

PHYSICIAN ASSISTED SUICIDE

(A&P 2017, p. 241–73, 25)

Introduction

Canada's changing attitudes towards Physician Assisted Suicide (PAS; see p. 246–49 for explanation of terminology) prompted a number of legal changes in the past number of years. In response to these changes, the Committee on Church Doctrine evaluated the current doctrinal stance towards PAS and discerned that there were no major changes required at this time. The committee does see that what was once a nearly universal prohibition has begun to change within different parts of the Christian community. While acknowledging these changes, a majority of the committee believed that The Presbyterian Church in Canada should not change its current stance.

Instead of launching into a significant theological justification for this position, the committee decided that The Presbyterian Church in Canada would benefit from a resource that could help individuals, congregations, sessions and ministers to grapple with the underlying theological issues at play in PAS. The “individuals” mentioned are not just those who are facing an imminent death and their families, but the medical staff and professionals who engage in these situations as part of their everyday work life. The Presbyterian Church in Canada must provide resources for those living out their God given call working in the medical field. In addition, we believe that those who work within health care, such as chaplains and spiritual care providers, could also use this resource to good effect.

This portion of our report is that resource. It is presented here less as a “report” but rather as a record of the resource that will be made available to the church in the near future. There are a few places in the resource which will need editing and addition. For instance, there is a reference to a website that is under construction. This is therefore a near final draft of the resource.

The Subcommittee – Members

The Rev. Dr. Roland De Vries joined the faculty of Presbyterian College as Director of Pastoral Studies in July, 2015. He has been the minister of two congregations, helping them to engage in various forms of renewal. As Director of Pastoral Studies, Dr. De Vries' interest is in the formation of ministers through the integration of academic theology with the practice of ministry and growth in personal Christian character. He oversees the field education program and teaches in areas such as preaching, worship, congregational leadership, and the theology and practice of ministry. Dr. De Vries has a deep commitment to the wellbeing of Christ's church and to the formation of ministers who are able to serve faithfully, competently and imaginatively within a congregational setting. His primary interest is in the missional identity of the church and the relationship between the gospel and culture.

Mrs. Myrna Talbot is a member of the Committee on Church Doctrine and serves as its secretary. She has had a 33 year career as a consultant, specializing in social research, to all levels of government. End of life issues are of vital importance to her, as she recently lost her husband to a brain aneurism and was faced with the heartbreaking decision to withdraw treatment. Her personal story is included towards the end of this report.

Dr. M. Terence O'Reilly, cancer researcher, Novartis Pharmaceuticals, Basel, Switzerland. Dr. O'Reilly is an award winning researcher who is currently on long term disability. Dr. O'Reilly has early onset Parkinson's Disease (18 years), has had deep brain surgery to alleviate symptoms, and is a cancer survivor, currently undergoing treatment for his third battle with non-Hodgkin's lymphoma (mantle cell). Dr. O'Reilly is an active member of the Anglican Church in Basel, a chaplaincy of the Anglican Communion, and a multi-ethnic congregation that attracts professionals from every continent.

Ms. Loraine Warnock, Nurse Manager at London Health Sciences Centre, University Hospital, and since 1984, has had a wealth of nursing experience in various aspects of health care in Ontario. Ms. Warnock is an elder, a cancer survivor, and has travelled on medical mission trips to Yemen and Central America.

The Rev. Jinsook Khang is on the ministry team at Vaughan Community Church. The Rev. Khang serves at the Clerk of the Presbytery of Eastern Han-Ca Presbytery. She has a deep interest in small group ministry, Bible study and pastoral care. Jinsook Khang has been on the Committee on Church Doctrine since 2015.

The Rev. Dr. Christine O'Reilly has over 30 years' experience as a pastor in rural and small town settings. Dr. O'Reilly has been an advocate for small congregations within the denomination for many years, and has led workshops for small congregations across Canada in renewal, visioning, worship and lay leadership. Her interests include worship planning and leadership, rural ministry, mentor groups for pastors, spiritual formation, community

engagement and the renewal of vital mission and ministry in the local congregation. She has served two terms on the Committee on Church Doctrine. She is the convener of this subcommittee.

Preface

The Committee on Church Doctrine was assigned the task of preparing a report on “Physician Assisted Death” by the 2015 General Assembly. (A&P 2015, p. 49) An extension on the work was given by the 2016 General Assembly (A&P 2016, p. 278), in light of pending legislation by the federal government, as required by the Supreme Court of Canada; with the expectation that a report would be available for the 2017 General Assembly.

The task has been undertaken in good faith and with a will to discuss, explore, pray and work by the subcommittee. We come from a variety of experiences, both personal and professional; we all share a common faith in Christ, and a desire to care for people as God calls us. The scope and weight of the task, the legal and medical changes that have been made in the past year have been almost overwhelming. The real-life stories we all brought impacted us profoundly. We do not feel in any way qualified as “experts”, but humbled by the work we have undertaken.

Since the 2016 Assembly, the matter of end of life decisions has changed rapidly, and remains in flux even as we present this interim report. Government legislation has opened the way for not only choices to end life, but deep discussions about end of life care, the care and protection of the vulnerable, and the role, responsibility and rights of health care providers. The perceptions of the public and within the wider church of Christ are complex.

Our committee has noted how even the language and acronyms around end of life decisions have (and are) changing. What was once called “euthanasia” has moved to “mercy killing”, then to “Physician Assisted Suicide” (PAS) to “Physician Assisted Death” (PAD) to “Medical Assistance in Dying” (MAID). The change in language seems to us to reflect a change in both opinion and understanding of end of life choices in an increasingly secular, technological and utilitarian society.

What do these different terms truly mean, and what do they say about our changing attitudes and practices to life and death, to values such as compassion, long term care and sacrifice, and the worth of the vulnerable and their caregivers in our culture? What does the term “dying with dignity” truly mean? What is the place of death in an increasingly death-denying, industrialized society? Is there a difference between end of life choices for a person with a spinal cord injury, an acquired brain injury, some who has a mental illness, or has a diagnosis of a chronic, progressive, debilitating disease or a terminal, untreatable cancer?

These are but a few of the questions we have wrestled with over the year.

We have noted in recent months, the advent of a Canadian produced television show “Mary Kills People” described by the Global Television Network as “a character-driven, six-part television event that follows Dr. Mary Harris – an overworked single mother and an emergency room doctor who also moonlights as an underground angel of death – working outside the law assisting patients who want to die on their own terms. So far Mary has managed to stay under the radar, but business is booming, and her double life is getting complicated.” (globaltv.com/marykillspeople)

A recent report from researchers at the University of Calgary noted yearly cost savings between \$35 million to about \$140 million for the health care system when people choose “MAID”. (theglobeandmail.com/news/national/assisted-suicide-could-save-canada-up-to-138-million-a-year/article33701475)

Both of these items cause us to ask questions on many levels. Have we more quickly than imagined begun to normalize and even promote the choice to end life? There are guidelines from government and medical ethicists in hospitals. There is increasing divergence in the Christian church over what was once a basically unified stance. There are some who embrace the “right to die” under their own control, and some who fear it. There are many who wonder if we will come to a time when there will be subtle (and perhaps not so subtle) pressure upon the vulnerable, the sick, the struggling, the elderly, and those with mental or physical illnesses to end their lives.

The subcommittee has decided unanimously to consistently use the term “physician assisted suicide” (PAS). This decision was not made lightly. Reasons for adopting the term PAS include:

- clarity in what we are talking about: someone choosing to end their life, and seeking the help of medical professionals to do so. Other terms like “physician assisted death” or “medical aid in dying” could include

withholding or minimizing treatment, that will hasten death, but not be a pre-planned, intentional administration of a substance to cause death.

- our understanding as a denomination that suicide is not considered an unforgiveable sin, but rather deserves intense and engaged compassion, comfort, attention and involvement with the person in such physical, mental and/or emotional pain that life itself seems unbearable.

An underlying theological question has been presented and discussed at every meeting of the subcommittee: the question of autonomy. What do we believe as Christians about personal autonomy? This is a key question in this (and other) debates in our time.

We live in a culture enamoured with the closing lines of *Invictus* by William Earnest Henley: “I am the master of my fate: I am the captain of my soul.” *Invictus* is a stirring work of literature, but it decries any trust by God.

As Reformed Christians, we profess a different heritage, powerfully stirring to our souls that proclaims a complete and utter trust in God, as in the words of the Heidelberg Catechism:

Q. What is your only comfort in life and in death?

A. That I am not my own, but belong – body and soul, in life and in death – to my faithful Saviour, Jesus Christ.
He has fully paid for all my sins with his precious blood,
and has set me free from all the power of the devil.
He also preserves me in such a way
that without the will of my heavenly Father
not a hair can fall from my head;
indeed, all things must work together for my salvation.
Therefore, by his Holy Spirit he also assures me of eternal life
and makes me heartily willing and ready from now on to live for him.

Our deliberations are not nearly complete. We believe this issue is of deep and fundamental importance to The Presbyterian Church in Canada, to those who find a church home in a Presbyterian congregation, to those who are medical professionals, pastors, family members, patients, caregivers, and all who seek to live faithfully and walk humbly with God. Rather than succumb to pressure and produce a hastily written, shallow or doctrinaire report, the subcommittee offers an interim report to the church. This is a “work in progress”; it is offered with the hope, plea and expectation that the church will read and respond to this interim offering, in our ongoing work of understanding faithful, informed, Reformed, scriptural, theological and pastoral wisdom for this matter of life and death.

In this report, note the following:

- The subcommittee strongly advocates quality palliative care accessible to all Canadians as our first response, rather than strongly advocating in favour of physician assisted suicide. We believe there is a difference between “letting go of earthly life” and “deliberately inducing death”.
- We also strongly advocate for compassionate pastoral care, pastoral support and understanding for those facing these matters of life and death (patients, family members, health care professionals, funeral directors and staff, pastors, personal support workers). Those in the health care field face new challenges in matters of conscience that require our church community to listen, to learn and to live with our brothers and sisters on the front lines of this growing, ever-changing debate and practice.
- Ongoing research in this field seems to indicate a growing trend that people are choosing physician assisted suicide not simply over a fear of pain, but a sense of loneliness, of being a burden to others, and feelings of hopelessness. Surely this is a call from Christ to the church: to cultivate communities that accompany people through the valley of the shadow of death to the light of God’s grace and promise of life eternal.
- “Dying with dignity” is slogan prevalent in this debate. We would take a broader view of what those words mean. Life is messy; death is messy. Life and death are often uncomfortable and difficult. In both life and in death, “dignity” is not limited to our physical circumstances but being assured of and surrounded by the love of God, and the love of God shown through the loving care of God’s people. That care is also messy and difficult, but is what we believe Christians are called to undertake.
- We recognize that this position is “out-of-step” with our current culture. We believe that being “counter-cultural” in this matter is part of our mandate as followers of Jesus Christ, who knew the sorrow and pain of

death, and did not acquiesce to culture. He who “holds the keys” also holds us as distinctive from our culture’s patterns regarding both living and dying.

In its approach to the question of physician assisted suicide, the Committee on Church Doctrine has decided that it will not follow the same path it has with theological questions or issues in the past. Rather than write a 50-page theological and scriptural approach to the question of physician assisted suicide, for example, we are offering a collection of writings that approach this issue from different points of view. We will address some of the bigger questions around physician assisted suicide in a way that we hope is both succinct and accessible.

The committee will offer an online opportunity for comments and responses, stories and questions that individuals have and invite them to share their reflections and pose their questions to the committee.

The Current Legal Landscape in Canada

The Carter Decision

The “Carter Decision” refers to a case decided by the Supreme Court of Canada in 2015. The judgement of the court was that the criminal code provisions outlawing assisted suicide and euthanasia are unconstitutional – to the extent that they prevent suffering persons from accessing medical services by which their lives may be ended. The court decided unanimously that the Charter of Rights and Freedoms protects the right of Canadians to physician assisted suicide, broadly defined.

The summary of the court’s judgement is as follows:

The criminal code provisions (against physician assisted suicide and euthanasia) unjustifiably infringe section 7 of the charter and are of no force or effect to the extent that they prohibit physician assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.

The government of Canada was given one year (in February 2015) to enact new legislation that allowed for physician assisted suicide and euthanasia. In February of 2016 the government was given four additional months to come up with new legislation. In February of 2016, also, a parliamentary committee submitted a report to the House of Commons with recommendations about what should be included in the new legislation.

Federal Legislation on “Medical Aid in Dying”

Bill C-14 (a legislative proposal concerning medical aid in dying) received Royal Assent on June 17, 2016. The effect of this legislation was to make physician assisted suicide legal and to provide a framework within which such a “treatment” could be accessed by Canadians.

Here is a summary of the effect of this legislation as provided by Health Canada:

There are 2 types of medical assistance in dying available to Canadians. They include where a physician or nurse practitioner:

1. directly administers a substance that causes death, such as an injection of a drug [this is commonly called voluntary euthanasia]; or
2. gives or prescribes a drug that is self-administered to cause death [this is commonly known as medically-assisted suicide].

Who is eligible for medical assistance in dying?

In order to be eligible for medical assistance in dying, you must meet all of the following conditions:

- be eligible for health services funded by the federal government, or a province or territory. Generally, visitors to Canada are not eligible for medical assistance in dying;
- be at least 18 years old and mentally competent (this means capable of making health care decisions for yourself);
- have a grievous and irremediable medical condition;
- make a request for medical assistance in dying which is not the result of outside pressure or influence; and

- give informed consent to receive medical assistance in dying (this means you have consented to medical assistance in dying after being given all of the information needed to make your decision, including information about:
 - your medical diagnosis
 - available treatment
 - available options to relieve suffering, including palliative care

Who is eligible for medical assistance in dying?

To be considered as having a grievous and irremediable medical condition, you must meet all of the following conditions:

- have a serious illness, disease or disability,
- be in an advanced state of decline that cannot be reversed,
- be suffering unbearably from your illness, disease, disability or state of decline,
- be at a point where your natural death has become reasonably foreseeable, and
- which takes into account all of your medical circumstances.

You do not need to have a fatal or terminal condition to be eligible for medical assistance in dying.

Mental Illness

People with a mental illness are eligible for medical assistance in dying as long as they meet all of the listed conditions.

However, you are not eligible for this service if:

- you are suffering only from a mental illness;
- death is not reasonably foreseeable when considering all the circumstances of your medical condition;
- mental illness reduces your ability to make medical decisions.

The process for medical aid in dying in Ontario

The College of Physicians and Surgeons of Ontario has provided guidelines for medical professionals within its jurisdiction, providing guidance on the steps that must be taken when physician assisted suicide takes place. Other professional bodies across the country have provided their own guidelines, and those of the College of Physicians and Surgeons of Ontario are provided here for illustrative purposes. The following steps are outlined by the college.

- Step 1: Patient makes initial inquiry for medical assistance in dying to a physician or a nurse practitioner.
- Step 2: Physician or nurse practitioner assesses the patient against eligibility criteria for medical assistance in dying.
- Step 3: Patient makes written request for medical assistance in dying before two independent witnesses.
- Step 4: The physician or nurse practitioner must remind the patient of his/her ability to rescind the request at any time.
- Step 5: An independent second physician or nurse practitioner confirms, in writing, that the patient meets the eligibility criteria for medical assistance in dying.
- Step 6: A 10-day period of reflection from the date of request to provision of medical assistance in dying.
- Step 7: Physician or nurse practitioner informs dispensing pharmacist that prescribed substance is intended for medical assistance in dying.
- Step 8: Provision of medical assistance in dying.
- Step 9: Certification of death.

Definitions – A word about words

The language we use to describe death and dying, and the language we use to describe the act of taking another person's life, is very important. Sometimes we may think that our words are neutral (that our words simply describe acts), but very often the words we use imply subtle ideas or political agendas. Also, the language used in the wider culture may or may not match our understanding of life and death as these are lived in relation to the good news of Jesus Christ.

Here is a rather simple example to explain this point. When we talk about these issues, why do some speak about “physician assisted death” rather than speaking about “a physician ending a patient’s life”, or about “a physician killing a patient”? Is this newer language intended to change how we feel about these acts?

One other example: In the province of Quebec, the language of “medical aid in dying” is now used to describe a physician’s role in ending a patient’s life. But when this language was introduced in Quebec, the “father” of palliative care medicine (Dr. Balfour Mount) reacted with deep frustration, by saying that “medical aid in dying” is what palliative care physicians have been providing for 40 years.

Medical Aid in Dying

The government of Quebec passed Bill 52 in 2015. The first version of the Bill actually did not provide any definition of the phrase “medical aid in dying”. During the period in which the Bill was revised, however, it became apparent that the law would need to include an explicit definition.

The definition of “medical aid in dying” is, finally, as follows:

A treatment consisting of the administration of drugs or substances by a physician to a person at the end of life, at that person’s request, in order to relieve his suffering resulting in his death.

This means that “medical aid in dying” is an act by a physician to inject drugs (or provide several successive injections of drugs) to end a person’s life and suffering at his or her request – that is, it is not the provision of a prescription for drugs that a patient will fill and then take at his or her own discretion. The Quebec law requires that the person receiving “medical aid in dying” be near the end of life, be suffering physically or psychologically, and be competent to consent to such an act.

Physician Assisted Suicide

The language of “physician assisted suicide” can be used to describe various ways in which a doctor might actively participate in the death of a person. Very often (in such jurisdictions as Oregon and California) this refers to the physician’s act of writing a prescription for a “cocktail” of medicines by which a person may take his or her own life. In those jurisdictions, the physician who prescribes the medications may not be present when the person takes the “cocktail” to end his or her own life.

In some instances, the language of physician assisted suicide is used for other ways that a doctor may end the life of a patient, since it is assumed that the physician is simply acting on the request of the patient him or herself to have their life ended.

Euthanasia

Euthanasia is somewhat older language that is used to describe the act by which one person takes another person’s life, as a presumed act of mercy to end his or her suffering. The Canadian Medical Association defines euthanasia as follows:

Knowingly and intentionally performing an act, with or without consent, that is explicitly intended to end another person’s life and that includes the following elements: the subject has an incurable illness; the agent knows about the person’s condition; commits the act with the primary intention of ending the life of that person; and the act is undertaken with empathy and compassion and without personal gain.

Although this concept has a mixed meaning (and may sometimes imply a lack of consent), it has been used by medical professionals in Quebec to describe “medical aid in dying”. Specifically, Dr. Yves Robert, who is secretary of the Quebec Medical Association, has used the language of euthanasia in place of “medical aid in dying”. Sometimes two types of euthanasia are defined as voluntary euthanasia and involuntary – in the latter case, the person’s life is ended without their active participation in any decision-making process that leads to their death.

Palliative Care

There is increasing awareness today of what palliative care is, and how few Canadians are actually able to gain access to such care at the end of their lives. Some statistics suggest that as many as 75% of Canadians do not have access to palliative care, which is defined by the Canadian Hospice Palliative Care Association as follows:

Palliative care is a special kind of health care for individuals and families who are living with a life-limiting illness that is usually at an advanced stage. The goal of palliative care is to provide comfort and dignity for the person living with the illness as well as the best quality of life for both this person and his or her family.

A “family” is whoever the person says his or her family is. It may include relatives, partners and friends.

The World Health Organization defines palliative care as:

An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

An important objective of palliative care is relief of pain and other symptoms. Palliative care meets not only physical needs, but also psychological, social, cultural, emotional and spiritual needs of each person and family. Palliative care may be the main focus of care when a cure for the illness is no longer possible. Palliative care services help people in later life who are ill to live out their remaining time in comfort and dignity.

Within a Christian framework, palliative care includes prayerful exploration of the presence of Christ with his people in their suffering. It also reaches toward the meaning and hope that are given to us in Jesus Christ, a spiritual challenge for all of us whether in the course of daily life or at the end of life.

Hospice Palliative Care

A hospice (or hospice palliative care) simply refers to palliative care that is offered in a more home-like setting. Rather than receiving such care, and dying, within the austere and institutional context of a hospital, hospice care provides a home-like environment to die in the care of family, friends and medical professionals in a way that seeks the dignity and familiarity of daily life lived in relationship.

Termination of Treatment

This refers to those situations where medical treatment is no longer indicated and all treatment except palliation (food, hydration, pain relief, etc.) is withdrawn. The intention is not to cause death, but rather to recognize that it can no longer be effectively resisted. The results intended by the provision of certain therapies can no longer be attained, so the treatment is deemed useless and withdrawn – again, the intention is not to cause death, but rather to recognize that it can no longer be effectively resisted.

The termination or withdrawal of treatment is best understood as an expression of the right of patients, or those legally appointed to act for them, to refuse treatment. The right of patients to refuse even life-saving medical interventions is well-established in the Canadian legal landscape. Importantly, it is the right to refuse treatment that undergirds the corresponding requirement of informed consent in Canada – that is, the right to refuse treatment goes hand in hand with the legal requirement that medical practitioners provide all pertinent information to a patient concerning her or his condition and the possibilities for medical treatment (including the possible success or failure of those treatments).

It is important to clarify, in the context of the present report, that the withdrawal of treatment cannot be equated with the act of physician assisted suicide nor can it be equated with the act of a physician in ending a patient’s life or the act of a patient in taking medicines prescribed to end his or her life. As stated above, the withdrawal of treatment *does not cause death* – rather, the withdrawal of treatment allows underlying biological processes (related to a disease or medical condition) to take their course.

Conscience Rights

When we speak of conscience rights, we refer to the fact that medical professionals, such as doctors and nurses, may wish to exempt themselves from the provision of certain medical procedures or services. For example, a doctor may not wish to provide abortions, and cannot be compelled to provide an abortion if it is against her or his religious convictions or firmly held personal beliefs.

In the case of physician assisted suicide and euthanasia, the Supreme Court of Canada and legislation in Quebec both indicate that a physician cannot be compelled to provide a physician assisted suicide if it goes against their conscience.

However, complications arise here. For example, if a patient asks his doctor for assisted suicide (and the doctor is morally opposed to that action), must the doctor provide a referral to another doctor, who would provide assisted suicide? From the point of view of the referring doctor, isn't he or she still complicit in an immoral action if he or she provides a referral? The point of view of the conscientious objector could be expressed bluntly like this: "I won't kill you, but here is the business card of someone who will kill you."

As a result, there are ongoing discussions (and serious concerns) within religious and medical contexts about protecting the religious freedom of doctors, nurses and other health care professionals. This is an area for the church of Jesus Christ to show courage and support to those who seek to serve Christ as they serve in these professions.

Vulnerable Patients

The Supreme Court and the Quebec government have both indicated that only consenting adults may receive physician assisted suicide. This is to ensure, in part, that vulnerable adults are not coerced into receiving physician assisted death.

One can imagine a scenario, for example, in which a person might be coerced into physician assisted death by family members who have a financial interest in their death.

The question of who is vulnerable, however, may be a complex question. For example, could new openness to physician assisted death create situations in which elderly persons feel that they should ask for physician assisted death rather than asking their family to deal with their suffering? Is such a person vulnerable in a way that the Supreme Court justices or the law might not have imagined? Also, since a Parliamentary Committee has recommended that individuals with mental health diagnoses may seek physician assisted suicide, what are we to say about the possible or inherent vulnerability of such persons?

Terminal or Continuous Palliative Sedation

A treatment offered in the context of palliative care consisting of the administration of sedative medications for patients who are terminally ill – the patient is rendered unconscious or is significantly sedated. The intent of medication is to alleviate suffering and to manage symptoms. Although it is not the primary intention of the treatment, a foreseeable consequence of this treatment is sometimes a hastening of death through the giving of these medicines, but is not the primary intention of prescribing them.

This treatment is used fairly widely within the Canadian medical context, although we may not be familiar with this particular label.

The definition provided in the Quebec law is as follows:

A treatment offered in the context of palliative care consisting of the administration of drugs or substances to a person at the end of life in order to relieve his suffering by making him continuously unconscious until his death.

A starting point

Where does one begin to explore, to understand and to reflect faithfully upon the very real topic of "physician assisted suicide"? Does this task begin with medical terminology? Does it begin with research into disease and medical ethics? Does it focus on a series of events: the diagnosis of a terminal illness, declaration of life expectancy, and anticipation of probable outcomes and the clinical stages at the end of life? Does it begin with an examination of why healthy individuals place PAS into an advance directive, and/or encourage others to do likewise? Does it begin with a careful examination of the newly adopted laws of Canada, and the nature of the society who support the implementation of these laws? Even the terms and language used are changing almost daily, from "euthanasia" to "assisted suicide" to "physician assisted suicide" to physician assisted death" to "medical assistance in dying". How does the language employed reflect the changes within culture and society? Where do we begin to interpret language and the nuances behind the terms and definitions?

Or should we begin at the beginning – with an understanding of our identity? Should we perhaps begin with an embrace of the living faith that provides both the foundation upon which we live our days on earth and end them – the foundation upon which we make choices about both our living and our dying?

As we prayerfully and thoughtfully explore this important and complex matter of physician assisted suicide, it is our contention that understanding our identity as Christian people precedes and provides the basis of our belief and our behaviour in matters of life and death. This interim report cannot offer in depth medical or legal analysis. What we have chosen to do is approach these issues from a variety of angles, always taking the framework of faith as the starting place for our discussion, our decision-making, and our determination as Presbyterians in Canada. Such a framework and foundation will guide our questions and answers, our attitudes and our actions.

It is crucial to note at the outset that the culture in which we live as Canadians has undergone radical shifts of belief. The Judaeo-Christian culture in which many Canadian Presbyterians grew up is no longer our experience; in fact, it has not been the common culture for some fifty or more years. Simply put, Christendom left Canada a long time ago.

This fact is important to note, for we can no longer presume, in fact we must no longer presume, that Canadian society shares an overarching set of beliefs and values that determine our laws and day-to-day practice of living. Living in a democracy, diminished religious commitment, pluralism, the value attached to human self-determination (autonomy), greater freedom to express opinions and the technology to disseminate the same rapidly and broadly, and an increased sense of individualism are all features of societies that accept PAS. Christians in Canada must learn now what our earliest faith ancestors knew that we are called to live our faith with both commitment and courage, for we are no longer the majority opinion.

Our foundational beliefs and values need to be constantly explored, explained and experienced, which will often set us apart from the culture of our day and time. The first century church was known for being different than mainstream society, particularly in the care of the sick and the dying:

Ancient societies and religion were not known for their care for the sick and dying. Christians who often risked their lives to care even for non-Christians represented a radical difference... It was common in ancient societies, including Rome, which saw the inception and rise of Christianity, to abandon the sick and dying. Roman religion did not teach followers to care for the helpless.

Destitute families lacking any resources to help sometimes even abandoned the chronically ill to die. In Rome, sick or elderly slaves were routinely left to waste away on Tiber Island. Unwanted children were often left to die of exposure. If a father decided that the family could not afford to feed another child, that child would be abandoned on the steps of a temple or in the public square. Almost without exception defective newborns were exposed in this way.

The churches' program of benevolent care soon expanded, owing to an unfortunate cause. A devastating epidemic began in 250 and spread from Ethiopia across North Africa, then to Italy and the western Empire. It lasted 15 to 20 years, and at one point in Rome, 5,000 people died in one day. Christians buried the dead left in the streets and cared for the sick and dying.

Prominent historian of medicine, Henry Sigerist, once wrote that Christianity introduced the “most revolutionary and decisive change in the attitude of society toward the sick”, giving sick people a “preferential position” in society that they retain to this day. Christian saw the suffering of others as an opportunity to provide compassionate care in the name of Christ. This was Christianity's novel contribution to healthcare, providing the foundation for the whole tradition of western medical philanthropy.

By the fourth century it led to the creation of the hospital as a uniquely Christian institution. But the hospital would never have succeeded without an earlier long tradition of medical philanthropy integral to the ministry of the early church.¹

The reason for this radical difference was grounded in the Christian belief that life is a gift from God, and our identity is as God's creation, beloved daughters and sons. That belief shaped behaviour.

From the beginning of scripture, human beings are created in the image of God.² They are entrusted by God to care for creation, and to love and care for one another, which care is particularly exemplified in the life and ministry of Jesus Christ.³ Theological understanding and application of the life and ministry of Christ taught that God loves the world, and that those who follow Christ are to live alongside and love one another as He did. In fact, this was the mark the identity of a disciple.⁴

In teaching the way of Christ, and reflecting theologically upon his life, death and resurrection, the apostle Paul and other New Testament writers made caring for one another a hallmark of Christian community.⁵ For the earliest Christians, death was not seen as the final word – rather, the power of Jesus Christ’s own death and bodily resurrection meant a sure and certain hope of eternal life for those who belonged to him.⁶ Death was no longer the ultimate enemy, Christ’s victory over death gave everyday life its fundamental meaning, as well as confidence in the call to compassionate care even as we face death.

For the early Christians, these truths formed the foundation upon which they lived their lives, cared for others, and faced death. Their identity as sons and daughters of the living God changed everything.

The Apostles’ Creed, which many of us proclaim aloud each Sunday, declares “I believe...in the resurrection of the body and the life everlasting”. This, too, is part of our identity as followers of Jesus Christ, providing a firm foundation upon which we stand to make decisions, to accompany one another, to live and to die with grace and dignity.

It is these truths and this fundamental identity that calls for our attention and allegiance as we find our way through the current discussion and implementation of physician assisted suicide. As Christians, we are called to live differently and at times “at odds” with the culture around us. This can take many forms: how we spend our time and our money; how we express hospitality, give generously and demand nothing in return; how we value others, regardless of status, gender, gender identity, sexual orientation, ability, creed or race; and how we value life as God’s gift to be cherished and nourished. We may disagree with others’ beliefs, for example, but are still called to live and to serve and honour life.⁷

As Living Faith records:

- 2.2.1 The mystery of human existence is that we belong to God and have been made in the divine image. In God we live and move and have our being.
- 7.6.5 Baptism assures us that we belong to God. In life and in death our greatest comfort is that we belong to our faithful Saviour Jesus Christ.

As we and our loved ones face illness, and as life becomes increasingly fragile and fraught with debilitating disease and the imminence of death, we face many questions borne out of the gospel call to love, to care and to treat one another as creations of God. We sometimes face painful and tragic circumstances, which test our faith and leave us with more questions than answers. Even then, those who profess “Christ is Lord” are called to walk the difficult path of faith and doubt. Living Faith expresses this well:

6.1 Faith

- 6.1.1 Faith is a gift of God constantly renewed in Word and Sacrament and in the shared life of God’s people. It is trust in God, involves personal repentance of sin, acceptance of Jesus Christ as Saviour, and commitment to him as Lord. It includes assent to the truth of the gospel. By faith we receive the very life of God into our lives and joyfully discover that God knows, loves and pardons us.
- 6.1.2 God brings us to faith in many ways. We may have trusted in God from childhood; or our faith may have come later in life. Faith may come suddenly

or only after a struggle to believe.
Whatever the spiritual journey we have travelled,
God honours our faith, great or small.

- 6.1.3 Faith is a response
to God's presence in the midst of life.
It says "yes" to the God who is here.

6.2 Doubt

- 6.2.1 We are not always certain that God is with us.
At times God calls us
to live in this world
without experiencing the divine presence,
often discerning God's nearness
only as we look back.
At other times God seems absent
in order that our faith may be tested.
Through such struggle we mature in faith.
God may also chasten and strengthen us
through the hard circumstances of life.
- 6.2.2 Questioning may be a sign of growth.
It may also be disobedience:
we must be honest with ourselves.
Since we are to love God with our minds,
as well as our hearts,
the working through of doubt
is part of our growth in faith.
The church includes many who struggle with doubt.
Jesus accepted the man who prayed
"Lord, I believe. Help my unbelief."
- 6.2.3 Though the strength of our faith may vary
and in many ways be assailed and weakened,
yet we may find assurance in Christ
through confidence in his word,
the sacraments of his church,
and the work of his Spirit.

As we consider the implications of physician assisted suicide, we stand on the foundation of God's love and faithfulness to us, and God's hold upon our lives, with the promise that there is more to come than we can see and understand here and now. This instructs and influences how we prepare not only to live but also to die, and how we accompany one another (as family members, friends and medical professionals) on this journey towards death and eternal life.

The foundation upon which we, as Christians, live and make decisions in both life and death, is very different from the current increasing secular culture within Canada. We may well be a "peculiar people" in both the decisions we make for ourselves at the end of life and the way we care for those who have a chronic condition such as Amyotrophic Lateral Sclerosis (ALS), who struggle with mental illness, or who face a terminal illness themselves, with their children or adult loved ones. We believe that all of life has meaning, including our journey towards earthly death and eternal life by God's grace in Christ.

We believe that Christians and congregations are called to teach and practice end of life care that reflects and embodies the commands and vision of scripture and the example of Jesus Christ. So we come alongside those who are ill, those facing the end of life, those caring for patients as family members and professionals, those providing pastoral care, prayer, presence, and funeral and memorial services. We will not always agree with one another, but we are called to always act with grace and love.

We believe that communities of faith are particularly commanded to be in the forefront of the palliative care movement. Palliative care offers compassionate, pro-active, medical, emotional and spiritual resources to patients

and their families and friends. As noted earlier in this report, research indicates that 75% of Canadians do not have access to quality palliative care. It is the intention of the committee that this is a call, a command and an opportunity for the worldwide Church of Jesus Christ and The Presbyterian Church in Canada, in the scope of this report, to show courage and leadership in advocating for, encouraging, providing and supporting palliative care in every community across the nation. The heritage of early Christianity inspires us to take up this mantle and in the name of Christ, minister to the sick and dying, offering them, their families and friends tender, compassionate, excellent service that attends to medical, emotional, mental, physical and spiritual care. We exhort The Presbyterian Church in Canada at the national, synod, presbytery and congregational level to take a leading role in the palliative care movement. We have heard stories of church buildings that now serve as palliative care or hospice centres, and see this as a way the church continues to minister to a community after the congregation has ceased to require a building.

A recent statement of the Canadian Council of Churches offers a strong call to congregations and individuals to advocate for, and actively work towards, universal access to palliative care in Canada. The full statement is found at councilofchurches.ca/wp-content/uploads/2013/12/Bruised%20Reed%20Proof_7_txt.pdf.

Providing palliative care to all in need of it is the joint responsibility of all members of society including private caregivers, the health care system, and government. We understand that dignified palliative care need not always occur in hospital or hospice, but may well happen at home. But in any case, mutual support between government-supplied health care workers, family, friends and others is the foundation of any experience of palliative care. Our churches are committed to participating in this work, and to collaborating wherever possible to ensure that no one in Canada need face death and dying without the dignity and support of quality palliative care. We rely upon all levels of government to accept and support their necessary role in this key aspect of universal health care.⁸

As part of this interim report, we are seeking responses from Presbyterians in Canada.

We include some questions and answers in this report, (p. 255–64) and seek yours; we include stories of real people facing end of life issues, as patients and caregivers, and seek your stories and reflections.

One of the faithful servants of Christ and The Presbyterian Church in Canada is the Rev. Dr. Tony Plomp, a former minister and a former Deputy Clerk of the General Assembly for many years. Tony, and his family with him, faced a difficult diagnosis of, and journey with, lung and bone cancer. As he faced his own death, Tony took the time to write of his faith and how he was living faithfully during this experience, in the October 2015 issue of the *Presbyterian Record*. He closed the article with these wise words:

I do not know what shape the immediate and long-term future will take. What does it mean to die? What does it mean to confess, “I believe in the resurrection of the dead?” What does it mean to embrace the Christian hope of life eternal? Some folk have told me they know exactly what that future will be like based on their reading of scripture. I confess that I do not know. It is a mystery as deep and profound as is the mystery of faith and the God in whom we place our trust. All I know is that God is at the centre of that mystery and so here, too, I confess that I believe “He does all things well.”

In an address to the General Assembly I quoted a part of the first question and answer of the Heidelberg Catechism. “What is your only comfort (strength) in life and in death?” The answer: “My only comfort in life and in death is that I belong, body and soul, to my faithful saviour Jesus Christ.” We belong to God. We belong to each other. We belong to “all the saints who from their labours rest” (Book of Praise No. 611). And so in faith I will enter into the mystery of that new and boundless life that God has prepared for all God’s people and of which, by God’s grace, we may receive a foretaste even now – just as I did on that dark and dreary night when I experienced the beauty of the Lord and knew a peace that passes understanding.

As I said, I have many regrets. Yet one thing I do not regret: having placed my faith in God and Jesus Christ whom God has sent the one in whom we find peace, hope, joy and love.

When Dietrich Bonhoeffer, the German pastor and leader of the Confessing Church in Germany during the Nazi period, was led away to be executed he is reported to have said, “This is the end. For me the beginning of life.”

May such be also our conviction when our time comes to enter into the full glory of the love of God.⁹

It is our hope and prayer that this interim report will encourage you – as a Christian, a family member, a friend, a health care professional, a funeral director, a pastor, elder and caregiver, and as one who someday will face your own death – to think deeply, Christianity, courageously, compassionately and confidently making choices that reflect your identity as a beloved daughter or son of God, created in God’s image, and created for life on earth and life for all eternity in the presence of the living Lord.

- 10.1 God has prepared for us things beyond our imagining.
Our hope is for a renewed world and for fullness of life in the age to come.
- 10.4 Eternal life is resurrection life.
As God raised Christ,
so shall we be raised
into a condition fit for life with God.
Eternal life begins in this life:
whoever believes in the Son of God
already has eternal life.
In Baptism by faith we die and rise with Christ
and so are one with the risen Lord.
In death we commit our future confidently to God.
- 10.5 Life had its beginning in God.
In God it will come to completion
and its meaning be fully revealed.
All creation will find fulfillment in God.
Christ will come again.
Only God knows when and how
our Lord will return.
Now we see in part.
Then we shall see face to face.
- 10.6 Come, Lord Jesus!
- 10.7 May the God of hope
fill us with joy and peace in believing
so that by the power of the Holy Spirit
we abound in hope!

Additional recommended resources

This is by no means an exhaustive list. The committee welcomes your further recommendations for resources.

1994 The Presbyterian Church in Canada Statement “Euthanasia: A Matter of Life and Death”.
presbyterian.ca/wp-content/uploads/gao_social_action_handbook.pdf.

Presbyterian Church (USA) 2001 Study Guide. presbyterianmission.org/resource/paper-life-and-death-we-belong-god-euthanasia-assi/?mode=grid.

evangelicalfellowship.ca/Resources/Documents/Euthanasia-and-Palliative-Care-Guide.

evangelicalfellowship.ca/Topics/Palliative-Care.

evangelicalfellowship.ca/conscience.

presbyterianrecord.ca/2015/02/06/assisted-suicide.

presbyterianrecord.ca/2015/03/01/supreme-court-says-yes-to-assisted-dying.

presbyterianrecord.ca/2016/01/27/supreme-court-confusion.

councilofchurches.ca/wp-content/uploads/2013/12/Bruised%20Reed%20Proof_7_txt.pdf.

timothykeller.com/books/walking-with-god-through-pain-and-suffering.

Joni Eareckson Tada speaks about God, pain and suffering. youtube.com/watch?v=ejbHemlrBU4.

Endnotes

¹ str.org/blog/the-witness-of-christian-compassion#.V42q-LgrKhc; christianhistoryinstitute.org/magazine/article/new-era-in-roman-healthcare

² Genesis 1:27

³ Genesis 4:9–10; Exodus 20:8–17; Leviticus 19:1–18; Matthew 7:12; Mark 12:29–31

⁴ John 13:33–35

⁵ Romans 12:10; Ephesians 4:2

⁶ 1 Corinthians 15; Romans 8:18–39; 2 Corinthians 7: 11–16; 5:5; I Thessalonians 4:13–18

⁷ Deuteronomy 30:19–20; Luke 10:25–37

⁸ councilofchurches.ca/conseildeseglises.ca October 2016 Statement; January 2017 letter of release

⁹ Plomp, Tony “The Beginning of Life”, *Presbyterian Record*, October 2015 p. 38. Tony was given the gift of eternal life on Friday, September 23, 2016. Well done, good and faithful servant!

Questions and Answers – Physician Assisted Suicide

With this Questions and Answers section we address some of the bigger questions around physician assisted suicide in a way that we hope is both succinct and accessible.

What does “autonomy” mean?

Most arguments for physician assisted suicide appeal to the idea of human autonomy, to the idea that individuals have the right to make decisions about their own bodies, their own lives, their own medical care and their own deaths. This appeal to autonomy is closely related to the modern, western idea that there is no one answer to the question of what is good and beautiful – rather, individuals have the right to live according to their own idea of what is good and beautiful. And, they should not be prevented from pursuing or living that vision so long as it does not cause harm to anyone else. The Supreme Court of Canada appealed to this idea of autonomy when it argued (in the Carter case) that women and men who are in situations irremediable suffering have the right to make decisions concerning their bodily integrity and medical care (including their death) – that is, their autonomy must be respected.

In popular culture this idea of autonomy is captured in Harold Brodkey’s words, “I must say I despise living if it can’t be done on my terms.”¹ And it is equally captured by Dr. Donald Low’s expression of frustration at “not being able to have control of my own life, not being able to make the decision for myself when enough is enough.”² Autonomy in our culture simply means the wish and right of individuals to control their own living and dying. The logic goes like this, “If my decisions don’t cause any one else harm, then I should be free to do whatever I want.”

This understanding of autonomy is widespread in western culture, yet it must be interrogated from the perspective of Christian faith – from the perspective of the gospel. Our decisions about our living and dying are not ours only, but are to be taken under the grace and judgement of the God who has created and redeemed us in Christ. These decisions must also be taken in the recognition that we have our life and identity with others in community, and never merely as individuals. It is never simply a question of whether my actions cause anyone else harm, but is always a question of whether my decisions bear witness to the kingdom of the risen Jesus and the community that has come to life in him. Above all, we have our identity with sisters and brothers in Christ. All of which is to say that freedom for the Christian means freedom *in Christ*, and not our freedom to live or die according to our own vision of what is right and good for us.

What does it mean to “die with dignity”?

The ideas of autonomy and dignity are very closely linked in arguments for physician assisted suicide – so much so that they often mean virtually the same thing. Freedom to decide about your own life and death (your autonomy) simply means freedom to die in a way that you believe is dignified. The appeal to dignity and autonomy are often two different ways of saying “You get to decide”.

But it is also important to note that many who speak of “death with dignity” do so in a way that suggests there is an obvious and universal meaning to that phrase. It is assumed that we will all agree that dying with dignity includes: the ability to carry out one’s own bodily functions to the end; the ability to feed oneself and care for one’s own basic needs; not needing others to provide basic care for oneself; freedom from pain and suffering; dying peacefully surrounded by family (if one has family); control over one’s own decisions; control over the timing and method of one’s death.

A fundamental question, though, is whether death with dignity (human dignity) requires any of the elements listed above. From both a human and a Christian point of view, we want to ask:

Do we want to say that men or women have lost their dignity when others care for them, feed them, or bathe them?

Do we want to say that we have lost our dignity if we are not in control of our own bodily functions or care?

Do we want to say that those who are in pain or suffering have diminished dignity?

Do we want to say that it is somehow undignified to have decisive elements of one's life controlled by a timing and reality beyond oneself?

Here it is instructive to point out that a significant majority of those who have accessed physician assisted suicide in the United States (in those states where it is available) have been white, college-educated and privately insured (affluent) individuals – in other words, those who put a premium on control of their own lives, who have had control over many aspects of their own lives, and who balk at the possibility they might not be in control.³

From the perspective of the gospel, the dignity of our lives does not arise from our autonomy or our capacity to control our own lives; our dignity is not diminished by the profound care we receive from others, or by our need of them at every level of our existence; our dignity is not undermined by the loss of bodily functions; our dignity is not threatened by the fact that events beyond our control shape us and have an impact upon us.

Rather our God-given humanity and dignity are in the recognition that we need others, that God has created us both to receive and to extend care at every moment of life, and that the risen Jesus is present to us in all circumstances. To approach death with dignity is to approach death with a willingness to receive care and compassion from those around us, to exhibit grace and gratitude in receiving such care, and is to be on a journey in which we are learning to put our trust in the God who has redeemed us through the life, death and resurrection of Jesus Christ. In other words, there is no difference between a life with dignity and a death with dignity – in either case, we are not our own but belong body and soul, in life and in death, to our faithful saviour Jesus Christ. We find our dignity in relation to the Triune God.

Why do we not use the phrase “medical aid in dying”?

The language of physician assisted suicide has given way to the language of “medical aid in dying” within the political, medical and legal landscape of Canada. This shift in language is not one to which we should quickly acquiesce as we think through the significant ethical, theological and personal questions that are at stake in this conversation or debate. This is especially so since the shift to “medical aid in dying” is a very good example of the way that advocates for social change often message and manipulate language in service of their agenda.

When the language of “medical aid in dying” was first introduced within the province of Quebec, Dr. Balfour Mount (one of the earliest and longest-serving practitioners of palliative care in Canada) pointed out that providing medical aid in dying is what palliative care physicians in Canada have been providing for decades. They have provided medical care, psychological counselling and spiritual resources to the dying and their families – in other words, they have provided medical aid in dying. For Dr. Mount, advocates for physician assisted suicide were both appropriating language that belongs to palliative care, and using that language in ways that undermined the importance and meaning of palliative care.

Perhaps the most important thing to observe about the phrase “medical aid in dying” is that it obscures what is happening – it obscures the fact that we are talking about the ending of a person's life. The phrase obscures the fact that a physician, in the Quebec context at least, is giving a man or woman an injection (or series of injections) that kills them, or causes them to die. It obscures the fact that, in other jurisdictions, a physician is providing a prescription by which a man or women can commit suicide – end his or her own life. That is, the phrase “medical aid in dying” is an oddly passive construction that makes us forget that *someone is doing something*. Expressed more strongly, it is deceptive language.

Perhaps a question will be raised as to whether physician assisted suicide is a helpful term since it seems different in kind from suicide as we more generally think of it. Suicide is very often the result of depression, severe anxiety, abuse, alcoholism, or serious financial stress – it is usually a desperate attempt, sometimes driven by mental illness, to avoid deep suffering.

Further, there are interventions from mental health and other professionals that can assist those with suicidal ideation and help them in achieving a degree of health and wellbeing so that suicide is no longer seen as an answer.

In some respects, again, physician assisted suicide is different from suicide as we usually think of it. For example, we would have to object to any suggestion that Dr. Donald Low was requesting “medical aid in dying” on account of depression or anxiety or serious financial stress. The paradigm cases of physician assisted suicide are different from the paradigm cases of suicide in general.

Yet we can point out that physician assisted suicide is in continuity with suicide more generally in at least three senses. (1) Physician assisted suicide includes an action of causing one’s own death, even if with someone else’s assistance. (2) Physician assisted suicide is about causing one’s own death in order to avoid suffering. (3) We can easily imagine that a person seeking physician assisted suicide might decide not to pursue this path if provided with comprehensive care that points to other ways through the suffering of their last days. For these reasons, the use of the phrase physician assisted suicide is not out of place.

Equally important, use of the broader phrase “physician assisted suicide” (and not simply the word “suicide”) identifies this act of causing self-death in a unique context, and thus does not reduce it to suicide as we have generally thought about it. Finally, this phrase has the distinct advantage that it does not give in to the euphemism of “medical aid in dying”, a phrase that, by way of passive language, pretends that no one is actually causing death. Physician assisted suicide means precisely that a doctor is giving a series of injections to cause a person’s death, or that a doctor is providing a means (a prescription) so that a person can cause his or her own death. Let us not pretend otherwise and hide behind euphemisms.

What is the slippery slope?

In the debate over physician assisted suicide, those who raise hesitations about this practice are sometimes accused of using a “slippery slope argument”. A slippery slope argument goes something like this: “If you allow people to do action A, then very soon you will find them doing action B.” What makes this a slippery slope argument is the fact that there has been no demonstration why A will necessarily lead to B – rather, the person is simply asserting that B will result. Slippery slope arguments often play on people’s fears by suggesting that something dangerous or worrisome will happen in the future if we take a decision now that seems innocent. Rather than working to change people’s minds through careful thought and argument, fear is the basis of a slippery slope argument.

In the debate over physician assisted suicide, an opponent of this practice might argue along these lines: “If we allow physician assisted suicide for those who are suffering and near to death, then soon enough we will be allowing physician assisted suicide for healthy adults who are simply tired of living.” But someone else might object and respond “That’s just a slippery slope argument. The new law only allows physician assisted suicide for those who are suffering and dying – no one else. You are just trying to scare us. Men and women who are tired of life are never going to have access to this.”

But is the argument about healthy adults and physician assisted suicide just a slippery slope argument? Perhaps the first thing to point out is that the Supreme Court of Canada, in its Carter decision, does not require that a person to be dying in order to receive what that court refers to as physician assisted death or physician assisted dying. What the court said, rather, is that to receive physician assisted death a person must have a grievous and irremediable medical condition that causes suffering that is intolerable to the individual in the circumstances of his or her condition. This means that the person does not have to be dying. It is true that the federal legislation requires that a person be dying in order to receive “medical aid in dying”, but the Supreme Court of Canada has already set the stage for someone to successfully appeal this limit of “medical aid in dying” to the dying.

But what about the idea that those who are simply tired of life might eventually have access to physician assisted suicide – is that just a slippery slope argument? Referring again to the Supreme Court’s ruling, the court insists that the person must have a medical condition that causes suffering, which suggests that no room is being made for those who are simply tired of life. But on the other hand, we observe that the person’s suffering simply needs to be “intolerable to the individual in the circumstances of his or her condition”. That makes the person himself or herself the measure of acceptable suffering, which opens us toward suffering that may not be as significant or dramatic as we initially think would be required. That is, if a person considers himself to be suffering from life, is there anything in the logic of the Supreme Court judgement that would finally prevent this?

Speaking more concretely, it is important to observe that a trajectory of practice is in evidence in a place like The Netherlands, which has provided physician assisted suicide now for well over a decade. At this moment, 1 in 25 deaths is the result of physician assisted suicide. A Dutch physician and ethicist, Theo Boer, describes an important shift that has taken place over past years:

A shift has also taken place in the type of patients who seek assisted dying. Whereas in the first years the vast majority of patients – about 95 percent – were patients with a terminal disease who had their lives ended days or weeks before a natural death was expected, an increasing number of patients now seek assisted dying because of dementia, psychiatric illnesses and accumulated age-related complaints. Terminal cancer now accounts for fewer than 75 percent of the cases. Many of the remaining 25 percent could have lived for months, years, or even decades. In some reported cases, the suffering largely consists of being old, lonely, or bereaved.

In other words, it is evident that the introduction of physician assisted suicide within The Netherlands led to a cultural change in which life and death began to be understood differently. And in such a way that what was previously unimaginable became imaginable. This is not a slippery slope argument, but reflects an understanding of how shifts in practice can lead to transformations in ethical understandings and cultural frameworks. It is also worth noting that a new law has been proposed by the Ministers of Justice and Health in The Netherlands – which insists that those who “have a well-considered opinion that their life is complete, must, under strict and careful criteria, be allowed to finish that life in a manner dignified for them”.

It is important to nuance this carefully by pointing out that there are careful epidemiological studies that demonstrate that in Oregon and Washington, for example, that vulnerable populations have not taken advantage of physician assisted suicide in disproportional numbers. But it is also important to point out that these jurisdictions only provide physician assisted suicide by means of a prescription that the patient must fill and take him or herself – rather than through a doctor’s injection – the difference between such practices and those that will be deployed in Canada is not insignificant. Also, the kind of slippery slope we have alluded to above is one in which there is a slow and progressive widening of the categories of those captured by the practice of physician assisted suicide, rather than simply a capture of those who are vulnerable to coercion or manipulation.

Is there meaning in suffering?

This is one of those incredibly difficult questions, and yet a simple or simplistic answer to this question is sometimes given by those who defend or advocate for physician assisted suicide. It goes something like this: “I’m at the end of my life, and I don’t want to endure this meaningless suffering.” There is a sense that, with death on the horizon, it is possible for suffering and pain to be so great that it overcomes any meaning that life might have. It is as if life and its blessings and gifts are weighed on a scale, against the reality of pain and suffering, and the scale tips in favour of pain and suffering. This point of view also suggests that suffering itself has no meaning – suffering seems to be something that must be merely endured.

A theological and logical response to this begins with a realization that our dying cannot be approached differently than our living, if only because it is by no means obvious that we can distinguish that moment when we are dying from the moment when we are not dying. The conviction that we can identify the moment we have crossed the threshold from living to dying is an untenable one. More importantly, however, we must ask whether it is legitimate to separate out our living from our dying, as if our dying should be approached differently our living – as if our suffering at the “end” of life should be approached any differently than our suffering during life.

John Swinton, Professor of Theology at the University of Aberdeen, and a minister of the Church of Scotland, points out that “end of life care does not begin when a person is faced with a terminal illness. End of life care finds its roots in the processes of formation that go on through a person’s life and that come together in quite particular ways to produce the individual’s unique experience of dying.” Which means, in part, that our dying cannot be thought of or approached differently than our living – or, simply that it will not be approached differently. We will walk through the process of dying as we have lived.

Swinton gets close to the point of this particular Questions and Answers section when he writes: “An absence of illness and disturbance may be desirable, but it is not definitive of abundant life. Indeed, those who choose to follow the crucified Saviour may well find that faithfulness to that Saviour involves pain and suffering. What is definitive of abundant life is the desire to love God in all things and at all times.” Which is to say that, in Christ, suffering cannot be conceived as meaningless, whether we are living or have (if we can even pinpoint that moment) crossed the threshold to the point that we can say we are dying.

Those who follow the crucified and risen Jesus, the suffering servant, are invited to walk through their suffering at all stages of life in the same pattern – seeking his grace and mercy, asking him what he is teaching and inviting, and seeking to extend love and receive love from those who surround us. Suffering is difficult, sometimes immensely so, yet from the perspective of faith it can be a moment of deep meaning in company with Jesus, who walks through the valley of the shadow of death with us.

This implies that the church is also encouraged and challenged to develop a greater attentiveness to the prayerful practices by which we work through our suffering, so that each of us is equipped with faithful practices to approach the possible suffering of our last days. In many respects the church, as an institution of Christendom, has simply failed to foster deep practices of faith and so the default logic of the wider culture prevails in many of our lives.

And that culture is simply incapable of helping women and men of Christian faith to approach their dying in the trust and grace of Christ.

How do we protect the vulnerable?

One of the preoccupations of those who advocate for physician assisted suicide, and of the court judgements that have been rendered on this subject, is with protection of the vulnerable. It is a question of protecting the vulnerable from coercion, in situations where the vulnerable might be manipulated into seeking physician assisted suicide.

We could imagine a simple example of a vulnerable senior citizen who is pushed by a family member to seek physician assisted suicide because it is in the immediate financial interest of that family member for the vulnerable senior citizen's life to be ended.

In its ruling in the Carter case, the Supreme Court of Canada argued that it is vitally important to protect the vulnerable within any physician assisted suicide regime. The court also found that the trial judge (whose judgement was being appealed) made no significant error in finding that a regime of physician assisted suicide could be created with adequate safeguards that would protect the vulnerable from abuse and error. The conclusion was that physicians and medical institutions can assess individual cases and ensure that no person is being coerced into committing suicide.

The challenge, here, is that the logic employed by the Supreme Court of Canada is narrow, in terms of what it means to protect the vulnerable. What it fails to acknowledge is the way that the practice of physician assisted suicide will create a new cultural circumstance in which individuals, including vulnerable ones, will internalize a logic that characterizes their suffering lives as (i) too costly for the medical system, (ii) too great a source of grief for their family, or (iii) simply not worthwhile. When such ways of thinking are internalized within a culture, and within individuals, then those who seek physician assisted suicide for these reasons will not present as coerced or manipulated – rather, they will present as those who wish to end their lives and suffering. The idea that physicians would understand and resist this cultural transformation is nothing short of naïve. And the truth will also be that they have sought the end of their own lives for the reasons indicated which certainly represent a kind of coercion.

On the question of a person's cost to the medical system, we note that there have already been widespread media reports of a study in the *Canadian Medical Association Journal*, which recently found that physician assisted suicide has already saved the medical system between \$35 and \$135 million dollars.

On the question of minimizing the grief of one's family in watching oneself suffer, we note the comment of the complainant in the Carter case that "I do not want my mode of death to be traumatic for my family members".

On the question of seeing one's life as simply not worthwhile, we note, again, that the logic of "death with dignity" implies that a life of physical decline, loss of bodily control, and suffering is an undignified life. It will not take long for our culture to internalize these interpretations of life, and it is happening already.

Congregations, pastors, friends and family members need to be made aware of the potential risk to vulnerable people. They need to feel supported to be able to speak up and protect this population against any potential coercion, or those who give in to loneliness, fear, or the belief that their lives are not worth caring about or caring for.

Is physician assisted suicide a form of treatment?

Among those who advocate for PAS are some who proclaim that PAS is indeed a form of "treatment and care" for the sick, the suffering and the dying. We would differ on this point, contending that treatment is meant to provide comfort, relief and make living as meaningful as possible, until the natural functions of illness bring about death.

How do we relate to those who choose physician assisted suicide?

In life we sometimes find ourselves in situations that are relationally and ethically complicated. One way a situation or experience might be complicated is because we get the feeling that someone else thinks we agree with what they are saying or doing, when in fact we do not agree. For example, we may find ourselves listening to someone tell their story – and we are nodding along or saying “hmm” to let them know that we are attending to their words. Also in that sharing together we might find ourselves nodding along and saying “hmm” to something that we believe is contrary to what God intends for his people. Even if we act as a good friend or pastor by objecting to, or raising questions about, the other’s words or actions, there will still be moments when we might give the impression that we agree them, even if we are only trying to listen.

With this in mind, the question arises: How do we respond, personally and pastorally, to someone who has decided that he or she will seek physician assisted suicide? What should we say? How do we respond? And what if this person requests that we be present with them in the moment when their life is ended (whether at their own hand or that of a physician)? Would our presence in such a moment mean that we condone the act, even if we think that this approach to suffering and death represents a failure to live in obedience to Christ and his way?

These are difficult questions that require careful thought, and we cannot attend to every issue or nuance that arises. But perhaps the first part of an answer is to say that not everyone must respond to situations in the same way. Every relationship is different, each person is unique, and so we do not have to offer a one-size-fits-all answer to the question of how we accompany someone who has chosen physician assisted suicide.

There are different scenarios that face us with those who choose physician assisted suicide: is this an “advanced directive” – a decision someone is making and recording for their future? or is this an emergent or emergency situation, with someone who is in extreme physical pain, for example? How would our response differ if we were involved as a family member or friend, elder or pastor, Christian caregiver or medical personnel?

There may be someone (family member, friend, pastor or elder), for example, who feels that her presence would precisely indicate tacit approval of the action, and so this person would not feel comfortable being present. But there may be another person who similarly feels that his presence would indicate tacit approval, but who would not therefore be dissuaded from being present at the moment of death – perhaps this person believes that we cannot control every perception of others, and that we have no responsibility to do so. Again, there is no “one-size-fits-all response” to every circumstance.

We should also attend to the fact that The Presbyterian Church in Canada does not consider suicide a mortal sin that necessarily and invariably cuts a person off from God. Neither suicide nor physician assisted suicide is an unforgivable sin, and it is always necessary for us to accompany others in a way that embodies the grace of Jesus Christ and points to his grace.

This does not mean that there will not be moments when we invite faithfulness and obedience to the way of life and hope revealed in Christ, in the midst of suffering. But it does mean that being a faithful, prophetic or pastoral witness to Christ does not require that every parishioner, pastor, family member or friend display perfect obedience (how could they?) as we accompany and care for them in the name of Jesus.

What are social aspects regarding acceptance of PAS?

Cultural character appears to have an important aspect in the acceptance of PAS within a nation. However, cultural diversity within a nation can be widely different, and some ethnic groups approach end of life issues (and PAS) differently, requiring sensitivity of medical care workers.⁴ Democratic government, diminished religious activity, pluralism (diversity of views and understandings and means of identifying truth is the valid approach rather than a single approach or method of interpretation), the value attached to human self-determination (autonomy), candour (openness of expression of opinion) and individualist (emphasis on the moral value of the individual, promotion of the exercise of one’s goals and desires, independence and self-reliance) are all features of cultures accepting PAS.

It should be noted that many of the nations either permitting or forbidding PAS possess a well-developed national health care system, including palliative and hospice care; note, however, that the distribution of such services may be limited. This suggests that in the countries permitting PAS, euthanasia is seen as one option amongst a series of options for end of life care.

Religious belief plays a big role in attitudes towards PAS amongst both physicians and the general population.⁵ The pro-euthanasia view is, in part, a consequence of a growing belief in atheistic (agnostic) views throughout the world. Atheistic/agnostic views place humans at the centre of life, and this drive for “autonomy”, places all issues of life under the sole authority of humans; that is the control of, and responsibility for, human affairs lies with humans. This eliminates the need for, or denies entirely the existence of God, but also eliminates the benefits and responsibilities of belief in God. Religion challenges this view, placing God at the centre of life, with the concordant responsibility of humans (God-created life) to both respect and enjoy God’s providence and care. This God-centred view as expressed by the many religions is opposed to any form of PAS.

The issue presented by the autonomy view is that humans have the ultimate right to decide health care issues and end of life issues including control over when life ends either at one’s own hand with or a medical worker’s help (suicide, or PAS), or as directed by the consenting patient (voluntary PAS or voluntary euthanasia), but when combined with a utilitarian view of society, eventually may also permit euthanasia of non-consenting or non-competent patients (involuntary euthanasia).

Public opinion in the United States (and many other countries) has been increasingly favourable towards PAS since the middle of the twentieth century. This appears to represent a change in the sociocultural nature, driven by individualism, a collection of values (e.g. self-determination [or autonomy], pursuit of self-interest and may also possess certain pluralistic [acceptance of many views as an ethical principle].)⁶ The extent of individualism and attitudes towards PAS have been extensively studied in university students in the United States, Germany and Poland.⁷ They postulated that individualistic cultures (societies where people express a higher degree of belief in individualism) show a more favourable attitude towards PAS. To evaluate this, they asked university students to complete questionnaires using constructed quantitative scales of belief in principles of individualism and authoritarianism. Individualism was subdivided into *vertical individualism* (which emphasizes competition, winning and status inequality), *horizontal individualism* (which emphasizes distinctiveness and uniqueness amongst equal individuals, self-determinism [autonomy] and self-actualization), *vertical collectivism* (emphasizes on tradition, respect for family and respect for authority), *horizontal collectivism* (emphasizes, interdependence of and connection between common groups of people) and a scale reflecting belief in authoritarianism as a valid social construct. The results from these scales were compared with a scale showing the importance of the subject’s attitude towards PAS. The resulting data were analyzed using a mathematical model. Their results showed that horizontal individualism, that is the attitude towards self-determination (autonomy) and self-actualization, was associated with acceptance of PAS. However, their model showed that other factors (as yet unidentified) also contribute to a society’s view of PAS. This research supported earlier findings by the same researchers⁸ and suggests that society’s emphasis on autonomy plays a major role in the acceptance of PAS, but that other factors play a role.

What are secular ethical arguments for and against PAS?

The (secular) ethical arguments (summarized below)⁹ for and against PAS consider consistency with socially accepted practices and emphasize human autonomy, which now forms the basis of a medical practitioner’s general approach to dealing with patients,¹⁰ and a utilitarian view of healthcare resources. This latter point is seen, for example, in the proposal that in an era of diminishing resources, savings in healthcare costs is afforded by PAS implementation,¹¹ but they may be minimal.¹²

PAS position	Consistency with socially accepted practices	
	Aspect	Comments
For	Suicide is accepted (and legal)	Some acts of suicide are considered rational. For those who are disabled, and cannot tolerate their situation, they may need assistance in an end of life choice.
	From passive to active euthanasia	Withdrawing and withholding life-prolonging treatment is widely accepted and practiced. The “slow death” which ensues may cause more suffering than would a more rapid onset of death. Therefore, active euthanasia may be more ethically acceptable.

From painkillers to lethal injections

Widely accepted that administration of painkillers or sedatives, which may unintentionally shorten lifespan, are used as part of palliative care.

Euthanasia is allowed by ethical principles

PAS position	Aspect	Comments
For	Mercy/beneficence	The suffering experienced by the patient may be so great as to outweigh any benefits of continuing to live. Palliative care may not effectively address these needs. Even if passive euthanasia would result in less suffering, active euthanasia may be preferred in some cases.
	Patient autonomy	Respect for patient autonomy may include respect for their wish for active (or passive) euthanasia.
	Euthanasia in an age of resource limitation	Euthanasia decreases the costs involved in caring for terminally-ill patients, thus freeing resources to care for other patients (utilitarian argument).
Against	Palliative care overrides the need for euthanasia	Great advances in pain relief and other aspects of palliative care have been made, largely eliminating the argument for euthanasia based upon alleviation of suffering. Palliative care (especially pain control) is not yet “perfect”, but it is effective.
	Manipulation of others	Coercion of the severely ill or disabled (which are likely to be vulnerable) is disrespectful of patient autonomy.
	“Slippery slope” objections	If assisted suicide (voluntary euthanasia) is legalized, progression to non-voluntary euthanasia would be facilitated.
	Contrary to the aims of medicine	Medical practice aims to promote health and life and to “do no harm”.

What is the sanctity of life?

It may come as a surprise to hear that the sanctity of life is both a deeply meaningful idea and a somewhat ambiguous one. It is a deeply meaningful idea since it captures something of what the scriptures and the gospel reveal about human life. But it is also an ambiguous idea because it is sometimes used in ways that might depart from a Reformed theological and ethical framework.

The sanctity of life – or the holiness of human life – is rooted primarily in its quality as a gift of God. From creation, God called life “good”. In the Ten Commandments, God’s people are told “Do not murder”. Life is something given as pure gift, and is something we can only receive with gratitude and thanksgiving. Within the creation narratives this gift is characterized in the most remarkable terms, for those narratives reveal that man and woman, and these two in community with each other, are created in the image of God. The human resembles God – or we might say, has a share in the identity of God as relational, creative and rational. Human life is therefore precious and beautiful, and a treasure to be held in esteem and with care.

With the incarnation, the fundamental goodness of life is affirmed in decisive sense, for in Jesus Christ God takes on human flesh and identity – God takes on embodied, temporal human life, thereby declaring it good. Further, through the life, death and resurrection of Jesus, human life is redeemed and restored. Given that life is gift and treasure –

that life is fundamentally good – we understand that killing a human being means acting contrary to the creative, loving and redemptive purposes of God. It is to refuse the gift, and become master of it.

Having said all of these, we should also acknowledge that the idea of the sanctity of life is sometimes pushed beyond what the gospel requires. In some contexts, for example, the notion that life is sacred has meant we must make every possible effort to preserve life – in the sense of deploying every possible treatment and procedure that might extend or maintain life when death threatens. From this point of view, a failure to deploy every resource or technological capacity to keep a person alive is translated as a denial of the sanctity of human life.

Yet the sanctity of life does not translate into a fear of death or an avoidance of death – rather, we are invited to approach our death in the confidence that we belong to our faithful Saviour Jesus Christ in both life and death. We are not called to avoid death at every cost, but to approach our inevitable death with a confidence that God has walked through this valley with us, and will be present to us in our own dying.

The idea of the sanctity of life has sometimes also become the basis of a disproportionate privileging of human life over non-human life. That is, the view that human life is sacred has not always been held together with an affirmation of the sacred nature of all created life as given by God. This view has also neglected the New Testament witness that God in Christ is at work redeeming the creation itself, which groans in expectation of its redemption. While this hesitation about “the sanctity of life” may seem tangential to the questions we are addressing here, it should help us understand the limits of this concept.

Life is sacred. It is a gift. It is ours to receive with gratitude and thanksgiving. And the full implications of this must be worked out through theological and ethical reflection, in the way that we are attempting to do within this wider report.

Endnotes

¹ Brodkey, Harold, *This Wild Darkness: The Story of my Death*.

² Dr. Donald Low was a Canadian microbiologist most famous for his public role in addressing the SARS outbreak in 2003. He is also well known for a video that was produced in the last days of his life (when he was suffering from brain cancer), in which he expressed frustration that it is not possible to “die with dignity” in Canada.

³ *Yale Journal of Biology and Medicine*, 85/2 (2012), p. 271–284. Accessed at ncbi.nlm.nih.gov/pmc/articles/PMC3375669.

⁴ Searlight, H.R., J. Gafford. *Cultural Diversity at the End of Life: issues and guidelines for family physicians*. *American Family Physician* 2005, p. 71; p. 515–522. Nortje, N. Cultural perspective on euthanasia. *Research in Psychology and Behavioral Sciences* 2013, 1; p. 77–80.

⁵ Traina, C.L.H. “Religious perspectives on assisted suicide”. *Journal of Criminal Law and Criminology* 1998, p. 881147–881154. Baume, P., E. O’Malley, A. Bauman. Professed religious affiliation and the practice of euthanasia. *Journal of Medical Ethics* 1995, 21; p. 49–54. Lee, W. A. Price, L. Rayner, M. Hotopf. “Survey of doctor’s opinions of the legalization of physician assisted suicide”. *BMC Medical Ethics* 2009, 10; p. 2. Bachman, J.G., K.H. Alcer, D.J. Doukas, et al. Attitudes of Michigan physicians and the public toward legalizing physician assisted suicide and voluntary euthanasia. *New England Journal of Medicine* 1996, 334; p. 303–309.

⁶ Mwarira C. “Physician assisted suicide: an anthropological perspective”. *Fordham Urban Law Journal* 1996, 24L859–868

⁷ Kimmelmeier, M, G Wiczorkowska, H-P Erb, E Burnstein. “Individualism, authoritarianism, and attitudes toward assisted death: Cross-cultural, cross-regional and experimental evidence”. *Journal of Applied Social Psychology* 2002, 32; p. 60–65.

⁸ Kimmelmeier, M, E Burnstein, K. Peng, “Individualism and authoritarianism shape attitudes towards physician assisted suicide”. *Journal of Applied Social Psychology* 1999, 29; p. 2613–2631.

⁹ Adapted from Hope, T, J Savulescu and J Hendrick. 2003. *Medical Ethics and Law*, Churchill Livingstone, Edinburgh, Scotland. Chapter 5.

¹⁰ Hope, T, J Savulescu and J Hendrick. 2003. *Medical Ethics and Law*, Churchill Livingstone, Edinburgh, Scotland. Chapter 12.

¹¹ Singer, P.A., M. Siegler. “Euthanasia – a critique”. *New England Journal of Medicine* 1990, 322; p. 1881–1883.

¹² Emanuel, E.J., M.P. Battin. “What are the potential cost savings from legalizing physician assisted suicide?” *New England Journal of Medicine* 1990, 339; p. 167–172.

A pastoral response to PAS

Jesus made a circuit of all the towns and villages. He taught in their meeting places, reported kingdom news, and healed their diseased bodies, healed their bruised and hurt lives. When he looked out over the crowds, his heart broke. (Matthew 9:35–36)

Teaching the truth;
bringing the truth of the Kingdom of God to the people;
healing for the physical body;
healing for bruised and hurting hearts, minds, and souls.
All part of the ministry of Jesus Christ.
And behind the ministry – a compassionate heart;
breaking over the pain, the sorrow, the confusion, the needs of people for
truth, grace, hope and healing.

Ministers, elders, pastoral visitors and friends come face to face with people as Jesus did. In this day and age, we also come face to face with choices available to people as they and their loved ones face the end of life here on earth. Now, choices include the legal right to seek to terminate life at a specific time, after a process of consultation with medical professionals and ethicists.

Where is the pastor in the midst of this? People in our faith communities and those who call upon a pastor in a time of crisis seek our help. What help do we bring?

As Jesus did in his ministry on earth, our task is to teach the truth, bring kingdom news and hope to our people; bring grace and healing for bruised and hurting hearts, minds and souls; and bring our own compassion, and a ministry of presence, to every visit, every conversation with those who face chronic conditions and terminal illness.

In the course of ministry, outside of times of crisis and difficult decisions, our calling is to love the people God entrusts to us. Loving them through thoughtfully prepared and led worship, sermons, studies, fellowship, visitation, encouragement and pastoral care. We are called, as ministers of the Word, to teach the truth of the gospel of Christ and the Kingdom of God: that we belong to God, in life and in death; that we serve a God whose grace and love are more powerful than suffering and death; that God's great promise is for life eternal, and that life here includes suffering and service to those who suffer, in the name of Jesus Christ, with the Spirit's power at work. The foundation of this kind of ministry and pastoral leadership is of great help to people at any time, but especially in times of crisis.

When those times of crisis come, and when end of life choices are being called for, pastors do have a role to play, especially in the lives and decisions of followers of Christ. A few reflections for consideration; we look forward to responses from Presbyterians (and others) in Canada.

Our first response is to be present

It is often much more important to simply be present than to offer many words of wisdom. Pastoral presence, Holy Spirit led pastoral presence, brings a sense of hope, a sense of God's care to people who are grieving, frightened, in confusion and struggling with what to do or not do. In the hospital room, the Intensive Care Unit floor, the quiet room, chapel or interfaith space, a private home, a nursing home, an emergency ward, a doctor's office: any and all and more besides are places for pastors to be present, when news reaches or an invitation is given. A humble, quiet, servant-hearted presence in times of need is ministry in the name and manner of Jesus.

Our second response is to listen

Listening is an art, a skill, a gift. Listening is intentional; it requires self-discipline, energy, commitment and compassion. To listen as a pastor (or elder, or friend, or care-giver) means to listen in order to understand, not reply to the one speaking. To listen means allowing space for silence, tears, anger and questions that may not have or need our answers. When Job faced his multitude of sorrows, the best response from his three friends was simply their presence and their listening. When they began to speak and offer their advice or interpretation, their words of wisdom or attempt to find fault, trouble descended upon an already overwhelmed soul.

Our third response may be to speak

- If and when we speak, may we be well aware of our own opinions, experiences, prejudices and relationships *before* we offer any words. This moment, this crisis, this time of decision is not about us; it

about God and the persons involved. Pastors who pursue continuing education in the areas of pastoral care, end of life and crisis care do themselves and their parishioners a great service. Pastors who are part of healthy peer support groups, have a spiritual director or counsellor, and faithfully practice spiritual disciplines will be better equipped and guided in ministry at any time, but particularly in the challenges and opportunities of chronic debilitating conditions or terminal illness.

- Pastors are wise to draw their parishioners towards the Triune God, the God described in Living Faith 9.3.3:

The Bible witnesses to God in Christ
entering deeply into human suffering.
As we behold our Saviour on the cross,
we are convinced of God's love for us.
Faced with the pain and agony of the world,
only a suffering God can help.
God is with us in our anguish.

- Pastors are called to pray, pray with laying on of hands, anointing with oil and referring to scripture as they minister. The Psalms are an especially rich resource for God's people in times of crisis, sorrow and uncertainty.
- Pastors may be called upon to advocate for their parishioners; to help them find health care, ongoing care, and counselling resources; voice their concerns to medical and government care teams; and encourage the faith community to assist with transportation, food, respite care, practical needs and simple errands.
- Pastors can help bring the understanding of the Christian faith that suffering does have meaning:

...the suffering of our final days is not meaningless.

Though our outer self is wasting away, our inner self is being renewed day by day. For this light momentary affliction is preparing for us an eternal weight of glory beyond all comparison, as we look not to the things that are seen but to the things that are unseen. For the things that are seen are transient, but the things that are unseen are eternal.

(2 Corinthians 4:16–18)

Before anyone mocks the phrase “light momentary”, let that person realize that Paul was referring to his *lifetime* of suffering, the details of which are almost unbearable to read 2 Corinthians 11:23–28. “Light” contrasts with *weight* of glory. “Momentary” contrasts with *eternal*. Paul knew what it was to be “so utterly burdened beyond our strength that we despaired of life itself” (2 Corinthians 1:8). Such suffering was not light. It was not momentary. Except in comparison to the length and the glory of heaven.

But the point of this text is that our final sufferings are not meaningless. They are “*preparing* for us an eternal weight of glory”. “Preparing” – working, effecting, bringing about...¹

- Pastors can assure family members and loved ones of the person with a chronic condition or terminal diagnosis that they have a role to play that is God-given. The call to care for the vulnerable, the aged, the young, the sick, the troubled is woven throughout scripture. The familiar words of Jesus, “In as much as you have done this to one of the least of these, you have done it unto me” resound in the decisions and commitments many make to care for their loved ones through mental illness, chronic conditions and terminal diagnoses.

...the grieving spouses and mothers and fathers and brothers and sisters and sons and daughters are not merely watching. They are serving, caring, loving. Yes, suicide spares them the pain of watching. But it also denies them the privilege of serving. There are moments in the tireless care of the dying beloved that are so intense with self-giving love that they would not be traded for any death.²

- Pastors can be advocates for, involved in and work for quality palliative care in the communities where they serve. As stated earlier in this report, we believe this is a calling for us to take up with courage and deep commitment, with practical action and service. Palliative care offers expert, compassionate support and assistance to those who are, and whose loved ones are, facing the end of life. The availability of quality palliative care varies widely across Canada, from province to province, community to community, and between those in urban, rural and remote settings; the suitability of palliative care for a multi-cultural, multi-faith society also needs to be addressed.

Joni Earckson Tada, a long term quadrapalegic and breast cancer survivor, has spoken often about suffering, faith and end of life matters. Her voice carries credibility as one who suffers chronic pain, requires daily care in every detail of personal care, and has authentically struggled to come to faith, has said,

First, instead of pouring all of our financial resources in helping people die through physician assisted suicide, let us pour those resources into developing better pain-management therapies. You do not have to live in intractable pain. The problem is, there are so few doctors who understand good pain management, and there are good therapies which are now still in the research stage. We need to pour more resources into helping people die with dignity and into better palliative care and better pain management.

Second, when people are nonresponsive, I think that is an opportunity for family members to come around and support them through those final days. The critical issue is finding the difference between treatments that will sustain the life that one richly deserves as opposed to treatment that does nothing more than prolong the process of dying. No one should have to have the process of their dying prolonged with needless treatment. That is the challenge, and I think that is a good challenge for people in hospice medicine – to help families ascertain that clear distinction between treatment that will help life, and treatment that does nothing more than prolong the painful process of dying. We do not want that. That takes wisdom. That is why I encourage so many Christians to go into hospice care and palliative care, and also into pain management specialties. We need people who have a true handle on the wisdom of God to help families understand the difference between living and dying.³

What is our response if a decision is made that disagrees with what we believe?

For example, if someone chooses physician assisted suicide, or calls for medical intervention to prolong life, pastors need not feel compelled to bless or encourage the choice. Pastors do need to show humility, grace and compassion.

We would not share the stand as some other ecclesial bodies have made to deny pastoral care or funerals or memorial services to those who choose PAS. Ministers can still serve and care for persons whose choices differ from their own, with respect and care.

Pastors and faith communities may be called upon to support parishioners in health care professions who feel compelled or subtly pressured to be involved in treatment or end of life decisions that conflict with their own beliefs. The practices of presence, listening and wisdom in speaking apply here as well.

At the present time, the climate in the medical profession is still fluid. There have been suggestions that “thanatology” will become a specialization in medical schools and nursing programs, producing physicians and nurses who specialize in physician assisted suicide. There are those in the health care field who are facing challenges of ethics and conscience:

- The nurse who knows that PAS is being administered to the patient down the hall she has cared for on previous shifts and is troubled by this.
- The nurse who is also a single parent and needs a job – and the jobs listed would require him to be part of PAS, something he does not believe in, yet he needs the income to support himself and his children.

These health care professionals will need pastoral care and support in this brave new world we live and die in. Pastors will need to think through their own beliefs and responses. Congregations will need to be prepared to offer care in new ways to members who face these real life situations.

Upholding pastoral care ethics in each and every situation is crucial. Confidentiality, respect and appropriate boundaries are key foundations for every pastor or pastoral care servant. As noted earlier, the importance of self-care and a healthy spiritual life cannot be overstated.

These reflections on pastoral care during end of life matters are neither exhaustive nor to be seen as fiats. They are offered as points for reflection, discussion and ongoing education as we seek to serve God and God’s people in the manner of Jesus Christ, following the promptings of the Holy Spirit.

Questions for reflection

1. If you are a teaching or ruling elder, what questions has this section prompted in you?
2. What resources would help you think through your own “pastoral response” to PAS?

3. What palliative care options are available in your community? What do you know, and what do you need to learn, about what is offered? how might you and your congregation be involved? why would you be involved?

Endnotes

¹ Piper, John desiringgod.org/articles/we-are-not-our-own-on-god-brittany-maynard-and-physician-assisted-suicide.

² Ibid.

³ gospelherald.com/articles/62799/20160309/joni-eareckson-tada-discusses-todays-culture-of-death-why-the-church-must-be-at-forefront-caring-for-societys-most-vulnerable.htm

A Korean Perspective

The Presbyterian Church in Canada is a diverse denomination including congregations that worship in English, French, Korean, Chinese, Taiwanese, Hungarian, Spanish, Ghanaian, Arabic, Filipino and Portuguese¹. The membership of these different ethnic congregations within The Presbyterian Church in Canada is a testament of our denomination's openness and willingness to serve together in Christian unity.

Korean Canadian Presbyterians account for roughly 6,900 people, in average attendance, in approximately 30 congregations located throughout Canada.

As The Presbyterian Church in Canada prepares a report on physician assisted suicide, it is both important and helpful to include a very brief outline of some of the cultural aspects and traditions that affect the decisions of the Korean church members concerning end of life issues. It is our hope that this would be a gateway to understanding, respecting, learning about and learning from the various cultures within our denomination and our congregations.

One of the strongest underlying cultural aspects is filial piety (*hyo*). The concept of filial piety can be defined as "one's devotion to and respect for parents". Whereas western culture places more emphasis on individualism and autonomy, Koreans are grounded in family and community. According to a study of Korean American seniors,² the family is an integral part of the patient's diagnosis, treatment and decisions revolving around end of life issues. It is best described as "family-centred" where the responsibility of the family is to "hear the bad news about the patient's diagnosis and prognoses and to make the difficult decisions for those who are too sick or too ignorant to make meaningful choices".

This is not to say that patients, especially the elderly, give up their rights to make their own choices. Instead, they consider their family's involvement in the decisions about treatments as a sign of caring (Seo et al., 2000). Whereas in North American culture a greater emphasis is placed on individual autonomy to make end of life decisions, Koreans tend to lean heavily on their families in the decision-making. Families, on the other hand, take the responsibility of caring very seriously, to the extent of seeking aggressive care to "extend the patient's life and to provide every treatment", which at times, may be contrary to the wishes of the patient, who is ready to allow the natural process of dying to proceed and simply be kept comfortable. Churches can honour, uphold and respect Korean members and their families by listening, learning and walking alongside them when end of life matters arise. Churches can teach, offer small groups, forums and resources to assist their members explore and understand the issues around end of life, and navigating a health care system that can be overwhelming, frustrating and utilitarian.

Death is not a topic of regular conversation for many in general, and Koreans are no exception. As much as the Christian is promised life eternal, and death is only the beginning of that life, the hesitation to address the topic is this tiny belief that if one talks about death, one will hasten it. Many Koreans do not have an "advance directive" or a "living will" in place for end of life issues. It is almost taboo to talk to family members about their death, especially the elders, since completing advance directives is contrary to focusing on living.³ The church can encourage members' discussions about end of life issues as being part of the Christian journey so that individuals can be prepared and families can be informed of their wishes around end of life issues.

Koreans are reluctant to seek palliative care, as there is a sense palliative care means "giving up" fighting the disease. In Korea, palliative care and hospice are used interchangeably and is seen as a place where you go to die. Korean Canadians also have this understanding and do not seek palliative care that can give them quality of life as they receive treatment for their illness. Families who often have a "fighting spirit" when it comes to the wellness of their members can be assured that palliative care empowers the patient family member in dealing with the illness, and lifts of some of the tremendous stress placed on them.

It is important that The Presbyterian Church in Canada listen and learn from our “ethnic” members, as full partners; including and taking seriously their understanding and practices.

Endnotes

¹ The Presbyterian Church in Canada, presbyterian.ca/about/more

² Ethnicity and Attitudes Toward Patient Autonomy (Blackhall LJ, Murphy ST, Frank G, et al. *JAMA* 1995, 274; p. 820–825)

³ Advance Directives Among Korean American Older Adults: Knowledge, Attitudes and Behavior (Ko EJ, Berkman, CS *Journal of Gerontological Social Work*, 2012, 55; p. 484–502)

Stories of life and death

This section offers some true stories of Christian people who have experiences with making choices about life and death. We offer them, with thanks to the authors, for your reflection. We recognize that not every story will resonate with your experience or opinion. We welcome other stories to be shared on the website that will be set up. Being aware of privacy and confidentiality ethics before sharing an experience. All submissions will be moderated.

An end of life story – (Myrna Talbot of Knox Church, Toronto)

We had just finished our wills on November 28. Eleven days later, at 9 am on an ordinary Tuesday morning, Les, my husband of 31 years turned to me and said, “I can’t move my left arm – think I am having a stroke!” No time was wasted in calling an ambulance and we were at St. Michael’s hospital within the half-hour. I spent the next few hours trying to make life and death decisions while in a complete state of shock. I was thankful that my former pastor, my husband’s best friend, joined me at the hospital almost immediately and walked beside me, offered me support, prayer and wise council as I, zombielike, made the decisions that needed to be made.

The CT scan revealed an eight-inch brain bleed. I suddenly found myself surrounded by a team of medical professionals with papers to sign, asking me if I was *sure* that I wanted them to operate, warning me that it was a very significant aneurism, offered very little hope of recovery and a spectre of hard times ahead. But I felt that I needed to give it every chance; perhaps God would work a miracle! The surgery was completed by one of Canada’s top neurosurgeons: a man of faith who also believes in miracles.

The first week following the surgery there seemed to be hope. Les was responding to simple commands – he could squeeze my hand, give me thumbs up, and wiggle his toes when I asked him to. He even wrote “I love you” on my hand. However, his left side was paralyzed and he could not open his eyes. He was on a ventilator.

By the second week, the effects of the aneurism began to overwhelm his body and his condition began to deteriorate. Blood clots formed in both pulmonary arteries. Then he had a heart attack. On the advice of the neurosurgeon, I agreed to blood thinners to dissolve the clots but they started the brain bleed again. His kidneys and pancreas began to shut down.

After talking it over with my pastors, I requested a meeting with the medical staff. I was joined by two of my pastors and their wives, who weighed in with their observations and perspectives. I brought with me to the meeting the personal directive that Les had written in his will only days before. It read, “If at such a time the situation arises in which there is no reasonable expectation of my recovery from severe physical or mental disability to a state of meaningful interaction with loved ones, family or friends, I direct that I be allowed to die and not be kept alive by medications, artificial means or ‘heroic measures’”. I read the statement and asked the medical team if, medically, Les’ condition had reached this point. They all agreed that he was only being kept alive with the assistance of machines, and that following the directive involved removing them.

I spent the afternoon talking to the children and grandchildren, and ensuring they had said their goodbyes. That evening, a gathering of ten close friends (and our daughter by phone) surrounded his bed. We read his favorite scriptures. As we prayed and sang, the nurse slowly unplugged the machines. We were singing “Sleep in heavenly peace” when Les took his last breath. I kissed him and said, “The angels are coming for you, darling!” I held his hand as gave up his spirit. It was a holy moment.

Observations: From my own personal experience I offer the following, which may prove helpful in guiding others through this difficult process:

1. Prepare a personal directive that clearly outlines your end of life wishes. I was so thankful that Les and I had had the discussion, and that I knew exactly what to do to carry out his wishes.
2. Engage your pastors. I was fortunate enough to be surrounded by four of my current and former pastors who knew Les and I well, and who were able to address the ethical side of the decisions that had to be made. The comfort and support they offered was profound. And in the dark moments of grief that followed, I had the peace of knowing that I had acted ethically in the situation, and not just done what was best for me.

Questions for reflection

1. Who would you call in a time of crisis? Why? What kind of help and advice would you hope they would offer you and your loved ones?
2. What influence does your faith have in preparing your wishes for the end of life – your own, and/or a loved one?
3. Would you agree that “death” is “a holy moment”? why or why not?

Living and dying with ALS – (Maureen, Doug’s wife)

March 5, 2008 was the most devastating and life changing day of my life. My husband of 28 years was showing signs of muscle atrophy in his left hand and after a visit with a neurologist he was diagnosed with ALS (Lou Gehrig’s disease). We were told this disease was fatal with no proven treatment to slow the progress. Life expectancy for Doug was estimated at two to five years.

Doug accepted this with courage and calm. I fell apart. Being a nurse, I knew what to expect in the ensuing years as Doug’s muscles wasted away. Unable to speak, swallow, move and finally unable to breathe. Imagining the future was heartbreaking and sad.

Doug was determined to live life to the fullest. He had retired from the police force the year before and had taken up driving as a tour guide for Toronto tours. He enjoyed meeting people from around the world and was proud to show them the city he loved. Although life went on essentially unchanged for a couple of years the diagnosis of ALS was a heavy burden to bear.

By January 2010, Doug’s speech had become slurred and his left arm was lifeless so he resigned from his job. In that two year period Doug had travelled alone to the Philippines to visit friends, we had explored England and Scotland, he continued as an active elder at our church, and was a loving and wise husband and father to myself and our two daughters.

By February 2011, Doug could not swallow food or liquids including his own saliva. We travelled with a suction machine which he or I would use if his secretions became overwhelming. He was losing weight. At this point he had to make a decision: Would he accept a feeding tube inserted into his stomach? I and his medical team encouraged him to agree to the feeding tube so he would not continue to lose weight and so he could receive his daily medications. He agreed but stated that this was the only intervention he wanted. He did NOT want CPR nor to be placed on a ventilator should he experience respiratory difficulty or arrest.

For the next ten months, Doug’s muscles continued to deteriorate and eventually he was confined to a motorized wheelchair. Doug was using an iPad to communicate. During the following months, he was able to enjoy his youngest daughter’s wedding, even escorting her down the aisle. Ian, our first grandchild was born, and Doug had enough strength in his right arm to hold and cuddle him.

In early December 2011, Doug was admitted to hospital with a fever which was the result of serious infections. We thought he was responding to treatment but one evening, unexpectedly, he experienced severe difficulty breathing. The arrest team was called and I was asked whether he wanted to be ventilated, considering his diagnosis of ALS. When I asked Doug, he shook his head “yes”. So, he was ventilated and sent to ICU. I thought this was the end, but the next morning I received a call from our minister telling me that Doug was alert and in good spirits though still ventilated.

Over the next week they tried to wean Doug off the ventilator with little success. After a week, the medical team approached us with the idea of performing a tracheotomy. Doug was against that and wanted the tube removed. The tube was removed and miraculously Doug breathed on his own.

He lived for another two weeks in palliative care during which time our family, a few friends and our pastors spent precious time loving and supporting him in his final days. It was a gift from God.

Observations

1. Doug was a strong Christian and throughout his life's journey he maintained a close walk with God, believing that nothing could separate him from the love of God, in Christ Jesus. I know that his relationship with God influenced how he lived with ALS and the decisions he made surrounding treatment.
2. Doug loved life and his positive attitude made all the difference. In dealing with ALS he dwelt on the positives, what he could do, not on what he was no longer capable of.
3. As the disease progressed, Doug was informed and supported by the medical team but he was allowed to make his own decisions. If he had wanted to live on life support they would have accepted that.
4. We as a family were advocates for Doug's wishes when he could no longer communicate. Shortly after he was diagnosed a will was drafted and I was designated as the Power of Attorney for personal care. In the end we were content that Doug's wishes were honoured, although he was not able to die at home as we hoped for.

Questions for reflection

1. What parts of Doug and Maureen's story touch you? Why?
2. Is there something you would do differently, if faced with the same circumstance, either as the patient or the caregiver? What would that be? Why would you do things differently?
3. If you were Doug and Maureen's elder or minister, how might you care for this couple on this very difficult journey?

Encouragement unaware – (Dr. M. Terence O'Reilly)

Dr. O'Reilly was born and raised in Canada, and became a member of The Presbyterian Church in Canada as a young adult. His post-doctoral studies led him from McGill University overseas, where he accepted a position in cancer research with a leading multi-national pharmaceutical company in Switzerland over thirty years ago. Dr. O'Reilly has had a successful career in cancer research, but has been on an early retirement due to disability. Dr. O'Reilly was diagnosed with early onset Parkinson's Disease 18 years ago; and is currently undergoing his third battle with non-Hodgkin's Lymphoma cancer.

PAS is legal in Switzerland; several para-health care organizations facilitate PAS; the most popular organization is named "EXIT". PAS is one of the "treatment options" that terminally ill patients are offered. Patients with pending poor outcomes of their diseases often establish PAS as an advance directive. In conversation with people who have chosen PAS, it appears that the main reason for this choice is the unwillingness to endure suffering associated with disability, or the humiliation of loss of independence, rather than fear of extreme pain that may be associated with the final stages of their disease. Rather than suffer with them, those who choose PAS thus remove themselves from any communities of families, friends and others facing sickness and death.

Many do not choose PAS. As a cancer researcher, I am well aware of treatments, prognoses and the difficulty of predicting outcomes. I am also aware of the need for, and medications available for, successful pain relief in most cases. As a three-time cancer (mantle cell lymphoma) survivor, I have spent much time in hospital, for which I am grateful to have access to excellent health care. I have also had access to excellent people: physicians and health care staff who have taken such good care of me; but it is my fellow cancer survivors who have inspired me. These are true heroes in my eyes, whose stories will not make the news, but have affected me, even though I never spoke to many of them. Here are some of the moments that stay with me.

The elevator opened, and I saw them again, perhaps the third or fourth time I witnessed the same event. A boy and a girl, about 7 or 8 years old, came running out, dashing down the hallway along a well-known path to visit someone they obviously were excited to see. They were always only accompanied by a man, perhaps in his late 30s, who was a bit bewildered and perhaps slightly embarrassed by this enthusiastic spectacle, but his attempts to contain the passion of the children appeared half-hearted and doomed to failure. Who was the person these children so excited to visit? A mother, or perhaps a grand-parent? But for me, the more important question was, "How did this person induce such love?" A friend of mine told me "When you are sick you need to be loved, but you are probably at your least lovable state". In their least lovable state, someone was able to induce love from two children – and children

are pretty good judges of authenticity. Perhaps with selfish intent, I am constantly challenged to become a person who could induce such love.

I shared a room with him, but only for two nights as his round of chemotherapy was finished. He had yet again tolerated his treatment and was going home. Although he was tired, we had some good conversations. He was a wine maker from the French-speaking part of Switzerland near Neuchatel. He told me how he was looking forward to returning to his vineyard and start making wine again. But his voice revealed that the simple words he used were describing his passion, not just his occupation. He had a reason to survive his cancer and he was closer to achieving this. This challenged me to access my goals and the many reasons to fight my cancer, for like him, I was not done with life just yet.

I saw her on one of the many hallway walks I was encouraged to make by the health care staff. She was an older lady, perhaps in her late seventies. She stood, resting ever so gently on her cane, outside the room where outpatients received their treatments. Although I never saw her face, she was turned towards the doorway and speaking to the staff simply saying “Thank you for all of your help. See you in five years.” This lady had finished her chemotherapy regimen and was now on the path of being a long-term survivor! Her response to this was gratitude. As she walked away, I hoped that I would be like her.

Our station nurse introduced us. He was an American in the next room, so our common language provided the initial connection which was later strengthened by our shared belief in Jesus Christ. Despite his terrible prognosis, he was authentically positive, his words of salt and light pushing away the darkness that tried to engulf us. He also shared with me how impressed he was by a special carol service he recently attended, and in particular the sermon he heard at that service – service offered by my own congregation. Although I missed that service due to illness, I was able to introduce our minister to him, which proved to be a blessing to both. He was so pleased to speak to our minister, and our minister was impressed that God has used him to speak to and encourage another. His positive demeanor strengthened me and the opportunity he provided to serve both him and my minister provided hope to me that even in my depleted state, I could accomplish good things through small actions.

Some people have the ability to light-up a room as they enter. The outpatient cancer treatment room is often a gloomy place. Cancer patients receiving sickness-inducing chemotherapies are often gripped by the fear that the drug infusions cause suffering without producing cure.

One time when I was receiving a rather benign, but surprisingly effective, red blood cell transfusion, a woman walked in, and at least for me, the room filled with light. Standing straight and tall, with the only sign of her cancer was a brightly coloured scarf over her head to cover her chemotherapy-induced hair loss. She smiled at the medical staff as she calmly waited for a bed to become free. There was no anxiety in her voice or in her body language. As the bed next to mine became free, she took this place and calmly waited for her drug infusion to be brought in. She winced as the needle punctured her vein, showing she was not some super-human who was immune from pain, smiled at the nurse who produced the moment of pain, and returned to her book while the taxol dripped into her bloodstream. She was for me a beautiful person, filled with grace, serenely bearing her suffering with dignity. As my therapy finished, I left the clinic, with this image of her seared in my mind causing me to want to be like her.

All of these people could have chosen PAS. If they had, their opportunity to encourage a fellow struggler would have been lost. I do not know what became of each of these people or even if they eventually chose PAS as a way to end their suffering. But somehow I think not, as their will to live seemed so strong. They had much to live for; and in these small moments, gave much to me. What I do know is how grateful I am for the encouragement they gave me, unknown to them; they were examples of hope, strength and courage which helped me. Ultimately they ministered to me, and led me to become a better, fuller person.

I am glad they did not choose PAS.

Questions for reflection

1. Can you think of a time when someone else – known or unknown to you – encouraged and influenced you?
2. As people of faith, how might we witness to Christ without a word when facing end of life issues ourselves or with our loved ones?
3. Is there meaning in suffering, in your understanding and experience? What stories can you share?

The subcommittee is seeking those within our denomination, and has found at least one member of The Presbyterian Church in Canada, who would seek PAS for themselves or their loved one and is willing to share their story. It is our intention to offer these stories and subsequent questions for reflection as well.

The end of the beginning

The committee is grateful for the opportunity to explore this matter, and realizes that we have truly just begun. There is much more to learn and read and listen to; the effects of the legislation in Canada are new, and practices, ethics and responses are being shaped daily.

We anticipate that the response of The Presbyterian Church in Canada will also be formed and shaped in new ways as time proceeds. It is our hope and prayer that the work we offer here will help Presbyterians in Canada continue think deeply, faithfully, lovingly and respectfully about the matters of life and death in our time and place.

We are thankful for the gospel of Jesus Christ, for the assurance of the grace of God, and the comfort and peace of the Holy Spirit, as we journey through this issue, and for the assurance of the Apostle Paul,

For we know that if the earthly tent we live in is destroyed, we have a building from God, a house not made with hands, eternal in the heavens. For in this tent we groan, longing to be clothed with our heavenly dwelling –if indeed, when we have taken it off we will not be found naked. For while we are still in this tent, we groan under our burden, because we wish not to be unclothed but to be further clothed, so that what is mortal may be swallowed up by life. He who has prepared us for this very thing is God, who has given us the Spirit as a guarantee.

So we are always confident; even though we know that while we are at home in the body we are away from the Lord – for we walk by faith, not by sight. Yes, we do have confidence, and we would rather be away from the body and at home with the Lord. So whether we are at home or away, we make it our aim to please him. For all of us must appear before the judgement seat of Christ, so that each may receive recompense for what has been done in the body, whether good or evil. (2 Corinthians 5:1–10)

What then are we to say about these things? If God is for us, who is against us? He who did not withhold his own Son, but gave him up for all of us, will he not with him also give us everything else? Who will bring any charge against God's elect? It is God who justifies. Who is to condemn? It is Christ Jesus, who died, yes, who was raised, who is at the right hand of God, who indeed intercedes for us. Who will separate us from the love of Christ? Will hardship, or distress, or persecution, or famine, or nakedness, or peril, or sword? As it is written, "For your sake we are being killed all day long; we are accounted as sheep to be slaughtered." No, in all these things we are more than conquerors through him who loved us. For I am convinced that neither death, nor life, nor angels, nor rulers, nor things present, nor things to come, nor powers, nor height, nor depth, nor anything else in all creation, will be able to separate us from the love of God in Christ Jesus our Lord. (Romans 8:31–39)

Recommendation No. 3 (adopted, p. 25)

That the above interim response to physician assisted suicide be commended for use by agencies, colleges, congregations, sessions, presbyteries, synods, committees and groups within The Presbyterian Church in Canada and that comments be reported back to the Committee on Church Doctrine by January 31, 2018.