

Frequently Asked Questions about Euthanasia & Assisted Suicideⁱ

1. What are euthanasia and assisted suicide?

Euthanasia is acting, or not acting, in such a way so as to directly and intentionally bring about someone else's death (i.e., homicide), whereas assisted suicide is when a person kills himself, but with the aid or encouragement of another.ⁱⁱ

2. Why are they wrong?

Euthanasia and assisted suicide are wrong because they involve one person assisting or committing the intentional killing of another person. Civil societies reject, rather than embrace, such killing. Civil societies consider human beings to have inherent dignity and worth. Civil societies acknowledge that everyone has a right to life, not because of some feature they possess (e.g., age, ability, sex, or belief) but rather because of *who* they are (members of the human family).

Someone may respond, "But what if the person being killed requests to be killed? Doesn't that factor make ending their life acceptable?" If it is okay to kill someone when they request it (e.g., assisted suicide), but not okay when they do not request it (e.g., shooting people in a movie theatre) then killing innocent people cannot be considered *inherently* wrong; instead, it can only be considered *conditionally* wrong. The danger with that is this: who decides the conditions? A condition that seems reasonable to one person could seem unreasonable to another, so the determining factor of whether people are killed or not would become dependent on the will of either the majority and/or of those who hold power. That flies in the face of human rights doctrines.

Consider the United Nations Universal Declaration of Human Rights, which was adopted by the UN General Assembly in December 1948. It says the following:

...recognition of the inherent dignity and of the equal and inalienable rights of all

*members of the human family is the foundation of freedom, justice and peace in the world...All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood...Everyone has the right to life, liberty and security of person.*ⁱⁱⁱ

What is a "spirit of brotherhood"? What is it about familial relationships that make them something worth modelling? It is the notion that humans are to be treated with kindness, respect, and charity; in other words, family members don't kill each other. So to maintain a "spirit of brotherhood" is to ensure we do not kill people. If one person has a right to life, another person is not to deprive her of that.

Moreover, what's significant about this human rights document is that it was adopted within the same decade as World War II when human rights had been considered conditional, *not* inherent. As a result, some humans (e.g., Jews, homosexuals, gypsies, the disabled) were killed. The *universal* declaration of human rights became a remedy to this, abolishing the idea that fundamental rights are conditional. Its history is described as follows:

With the end of that war, and the creation of the United Nations, the international community vowed never again to allow atrocities like those of that conflict happen again. World leaders decided to complement the UN Charter with a road map to guarantee the rights of every individual everywhere.^{iv}

Some may nonetheless persist in highlighting a dying person's desire to be killed; however, just because someone says they desire something, doesn't mean we should follow through. Consider what we do when a depressed teenager threatens to hang himself: Do we help him hang himself, or do we strive to stop him? What about an anorexic girl who is starving herself in a slow suicide? Do we encourage her to restrict food intake, or do we instead try to return her to health?

If suicide is wrong for these teenagers, why is it right for a dying cancer patient? Some might say because the latter is someone clearly at the end of her life whereas suicidal teenagers technically are not. Ultimately, however, the cancer patient and suicidal teenagers may wish death for the same reason: because they wish their suffering to cease. Whether one person's suffering is physical and another's is emotional is a distinction without a difference. If suffering, and a personal desire, is grounds to aid killing, consistency compels us to allow killing for any type of suffering, including for those teenagers. That is the problem when the right to life is conditional. Instead, when the right to life is inalienable, humans who will all eventually die naturally will at least be protected from being killed purposefully.

Consider this perspective from Liz, a mother of four, who is living with advanced, incurable, kidney cancer:

The moment we label suicide an act of dignity, we've implied that people like me are undignified for not ending our lives; or worse, we're a costly burden for society. What a lonely, uncharitable, and fake world we live in if we think it's somehow undignified to let people see us suffer, to love us and care for us to the end."

3. What about those who suffer—don't they need euthanasia and assisted suicide to alleviate that?

There is no denying that death is a part of life. So is suffering. In many ways, throughout one's life—not just at the end—suffering is a reality. The simple mantra we should live by is this: ***Let us alleviate suffering, not eliminate sufferers.***

In order to alleviate suffering we need to identify *why* someone is suffering. Identifying that will allow us to address what is underneath the request to die so that we can develop a truly appropriate response. By way of analogy, consider when a patient comes to a physician about abdominal pain—a good doctor finds out *why* the patient is experiencing abdominal pain, and then addresses that. Or consider a teenager who cuts—a good counselor finds out *why* she is doing that. If the pain in the former patient is because of cancer and the cutting in the latter patient is because of memories of childhood molestation, we see the original problems that got our attention are actually

just symptoms. Those who care don't stay on the level of symptoms—they dig deeper so they can truly help a person.

So now consider if someone is suffering and they say they want to die—that is the symptom. Asking why helps us identify what the problem is:

- a) Are they in physical pain?
- b) Are they in emotional pain?
- c) Do they feel like they are a burden? Have they put their worth in their accomplishments, and in the absence of being able to *do* much, do they feel worthless?

Each of these situations are problems that need to be addressed—what matters is *how*. We need to kill the problem without killing the person.

a) Physical Pain

Physical pain can be an excruciating experience of suffering and we ought to respond. The way to do so is to provide medication that will alleviate such pain. And thanks to advancing technology and research, we can do that: “Conventional medications such as morphine and other narcotics are able to control up to 97% of pain.”^{vi}

Moreover, if we kill people instead of killing pain, we won't have motivation to develop better pain management. Indeed, as family physician and chair of the Euthanasia Prevention Coalition, Dr. Will Johnston, once said,

When you see only death as a solution you throw creativity out of the window. Medical diligence goes out the window. The need to actually solve the problem, the need to actually examine the patient, and find a solution, goes out the window.”^{vii}

b) Emotional Pain

Some people who are dying may experience profound emotional pain from regrets in their lives, broken relationships, fear of the unknown, of suffering, or of the process of dying, or they may experience emotional pain from unfinished business related to relationships, practical matters, and spiritual questions. Resolving unfinished business, however difficult, leads to a better death than “escaping” these problems through euthanasia. And so, if any of this is the case, a truly compassionate person would journey

with the individuals *through* this, making sure they don't feel alone, and helping them seek answers, closure, and healing.

In 2013, Pope Francis spoke in Lampedusa, a small island off the coast of Italy where migrants often travel there by sea from Africa, many of them losing their lives during the rough journey. In remembering such tragedies there, Pope Francis said the following during his visit regarding suffering:

Who among us has wept for these things and things like this? Who has wept for the deaths of these brothers and sisters? Who has wept for the mothers carrying their babies? For these men who wanted something to support their families? We are a society that has forgotten the experience of weeping, of suffering with.

In moments of emotional fragility, there can be comfort when another simply suffers with, when another weeps with. When the suffering soul doesn't feel alone, when he knows his suffering can be shared, he can take comfort in what's left of his life by immersing himself in relationship with others.

c) Feeling Like a Burden/Feeling Worthless

Generally it is human nature to not want to overburden another. Some people who are dying may feel that they are stretching their friends, family, or "the system" too much. If a caregiver is tired, stressed, or drained, the dying person may take the blame, feeling that they are responsible. If that is the case, however, shouldn't we eliminate the impressions we give, rather than eliminate the person who needs help?

Having said that, it is important to acknowledge that taking care of the sick isn't easy. The ultimate reason for this difficulty, though, is the disease, not the person herself. Instead of blaming her for the burden, shouldn't we share the burden?

Consider pro-life speaker Camille Pauley^{viii}. Many years ago she spoke about how she visited an elderly, unresponsive man in a hospital. It didn't matter that he couldn't hold a conversation with her, because what mattered was that she communicated, by her time and presence and love, that he was valuable, that he was unrepeatable and irreplaceable, and that he had dignity by his very existence, not by anything he could do. By simply "Being With" (the name of the program she

developed for this very outreach), she affirmed his worth.^{ix}

That is a powerful way to alleviate suffering, particularly for someone who feels worthless because they can no longer "accomplish" anything. By "being with" we are communicating to them that their value is in who they are, not what they do.

Consider, for example, what we tell teenage girls with self-esteem issues: Your value, we say, is *not* in how popular you are, how intelligent you are, or how accomplished you are. Your value is in *who* you are. Or consider babies: they do not accomplish anything besides eating and sleeping; they don't discover cures for cancer or invent technology to make our lives easier. But we value them nonetheless—even if they do not live beyond infancy. If this is true for the teenager or the infant, it is true also for the dying person: Our accomplishments may say something about us, but they do not define us. Since we exist, we have value. The presence or absence of abilities does not impact our value. Therefore, if someone feels they have no value because they cannot do much, the solution is to change their perspective, to remind them of this fundamental truth that their worth isn't in their accomplishments.

That is the message conveyed in a billboard campaign of the Canadian Down Syndrome Society; alongside a picture of a little girl with Down Syndrome is this simple caption: "Celebrate Being." Indeed, while some of us may "do" a lot, we are ultimately human *beings*, not human doings, and we should simply celebrate that we *are*.

Moreover, it is worth pointing out that the suffering and dying who need us to care for them actually do accomplish something very important and profound: They give us able-bodied individuals an opportunity to look outside ourselves. So whether we just sit and hold their hands, or read them a book, or sing them a song, they give us an opportunity to love.

5. What is a good alternative to assisted suicide and euthanasia?

Having identified three underlying problems behind a request to be killed before natural death, we can see that the way to truly help people in this situation is to provide a) proper pain relief and b) give our presence.

One thing we cannot do, however, is take away the reality that the person is dying. Proponents of euthanasia may characterize opponents of euthanasia as people who want to keep others alive forever: That is simply not true. Opponents of euthanasia recognize death is inevitable; it is just that they won't inflict homicide; instead, they let nature take its course while offering physical and emotional comfort.

This is what palliative care does, which is a great alternative to euthanasia. Consider this definition:

Palliative care is care given to improve the quality of life of patients who have a serious or life-threatening disease, such as cancer. The goal of palliative care is to prevent or treat, as early as possible, the symptoms and side effects of the disease and its treatment, in addition to the related psychological, social, and spiritual problems. The goal is not to cure. Palliative care is also called comfort care, supportive care, and symptom management.^x

The goal isn't to cure because it is recognized cures don't yet exist. So when eliminating the disease is beyond our human control, giving care and attention to those inflicted with the disease is still very much within our control. And when we handle that properly, people are unlikely to request euthanasia. Consider the words of Jean Echlin, RN, MScN, a nurse consultant in palliative care:

With 26 years experience as a palliative care nurse specialist and consultant[,] I have been at the bedside of more than one thousand dying individuals. Thus, I can assure you that persons who receive timely, appropriate and expert pain and symptom management, including attention to significant socio-spiritual, psychological and emotional issues, do not ask for assisted suicide or euthanasia. With the inclusion of family members as the 'unit of care,' people want to live as long as possible! In fact, good hospice/ palliative care can actually extend the life span. As well, it gives patients an improved quality of life at the end of life.^{xi}

6. How do I guard against being euthanized if I become gravely ill?

Some people would suggest a living will, which is an advance directive that puts in writing, in advance of serious illness, the direction you would like the medical community to take, or not take, when it comes to interventions/treatment in such a situation. In theory this seems like a good idea; however, in practice it is unwise. The reason for that is as follows: The course a particular disease takes can be different for different people. Correspondingly, certain interventions/treatments can affect different people differently (just consider pharmaceuticals: these come with possible negative side effects, but not everybody will have those side effects). It's really only in the moment, when a person is facing an illness and possible interventions, can the best course of action for a unique individual be determined (especially considering that there could be medical advances developed after a living will was written).

What, then, is an alternative? Instead of a living will, people should appoint a surrogate, described as follows:

We can choose a surrogate, a living person, who will make health care decisions in real time on our behalf if we are rendered unable to do so. The proposed surrogate (also called a 'health care proxy') is someone who cares deeply about us, who loves us, and is reasonably able to make decisions in accord with our known wishes and with our best medical and spiritual interests in mind. Filling out a form to designate our health care proxy is something that each of us should do as a sensible way to prepare for difficult end-of-life situations that may arise. Preparing such a document can also prompt us to begin discussing these important topics more effectively with our families and loved ones.^{xii}

So what should guide people who act as surrogates when someone is incapable of making their own medical decisions?

- a) Respect for the dignity of the person and their life.

The disposition of surrogates should be one of seeing the patient's life as valuable and to be protected from intentional death.

- b) Determining whether an action is proportionate or disproportionate.

Proportionate: "Any treatment that, in the given circumstances, offers a reasonable hope of benefit and is not too burdensome for the patient or others."^{xiii}

Disproportionate: "[A]ny treatment that, in the given circumstances, either offers no reasonable hope of benefit (taking into account the well-being of the whole person) or is too burdensome for the patient or others, i.e., the burdens or risks are disproportionate to or outweigh the expected benefits of the treatment."^{xiv}

For one individual, an intervention may **not offer a hope of benefit and it be excessively burdensome**, so that patient (or the surrogate) could deny such a treatment. But for another individual, the body may react differently, and there could be a hope of benefit and it not be excessively burdensome—so such an individual should accept treatment.

Those two criteria are good because they are objective standards to measure against an individual's condition and a proposed method of treatment. It is important to note that this perspective purposefully does not consider an individual's "quality of life." Such a standard is subjective. Someone who cannot imagine wanting to live as a quadriplegic might hold a different perspective once in the situation; persons with disabilities can attest to this. Setting quality of life as a standard also places value on another for what they can do as opposed to what they are. Certainly we should aim to make peoples' lives as good as possible, but when struggling to achieve that, we shouldn't end their lives.

- c) Distinguishing treatment from care

Contrasting treatment versus care enables us to see that some human needs are so basic, they shouldn't be classified as "treatment" (something only those with specific conditions need) but, rather, "care" (something everyone needs).

Administering nutrition and hydration is an example of care, not treatment, because food and water are basic requirements for humans to live. The general rule should therefore be to administer these. The exception to this rule (but not the rule itself) of not

administering these would be if this care became excessively burdensome and had no hope of benefit. Although rare, this can happen:

For example, a patient in the last stages of stomach cancer is already dying from that condition. Such a dying patient, or others who can speak for the patient, may decide to refuse further feeding because it causes pain and gives little benefit. The administration of nutrition and hydration in this case would pose a burden on the stomach cancer patient that is disproportionate to its benefit.^{xv}

- d) Comprehending the Principle of Double Effect

Administering some pain medication may have the effect of shortening a person's life. As a result, some may suggest that if pain medication does this, that it is euthanasia. That is not accurate. A helpful way to understand this is to consider The Principle of Double Effect:

1. *The action in itself must be good or indifferent. The action must not be intrinsically evil.*
2. *The good effect cannot be obtained through the bad effect (because then the end would justify the means).*
3. *There must be a proportion between the good and bad effects brought about (e.g. life against life); The foreseen beneficial effects must be equal to or greater than the foreseen harmful effects (the proportionate judgment).*
4. *The intention of the subject must be directed towards the good effect, and merely tolerate the bad effect.*
5. *Some say there is also a fifth requirement - that there does not exist another possibility or avenue.^{xvi}*

The action of administering pain medication when someone is in pain is a good, not an evil action, so it fulfills the first criteria. From that good action flows two effects: The good effect is the alleviation of pain; the bad effect is the shortening of the patient's life. There is proportion between these effects, and the intention should be directed toward the good effect. Of course, if there were pain medication that only had the good effect and not the bad, that ought to be used. But in the absence of an alternative, it is not killing a person to administer pain killers, it is killing pain. It

is worth noting that when administering pain killers, only the amount necessary to actually alleviate the pain should be administered. If someone gives more pain killer than necessary (wrong action) with the intention of killing the patient (wrong intention), then that is immoral. But if someone gives the amount of pain killer necessary to alleviate pain (good action) with the intention of helping the living patient (good intention), then that is moral.

In all of these situations, it is important that one's surrogate be aware of terminology and communicate clearly with the doctors. They should ask lots of questions and be aware that euthanasia will become veiled, so the surrogate should clarify what is being proposed.

Finally, when acting as a surrogate for someone who cannot express themselves, besides following the guidelines in this document, use this resource: The National Catholic Bioethics Center (www.ncbcenter.org) has a 24-hour/day, 7 days/week ethical consult phone line (215-877-2660) for people whose loved ones or patients are in a situation where an ethical analysis is needed for a medical situation. You do not need to be Catholic to call them.

7. What if people argue that it is the role of the medical community to provide assisted suicide or euthanasia?

To answer that question we must ask another first: What is the nature of the medical profession? Whether involving physicians, nurses, pharmacists, or others, there is a long history of health care providers being healers, not killers. People who are weak and vulnerable should be able to have confidence that the medical professionals attending to them will seek to preserve and respect their lives, not intentionally end them.

This is why the Ancient Greek physician Hippocrates' "Hippocratic Oath" is comforting—it is a commitment to guarding the art of medicine as serving the sick. Doctors pledged that they would not "give a deadly drug to anybody if asked for it."^{xvii}

Indeed, of this Margaret Mead observed,

For the first time in our tradition there was a complete separation between killing and curing. Throughout the primitive world, the doctor and the sorcerer tended to be the same person. He with power to kill had power to cure, including specially the undoing of his own killing activities. ... With the Greeks, the distinction was made clear. One profession, the followers of Asclepius, were to be dedicated completely to life under all circumstances, regardless of rank, age, or intellect – the life of a slave, the life of the Emperor, the life of a foreign man, the life of a defective child. ... [T]his is a priceless possession which we cannot afford to tarnish, but society always is attempting to make the physician into a killer – to kill the defective child at birth, to leave the sleeping pills beside the bed of the cancer patient. ... [I]t is the duty of society to protect the physician from such requests.^{xviii}

Certainly it is. And that is why it is so horrifying when medical personnel act against this. Consider Holocaust-survivor Elie Wiesel's observation about physician involvement in the Holocaust:

During the period of the past century that I call Night, medicine was practiced in certain places not to heal but to harm, not to fight off death but to serve it.

...instead of doing their job, instead of bringing assistance and comfort to sick people who needed them most, instead of helping the mutilated and the handicapped to live, eat, and hope one more day, one more hour, doctors became their executioners.^{xix}

Rather than repeat such history, today's medical professionals must reject it. Instead, they ought to practice according to the standards of the Hippocratic tradition. In fact, the Canadian Medical Association says the following in its Code of Ethics:

Practise the profession of medicine in a manner that treats the patient with dignity and as a person worthy of respect.

Provide for appropriate care for your patient, even when cure is no longer possible, including physical comfort and spiritual and psychosocial support.^{xx}

These principles reinforce that the medical community ought to alleviate suffering but not eliminate sufferers.

ⁱ An educational resource developed by Stephanie Gray for The Chilliwack Pro-Life Society: chilliwackprolife.com

ⁱⁱ “Protecting People from Euthanasia & Assisted Suicide,” Euthanasia Prevention Coalition, www.epcc.ca/wp-content/uploads/2015/07/pamphletFORWEB.pdf, Accessed July 24, 2015

ⁱⁱⁱ The Universal Declaration of Human Rights, Full Text, <http://www.un.org/en/documents/udhr/index.shtml>, Accessed July 31, 2015.

^{iv} The Universal Declaration of Human Rights, History, <http://www.un.org/en/documents/udhr/history.shtml>, Accessed July 31, 2015.

^v “Death With Dignity,” https://www.youtube.com/watch?t=66&v=0nf_rb2qkbE, Accessed August 7, 2015.

^{vi} “How Will You Say Goodbye to Someone You Love?” Paper by the Euthanasia Prevention Coalition, January 2006

^{vii} “Euthanasia in Canada,” speech by Dr. Will Johnston, <https://www.youtube.com/watch?v=SCKVqnO4n2U>, Accessed August 7, 2015

^{viii} healingtheculture.com/about/camille-pauley/

^{ix} “On Assisted Suicide and Perspective: A Practical Response,” Stephanie Gray <http://www.stephaniegray.info/blog/2015/2/11/on-assisted-suicide-and-perspective-a-practical-response-by-stephanie-gray> Accessed August 7, 2015.

^x “Palliative Care in Cancer,” National Cancer Institute, <http://www.cancer.gov/about-cancer/advanced-cancer/care-choices/palliative-care-fact-sheet#q1> Accessed August 8, 2015.

They reinforce that when we die—as we all will—that our death be natural, not at the hands of a fellow human.

^{xi} “How Will You Say Goodbye to Someone You Love?” Paper by the Euthanasia Prevention Coalition, January 2006

^{xii} “Should I have a Living Will?” Fr. Tad Pacholczyk, National Catholic Bioethics Center, <http://www.ncbcenter.org/page.aspx?pid=292>, Accessed August 7, 2015

^{xiii} MODULE 2-2 Readings, NCBC—National Certification Program in Health Care Ethics course taken in 2008-09, Module 2-2—Principles of Medical Ethics

^{xiv} Ibid.

^{xv} “Q&A from the USCCB Committee on Doctrine and Committee on Pro-Life Activities regarding The Holy See’s Responses on Nutrition and Hydration for Patients in a ‘Vegetative State’”

http://www.usccb.org/_cs_upload/7666_1.pdf Accessed August 7, 2015.

^{xvi} MODULE 2-2 Readings, NCBC—National Certification Program in Health Care Ethics course taken in 2008-09, Module 2-2—Principles of Medical Ethics

^{xvii} http://www.hippocraticregistry.com/?page_id=12 Accessed August 7, 2015.

^{xviii} http://www.hippocraticregistry.com/?page_id=1934 Accessed August 7, 2015.

^{xix} “Without Conscience,” Elie Wiesel, *New England Journal of Medicine*, 352; 15, April 14, 2005.

^{xx} CMA Policy: Code of Ethics, Updated 2004, last reviewed March 2015, still relevant, <http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf>, Accessed August 7, 2015.