1

PM-1 3½"x4" PHOTOGRAPHIC MICROCOPY TARGET
NBS 1010a ANSI/ISO #2 EQUIVALENT

PRECISION^{SM} RESOLUTION TARGETS

PIONEERS IN METHYLENE BLUE TESTING SINCE 1974

MicroD
OPTICAL SYSTEMS

13800 CUMMINT - HEALD'S SPRINGVILLE, NY 14457 USA
TEL: 614-432-7801 FAX: 614-432-7801 TLR: 510000488

National Library
of Canada

Bibliothèque nationale
du Canada

Canadian Theses Service   Service des thèses canadiennes

Ottawa, Canada
K1A 0N4

NOTICE

The quality of this microform is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us an inferior photocopy.

Reproduction in full or in part of this microform is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30, and subsequent amendments.

AVIS

La qualité de cette microforme dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de qualité inférieure.

La reproduction, même partielle, de cette microforme est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30, et ses amendements subséquents.

CANADIAN CHRISTIAN CHURCH PERSPECTIVES ON REQUESTS FOR
ACTIVE VOLUNTARY EUTHANASIA BY TERMINALLY ILL PATIENTS.

by

JEFFREY M. SPOONER, B.A.

A thesis submitted to
the Faculty of Graduate Studies and Research
in partial fulfilment of
the requirements for the degree of

Master of Arts
Department of Religion

Carleton University
Ottawa, Ontario
April 22, 1992
© Copyright
1992, Jeffrey M. Spooner

National Library
of Canada

Bibliothèque nationale
du Canada

Canadian Theses Service   Service des thèses canadiennes

Ottawa, Canada
K1A 0N4

The author has granted an irrevocable non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of his/her thesis by any means and in any form or format, making this thesis available to interested persons.

The author retains ownership of the copyright in his/her thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without his/her permission.

L'auteur a accordé une licence irrévocable et non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de sa thèse de quelque manière et sous quelque forme que ce soit pour mettre des exemplaires de cette thèse à la disposition des personnes intéressées.

L'auteur conserve la propriété du droit d'auteur qui protège sa thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

ISBN 0-315-75948-8

Canada

The undersigned recommend to the Faculty of Graduate Studies
and Research acceptance of the thesis

"CANADIAN CHRISTIAN CHURCH PERSPECTIVES ON REQUESTS FOR
ACTIVE VOLUNTARY EUTHANASIA BY TERMINALLY ILL PATIENTS:

submitted by Jeffrey M. Spooner, B.A.
in partial fulfilment of the requirements for
the degree of Master of Arts

Antonio R. Gualtieri

Thesis Supervisor

J.G. Wilson

Chair, Department of Religion

Carleton University

11 May 92

Abstract

While few Canadian Christian churches have prepared official position statements on the moral issue of active voluntary euthanasia (AVE), some have asserted that requests for AVE by dying patients are not to be regarded as authentic requests for death, but rather as cries for 'help' or 'love'. In the absence of empirical evidence supporting such claims, a model is proposed to account for church thinking. It is argued that this allegation ought to be regarded as an attempt to avoid anticipated threats to fundamental Christian theology responsible for formulating and maintaining opposition to AVE. The implications of such thinking upon the broader public debate over euthanasia are discussed.

Acknowledgements

I would like to express my heartfelt appreciation to **Dr. Antonio R. Gualtieri**. While I am indebted to Nino for his untiring efforts in the preparation of this work, his uncompromising professionalism and willingness to assist over and beyond the call typifies the care and attention he has given all of my research over the past seven years. A student could not have wished for more from an instructor or friend.

I am indebted to **Dr. Joseph G. Ramisch** for his years of open-door policy and a never ending willingness to accommodate a wide range of research requests. This paper would not have been possible without his guidance or encouragement.

I would also like to express my thanks to the **Department of Religion** at Carleton University for its genuine concern for the well-being and academic development of its students.

Finally, to **Margaret Elizabeth Spooner**, I extend all of my love and appreciation for her unwavering support and painstaking efforts throughout this project and all others along the way. Thanks for the 'vibes' Mom!

"The Attitudes of patients and relatives who ask for voluntary euthanasia and the decisions of doctors who might, if it were legalized, administer it, would be influenced to a considerable extent by conscience .... Conscience is much influenced by customary morality and by religion. It is therefore important to know the teaching of various religious groups on the question of suicide and voluntary euthanasia and to assess if possible the reactions of more modern groups, such as those who have diluted traditional religious attitudes with modern secularism. Religious views still carry weight. Thus a doctor who believed firmly in reincarnation might view euthanasia differently from an agnostic doctor who was equally convinced about personal extinction; both would differ from the Catholic doctor who regarded the final hours of a conscious dying person as influencing eternity."

- Dr. Hugh Trowell
The Unfinished Debate on Euthanasia (pp. 4-5).

"To everything there is a season. The Immutable fact of our existence is that it will end. Sooner or later death comes to us all. Modern technology with all of its miracles can't shield us from that reality, but it can keep us suspended in a limbo world between life and death, putting off our day of reckoning indefinitely. No matter what you feel about euthanasia, it must be clear by now that these issues should be brought out in the open and discussed by us all. The manner of our dying should be made the subject of a conscious ethical and philosophical choice, otherwise the continuing advance of modern technology will keep subdividing the process of dying into ever finer gradations of suffering, and thus deny us the possibility of accepting our own deaths."

- Dr. David Suzuki, "The Nature of Things"
CBC Television, October 11, 1989.

Table of Contents

	Page
Acceptance Sheet	ii
Abstract	iii
Acknowledgements	iv
Table of Contents	vi
 CHAPTER I: Euthanasia: The Emerging Canadian Debate	 1
 CHAPTER II: Canadian and Dutch Christian Church Positions	 20
 CHAPTER III: Patient Requests For Euthanasia: Ecclesiastical and Empirical Perspectives	 35
 CHAPTER IV: Worldviews and The Psychological Dynamics of "Active Voluntary Euthanasia"	 63
 CHAPTER V: Social Ramifications	 106
 APPENDIX 1: The Salvation Army Positional Statement on Euthanasia	 (110)
 APPENDIX 2: Vatican Declaration on Euthanasia (1980)	 (121)
 APPENDIX 3: Questionnaire - <u>Euthanasia and Religion</u> (Gerald A. Larue, 1985)	 (131)
 REFERENCES	 (134)

Chapter One

Euthanasia: The Emerging Canadian Debate

According to Patrick Nowell-Smith, "Euthanasia has replaced abortion as the preeminent medical ethical issue of our day" (The Scott Lecture, Queen's University, Ontario, March 20, 1991). Unlike unwanted pregnancy, the manipulation of human genes, or punishment for criminal activity, which have all elicited widespread national attention over the past few decades, euthanasia's recent rise to the 'top' may be partially linked to its existential qualities. While 'euthanasia' defines an array of issues and sub-issues across a multitude of disciplines, academics are intrinsically aware of the inescapable nature of that which constitutes its general subject matter (i.e., unavoidable as humans). For many, the mere mention of the word triggers unpleasant mental images and raises painful moral questions which defy efforts to seek solace in dispassionate intellectual reflection.

Existential considerations aside, euthanasia has also risen to prominence as a result of a lengthy series of coinciding social, economic, and technological factors. Most notable perhaps, has been the relatively rapid development

of life-sustaining medical technology. While bringing unheralded success to many sectors of the health care industry, these 'modern miracles' have also made chronic illness the leading cause of death among the elderly, and have been criticized for making dying " ... a painfully protracted process over which the dying person may have at best minimal control" (Campbell, 1991, p. 4). In a related manner, and despite advancements in palliative medicine, approximately one-third of dying patients continue to experience painful or burdensome physical symptoms prior to death (Lichter & Hunt, 1990). As a result, this has helped fuel increasingly vocal demands by seniors for greater consideration of personal autonomy and quality of life concerns throughout all phases of medical treatment. A concurrent North American demographic shift in favour of an increasing proportion of elderly has also helped to further advance these concerns (Manning, in Melton, 1991).

With the recent onset and continued spread of AIDS, senior citizens are being joined in their cries by growing numbers of younger patients and families, actively petitioning medical associations to re-evaluate traditional restrictions on therapeutic options for the dying. One thinks of former Vancouver Psychologist David Lewis, who in 1990 publicly endorsed the legalization of active voluntary euthanasia, after having admitted to assisting eight fellow

AIDS sufferers in their efforts to prematurely terminate their lives.

While some seek to overturn standard medical therapy policies, others strive to abolish the threat of punitive damages for health care workers opting to reject traditional 'treat-at-all-costs' medicine. Relatively recent amendments to the Canadian Criminal Code rendering suicide legal, but maintaining the illegality of assisted suicide, have also helped serve to generate widespread public discussion over the right-to-die for terminally ill patients.

While vehemently denied by North American Medical Associations, many believe that economic factors are forcing euthanasia 'onto the table', as health care authorities strive to engineer fiscally responsible intervention strategies for dying patients. By capitalizing on the emotional reactions which have accompanied these developments, American public lobby associations such as the pro-euthanasia 'Hemlock Society', and the 'International Anti-Euthanasia Task Force' have also been instrumental in forcing euthanasia onto the center of the 'bioethical stage'.

I am of the opinion that the decision by the Royal Dutch Medical Association of Holland to endorse the practice of active voluntary euthanasia (AVE) under strict circumstances, and in defiance of Dutch legal code

prohibitions, has also had a profound influence on provoking what Manning describes as the 'new debate' over euthanasia in North America (in Melton, 1991, p. xxi). Among other effects, this policy has served to place increasing pressure upon medical and related professional associations to examine and draft official policy guidelines or position statements on the issue. While the Canadian legal code continues to prohibit the practice of AVE, recent provincial and federal legislative efforts to secure amendments to existing 'end-of-life' measures have also contributed to the popularity of the euthanasia discussion in Canada. (1)

National interest in AVE has also been advanced by a seemingly ongoing series of high-profile North American 'euthanasia events' which have received widespread international media attention. When Alzheimer's patient Janet Adkins, a 54 year old married mother of three, accompanied Dr. Jack Kevorkian to a park in rural Michigan and participated in an act of chemically assisted suicide, both the retired pathologist and the AVE issue "... exploded into America's consciousness" (James Risen, The Toronto Star, June 24, 1990, p. F4)

With Dr. Lewis' admission making headlines only a month later, followed shortly afterwards by a further admission of assisted suicide by Rochester's Dr. Anthony Quill, public interest escalated. While Dr. Quill's actions had been

preceded by an endorsement of physician-assisted suicide by the editorial board of The New England Journal of Medicine (March 30, 1989), his decision to invoke the guidance of the Hemlock Society in the process, seems to have bolstered public attention.

With regard to the Hemlock Society, however, nothing has brought greater public awareness to the efforts of this American euthanasia society than has the publication of Final Exit, by its director Derek Humphry. Released in the spring of 1991, this 'manual for self deliverance', eventually reached number one position on a New York Times best-seller list by mid-summer (Vancouver Sun, August 9, 1990, p. A2). Despite consumer and industry concerns over the appropriateness of making such literature commercially available, a General Publishing [Canadian distributor] spokesperson acknowledged that sales in Canada had also been 'substantial' (in conversation, October 28, 1991).

In a further euthanasia related media development, Canadians were kept abreast of the lengthy judicial efforts of Americans Joyce and Joe Cruzan in attempting to secure the removal of feeding tubes from the unconscious body of their thirty-two year old daughter. In a persistent vegetative state since an auto accident in January 1983, Nancy Cruzan's parents eventually succeeded in arguing that despite the absence of an advanced directive, there was

sufficient evidence to assume that Nancy would also endorse such a petition (Hastings Center Report, Jan/Feb 1990, p. 38, and Time, March 19, 1990, p. 52).

While Canadian courtrooms have not been the scene of high-tension landmark decisions involving the right-to-die, (2) another young 'Nancy' recently captured national attention as she successfully lobbied for, and then exercised, the legal right to remove a respirator if desired (The Globe and Mail, February 14, 1992, p. A1). While heralded by some as a significant development in guaranteeing Canadian patients their right to refuse medical treatment, others have suggested that a largely overlooked, March 1990 ruling will eventually have a greater influence in subsequent right-to-die decisions. After an Ontario Court of Appeal confirmed a \$20,000 damage award against Dr. David L. Shulman for having disregarded Jehovah Witness Georgette Mallette's 'no blood transfusion' advanced directive, Eike Kluge, C.M.A. Director of Ethics and Legal affairs, confirmed that this would help lessen physician fears over the legal implications of obliging such requests (Dying With Dignity Newsletter, Vol. 7, No. 3, July, 1990).

It is clear, however, that in spite of the subsequent media developments which have helped elevate 'euthanasia' to the bio-ethical status it now enjoys in Canada, we may still regard the Kevorkian and Lewis episodes as being preeminent.

In addition to the extensive public attention which accompanied the actions of both men, these two 'events' must also be credited with having helped transfer a great deal of the complex terminology and many of the classic philosophical arguments over AVE, into a form of popular dialogue.

Following an extensive review of the print media publications issued over the summer of 1990, it became apparent that much of the euthanasia discussion normally reserved for textbook chapters and ethics journals had re-materialized in editorials and opinion columns of nationwide newspapers.(3) While it is beyond the scope of this work to attempt to include more than a few examples of the wide range of terms and arguments often employed in conjunction with professional, and now public, discussion of AVE, the following summary may be of interest.

'Mercy killing', 'assisted suicide', 'good death', and 'easy death', are a few of the popular synonyms routinely employed to denote 'euthanasia'. The establishment of such a diverse nomenclature, however, should not be regarded as a chance development. Rather, it may be interpreted as a testimony to the complex nature of the medical, philosophical, theological, and legal arguments which have evolved since the introduction of 'euthanasia' into the lexicon in 1646 (Fye, 1979, p. 492). Literally 'well death',

derived from the Greek 'eu' and 'thanatos' (Choron, 1972 p. 102), 'euthanasia' has come to represent a diverse assortment of definitions, arguments, and opinions regarding the deliberate manipulation of dying. (4) In fact, there are now representatives from Canadian provincial and federal legislative bodies, who feel that the term has become so diluted as to be of little, if any, denotative value. As a result, some have expressed interest in seeing 'euthanasia' unofficially, if not officially, excluded from formal legal usage. While I believe that such a decision would only serve to proliferate linguistic confusion, there are many who would support their position. (5)

To suggest that there exists a broad range of terminology which accompanies the issue of 'well death', is at best an understatement. While most are familiar with the adjectives, 'active', 'passive', 'voluntary', and 'involuntary', most are often surprised to learn of the multitude of buzzwords periodically employed in the professional literature.

One of the most effective means of illustrating many of the more obscure terms is to review a presentation of the medical concerns surrounding the use of 'ordinary' and 'extraordinary' medical treatment in cases involving decisions to withhold or continue feeding and hydration of terminally ill patients. According to Lynn and Childress,

procedural options are

... distinguished according to their simplicity (simple / complex), their naturalness (natural / artificial), their customariness (usual / unusual) their invasiveness (noninvasive / invasive), their chance of success (reasonable chance / futile), their balance of benefits and burdens (proportionate / disproportionate) and their expense (inexpensive / costly) (in Mappes & Zembaty, 1987, pp. 91-92).

In addition to such an extensive range of treatment considerations, which some refer to as the philosophical issues confined to "the act" of euthanasia, (Kluge, 1981), one must also consider the infinitely broader array of individual, communal, economic, legal, and medical perspectives which encompass the 'right-to-die'. It is not until one explores the seemingly endless variety of permutations and subsets of issues contained within each of these broader headings, however, that one acquires a sense of the complexity associated with the "euthanasia debate".

In the same way that it is beyond the parameters of this paper to present an extensive review of the terminology which accompanies "euthanasia", it is both superfluous and inconceivable to attempt to replicate more than a fraction of the arguments which have surrounded AVE over the years. Nevertheless, it would be negligent to fail to include a brief summary of two of the positions which have dominated the debate over active euthanasia for more than a decade.

In January 1975, Philosophy Professor James Rachels [University of Alabama] published a highly influential article in the New England Journal of Medicine (Vol. 292, 1975) entitled "Active and Passive Euthanasia". In this article, Dr. Rachels takes exception to a then recent AMA policy statement of 1973, which states that:

the intentional termination of the life of one human being by another - mercy killing - is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association....[But].... The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family (in Abelson and Friquegnon, 1982, p. 67).

In Rachels' opinion, the notion that it is permissible, at least in some cases, to withhold treatment and to allow a patient to die (i.e., "passive euthanasia"), but that it is never permissible to take direct action designed to kill the patient (i.e., "active euthanasia"), is both logically and morally wrong. As examples, he cites the arguments of those who advise 'withholding treatment in situations where patients in terrible agony are expected to die shortly', and the practice of medical staff who routinely subject newborns to death by dehydration in cases where parents reject options to surgically correct congenital defects found in

Down's syndrome children. According to Rachels, by following current AMA guidelines, and not administering lethal injections, medical personnel unnecessarily prolong the suffering which they seek to eradicate.

By way of his often referenced 'Smith vs Jones' philosophical scenario, Rachels argues that there exists no moral difference between the actions of one who deliberately seeks to take the life of an innocent, and another who merely allows an innocent to die. Therefore, argues Rachels, it is not appropriate to suggest that in a case of passive euthanasia the doctor does nothing to facilitate death. On the contrary, the doctor 'lets the patient die', and "the decision to let a patient die is subject to moral appraisal in the same way that a decision to kill him would be subject to moral appraisal: it may be assessed as wise or unwise, compassionate or sadistic, right or wrong" (in Abelson and Friquegnon, 1982 p. 71).

While Rachels' argument has been heralded by many who promote the liberalization of AVE, it has been countered by others on the basis of the "slippery-slope" or "wedge" argument. While the historical origin of this argument is not normally attributed to a single thinker, Gruman believes that its roots may be traced to the middle of nineteenth century. It was during the 1860's, when Herbert Spencer made 'Darwinist-positivism' an established creed, that "the aged,

the ill, the handicapped became suspect, 'parasitical' categories..." (Gruman, 1973, p. 108). It was biologist Ernst Haeckel, however, who claimed that "... putting a high value on life per se was a 'dangerous sentiment'" and, in the interests of reducing welfare and medical costs "... urged in 1904 the elimination of 'hundreds of thousands of incurables - lunatics, lepers, people with cancer, etc.' by means of morphine or some other 'painless and rapid poison'" (Gruman, 1973, pp. 108-9). Finally, notes Gruman, "The teachings of Haeckel were widely publicized by his followers and found an echo in the policies of the regime of the National Socialists ... led by Hitler" (p. 109).

Generally, therefore, the supporters of the slippery-slope position argue that regardless of whether one agrees with Rachels, the fact remains that were AVE to be declared a legally viable option for the dying, such a decision would unavoidably 'open the door' to a series of catastrophic abuses. Hence, any decision to legally grant a terminally ill patient a request for AVE, would eventually and unavoidably establish a basis for Involuntary killing (e.g., see Barry, 1982, p. 408). (6)

If we return to the discussion of the ramifications of Kevorkian and Lewis on the emerging national dialogue over AVE, there is a further observation worth noting. In

addition to their role in helping to stimulate widespread public discussion along traditional philosophical lines, both events also contributed to the development of another 'classic' phenomenon, which routinely accompanies ethical debates. This phenomenon was present during the months which preceded the federal government's efforts to provide a legislative solution to the abortion issue, as well as during the preceding capital punishment and seal-hunt disputes of the 1970s and 1980s. Specifically, I am referring to the escalation of accusations and general disdain which unfolds between those endorsing opposing stands on moral matters. (7)

While perhaps only a complex series of social and psychological explanations could ever fully account for the reasons some choose to bomb abortion clinics, destroy animal testing facilities, or chain themselves to the anchor lines of sealing ships, I believe that these actions may be precipitated in part, by a breakdown in basic communication. Perhaps out of fear of giving up ground, it appears that those holding moral opinions rarely attempt to comprehend the positions of their counterparts. As a result, misunderstandings often arise, and before long, hopes for constructive dialogue dissolve. (8)

Occasionally, however, a party which is expected to take a stand on an issue, in light of the subject matter

under consideration, fails to forward a position and opts to remain silent. In this situation, the potential for misunderstanding increases exponentially.

Such was the case with both the Kevorkian and Lewis episodes. Over the weeks which followed, Canadians were exposed to a variety of opinions from those representing the fields of philosophy, bio-ethics, medicine, and law. With regard to the Christian churches, however, there was virtual silence. In light of their traditional capacity as the custodians of morality, having historically sought to maintain a monopoly over questions of cosmological truth and values, the Christian perspective was conspicuous by its absence (Gualtieri, in conversation, Spring, 1991). Perhaps, hoping to stay clear of the 'fray' or to deliver an implicit commentary on both acts, by declining to dignify either with a response, the churches refrained, and have continued to refrain, from issuing opinions on issues involving the right-to-die in Canada. As indicated above, failing to issue a perspective on a matter where one is generally assumed to have formulated an opinion, only serves to exacerbate the opportunities for potential confusion between parties. In the event of there being nothing official upon which to react or respond, those who have prepared and made public their positions, are apt to make assumptions and conjectures about the views of others, in anticipation of having to

advance or defend their own perspectives.

Therefore, in the interest of helping to reduce the disruptive influence of deficient communication on the emerging dialogue over AVE, it seemed reasonable to petition the Canadian churches to share their views on the matter. If one could persuade them to express their official opinions in a public manner, one would help facilitate opportunities for shared dialogue between major interest groups. As a result, it became my goal to compile, and make public, a collection of Canadian Christian church perspectives on AVE, and to provide a general overview on the role of the churches in the debate to this point.

ENDNOTES

- 1) Notably, MPP Norm Stirling's Private Member's Bills 7 and 8, "An act to Amend the Powers of Attorney Act" and "An Act Respecting Natural Death" respectively (April, 1991), along with recent Federal efforts by M.P. Chris Axworthy, "An Act to legalize the administration of euthanasia under certain conditions to persons who request it and who are suffering the withholding and cessation of treatment and to amend the Criminal Code" (July, 1991), and M.P. Bob Wennman's proposed "Act to Amend The Criminal Code (Terminally Ill Persons)" (May, 1991).
- 2) Manning cites 151 U.S.A. euthanasia cases reported between 1920 and 1985. As a reflection of the 'dramatic increase in the incidence of euthanasia' he notes that 70% [i.e., 106] of these occurred between 1980 and 1985 (In Melton, 1991, p. xxii).
- 3) Included among the newspapers reviewed were, The Vancouver Province, The Vancouver Sun, The Calgary Herald, The Edmonton Journal, The Winnipeg Free Press, The Windsor Star, The Toronto Star, The Globe and Mail, The Ottawa Citizen, The Gazette, and The Telegram (Period: June 4, 1990, through August 1, 1990).

- 4) While normally reserved for use in matters of human demise, it is not uncommon to hear of animals destroyed or 'euthanized' following illness or severe injury. Supporters of active voluntary euthanasia, however, may argue that the interchangeable use of these terms serves to dampen their public credibility by mistakenly establishing a conceptual link between euthanasia and involuntary destruction.
- 5) Rather than seek to strike euthanasia from the lexicon, I would promote a Dutch-like effort to advance a uniform definition of the term. Specifically, "euthanasia" in Holland is widely recognized as "the intentional termination of life by another party at the request of the person concerned" (from "Final Report of the Netherlands State Commission on Euthanasia: An English Summary", Bioethics, Vol 1, No. 2, 1987).
- 6) For a more thorough review of the popular euthanasia arguments, see: Barry, 1982, Beauchamp & Perlin, 1978, Brody, 1988, Downing & Smoker, 1986, Kluge, 1975, 1981, Kohl, 1975, Ladd, 1979, Rachels, 1980, Weir, 1986, and Wilson, 1975.

7) While Dr. Kevorkian was heralded as 'a hero', 'a necessary zealot', and 'a great humanitarian worthy of the Nobel Prize' by some, (The Toronto Star, June 14, 1990, p. A26, The Vancouver Province, June 7, 1990, p. 14, and The Gazette, July 3, 1990, p. B2) he was also nicknamed 'Dr. Death', accused of 'trying to play God', of being a 'monster turned media star, who's eyes bug out and arms flail when he speaks', 'a medical maverick', 'a hired gun', and 'the world's biggest publicity seeker since Don King and Donald Trump' (The Winnipeg Free Press, June 7, 1990, p. 28, The Vancouver Province, June 7, 1990, p. 14, The Windsor Star, June 13, 1990, p. A7, The Edmonton Journal, July 7, 1990, p. F5, The Globe And Mail, June 8, 1990, p. A8, The Toronto Star, June 14, 1990, p. A25)

8) While admittedly a complex matter, I believe that part of the explanation for the violence which accompanies moral debates may be found within the theoretical framework of comparative religionist Dr. A. R. Gualtieri's approach to religious ethics.

According to Gualtieri, 'religion' may be "... summarized as human participation in an historical tradition (or symbol system) in such a committed way that its implicit world and value view generates and

expresses the existential selfhood or personal faith of the participants" (1984, p. xiii). As a result, one is understood to acquire a perspective on the meaning of humans, history, nature, and ultimacy.

Additionally, participation in a religious tradition is believed to

... change one's acting by changing one's being (selfhood). Internalization of certain presuppositions about reality produces a certain feel for the world and persons, what has been called 'a style of life' or 'a form of life'. This does not provide precise direction for right conduct in actual situations, but it does create a general direction in which decisions will be made, a bias to act in a way commensurate with the basic life stance entailed in those religious, ontological assumptions (Gualtieri, 1992a).

As a result I believe that zealous debate over ethical issues ensues from a perceived threat to one's (or a collective) underlying cosmological orientation which grounds one's moral perspectives. In other words, an opposing ethical stand may be interpreted as a threat to one's very selfhood; an attempt to discredit one's most fundamental knowledge of reality.

Chapter Two

Canadian and Dutch Christian Church Perspectives

In my attempt to acquire Canadian Christian church perspectives on AVE, I first sought to obtain examples of parallel efforts having been previously conducted in North America. After failing to locate a suitable model upon which to pattern my own research, however, I chose to proceed in the following manner. Drawing on information contained in The Canadian Almanac & Directory, 1989, (i.e., "Religious Organizations - Section 2"), 17 mainline Canadian Christian churches were arbitrarily selected for inclusion in the project. Using the designated mailing addresses and names of the most senior administrative officials provided, I forwarded copies of a prepared survey to the head office of each religious organization. (9)

In an attached covering letter it was explained that as a graduate student completing a Masters degree in Religion, I was seeking all available information on Canadian Christian church perspectives regarding active voluntary euthanasia. Each institute was petitioned for the following:

- 2) The most recent official pronouncement issued on euthanasia (or related bioethical issues) by your religious organization

- b) All 'working papers' prepared with regard to this matter even if only drafted for the purposes of general clarification.
- c) All committee study findings on this or any other related issue concerning 'end of life' matters.
- d) Any information generated as a result of related 'in-house' archival studies, either recently completed or currently in progress.
- e) All statements (official or otherwise) issued by your organization in response to the actions of Dr. Jack Kevorkian and the recent use of his 'death machine' (whereby assisting Alzheimer's patient Mrs. Janet Adkins end her life: June, 1990), as well as any statements issued in response to the actions of David Lewis, the former Vancouver resident who claimed to have assisted eight AIDS sufferers end their lives prematurely and deliberately via drug overdoses.
- f) All statements, if any, issued in response to the euthanasia related practices of the Royal Dutch Medical Association in the Netherlands.
- g) Finally, any other additional materials that you feel would be germane to such a study, as well as all personal comments that you may wish to express in this regard.

While requesting that the churches forward their materials [at my expense, if required] as quickly as possible, I made the assumption that it would take all interested organizations a considerable period of time in which to reply. As a result, I chose to take advantage of a recently established research exchange program to The Erasmus University of Rotterdam (Netherlands), and travelled to Holland in the Fall of 1990.

If I may return once more to the Kevorkian and Lewis episodes of the earlier summer, I should add that there emerged a further notable trend in the wake of the public reaction which followed. Despite the feelings expressed with regard to Dr. Kevorkian's use of his 'suicide machine' or Dr. Lewis' role in assisting dying AID's patients, many respondents made mention of the practice of AVE in the Netherlands.

Long known for its liberal policies on freedom of expression and individual autonomy, Holland is now recognized as the only country in the world where AVE is practiced on a routine basis. As a result, euthanasia is no longer a strict philosophical issue to the Dutch, but has become reality in approximately 2318 cases annually [or 2704, if one includes approximately 386 annual cases of assisted suicide] (Van Der Maas, p. 670). (10)

While still technically illegal, despite the

majority recommendation by a Dutch Government Commission that "... euthanasia, in certain circumstances and under certain conditions, should be possible without legal penalty" (Summary of The Final Report of the Dutch Government Commission on Euthanasia, presented August 19, 1985), and Private member efforts calling for the legalization of euthanasia (e.g., The 1984 'Kohnstamm Bill', MP for Wessel-Tuinstra), AVE is, however, popularly regarded as 'de facto' legal. In order to receive judicial exemption, however, physicians are required to adhere to specific guidelines which have been derived from relatively recent court proceedings on euthanasia related matters (i.e., 1973 to date) (de Wachter, 1989, pp. 3317-3318, John Blad, Department of Law, Erasmus University of Rotterdam, in conversation, Fall, 1990). (11)

As expected, the comments 'on Holland' as contained within the Kevorkian and Lewis reactions, represented a range of opinion. While some expressed strong opposition to the Dutch policy, alleging that the euthanasia situation in Holland actually constitutes a serious legal problem for Dutch officials [expressed in private conversations, fall 1990], others reiterated their calls for a Dutch-like model, in Canada, replete with "... strict regulations and safeguards to reduce abuse" (The Toronto Star, June 14, 1990, p. A25).

Given the absence of virtually any Canadian Christian church-based response to the Kevorkian and Lewis events, however, it came as little surprise to learn that there were no public comments issued on Dutch Christian church views of euthanasia. In fact, after a considerable outpouring of energy spent investigating the Dutch situation, it became clear that there is little academic research available regarding the views of the Dutch churches on AVE. As a result, and in light of the research opportunity at Rotterdam, I prepared additional copies of the Canadian church survey and journeyed to the Netherlands in the interest of conducting a parallel study among Dutch religious organizations.

Unfortunately, my inquiries of the Dutch churches were generally met with disappointment. While the largest of the Reformed Churches in Holland, by way of the 'General Senate of the Netherlands Reformed Church' [De Generale Synode van de Nederlandse Hervormde Kerk] had issued unofficial support for passive euthanasia, and had 'left the door open' to AVE, (Euthanasie En Pastoraat, 1988, p. 19, (12)), only the Roman Catholic Church could claim to have developed an official position statement on AVE. Therefore, other than the "Vatican Declaration on Euthanasia" (1980), and a 1985 Pastoral Letter by the Bishops of the Netherlands ("Suffering and Dying of the Sick") (13), it may be

concluded that on the matter of AVE, the majority of Dutch churches have opted for ecclesiastical 'silence' (i.e., failure to issue a position) or 'deference', (i.e, a position which recommends leaving euthanasia options to the will of the individuals involved) (Campbell, 1991, pp. 5-6). While a frustrating development from a research perspective, this lack of church participation had further served to confirm opinions by both Christians and non-Christians, that the role of the Dutch churches in the euthanasia debate of the 1970s and 1980s, had been negligible. This observation is underscored in Dutch physician Dr. Pieter Admiraal's comments that in keeping with a widespread post-war decline in religious participation in the Netherlands, "... many [Dutch] no longer entertain contact with pastors and .... do not appreciate accompaniment in dying by a pastor or priest (1986, pp. 102-3). Dr. Admiraal's observation was supported by my findings. Of the religious officials contacted, only a few had ever been summoned by patients contemplating euthanasia. In addition, it was also reported that on those rare occasions when a minister was contacted, patients had usually completed all 'necessary arrangements' for AVE, and were seeking only the church's blessing. According to Dutch medical ethicist Dr. Heleen Dupuis, "for the most part, the churches have really given up the fight against euthanasia"

(In conversation, Fall, 1990).

In fact even Dr. Isaac Van Der Sluis, of the religiously affiliated Nederlands Artsenverbond ["Dutch League of Physicians", 80% of whom are Christians, and recognized for their opposition to euthanasia] stated that their organization 'fails to find serious objection' in eighty-five to ninety percent of all reported euthanasia cases (in conversation, Fall, 1990, and Hilhorst, p. 495).

(14)

While my research efforts in Holland had been largely unproductive, I was not prepared for results of my Canadian Church surveys which awaited me on my return home. Excluding the Seventh-Day Adventist and Greek Orthodox Churches who did not respond, I discovered that 13 of the remaining 15 mainline Christian Churches in Canada have failed to prepare a formal position statement on AVE. (15) Specifically, only the Canadian Conference of Catholic Bishops, citing the Vatican Declaration of 1980, and Salvation Army could confirm that they possessed positional statements on euthanasia.

Therefore, despite those church officials who expressed interest in exploring the matter further, as well as the Anglican and Presbyterian publications Dying and Euthanasia [both unofficial documents], 'ecclesiastical silence' seems to be the order of the day on AVE in Canada. (16)

ENDNOTES

- 9) Churches receiving both the original survey and a follow-up letter requesting AVE-related information:
- a) The Anglican Church of Canada
  - b) Baptist Convention of Ontario and Quebec
  - c) Free Methodist Church in Canada
  - d) Evangelical Lutheran Church in Canada
  - e) The Lutheran Church-Canada
  - f) The Mennonites in Canada
  - g) Church of the Nazarene Canada
  - h) Greek Orthodox Church
  - i) The Pentecostal Assemblies of Canada
  - j) The Presbyterian Church in Canada
  - k) The Religious Society of Friends (Quakers)
  - l) Roman Catholic Church in Canada
  - m) The Salvation Army in Canada
  - n) Seventh-Day Adventist Church in Canada
  - o) The Swedenborgian Church
(Church of the Good Shepherd)
  - p) Canadian Unitarian & Universalist Churches & Fellowships
  - q) The United Church of Canada
  - r) The Christian Reformed Church-Calvin (Ottawa) *

* - Not found in the Almanac

- 10) As derived from the reported "Best Estimate" figures for euthanasia and assisted suicide of 1.8% and 0.3% respectively, on 128,786 reported deaths in 1990 (Van Der Maas et al., p. 670).
- 11) Holland's General Euthanasia Guidelines:
- *) The patient must repeatedly and explicitly express the desire to die.
  - *) The patient's decision must be well informed, free and enduring.
  - *) The patient must be suffering from severe physical or mental pain with no prospect for relief.
  - *) All other options for care must have been exhausted or refused by the patient.
  - *) Euthanasia must be carried out by a qualified physician.
  - *) The physician must consult at least one other physician.
  - *) The physician must inform the local coroner that euthanasia has occurred.

(Horgan, p. 17)

Note: these guidelines represent a condensed version of more detailed instructions issued by the Royal Dutch Medical Association to its members, concerning patient requests for AVE.

- 12) Specifically, they expressed support for medical freedom to forgo 'meaningless treatment' which only serves 'to delay the process of dying' (Euthanasie En Pastoraat, Translation, p. 10). With regard to AVE, "We are of the opinion, that the decision to terminate one's own life or to let it be terminated under certain circumstances in the light of faith does not need to be irresponsible" (Euthanasie En Pastoraat, Translation, p. 19).
- 13) The following is a listing of Dutch Churches and their positions on AVE, ascertained by way of interviews, calls, or correspondence. In all but a single instance, I spoke with at least one official representative from parishes located in Zwijndrecht, Holland. In the case of the Doopsgezinde Gemeente, I spoke with a minister from a small church in Dordrecht, Holland.
- *) Christelijke Gereformeerde Kerk [Calvinist]
No official position statement, yet strong congregational opposition to AVE.
  - *) Doopsgezinde Gemeente [Mennonite]
Apparently no official position statement, yet

strong emphasis on the forbidden nature of taking human life. Nevertheless, apparent widespread congregational support for AVE. Passive voluntary euthanasia (PVE) does not seem to violate church teaching.

*) Evangelisch Lutherse Gemeente [Lutheran]

No official position statement, yet generally strong opposition to AVE, with concerns about the widespread practice of PVE.

*) Gemeente van Apostolische Christenen

No official position statement, as cases are decided on an individual basis, but seemingly little church support for AVE.

*) Gereformeerde Kerk Zwiøndrecht [Calvinist]

No official position statement at this time, due largely to the divisive nature of the issue. General congregational support for PVE, with mixed opinion on AVE.

*) Gereformeerde Kerk Zwiøndrecht (Vrijgemaakt) [Free Calvinist]

No official position statement, yet general opposition to AVE, with room for PVE under strict circumstances.

*) Jehova's Getuigen

No position statement available, but strong support for the need and right to exercise personal judgement on such matters.

*) Oud Gereformeerde Gemeente [Old Calvinist]

While I was unable to reach an official representative, popular opinion was unanimous in declaring strong opposition to AVE. It is assumed that there is no official position statement available, but that remains to be confirmed.

*) Remonstrantse Gemeente [Remonstrate/Protestant]

No official position statement, but apparent widespread congregational support for the right to opt for AVE under strict conditions.

*) Volle Evangelie Gemeente Esra (Evangelical)

No apparent official position statement, but widespread opposition to AVE, with strong support for PVE under appropriate circumstances.

- 4) As a result of my research, I am firmly convinced of the erroneous nature of claims by Canadian legal officials, that great numbers of Dutch physicians are tried annually for AVE violations, while many others live lives in fear of eventual prosecution. When I

questioned representatives of the Dutch legal, medical, ethical, and social communities, about these concerns, I was met with bewilderment. On one occasion, a Dutch medical student sought assistance from a translator, assuming that her weak grasp of English was responsible for the seemingly bizarre nature of my inquiry.

Of greater concern to the Canadian officials, however, may be Van Der Maas' recently reported findings that "In .08(%) of all deaths [or 1030 cases based upon 128,786 reported deaths in Holland, 1990] drugs were administered with the explicit intention to shorten the patient's life, without the strict criteria for euthanasia being fulfilled" [Although it is reported that "In more than half of these cases the decision had been discussed with the patient, or the patient had expressed in a previous phase of the disease a wish for euthanasia if his/her suffering became unbearable" (p. 671)] (Van Der Maas, et al., p. 671).

- 15) Note that both the Canadian Unitarian Council and the Christian Reformed Church-Calvin, have adopted Campbell's 'deferred stance of personal choice' (1991, pp. 5-6). Note as well, that The Lutheran Church of Canada, expressed that it was a '... new church body

and had not adopted many statements or written many documents in the areas under consideration'. I was, however, referred to the parent body, The Lutheran Church-Missouri Synod for their position, which the Canadian church also adopts as their own'.

- 16) Following the conclusion of my efforts to secure Canadian/Dutch official church position statements on AVE, there have been three relevant USA publications which will be of interest to those pursuing research in this area.

The Park Ridge Center's Active Euthanasia, Religion and The Public Debate (1991), provides a summary of the views of the major faith traditions, in conjunction with a series of broader philosophical and ethical concerns which continue to accompany the issue.

Dr. Courtney S. Campbell's "Sovereignty, Stewardship, and the Self: Religious Perspectives on Euthanasia" (unpublished, presented at the American Medical Association Conference "Controversies in the Care of the Dying Patient, Orlando, Florida, February 14-16, 1991) offers a succinct report of the results of a nationwide mail-out effort, reviewing American Christian Church publications on euthanasia, and offering a brief synopsis of Christian theological

objections to AVE.

Finally, there is J. Gordan Melton's The Churches Speak on Euthanasia (1991), containing a brief overview of the historical, philosophical, and legal arguments surrounding euthanasia, followed by a series of unedited 'official euthanasia statements from Religious Bodies and Ecumenical Organizations' worldwide.

Chapter Three

Patient Requests For Euthanasia: Ecclesiastical and Empirical Perspectives

In light of repeated mailings and follow-up calls to a number of mainline Christian religious organizations in Canada, it must be concluded that there exists little official 'positional' information available upon which to comment about AVE. Nevertheless, both the Salvation Army and Roman Catholic statements echo other national and international nonpositional euthanasia related church documents. In light of the implications of this claim on treatment options for terminally ill patients, and in an era where national interest in euthanasia continues to escalate, it would appear to merit further attention.

In addition to their shared opposition to AVE, however, one also finds in the "Salvation Army Positional Statement on Euthanasia" [See **Appendix 1**] and the "Vatican Declaration on Euthanasia (1980)" [See **Appendix 2**] a statement regarding the psychology of dying patients seeking AVE. While the Salvation Army refers briefly to the "... impaired judgment..." which clouds the end of life for many people (1990), the Vatican pronouncement contains the more explicit

version of this shared perspective. According to the Roman Catholic church,

The pleas of gravely ill people who sometimes ask for death are not to be understood as implying a true desire for euthanasia; in fact it is almost always a case of an anguished plea for help and love (in Melton, 1991, p. 10).

In addition to official position statements, we find the same opinion expressed by an Ottawa Presbyterian minister, who with regard to petitions by patients for death, suggests that "the lament you hear isn't at heart a suicidal cry. It's a cry for help. I don't hear them say please kill me'. They're saying 'I need help. Give me a reason to keep living'" (Dr. John Scott, in Bob Harvey, The Ottawa Citizen, June 8, 1991, p. A21).

Aside from the associated treatment implications, (i.e., a rejection of the euthanasia option) and the use of such claims by the churches to help substantiate their general opposition to AVE, there is a further contentious issue at work with regard to these pronouncements. In each of the above examples one finds that none of the statements are issued with any obvious empirical or compelling [personally] theological support. In fact, in the case of the Vatican pronouncement, one may detect an air of 'matter of factness' about the assertion. There have been those, of course, who have deliberated over the potential dangers of

legalizing AVE, on the basis that patients may inadvertently request assisted dying during moments of intense pain or suffering (Kamisar, in Abelson & Friquegnon, 1982, p. 47). The Roman Church, however, among others, appears confident of its ability to declare in a sweeping fashion, that virtually all claims for AVE are to be regarded as something other than genuine petitions for premature death.

Without guaranteeing the validity of this perspective, it must be acknowledged that widespread agreement on such a position across national medical/ethical circles would certainly de-escalate the potential for controversy over this matter. On the subject of patient requests for AVE, however, there exists no such agreement. As a result, it would appear that a careful examination of the issue is in order, with a particular need for assessing the bases upon which these churches have come to express their respective opinions.

According to Christian Hospice Care founder Cicely Saunders (17), "if you relieve a patient's pain and if you can make him feel like a wanted person ... then you are not going to be asked about euthanasia" (Whytehead and Chidwick, in Melton, 1991, pp. 68-69). Toronto Oncologist Dr. Robert Buckman, however, disagrees. According to Dr. Buckman, approximately 'five (5) to ten (10) per cent of terminally ill patients, who are 'competent' and pain-free, seek to

deliberately and prematurely end their lives' (in Conversation, November 26, 1991). It is Algonquin College Palliative Care Coordinator Judi Paterson-Tucker's opinion, that under ideal palliative circumstances, approximately three (3) to five (5) percent of terminally ill patients will continue to petition for accelerated death (in conversation, December 6, 1991). According to Dr. Marcel Boisvert, of the Royal Victoria Hospital in Montreal,

... I think of several patients I have cared for over the years who, one day, one week, one month before a predictable death and after prolonged dialogue where 'all things were being considered' told me their life was no longer worth it and asked me for help to end it. They had no pain or symptoms, were not depressed, did not lack love or support. Their spouse or family agreed. (1988, p. 116).

It is physician Dr. Avery Weisman's opinion [Harvard Medical School] that "... fallacies about dying patients may be perpetuated from one generation to the next, insulated by a tradition that exempts these beliefs from investigation" (in Shneidman, 1976, p. 439). As an example of such a fallacy, he cites the claim that "Only suicidal people and psychotic people are willing to die ... even when death is inevitable..." (in Shneidman, 1976, p. 439). Finally, according to Levitt & Guralnick, "... some people do want to die, and cannot be dissuaded from their yearning by reason, fear, drugs, or love" (1985, p. 260).

One need not limit the opinions of those who disagree with these churches, to the increasingly secular circle of medicine. According to a 1975 Church of England statement, "On Dying Well: An Anglican Contribution to the Debate on Euthanasia", reference is made to "a sophisticated few" who represent "... a very small minority of patients who have apparently decided for themselves that their time has come and that they now wish to depart" (In Melton, 1991, pp. 129 & 118). Similarly, in a 1973 statement issued by the United Church of Christ, we find that "Some adults, suffering varying degrees of pain, indignity or meaninglessness, but knowing what they are doing, do ask their physicians to help them go, quickly and painlessly" [emphasis mine] (in Melton, 1991, p. 184).

It is clear, from these comments that there exists a lack of unanimous support for the contention that dying patients who request AVE are 'not really asking to die'. While some may suggest that in light of the apparently insignificant percentages cited by Dr. Buckman and Ms. Paterson-Tucker, that for all intents and purposes, there exists a general agreement between parties on patient requests for euthanasia.

While I would remind those inclined to support this argument that 'three to ten percent' becomes 3,696 to 12,320 respectively, when converted to national case figures (18),

our interest in this issue concerns the basis of church thinking on this matter. Simply put, where is their data? What is the basis of their claims? Upon what authority does a Christian church, or a Protestant minister, instruct others to interpret requests for AVE from dying patients in this manner?

Let us return to the "Vatican Declaration" (1980). For those unfamiliar with Catholic teaching on moral matters it is important to recognize the 'Natural Law' elements at work within the document. Natural law thinking, for example, may account for the claim that "Intentionally causing one's own death [is] .... the denial of the natural instinct to live" (in Melton, p. 10). (19) While there exists a considerable degree of non-Catholic opposition to this perspective, (e.g., Choron, 1972, p. 98, Vernon & Payne, 1973, pp. 69-70, Cappon, in Vernon & Payne, 1973, pp. 70-71, Neuringer, 1987-88, p. 156, and Donne, in Campbell & Collinson, 1988, pp. 26-28), the claim is congruent with a long history of Roman Church thought on the matter. (20)

It is also important to recognize the appeal made to 'erroneous conscience' within the declaration, where we read that as a result of "... prolonged and barely tolerable pain...", psychological factors may lead people to believe "... that they can legitimately ask for death or obtain it for others in a reduced or guilt-free manner" (in Melton, p. 10). (21)

In addition to difficulties regarding the natural law argument within the Vatican Statement (22), there remains another confusion with regard to the specific passage under consideration. At first glance, one may justifiably presume that one ought to reject patient requests for AVE on the basis of the deliberately misleading nature of such pleas. Rather than sincere requests for expiration, it appears that church thinking regards these petitions as potentially disguised efforts to acquire help or love. In other words, rather than seeking death, patients may be understood as striving to enhance their quality of life. If so, then the difficulty with this passage concerns the church's preparedness to acknowledge the presence of 'psychological factors which may obscure their thinking on such matters' (in Melton, 1991, p. 10). In light of this particular reading of 'untrue', one is left to speculate about the basis upon which requests for AVE are rejected as legitimate by-products of the above mentioned psychological considerations. (23) More troubling still, as in keeping with traditional Roman Church pronouncements, is that the church would have its devotees accept this distinction without explanation. In light of the quasi-empirical nature of the issue under consideration, it would seem appropriate to petition the church for a response to the apparent inconsistency.

It may be argued by church officials, however, that such a reading of "true" is contrary to that which is intended by the declaration. As a corrective measure some may specify that requests for AVE 'can not be taken at face value in light of the human instinct to live' which naturally prohibits such thinking. If we accept this as the more accurate denotation, however, it must be argued that the problematic nature of the assertion is still not eradicated.

If we are to interpret "true" according to natural law thinking, then church officials must be prepared to offer an explanation for their use of the term 'almost' as it appears in the statement. Specifically, we read that a request for AVE "... is **almost** always a case of an anguished plea for help and love" (in Melton, 1991, p. 10). What is to be made of 'almost'? How is it to be interpreted? Is it to be regarded as a synonym for a percentage figure? If so, what is the percentage involved, and upon what basis is the percentage established? If not a percentage, then might "almost" not be taken to imply, as Cardinal Bernardin has indicated, that the human instinct to live is subject to **erosion** following prolonged periods of fear over pain or discomfort [emphasis mine] (in Melton, 1991, p. 26)? If so, what is one to infer about the interaction between 'instinct' and 'psychological factors' believed to be at work in the minds of dying patients? More importantly, are we to understand that the church possesses such a solid

grasp of this neurological blend that it is completely acceptable, even advisable, to disregard pleas for assisted dying from terminal patients, on the basis of their confused state?

If we turn to protestant church thinking, we must also attempt to discern the origin of their parallel, if less overt, claims. On what basis should requests for AVE be more suitably regarded as petitions for love or 'a reason to keep living'?

While protestant theology is not normally recognized for its reliance on natural law reasoning, it is conceivable to suggest that there has been an incorporation of Catholic natural law thinking on this matter. Additionally, we ought not to reject the possibility of the use of unreferenced scientific findings in order to justify dismissing patient requests. Regardless of the extent to which empirical results may be at work in protestant thinking, it would seem incumbent upon an investigation of this nature, to provide a review of the 'scientific literature' as it pertains to the issue at hand.

After unsuccessful efforts to locate North American and Dutch literature on requests for AVE (including a thorough review of American Psychological Association clinical and neuropsychological literature), it can be concluded that there remains a virtual absence of psychological research

results upon which to offer comment for review in this area. At present, perhaps the most relevant findings available are contained within the results of a long awaited Dutch study released in the Fall of 1991. According to Van Der Maas et al., it was found that in 187 cases of combined euthanasia and assisted suicide in Holland, "The patients made the request for reasons of loss of dignity (mentioned in 57% of cases), pain (46%), unworthy dying (46%), being dependent on others (33%), or tiredness of life (23%). In only 10 of the 187 cases was pain the only reason" (1991, p. 672). While such findings may be dismissed out of hand by Catholic theologians as examples of psychological factors which may occasionally cloud the "true desire" of dying patients, it would appear that alleviating the 'prolonged and barely tolerable pain' to which the 1980 Declaration refers, may be insufficient to eradicate requests for AVE by terminally ill patients.

With so little direct research available, perhaps we might turn our attention to a related matter - suicide. Before doing so, however, it should be acknowledged that there are those who would object to the implications involved in reviewing suicide results in order to shed light on the issue of AVE. (24) Nevertheless, research findings from this field of study continue to reveal that it is erroneous to suggest that 'all those who commit suicide are

depressed or are insane' (Davison & Neale, 1982, p. 263, Phipps, 1985, p. 972, and Neuringer, 1987-8, p. 159).

While according to Davison & Neale, it is incorrect to assume that people with a terminal physical illness are unlikely to commit suicide (1982, p. 263), according to Weisman, figures vary as to the rate of suicide among cancer patients as reported by physicians (in Wallace & Eser, 1981, p. 30). This issue is made more complicated by Saul & Saul's disclosure that it is also difficult to attain statistics on suicide rates of elderly residents in institutions (1988-1989, p. 239). (25)

In spite of objections to the use of suicide research in euthanasia discussions, the suicide issue is important as it pertains to the authenticity of requests for AVE. It has been argued, for example, that with the dying process representing such a physically trying ordeal for so many, one would expect terminally ill patients to kill themselves rather frequently. It is suggested, however, that the dying "... seldom commit suicide even when they have the chance" (Editorial, Theology Today, October, 1980, pp. 291-292).

(26) In a similar vein, one hears from those who believe that cases where patients initially petition a physician for AVE, then curtail these requests as death approaches, should be regarded as evidence to support the claim that terminally ill patients do not genuinely wish to die (The Bishops of the Netherlands, 1985, p. 12). (27)

In the end, however, despite such speculation, we may extract little from the empirical evidence concerning suicide, with regard to the "true" intentions of those seeking AVE. Nevertheless, and regardless of the debate over the authenticity of patient requests for accelerated death, it should be kept in mind that terminally ill patients **do commit suicide** [emphasis mine] (Choron, 1972, p. 106). (28)

Finally, we may wish to review the results of research undertaken in the psychological study of 'death and dying'. In fact it appears that the Roman Church has incorporated some of this material into its 1981 declaration. Appearing only a few lines after the comments on AVE requests, we read

Numerous testimonies which confirm one another lead one to the conclusion that nature itself has made provision to render more bearable at the moment of death separations that would be terribly painful to a person in full health. Hence it is that a prolonged illness, advanced old age, or a state of loneliness or neglect can bring about psychological conditions that facilitate the acceptance of death (in Melton, 1991, pp. 10-11).

While not stated, it would appear that the church may be drawing upon the research results contained in one of North America's most celebrated works in this field: On Death and Dying, by Psychiatrist Dr. Elizabeth Kubler-Ross (1969). In a similar manner, British physician and committed

Christian Dr. Hugh Trowell, also speaks of the 'acceptance of death' in an effort to support his anti-AVE position, but makes explicit reference to Dr. Kubler-Ross' findings.

According to Kubler-Ross, terminal patients, once aware of their prognosis, pass through a series of five distinct psychological stages prior to death (i.e., 'denial', 'anger', 'bargaining', 'depression', and 'acceptance'). As a result, the dying process is regarded as an emotionally unsettled period for terminally ill patients. On the basis of Dr. Kubler-Ross' findings, Dr. Trowell states that "the only steady state is that of the final serene and sedated acceptance of death" (p. 107). He further asserts that since voluntary euthanasia demands "... a rational, steady, determined, informed desire for death..." it is unacceptable to entertain requests for AVE during the first four phases of dying (1973, p. 107).

If I am correct in my assumption that Dr. Kubler-Ross' findings are at work in the Vatican declaration, then it is important to point out that while there may be 'numerous testimonies which confirm one another' (The Vatican Declaration, in Melton, 1991, p. 10), both the church and Dr. Trowell should be made aware of the multitude of others who have criticized her methodology or have been unable to replicate her findings (Kastenbaum (1977) and Antonoff & Spilka (1984-5) in Schulz & Schlarb, 1987-88, Schulz and

Aderman, 1974, Shneidman, 1976, Pattison, 1977, Metzger, 1979-80, Nighswonger (1971) in Fitchett, 1980, Viney & Westbrook, 1986-87, Admiraal, 1988, and Baugher, et al., 1989-90).

Nevertheless, while all five stages of Dr. Kubler-Ross' model may be germane to the particular issue under consideration, it would seem that 'acceptance' may be most relevant for our purposes. As with many other aspects of her findings, there have been criticisms made of the proposed final stage. According to some, the public popularity which 'acceptance' has received, ought to be more properly attributed to the 'symbolic nature of its opposition to the organized technology of modern medical systems' rather than any scientific basis (Klass, 1981-82, p. 241). Others, like Fitchett, have argued that

For Kubler-Ross the fifth stage, acceptance, is simply not something that was observed. It is the final stage of the dying experience that we all ought to experience. The philosophical or ethical principles upon which this moral assumption is constructed are not argued by Kubler-Ross. The matter is stated as if it were self-evident. 'We may achieve peace by facing and accepting the reality of our own death'. While I believe this is a moral statement, it has been treated by many clinicians as if it were a scientific observation (1980, p. 212).

Despite these concerns, however, the implications of the 'acceptance' stage may be substantial with regard to the

emerging debate over AVE. (29) While it is imperative to respect Dr Kubler-Ross' charge to her readers which appears in the Preface of On Death and Dying (i.e., that "It is not meant to be a textbook on how to manage dying patients, nor is it intended as a complete study of the psychology of the dying" (p. xi)), her apparent influence on Christian perceptions regarding the psychological dynamics of dying, warrants the following observations.

Firstly, the term 'euthanasia' never appears among Dr. Kubler-Ross' comments on the transcripts of those patients interviewed during the compilation of her work. In fact, other than two passing remarks issued by patients regarding the prospect of premature death (1969, pp. 151, 175), one may state that no direct discussion regarding deliberate intervention in the dying process appears anywhere in the work. (30) Rather than drawing the conclusion however, that any such thoughts among dying patients ought to be regarded as psychologically abnormal, I believe that a serious methodological oversight may have been responsible for the lack of discussion about suicide among Kubler-Ross' terminally ill subjects.

While I am somewhat surprised by the inattention paid by Kubler-Ross to the religious orientation of her patients in On Death and Dying (31), she must be criticized for having failed to account for the potentially confounding

influence of hospital chaplains on the self-reports of the dying. In spite of the significance she attaches to the influence of physician attitudes toward death on dying patients (1969, pp. 32, 246, and Trowell, 1973, p. 104), Kubler-Ross seems to have overlooked a plausible interaction effect between religious official's attitudes toward self-death, and the terminally ill. (32) Consider the willingness, for example, of a Roman Catholic patient to express openly thoughts or plans for euthanasia before a hospital chaplain, in an era when suicide would have brought dishonor to oneself and one's family.

Some may object, of course, and argue that while theoretically conceivable, my concerns remain purely speculative. Nevertheless, in light of the potential influence a 'clergy-free' interview environment might have had upon Kubler-Ross' depiction of the psychological response to death - and perhaps the euthanasia debate as a whole - I believe that such speculation is warranted.

Moreover, I will add that my methodological concerns do not reflect mere conjecture. Instead they may be attributed in part, to the findings of Dr. Daniel Cappon (Assistant Professor of Psychiatry, University of Toronto). In 1961, Dr. Cappon released results from a study assessing attitudes of terminally ill patients on death and dying, which showed that 73% of dying patients were in favor of euthanasia

[emphasis mine] (1962, p. 696). In his concluding remarks, he states that

Favouring euthanasia seemed to be a psychologically desirable attitude towards life and death. Euthanasia would be well worth the study by both the law-givers and the physicians .... In this age of anxiety, the question of giving the dying patient a painless and untroubled passage must not be obscured by a society which seems uneasy and denying of death, and inclined to eschew mature responsibility. (1962, p. 698).

Even though we are not provided with a sample of the questionnaire administered to these patients, we may be confident that Dr. Cappon's reference to a "quick exit" (p. 698) ensures that he is referring to AVE. As a result, and while we must always remain cautious about drawing inferences from individual studies, the apparent 'clergy-free' nature of this research, would appear to lend credibility to my speculation about Dr. Kubler-Ross' findings. (33)

Though we may be left to muse over such questions, I believe that there exists little if any 'scientific evidence' upon which to support church thinking that requests for AVE by dying patients are to be regarded as anguished pleas for help, love, or 'reasons to keep going'.

ENDNOTES

- 17) Hospices [Latin, for 'hospitality'], are resting places for the sick and dying, originating in "Medieval houses of hospitality for pilgrims on their journeys to the Holy land..." (Labus & Dambrot, 1985-6, p. 231). Anglican physician Dr. Cicely Saunders is normally credited with establishing the modern hospice movement, after founding St. Christopher's, (London, England) in 1967 (Spring & Larson, 1988, p. 175).
- 18) Figures based on Statistics Canada reports of annual deaths in Canadian Hospitals for the fiscal year 1987-1988 (i.e., 123,205). I was told that hospital deaths normally account for approximately 62.5% of all deaths in Canada. If so, this would push the 'three to ten percent' figures to 5,912 and 19,713 respectively. While many of these deaths would have been of the instantaneous (i.e., accidental) variety, where AVE issues would not have been involved, these figures clearly underscore the significance of the matter at hand.

- 19) Natural Law: "As distinct from revealed law, it is 'nothing else than the rational creature's participation in the eternal law' (Summa Theologica, 1a, 2ae, quest. 91, art. 2). As coming from God, the natural law is what God has produced in the world of creation; as coming to human beings, it is what they know (or can know) of what God has created." (Hardon, 1985, p. 279).
- 20) With reference to what Amundsen terms Aquinas' 'classic treatment of suicide' (In Brody, 1989, p. 142) we read "... everything naturally loves itself, the result being that everything keeps itself in being, and resists corruption so far as it can. Wherefore suicide is contrary to the inclination of nature..." (Aquinas, 1947, Vol. 2, p. 1469, Pt.11-11, Q.64 Art.5).
- 21) According to Catholic teaching, 'conscience' is understood to mean "... the voice of God within man .... rooted ultimately in the transformation of human nature by grace, but it comes to act in the reality of faith, which, in its fullness, is the full, personal, and conscious commitment of the human person to God and to Christ the Redeemer" (New Catholic Encyclopedia, Vol. 4, 1967, pp. 200-202). 'Errors of

conscience' refer to seemingly permissible dictates of conscience which upon "... careful, disinterested consideration and judgement would show them to be contrary to the moral order" (Nelson, 1973, p. 108).

- 22) While theoretically manageable, it seems difficult to accept that a patient's decision to refuse anything more than the "... normal means that medicine can offer.... [in order].... not to impose excessive expense on the family..." (in Melton, 1991, p. 12) is not to be regarded as the 'equivalent of suicide', and therefore not a violation of the 'natural instinct to live'.

In other words, according to this pronouncement, a patient's decision to 'refuse treatment', and to request a heavy barbiturate followed by the turning down of one's respirator, thus 'allowing' a particular virus, disease, injury, or biological defect, to cause respiratory failure and death within minutes, is not regarded as a violation of the natural instinct to live.

If, however, a patient seeking to spare one's family excessive expense, requests a heavy barbiturate followed by the injection of a chemical substance, which would also cause respiratory failure and death in

a matter of moments, then this is to be regarded as a violation of the natural instinct to live!

- 23) Under this circumstance, one gets a sense of the church having taken away with one hand what it just gave with the other. Initially, the Vatican is fully prepared to recognize the presence of psychological factors which may lead people to say or do things which they would not normally, except under conditions of prolonged and excruciating pain. In light of this interpretation, however, the church seems to arbitrarily reject the possibility of such atypical expressions or acts taking the form of petitions for AVE.

(I am indebted to Dr. A. R. Gualtieri for his assistance in helping to bring to light this discrepancy).

- 24) According to Wallace & Eser,

What does jumping off a bridge have to do with the mercy killing of a person presumed dying with an irreversible disease? How can the despair and irrationality associated with suicide be linked to the compassionate concern expressed by those who would commit euthanasia to end suffering? What, if any, is the relationship between suicide and euthanasia? (1981, p. 3).

- 25) The question of suicide rates among the elderly and/or terminally ill, is made more complicated by Levitt & Guralnick's observation that

Those who refuse to undergo therapy have clearly made a conscious choice to acquiesce in death. But what of those who forget to take their medicine, or violate their diets, or confuse all instructions? And what of those who submit to an experimental treatment in the hope that the treatment will kill them .... Few doctors, for example, will admit that suicide is much of a problem among people on hemodialysis; yet if it's suicidal to refuse to accept treatment, to compulsively drink water against severe restrictions, to insist on ill-advised kidney transplants, to fail to follow instructions for working a home dialysis machine, and to occasionally remove a shunt so that death results from loss of blood, then people on hemodialysis have a suicide rate 400 times that of the general population (1985, p. 260).

- 26) While it is difficult to interpret what is intended by such a comment, I believe that 'given the chance' is a matter of opinion. What may seem to qualify as an 'ideal opportunity' to an outsider, may appear to be wrought with complications for a terminally ill patient.

With regard to hospitalized patients, for example, one must consider everything from restricted movement, to the effects of the 'depersonalization process' which rewards patients for conforming to hospital regulations (Goffman, in Kubler-Ross, 1975, p. 16) to the 'watchful eye' put on those exhibiting

suicidal tendencies. For some, there may be difficulties associated with determining and securing medication capable of guaranteeing 'a quick, painless, and dignified death' without fear of 'bungling the act', and risking further pain, discomfort, and loss of dignity. For others, there may be concerns over communicating unintended messages to hospital staff in response to long standing efforts to deliver comfort.

- 27) This argument is clearly at work in the Church of England's 1975 document, "On Dying Well" (in Melton, 1991, pp. 108-117) where through a series of case studies it is implied that requests for AVE are not to be taken at face value given that patients routinely change their minds on the matter.

Generally, there is a difficulty at work in this argument which social scientists often identify as the 'problem of equating correlation with causation'. One commits this error whenever an assumption is prematurely made that an event or phenomenon which varies with another, has also caused or has been caused by the other.

Firstly, it is important to distinguish between specific and repeated requests for AVE by the

terminally ill, and those comments issued by patients expressing support for the notion of AVE. This distinction is terribly significant, as a specific request for AVE, in any other country than Holland, represents a petition to the physician or nurse to commit a violation of the criminal law, and perhaps a code of ethics, at great risk to one's personal and professional welfare.

Consequently, a patient's decision to inform medical personnel of their feelings regarding AVE may only be intended as a 'testing of the waters' for staff reaction. In other words, the patient may be understood to be tossing the proverbial 'ball' into the physician's/nurse's 'court'. As an example, it would be unlikely for a patient to infer a supportive position from those physicians opting to respond, as Dr. Lynn recommends, by 'avoiding any direct answer' to AVE requests (1988, p. 100).

While this may not prevent a patient intent on securing AVE from initiating further attempts, it would likely force the individual to exercise a great deal of discretion in subsequent efforts. If so, it is then conceivable to suggest that physicians such as Dr. Cicely Saunders, who claim that requests for AVE should be regarded as 'cries to alleviate pain' (In Melton,

1991, pp. 68-69) based on the fact that once the pain is treated requests for AVE disappear, may be guilty of confusing correlation and causation. Rather than losing their desire to receive AVE, the ensuing cessation of requests may only reflect a lack of willingness on the part of a patient to raise the matter further with a physician obviously opposed to the notion of AVE!

In other words, one cannot infer that by treating or alleviating pain, and perhaps bringing an end to patient explicit requests for AVE, one has also eliminated both the source and implicit desire for accelerated death.

In a related manner, is the Vatican prepared to explain 'almost all' cases of patients withdrawing earlier requests for AVE on the basis of their having received love? Perhaps it is worth reminding The Church of England, that the following comments found in the discussion portion of 'Case History #5' - "Miss P" ('On Dying Well') may work both ways:

Only those in close contact with her could really see Miss P. A more distant observer might feel that her true desire must surely have been to have her life brought painlessly to an end .... (We cannot emphasize sufficiently the impact that seeing the seriously ill has on healthy people. This shock reaction often causes them to read into the minds of patients thoughts which are merely projections of their own emotional reactions) (in Melton, 1991, pp. 113-114).

- 28) While there is clearly a lack of scientific research currently available to assess the nature of requests for AVE, a 1989 international panel of ethicists recommended that "Studies be undertaken to assess the frequency of, and to determine the reasons for, patients' demands that their lives be terminated" (Roy, 1989, p. 60).
- 29) Note the significant implications of 'acceptance' on the debate over AVE. If acceptance is recognized as part of a natural psychological response to death, and becomes identified as a goal for palliative care medicine, then requests for AVE will merely confirm that one has yet to reach this final, and desired, stage.
- 30) Some may look to Kubler-Ross' brief remark that no patient had "... at all times maintained that there is no wish to live at all" (1969, p. 31), in an effort to substantiate church thinking on AVE. Her use of the qualifier "... the hope which every patient has to keep..." [emphasis mine] (1969, p. 31), however, betrays a philosophical orientation which may serve to negate her credibility on such matters.

- 31) Religious patients seemed to differ little from those without a religion. The difference may be hard to determine since we have not clearly defined what we mean by a religious person. We can say here, however, that we found very few truly religious people with an intrinsic faith. (1969, p. 265-266).

In addition, one can not help but consider the potentially confounding influence of a religiously imparted transformative and therapeutic response to death, on subjects participating in a study intended to assess the human psychological response to dying.

- 32) I am referring here to the influence of chaplains, ministers, rabbis, and priests upon terminally ill patients, during interviews conducted in the presence of physicians and clergy (Kubler-Ross, 1969, pp. 254, 256).

Note that by Kubler-Ross' own admission she and the hospital chaplains 'joined forces' only in order to satisfy their respective needs. Apparently Kubler-Ross required a list of available 'critically ill patients' and the clergy required additional assistance in their dealings with such individuals (1969, p. 254). Note as well, that the presence of the clergy "... changed the seminar a great deal" (1969, p. 253). According to Kubler-Ross,

What amazed me ... was the number of clergy who felt quite comfortable using a prayer book or a chapter out of the Bible as the sole communication between them and the patients, thus avoiding listening to their needs and being exposed to questions they might be unable or unwilling to answer. [emphasis mine] (1969, p. 254).

- 33) One also wonders about Dr. Kubler-Ross' reaction to the apparent discrepancy in findings, given that Dr. Cappon's work appears among the references of On Death and Dying.

Chapter Four

Worldviews and The Psychological Dynamics of "Active Voluntary Euthanasia"

Having established that appeals to psychological research may not be used to unequivocally substantiate church thought on the 'true' nature of requests for AVE, perhaps a rethinking is in order. In its place, I will forward a theoretical explanation which may account for the basis of church thinking in this area.

In the preparation period which preceded the drafting of my AVE church surveys, I uncovered a work which until recently may have been the only readily available publication of its kind pertaining to religious perspectives on AVE. Authored by former Hemlock Society President Gerald Larue, and entitled Euthanasia and Religion: A survey of the attitudes of world religions to the right-to-die (1985), I reviewed the work in detail, hoping to derive suggestions or guidelines for the preparation of my questionnaire. Unfortunately, the high expectations I had originally held for the text, were short lived. As an academic publication, the book is weak with regard to its method and discussion. While Larue claims to have prepared the material in part,

for the students enrolled in his "Social and Psychological Aspects of Death and Dying" course at The University of Southern California (1985, p. ix), it rather resembles a hasty effort to produce a personal digest concerning religious thinking on the matter. This is not to imply, however, that Larue has necessarily failed to provide both his students and the academic community with a reliable summary of American based Christian and non-Christian theological leanings on AVE. To a researcher in this field, however, Euthanasia and Religion reads like a hurriedly prepared summary of religious perspectives which ought not to be regarded as anything further. (34)

Of significance for our purposes though, are items #1 and #2 of the questionnaire which he prepared, and distributed to "... religious leaders and officials..." (1985, p. 1):

1. What stand or position (if any) has your religious organization taken regarding so-called 'passive' euthanasia? ....

For example: K, 22 years old, is suffering from 'a rapidly fulminating type of multiple sclerosis.' He has been in a coma for 2 months and does not respond to any attention. He is immobile and body wastes are excreted involuntarily into plastic receptacles. According to his physician, his brain 'is gone,' his nervous system is rapidly degenerating. He will never recover and, indeed, if it were not for the artificial support system, both

heart and breathing would cease to function.
 (Case drawn from David Hendin: Death as a Fact of Life, New York, 1973, pp. 17f.)

In such a situation would your religious organization sanction the removal of the life-support system and permit K to die? ...

2. What stand or position (if any) has your religious organization taken with regard to so-called 'active' euthanasia? ....

For example: M is 69 years old and is suffering from a virulent form of cancer that will, according to her doctors, terminate her life within a period of weeks. Her pain is excruciating; and although it is somewhat relieved by drugs, the medications leave her in a semi-comatose state which she resents. She has saved dozens of sleeping pills and other potentially lethal medications which she has hidden away. She knows she is terminal and does not want to live her remaining days in pain and in a semi-comatose state?

In such a situation would your religious organization sanction her taking the medication and thereby shorten her time of suffering and end her life, in other words - commit suicide?... (1985, pp. 145-146).
 [See **Appendix 3**]

While Larue's material is difficult to follow in places, we may clearly see in questions #1 & #2, that he has requested official positional information on 'passive' and 'active' euthanasia. With regard to his comments however, on the examples he provides in both questions (35), it is clear that Larue intends these case scenarios to function in more than an explanatory fashion. It is this intention which

raises concerns about the nature of his research. Specifically, I am troubled by what I have deemed to be Larue's 'error of assumption', at work within his questionnaire.

Let us begin by considering a prospective respondent's reaction to items # 1) & #2) of the survey. (36) In both questions, we see that after petitions for 'positional' information, and Larue's enclosed interpretation of 'passive and 'active' euthanasia respectively, we find an accompanying case study. It is here where Larue executes his erroneous assumption. It must be asked, in whose opinion do these case scenarios qualify as universally acceptable examples of 'passive' and 'active' euthanasia? What guarantee does Larue have that these cases will necessarily satisfy the demands of his respondent's religious organizations for appropriate examples of passive and active euthanasia (especially question #2)?. Keep in mind Larue's admission, that in the interests of brevity,

... it had to be assumed that the reader would know that all reasonable treatments for the diseases mentioned in the questionnaire had been exhausted and that the patient's condition was irreversible; also, it was assumed that in or out-patient care, the potential discomforts of continuing care, and the financial resources of the patient and family had been explored (1985, p. 2).

Though we may feel empathetic toward any respondent forced to contend with this problematic aspect of the questionnaire, of significance for our purposes is the general constitution of Larue's oversight. Of particular interest, is the source of his erroneous assumption.

Let us consider the two case studies under consideration. In presenting these two detailed examples, Larue has assumed that each will elicit the same fundamental perspectives on the question of AVE in his respondents, as they do in himself. Specifically, Larue has made the assumption that upon reading these examples, his respondents will automatically assign the same 'weight' or rank ordering of importance to the facts of these cases, as he does. There is no basis, however, upon which to do this. Generally, Larue is working with an unintentional presumption that prospective respondents are willing or able to look upon examples such as these, free of a priori perspectives or involvement with "euthanasia".

In the end, therefore, we are left with Larue's general problem of assuming that all respondents who read an AVE directed question or case scenario, are understood to be internalizing the originally intended question (i.e., an assumption is made that one is able to draft a question or case study which will be perceived and accepted by all respondents as a suitable example of the matter under

investigation). More precisely however, we are left with Larue's failure to acknowledge or recognize the role of 'categorical conceptualization' inherent in questions involving the morality of AVE. Allow me to elaborate.

Larue, in committing what I have referred to as an 'error of assumption', has fallen victim to a phenomenon which has plagued polling efforts in the past, and which stunned the Hemlock Society as a whole three years after the publication of Euthanasia and Religion. In the spring of 1988, despite widespread unanimity among opinion polls showing 70% of Californians supporting the notion of AVE, "A ballot initiative to legalize the provision by doctors of active euthanasia services would attract just 130,000 signatures to its qualifying petitions. The total would be less than a third of the number required to place it on the statewide November ballot..." (Parachini, 1989, p. 10). While Parachini reports that "... for bioethics scholars, it became a curious postmortem..." (1989, p. 10), a closer look at the wording utilized in two examples cited by Parachini, will illustrate a similar error of assumption as found in Larue. In 1986, an 'SRI Gallup Hospital Market Research Poll' asked Californians "Should adults who are terminally ill be allowed to legally end their lives?". Again in 1988, a 'Roper Poll' (commissioned by the Hemlock Society) asked Californians "When a person has a painful and distressing

terminal disease, do you think doctors should or should not be allowed by law to end the patient's life if there is no hope of recovery and the patient requests it?" (in Parachini, 1989, pp. 10-11, 12). According to University of Southern California Law professor Alexander Capron, by "... glossing over the distinction between active and passive euthanasia, polls of the general public had lost their claim to great relevance" (in Parachini, 1989, p. 12). More precisely, as with the Larue, we can see that by failing to recognize that respondents may answer 'questions' never originally intended by questionnaire authors, many were mistakenly led to believe that they held an accurate impression of the views of those surveyed. (37) While I am more interested in Larue's methodological oversights than I am in casting doubt over the accuracy of his findings, his inherent error of assumption may justifiably elicit such concerns.

As we move beyond the identification process however, we turn to an explanation for what it is that constitutes the erroneous aspect of this 'error'. Generally, we may attribute the confounding nature of this problem to a failure in accounting for the process by which individuals derive and maintain perspectives on the morality of AVE (i.e., categorical conceptualization). By 'categorical conceptualization', I intend a psychological process which

transpires in response to exposure to the issue of AVE, and which extends Gualtieri's methodological approach to religious ethics.

Firstly, there can be little doubt as to that which constitutes the essential moral issue of AVE - the question of the deliberate and premature termination of life (i.e., killing, under specified conditions). Secondly, according to Gualtieri (See Endnote #8) participants in religious traditions [including secularism] invoke internalized worldviews and value systems in order to provide guidance on matters of moral significance such as 'active voluntary euthanasia' (1992a). As with all moral issues involving the legitimacy of killing however, I maintain that there first unfolds a process which enables devotees to operationalize their cosmologies and axiologies in a conceptually manageable fashion. Specifically, I believe that via a complex intermingling of life experiences and cosmological perspectives, the multi-faceted 'AVE issue' is reduced to a single or limited number of primary elements, while the remaining facets are rendered largely extraneous.

Therefore, in keeping with Gualtieri's methodological approach to religious ethics, I believe that individual judgement on the morality of AVE is derived in response to the world and value views contained within one's religious tradition. Beyond Gualtieri however, I am suggesting that

one's world and value view is not brought to bear upon the entire range of issues which comprise the 'AVE debate', but rather upon a single, or limited range, of 'categories' which devotees define for themselves as preeminent to the discussion. As a result, I believe that the following scenarios may be used to account for the way in which individuals arrive at what is popularly recognized as a 'stand' on AVE.

- a) In the case of those having reduced the multifaceted AVE issue to a **single** fundamental category, then a position (i.e., normally 'pro' or 'con') is derived through an appeal to one's world and value view. Hence, one's stand on this complex matter, is largely a reflection of one's personal perspective on that which is recognized as most central to the discussion.
- b) In a situation, however, where one qualifies **more than a single** category upon which to invoke a symbolically mediated cosmology, we encounter a number of possible outcomes.

In the event that one's worldview and value system indicates a unanimous 'pro' or 'con' orientation

across each of the categories involved, one is apt to adopt a very strong position on the issue (i.e, perhaps becoming an advocate 'for' or 'against' the movement).

In circumstances where one's worldview and value system communicates a series of 'mixed messages' to the devotee, one is more likely to adopt a weak 'pro' or 'con', if not 'undecided', stand. (See Model #1a)

Model #1aa) Gualtieri's theoretical Orientation (1992a)

(->) = 'is directed upon'
 (=>) = 'leads to' or 'produces'

b) Gualtieri plus 'Categorical Conceptualization'

Note: Though a symbolically mediated worldview and value system is instrumental in the formation of the 'Categorized' version of the issue, "->" is intended to read as 'directed upon' in this model.

* - a) May involve a single fundamental Category.

b) May involve both a dominant and secondary category(ies)

If So: In the event that one's symbolically mediated worldview and value system indicates unanimous support for a 'pro' or 'con' position across all categories, one adopts a firm stand on AVE.

In the event that one's symbolically mediated worldview and value system dictates a series of contradictory perspectives across all categories, one adopts a weak 'pro', 'con', or 'undecided' stand on AVE.

In light of the multifaceted nature of "AVE", in conjunction with the uniquely individual weighing and balancing which may take place in assessing the fundamental issue(s) involved, it becomes difficult to speak of these 'categories' in ways other than generalizations. Nevertheless, and though not exhaustive, I believe that the following represent a core of general categories which many come to regard as most central to the AVE debate.

- 1) Pain - understood as the physical ramifications of illness, disease, or medical treatment, occasionally extended to immediate family in light of their commensurate mental anguish.
- 2) Suffering - understood as the psychological ramifications of illness, disease, or medical treatment, often extended to immediate family in light of the patient's condition. May also incorporate 'compassion'.
- 3) Health & Illness - for some incorporating broader questions involving 'the meaning of the body', and perhaps for Christians, questions of satanic involvement.

- 4) Afterlife - perhaps a central category for many in light of Tom Harpur's recent findings that 70% of Canadians continue to believe in some form of afterlife (1991); also involving issues of personal salvation/soteriology.
- 5) Suicide - representing a wide range of issues, from Durkheim's 'egoistic', 'anomic' and 'altruistic' evaluation of suicide, (in Davison & Neale, 1982, p. 264) to traditional Greco-Roman perspectives on the taking of one's life (e.g., Hastings, Vol. 12, 1921, p. 26ff.).
- 6) Death & Dying - incorporating issues regarding the existential threat of death and transformative/therapeutic solutions to human mortality (e.g., Gualtieri, 1984).
- 7) Sanctity of Life/Quality of Life -
very general category incorporating a wide range of 'end of life issues' (e.g., Keyserlingk, 1979).
- 8) Personal Self/Communal Self -
incorporating questions of personal autonomy and communal responsibility in matters concerning the taking of human life.

Model #1bGualtieri plus 'Categorical Conceptualization'

* - a) May involve a single fundamental Category.

b) May involve both a dominant and secondary category(ies)

If So: In the event that one's symbolically mediated worldview and value system indicates unanimous support for a 'pro' or 'con' position across all categories, one adopts a firm stand on AVE.

In the event that one's symbolically mediated worldview and value system dictates a series of contradictory perspectives across all categories, one adopts a weak 'pro', 'con', or 'undecided' stand on AVE.

** - Likely to consist of one or more of Pain, Suffering, Heath & Illness, Afterlife, Suicide, Death & Dying, Sanctity of Life/Quality of Life, Personal Self/Communal Self

*** - In light of Spiro's theory of religious 'subsystems' according to which dissimilar cosmologies may be generated among participants loyal to the same observable symbol system (1970, p. 12), it cannot be presumed that devotees of a shared tradition will embrace an identical perspective on AVE.

If we return to Larue's work, we can now offer a specific explanation for the problematic nature of his use of "for example", as it accompanies each of the two case studies. On the basis of categorical conceptualization we may suggest that what constitutes a suitable example of active euthanasia on the part of Larue, (i.e., in keeping with what he understands to represent the essential nature of the AVE issue, - perhaps pain and/or suffering, see case description #2), may not be regarded as such by the religious officials. (38)

Turning to the Introduction of Euthanasia and Religion we see that while Larue may be unaware of the intricacies of categorical conceptualization, he appears to be familiar with its general presence. In conjunction with a discussion regarding petitioning church officials for perspectives on afterlife, Larue adds that a "A wider sampling might include questions about belief in punishment in Hell for sinners, belief in an eternal paradise, belief in a physical or spiritual resurrection and so on" [emphasis mine] (1985, p. 1). (39)

Leaving Larue aside, we can also find evidence to support the presence of 'categorical conceptualization' in the public debate over AVE. As indicated above, I believe that the verbal aggression which arises between representatives occupying 'opposing camps' on moral

matters, is often precipitated by perceived threats to respective cosmologies and their resultant identities or selfhoods (See Endnote #8). Of significance, however, with regard to the verbal aggression which unfolds in response to those fears, is the particular form which that aggression occasionally takes. While some resort to 'name calling' of a derogatory nature (e.g., see Endnote #7), others invoke terminology which reflects a specific vision of the dispute, as they have come to define it. Anyone familiar with the public debate over euthanasia will have heard those who support AVE, accuse others of being 'sadists', 'uncompassionate', 'inhumane', or generally insensitive individuals. I would argue that these terms reflect the opinions of those who have reduced the AVE issue to the categories of "pain"/"suffering" and/or "personal self" (i.e., personal autonomy). Conversely, we have also heard from those opposed to AVE, accuse others of 'playing God', or being 'Nazi's' (Dying with Dignity Bulletin, Vol. 5, No. 1, 1988), perhaps in response to a fundamental "sanctity of life", and/or "communal self" orientation.

Generally, I believe that among attempts to assess public thinking on AVE, there has been a widespread failure to account for the problems of assumption inherent in many dimensions of this issue. In light of the uniquely individual perspectives we adopt on the matter, it is

unrealistic to expect prospective respondents to be either capable or willing to complete AVE surveys in a vacuum-like environment. (40) Therefore, though methodologically appealing, I believe that efforts to ensure that AVE surveys "... leave no question in the mind of the respondent concerning the nature of the issue involved" (Larue, 1985, p. 2) are largely unachievable. (41)

While categorical conceptualization remains an important consideration for those seeking to derive insight on religious perspectives regarding AVE, of more importance for our purposes is the 'cosmology-category' interaction effect described in model #1b. Again, according to this hypothesis, one derives a 'stand' on AVE by way of a two-part process of bringing to bear one's symbolically mediated world and value view upon one's 'categorically defined' interpretation of the matter. The strength of one's conviction, is dependent upon the number of categories 'admitted' or recognized as fundamental, and the commensurate guidance one's worldview imposes on those issues.

Let us now return to the matter at hand. In the case of both the Salvation Army and the Roman Catholic Church (as well as Dr. Scott, see Scott, 1988, p. 119), we are aware of their publicly expressed opposition to AVE - the result of an interaction process as depicted in model #1b [Note, that for purposes of explanation, I will now treat all Christian denominations as 'individuals']. On the basis of Festinger's theory of 'cognitive dissonance', (42) we may also assume that the Salvation Army, The Roman Catholic Church, and Reverend Scott, among others, will strive to maintain their opposition to AVE, in order to avoid suffering the undesirable ramifications of having to admit to errors in

theological or moral reasoning. Therefore, in terms of the proposed outline displayed in model #1b, what type of process(es) or series of events would we expect to find these 'individuals' most inclined to avoid? Logically, we would deduce, those with the potential to threaten currently held positions!

According to model #1b, one can envision two basic ways in which an individual's stand on AVE may be jeopardized.

- a) the introduction or elimination of fundamental 'categories' such that worldview and value perspectives brought to bear on one's essential impression of the issue, may dictate a more neutral, if not opposite stance.

AND/OR

- b) Challenges to traditional theological perspectives invoked to provide moral guidance upon one's categorical conceptualization of the issue.
(See model #2)

Model #2

(->) = 'is directed upon'
 (==>) = 'leads to' or 'produces'

(A) ==> The introduction or elimination of fundamental 'categories' such that worldview and value perspectives brought to bear on one's essential impression of the issue, may dictate a more neutral, if not opposite stance.

(B) ==> Challenges to traditional theological perspectives invoked to provide moral guidance upon one's categorical conceptualization of the issue.

In light of these considerations, I would like to return to the Dutch Pastoral Letter "Suffering and Dying of the Sick" (1985). According to the Dutch Bishops, in conjunction with the Vatican Declaration of 1980, it is important to assess the 'real meaning' behind requests for the deliberate termination of life. In the explanation which follows, again in keeping with the 1980 pronouncement, we read that with regard to patients genuinely seeking death, "... this **cannot** be their intention at all", [emphasis mine] (1985, p. 12). In terms of natural law reasoning, it is logical to assume that by "cannot" the bishops intend the impossibility of thinking otherwise, given the human instinct to live. In keeping with Festinger's theory of cognitive dissonance and the theoretical material proposed in model #2, however, perhaps one should consider assessing the 'real meaning' behind "cannot". In other words, while attempting to scrutinize religious pronouncements and scientific literature for evidence to account for church thinking on requests for AVE, perhaps I may have overlooked a more rudimentary explanation.

In the same way that I have stressed the need to examine the 'general in terms of the specific', by way of categorical conceptualization, perhaps we ought to apply the same logic to church opinion on requests for AVE. In light of Festinger's theory of dissonance, and the proposed

material in model #2, is there any reason to conclude that authentic requests for death by terminally ill patients might constitute a threat to the churches' publicly expressed stand on AVE? I believe there is. Let me begin, however, by stating that it would be improper for anyone to speculate upon the categories invoked by those 'individual' Christians who have issued comments on the 'true' nature of requests for AVE by dying patients. Nevertheless, I believe that a convincing case can be made to suggest that bona fide petitions for 'release' by dying patients could serve to undermine the basis upon which many Christians may have come to adopt an anti-AVE position. Allow me to demonstrate in terms of proposed model #2.

1) Compassion

In the event that requests for AVE were deemed authentic, it is conceivable to suggest that 'compassion' may force its way into the categorical framework of those having previously excluded it. If so, and given traditional Christian perspectives on this issue, it is reasonable to assume that one would feel compelled to lessen a strong anti-AVE position, or even reverse a weakly held stand. In the event that 'compassion' may already be represented among one's categories as "... a balance of care and respect, and a willingness to share in the burdens

and suffering of others..." (Campbell, 1991, p. 14), authentic requests for AVE may render such an interpretation less persuasive in light of the 'apparent uncaring and disrespectful nature' of depriving terminally ill patients their genuine request for death (Campbell, 1991, p. 15).

2) Suicide

Without theorizing, it would appear that among the Roman Catholic and Salvation Army churches, suicide seems to play a dominant role in their efforts to assess the morality of AVE. As a result, any AVE request deemed authentic (i.e., on a fundamental level) would clearly detract from the basis upon which these respective organizations had come to oppose AVE.

For Christians who may regard all forms of suicide as desperate solutions to transitory circumstances, or for those having rejected the possibility of humans 'accepting' their own demise (See Kubler-Ross, 1959, p. 27, Branson, 1975, p. 467, and Fitchett, 1980, p. 213), authentic requests for AVE would force a re-examination and perhaps a redefining of relatively narrow perspectives on self-death (see Hastings, Vol. 12, 1921, p. 26ff., Wallace & Eser, 1981, p. 3, Shneidman, in Chilstrom, 1989,

p. 202). Such seems to be the message contained in Vancouver Anglican priest Neil Gray's call for the church to reexamine its "... absolute blanket 'no'..." to suicide (The Vancouver Province, July 8, 1990, p. 20). In any event, accepting the legitimacy of requests for AVE would likely serve to alter traditionally held views on suicide. As a result, any anti-AVE stand which had been derived in part on the basis of one's opposition to an 'earlier version' of suicide could be weakened, if not overturned.

In the case of the Roman Church, authentic requests for AVE may result in pressure from those either within or outside the tradition to exempt such cases from those regarded suicidal. Arguing that if not qualified for exemption by way of efforts to 'spare the community excessive expense' (in Melton, 1991, p. 12), then perhaps by way of 'service to one's brethren' via sparing others the anguish and torment of witnessing a loved one's painful passing (in Melton, 1991, p. 10).

3) Individual vs. Communal Self

Consider the effect of authentic requests for death on Christians whose anti-AVE views are grounded in a fundamentally 'social' or 'relational' perspective on the self (Campbell, 1991, p. 16).

For those having rejected the plausibility of such requests in light of the potential threat to the greater community (i.e., therefore an act which would violate our essentially communal nature) (See Aquinas, Vol. 2, 1947, p. 1469, Hauerwas & Bondi, 1976, p. 443ff., Roman Catholic Bishops of California, 1988, p. 819, & Schmidt, 1989, p. 476), an admission of authenticity, could significantly undermine the basis of one's original anti-AVE stand.

Rather than dismissing the issue of 'personal autonomy' as an unacceptable secularist argument, a genuine request for AVE could undermine Christian perspectives on human nature. If nothing else, this could force Christians to entertain the possibility of there being times when one's communal instincts may be overridden by personal concerns.

4) Death and Dying

Consider as well the implications of authentic requests for death upon Christians whose anti-AVE positions are predicated on the belief that the existential terror of death is only resolvable through faith in Christ (e.g., Cullmann, in Branson, 1975).

In other words, consider the effect that genuine requests for AVE would have upon one's 'knowledge' of

'the solution' for humans seeking to defeat 'the last enemy', while on earth (e.g., Harakas, in Larue, 1985, p. 48, Anderson, p. 1986, p. 126, Roman Catholic Bishops of Oregon and Washington, 1991, p. 351) (43)(44)

Therefore, in conjunction with the implications of traditional Christian theological teaching in these areas, I am prepared to forward the following conclusions on the nature of Christian church thinking which largely rejects the authenticity of requests for AVE by terminally ill patients. In light of a lack of evidence to the contrary, I do not believe that these pronouncements represent the findings of empirically grounded research studies. In fact, in some cases, I do not believe that these claims stem from efforts to incorporate more than even a cursory review of the observable matters at hand. Rather, in keeping with Festinger's theory of dissonance, I believe that they ought to be more accurately regarded as theological by-products, conceived in response to anticipated threats to fundamental Christian perspectives responsible for formulating and maintaining opposition to the moral issue of AVE. I believe it is conceivable to suggest that Christians who report 'hearing' pleas for 'help and a reason to keep living' communicated within requests for AVE, are responding, at

2

of/de

2

PM-1 3½"x4" PHOTOGRAPHIC MICROCOPY TARGET
NBS 1010a ANSI/ISO #2 EQUIVALENT

PRECISION^{SM} RESOLUTION TARGETS

PIONEERED BY METHYLENE BLUE TESTING SINCE 1974

Microlith

THOMAS L. KELLY, INC. • BURLINGAME, CALIF. 94010 USA
TEL: 415/485-7800 FAX: 415/485-7801 TOLL FREE: 1-800-541-0000

least in part, to a sense of 'uneasiness' sure to arise in the face of authentic petitions for assisted dying.

As a result, I would hypothesize that in response to such a perceived threat, one would expect to find these individuals engaged in efforts to acquire credible evidence to support their claims. I believe that we have seen just such an effort put forth by Reverend Dr. John Scott in his submission to the Federal Legislative Committee on Bill C-203 (Presented, general rounds, November 1991, Elisabeth-Bruyere Health Centre, Ottawa).

During the course of Dr. Scott's presentation, where he reiterates his earlier opposition to AVE, (see 1988, p. 119ff.), he references a 1983 research study investigating symptoms of delirium among terminally ill patients in a New York hospital (i.e., Massie et al., 1983). According to Dr. Scott, in light of these authors having found 11 of 13 patients exhibiting symptoms of delirium (45), it is deemed acceptable to conclude that "... assessing competence in the terminally ill is a difficult issue.... [as].... Studies have shown that approximately 85% of patients with cancer or AIDS in the last month of life have major problems with brain function due to the effects of disease, drugs, and secondary metabolic changes" (Scott, Parliamentary Submission, November 19, 1991). Of additional interest however, is that in an apparent effort to provide further

support to suggest that at least some terminally ill patients ought not to be considered mentally competent, Dr. Scott invokes the use of the term "studies" in conjunction with his '85%' comment. Somewhat surprisingly, however, Dr Scott does so without reference to other research, and in opposition to the findings of Massie, Holland, and Glass who themselves report having found among other studies, reports of delirium in cancer patients ranging from 10% to 40% [emphasis mine] (Massie et al., 1983, p. 1049).

Additionally, I will hypothesize that in cases where little direct or clearly convincing evidence is uncovered to support the rejection of AVE claims as inauthentic, we will find a general down-playing of the matter. While the position will be maintained and expressed, I believe it will be done in a quiet, unassuming fashion - precisely the way we find it presented in the Salvation Army Positional Statement on Euthanasia.

In other cases however, the rejection of AVE requests as inauthentic, may be regarded as significant in terms of traditional theology and/or perhaps an individual's overall view of this issue. In these instances, I propose that we may expect to see either prolonged silence on the matter, or an aggressive endorsement of the position. I believe that we may consider the seemingly uncomfortable reaction, yet continued silence, of palliative care nurse Patricia

Bartle to Dr. Robert Buckman's claims that dying patients, on occasion, desire death, to be an example of the first response (CBC Television panel discussion, "The Journal", August 15, 1991) (46). I would propose the 1980 Vatican statement to be an example of the other (in Melton, 1991, p. 10).

It is important to note, however, that these processes of playing down, avoiding, or seeking to exaggerate research results, are not to be construed as deliberate acts of deceit or fabrication. Instead, I would prefer that what I have described above, be regarded more properly as a version of what psychologists deem 'self-fulfilling prophecy'. In other words, while there are those who are prepared to accept requests for AVE as genuine, in cases of terminal illness, I feel that those who claim to 'not hear' authentic requests for AVE, do not, in fact 'hear' such requests. In the same way that the process of 'selective attention' directs our awareness toward certain stimuli, while making us largely oblivious to others, I believe there are those who 'hear', and those who 'do not'. (47)

In an effort to present a visual explanation to account for the internal or underlying processes involved, I have presented my findings in Model #3. Keep in mind that this scenario is to be interpreted in terms of those who understand themselves to have already made public their

impressions on AVE. Recall as well, for purposes of explanation, I have opted to regard those Christian churches having expressed an opinion, as 'individuals'.

Model #3: Theoretical Account of Cognitive Processes Involved in The Formulation of Responses To AVE-Related Phenomenon (e.g., Issues, Questions, or Cases')

Objective Phenomenon
(e.g., Issues, Questions,
or Case Scenarios)
Actual or Hypothetical Data,
consisting of 'Hard'* and 'Soft'**
Facts

||
VV

Personal Adjustment Process

Information is Arranged, Filtered,
Supplemented, Rejected and 'Slotted'
According to a priori, cosmologically
generated view of AVE as:

'Pro', 'Con', or 'undecided'.

Note that original "Soft Facts" may
become "Hard Facts" during
personal adjustment process

||
VV

**Personally Reformulated
Question or perception of Issue**
put to oneself for ensuing
'cosmological analysis'

||
VV

Moral Issue as Personally Categorized

^
|

----->
----->

Position
On
Objective
Phenomenon

**Symbolically Mediated Worldview and
Value System**

* - By "hard facts", I intend those indisputable details of an AVE-Related issue (contrived or actual), which can be readily affirmed by all (e.g., a patient's name, age, physical location, current medication, and a clearly expressed request(s) for AVE)

** - By "soft facts" I intend those less concrete aspects of an AVE-Related issue (contrived or actual), made disputable as a result of subjective a priori thinking on the issue (e.g., the 'true' nature of patient requests for AVE)

|| - 'leads to' or 'produces'
vv

^ - 'is directed upon'
|

----> - 'results in'
---->

In light of the visual presentation, it becomes easier to comprehend my objections to those such as Larue, who call for AVE surveys to "... leave no question in the mind of the respondent concerning the nature of the issue involved" (1985, p. 2). As is demonstrated in model #3, we can see that once presented, the original 'case study' is then subjected to a process of filtering and adjustment, beyond any pollster's best efforts to insure precision and/or clarity.

In addition to the cognitive rearrangement and adjustment processes which may take place, I also believe that on occasion, original data may be supplemented in response to a priori involvement with AVE. According to Christianity Today editor David Neff for example, (and contrary to pre-recorded statements made by Janet Adkins prior to her death, The Calgary Herald, June 7, 1990, p. C9, or any other media report of which I am aware) it was as a result of her husband Ron's difficulty in dealing with her illness, which resulted in Janet's perceived need to "... get out of the way of the living" (1990, p. 14), and to enlist Dr. Kevorkian's services. (48)

In essence, I have put forth a model which demonstrates an interesting variation of the above mentioned slippery-slope phenomenon. In the same way that some reject the liberalization of AVE for fear of 'where it may lead', I

believe that it is common for many to filter AVE-related data with an eye toward the perceived ramifications of such thinking on one's overall impression of the issue. (49)

I must reiterate, however, that this model may be as easily applied to those who find themselves in favour of AVE as to those who do not. Nevertheless, in keeping with the particular subject matter under consideration, I cannot help but recognize those Christians who have come to reject the authenticity of requests for AVE, echoed in the words of Charles Neuringer: "Suicide is a terrifying event. Since it frightens us that some people rush to embrace the one event that all humans are supposed to fear and loathe, we avoid understanding self-destruction in order to remain comfortable in our minds" (1987-88, p. 160).

ENDNOTES

- 34) I believe that comments contained in the Preface may reflect an awareness of these difficulties:
"Because of pressures of time and another research project, my findings were limited to what was available during the allotted period" (Larue, 1985, pp. ix-x).
- 35) "It should also be noted that the questionnaire limits the discussion of euthanasia to the terminally ill. It does not include the termination of life by those who may be painfully afflicted but are not terminally ill. Nor does it embrace the plight of the emotionally distraught, who find the pressures of life overwhelming and wish to commit suicide. By limiting the discussion to those suffering terminal illness, the concerns about potential excesses as expressed in so-called 'wedge' or 'domino' theories or 'slippery-slope' arguments are avoided". (Larue, 1985, pp. 4-5)
- 36) Setting aside the inherent difficulties associated with the artificiality of a 'Religion, and Adjunct Professor of Gerontology' attempting to ascertain euthanasia perspectives of religious officials, via a medium so foreign to both professions.

- 37) On the basis of a similar error of assumption, I will suggest that a 1989 Canadian Gallup Poll survey indicating widespread national support for AVE across Canada, has presented a partially flawed result. According to Gallup, "... four-in-five citizens of the province of Quebec (81%) believe that mercy killing should be allowed" [with 83% of Montrealers in agreement], giving Quebec the highest percentage of regional support in Canada (Bozinoff & MacIntosh, 1989). The problem with the survey, however, lies in the translated version of the English question which originally asked: "When a person has an incurable disease that causes great suffering, do you, or do you not think that competent doctors should be allowed by law to end the patient's life through mercy killing, if the patient has made a formal request in writing" (Bozinoff & MacIntosh, 1989). Unfortunately, in the French translation, we find "mercy killing" replaced with "euthanasie". Therefore, as in the California example, one should not be surprised by the Quebec findings, given the imprecision of the term "euthanasie" in relation to the more restrictive "mercy killing".

* "Lorsqu'une personne est atteinte d'une maladie incurable lui occasionnant des grandes souffrances, croyez-vous, ou non, qu'en vertu de la loi, des médecins compétents pourraient mettre un terme à la vie du patient par euthanasie, si le patient en fait la demande formelle par écrit? (1989).

38) While I have been critical of Larue at times, I believe that he is to be commended for having thought to petition the churches for their ethical and theological reasoning on such matters (i.e., 1985, pp. 145-6).

39) Note however, that Larue is only inferring his perspective on what might qualify as a 'wider sampling' on this issue.

As a further assumption we also see Larue commit an oversight of which others have been guilty. By providing his readers with a brief historical review of church thinking on suicide (1985, p. 3ff.), Larue implies that we are to regard current church perspectives on PVE/AVE in light of such historical teaching (See also Brody, 1989, p. 1ff., and Fye, 1979, pp. 493-4).

As support for my objection, I include Dr. Darrel Amundsen's comments that in his opinion, tracing the Christian response to pain/and or suffering seems the more appropriate decision, in light of Protestant

church thinking on euthanasia (In conversation, Spring, 1991). It is Dr. Royce Clark's view that the "... church's aversion to suicide need not inform its position on voluntary active euthanasia any more than it informs its understanding of the role Jesus played in securing his own death" (1986, p. 264). In fact, according to Dr. Gary Ferngren, prior to Roman Catholic teaching on euthanasia which began in the early 1950's, 'there is really no history of AVE in the Christian church' (in conversation, Spring, 1991).

- 40) I feel that the tendency to define an issue on the basis of one's involvement with it, has become dangerously widespread in the euthanasia matter. In fact I believe that we have reached a point where we can no longer assume that surveys conducted in order to provide a current consensus on the euthanasia issue in Canada, are not riddled with respondent specific a priori notions of euthanasia, and stand to do more harm than good, if interpreted as a partial basis upon which to eventually propose legislation.

Citing similar concerns, I have been informed by members of the "Law Reform Commission of Canada" of the highly skeptical view they take of such 'findings'.

- 41) As a result of the obvious need to ensure precision of language in such cases, and in light of the absence of a nationally recognized strict definition of 'euthanasia', I believe that rather than eliminating the traditional qualifiers 'active', 'passive', 'voluntary' or 'involuntary', as some have suggested, we should seek to preserve them. In fact, I support suggestions that the term 'uninformed', rather than 'involuntary', be implemented in euthanasia cases where, as a result of one's medical condition, two-way communication between patient and physician is not possible.
- 42) Cognitive Dissonance: "An internal state of unease produced when one perceives inconsistencies between one's attitudes or between one's attitudes and one's actions" (Rubin & McNeil, 1981, p. 623).
- 43) Nevertheless, it remains somewhat unclear as to the influence of this 'knowledge' upon the existential fear of death, over the course of one's remaining days (Gualtieri, in Conversation, March, 1992).
- 44) As things stand, however, it might be argued by Christians that 'all this talk about AVE' ought to be

force, in answer to a group of doctors who had put the question: "Is the suppression of pain and consciousness by the use of narcotics ... permitted by religion and morality to the doctor and the patient (even at the approach of death and if one foresees that the use of narcotics will shorten life)?", the Pope said: "If no other means exist, and if, in the given circumstances, this does not prevent the carrying out of other religious and moral duties: Yes".⁵ In this case, of course, death is in no way intended or sought, even if the risk of it is reasonably taken; the intention is simply to relieve pain effectively, using for this purpose painkillers available to medicine.

However, painkillers that cause unconsciousness need special consideration. For a person not only has to be able to satisfy his or her moral duties and family obligations; he or she also has to prepare himself or herself with full consciousness for meeting Christ. Thus Pius XII warns: "It is not right to deprive the dying person of consciousness without a serious reason".⁶

IV

DUE PROPORTION IN THE USE OF REMEDIES

Today it is very important to protect, at the moment of death, both the dignity of the human person and the Christian concept of life, against a technological attitude that threatens to become an abuse. Thus, some people speak of a "right to die", which is an expression that does not mean the right to procure death either by one's own hand or by means of someone else, as one pleases, but rather the right to die peacefully with human and Christian dignity. From this point of view, the use of therapeutic means can sometimes pose problems.

In numerous cases, the complexity of the situation can be such as to cause doubts about the way ethical principles should be applied. In the

⁵ Pius XII, *Address of 24 February 1957*: AAS 49 (1957), p. 147.

⁶ Pius XII, *ibid.*, p. 145; cf. *Address of 9 September 1958*: AAS 50 (1958), p. 694.

- 48) In a similar example, we learn in Lyn Cryderman's account of a second couple having travelled to meet with Dr. Kevorkian [supported], with 'her, weary from living with a disease', and "... **he at rope's end over caring for a sick wife**" [unsupported] [emphasis mine] (Christianity Today, October 22, 1990, p. 23)
- 49) As a testimony to the adaptability of this model, consider Bishop William Skylstad's charge in a paper submitted to the U.S. bishops' Ad Hoc Committee for the Canonical Determination of the Age of Confirmation, entitled "What is the Right Question About Confirmation Age?". According to Skylstad "'I would like to suggest that it is important that we address the correct question' in examining the age for confirmation .... [because] .... 'if you ask the wrong question, you get the wrong answer'" (1992, p. 701). Bishop Skylstad then adds, "the review of the original American norm [i.e., the rite of confirmation] gives us an appropriate opportunity to **reframe** this important pastoral question". [emphasis mine] (1992, p. 703).
- Finally, as a clear example of the recognition and use of 'categories' inherent in this particular 'issue', he proposes that

It seems to me that the **fundamental question** must be **framed** within the traditional understanding of the sacramental ministry of the bishop. While I would not dare to say that I have "'custody of the question'", I believe that it must **center** on the role of the bishop rather than on the age of the candidates. If this proper focus is not gained, then **competing and inappropriate questions** evade the **real** issue [emphasis mine] (1992, p. 703).

Chapter Five

Social Ramifications

Having forwarded a proposed explanation by which to account for church thinking on requests for AVE, we may wish to consider Courtney Campbell's rhetorical charge: "So What?". According to Campbell "... in a pluralistic society that requires a secular rationale for public policy, explicitly religious appeals and arguments have at best limited relevance" (1991, p. 2). "So what", for example, if the Lutheran Church-Missouri Synod maintains that on matters of extraordinary care, "the patient cannot, as a rule, be consulted because of the great confusion and disorientation resulting from the effects of both the disease and the medication?" (1979, p. 12). Of what significance is this beyond the confines of the Lutheran Church, or possibly the Christian community?

As a partial response to his own question, Campbell reminds us that "... religious discourse on euthanasia as a public policy issue may not always be recognizably religious" (Campbell, 1991, p. 18). While one is unlikely to find Church pronouncements presented in terms of official public policy on this issue, we must not fail to consider

alternative means by which Christian thinking on requests for active voluntary euthanasia may find more subtle forms of expression. (50)

Consider, for example, the potential influence of Reverend Dr. John Scott on this matter. In addition to his being a staunch anti-AVE supporter, Dr. Scott is also a physician at the Elizabeth-Bruyere Health Centre (Ottawa), and is chairman of the Palliative Care Committee for the Ontario Medical Association (Harvey, The Ottawa Citizen, June 8, 1991, p. A21). As a result, in addition to his involvement with individual cases on a routine basis, Dr. Scott is also in a position to advance his opinion on requests for AVE across a variety of health care and related associations in Ontario, and beyond.

In light of Reverend Dr. Scott's religious affiliation, we are able to surmise that his perspective on requests for AVE are in large part a reflection of his Christian theological leanings. In cases however, where less is known of the religious orientation of those sharing a similar point of view (e.g., American physician Dr. Robin Bernhoft (51)), one must proceed more cautiously with one's assumptions. Nevertheless, while it would be presumptuous to attribute a Judeo-Christian cosmology to all health care professionals holding a similar position to Dr. Scott's, such an assumption would not be unfounded. We may cite, for

example, a recent research finding which has established a link between the religious orientation of medical personnel and their commensurate views on active mercy killing (i.e., with a correlation between MD and RN opposition to AVE, varying in response to subject age and religious attachment) (De Veber and Henry in Journal of Palliative Care, Vol. 6, No. 3, 1990, p. 53). Though a significant result in itself, a great deal more research is required before a causal relationship between church thinking on AVE requests and the views of medical staff who oppose euthanasia, might be established. In the interim, however, it can be argued that pronouncements such as those issued by the Roman Church and Salvation Army will certainly serve to support those sharing similar perspectives on the 'true' nature of requests for AVE by dying patients. (52)

Let us turn our attention to the potentially influential role of church thinking upon Canadian Hospice Care Policy. As indicated above, the now North American-wide presence of the 'hospice movement' may trace its modern historical roots to the founding work of Anglican Physician Dr. Cicely Saunders (See Endnote # 17). While the traditionally Christian orientation of this program may be waning somewhat, it is well recognized that the teachings of Dr. Elizabeth Kubler-Ross still comprise the foundation of Hospice treatment philosophy (Rinaldi and Kearl, 1990,

pp. 289-290). Of significance therefore, is the way in which those such as committed Christian Dr. Hugh Trowell have invoked Kubler-Ross' work in order to cast doubt upon the reliability of requests for death by dying patients (see Chapter 3). Though I may only speculate as to the direct influence, if any, of church thinking upon hospice care facilitators, we do know that according to Dr. Frank Foley (medical director of 'Casey House' hospice in Toronto), "Finding a way to help people end their lives is barking up the wrong tree" (The Globe and Mail, June 30, 1990, p. D8).

In keeping with Dr. Trowell's comments, we may turn to the measurement of psychological competency in dying patients in order to further assess the potentially influential effects of Church thought regarding AVE. From the outset, there may be those prepared to regard Church teaching in this area, as indicative of a broader historical influence of Christian thought on shaping conventional definitions of 'normality'. Nevertheless, and while it is beyond the scope of this paper to attempt to demonstrate a causal relationship between church thought on AVE and psychiatric/psychological opinion, we may illustrate that such thinking lends credibility to the A.P.A. view that 'recurrent thoughts of death, suicide, or wishes to be dead' are indicative of clinical depression (in Woo, 1988, pp. 50-51). (53) Although the habitual linking of suicidal thought

with criteria for depressive disorder has been deemed problematic (Brown, et al., 1986, p. 208), it is evident that Christian perspectives on the 'true nature' of requests for AVE may function to endorse this diagnostic classification.

Finally, let us speculate somewhat about the influence such thinking may have had on the above mentioned case of 'Nancy B'. On November 14, 1991 it became public knowledge that a 24 year old Quebec City woman, suffering from a degenerative muscular disease which had left her paralyzed from shoulders to feet, had filed suit in Quebec court seeking the removal of all life-support equipment.

Initially, it was conveyed by the media that "She wants to die, and has... wanted to die since last April" [i.e., when Nancy initiated the first of two hunger strikes, both of which later ended as a result of severe stomach pain] (The Ottawa Citizen, November 14, 1991, p. A6). In the weeks which followed, we also learned of her mother's expressed testimony that "... her daughter was so determined to die that she [Nancy] willed her furniture to charities" (The Ottawa Citizen, November 28, 1991, p. A1). Finally, we heard Nancy herself proclaim that "I don't want to live any more..." (The Ottawa Citizen, November 29, 1991, p. 1), in conjunction with psychiatric assurances that she had been consistent in her requests and was not suffering from

psychosis (The Ottawa Citizen, November 28, 1991, p. A2).

Nevertheless, it was lawyer Edward Keyserlingk (CBC Radio, December 4, 1991) and ethicist Jim Lavery's professed opinion that Nancy 'did not actually want to die' (The Globe and Mail, January 7, p. A15). (54) According to these two individuals, and a host of medical-ethical experts, it was argued that though Nancy's comments may have given the impression that she was actively seeking death, she was, more accurately, seeking an opportunity to allow nature to 'retake its natural course' (The Ottawa Citizen, November 30, 1991, p. 3). (55) While neither Keyserlingk nor Lavery uttered their remarks in conjunction with a clearly professed Christian religious affiliation (56), we certainly see the presence of 'church-like' thinking in their respective pronouncements.

With church thinking on requests for assisted death playing a supporting role in each of these instances, there is a further AVE-related development worth noting. While retaining my reservations about opinion poll results, a 1991 survey conducted as joint venture by The Boston Globe and The Harvard School of Public Health, found that 71% of Catholics and 57% of Protestants said they would vote in favour of the Washington initiative legalizing doctor assisted suicide (in the case of the Catholics, putting them 10% over the 61% National American Average) (Lawton, 1991, p. 50). While officials might be tempted to dismiss these

results, on the basis of their isolated nature, it may be of more concern to find that these figures are in accordance with a growing trend among poll findings. According to a 1990 USA Roper Poll, for example, it was found that 65% of Protestants and 62% of Catholics favoured doctor assisted euthanasia. According to the Park Ridge Center in Chicago, citing "... changes in certain religious and moral beliefs ..." research shows that there are now a growing number of Christians who consider euthanasia to be an acceptable practice under strict circumstances (1991, p. 30).

Therefore, while ecclesiastical teaching on euthanasia may be contributing support to traditional medical/legal opposition to AVE, ironically, it may also be responsible for simultaneously alienating its own devotees. While surely not solely responsible for recent opinion poll figures, church thinking on requests for AVE may be operating in a further supportive, yet highly paradoxical, fashion. Specifically, church opinions on petitions for assisted death may be contributing to a growing resentment among Christians over religious teaching and/or practice in the following areas:

- a) a general perception of the dying not being 'heard' from in meaningful ways. One thinks of cries from pain and discomfort being met with subtle reminders of the merits of suffering, (Sullivan, 1950, p. 75, New Catholic

Encyclopedia, Vol. V, 1967, p. 640) or ministers speaking of the ways in which "the dying may teach the living" - provided that the message delivered is in conformity with established church thought (e.g., Clark, 1980-81, p. 166). (57)

- b) an increasing hostility toward church thinking on 'suicide', as evidenced by Christians now questioning early church decisions to collapse and renounce all 'types' of Hellenistic suicide as sinful, (e.g., see Suicide - 'Greek & Roman', in Hastings, Vol 12, 1921, p. 26ff.) (58)
- c) a growing resentment among Christians over the lack of 'control' awarded terminal patients with regard to treatment options. (59) (60)

One could speculate at great length over what may be responsible for the apparent increased support given 'assisted suicide' by Christians. Until church officials are thoroughly satisfied with an explanation however, I would not recommend overlooking the influence of thinking which regards requests for AVE by dying patients as petitions for 'help, love, or 'a reason to keep living'.

ENDNOTES

- 50) As in earlier chapters where reference is made to 'Christian perspectives on the nature of requests for AVE', the scarcity of official positional statements limits me to speaking directly to the Roman Catholic, Salvation Army, and to a lesser extent, Lutheran (Canada) churches.
- 51) Bernhoft was President of the "Washington Physicians Against 119" - the 1991 Washington State initiative to legalize active voluntary euthanasia, which was defeated by a margin of 54% to 46% (The Ottawa Citizen, November 6, 1991 p. A6).
- 52) More broadly, we must also recognize the pervasive influence which Christian theology continues to exercise upon the increasingly secular philosophical tenets of western medical ethics (Sevensky, 1983, Boisvert, 1988, p. 115, and Verhey, 1990, p. 23).
- 53) Note that equating suicidal ideation with clinical depression may also prevent the development of a Dutch-like response to euthanasia in Canada.

By stressing the need to **determine** competency in matters requiring voluntary consent (Paterson-Tucker, 1989, pp. 20-21), Canadian legal/medical officials have opposed Dutch thinking which generally regards terminally ill patients **as competent** unless proven otherwise (Dupuis, in conversation, Fall, 1990, & Winter, 1991).

Note as well, the lack of consideration given the conceivably rational and logical nature of a decision to terminate prematurely an anticipated period of pain or anguish prior to death.

- 54) Note, that in addition to my speculation about the role that Christian church claims regarding 'inauthentic requests for death by patients' may have had on this case, we see in the comments of both men a further example of the proposed 'filtering' and 'rejecting' of 'soft data'.
- 55) While many would agree that the fields of Law, ethics, and medicine owe their traditional moral perspectives on the taking of human life to Christian theology, this argument also serves to demonstrate the extent to which all three professions have

subsequently incorporated the secular values commensurate with a technologically driven worldview.

I believe that for some the 'killing/ letting die' position became an ethical 'line in the sand' which enabled these parties to avoid the moral dilemmas associated with the axiological implications of adopting dissimilar worldviews. By maintaining this distinction, and rejecting Rachels' argument*, they managed to balance Christian demands for a prohibition against killing, and the rights of the community, with secular calls for 'personal autonomy' and a technological say in the dying process (i.e., the manipulation of death by mechanical means).

* - In the case of Nancy's physician, Dr. Daniele Marceau however, it is important to note that she had initially balked at the notion of participating in the process until having convinced herself that she was only a 'spectator' at Nancy's death, "Not an actor. Being an actor would have meant killing" (The Ottawa Citizen, December 9, 1991, p. A3).

Note: According to the Clinical Care Committee of the Massachusetts General Hospital, turning off a respirator has been considered a definite act of commission since 1976 (in Melton, 1991, p. 66).

- 56) A Roman Catholic Church official from Quebec did issue ecclesiastical support for Nancy's actions on the grounds that such treatment legitimately constituted 'disproportionate means'.
- 57) In a similar fashion, we saw evidence during the 'Nancy B' case of the need to ensure that Nancy's petition was presented in such a manner as to enable the courts to comply with her request, without jeopardizing public interest. Note the gradual transposition of commentary over the three month period from that of 'Nancy wants to die', to 'Nancy wants to be free of her respirator', etc. Note as well, that in light of the absence of virtually any published response from Nancy following the court decision, public concern was eased as we were left to assume that Nancy had received that which she had sought, on the basis of **why** she had sought it! (i.e., to 'live' free of the respirator, and not to become dead!)
- 58) We see these concerns expressed in Aids counsellor, Reverend Neil Gray's opinion, where "... if there is just deterioration it may be possible to co-operate with God in the death process (The Vancouver Province, July 8, 1990, p. 20).

In accounting for the increasing Christian support for AVE, the Park Ridge Center reports that

Some [Christians] maintain that euthanasia should not be lumped with other forms of prohibited killing. The motive for the killing is different; the circumstances surrounding it are different. The moral evil present in other forms of taking innocent life may not be present here. Hastening someone's dying at her request does not seem to be morally the same as depriving someone of future life against her will for such reasons as greed, revenge, jealousy, and hatred (1991, p. 30).

Note as well, that in light of traditional Christian aversion to the notion of 'types' of suicide, it is not difficult to accept the results of a study which name clergy as those mental health professionals least capable of identifying signs of suicide (Domino & Swain, 1985-6).

- 59) In this instance, the churches may be regarded as 'guilty by association' in light of their anti-AVE stand which limits patient options on end-of-life matters.

Nevertheless, there is now increasing support for psychological evidence which clearly suggests that terminally ill patients desperately desire and benefit from a sense of control over their destiny (Levitt & Guralnick, 1985, pp. 255-6, Pepler & Lynch,

in The Journal of Palliative Care, Vol 6, No. 3, 1990, p. 58, Tuohey, in Corless, 1991, p. 57, and Bergen and Nelson 1982, p. 177). It is also acknowledged, for example, in a 1974 Methodist Conference Statement (England) that "There are people whose lives are consciously or unconsciously shadowed by the fear of a painful and difficult death" (in Melton, 1991, p. 178).

- 60) The issue of control raises an interesting point with regard to Christian support for AVE. In light of evidence that liberal access to abortion or euthanasia apparently fails to generate excessive requests, (Abbing, 1988, p. 72, Van Der Maas, 1991) and given the increasing significance attached to patient participation in the treatment process, perhaps we should consider the following. Might not the Boston Globe/Harvard Poll results be a reflection of a growing demand among Christians for the 'right-to-dictate', rather than the right-to-die. Instead of inferring that Christians are increasingly prepared to participate in AVE if desired, perhaps these figures ought to be regarded as an expressed desire for options on all end-of-life matters.

Appendix 1

The Salvation Army Positional Statement on Euthanasia

The Christian faith puts death into proper perspective as the transition from earthy life to life eternal. In this context, The Salvation Army believes that man has not the right to death by his own decision, whether procured by his own act or by the commissioning of another person to secure it.

The common experience of Christians throughout the ages has been that the grace of God sustains heart and mind to the end. To many, the end of life is clouded by pain and impaired judgement, and whilst we believe that it is right to use all and any medical treatment to control pain, experience denies the rightness of legalizing the deliberate termination of life by a doctor, authorized by a statement signed by the patient whilst in health. Such euthanasia threatens to debase the function of doctors and impairs the confidence of their patients.

As an extension of this subject, The Salvation Army accepts that a next-of-kin to a patient is justified in agreeing to medical advice to remove life support systems when brain death has occurred.

We promote the concept of palliative care and death with dignity in treating the patient in social, medical and spiritual aspects

- Issued by the authority of the Territorial Commander, Canada and Bermuda Territory, 1990.

Appendix 2

SACRED CONGREGATION FOR THE DOCTRINE OF THE FAITH

DECLARATION ON EUTHANASIA

INTRODUCTION

The rights and values pertaining to the human person occupy an important place among the questions discussed today. In this regard, the Second Vatican Ecumenical Council solemnly reaffirmed the lofty dignity of the human person, and in a special way his or her right to life. The Council therefore condemned crimes against life "such as any type of murder, genocide, abortion, euthanasia, or wilful suicide" (Pastoral Constitution *Gaudium et Spes*, 27).

More recently, the Sacred Congregation for the Doctrine of the Faith has reminded all the faithful of Catholic teaching on procured abortion.¹ The Congregation now considers it opportune to set forth the Church's teaching on euthanasia.

It is indeed true that, in this sphere of teaching, the recent Popes have explained the principles, and these retain their full force;² but

¹ *Declaration on Procured Abortion*, 18 November 1974: AAS 66 (1974), pp. 730-747.

² Pius XII, *Address to those attending the Congress of the International Union of Catholic Women's Leagues*, 11 September 1947: AAS 39 (1947), p. 483; *Address to the Italian Catholic Union of Midwives*, 29 October 1951: AAS 43 (1951), pp. 835-854; *Speech to the members of the International Office of military medicine documentation*, 19 October 1953: AAS 45 (1953), pp. 744-754; *Address to those taking part in the IXth Congress of the Italian Anaesthesiological Society*, 24 February 1957: AAS 49 (1957), p. 146; cf. also *Address on "resurrection"*, 24 November 1957: AAS 49 (1957), pp. 1027-1033; PAUL VI, *Address to the members of the United Nations Special Committee on Apartheid*, 22 May 1974: AAS 66 (1974), p. 346; JOHN PAUL II, *Address to the Bishops of the United States of America*, 5 October 1979: AAS 71 (1979), p. 1225.

the progress of medical science in recent years has brought to the fore new aspects of the question of euthanasia, and these aspects call for further elucidation on the ethical level.

In modern society, in which even the fundamental values of human life are often called into question, cultural change exercises an influence upon the way of looking at suffering and death; moreover, medicine has increased its capacity to cure and to prolong life in particular circumstances, which sometimes give rise to moral problems. Thus people living in this situation experience no little anxiety about the meaning of advanced old age and death. They also begin to wonder whether they have the right to obtain for themselves or their fellowmen an "easy death", which would shorten suffering and which seems to them more in harmony with human dignity.

A number of Episcopal Conferences have raised questions on this subject with the Sacred Congregation for the Doctrine of the Faith. The Congregation, having sought the opinion of experts on the various aspects of euthanasia, now wishes to respond to the Bishops' questions with the present Declaration, in order to help them to give correct teaching to the faithful entrusted to their care, and to offer them elements for reflection that they can present to the civil authorities with regard to this very serious matter.

The considerations set forth in the present document concern in the first place all those who place their faith and hope in Christ, who, through his life, death and Resurrection, has given a new meaning to existence and especially to the death of the Christian, as Saint Paul says: "If we live, we live to the Lord, and if we die, we die to the Lord" (*Rom* 14:8; cf. *Phil* 1:20).

As for those who profess other religions, many will agree with us that faith in God the Creator, Provider and Lord of life — if they share this belief — confers a lofty dignity upon every human person and guarantees respect for him or her.

It is hoped that this Declaration will meet with the approval of many people of good will, who, philosophical or ideological differences

notwithstanding, have nevertheless a lively awareness of the rights of the human person. These rights have often in fact been proclaimed in recent years through declarations issued by International Congresses;³ and since it is a question here of fundamental rights inherent in every human person, it is obviously wrong to have recourse to arguments from political pluralism or religious freedom in order to deny the universal value of those rights.

I

THE VALUE OF HUMAN LIFE

Human life is the basis of all goods, and is the necessary source and condition of every human activity and of all society. Most people regard life as something sacred and hold that no one may dispose of it at will, but believers see in life something greater, namely a gift of God's love, which they are called upon to preserve and make fruitful. And it is this latter consideration that gives rise to the following consequences:

1. No one can make an attempt on the life of an innocent person without opposing God's love for that person, without violating a fundamental right, and therefore without committing a crime of the utmost gravity.⁴

2. Everyone has the duty to lead his or her life in accordance with God's plan. That life is entrusted to the individual as a good that must bear fruit already here on earth, but that finds its full perfection only in eternal life.

3. Intentionally causing one's own death, or suicide, is therefore equally as wrong as murder; such an action on the part of a person is to be

³ One thinks especially of Recommendation 779 (1976) on the rights of the sick and dying, of the Parliamentary Assembly of the Council of Europe at its XXVIIth Ordinary Session; cf. SIPECA, No. 1, March 1977, pp. 14-15.

⁴ We leave aside completely the problems of the death penalty and of war, which involve specific considerations that do not concern the present subject.

considered as a rejection of God's sovereignty and loving plan. Furthermore, suicide is also often a refusal of love for self, the denial of the natural instinct to live, a flight from the duties of justice and charity owed to one's neighbour, to various communities or to the whole of society—although, as is generally recognized, at times there are psychological factors present that can diminish responsibility or even completely remove it.

However, one must clearly distinguish suicide from that sacrifice of one's life whereby for a higher cause, such as God's glory, the salvation of souls or the service of one's brethren, a person offers his or her own life or puts it in danger (cf. *Jn* 15:14).

II

EUTHANASIA

In order that the question of euthanasia can be properly dealt with, it is first necessary to define the words used.

Etymologically speaking, in ancient times *euthanasia* meant an *easy death* without severe suffering. Today one no longer thinks of this original meaning of the word, but rather of some intervention of medicine whereby the sufferings of sickness or of the final agony are reduced, sometimes also with the danger of suppressing life prematurely. Ultimately, the word *euthanasia* is used in a more particular sense to mean "mercy killing", for the purpose of putting an end to extreme suffering, or saving abnormal babies, the mentally ill or the incurably sick from the prolongation, perhaps for many years, of a miserable life, which could impose too heavy a burden on their families or on society.

It is therefore necessary to state clearly in what sense the word is used in the present document.

By euthanasia is understood an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated. Euthanasia's terms of reference, therefore, are to be found in the intention of the will and in the methods used.

It is necessary to state firmly once more that nothing and no one can in any way permit the killing of an innocent human being, whether a foetus or an embryo, an infant or an adult, an old person, or one suffering from an incurable disease, or a person who is dying. Furthermore, no one is permitted to ask for this act of killing, either for himself or herself or for another person entrusted to his or her care, nor can he or she consent to it, either explicitly or implicitly. Nor can any authority legitimately recommend or permit such an action. For it is a question of the violation of the divine law, an offence against the dignity of the human person, a crime against life, and an attack on humanity.

It may happen that, by reason of prolonged and barely tolerable pain, for deeply personal or other reasons, people may be led to believe that they can legitimately ask for death or obtain it for others. Although in these cases the guilt of the individual may be reduced or completely absent, nevertheless the error of judgment into which the conscience falls, perhaps in good faith, does not change the nature of this act of killing, which will always be in itself something to be rejected. The pleas of gravely ill people who sometimes ask for death are not to be understood as implying a true desire for euthanasia; in fact it is almost always a case of an anguished plea for help and love. What a sick person needs, besides medical care, is love, the human and supernatural warmth with which the sick person can and ought to be surrounded by all those close to him or her, parents and children, doctors and nurses.

III

THE MEANING OF SUFFERING FOR CHRISTIANS AND THE USE OF PAINKILLERS

Death does not always come in dramatic circumstances after barely tolerable sufferings. Nor do we have to think only of extreme cases. Numerous testimonies which confirm one another lead one to the con-

clusion that nature itself has made provision to render more bearable at the moment of death separations that would be terribly painful to a person in full health. Hence it is that a prolonged illness, advanced old age, or a state of loneliness or neglect can bring about psychological conditions that facilitate the acceptance of death.

Nevertheless the fact remains that death, often preceded or accompanied by severe and prolonged suffering, is something which naturally causes people anguish.

Physical suffering is certainly an unavoidable element of the human condition; on the biological level, it constitutes a warning of which no one denies the usefulness; but, since it affects the human psychological makeup, it often exceeds its own biological usefulness and so can become so severe as to cause the desire to remove it at any cost.

According to Christian teaching, however, suffering, especially suffering during the last moments of life, has a special place in God's saving plan; it is in fact a sharing in Christ's Passion and a union with the redeeming sacrifice which he offered in obedience to the Father's will. Therefore one must not be surprised if some Christians prefer to moderate their use of painkillers, in order to accept voluntarily at least a part of their sufferings and thus associate themselves in a conscious way with the sufferings of Christ crucified (cf. *Mt 27: 34*). Nevertheless it would be imprudent to impose a heroic way of acting as a general rule. On the contrary, human and Christian prudence suggest for the majority of sick people the use of medicines capable of alleviating or suppressing pain, even though these may cause as a secondary effect semiconsciousness and reduced lucidity. As for those who are not in a state to express themselves, one can reasonably presume that they wish to take these painkillers, and have them administered according to the doctor's advice.

But the intensive use of painkillers is not without difficulties, because the phenomenon of habituation generally makes it necessary to increase their dosage in order to maintain their efficacy. At this point it is fitting to recall a declaration by Pius XII, which retains its full

force, in answer to a group of doctors who had put the question: "Is the suppression of pain and consciousness by the use of narcotics ... permitted by religion and morality to the doctor and the patient (even at the approach of death and if one foresees that the use of narcotics will shorten life)?", the Pope said: "If no other means exist, and if, in the given circumstances, this does not prevent the carrying out of other religious and moral duties: Yes".⁵ In this case, of course, death is in no way intended or sought, even if the risk of it is reasonably taken; the intention is simply to relieve pain effectively, using for this purpose painkillers available to medicine.

However, painkillers that cause unconsciousness need special consideration. For a person not only has to be able to satisfy his or her moral duties and family obligations; he or she also has to prepare himself or herself with full consciousness for meeting Christ. Thus Pius XII warns: "It is not right to deprive the dying person of consciousness without a serious reason".⁶

IV

DUE PROPORTION IN THE USE OF REMEDIES

Today it is very important to protect, at the moment of death, both the dignity of the human person and the Christian concept of life, against a technological attitude that threatens to become an abuse. Thus, some people speak of a "right to die", which is an expression that does not mean the right to procure death either by one's own hand or by means of someone else, as one pleases, but rather the right to die peacefully with human and Christian dignity. From this point of view, the use of therapeutic means can sometimes pose problems.

In numerous cases, the complexity of the situation can be such as to cause doubts about the way ethical principles should be applied. In the

⁵ Pius XII, *Address of 24 February 1957*: AAS 49 (1957), p. 147.

⁶ Pius XII, *ibid.*, p. 145, cf. *Address of 9 September 1958*: AAS 50 (1958), p. 694.

final analysis, it pertains to the conscience either of the sick person, or of those qualified to speak in the sick person's name, or of the doctors, to decide, in the light of moral obligations and of the various aspects of the case.

Everyone has the duty to care for his or her own health or to seek such care from others. Those whose task it is to care for the sick must do so conscientiously and administer the remedies that seem necessary or useful.

However, is it necessary in all circumstances to have recourse to all possible remedies?

In the past, moralists replied that one is never obliged to use "extraordinary" means. This reply, which as a principle still holds good, is perhaps less clear today, by reason of the imprecision of the term and the rapid progress made in the treatment of sickness. Thus some people prefer to speak of "proportionate" and "disproportionate" means. In any case, it will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources.

In order to facilitate the application of these general principles, the following clarifications can be added:

— If there are no other sufficient remedies, it is permitted, with the patient's consent, to have recourse to the means provided by the most advanced medical techniques, even if these means are still at the experimental stage and are not without a certain risk. By accepting them, the patient can even show generosity in the service of humanity.

— It is also permitted, with the patient's consent, to interrupt these means, where the results fall short of expectations. But for such a decision to be made, account will have to be taken of the reasonable wishes of the patient and the patient's family, as also

of the advice of the doctors who are specially competent in the matter. The latter may in particular judge that the investment in instruments and personnel is disproportionate to the results foreseen; they may also judge that the techniques applied impose on the patient strain or suffering out of proportion with the benefits which he or she may gain from such techniques.

— It is also permissible to make do with the normal means that medicine can offer. Therefore one cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or the community.

— When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted. In such circumstances the doctor has no reason to reproach himself with failing to help the person in danger.

CONCLUSION

The norms contained in the present Declaration are inspired by a profound desire to serve people in accordance with the plan of the Creator. Life is a gift of God, and on the other hand death is unavoidable; it is necessary therefore that we, without in any way hastening the hour of death, should be able to accept it with full responsibility and dignity. It is true that death marks the end of our earthly existence, but at the same time it opens the door to immortal

life. Therefore all must prepare themselves for this event in the light of human values, and Christians even more so in the light of faith.

As for those who work in the medical profession, they ought to neglect no means of making all their skill available to the sick and the dying, but they should also remember how much more necessary it is to provide them with the comfort of boundless kindness and heartfelt charity. Such service to people is also service to Christ the Lord, who said: "As you did it to one of the least of these my brethren, you did it to me" (Mt 25: 40).

At the audience granted to the undersigned Prefect, His Holiness Pope John Paul II approved this Declaration, adopted at the ordinary meeting of the Sacred Congregation for the Doctrine of the Faith, and ordered its publication.

Rome, the Sacred Congregation for the Doctrine of the Faith,
5 May 1980.

FRANJO CARD. ŠEPER
Prefect

✠ Jérôme Hamer, O. P.
Tit. Archbishop of Lorient
Secretary

PUBLICATIONS SERVICE
CANADIAN CONFERENCE OF CATHOLIC BISHOPS
90 PARENT AVENUE
OTTAWA, ONTARIO
K1N 7B1

Appendix 3

QUESTIONNAIRE

1. What stand or position (if any) has your religious organization taken regarding so-called 'passive' euthanasia? By 'passive' euthanasia I refer to the removal of life-support systems or the cessation of what have been called 'heroic measures' to continue life when the patient is in intractable pain with a terminal illness, or is in irreversible coma, and when the removal of the support system will result in the death of the patient?

For example: K, 22 years old, is suffering from 'a rapidly fulminating type of multiple sclerosis'. He has been in a coma for 2 months and does not respond to any attention. He is immobile and body wastes are excreted involuntarily into plastic receptacles. According to his physician, his brain 'is gone', his nervous system is rapidly degenerating. He will never recover and, indeed, if it were not for the artificial support system, both heart and breathing would cease to function. (Case drawn from David Hendin: Death as a Fact of Life, New York, 1973, pp. 17f.)

In such a situation would your religious organization sanction the removal of the life-support system and permit K to die? If so: Why and on what ethical and theological grounds? If not: Why not?

2. What stand or position (if any) has your religious organization taken with regard to so-called 'active' euthanasia? By 'active' euthanasia I refer to the deliberate intervention into the life process by the patient who is terminally ill and in intractable pain, or by the patient acting with the assistance of some other person, or by some person acting on behalf of a patient.

For example: M is 69 years old and is suffering from a virulent form of cancer that will, according to her doctors, terminate her life within a period of weeks. Her pain is excruciating; and although it is somewhat

relieved by drugs, the medications leave her in a semi-comatose state which she resents. She has saved dozens of sleeping pills and other potentially lethal medications which she has hidden away. She knows she is terminal and does not want to live her remaining days in pain and in a semi-comatose state?

In such a situation would your religious organization sanction her taking the medication and thereby shorten her time of suffering and end her life, in other words - commit suicide?

Yes _____ No _____

If 'yes': Why and on what ethical and theological grounds? If 'no': Why not?

Suppose M was not able to collect the lethal medications, but persuaded her doctor or a friend or a relative to **provide** her with the lethal dosage. In such a situation would your religious organization sanction the participation of her associates in her taking of her own life to end suffering? (Assisted suicide)

Yes _____ No _____

If 'Yes': Why and on what ethical and theological grounds? If 'no': Why not?

Suppose the doctor or a friend or relative, acting in accord with M's expressed wishes, **administered** the lethal medications that shortened the time of suffering and caused death. In such a situation would your religious organization sanction this act which can be labeled 'homicide' or 'murder' or even 'compassionate murder'?

Yes _____ No _____

If 'Yes': Why and on what ethical and theological grounds? If 'no': Why not?

3. Does your religious organization espouse belief in a soul or afterlife or in divine judgement or Karma? If 'yes', circle appropriate terms

No _____

If 'yes'; What effect would participation in active euthanasia have upon the afterlife of the deceased and/or the one who participated in the termination of the patient's life?

4. Would the fact that death came by 'active' euthanasia affect the rituals or burial patterns of the deceased person? If 'yes': How and why? If not: Why not?
5. What sort of counseling would your religious organization provide for someone contemplating 'passive' euthanasia for the self or for another (as in the case of K)?

For 'active' euthanasia?

6. Will you please provide me with references in Scripture or other religious writings, or to ethical or moral doctrines or statements made by your religious organization or its members pertaining to euthanasia?
7. Are there other persons in your religious organization with whom you think I might communicate for further information about this important subject?

Your name? _____ Organization: _____

REFERENCES

Books

- Abelson, Raziel & Friquegnon, M. L. (eds.) Ethics for Modern Life. (2nd ed.). New York: St. Martin's Press, 1982.
- Aiken, Lewis R. Dying, Death, and Bereavement. (2nd ed.). Massachusetts: Allyn and Bacon, 1991.
- Anderson, Ray S. Theology, Death, And Dying. New York: Basil Blackwell, 1986.
- Aquinas, Thomas Summa Theologica. (Vol. 2). trans. by Fathers of the English Dominican Province. New York: Benziger Brothers, 1947.
- Augustine City of God. trans. by M. Dods. New York: Random House, 1950.
- Barry, Vincent Moral Aspects of Health Care. Belmont, California: Wadsworth Publishing Company, 1982.
- Beauchamp, Tom L. & Seymour, Perlin Ethical Issues In Death And Dying. Englewood Cliffs, New Jersey: Prentice-Hall, 1978.
- Boswell, John The Kindness of Strangers. New York: Pantheon Books, 1988.
- Bowker, John Problems of Suffering in Religions of the World. London: Cambridge University Press, 1970.
- Bracken, Susan (ed.) Canadian Almanac & Directory 1989. Toronto: Copp Clark Pitman, 1989.

Brody, Baruch Life and Death Decision Making. New York: Oxford University Press, 1988.

(ed.) Suicide And Euthanasia. Dordrecht: Kluwer Academic Publishers, 1989.

Bugelski, B. Richard & Graziano, Anthony, M. The Handbook of Practical Psychology. Englewood Cliffs, New Jersey: Prentice-Hall, 1980.

Campbell, Robert & Collinson, Diane Ending Lives. New York: Basil Blackwell, 1988.

Carrick, Paul Medical Ethics in Antiquity. Dordrecht: D. Reidel Publishing Company, 1985.

Choron, Jacques Death and Western Thought. New York: The Macmillan Company, 1963.

Suicide. New York: Charles Scribner's Sons, 1972.

Cragg, Wesley (ed.) Contemporary Moral Issues. Toronto: McGraw-Hill Ryerson, 1983.

Crook, Roger, H. An Introduction To Christian Ethics. Englewood Cliffs, New Jersey: Prentice-Hall, 1990.

Davison, Gerald, & Neale, John M. Abnormal Psychology. (3rd ed.). New York: John Wiley & Sons, 1974.

Downing, A.B. & Smoker, Barbara (eds.) Voluntary Euthanasia. London: Peter Owen Publishers, 1986.

Fedden, Henry Romilly Suicide. New York: Arno Press, 1980.

Gualtieri, Antonio R. The Vulture and the Bull. Lanham: University Press of America, 1984.

Hardon, John A. Pocket Catholic Dictionary. Garden City, New York: Image Books, 1985.

Harpur, Tom Life After Death. Toronto: McClelland and Stewart, 1991.

Hastings, James (ed.) Encyclopedia of Religion and Ethics. (Vol. 12). Edinburgh: T. & T. Clark, 1921.

Horan, Dennis J. (ed.) Death, Dying, and Euthanasia. Washington: University Publications of America, 1977.

Horbury, William & McNeil, Brian Suffering and Martyrdom in the New Testament. London: Cambridge University Press, 1981.

Humphry, Derek Final Exit. Eugene, Oregon: The Hemlock Society, 1991.

Humphry, Derek & Wickett, Ann The Right To Die. Eugene, Oregon: The Hemlock Society, 1986.

Keyserlingk, Edward Sanctity of Life or Quality of Life. Ottawa: Minister of Supply and Services Canada, 1979.

Kluge, Eike-Henner W. The Practice Of Death. New Haven: Yale University Press, 1975.

The Ethics of Deliberate Death. Port Washington, New York: Kennikat Press, 1981.

Kohl, Marvin (ed.) Beneficent Euthanasia. Buffalo, New York: Prometheus Books, 1975.

Kübler-Ross, Elisabeth On Death And Dying. New York: Macmillan Publishing Company, 1969.

Death: The Final Stage Of Growth. Englewood Cliffs, New Jersey: Prentice-Hall, 1975.

Ladd, John Ethical Issues Relating To life and Death. New York: Oxford University Press, 1979.

Larue, Gerald Euthanasia and Religion. Los Angeles: The Hemlock Society, 1985.

Law Reform Commission of Canada Euthanasia, Aiding Suicide And Cessation Of Treatment. (Report No. 20). Ottawa: Minister of Supply and Services, 1983.

Levitt, Paul M. & Guralnick, Elissa S. You Can Make It Back. New York: Facts On File Publications, 1985.

Mappes, Thomas A. & Zembaty, Jane S. Social Ethics. (3rd ed.). New York: McGraw-Hill, 1987.

McCormick, Richard A. How Brave A New World. Washington: Georgetown University Press, 1981.

Melton, J. Gordan The Churches Speak On Euthanasia. Detroit: Gale Research, 1991.

Meyer, Charles Surviving Death. Mystic, Connecticut: Twenty-Third Publications, 1990.

Molloy, D. William & Mepham, Virginia Let Me Decide. Hamilton: McMaster University Press, 1990.

Moore, Charles A Full Enquiry Into The Subject Of Suicide. (Vols. 1-2). London: John Hatchard, 1790.

Nelson, C. Ellis (ed.) Conscience: Theological and Psychological Perspectives. New York: Newman Press, 1973.

- Park Ridge Center Active Euthanasia, Religion, And The Public Debate. Chicago: The Park Ridge Center, 1991.
- Paterson-Tucker, Judi Ethical, Legal and Spiritual Concerns in Palliative Care. Ottawa: Health Sciences Department, Continuing Education, Algonquin College, 1989.
- Pattison, E. Mansell The Experience of Dying. Englewood Cliffs, New Jersey: Prentice-Hall, 1977.
- Pellegrino, Edmund D., Langan, John P., & Harvey, John Collins Catholic Perspectives On Medical Morals. Dordrecht: Kluwer Academic Publishers, 1989.
- Pohier, Jacques & Mieth, Dietmar (eds.) Suicide And The Right To Die. Edinburgh: T. & T. Clark, 1985.
- Rachels, James Matters of Life and Death. New York: Random House, 1980.
- Ramsey, Paul The Patient As Person. New Haven: Yale University Press, 1970.
- Ethics at the Edge of Life. New Haven: Yale University Press, 1978.
- Rubin, Zick & McNeil, Elton B. The Psychology of Being Human. (3rd ed.). New York: Harper & Row, 1981.
- Shneidman, Edwin S. Death: Current Perspectives. Palo, Alto, California: Mayfield Publishing Company, 1976.
- Slaby, Andrew E. & Glicksman, Arvin S. Adapting To Life-Threatening Illness. New York: Praeger Publishers, 1985.

- Spiro, Melford E. Buddhism and Society: A Great Tradition and Its Burmese Vicissitudes. New York: Harper & Row, 1970.
- Spring, Beth & Larson, Edward Euthanasia: Spiritual, Medical & Legal Issues in Terminal Health Care. Portland: Multnomah Press, 1988.
- Sullivan, Joseph V. The Morality Of Mercy Killing. Maryland: The Newman Press, 1950.
- Surin, Kenneth Theology and the Problem of Evil. New York: Basil Blackwell, 1986.
- Taylor, Rodney L. & Watson, Jean They Shall Not Hurt. Boulder: Colorado Associated University Press, 1989.
- Triche, Charles W. & Triche, Diane Samson The Euthanasia Controversy 1812-1974. Troy, New York: The Whitston Publishing Company, 1975.
- Trowell, Hugh The Unfinished Debate on Euthanasia. London: SCM Press limited, 1973.
- Turnbull, Richard (ed.) Terminal Care. Washington: Hemisphere Publishing Corporation, 1986.
- Vaux, Kenneth Health and Medicine in the Reformed Tradition. New York: Crossroad Publishing, 1984.
- Veatch, Robert M. Death, Dying, and the Biological Revolution. New Haven: Yale University Press, 1976.
- Vere, Duncan W. Voluntary Euthanasia - Is there an Alternative. London: C. M. F. Publications, 1971.
- Wallace, Samuel E. & Eser, Albin Suicide and Euthanasia. Knoxville: The University of Tennessee Press, 1981.

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

Wilson, Jerry B. Death By Decision. Philadelphia: The Westminster Press, 1975.

REFERENCES

Articles

- Abbing, Henriëtte D. C. R. "Dying with Dignity, and Euthanasia: A View from The Netherlands." Journal of Palliative Care Vol. 4 No. 4, 1988: 70-74.
- Admiraal, Pieter "Euthanasia Applied at a General Hospital." The Euthanasia Review Vol. 1 No. 2, Summer 1986: 97-107.
- "Euthanasia in The Netherlands." The Euthanasia Review Vol. 3 No. 2, Fall/Winter 1988: 107-118.
- Baugher, Robert J., Burger, Candice, Smith, Roberta & Wallston, Kenneth "A Comparison of Terminally Ill Persons at Various Time Periods to Death." Omega Vol. 20 No. 2, 1989-90: 103-115.
- Bergen, Bernard, J. & Nelson, William A. "A Look at Social Support Patterns." Pastoral Psychology Vol. 30 No. 4, Summer 1982: 171-178.
- Boisvert, Marcel "All Things Considered ... Then What?" Journal of Palliative Care Vol. 4 Nos. 1 & 2, 1988: 115-118.
- Bozinoff, L., & MacIntosh, P. "Dramatic Increase in Support For Euthanasia." Gallup July 24, 1989.
- Branson, Roy "Is Acceptance a Denial of Death? Another Look at Kubler-Ross." The Christian Century May 7, 1975: 464-468.

- Brown, J. H., Henteleff, P., Barakat, S. & Rowe, C. J.
"Is it Normal for Terminally Ill Patients to
Desire Death." American Journal of Psychiatry Vol.
143 No. 2, February, 1986: 208-211.
- Campbell, Courtney "Sovereignty, Stewardship, and the Self:
Religious Perspectives on Euthanasia.",
(Unpublished), 1991.
- Cappon, Daniel "Attitudes of and Towards the Dying."
Canadian Medical Association Journal
Vol. 87, September 29, 1962: 693-700.
- Chilstrom, Corinne "Suicide and Pastoral Care." The Journal
of Pastoral Care Vol. 43 No. 3, Fall, 1989:
199-208.
- Clark, Geoffrey "The Pastor's Problems: Ministering to the
Dying." The Expository Times Vol. 92, October,
1980 - September 1981: 164-166.
- Clark, Royce "The Example of Christ and Voluntary Active
Euthanasia." Journal of Religion and Health
Vol. 25 No. 4, Winter, 1986: 264-277.
- Corless, Inge B. "Caring for Persons with AIDS and Cancer:
Ethical Reflections on Palliative Care for
the Terminally Ill, by Touhey, J. F. - A
Review" Journal of Palliative Care Vol. 7
No. 2, 1991: 56-58.
- Cryderman, Lyn "The Will To Die." Christianity Today
October 22, 1990: 23.
- de Wachter, M. A. M. "Active Euthanasia in the
Netherlands.", Journal of the American Medical
Association Vol 262 No. 23, December 15, 1989:
3316-3319.

- Domino, George & Swain, Barbara J. "Recognition of Suicide Lethality And Attitudes Toward Suicide In Mental Health Professionals." Omega Vol. 16 No. 4, 1985-86: 301-308.
- Fitchett, George "Wisdom and Folly in Death and Dying." Journal of Religion and Health Vol. 19 No. 3, Fall, 1980: 203-216.
- Fye, Bruce W. "Active Euthanasia: An Historical Survey of its Conceptual Origins and Introduction into Medical Thought" Bulletin of the History of Medicine Vol. 52 No. 4, 1979: 492-502.
- Gruman, Gerald J. "An Historical Introduction To Ideas About Voluntary Euthanasia: With a Bibliographic Survey and Guide For Interdisciplinary Studies" Omega Vol. 4 No. 2, 1973: 87-138.
- Gualtieri, Antonio R. "What is Comparative Religion Comparing." Journal For The Scientific Study Of Religion Vol. 6 No. 1, Spring 1967: 31-39.
- "Religious Cosmologies as Justifications of Moralities." SR: Studies in Religion/Sciences Religieuses (Forthcoming), Vol. 21, 1992(a).
- "Founders and Apostates." Journal of The American Academy of Religion (Forthcoming), Vol. 60 No. 2, 1992(b).
- Hauerwas, Stanley & Bondi, Richard "Memory, Community and the Reasons for Living: Theological and Ethical Reflections on Suicide and Euthanasia." Journal of the American Academy of Religion Vol. 44 No. 3, 1976: 439-452.
- Hilhorst, Henri W. "Religion and Euthanasia in the Netherlands: Exploring a Diffuse Relationship." Social Compass Vol. 30 No. 4, 1983: 491-502.

- Horgan, John "Death with Dignity." Scientific American March, 1991: 17-20.
- Klass, Dennis "Elisabeth Kubler-Ross and The Tradition of The Private Sphere: An Analysis of Symbols." Omega Vol. 12 No. 3, 1981-82: 241-267.
- Labus, Janet G. & Dambrot, Faye H. "A Comparative Study of Terminally Ill Hospice and Hospital Patients." Omega Vol. 16 No. 3, 1985-86: 225-232.
- Lawton, Kim A. "The Doctor as Executioner." Christianity Today, December 16, 1991: 50-52.
- Lichter, Ivan & Hunt, Esther "The Last 48 Hours of Life." Journal of Palliative Care Vol. 6 No. 4, 1990: 7-15.
- Lynn, Joanne "The Health Care Professional's Role When Active Euthanasia is Sought." Journal of Palliative Care Vol. 4 Nos. 1 & 2, 1988: 100-102.
- Massie, M. J., Holland, J., & Glass, E. "Delirium in Terminally Ill Cancer Patients." American Journal of Psychiatry Vol. 140 No. 8, August 1983: 1048-1050.
- Metzger, Anne M. "A Q-Methodological Study of The Kubler-Ross Stage Theory." Omega Vol. 10 No. 4, 1979-80: 291-301.
- Neff, David "The Suicide Machine: Arguments for Self-Administered Euthanasia Quickly Turn Gruesome Under Close Scrutiny." Christianity Today, August 20, 1991: 14.
- Neuringer, Charles "The Meaning Behind Popular Myths About Suicide." Omega Vol. 18 No. 2, 1987-88: 155-162.

- Parachini, Allan "The California Humane and Dignified Death Initiative." Hastings Center Report Vol. 19 No. 1, January/February 1989: 10-12.
- Phipps, William, E. "Christian Perspectives on Suicide." The Christian Century October 30, 1985: 970-973.
- Rinaldi, Anoel, Kearl, Michael C. "The Hospice Farewell: Ideological Perspectives of its Professional Practitioners." Omega Vol. 21 No. 4, 1990: 283-300.
- Roy, David J. "Ethical Issues in the Treatment of Cancer Patients." Journal of Palliative Care Vol. 5 No. 2, 1989: 56-61.
- Saul, Sidney & Saul, Shura "Old People Talk About Suicide: A Discussion About Suicide in a Long-Term Care Facility for Frail and Elderly People." Omega Vol. 19 No. 3, 1988-89: 237-251.
- Schmidt, Stephen "Living With Chronic Illness: Why Should I Go On." The Christian Century May 3, 1989: 475-479.
- Schulz, Richard & Aderman, David "Clinical Research and The Stages of Dying." Omega Vol. 5 No. 2, 1974: 137-143.
- Schulz, Richard & Schlarb, Janet "Two Decades of Research on Dying: What Do We Know About the Patient." Omega Vol. 18 No. 4, 1987-88: 299-317.
- Scott, John F. "Lies and Lamentation - A Solid No to Euthanasia." Journal of Palliative Care Vol. 4 Nos. 1 & 2, 1988: 119-121.
- "Submission to Legislative Committee on Bill C-203 An Act to Amend The Criminal Code (Terminally Ill Persons)." November 19, 1991.

- Sevensky, Robert L. "The Religious Foundations of Health Care: A Conceptual Approach." Journal of Medical Ethics Vol. 9, 1983: 165-169.
- Skylstad, William "What is the Right Question About Confirmation Age." Origins Vol. 21 No. 44, April 9, 1992.
- Van Der Maas, P. J., Van Delden, J. J. M., Pijnenborg, L., & Looman, C. W. N. "Euthanasia and other medical decisions concerning the end of life." The Lancet Vol. 338, September 14, 1991: 669-674.
- Verhey, Allen D. "Talking of God - But With Whom." Hastings Center Report Vol. 20 No. 4, July/August, 1990: 21-24.
- Vernon, Glenn M. & Payne, William D. "Myth-Conceptions About Death." Journal of Religion and Health Vol. 12 No. 1, January, 1973: 63-76.
- Viney, Linda L. & Westbrook, Mary "Is There a Pattern of Psychological Reactions to Chronic Illness Which is Associated With Death." Omega Vol. 17 No. 2, 1986-87: 169-181.
- Woo, Stephen, K. "The Psychiatric and Neuropsychiatric Aspects of HIV Disease." Journal of Palliative Care Vol. 4 No. 4, 1988: 50-53.

REFERENCES

Christian Denominational Publications

Bishops of California "California Bishops Oppose Assisted Suicide Measure." Origins Vol. 17 No. 47, May 5, 1988: 819-820.

Bishops of the Netherlands "Suffering and Dying of the Sick." March 3rd, 1985.

Bishops of Oregon and Washington "Living and Dying Well." Origins Vol. 21 No. 22, November 7, 1991.

Commission on Theology and Church Relations, Lutheran Church-Missouri Synod Report On Euthanasia With Guiding Principles. USA: Lutheran Church-Missouri Synod, 1979.

De Generale Synode van de Nederlandse Hervormde Kerk Euthanasie En Pastoraat. 'S-Gravenhage: Boekencentrum, 1988.

Tattrie, George Euthanasia. Don Mills, Ontario: The Presbyterian Church in Canada, 1982.

Whytehead, Lawrence & Chidwick, Paul Dying: Considerations Concerning the Passage from Life to Death. Toronto: The Anglican Church of Canada, 1980.

END

22.12.92

FIN