CMDA Ethics Statement on Euthanasia

We, as Christian physicians and dentists, believe that human life is a gift from God and is sacred because it bears His image.

The role of the physician is to affirm human life, relieve suffering, and give compassionate, competent care as long as the patient lives. The physician as well as the patient will be held accountable by God, the giver and taker of life.

We oppose active intervention with the intent to produce death for the relief of suffering, economic considerations or convenience of patient, family, or society.

We do not oppose withdrawal or failure to institute artificial means of life support in patients who are clearly and irreversibly deteriorating, in whom death appears imminent beyond reasonable hope of recovery.

The physician's decisions regarding the life and death of a human being should be made with careful consideration of the wishes and beliefs of the patient or his/her advocates (including the family, the church, and the community). The Christian physician, above all, should be obedient to biblical teaching and sensitive to the counsel of the Christian community. We recognize the right and responsibility of all physicians to refuse to participate in modes of care that violate their moral beliefs or conscience.

While rejecting euthanasia, we encourage the development and use of alternatives to relieve suffering, provide human companionship, and give opportunity for spiritual support and counseling.

Christian Medical and Dental Associations
Approved by the House of Delegates
Passed unanimously
April 29, 1988. Seattle, Washington.

Explanation

Physician-assisted suicide occurs when a physician helps a person take his or her own life by giving advice, writing a prescription for lethal medication, or assisting the individual with some device which allows the person to take his or her own life. The physician lends expertise, the person does the act.

Voluntary euthanasia occurs when another person, out of compassion, does an action with the intention of ending the life of a suffering patient at his or her request. Non-voluntary euthanasia is a similar compassionate act, but in circumstances where the patient is unable to make a voluntary request (e.g. an unconscious, retarded or demented adult; an infant or child). Involuntary euthanasia is a compassionate act to end the life of a patient who is perceived to be suffering and could make a voluntary request, but has not done so.

Distinction between active euthanasia and passive euthanasia is not helpful, and often confusing. It is clearer to limit the term euthanasia to situations in which one person acts to cause the death of another (which is what many people mean by active euthanasia). According to this understanding, acts of discontinuing treatment with the realization that patients will die of their disease do not constitute euthanasia. Thus using the term passive euthanasia to describe such acts is a misnomer. When

discontinuation is done with the intention of ending the life of someone who is not already unavoidably in a dying process, it is morally objectionable for many of the same reasons that euthanasia is objectionable. But since discontinuation in other situations is morally acceptable, it is helpful not to refer to discontinuation under any circumstances as a form of euthanasia.

Secular Perspective

Societal changes of the 1960's - 1980's have led to a focus and emphasis on an individual's right to self-determination. While this includes some increased acceptance of suicide as a rational option for an individual who feels that life has become too burdensome, the act of suicide is still often viewed by others as a tragic and lonely experience. This is especially true when the means of self-destruction involves violence (e.g. guns and other self-inflicted wounds, hanging, jumping from heights, etc.). Thus there has been a move to depersonalize suicide by involving others (assisted suicide) and to sanitize it by making it a medical procedure (physician-assisted suicide and euthanasia).

Proponents of legalization of euthanasia offer several reasons why society should allow physicians to be involved in these acts: some people have no loved one who can help them; some people are unwilling or unable to help their loved ones commit suicide; physicians know the prognosis so are better able to assess the appropriateness of a request; physicians have access to and know how to use lethal drugs; medical expertise can prevent "botched up" suicide attempts; physicians know how to obey standards; and, physicians can be more objective because they are not emotionally involved.

Legal Perspective

Euthanasia has been openly practiced by physicians in The Netherlands since 1984, and such acts were decriminalized in 1993, although legal and judicial oversight continues. The best estimates are that about 3% of all deaths in that country are induced by physicians. There is public debate about extending the availability of euthanasia to children and incompetent adults, and there is a professional inclination to change the system to physician-assisted suicide rather than direct physician involvement.

The Northern Territory of Australia legalized physician-assisted suicide and physician-administered euthanasia in 1995.

Attempts in several states in the U.S. to pass legislation allowing physician-assisted suicide and/or euthanasia failed by narrow margins in the late 1980's and early 1990's. In 1994, the state of Oregon passed a voter initiative to allow physician-assisted suicide with restrictions, but it has not gone into effect at the time of this writing because of legal challenges.

Case law (as opposed to statutory law) in the U.S. addressed the issue of physician-assisted suicide in early 1996. The 9th Circuit Court of Appeals in San Francisco and the 2nd Circuit Court of Appeals in New York declared unconstitutional state laws in Washington and New York (respectively) which prohibited physician-assisted suicide. Different legal arguments were used in the two cases. It is anticipated that these judicial rulings will be appealed to the U.S. Supreme Court.

Professional Perspective

Physician-assisted suicide and euthanasia were explicitly proscribed in the Hippocratic Oath. Although this was a minority opinion when introduced 2500 years ago, the Hippocratic ethic gradually became the dominant influence for practitioners of modern medicine and dentistry. Practitioners have adopted the role of healer with the goals of healing when possible, and relief of suffering. While there have doubtless been individual physicians and dentists over the centuries who have occasionally helped their patients to die, this activity has clearly remained outside the boundaries of acceptable medical treatment.

There is professional concern that acceptance of physician involvement in either direct or indirect induced death would seriously undermine the trust that is a necessary component of the physician-patient relationship. If euthanasia becomes accepted, a physician might be tempted to end a patient s life without a request, either out of compassion, or out of self-interest (e.g. when the care of a patient becomes too difficult or burdensome). In addition, there is concern that there might be less impetus to continue work on the significant gains made in good palliative care in the past 20 years.

Christian Perspective

What is fundamentally wrong with euthanasia from a biblical perspective is that it involves the killing of human beings who are necessarily made in the image of God (Genesis 9:6). Physician-assisted suicide is wrong for similar reasons, in that people kill human beings (themselves) with the assistance of others who thereby become accessories to killing. As discussed further in the "Explanation of the Statement on **Patient Refusal of Therapy**", patient autonomy (or better: freedom) must be understood within the limits of God s sovereignty and does not include the right to dispose of that which is not one s own ("you are not your own" ---I Cor. 6:19).

Christians are indeed called upon to be compassionate and to relieve suffering, but not at any expense. If happiness were what life is all about, then suffering would be the ultimate evil to be avoided at all costs. The cross would represent the epitome of what is to be avoided. Its crushing load on Jesus back and the nails driven through his hands and feet graphically display the burden of the fallenness of the world that Jesus had to bear, in fact, chose to bear. Yet, those who follow Jesus are not called to avoid such suffering but to suffer this fallenness with him, to take up crosses of their own.

The basic question, then, is whether God or suffering is going to set the agenda of one's life---and death. Christian physicians and their patients will not find God s way by trying to avoid all suffering at any cost. They will find it by remaining true to God s biblically-revealed character and will, especially in the midst of suffering. The ultimate test of what is setting the agenda of our lives may well be how we deal with suffering in the face of death.

Such was the case for Jesus in the garden of Gethsemane. He was "overwhelmed with sorrow to the point of death" (Mark 14:34) and zealously prayed to be spared from the suffering that he knew would only get worse. Yet he affirmed that his primary commitment was to the larger purposes of God, whatever suffering they might entail. The absence of suffering is, generally speaking, something good---which is why Jesus prayed for it. But it is not the highest good---which is why he was willing to forgo it.

Yielding to the call of "compassion" to kill or assist in the killing of a patient is misguided for another reason as well. It is all too easy to underestimate the fallenness (self-centeredness) of human nature, particularly when the people in view seem to have the needs of others at heart. The statements of so-called "mercy killers" in the past have often been telling in this regard. "I killed her because I could not bear to see her suffer" generally means what it says---that first and foremost the action reflected the killer s need to be free from his or her own discomfort. Barriers to killing patients or assisting them to kill themselves not only protect society in general and patients in particular but also protect physicians and surrogate decision-makers from their own weaknesses---from subtly self-centered decisions that may well haunt them for the rest of their lives. The CMDS statements on **Physician-Assisted Suicide** and **Euthanasia** are designed to uphold such protections while affirming more constructive expressions of compassion.

Abstracts

Gaylin W, Kass LR, Pellegrino ED, Siegler M. Doctors must not kill. JAMA 1988; 259(14):2139-2140

In January of 1988, JAMA published an anonymous piece by an OBGYN resident who tells of giving a lethal overdose of morphine to a dying young woman, perhaps at her request. These four authors, noted in the field of medical ethics, question the authenticity of the reported event. If it is true, they conclude that he or she committed a felony and acted both unethically and unprofessionally. They find his or her conduct inexcusable. They go on to criticize JAMA for publishing a supposed account of medical malfeasance.

Schiedermayer D. Nazi doctors and the medicalization of killing. CMDS Journal Fall 1988;XIX(3):23-27

The author begins by examining the transgressions of the Hippocratic Oath in Nazi Germany. He borrows from the work of Robert Lifton to discuss the psychological concept of "doubling" which allowed physicians to cope with the healing-killing paradox. He then describes some physicians who resisted doubling. He goes on to discuss the specific issues of euthanasia and abortion. He concludes by encouraging Christian physicians to be sensitive to their dying patients, to avoid prolonging their suffering, but to resist the resist the temptation to doubling. He encourages Christian physicians to (1) pray about these issues, (2) talk to each other about our

concerns in these areas, and (3) refuse to participate in procedures and practices which violate our consciences.

Doerflinger R. Assisted suicide: pro-choice or anti-life? Hastings Center Report 1989;19(1):S16-19

The author is one of 9 included in this special supplement to the HCR entitled "Mercy, Murder, & Morality: Perspectives on Euthanasia." Writing from a Roman Catholic perspective, he begins by declaring the intrinsic wrongness of directly killing the innocent because of the Judeo-Christian conviction that human life is sacred because it is created in the image and likeness of God, and called to fulfillment in love of God and neighbor. In discussing "slippery slopes and loose cannons", he contends that socially accepting killing of innocent persons will interact with other social factors to threaten the lives of others whom we all agree should be protected. The social factors he enumerates are: the psychological vulnerability of elderly and dying patients, the crisis in health care costs, legal doctrines on substituted judgment , expanded definitions of terminal illness, prejudice against citizens with disabilities, the character of the medical profession, and the human will to power. He concludes that the combined force of these arguments provides a serious case against assisted death for any class of persons.

Gomez C. Regulating Death: Euthanasia and the Case of the Netherlands. New York: Free Press, 1991, 171 pages

The author, a physician/ethicist, went to Holland to study euthanasia practices and says that he found a scarcity of information about regulatory mechanisms. He believes that regulatory criteria are unenforceable. He describes euthanasia deaths in 26 patients, and he evaluates each. It is his opinion that significant abuses would likely go undetected by public authority.

Eareckson-Tada J. A right to die? CMDS Journal Winter 1992; XXIII(4):20-24

The author begins with by telling the story of her family's decision against using a feeding tube to forestall her father's inevitable death. She then relates some of the dilemmas presented by new technology and suggests that in order to gain wisdom for these decisions, we must (1) become well acquainted with the Scriptures, (2) understand how the Scriptures apply to the situation, and (3) put the two together in a process of personal decision making. She reminds the reader of the following Scriptural principles: life is precious, suffering people should have every access to the means of God's grace, love for God and love for others is paramount, and God demands that we must examine our motives. She states that if we are motivated by faith and love, conscience cannot be violated. After a discussion of "pulling the plug", she goes on to address the issue of mercy-killing. She concludes that "any means to produce death in order to alleviate suffering is never justified."

Emanuel, EJ. Euthanasia: historical, ethical, and empiric perspectives. Archives of Internal Medicine. 1994;154(9):1890-1901

Debates about the ethics of euthanasia date from ancient Greece and Rome. In 1970, S.D. Williams, a nonphysician, proposed that anesthetics be used to intentionally and the lives of patients. Between 1870 and 1936, a debate about the ethics of euthanasia raged in the United States and Britain. These debates predate and invoke different arguments than do debates about euthanasia in Germany. Recognizing the increased interest in euthanasia, this article reviews the definitions related to euthanasia, the situation in the Netherlands, and the empirical data regarding euthanasia in the United States.

Arkes, Hadley, et al. "Always to Care, Never to Kill: A Declaration on Euthanasia". First Things 2/92; 20: 45-47

In asserting the necessity for Christians to expose euthanasia for the immoral act that it is, the author contends that in caring for the sick and the dying, we are called "always to care, never to kill". He maintains that it is imperative that the distinction between allowing to die and killing be upheld, with the former being sometimes permitted and the latter always proscribed. He warns that, with the loss of such a distinction and the subsequent legalization of euthanasia, euthanasia will not remain limited as an option only for those who are terminally ill. Once euthanasia becomes legal on the basis that persons have the right to self-determination and to the relief of suffering, there will be no justification for restricting such an option to the terminally ill. If one has a "right" to die, why must she wait until she is dying to claim that right? If one has a "right" to the relief of suffering, might he not be relieved of such via euthanasia even without his consent? In considering these issues, the author invokes a discussion of religious, moral, political, and institutional wisdom as modes of countering the expressed "right" to euthanasia.

Cameron, Nigel M. de S. Theological Perspectives on Euthanasia, in Death Without Dignity. Edinburgh, Scotland: Rutherford House Books, 1990.

In this analysis of euthanasia, the author contends that to properly address issues of death and dying, one must simultaneously invoke a consideration of the nature of health, healing, and human life. According to him, "[i]t is the isolation of the question of death and dying from other human questions that helps lead us into the blind alley of a programme of euthanasia." He asserts that the physician s role as healer must be seen as an eschatological one which foreshadows the Christian hope of the final Resurrection of the body. Therefore, physician assistance in bringing about patients' deaths must be absolutely prohibited. It is maintained that Christians must engage in the euthanasia debate with the perspective that human dignity is a fundamental attribute of human life bestowed on us by God; our dignity is not, therefore, defined by or limited to a state of good health. Consequently, Christians must proscribe the act of euthanasia as one which is an affront to, and not an acknowledgment of, the inherent dignity of human beings.

Jochemsen, Henk. "The Netherlands Experiment," in Dignity and Dying: A Christian Appraisal. Grand Rapids, Mich.: Eerdmans; and United Kingdom: Paternoster, 1996.

Research by Van der Maas reveals that in 1990, there were 1,000 instances in which physicians terminated the lives of their patients without being requested to do so. (This constitutes what the Dutch would term "non-voluntary euthanasia".) In addition, Van der Maas' data shows that in 7,100 other cases, physicians administered treatment for pain relief with the partial or explicit intent (and not merely the foreseen but unintended side effect) of hastening death. Further, in 7,875 cases, physicians either failed to initiate or withdrew treatment with the partial or explicit purpose of ending life. In the 1,000 cases in which physicians terminated the lives of their patients in the absence of a patient request to do so, the physicians involved saw a distinction between killing patients without their request and increasing the administration of pain-relieving treatment with the expressed intent of shortening his life. Although there is a firm belief among many people that the nature of the medical profession proscribes the intentional ending of life, the actual practice of euthanasia is difficult to discern and monitor because it consists of the "actual intentional shortening of life" and not just the intention. That is, it is not always clear whether physicians actions constitute euthanasia. In considering this difficulty, the author invokes a discussion of cases and rulings on euthanasia and also provides a summary of the common arguments both in favor of and in opposition to euthanasia.

Kass, Leon R. Death With Dignity and the Sanctity of Life. Commentary 3/90; 89: 33-43

This physician and scholar asserts that a false dichotomy between the terms "death with dignity" and the "sanctity of life" is often set up in the debate over issues at the end of life. By exploring the meaning and roots of these concepts, he concludes that the two concepts are in fact wedded so as to preclude, at one extreme, the continuation of all medical treatment regardless of prognosis and, at the other extreme, the act of euthanasia.

Bibliography

Kamisar Y. Some non-religious views against proposed mercy-killing legislation. Minnesota Law Review 1958; 42(6):969-1042

Predating the current debate by 30 years, this long treatise by a respected law professor argues persuasively that it is not necessary to invoke theological reasons to oppose euthanasia. He finds "substantial utilitarian obstacles" to such a proposed policy change including the possibility of error, abuse, and the discovery of new treatments.

Sacred Congregation for the Doctrine of the Faith (of the Vatican). Declaration on euthanasia. 1980

The Roman Catholic position against intentional ending of life is re-evaluated in light of recent scientific advances. Euthanasia is clearly defined and is discussed in the context of the value of human life and the meaning of suffering for Christians. While clearly condemning intentional killing, it replaces the older distinction of "ordinary vs extraordinary" treatments with the concept of "proportionate vs disproportionate" remedies and concludes that it is permissible to withhold or withdraw some treatments in some circumstances.

Kass LR. Neither for love nor money: Why doctors must not kill. The Public Interest Winter 1989; vol 94:25-46

Kass rejects the concept of medicine as a contract wherein the physician is paid money as a dispenser of services to meet the requests of autonomous patients. He also rejects the concept of medicine as a dispenser of services based purely on human compassion. He maintains that medicine is not morally neutral, but has its own intrinsic ethic which includes a taboo against killing patients---a taboo "which a physician true to his calling will not violate, either for love or for money."

Reichel W, Dyck AJ. Euthanasia: A contemporary moral quandry. Lancet December 2, 1989:1321-1323

The authors argue that legalization of voluntary euthanasia is likely to expand to involuntary. They also discuss the dominance given to cost-containment and express concerns that the idea of a "life devoid of value" will further drive the issue. They make a plea for good terminal care as the morally preferable alternative, and they conclude with a strong affirmation of life.

Singer PA, Siegler M. Euthanasia---a critique. New England Journal of Medicine 1990;322(26):1881-1883

The authors critique the two arguments offered by proponents (relief of suffering and individual rights) and make a strong case against euthanasia because it is perilous public policy and it violates the norms of medicine.

van der Maas PJ, van Delden JJM, Pijnenborg L, Looman CWN. Euthanasia and other medical decisions concerning the end of life. Lancet 1991; 338:669-674

This is a report of the Remmelink Commission appointed by the Dutch government to document the actual practice of euthanasia in the Netherlands. Of the nearly 129,000 deaths in 1990, 1.8% were caused by euthanasia, 0.3% by physician-assisted suicide, 0.8% by "life-terminating acts without explicit and persistent request" and an astonishing 17.5% by medication to alleviate pain and suffering.

Euthanasia: California Proposition 161. A Special Supplement to Commonwealth September 1992.

This 16 page supplement contains four essays: "What is at Stake?" by Alexander Capron & Vicki Michel, "Consider the Dutch" by Carlos Gomez, "Why Doctors must not Kill" by Leon Kass, and "Aid-in-Dying: the Social Dimension" by Daniel Callahan. All give well-articulated arguments against passage of state legislation allowing euthanasia.

Emanuel EJ. The history of euthanasia debates in the United States and Britain. Annals of nternal Medicine 1994; 121:793-802

This historical review shows that the arguments propounded for and against euthanasia in the 19th century are identical to contemporary arguments.

Professional Association position statements in opposition to euthanasia:

American Medical Association. Euthanasia, Report 12 (June 1988). In: Reports of the Council on Ethical and Judicial Affairs

American Geriatrics Society, Public Policy Committee. Voluntary active euthanasia [position statement]. Journal of the American Geriatrics Society 1991; 39(8):826

British Medical Association. Euthanasia: report of the working party on euthanasia. 1988

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