying invariably triggers memories, and people begin to tell stories about the final illness, or sudden life-and-death crisis, of people they have loved. There are likely to be some in the group who are still trying to cope with some traumatic sequence of events that preceded the death of a loved one. Others will have stories of a peaceful death, possibly surrounded by family and friends. However long ago these experiences have been, they have formed our ideas about dying and the kind of care and medical treatment we want, or do not want. It is important to make space for telling these stories. Those who have no stories can learn a lot from listening to other people's experiences.

1. Introduce the topic by talking about the goal of a peaceful death and summarizing the points from *Creating an Environment for a Peaceful Death* on pp.8 of the discussion paper (or have volunteers read aloud from pp.8).

2. Ask people to move back into their small groups to talk about their answers to the question: *What would matter most to you when you are dying?*

3. Call the group back together about 15 minutes before you have to close, explaining that it's time to see how our own hopes and fears, plus the experiences we have had of supporting others while they die, form our goals and values for how our society should be caring for the dying.

On the flipchart write two headings: **Hopes** and **Fears**. Draw a line down the middle. Ask people to name their hopes and fears and list them.

Conclusion

Reflect on how this list demonstrates what matters to us most as we die (e.g. to have those we love around us, to be assured we will not be left in unbearable pain); and how this suggests the values on which we want medical care to be based.

Tell people that the topic for the next session is decisions about care, avoiding futile medical interventions, and learning more about palliative care. Ask them to read pp.6-10 of the discussion paper as preparation.

Invite feedback as to what people found helpful or unhelpful, so that you can adjust the proportion of full group and small group discussion next time.

Closure

Close with prayer.

Session 2 Faithful Responses to Choices in Caring for the Dying

Introduction

Welcome today's group, and for the sake of newcomers to the group summarize the purpose of the discussion series and what was discussed last session. Refer to last session's flipchart list of fears and hopes and the group's "Conclusion." Draw the attention of newcomers to pp.8 of the study booklet where the goal of a peaceful death is described.

Purpose of Session 2

Display on flipchart and explain the purpose of today's session:

- To learn more about the kinds of treatment decisions that modern medical technology may oblige us to make
- To learn more about palliative care.

Prolonging life or prolonging death

Today it is often hard to make the judgement that a person is dying, or to be sure whether interventions such as life-support systems or artificial hydration and nutrition will prolong life or prolong dying. But families and medical professionals often press for any procedure that gives hope of continued life, both because we are afraid of death, and because the outcome, although likely to be futile, cannot be predicted to be so with certainty. For example, although cardiac resuscitation only enables a fraction of patients to survive for 24 hours, and only a small percentage of those ultimately leave hospital, it is routinely tried unless a Do Not Resuscitate notice is posted on the patient's chart; and families tend to resist this. The result of these radical interventions is often that physical life and suffering is prolonged for a period, but with little quality of life, and dying is experienced as a crisis or "failure" rather than a peaceful death.

Two options for presenting this dilemma:

1. Ask a doctor or nurse from your congregation or community who has experience of geriatric hospital care to assist your group. Ask him or her to pre-read the section in the discussion paper on Unnecessary and Futile Treatment (pp.6), and to talk to the group for 20 minutes about how families are advised and decisions made in cases where initiating or withdrawing life-support systems is at stake. Explain that the aim of the session is to help people prepare for a time when they may have to make such decisions. Ask the resource person to present some case histories (hypothetical or with names disguised).

Provide an opportunity for questions and discussion with your resource person. If your group is large (over 20) it may be wiser to move into smaller groups to give everyone a chance to share their reactions and prepare some questions or comments. Allow 10 minutes for this, and another 10 minutes to seek response in the whole group. People may prefer to stay together to talk with your resource person. In either situation, suggest moving on to learn more about palliative care (about 20 minutes before the end of your session).

or

2. If no resource person is available, summarize the section on Unnecessary and Futile Treatment in your own words, or present the dilemma as in the introductory paragraph above. Invite questions and comments, and draw on the experiences and stories of group members. After about 20 minutes ask people to move into small groups (three's or four's) to consider the following, posted in advance on the flipchart:

Prolonging physical life when relational and inner life appear to have failed forever, or when a terminally ill person is ready to die, does not show respect for the life that God has given us. Such actions are a kind of biological idolatry. We believe that we must make critical end-of-life decisions on the basis of valuing and respecting the dignity of the whole person. (pp.8)

Ask them to discuss as a small group: *When do you think a family should decide to withhold or withdraw treatment?*

After 10 to 15 minutes, invite participants to report their main points to the whole group.

Palliative care

Draw attention to the description of palliative care (pp.9) posted ahead of time on the flipchart. Explain that the availability of palliative care is crucial to the issue of legalizing voluntary euthanasia and assisted suicide, because patients sustained by the personalized symptom control of palliative care seldom ask to end their lives early.

Two options for learning more about palliative care:

1. If your resource person has experience with palliative care, ask him or her to describe the work and respond to questions and comments for the balance of your session time.

or

2. Point out that at the present time palliative care is only available to a very small percentage of dying patients. Invite people to move back into their small groups to debate the statements in the discussion paper (pp.10):

We believe that the church should support and work toward greater availability of palliative care.

We believe that this need is more urgent than, and would in fact reduce the perceived need for, the legalization of euthanasia and assisted suicide.

Conclusion

After 10 minutes, ask each small group to share their conclusions.

Inform participants that the third session will be on Voluntary Euthanasia and Assisted Suicide and ask them to read pp.11-16 of the discussion paper and the article "Choosing a Faithful Exit" pp.27-29 of the January 1995 *United Church Observer*.

Closure

Conclude with prayer.

Session 3 Voluntary Euthanasia and Assisted Suicide

Introduction

Welcome today's group, and for newcomers point out the purpose of the series (posted on flipchart). Stress that today's discussion builds on previous reflections on the ideal of a peaceful death as our goal in caring for the dying and the importance of moving from life sustaining interventions to comfort care when death appears inevitable. Add the conclusions about palliative care reached by the group during the last session.

Purpose of Session 3

Display on flipchart and explain the purpose of today's session:

- To agree on the use of terms to enable a constructive debate
- To clarify our convictions as Christians about voluntary euthanasia and assisted suicide
- To reach agreement on common concerns for feedback to DMC.

Definitions of terms

Explain that the discussion of this issue can often become confused and frustrating unless people agree to use terms clearly and consistently. Propose the following definitions (as used by the study paper and the January 1995 *Observer* article), posted ahead of time on the flipchart:

Allowed death should be used to refer to withdrawing or withholding life-prolonging treatment e.g. assisted breathing, surgery. (Some people may have been using the term "passive euthanasia" for allowed death. Explain that we should avoid doing this, because it blurs the critical distinction between allowing inevitable death to happen and causing it.)

Assisted suicide should be used to refer to providing patients with the means or the information to take their own life.

Physician-assisted suicide is when a physician provides the means and information.

Euthanasia and **mercy killing** should be used to refer to an act which has as its primary objective killing the patient.

Involuntary euthanasia or **involuntary mercy killing** should be used to refer to an act to take a person's life without that person's consent. Point out that in these sessions we are only discussing voluntary euthanasia. If people are anxious to discuss the Latimer case, arrange a further session.

Voluntary euthanasia is the killing of a patient who is suffering or is afflicted with an incurable disease or condition, for reasons of mercy, at that person's request, or with his or her consent.

At this point you will have to respond if there are any questions for clarification, but avoid preempting the discussion by getting hooked into lengthy debate. If challenged, say simply that these are the terms used in the medical literature and that they have proven the most constructive for public debate.

Allowing death but not hastening death

Currently both law and medical practice in Canada make a clear distinction between allowing death and hastening death through assisted suicide or voluntary euthanasia.

1. Describe a case of euthanasia, e.g. Case Study E of Sue Rodriguez, and a case of assisted suicide, e.g. Case Study F of Timothy Quill's patient (pp.11-12). Point out that the writers of the discussion paper saw no significant moral distinction between voluntary euthanasia and assisted suicide, and nor do many doctors, because the intent in both situations is to kill the patient (pp.12 footnote 26). Both the discussion paper and the Ontario Medical Association's Committee on Medical Bioethics refer to both together as euthanasia/assisted suicide. Doctors and legal authorities, on the other hand, including all the Supreme Court judges in the Rodriguez case, respect the right of patients to die by refusing treatment or asking for the withdrawal of treatment once commenced, even though the result will surely be to hasten death.

2. Refer to the following from the discussion paper, posted in advance on the flipchart:

To choose to stop active or aggressive treatment and request to be kept comfortable with adequate narcotics is not a request for euthanasia. It is a request to allow the person to "finish their dying." ... We believe that there is a significant moral distinction between allowing someone to die, and actually hastening their death with assisted suicide/euthanasia. (pp.12)

Point out that some United Church members do not accept this distinction that, for example, causing a patient to die by shutting off the breathing machine is morally acceptable, while causing death by a drug overdose is not. (See former Moderator Bruce McLeod's article in *The United Church Observer*, January 1995, pp.29.)

3. You may have decided during the first two sessions that those who disagree with the position of the discussion paper would feel more supported if they heard from someone who believes that voluntary euthanasia and assisted suicide should be legally available under certain conditions. In that case, invite such a person from your congregation or community to say briefly at this point why they believe this.

4. Ask for a recorder to note people's answers and their reasons, and invite people to move into small groups to discuss the following questions, posted in advance on the flipchart.

- Can the decision to put an end to life deliberately ever be a faithful one for those who believe that God is the giver of life?
- What does our God of compassion and mercy require of us?

5. Let the small groups discuss for as long as you can. Twenty minutes before closure call them together for report back. Ask recorders to post their groups' answers and reasons and speak briefly to the large group.

Conclusion

When all have reported, do your best to summarize the various perspectives in the group, and their theological base. Affirm the integrity of people's convictions, pointing out that very similar beliefs on this difficult issue can lead to very different conclusions. Note how those who have contributed stories of their experiences have helped to deepen everyone's understanding.

Follow-up

If legislation on voluntary euthanasia and assisted suicide is still under discussion in Parliament at the time your congregation is completing this study, suggest that people write to their members of parliament to make their concerns known. If there has been sufficient consensus on some points, propose a group letter to the MP for your congregation's riding.

Fourth session

Ask if anyone would be interested in a fourth session on Advance Health Care Directives (if this has not already been settled) and arrange for someone to locate a lawyer and/or doctor whose experience makes him or her a suitable resource person(s). Arrange a way of checking time and date with those interested.

Feedback form to DMC

Pass out copies of the feedback form (pp.37-38), explaining how essential it is for DMC to hear from all those who have discussed the paper in order to know whether it needs to be revised and whether the church wants further guidance, or a policy position, to be recommended to General Council in 1997. If possible, allow five minutes for the forms to be completed, and collect and mail to DMC right away. If not, please find a way for ensuring that all feedback is sent to DMC as soon as possible.

Closure

Thank everyone for coming and close with prayer.

Resources for a Fourth Session on Advance Health Care Directives or Living Wills

Members of a group who have discussed the issues in the first three sessions may well ask for an opportunity to learn more about Advance Health Care Directives or Living Wills. This could be offered as a fourth session in the series, or scheduled at a later date. Allow at least two hours so the group can consider one of the versions of Advance Health Care Directives, and try filling it in.

No process has been designed for this session, because the best approach is to find a resource person from the congregation or community with medical or nursing background who can answer questions about what is involved in the treatment options. (These are explained in non-technical terms in the advance directive forms, but questions invariably come up.) Your resource person should also be familiar with the current legal status of advance health care directives in your province as this is changing and varies from province to province; or you could consult or invite a lawyer. Order copies of an advance health care directive for the group, and ask your resource person to stay while group members complete them.

If you cannot locate a resource person, order copies of the booklet *Let Me Decide* and have as many of your group as possible read it before inviting them to a working session to discuss and try filling in the advance health care directive form stapled in the centre of the booklet (photocopy extras as needed). You could show the 20 minute video *My Health Care—I Decide* to introduce the session, and allow another 20 minutes for discussion.

A second resource is the booklet *Living Will* developed by the University of Toronto's Centre for Bioethics. It explains what a living will is, and provides forms for an instruction directive, a proxy directive, a personal statement, and witness information. It explains clearly and simply what each one of these is, how to fill them in, and gives definitions for each of the situations and the treatments it refers to. Working through the explanations would take a small group about an hour, and another half hour to fill in the forms. Order from the address below.

Before this session a member of your group should find out what is the current legal status of advance health care directives by phoning your provincial Attorney General's office.

Resources to order in advance

Let Me Decide: The Health Care Directive That Speaks for You When You Can't

Dr. William Molloy and Virginia Mepham, Penguin Books Canada, Toronto, 1992. (Available from United Church Book Rooms \$5.99)

This sets out clearly, briefly, and in simple non-technical language the importance of having an advance health care directive, and explains all the conditions and treatments referred to on the form provided. Bulk orders are available from the address on next page.

Let Me Decide

Audio-cassette for the visually impaired or those who learn best by listening. (\$15)
To order or receive additional information, write to the address below, allowing up to six weeks for delivery. Send cheque or money order and full name and address:

Let Me Decide
673 Upper James Street
P.O. Box 60615
Hamilton, ON
L9C 7N7

My Health Care—I Decide

This 20 minute video explores the need for and the role of advance health care directives in empowering individuals to take control of their health care. It contains interviews with health care providers, patients, and families in various settings: wards in community hospitals, the community, hospital family conferences, and nursing homes.

(Available from AVEL)

My Health Care—Understanding My Choices

A 14 minute video for patients and their families explaining the choices in the "Let Me Decide" directive.

(Available from AVEL)

Living Will

(order from) the Centre for Bioethics, University of Toronto

88 College St.

Toronto, ON

M5G 1L4

(416)978-2709

\$5 per copy, \$3 each for bulk orders of 10 to 49, \$2 for bulk orders of 50 to 99. Copyright (i.e. do not photocopy to use; but when completed a person may photocopy to share with their family, doctor etc.)

VIDEO LISTING

Help Me Die

Produced in Oregon in 1990, prior to the 1991 vote on assisted suicide/euthanasia, this video portrays seven people coping with intense pain or severe disability because of degenerative illness. A grandfather with advanced Parkinson's disease wants assistance with suicide when he can no longer look after himself, and the suicide note of a man with acute emphysema explains that he would not have shot himself alone in his basement if euthanasia had been legally available. On the other hand, an early Alzheimer's victim shares her belief that God never gives us more than we can handle, and we see several instances of effective pain control and loving palliative care combined with respite for the caregiver through a neighbouring hospice. Both sides of the debate for and against legalizing assisted suicide/euthanasia are movingly and

persuasively depicted, compelling viewers to examine their own conceptions of personal rights and social responsibilities.

60 minutes. Available through AVEL, or order from the Canadian Learning Company Inc. 63 Mack Avenue, Scarborough, ON M1L 1M5 (416) 691-9094, (800) 267-2977 Fax: (416) 691-8833.

Challenges of our Time: Euthanasia

This video, also produced in Oregon, features a lawyer arguing against permitting assisted suicide/euthanasia because of the dangers of abuse, and a member of the Hemlock Society insisting that concern for the quality of life should override prolonging physical life in cases of terminal illness. Then excerpts from lectures by two bio-ethicists, the Methodist Robert Nelson and the Roman Catholic Richard McCormick develop some of the theological arguments for distinguishing between withholding or withdrawing treatment, so that the disease causes a natural death, and deliberate killing. The video concludes with two doctors discussing their professional ethics: one would never cause death, the other would never give a lethal injection, but might be willing to discharge a patient knowing that they had an overdose of pills on hand and wanted to commit suicide. Thus the video highlights significant challenges to the Hemlock Society perspective, which is nevertheless credibly presented.

30 minutes. Order from the Canadian Learning Company Inc. 63 Mack Avenue, Scarborough, ON M1L 1M5 (416) 691-9094, (800) 267-2977 Fax: (416) 691-8833.

A Fate Worse Than Death

In this video the families of three patients in apparently irreversible comas wrestle with treatment decisions. Phil, the brother of an elderly accident victim Marvin, decides against any resuscitation or antibiotics, but opposes removing feeding and hydration tubes. David's family, after he has survived for four years in a persistent vegetative state (PVS) in a nursing home which refuses to remove artificial feeding and hydration, finally move him to a hospice where these life supports can be withdrawn and he is allowed to die. But Wayne, after eighteen months in a coma, is revived enough to respond and go home to be nursed by his wife. In each case, the viewer is asked: is this a fate worse than death? Doctors discuss their responsibility to the families, a nurse describes her pain at removing tubes, and the value of signing a Durable Power of Attorney (DAP) is stressed. The agony of decision-making that each family goes through are powerfully depicted, and will challenge viewers to voice their own beliefs.

58 minutes. Available from AVEL or order from the Canadian Learning Company Inc. 63 Mack Avenue, Scarborough, ON M1L 1M5 (416) 691-9094, (800) 267-2977 Fax: (416) 691-8833. Rental fee is usually \$75 for three days, cost of shipping born by renter; or cost of purchase for use at one site usually \$99.95. Phone to make special arrangements.

FEEDBACK ON CARING FOR THE DYING: CHOICES AND DECISIONS

The Division of Mission in Canada has to decide whether to develop this discussion paper in ways that would give more guidance and support to congregations. We need feedback from groups and individuals to determine this. Take a little of your time to respond to the following questions, and mail your response by April 30, 1996 to the address below.

Would you and your congregation find it helpful if this discussion paper was revised in the light of feedback from congregations and individuals?:

If so, what would you find most helpful:

Pastoral guidelines?:

A theological and ethical policy statement?:

If so, should such a policy statement be approved solely by the Division of Mission in Canada?:

or by the General Council as well?:

Other? (please comment)

If you think the discussion paper should be revised, what points do you think should be added or changed on the following issues?

1. Our Christian understanding of life and death:

2. Futile treatment and allowing to die:

3. Palliative care:

4. Assisted suicide and voluntary euthanasia:

5. Further theological considerations, e.g. suffering, sin, discipleship, caring community:

6. Advance health care directives:

Other comments:

Name and address of your congregation:

Is your feedback the result of group discussion?:

How many sessions?:

Name and address of person completing this form:

THANK YOU FOR TAKING TIME TO RESPOND

Please mail your response as soon as you or your group have finished reading and discussing this discussion paper. Send it by April 30, 1996 at the very latest to:

Office of Christian Development
Division of Mission in Canada
3250 Bloor St. West
Etobicoke, ON M8X 2Y4

