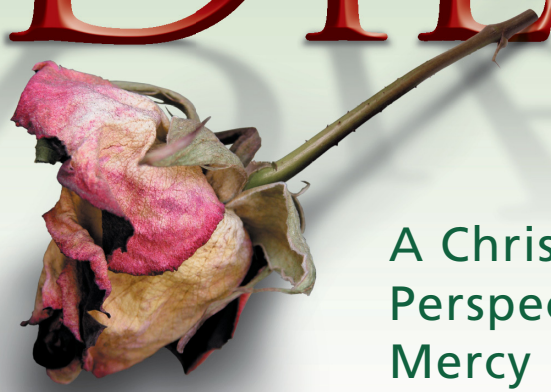
A Good Day to Die



A Christian Perspective on Mercy Killing

ALEX TANG

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GENESIS

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Dedication

To my beloved wife, Dr Agnes Tan,
my two daughters, Christina and Alexis,
and all my medical and other healthcare colleagues
who deal with life-and-death issues on a daily basis

Contents

Foreword

Almost all of us have faced or will face decisions concerning the care to be given to the sick and dying among us.

I first met Dr Alex Tang about 20 years ago when he was working at the Sultanah Aminah Hospital in Johor Bahru, Malaysia. Dr Tang is a Christian doctor, a paediatrician who has addressed his clinical practice from a Christian viewpoint. He also writes regularly on Christian topics.

He faces the challenges of tending to ill and "terminal" patients on a daily basis. He has had to make hard bedside decisions, sometimes with little time to receive help from colleagues or others.

This book is the result of Dr Tang's own experience in facing life-and-death issues and in it he explores theological, medical, ethical, moral and legal issues. He takes the reader from historical perspectives to contemporary issues that defy black-and-white definitions. Dr Tang addresses some very thorny issues, including euthanasia which he approaches from various angles. He contends that being contemporary is not necessarily being right.

The book makes the point that the Church, the individual Christian, the doctor, the layman and all caregivers will have to make a stand sometimes on many of these issues.

Dr Tang does not give pat answers but challenges all Christian caregivers to make decisions for the sick and the dying based on sound biblical foundations.

When clear guidelines are not available he has provided position statements from learned people for careful consideration.

Dr Tang's extensively referenced book is timely indeed, at a time of rapidly increasing knowledge and understanding of the human body.

It helps the Christian reader to make important decisions in an informed manner; decisions surrounding sickness and death.

Datuk Dr Alex Mathews
Consultant Obstetrician and Gynaecologist
Chairman,
Overseas Missionary Fellowship (OMF) Malaysia Home Council
17 June 2005

Preface

"Today is a good day to die" (*Heghlu'meH QaQ jajvam*) is the rallying cry of the Klingons. The Klingons are a warrior race in the science fiction worlds of Star Trek. In the 1960s, Star Trek started off as a television series, but has since become a universal phenomenon, spawning numerous other Star Trek television series, movies and books. The Star Trek universe is about a Federation of Planets where alien races live in peace or in a state of detente. The Klingons are among the favourite aliens, and loyal fans of Star Trek have created a culture and a language, Klingonese, for them.

To the Klingons, what is important is glory and honour. To die in battle is to die with full honour and with the accumulation of much glory. Hence, the rallying calls of a good day to die. This is in direct contrast to our culture where there is a denial of death. Death is something that we know will come but which we talk about in whispers, often tiptoeing around the subject. Unlike the Klingons, we do not welcome death as part of life. Instead, we try to distance ourselves from death by living as if we will live forever. So we pursue lifestyles that embrace the culture of youth (because youth is furthest from dying) and anti-ageing (the older we are, the higher the likelihood of death).

Even Christians have assimilated this culture of denial of death. We live in fear of death though the Bible teaches that

there is nothing to fear. Lord Jesus Christ, by His sacrificial death on the cross and His resurrection, has vanquished death. Death to Christians is a doorway to the everlasting presence of God the Father.

God in His sovereignty determines the time of our birth and of our death. We celebrate our birthdays as the time of our birth when we emerge from our mother's womb. We regard our birthdays as a good day. It is a good day because God has chosen that day for us. Can we not regard the time of our death as a good day too? God, who has chosen the day of our birth, has also chosen the day of our death. We trust in His infinite wisdom that these chosen days are good days, meaningful in His created order. Hence the title of this book, *A Good Day to Die*. If God has chosen that day for us to die, then it is a good day to die.

However, unlike birth, one can cause one's death. Then the day of dying is not of God's choosing but of ours. This is the subject of this book. Do we have the right to choose when we are to die? Will this not be an impingement on the sovereignty of God? Will we, by choosing our own day to die, miss out on more of God's blessings?

The question encompasses not only the day of our passing but also the manner of our passing. Do we have the right to determine the way we are to die? And do we have the right to ask someone to kill us? These are very searching questions because they deal with the limits of our self-determinism and also the sanctity of human lives.

I wish to acknowledge Rev Loh Soon Choy and Mr Tan Kong Beng, both of Malaysia Bible Seminari, for reading through and commenting on the earliest draft of this book. I also wish to thank Datuk Dr Alex Mathews for writing the Foreword, and Dr Allan

Harkness, Dean, Asia Graduate School of Theology, and my good friend, Dr Tong How Seong, for reading the various drafts and for their comments and encouragement throughout. Most of all, I want to thank my wife, Agnes, and my two daughters, without whose love and encouragement this book would not have been possible.

Soli Deo Gloria.

Alex Tang
June 2005

Chapter One

General Introduction

"It is not death to die."
— Edward England

A 56-year-old woman has advanced cancer of the cervix. The cancer has spread to her lungs and bones. She has difficulty breathing and is constantly in severe pain. She is unable to sleep and eat. Both she and her husband know that death is inevitable. She wants her doctor to give her something to help her to die.

A young man of 20 drove his car into the back of a stationary lorry. He sustained multiple fractures and his skull was crushed as a result of the accident. It took a neurosurgeon six hours to remove bone fragments and evacuate blood clots from his brain. During the surgery, his heart stopped beating three times and he had to be resuscitated each time. After the surgery, he was not able to breathe and was put on a mechanical ventilator. That was one month ago. He is still on the ventilator. Clinically, the doctors have classified him as "brain dead". His parents want the doctors to switch off the machines and let their son die.

A baby boy was born to a young couple. Unfortunately, the baby was born without a brain (anencephaly). The infant was able to breathe on his own, but would never be aware of his surroundings. He would not be able to feed because he did not have any sucking reflex. To survive, he would need to be fed through a feeding tube. The doctor asked the parents whether they wanted to allow the baby to be fed or to let him starve to death.

A 70-year-old man, once the powerful CEO of a multinational company, has Alzheimer's disease. He is bedridden and totally dependent on others. He needs constant nursing care. There is not a shadow left of his former self. His mind has left his body. His wife of 40 years cannot bear to see him in this condition any more. She has asked for help to let her husband "die in peace".

A young woman had a very serious heart attack and suffered severe brain damage. In spite of the damage to her brain, she was able to breathe on her own. However, she was not able to do anything else. Her neurologists diagnosed her to be in a persistent vegetative state with no chance of recovery. She was fed via a feeding tube and kept alive through good nursing care. Eight years later, her husband requested that the feeding tube be removed and she be allowed to die. Her parents objected. Subsequently, fifteen years after the heart attack, her feeding tube was disconnected, but only following a prolonged battle that divided an entire nation. Families, courts, lawyers, civil government, and religious and human rights movements — they all had something to say on whether or not to let her die.

Euthanasia or "mercy killing" will be an increasingly relevant issue as medical technology improves. With advances in medical technology, there is improved health. Unfortunately, the dark side of medical advancement is that it is capable of prolonging dying and death. Not only can it prolong dying, but it can also allow dying in instalments. This promotes the sense that we are losing control of our life — and even our own death! More and more

people are feeling the need to regain control of the way they will be treated if they are terminally ill or if they are incapacitated, and unable to make decisions. They want to die with dignity, not in a sterile hospital environment, surrounded by impersonal machines and monitors. Some want to decide on the when and how of their dying. And they want their doctors to help them die — physician-assisted suicide or euthanasia. The few examples given above describe real people struggling with the issue of euthanasia. As we move on in the twenty-first century, we can expect more of such issues to surface.

McCormick, a bioethicist, writing in *The Christian Century*, December 4, 1991, observes that there are five cultural trends in our global society which will cause us to accept physician-assisted suicide. These trends have moved society from having a morality based on Judeo-Christian principles to one based on a humanistic and materialistic view of the world.

Firstly, the absolutisation of autonomy without considering whether choices are good or bad, and the consequent intolerance of dependence on others. This is the emphasis on the "rugged" individual of the mythical wild west of the American frontier and the subsequent societal emphasis on individualism. It is translated into: "I can do what I want because this is my own body". Where once we lived in communities and know our neighbours, we now live "cocooned" behind locked doors and security grills and do our own thing.

Secondly, the secularisation of medicine which has divorced the profession from its moral tradition and made it into a business. The medical profession is devoted to the holistic care of human beings as persons. The concept of healthcare as a business, however, has changed medical care such that the bottom line is

not healing but dollars and cents. This means that patients are not treated as human beings but as commodities. Once we begin to treat people as means and objects, we devalue and dehumanise them. One example of such callous treatment of human beings is the Tuskegee experiment in the United States. In that government project named "Tuskegee Study of Untreated Syphilis in the Negro Male", more than 400 African-Americans were deliberately infected with syphilis and left untreated for decades. The study continued until 1972.

Thirdly, the inadequate management of pain. Pain control is an issue in a society that values its comfort zone, which means "no pain", and where the threat of pain is a frightening thought. Much of our modern life is focused on finding ways to avoid pain — physical, emotional, mental and spiritual. Alcohol and drugs, whose abuse is widespread, help to deaden the pain of daily living while the powerful entertainment industry invites us to escape it.

Fourthly, the nutrition-hydration debate and the distinction between killing and letting someone die. The nutrition-hydration debate involves the feeding of a person who is considered terminally ill and has almost no chance of survival. Do we continue to feed such a person? And how do healthcare personnel decide when it is time to stop treatment? Who decides if such treatment is no longer needed? And does giving food constitute a necessity or a treatment. If feeding is a necessity, then it must be given. But if is a treatment, then it may be permissible to withhold it. It is this blurring of the boundaries of basic medical care that predisposes a society towards accepting the termination of the life of one of its member when it deems that such a life is not worth saving.

Fifthly, the financial pressures of healthcare are tremendous, especially in chronic conditions. The rising cost of healthcare is

an acute problem faced by governments and all of us today. The allocation of limited healthcare resources is one major difficulty. Do we spend our healthcare budget on the chronically ill or for more treatable conditions and where more people will benefit? The economic and financial pressure on healthcare spending will become even more acute as people live longer and the pool of younger people supporting the older population dwindles.

The sixth cultural trend which I would add to McCormick's is that all the trends he has described occur in a moral vacuum.[1] Where once most people have a belief system to structure their lives around, we are now living in a pluralistic postmodern society where everything and anything are acceptable.

Euthanasia is already an issue faced by doctors dealing with very sick patients in Malaysia. Even though the civil laws do not have specific areas dealing with euthanasia, it is generally agreed that it can be prosecuted as voluntary manslaughter. However, so far, there has not been any test case in Malaysia. The people mentioned in the case studies at the beginning of this chapter are real. Doctors, nurses and the patients' spouses and relatives frequently face such dilemmas in hospitals. Are there any guidelines to help them when they are in such situations? Is euthanasia ever justifiable, especially when a patient is in severe uncontrollable pain? Euthanasia may have been practised quietly in hospitals, in the form of passive euthanasia where ineffective treatment is withheld from patients. The main reason for this is compassion on the part of the medical staff, as further treatment is seen to prolong suffering and pain. It is unlikely that euthanasia has been done for financial reasons because Malaysia has a highly subsidised healthcare system.

The former Malaysian Health Minister, Datuk Chua Jui Meng, was quoted in the *New Straits Times*, February 1, 1999, as saying that

the Health Ministry subsidised 98 per cent of the cost of medicine disbursed by government hospitals and clinics every year. He said that the government spent between RM200 million and RM300 million annually to make this possible, with patients having to pay only a registration fee of RM1 to enjoy the benefits. "For just RM1, patients are provided with medicine and the services of specialists, doctors, nurses and other medical staff," he said. This may change when the Ministry of Health continues its programme of corporatising the general hospital curative healthcare services, and healthcare becomes more expensive as a result.

In the United States, Canada, the United Kingdom and Australia, euthanasia is a big issue. Any Christian doctor, nurse or healthcare professional who professes to be walking the path of discipleship and practising medicine needs to be clear in his[2] thinking on the matter. It is also important for other Christians too, as, one day, euthanasia will impact all our lives in one way or another, and we need to build a strong biblical foundation from which positions on the subject can be taken.

Bioethics, as with all discourse impacting directly on human life and situation, is a complex issue. Broadly speaking, in euthanasia, we see how medical/technological advances have stretched traditional ethical and moral thinking as well as influenced behaviour and action. This pattern also relates to abortion, artificial insemination, genetic engineering, molecular biology, use of foetal tissue, gene splicing and gene therapy.

In exploring euthanasia, this book will employ a process of induction guided by pastoral and theological reflection. The "pastoral" aspect ensures sensitivity to the person (individual) and the community (collective) with regards to the human dimensions, predicaments and situations associated with euthanasia. The

"theological" aspect underlines a commitment to an approach that honours the unity and sanctity of all truth (what Francis Schaeffer has called "true truth" as distinguished from "pseudo truth") as coming from God wherever it is found.

Scott Burson and Jerry Wallis in their book, *C.S. Lewis and Francis Schaeffer*, comments:

> *If Christianity is to be taken seriously again, thinking Christians must be willing to dedicate themselves to their respective disciplines with unrivalled rigor. When Christian doctors, Christian biologists, Christian astronomers, Christian artists and Christian philosophers are all producing significant scholarship in their respective fields, the world will take notice. [C.S.] Lewis is a testament (for) this method.*

As Christians, we need to engage the issues of the world and offer our responses from a biblical worldview. Too often, we respond to issues by being dogmatic and defensive instead of being open to discussing new ideas, seeing the points of view of others and sharing our Christian understanding with love. It is hoped that this book will stimulate Asian Christian professionals to look at various moral issues in their respective disciplines through a biblical worldview.

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[1] Henri J.M. Nouwen, *The Wounded Healer* (New York: Doubleday, 1972, 1979). In this book, Nouwen wrote of a generation that is lost, and lives in a historically dislocated world with fragmented ideology. He suggests the faith of a "wounded minister" can lead this generation to hope and redemption.

[2] At various places in this book, the generic male term refers to both men and women. Apologies are conveyed for not using more inclusive language.

Chapter Two

A Look at Suicide, Euthanasia and Death

"The command 'Thou shall not kill' must be binding on the conscience of humanity if the terrible tragedy and destiny of Cain is not to be repeated."
— Pope John Paul II

Picking up a story from the previous chapter, Alice Teoh is the 56-year-old woman who has been steadily losing weight for the past six months. She had woken up one morning with severe abdominal pain and noticed a foul-smelling discharge from her vagina. After some tests, her general physician diagnosed that she was suffering from cancer of the cervix, which had spread to her lungs and bones. Alice was referred to Dr Goh, a gynaecologist, and Dr Ng, an oncologist, for treatment. That was four months ago.

Dr Goh has since operated on her to try to remove her cervix and uterus, but he was unable to follow through with the procedure because of the extensive spread of the cancer. Meanwhile, Alice continues to weaken, with symptoms of vaginal discharge, loss of appetite and difficulty in breathing. She needs continuous oxygen supplement as the cancer has infiltrated her lungs. She also suffers

constantly from severe pain in spite of the pain relief medication prescribed by Dr Ng, as the cancer has eroded into her spinal cord. Dr Ng has tried a couple of chemotherapy treatments on Alice but they have not been of much help. From his clinical experience and based on various scientific data on cervical cancer, Dr Ng knows that Alice is dying. He has gathered Alice and her family and given an open and honest assessment of the patient's prognosis. Now, Alice finds the pain so unbearable that she wants to die. She wants to commit suicide but does not know how. In fact, she has asked Dr Ng to kill her.

What are the various scenarios facing Dr Ng? Firstly, he can simply ignore Alice's request and continue with the course of treatment, even though it is not working. He will try his best to manage the pain and make the remainder of Alice's days as comfortable as possible. He will also continue to prescribe the oxygen supplement to help her breathe easier.

Secondly, he can make a decision to discontinue the present treatment, which includes stopping the use of oxygen but continuing with the pain relief medication. Stopping a plan of treatment that shows no evidence of being effective is good medical practice. Discontinuing the oxygen supplement for a patient who has difficulty breathing can be considered passive euthanasia, as this amounts to the stoppage of life-sustaining treatment.

Thirdly, instead of relying on Dr Ng, Alice can ask her husband to help her to die, either by removing the oxygen mask or by giving her some poison. This is assisted suicide.

Fourthly, Dr Ng can provide Alice with a means of taking her own life by offering her a syringe filled with an overdose of morphine. Alice can take her life by injecting the morphine herself or getting her husband to do it for her. Or Dr Ng can help Alice to

die by giving the injection himself. This is physician-assisted suicide. The third and fourth options are considered active euthanasia, as there is some action taken to end Alice's life. In these instances, the euthanasia is said to be voluntary as it is done at the patient's request.

The Concept of Suicide

An understanding of suicide, assisted suicide and physician-assisted suicide is helpful for us as we explore the issue of euthanasia. We have to very careful of the terms we use because there is much confusion about euthanasia. Often, different people may mean different things when they use the word "euthanasia". Commonly, though, euthanasia means mercy killing.

Suicide

Suicide is the act of intentionally taking one's life and is distinguished from natural death. There may be many reasons why it is done, such as to end one's suffering, to avert financial ruin and to escape unbearable pain. Where there is no intention to end one's life, there is no suicide. Thus, those who risk their lives to save others or those who refuse to renounce their faith, knowing that this will mean death, have not committed suicide when they die as a result of their action because they do not explicitly intend their own deaths.[1] Martyrdom is not considered suicide though there are many examples of Christians in the history of the persecuted church who willingly allowed themselves to be caught by the Roman authorities so that they could be martyred.

Assisted Suicide

Assisted suicide occurs when one person intentionally gives another the means or opportunity to take his life at his own request, often to relieve pain and suffering. For example, if a wife were to give her husband, who is terminally ill with cancer of the colon and in severe pain, a large quantity of poison at his request, the act would constitute assisted suicide.

Physician-assisted Suicide

Physician-assisted suicide occurs when a physician helps a person to take his own life by giving advice, writing a prescription for lethal medication, or assisting the individual with some device that allows him to die. The physician lends the expertise, the person does the act.[2] For instance, if a physician were to give a patient with a terminal condition who has requested it, a prescription for a large dose of barbiturates, knowing that the patient would use the medication to take his life, he would be participating in physician-assisted suicide. In Dr Ng's case, this would mean giving a syringe with an overdose of morphine to Alice or members of her family with instructions on how to use it.

Most medical associations in the world do not condone physician-assisted suicide because it goes against the Hippocratic Oath of "First do no harm". The Christian Medical Fellowship (a fellowship of Christian doctors and nurses) in the United Kingdom and the Christian Medical and Dental Society (a society of Christian physicians, nurses and dentists) in the United States oppose physician-assisted suicide in any form.[3]

The Concept of Euthanasia

Euthanasia is a term that has not been used consistently. In classical Greek, it means "good death." In modern usage, it has taken a different, more specific meaning. Euthanasia has come "to mean that one person intentionally causes the death of another who is terminally or seriously ill, often to end the latter's pain and suffering."[4]

Active and Passive Euthanasia

Usually, when euthanasia is mentioned, it refers to active euthanasia, i.e. an action is taken with the intention to cause death. For example, if a father were to inject his son who is dying and in great agony, with a lethal dose of a drug to end his suffering, it will be deemed an act of active euthanasia.

Passive euthanasia, on the other hand, describes the withdrawing and withholding of life-sustaining treatment with the result that death occurs as a natural consequence of the disease process. Take a patient who is terminally ill and whose heart is failing. Withholding medication that will strengthen the heart is withholding life-sustaining treatment. Without the medication, the heart will continue to fail to pump blood, and death will occur. The parallel in Alice's case is the withholding of oxygen supplement.

The Christian Medical Fellowship of the United Kingdom has always argued that the concepts of "active" and "passive" euthanasia are unnecessary and confusing when it is applied to physicians. They believe it is more helpful to use the concept of intent. What did the physician intend when he performed the act? What did the physician intend when he omitted to act? This discussion was

submitted to the Select Committee of the House of Lords on Medical Ethics during its deliberation on euthanasia:

> *A deliberate intervention to end life is always morally wrong and should remain unlawful. An omission may be an example of euthanasia (and therefore morally wrong) if its intention is solely to cause death. However, an omission would be a good example of good medical practice if its intention were, say, to maximise the quality of life remaining to the patient, or to respect the wishes of the patient and his family. The difference lies in the intention.*[5]

Similarly, the Christian Medical and Dental Society of the United States urged, "We do not oppose withdrawal or failure to institute artificial means of life support in patients who are clearly rapidly and irreversibly deteriorating, in whom death is imminent beyond reasonable hope of recovery."[6] The American Medical Association Judicial Council wrote:

> *…[where] a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who has responsibility for the care of the patient, it is not unethical to discontinue all means of life prolonging treatment… includes medication and artificially or technologically supplied respiration, nutrition, or hydration.*[7]

Based on this, it appears that the American Medical Association condones passive but not active euthanasia.

Voluntary, Involuntary and Non-Voluntary Euthanasia

Acts of euthanasia can be further differentiated according to the party who initiates the act. *Voluntary euthanasia* occurs when a person, out of compassion, does an action with the intention of ending the life of a suffering patient at his request.[8] If a man with end-stage lung cancer, who is mentally competent and under no compulsion, asks his friend who is a nurse, to give him a lethal injection to end his life, he raises the prospect of voluntary euthanasia. It is also voluntary euthanasia if a person writes a "living will" (more on this later), which limits the extent of medical treatment to sustain life.

In contrast to voluntary euthanasia, *involuntary euthanasia* is a compassionate act to end the life of a patient of sound mind who is perceived to be suffering, by a caregiver.[9] In this instance, the patient has not asked for his life to be ended. For example, if the man with end-stage lung cancer is given an overdose of barbiturate without his permission by his nurse-friend, his situation will be considered as involuntary euthanasia. There have been a number of cases brought to court of nurses or cleaners who switched off mechanical ventilators so that terminally ill patients would die. Clearly, there was no request for death from the patients. While the acts may have been done out of compassion, the law often regards them as murder.

Non-voluntary euthanasia occurs when a person, out of compassion, carries out an action to end the life of a suffering patient who is unable to make a voluntary request himself (e.g. an unconscious, retarded or demented adult; an infant or child).[10] For example, it will be an act of non-voluntary euthanasia if the 70-year-old ex-CEO with advanced Alzheimer's disease and in great distress, as described in chapter one, has his life taken by his daughter.

The Concept of Death

Clinical Definitions of Death

"When is death?" Dr Duncan Vere asked in his 1979 monograph on euthanasia:

> *The simple definition of death, acceptable for many generations, is now difficult to accept because new knowledge has forced us to redefine life…"Human life is the ability, actual or* in potential*, to respond to others or to be self-aware". Human death is then "all other states of organisation or disorganisation"…it seems best to reserve the idea of death for situations where there is no cerebral response or future possibility of it. (emphasis his)*[11]

Where once it was easy to define death, as Dr Vere has pointed out, new knowledge has forced us to redefine it. More sensitive monitoring machines, such as the 24-channel electroencephalograph (EEG) and positive emission tomography (PET), have given us a better understanding of how the brain functions, and moved the boundaries of life and death.

A pivot in the concept of death is the issue of brain death. It became so important that, in 1968, a committee known as the Harvard Brain Death Committee was set up to deliberate on a definition of death. This committee was made up of 10 doctors, a lawyer, a historian and a theologian. Its findings were published in the August 1968 issue of the *Journal of the American Medical Association*. This committee's findings are generally accepted by medical and legal professionals. In this regard, the Harvard criteria

outline four major components that must be evident before brain death can be pronounced:

- Firstly, there must be unreceptivity and unresponsiveness to the surroundings of the patient and to painful stimuli like a pinprick.
- Secondly, there are no spontaneous movements of breathing. The brainstem controls breathing and the beating of the heart. An absence of spontaneous breathing means that the brainstem is not functioning or is dead.
- Thirdly, there are no reflexes in response to tests. One common reflex is the pupillary reflex. The pupil in a healthy person will contract in the presence of bright light and dilate in dim light. In a person with brain death, the pupils will be fixed and dilated with no response to light. Another reflex is the gag reflex. In a healthy person, an insertion of a spatula to the back of the throat will elicit a gagging response. In a brain-dead person, such reflex is absent.
- Fourthly, there is a flat electroencephalogram (EEG), meaning that there is no electrical activity of the brain at all.

All these four criteria must persist over a 24-hour period before a person can be declared as being brain dead. And this declaration must be done with the agreement of two or three senior doctors. These criteria are universally accepted by all medical and legal societies. Again, returning to a story in the first chapter, the 22-year-old young man who was involved in a motor vehicle accident has been declared brain dead by his doctors. Hence, there will not

be any ethical issue involved if the ventilator is switched off, as the young man is already dead.

The definition of brain death is also critical in the issue of organ donation. There is a long waiting list of people needing organs for transplantation. The commonest organs required are kidneys, hearts, lungs and corneas. For these organs to be viable and transplantable, they are best removed when the heart is still beating, thereby continuing to supply oxygen to the organs. Thus, there needs to be a clear definition of death or brain death. It will be immoral, not to mention horrible, to harvest organs from a living human being. Patients who are on ventilators and certified brain dead may have their organs harvested for transplantation if their next of kin give consent. Morbid as it may seems, it is at this stage that the next of kin may be approached to agree to organ donation. Of course, it cannot be overemphasised that these organs will give new life to the recipients.

Persistent Vegetative State

At this juncture, let us look at the medical problem of the persistent vegetative state (PVS). PVS is not to be confused with brain death, where there is death of the whole brain, including the brainstem. A person in PVS, however, has lost only part of his brain — the cortex. The condition of PVS following brain damage was first described by Dr Bryan Jennet and Dr Fred Plum in 1972.[12]

The essential component of PVS is the absence of any adaptive response to the external environment. There is also no evidence of a functioning mind, which is either receiving, or projecting information, in a patient with long periods of wakefulness. The person in PVS apparently has no contact at all with his external environment. He is unaware of his surrounding and of himself.

But because the brainstem is still functioning, he can breathe and his heart works as normal. Clinical data shows that if the persistent vegetative state lasts for more than a year, then the chances of recovery are very poor.

A person in PVS is in no sense suffering, as we know it. According to the definition given by Dr Vere earlier, such a person would be "dead". Yet, he is not brain dead as evidenced by the functioning brainstem that controls respiratory and cardiac functions. The persistent vegetative state is also different from a coma. A person falls into a coma when he becomes unconscious because of infection, trauma or disease. The condition is reversible as the person can regain consciousness after the cause has been effectively treated. The comatose patient has brain activity, unlike the person in PVS.

To comment on the quality of life in the persistent vegetative state and to suggest that the person would be better off dead, is to say that we can judge the advantages of non-existence to be greater than the disadvantages of existence.[13] Such a position obviously moves one from the realm of medical science into that of faith, religion and metaphysics. The question of the quality of life cannot, therefore, be answered by medical science alone. However, society has a way of forcing the issue, as in the case of Terri Schiavo that made the headlines in the United States.

Terri Schiavo was a young lady with an eating disorder. At one point, she weighed 220 pounds but managed to reduce her weight to 100 pounds. In 1990, Terri suffered a massive heart attack, possibly as a result of potassium imbalance due to her eating disorder. The heart attack stopped the flow of oxygen to her brain, causing her to suffer severe brain damage. She never regained consciousness. But her brainstem was left intact and after she had been treated

for her heart condition, she could breathe on her own. She was diagnosed to be in a persistent vegetative state. Normally, if there is no recovery within three months of brain damage due to oxygen deprivation, as in Terri case, the chances of recovery are minimal. Terri was fed via a feeding tube and received good nursing care, which kept her alive. After eight years, her husband requested that the feeding tube be removed and that she be allowed to die. Terri's parents objected and thus began a legal battle that moved from the state to the supreme courts and drew in the Congress and the Senate of the United States. Eventually, the feeding tube was removed in 2005 and Terri died 15 years after her heart attack and brain damage.

The issue to be considered here is the withdrawal of food and water. When are food and water considered a necessity of life and when do they become a form of treatment? In Terri's case, they were deemed to be a treatment because of the length of time she was fed through a feeding time. So the courts decided that it was time to stop the treatment, as there was almost no chance that she would recover. The action amounted to passive euthanasia because it involved withholding life-sustaining treatment.

A consensus that has emerged is that artificially administered fluids and nutrition are different from eating and drinking, and are considered modes of treatment. They are thus optional, like any other treatment. This opinion is reflected in position statements from the American Medical Association, the American Geriatrics Society and the American Academy of Neurology.

Many Christians have been reluctant to agree with this consensus. They refer to Jesus' mention of his disciples giving a cup of cold water in his name (Matthew 10:42; Mark 9:41) and the pleading of the rich man in hell for the beggar Lazarus to dip his

finger in water to cool his tongue and ease his agony (Luke 16: 24). These passages assume that such actions will both sustain life and/or relieve suffering.[14]

J.R. Connery, a Jesuit priest concludes that:

> *…even if one does not place some positive act of violence but simply omits something necessary to preserve life, he can be guilty of euthanasia. It all depends on his intention. If his intention is to spare the patient a burdensome treatment, or one that is useless to preserve life, the omission can be justified. But if his intention is to bring on death, it is euthanasia. Since the latter intention is present when nutrition and hydration are omitted for quality of life reasons, the failure to provide them has to be condemned as intentional euthanasia by omission.*[15]

When brain death occurs, the cerebrum, which is the largest part of the brain, and brainstem die. Hence, in brain-dead patients, organs can be legally removed for transplantation, but nobody has even suggested or asked for organ donation from PVS patients. In PVS, the brainstem is still alive so in some respect, it is conceivable to picture the person as alive, with the exception of the brain. Is such a person still a person, to be accorded the rights of a human being? I believe so. It is not for us to take life but to preserve it, however much or little life that is left in the body. PVS patients can also be compared to severely mentally retarded children and adults. The anencephalic baby mentioned in chapter one is similar to someone in PVS, except that he was born without a brain. Our approach to such a baby should be similar to our approach to a person in PVS.

Problems in Determining Death

Reflecting on brain and heart death, James Mathers described three situations that illustrate the problems in determining death and deciding what to do with a patient:

> *In the first, circulation is maintained by a machine, but there is no evidence of brain activity (flat EEG). In the second, breathing and circulation continue without artificial help, but the cortex is severely damaged and the patient deeply unconscious. In the third, there is prolonged unconsciousness, evident of great cortical damage, and the circulation can only be maintained by machine.*
>
> *In the first case, the patient is presumed dead, in the second alive, and in the third, it is debatable whether the organism is a person, even though biologically there is life.*
>
> *In the first case where a flat EEG indicates death, a decision to unplug the machine poses no moral dilemmas. The latter two cases involve obvious moral dilemmas. There is biological life, and the criteria for death are not met, but could the individual ever regain consciousness? Is cortical damage too severe to know? In either of the cases, who really knows if the immaterial part has left the body?*[16]

Determining death is not as easy as it used to be. And with the difficulties comes the dilemma of choosing adequate medical treatment. James Mathers offers the following guidelines:

> *If a person is terminally ill (even hooked up to a machine), but according to the best medical opinion would not die*

> *within hours or even days, the obligation to preserve life takes precedence. This does not obligate the use of means whose benefit to the patient is dubious. It does mandate not leaving the patient to die without any care and not deliberately killing him. On the other hand, if the patient is terminal, and according to the best medical judgement will die within hours regardless of what is done, attempts to maintain life at all costs seem tantamount to refusing to accept the fact that it is that person's time to die. In these cases, allowing the person to die is morally acceptable.*[17]

Again, one must differentiate between euthanasia, which is intending to kill the patient, and withholding treatment, which may or may not kill the patient. It is morally acceptable to allow a patient, who is considered dying and will not benefit further from any more treatment, to die naturally. It is not acceptable to hasten that death by lethal medications. Again the differentiation of the intent is important.

Dignified Death

Can death be dignified? How is death dignified? The Center for Bioethics and Human Dignity in the United States has this definition:

> *Dignified death is one in which the suffering person takes advantage of all measures available to relieve pain and ameliorate the things that cause a loss of imputed dignity but also recognizes that his or her innate dignity remains. In a dignified death, we affirm ourselves as persons by giving ourselves over to God's presence even in our most*

> *despairing moments, just as Jesus did in the awful hours of Gethsemane and Golgotha.*[18]

Dying with dignity is the Christian answer to euthanasia. However, the concept of "dignity" may be even more difficult to clarify than the concept of death itself (as attempted above)! The former opens up a "host of issues interfacing different religious, moral, aesthetic, semantic, philosophical, psychological, social" and even legal considerations. A dignified death is the Christian response to euthanasia because a dignified death means dying in peace and secure in the knowledge that we have submitted to the sovereignty of God in the time of our death. It is also part of our spiritual growth, as we embrace death just as we embrace life. We shall discuss the issue further in the next chapter.

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[1] Committee on Medical Ethics, Episcopal Diocese of Washington, *Assisted Suicide and Euthanasia: Christian Moral Perspectives, The Washington Report (*Harrisburg, PA: Morehouse Publishing, 1997) p.11

[2] Definition of Physician-assisted Suicide provided by the Christian Medical and Dental Society, USA. Christian Medical and Dental Society Ethical Statement, "Physician Assisted Suicide" cited in the society's website

[3] Policy statements are given in Christian Medical and Dental Society Ethical Statement, "Physician Assisted Suicide" cited in the society's website and Saunders, Peter, Secretary, Christian Medical Fellowship in "The Christian Case Against Euthanasia" cited in http: //www.cmf.org.uk/home.htm

[4] *The Washington Report* (1997) p.12

[5] Discussion on "the distinction between the withholding or withdrawal of medical treatment, and deliberate intervention to end life". Submission from the Christian Medical Fellowship to the Select Committee of the House of Lords on Medical Ethics cited in http://www.cmf.org.uk/home.htm

[6] Christian Medical and Dental Society Ethical Statement, "Euthanasia" cited in the society's website

[7] Revised Opinion of the AMA Judicial Council, *Withholding or Withdrawing Life Prolonging Medical Treatment* (Chicago, IL: American Medical Association, 1986)

[8] Christian Medical and Dental Society Ethical Statement, "Physician Assisted Suicide" cited in the society's website

[9] Ibid.

[10] Ibid.
[11] Duncan Wright Vere, *Voluntary Euthanasia — Is There An Alternative?* (London: Christian Medical Fellowship, 1971, 1979) pp.9-10
[12] B. Jennet and F. Plum, "Persistent Vegetative State after Brain Damage: A Syndrome in Search of a Name" in *The Lancet*, April 1, 1971:734-7
[13] David L. Schiedermayer, "The Death Debate" in *Christian Medical and Dental Journal*, Spring 1992
[14] Christian Medical and Dental Society Ethical Statement on "Withholding or Withdrawing of Nutrition and Hydration" cited in the society's website
[15] J.R. Connery, "The Ethical Standards for Withholding/Withdrawing Nutrition and Hydration" in *Issues in Law and Medicine*, Vol. 2(2), 1986: 87-97 quoted in Christian Medical and Dental Society Ethical Statement, "Withholding or Withdrawing of Nutrition and Hydration" cited in the society's website
[16] James Mathers, "'Brain Death' or 'Heart Death'? Reflections on an Ethical Dilemma" in *ExposT87*, 1976:328 quoted in John S. Feinberg and Paul D. Feinberg, *Ethics for a Brave New World* (Wheaton, IL: Crossway Books, 1993) p.125
[17] Ibid.
[18] Gary P. Stewart, et. al., *Basic Questions on Suicide and Euthanasia: Are They Ever Right?* (Grand Rapids, MI: Kregel Publications, 1998) p.29

Chapter Three

A Right to Die?

"The right to choose to die when in advanced terminal or hopeless illness is the ultimate civil liberty."
— Derek Humphry

Janet Adkins was 54 years old when she was diagnosed to be in the early stages of Alzheimer's disease. When informed about the course of the disease, she decided that she did not want to live for years in that progressive, deteriorating condition. She decided to kill herself, but she wanted her death to be painless and dignified. She sought the help of Dr Jack Kevorkian, a pathologist from Michigan. On June 4, 1990, Dr Kevorkian hooked her up to a cardiac monitor and an intravenous line. Janet Adkins pushed a button that released a lethal dose of medication, which killed her in five minutes. A murder charge was filed against Dr Kevorkian but it was dismissed because the law of the state of Michigan in the United States was vague on assisted suicide.

The movement to legalise euthanasia, which grew within some liberal and religious circles in the United States during the

1920s and 1930s, gathered momentum around the 1950s. Joseph Fletcher, a popular liberal "situation ethics" proponent, published a defence of voluntary euthanasia in 1954. His ideas immediately encountered opposition from Karl Barth, Paul Ramsey and Carl F.H. Henry, who were prominent theologians and ethicists at the time. Opinion surveys, based largely on responses to individually compelling cases, showed growing support for both euthanasia and eugenics, meaning "good birth", which attempts to breed better human beings. However, this support lost ground as Americans began to realise that Nazi Germany had applied such concepts as a general practice in its eugenic programmes.[1]

Writing in *The New England Journal of Medicine* in 1949, Leo Alexander, a psychiatrist who worked with the office of the Chief of Council of War Crimes at Nuremberg, noted:

> *The beginning at first was merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the attitude, basic in euthanasia movement that there is such a thing as a life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-German. But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the non rehabitable sick…*[2]

This was a very significant observation on the change of the attitudes of doctors, as human beings were being categorised according to their value to society. When human beings cease to be seen as persons, then it becomes acceptable to deal with them as objects. In this regard, some objects which are deemed not useful can rightly be disposed of. It is a slippery road that has led to the extermination of millions of Jews, the mentally retarded and certain minority ethnic groups. It also justified experimentation on such people, as was done by some doctors at that time.

As a result of the Nuremberg trials, the early post-war period saw the adoption of two highly significant ethical declarations by the World Medical Association. The first of these, the Declaration of Geneva, included the following affirmation: *"I will maintain the utmost respect for human life from the time of conception; even under threat I will not use my medical knowledge contrary to the laws of humanity"*. The second was the International Code of Medical Ethics which affirmed that *"a doctor must always bear in mind the importance of preserving human life from the time of conception until death"*.

These two declarations, however, could not maintain their absolutism for long. Since 1948, there has been a gradual escalation of "therapeutic abortions". These are abortions performed by doctors to save the mother's life or for other therapeutic reasons. In time, the other "reasons" were expanded to include rape and incest. Gradually, they encompassed the "emotional well-being of the mother", which meant "the mother did not want the child", or abortion on demand. In 1970, the World Medical Association adopted the Declaration of Oslo, which established the precedent for therapeutic abortion in circumstances where "*the vital interests of the mother conflict with those of the unborn child",* thus formalising the trend. During the 35th World Medical Assembly in Venice in

October 1983, the phrase "from the time of conception until death" was changed to *"from its beginning*", thus begging the question of when human life begins.

Amendments to the International Code of Medical Ethics were even more radical. The phrase "from the time of conception until death" was excised from the declaration, and the new version read, *"A physician must always bear in mind the obligation of preserving human life"*. Neither the time at which human life begins nor the time it ends was defined. It was presumably left open to "individual conviction and conscience which must be respected".[3] Hence, as the medical fraternity relaxed its rulings, first on abortion and then on death, the discussion moved from the beginning of life to the end of life. When the battle against abortion was lost, the journey towards euthanasia began.

In 1974, the debate on the right to die and euthanasia was brought to a dramatic focus in the United States by Karen Ann Quinlan. After taking a dangerous mix of hallucinatory drugs and alcohol, Karen went into a coma and had to depend on a ventilator to breathe. Seven months later, her father requested that the ventilator be turned off. The hospital refused and the father went to court. In 1976, the New Jersey Supreme Court issued the landmark decision that Karen had a constitutional right to die. The ruling gained strength when the United States Supreme Court declined to review the case. Karen's plight received a lot of publicity and sympathy from the public, which began to perceive that euthanasia might be a viable option.[4] This posture was a shot in the arm for the right-to-die or euthanasia movement.

Another factor that has given support to the right-to-die movement is a purely pragmatic and economic one: the escalating cost of healthcare.

> *The raw figures are staggering. Between 1960 and 1995 heath spending in the United States has increased at more than twice the rate of inflation and now consumes nearly 15 percent of the nation's gross national product…The government spent $176 billion in Medicare in 1996…And payments [government spending on Medicare] are predicted to rise dramatically in the coming years, up at least 50 percent in 2001…Much of this federal spending and private dollars goes for end-of-life treatment…One out of every twelve dollars spent on healthcare in the United States pays for intensive-care treatment, and nearly 30 percent of all Medicare payments are attributable to patients in their last year of life.*[5]

Because of rising healthcare costs, many insurance companies, health care managers, organisations and governments are increasingly pushing for pro-euthanasia measures today.

Peter Saunders, formerly secretary of the Christian Medical Fellowship, United Kingdom, has argued that four factors have been responsible for the progression to euthanasia. They are (1) favourable public opinion, (2) a group of willing doctors, (3) economic pressure, and (4) a law allowing it.[6] These factors reflect a progressive decline of religious authority, and its isolation and separation from the public arena.

In 1989, the Society for the Right to Die brought together a panel of distinguished physicians. In the discussion that followed, 10 of the panel's 12 members agreed that if a hopelessly ill patient believed his condition was intolerable, then it should be permissible for a physician to provide him with the medical means and medical knowledge to commit euthanasia. For example,

the physician could prescribe sleeping pills for the patient and indicate how many pills there are in a lethal dose.[7] The World Medical Association, however, confirmed its stand that euthanasia was unethical and must be condemned by the medical profession in its 1992 Statement of Marbella.[8] The Christian Medical and Dental Society (CMDS) of the United States, in its Ethical Statement, affirmed that it "opposes physician-assisted suicide in any form."[9]

The Christian stand on euthanasia has always been an opposition to any form of euthanasia or assisted suicide. Pope John Paul II wrote in *The Gospel of Life*:

> *I confirm that euthanasia is a grave violation of the law of God,* since it is the deliberate and morally unacceptable killing of a person. This doctrine is based on the natural law and upon the written word of God, is transmitted by the Church's Tradition and taught by the ordinary and universal Magisterium." (italics his)[10]

In *Matters of Life and Death*, authors Beckwith and Geisler emphasised in stronger terms, "Active euthanasia, however good the motives, is in the same category as shooting someone with a gun or slitting the throat with a knife. Most moral people recognize it as a form of murder, regardless of the alleged merciful motives."[11] However, lately, there have been dissenting arguments even among Christians. Both proponents and opponents are committed Christians who seek to apply Scriptural teachings in their lives. The central difference between those who favour and those who oppose assisted suicide and euthanasia lies in (1) the judgement they make about God's purposes and power in the light of human suffering,

and (2) their evaluation of whether adequate safeguards can be built into a policy of assisted suicide/euthanasia.[12]

Survey of the Current State of Euthanasia

The United Kingdom

In 1935, the Euthanasia Society of England was formed. Its objectives were twofold. Firstly, it was to convince the public that people suffering severely from fatal, terminal illness should be allowed a painless death if they request it and, secondly, to promote legislation to that end. Despite the Society's effort, both 1936 and 1969 bills to legalise euthanasia were defeated in the House of Lords, a component of the British Parliament. On Thursday, February 17, 1994, a press release from the House of Lords Select Committee on Medical Ethics read:

> *Contrary to many expectations, the 14 members of the committee have reached an unanimous conclusion. They acknowledge that in difficult individual cases euthanasia may be seen by some to be appropriate, but argue that wider social considerations make its practice undesirable. "The issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole". The committee argue that individual cases are not sufficient reason to weaken the prohibition on intentional killing which protects us all…*[13]

Hence, while acknowledging that there were good reasons for the support of euthanasia, the committee reaffirmed the anti-euthanasia stand of the government. In spite of the strong

right-to-die and euthanasia lobby in the country, euthanasia is still illegal in the United Kingdom.

The Netherlands

The Dutch has one of the most liberal attitudes towards euthanasia. In 1984, the Royal Dutch Medical Association (RDMA) issued guidelines describing circumstances under which it was professionally acceptable for a physician to take the life of a patient. Although euthanasia and assisted suicide were then illegal in the Netherlands, prosecutors nationwide agreed not to prosecute physicians if the RDMA guidelines were followed. The *Remmelink Report* of 1991 showed that of 128,786 deaths in the Netherlands in the preceding year, 1.8 per cent were due to "euthanasia", 0.3 per cent to "assisted suicide", and 0.8 per cent to "life terminating acts without explicit and persistent request". In other words, euthanasia was performed on more than 3,000 people in the Netherlands in 1990, and in more than 1,000 of them, the act was not voluntary.[14] On February 9, 1993, the Lower House of the Dutch Parliament approved legislation that, while not specifically legalising euthanasia, guaranteed immunity from prosecution to physicians who followed the RDMA guidelines.[15]

On April 10, 2001, the Netherlands became the first country in the world to legalise euthanasia, thus allowing its citizens the right to choose to die. The criteria for voluntary euthanasia are stringent and doctors involved must:

a. Be convinced that the patient's request is voluntary, well considered and lasting.
b. Be convinced that the patient's suffering is unremitting and unbearable.

c. Have informed the patient of the situation and prospects.
d. Have reached the conclusion with the patient that there is no reasonable alternative.
e. Have consulted at least one other physician.
f. Have carried out the procedure in a medically appropriate fashion.[16]

It would appear that doctors in the Netherlands have moved from their role of healers, and are now also given the role of killers. In December 2004, three years after the legalisation of euthanasia, CNN carried a report stating that in Groningen Paediatric Hospital, a number of children had been euthanised because they were severely physically and mentally retarded. Again, one is reminded of the lessons of Nazi Germany's eugenic programmes.

The United States of America

The Euthanasia Society of America was formed in 1938. Public opinion in the United States has generally been against euthanasia until recently. The publicity given to Dr Kevorkian[17] and to the book *Final Exit*[18] has polarised public opinion on euthanasia and galvanised many into action.

A state-wide citizens' referendum to allow euthanasia by lethal injection failed narrowly in Washington in 1991 and in California in 1992. However, in November 1994, the state of Oregon passed Measure 16 by 53 per cent to 47 per cent. This gave qualifying patients (capable adults and residents of Oregon) with six months or less to live, the right to ask attending doctors for drugs to end their lives.[19] In 1998, the state passed a law allowing physician-assisted suicide for the terminally ill. Oregon is the only state in the United

States with this law, and the first person to use the opportunity to die under the new voter-approved physician-assisted suicide law did so on March 25, 1998.[20] Over the seven years that this law has been in effect, 171 terminally ill persons have ended their lives.

There is a battle royale in the United States over euthanasia, as the right-to-die and pro-euthanasia movements take on the right-to-live and anti-euthanasia organisations in court. In *Washington v Glucksberg*, a case heard in 1997, the Supreme Court determined that Washington's prohibition of assisted suicide did not violate the due process clause of the Constitution.[21] Thus the Supreme Court upheld that society has a responsibility to prevent people from committing suicide.

On March 6, 1996, an Appeals Court ruled that terminally ill adults had a "constitutional right to die". The judge who dissented in the ruling, Robert Beezer, warned that it would lead to the killing of the poor, elderly and disabled. A month later, on April 2, 1996, another Appeals Court struck down two New York state laws that banned physician-assisted suicide. The court proclaimed that allowing patients to refuse life-prolonging measures but not helping them to kill themselves was "discriminatory". However, in the following year, on June 26, the U.S. Supreme Court refused to establish physician-assisted suicide as a constitutional right under the specific arguments advanced in the two federal appeals court cases. Nonetheless, it left the door open to the possibility of states legalising physician-assisted suicide under different statutes.

Currently, euthanasia is actively championed by organisations such as the Society for the Right to Die,[22] Hemlock Society, EXIT, and Concern for Dying.

Australia

Euthanasia was legalised in the Northern Territory of Australia in July 1996, but the legislation was overturned by the Australian Parliament on March 24 after the death of four patients.[23] The Northern Territory has a population of only 150,000, with a majority consisting of the Aborigines. The bill was blocked by an interesting alliance of the "three As" — the Australian Medical Association, the Anglican Church and the Aborigines. This shows that many doctors, Christians and others in Australia do not support euthanasia.

Other Countries

Colombia passed a law allowing euthanasia on June 12, 1997. The decision expressed that euthanasia was permitted for individuals experiencing great pain, such as those suffering from AIDS, cancer, or renal deficiency, but not for those with degenerative diseases such as Alzheimer's or Parkinson's disease.[24] Switzerland and Belgium have also liberalised their laws to allow euthanasia. The Philippines and South Africa are also considering legislation. In Canada, physician-assisted suicide remains illegal after the 1993 *Rodriquez v British Columbia* case.

Euthanasia in Malaysia

Unlike the countries mentioned, Malaysia does not have any pro-euthanasia organisation although there is a "Pro-Life" organisation in Kuching.[25] There has not been much discussion about euthanasia even though it is a hot topic in other parts of the world. A careful search through Medline[26] showed that no articles on euthanasia had been published by the *Medical Journal of Malaysia* (the official journal of the Malaysian Medical Association). A review of the

1995-1997 contents of the *Asian Beacon*, a Malaysian Christian family magazine, also did not uncover any discussion on euthanasia.[27] It appears that euthanasia is not considered an issue in Malaysia at this moment.

Healthcare in Malaysia is still very "paternalistic". Doctors are regarded as authority figures and their decisions are seldom questioned. Even educated Malaysians will follow the recommendations of their doctors, after they have sought clarification for their concerns. Others, especially the rural Malays, may seek traditional treatments.[28] The Koranic condemnation of suicide is also an important consideration in Malaysia. Furthermore, the followers of Hinduism, Buddhism and Jainism regard euthanasia as unacceptable.[29]

But Malaysia is changing. More and more of those who are terminally ill are dying in hospital. Where once staying with the extended family is the norm, nowadays, the elderly and the sick increasingly have nowhere to go. Where once the dying are taken home for their last moments, nowadays they are left to die in the sterile, unfriendly environment of the hospital or nursing home. As the population ages, as healthcare services improve but strain the public healthcare budget, as the political and social climate changes and people learn to question more, there may well come a time when the issues of euthanasia will be debated, as they are now in the more developed countries.

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1 Edward Larson and Darrel Amundsen, *A Different Death: Euthanasia and the Christian Tradition* (Downers Grove, IL: InterVarsity Press, 1998) p.164

2 Leo Alexander, "Medical Science Under Dictatorship" in *The New England Journal of Medicine*, Vol. 241, 1949: 39-47

3 Saunders, op. cit.

4 Larson and Amundsen, op. cit., 166, 174-77, 191-2

[5] Larson and Admundsen, op. cit., pp.171-172
[6] Saunders, op. cit.
[7] S.H. Wanzer, D.D. Federman, S.J. Edelstein, et al., "The Physician's Responsibility Towards Hopelessly Ill Patients: A Second Look" in *The New England Journal of Medicine*, 1989, 320: 844-849
[8] Peter Saunders, "Abortion and Euthanasia" cited in the Christian Medical Fellowship website http://www.cmf.org.uk/home.htm.
[9] Christian Medical and Dental Society Ethical Statement, "Physician Assisted Suicide" cited in the society's website
[10] Pope John Paul II, "The Gospel of Life" in Michael M. Uhlmann, (ed), *Last Rights: Assisted Suicide and Euthanasia Debated* (Grand Rapids, MI: Eerdmans, 1998) p.229
[11] Francis Beckwith and Norman Geisler, *Matters of Life and Death* (Grand Rapids, MI: Baker Book House, 1991) p.142
[12] Committee on Medical Ethics, Episcopal Diocese of Washington, *Assisted Suicide and Euthanasia: Christian Moral Perspectives, The Washington Report* (Harrisburg, PA: Morehouse Publishing, 1997)
[13] Andrew Fergusson, "Euthanasia: An Update" cited in the Christian Medical Fellowship website http://www.cmf.org.uk/home.htm. The Select Committee of the House of Lords on Medical Ethics received submissions from the Christian Medical Fellowship. See Submission from the Christian Medical Fellowship to the Select Committee of the House of Lords on Medical Ethics http://www.cmf.org.uk/home.htm
[14] Fergusson, op.cit.
[15] Robert D. Orr, "Why Doctors Should Not Kill" cited in the Christian Medical and Dental Society website
[16] Section 293(2) of the Dutch Criminal Code
[17] Matt Bai, "Death Wish" in *Newsweek,* December 7, 1998, p.39-41 gives a good write-up on Jack Kervorkian. Dr Kervorkian is a pathologist who invented a "suicide machine" that helps patients commit suicide.
[18] Derek Humphry, *Final Exit* (Eugene, OR: Hemlock Society, 1991) was published in 1991. It is a "do-it-yourself" suicide manual. It was an immediate bestseller. Joni Eareckson Tada described her reaction when she first watched Derek Humphry talking about the book on television and her observation on the book's subsequent effect on Americans in her book *When Is It Right to Die?* (Grand Rapids, MI: Zondervan, 1992) pp.26-37. Derek Humphry also highlights the success of his book, *Final Exit* in *Dying With Dignity: Understanding Euthanasia* (New York: Carol Publishing Group, 1992) pp.27-36.
[19] Fergusson, op. cit.
[20] Jonathan Imbody, "Killing Isn't Caring: What You Should Know About Physician-Assisted Suicide" cited in the Christian Medical and Dental Society website
[21] Stewart, op. cit., p.49
[22] Formerly Euthanasia Society of America. In the early 1990s, the Society for the Right to Die merged with Concern for Dying.
[23] Christopher Zinn, "Australian Voluntary Euthanasia Law Is Overturned" in *British Medical Journal*, Vol. 314, April 5, 1997:993
[24] Stewart, op. cit., p.51
[25] Pro-Life Group, Association of Churches in Sarawak, is mainly a Roman Catholic organisation involved in counselling against abortion. It does not deal with euthanasia.
[26] Medline is a large database containing the text of most of the world's medical journals.
[27] *Asian Beacon*, Vol. 30/5 1998. Personal communication with the previous editor, Andrew Loh, also did not unearth any articles published on euthanasia in the *Asian Beacon*. To

date, the only article written on euthanasia in the *Asian Beacon* is by the author.

[28] Richard Winstedt, *The Malay Magician* (Kuala Lumpur: Oxford University Press, 1951, 1960)

[29] For a discussion on euthanasia in these three great religions, see Harold G. Coward, Julius J. Lipner and Katherine K. Young, *Hindu Ethics: Purity, Abortion, and Euthanasia* (New York: State University of New York, 1989) pp.71-121

Chapter Four

A Biblical Perspective on Suicide

"And even as each one of you stands alone in God's knowledge, so must each one of you be alone in his knowledge of God and his understanding of the earth."

— Kahlil Gibran

What does the Bible have to say about suicide, the act of killing oneself deliberately? Like in the case of intentionally induced abortion, the Scriptures are surprisingly silent on the issues of suicide and euthanasia.

The Bible and the Sanctity of Life

Four key principles about the sanctity of life can be derived from the Bible. They are: (1) human dignity comes from God, (2) all human life has equal dignity, (3) "thou shall not kill", and (4) love your neighbour.

Human Dignity Comes from God

Human life reflects the very life of God. We are created in the

image of God (Genesis 1:26-27), so God's and our dignity are closely related. "Whosoever sheds the blood of man, by man shall his blood be shed: for God made man in his own image" (Genesis 9: 6). Human life is a gift from God. In response, we should approach this life with gratitude, thanksgiving and deep responsibility.

Unfortunately, in our society, we ascribe value to people for what they do or contribute rather than who they are. Hence, professionals are more valuable than blue-collar workers, and the weak, the sick, and the mentally and physically impaired are the least valuable among us. In an Asian society, we may not voice such thoughts, but we express them through our behaviour. Thus our relentless pursuit of status symbols: degrees, big houses, fancy cars and trophy wives. We have equated human dignity with human status.

All Human Life Has Equal Dignity

In Genesis 1:27, we read: "So God created man in his own image, in the image of God he created him; male and female he created them." Men and women bear the same dignity and this applies to all of mankind of all ages, sex, race and conditions. However incapacitated, mentally retarded, chronically ill, physically dependent or in a persistent vegetative state, people bear that dignity and it has equal claims on us.

"Thou Shalt Not Kill"

The sixth commandment "Thou shalt not kill" (Exodus 20:13; Deuteronomy 5:17 KJV) has its roots in the Creation narrative: "Let us make man in our image" (Genesis 1:26), and in the Noahic Convenant: "Whoever sheds the blood of man, by man shall his blood be shed" (Genesis 9:6). Man, being made in the image of God,

is not to be intentionally killed. *Ratsach* is the Hebrew word that is translated as "kill" in the commandment. It is similar to the Greek *phoneuo*, which means "murder". Hence, the sixth commandment forbids murder or the "unauthorised, intentional or hostile killing of one human being by another".[1] It is because of this that many Christians will allow exceptions to this commandment, such as in martyrdom, killing in times of war and capital punishment. Such exceptions can also be inferred from the Scriptures.

Love Your Neighbour

Jesus summarised the Commandments as: "Love the Lord your God with all your heart and with all your soul and with all your mind and with all your strength". The second is this: "Love your neighbor as yourself" (Mark 12:30-31). Christians are called to love their neighbours. And this includes taking care of and looking out for each other. It does not include helping each other to die, though Christian "situation ethicists" may argue otherwise in the name of a new metaphysically contentless definition of "love" when a neighbour is in great suffering.[2]

The Bible and Suicide

In some cultures, suicide is morally acceptable or even honourable. Many early Greek and Roman philosophers felt that suicide constituted an honourable death. The Hindu practice of *suttee* (where a widow would throw herself onto her deceased husband's funeral pyre), the Japanese act of *hara-kiri* and the Inuit practice of "going out on the ice" (where an older individual would voluntarily freeze to death if he felt he was a burden to his family) were also considered to be instances of dying with honour.[3] In the Bible, there are seven recorded suicides.

Suicide of Abimelech

The first mentioned is that of Abimelech. After capturing the city of Thebez, he attacked a fortified tower in the centre of the city. The Old Testament described, "Abimelech went to the tower and stormed it. But as he approached the entrance to the tower to set it on fire, a woman dropped an upper millstone on his head and cracked his skull. Hurriedly he called to his armor-bearer, 'Draw your sword and kill me, so that they can't say, 'A woman killed him." So his servant ran him through, and he died" (Judges 9:52-54). The Bible neither approves nor disapproves of this act of assisted suicide nor comments on the sexist remarks. Abimelech's death was noted as a fitting end to an evil man. "Thus God repaid the wickedness that Abimelech had done to his father by murdering his seventy brothers" (Judges 9:56).

Suicide of Samson

The next suicide, though arguably there was a good cause and it was with divine sanction, was that of Samson. "Then Samson reached towards the two central pillars on which the temple stood. Bracing himself against them, his right hand on the one and his left hand on the other, Samson said, 'Let me die with the Philistines!' Then he pushed with all his might, and down came the temple on the rulers and all the people in it. Thus he killed many more when he died than while he lived" (Judges 16:29-30). Scripture passed no judgment on his act of suicide.

Josephus, a Jewish historian who lived in the first century, observed, "Such was his end, after governing Israel for twenty years. And it is but right to admire the man for his valour, his strength, and the grandeur of his end, as also for the wrath which he cherished to the last against his enemies. That he let himself be ensnared by

a woman must be imputed to human nature which succumbs to sins, but testimony is due him for his surpassing excellence in all the rest."[4]

Suicide of Saul and His Armour-bearer

The suicide of Saul and his armour-bearer elicited more comment:

> *The fighting grew fierce around Saul, and when the archers overtook him, they wounded him critically. Saul said to his armor-bearer, "Draw your sword and run me through, or these uncircumcised fellows will come and run me through and abuse me." But his armor-bearer was terrified and would not do it; so Saul took his own sword and fell on it. When the armor-bearer saw that Saul was dead, he too fell on his own sword and died with him (1 Samuel 31:3-5).*

Saul is condemned in 1 Chronicles 10:13-14:

> *Saul died because he was unfaithful to the LORD; he did not keep the word of the LORD and even consulted a medium for guidance, and did not inquire of the LORD. So the LORD put him to death and turned the kingdom over to David son of Jesse.*

Even though Saul killed himself by his own sword, the chronicler noted that God had killed Saul for his unfaithfulness. The armour-bearer chose to die with his king, an example of suicide by identification. There was no comment on their actions in the Bible.

Suicide of Ahithophel

Ahithophel was King David's counsellor. He became Absalom's when Absalom rebelled against his father. David prayed that God would turn Ahithophel's counsel into foolishness (2 Samuel 15: 31b). When Ahithophel found that his advice had been ignored by Absalom, he hanged himself (2 Samuel 17:23). Again, there was no comment in the Bible about his actions.

Suicide of Zimri

Zimri came to the throne of Israel with the assassination of his predecessor. When the Israelites heard about the murder, they rebelled against Zimri and besieged his city of Tirzah. "When Zimri saw that the city was taken, he went into the citadel of the royal palace and set the palace on fire around him. So he died, because of the sins he had committed, doing evil in the eyes of the LORD and walking in the ways of Jeroboam and in the sin he had committed and had caused Israel to commit" (1 Kings 16:18-20). Here, it is noted that his death was judgement for his sins.

Suicide of Judas Iscariot

The suicide of Judas Iscariot is the only one mentioned in the New Testament. When Judas saw that Jesus was condemned, he was filled with remorse and tried to return the money that he had received for betraying the Lord. Then he went away and hanged himself (Matthew 27:3-5). There is no further comment on Judas in Scripture, except the mention that his apostleship was given to Matthias (Acts 1:23-26).

It is interesting to note that in this brief survey of the seven suicides in the Bible, those of Abimelech, Saul and Zimri were recorded as direct judgment of God on their sins, with the text

even going as far as to say that God killed Saul. The Bible is silent on the other four suicides, although the silence of Scripture does not form the basis for positive argument, especially as the ignoble context in each case speaks for itself.

The Bible and the Right to Die

Autonomy, not in the absolute sense but in the sense of a God-given "human responsibility" as a biblical counterpoint to Divine Sovereignty, is the main issue of the argument for the right to die. Christians have distinctive, principled and compelling reasons to take the claims of autonomy rooted in our God-given free will with great seriousness. We are created in the image and likeness of God (Genesis 1:26-27). An essential part of that image is our ability to think and to choose. Hans Kung, a prominent Roman Catholic theologian who was one of the key figures in the renewal of the Roman Catholic Church (Vatican II) in the last century, observed that "life is…a human task and thus made our responsibility…[God] wants to have human beings, in his image, as free, responsible partners."[5] Hence we have the freedom to choose, but are expected to be responsible in making our choice. Ethical liberalism too ascribes a supreme value to the individual's freedom and rights.

Autonomy and Divine Sovereignty

Richard Gula, professor of moral theology at St Patrick Seminary in Menlo Park, California, and author of several books on morality and euthanasia, writes:

The dominant value upheld by the principle of autonomy is self-determination. It is such a supreme value because it means that you and I can live according to our own conception of the good life. I am ultimately responsible for my life and you are for yours. The human dignity attached to the freedom of self-determination demands respect for the freedom to choose and to control not only life but also how and when we die. The "right to die" and "death with dignity" in this view may be translated as something like the following: "It's my body; it's my freedom; it's my life; it's my death. Let me have control."

Absolutizing autonomy in this way makes "death with dignity" mean that each of us should be able to determine at what time, in what way, and by whose hand we will die. While no ones doubts that self-determination is an important value, the question in the euthanasia debate is, "How far does autonomy extend?"[6]

But is our autonomy absolute? As Richard Gula asked, "How far does autonomy extend?" The fundamental distinction between the Creator and the created (His creation) imposes limits on our freedom and the scope of our stewardship. The limitations to human autonomy or self-determination is found in Genesis 2:15-17:

The LORD God took the man and put him in the Garden of Eden to work it and take care of it. And the LORD God commanded the man, "You are free to eat from any tree in the garden; but you must not eat from the tree of the knowledge of good and evil, for when you eat of it you will surely die."

The story asserts a fundamental conviction of biblical faith that, from the very beginning, human freedom over life is limited or proscribed. God alone has sovereignty over life and death. The end of human life is not subject to a person's free judgement. Our freedom does not extend to absolute dominion, which is an exclusively divine prerogative. This is called the principle of sovereignty.[7] God alone has the right to decide when and how a person should live and die. God alone has the right to take a life. Man does not have the right to take his own life.

Human Stewardship

The Scriptural model for human responsibility is portrayed in Genesis 2:19-20:

> *Now the Lord God has formed out of the ground all the beasts of the field and all the birds of the air. He brought them to the man to see what he would name them; and whatever the man called each living creature, that was its name. So the man gave names to all the livestock, the birds of the air and all the beasts of the field.*

As Hebrew scholars have noted, to "name" something is not simply to label it; it is to give it a meaning and to order it in the nature of things. Hence, Adam was called upon to continue the creation by bringing order into being, rather than simply replicating preordained orders.[8] He and his descendants would be destined to be "co-creators" with God. This is also the principle of stewardship. As our stewardship encompasses that of all of God's creation, we are responsible not only for our world but also

for our own body; we have a special responsibility to take good care of it.

The principles of divine sovereignty and human stewardship and responsibility argue against unlimited autonomy in the discussion on euthanasia. In his encyclical *Veritatis Splendor*, Pope John Paul II rejected claims of personal autonomy and the belief that human beings can do what they want with their bodies[9] (cf. 1 Corinthians 6:19-20: "Do you not know that your body is a temple of the Holy Spirit, who is in you, whom you have received from God? You are not your own; you were brought at a price. Therefore honor God with your body").

While the Bible is silent on the topic of suicide and euthanasia, it does provide some principles for our guidance. The Bible teaches a limited human autonomy that is subject to the sovereignty of God, and the responsibility of human stewardship towards our bodies and others. Scripture also teaches about the sanctity of human life, which obviously argues against suicide and euthanasia. Our responsibility as believers then is to look for a Christian response to euthanasia that does not undermine the dignity of those seeking euthanasia as an end to their suffering, and that acknowledges their pain and needs, while offering a viable alternative to suicide as a means to end suffering.

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1 Saunders, op. cit.

2 Joseph Fletcher is the main proponent of "situation ethics". For a discussion on Situation Ethics, see Joseph Fletcher and John Warwick Montgomery, *Situation Ethics: Is It Sometimes Right to do Wrong?* (Minneapolis: Bethany Fellowship, 1972).

3 Orr, op. cit.

4 Josephus, "Antiquities of the Jews" 7.228-29. Quoted in Edward Larson and Darrel Admundsen, *A Different Death: Euthanasia and the Christian Tradition* (Downers Grove, IL: InterVarsity Press, 1998) p.257

[5] Hans Kung, "A Dignified Dying" in Hans and Walter Jens, *Dying with Dignity* (New York: Continuum, 1995) p.26

[6] Richard M. Gula, *Euthanasia: Moral and Pastoral Perspectives* (New York: Paulist Press, 1994) pp.9-10

[7] Gula, op. cit., pp. 11-14

[8] Delwin Brown, *To Set at Liberty: Christian Faith and Human Freedom* (Maryknoll, N.Y.: Orbis Books, 1981) pp.9, 15, 35, 53 quoted in Sally B. Geis and Donald E. Messer, *How Shall We Die? Helping Christians Debate Assisted Suicide* (Nashville: Abingdon Press, 1997) p.157

[9] Robin Gill, (ed), *Euthanasia and the Churches: Christian Ethics in Dialogue* (New York: Cassell, 1998) p.33

Chapter Five

A Biblical Perspective on Suffering

"Pain has two faces, human and divine. The human face is haggard, drawn, contorted and streaked with tears. The divine is calm, assuring, kind, and loving — but likewise streaked with tears."[1]

— D.B. Biebel

Compassion and suffering are key issues in any discussion on euthanasia. It is our nature to want to avoid suffering. And if we are suffering, we will seek ways to alleviate it. Often, when we are faced with suffering, especially in the terminally ill, we are filled with compassion. It can be extremely painful for us to know that a person is going through much suffering. In our compassion, we might consciously or unconsciously harbour this thought, "How I wish I can help to end his suffering." In this context, some might be led to think of euthanasia. And it explains why euthanasia is also known as mercy killing.

Suffering, however, is a broad and mysterious experience that touches all aspects of who we are. It can involve the prolonged physical pain attached to illness and injury as well as the unrelenting anguish that accompanies mental, emotional and

spiritual conflict.[2] Philosopher Peter Kreeft writes, "Modern man does not have an answer to the question of why. Our society is the first one that simply does not give any answer to the problem of suffering except a thousand means of avoiding it."[3]

Scripture is full of comments on suffering. God sends suffering to the unbeliever and disobedient as a means of judgement for sins (Job 4:7-9); to turn an individual back to Him (Jonah); or to bring a nation to salvation (Zechariah 12).

Being a Christian does not exclude one from suffering. The Scriptures note that sometimes Christians are afflicted as a means of punishment (Psalm 94:12-13); to be kept humble as with the Apostle Paul (2 Corinthians 12:7); or to prove to Satan that there are those who love God because of who He is, not because of what He gives (Job 1-2).[4]

Suffering also continues the process of sanctification in the spiritual lives of believers (1 Peter 4:1-2). It does this by refining the believer's faith (1 Peter 1:6-7); teaching endurance and perseverance (Romans 5:3-4; James 1:3-4); and teaching the Sovereignty of God (Job 42:2-4), and the imitation of Christ (Philippians 2:5-11; 1 Peter 3:17-18). On some occasions, suffering is God's way of preparing believers for the testing of their works for the purpose of rewards (1 Peter 1:7).

N. Hanson, writing in *School of Suffering in Moral Medicine*, shares four lessons on suffering presented by Paul in 2 Corinthians: (1) the importance of receiving comfort from others (1:3-4), (2) those who receive such comfort are especially equipped and therefore called to comfort other sufferers (1:3-11), (3) Christians who suffer share in the suffering of Christ (11:23-29), and (4) suffering is a medium for the revelation of God's power (12:9).[5] The lessons show that suffering involves not only the individual, but also includes

others, is helped by having a relationship with people, and forces us to learn to depend on God.

Many Christians take a literal interpretation of Romans 8:28: "And we know that in all things God works for the good of those who love him, who have been called according to his purpose." They claim that this verse promises wealth, health and avoidance of suffering. Douglas Moo, professor of New Testament in Trinity Evangelical Divinity School in Deerfield, Illinois, comments:

> *The idea that this verse promises the believer material wealth or physical well-being, for instance, betrays a typically Western perversion of "good" into an exclusive material interpretation. God may well use trials in these areas to produce what he considers a much higher "good": a stronger faith, a more certain hope. But the promise to us is that there is nothing in this world that is not intended by God to assist us on our earthly pilgrimage and to bring us safely and certainly to the glorious destination of that pilgrimage.*[6]

Moo does not believe that Romans 8:28 promises no suffering for believers. In the examples of Jesus and Paul, we see requests to eliminate suffering denied so that the perfect will of God can be accomplished. Elsewhere in Scripture, there are numerous examples of people who requested the alleviation of suffering or healing and received it.

Hannah wanted her womb to be fertile (1 Samuel 1:9-11); Naaman wanted relief from his leprosy (2 Kings 5:1-14); the Roman centurion wanted his dying servant healed (Matthew 8:5-7); and Jairus, the father of a young girl who was dying, begged Jesus for

her life (Mark 5:21-23). If you ask for relief from suffering, know that the answer to your prayer is for your good and for the glory of God. When God does not remove your trial — yet — that is as much an answer as a miraculous healing.[7]

Albert Schweitzer, Nobel Peace laureate and physician-missionary to Africa, reflects, "Whether we are active or suffering, we must find the courage of those who have struggled to achieve the peace that passeth all understanding."[8] Suffering can be a means for us to learn to achieve the peace that the Apostle Paul talked about.

Suffering is universal in that it affects us humans as well as the rest of creation. We live in a fallen, imperfect world. We are often not in control of situations and get drawn into the consequences of the actions of others. A thoughtless factory owner may pollute the environment with agents that can cause cancer. A drunken driver may kill a promising young neurosurgeon. A movement in the tectonic plate in the ocean may cause an earthquake and a giant tsunami that could wipe out whole communities. The Bible is honest in saying that there is and will continue to be suffering, but it also offers hope to cope with it and the promise that, one day, there will be an end to suffering and pain.

The Scriptures and Healing

The concept of inherent human dignity and value ultimately provided the basis for the Christian ethics of respect for human life. In the fourth century, Christians began to found hospitals, orphanages and homes for the poor and the aged. There are many Scriptural references to suggest that effective medical therapies are appropriate. What have been mentioned include cleansing,

bandaging, soothing with oil (Isaiah 1:5-6) or balm (Jeremiah 8: 22, 46:11, 51:8), and setting fractures (Ezekiel 30:21). Physicians are generally not viewed negatively (Jeremiah 8:22; Luke 5:31; Colossians 4:14), and it is accepted that God heals through His human agents.

Supernatural or miraculous healing was an important part of Jesus' ministry. Here, we are referring to supernatural, or miraculous, as opposed to natural healing. Jesus performed healing to show His authority and power over creation as the divine son of God (Matthew 8:28-34; John 9:35-41, 11:38-45). He commissioned His disciples to participate in His healing ministry (Matthew 10: 1-5; Luke 10:9), a role which the Church continues to play (Acts 3:1-11, 5:15-16, 9:33-34, 12:8-10). Any consideration of euthanasia must take into account this sovereign aspect of God's character, which is His ability to intervene supernaturally or miraculously when there is disease or sickness. If God will heal in response to our prayers, then there is obviously no need to consider euthanasia or suicide.

Peter Wagner of Fuller Seminary, Pasadena, United States, has described signs and wonders as the Third Wave of the Holy Spirit. The first wave was the Pentecostal Movement and the second the Charismatic renewal among the mainline denominations. Like the Jews, our present generation seeks miraculous signs. People want an experiential manifestation of God in their lives and they want to see the supernatural acts of God. One of the areas in which they want to see these supernatural or miraculous acts is healing.

In seeking to understand healing, especially in regard to prayer to God for healing, we need to consider three questions:

1. Does God heal today?
2. Does God heal supernaturally today? (Do miraculous healings occur?)
3. Does God heal supernaturally frequently today?

It is important that we understand the biblical concept of healing and how God works in the world today.

Does God Heal *Today*?

With the advances in medical and technological sciences, most of us can look forward to leading a healthy and active life until we are in our 70s. With the advent of antibiotics, infections have fallen from their position as the leading cause of death. Nowadays, coronary heart problems are the major cause of mortality and morbidity. But with new knowledge in diet, exercise, drugs and surgical procedures, even these problems can be kept at bay for a time.

So, to the question of whether God heals today, the answer is a resounding "yes". God heals by what He has programmed into our bodies; He created them with wonderful inherent healing abilities. Often, we do not appreciate how much wear and tear our body take in everyday living, and how efficiently it repairs and rebuilds itself. If we accidentally cut ourselves, the wound bleeds. In the blood are factors which cause it to clot, thus plugging up the wound. Then cells swing into action to bind up and repair the wound, and white blood cells are mobilised to prevent infection. All these occur automatically without our conscious knowledge. No wonder the Psalmist speaks of how wonderful our created body is. Diseases occur when the body's repair and protective abilities break down due to invading factors (infections, trauma), or malfunction in the genetic programming or breakdown of organs due to abuse or age.

God also heals through His instruments of healing — the doctors and nurses with their knowledge of the curative powers of the plants, herbs and minerals that He has created. The Church has always appreciated the help of physicians in fulfilling its mandate to help and treat the sick.

Does God Heal *Supernaturally* or Miraculously Today?

Some Christians would say "no". Their argument is that the miraculous happens for a special function. Its purpose is the authentication of Jesus as the true Messiah, or the confirmation of His disciples as the apostles or agents of revelation. One fifth of the Gospels (727 out of 3,779 verses) deals with healing and the discussions surrounding instances of healing. A total of 41 acts of healing were performed by the Lord Jesus. There were 10 cases where entire communities or villages were healed.

The healings of Jesus were undeniable, authoritative, awesome and convincing. They were simply spectacular and dramatic. They were instantaneous; complete healing with a word, sometimes over distances, with no relapses. He healed not only functional illness but also organic — cases of paralysis, blindness, leprosy, and mutism. The blind could see. The lame could walk. Withered hands were restored. It proved beyond a doubt that He is indeed the Messiah. The ministry of the apostles was also authenticated by their miraculous healings. With the passing of the Apostolic Age, many Christians believe that the gift of miraculous healing has ceased.

There are other Christians, though, who believe that God still heals miraculously today. When Jesus sends us out to make disciples of all nations (Matthew 28), He gives us the authority to heal every sickness and disease (Mark 16:15).

There is a profusion of miraculous healings recorded in the Gospels and Acts, but, strangely, there is a remarkable absence of the miraculous in the Epistles. In 1 Timothy 5:23, Paul could only advise Timothy to take wine for his stomach, and there is no record that he prayed for his healing. It implies that Paul could have prayed for Timothy to be healed, and he was not. In 2 Timothy 4: 20, Paul had to leave Trophimus at Miletus because he was sick. But Paul did heal a man from fever and dysentery in Acts 28:8-9. Could this indicate that the gift of miraculous healing was on the decline even in New Testament times? The writings of the New Testament church and the early church fathers have very little mention of miraculous healing. Many scholars take this to substantiate the belief that miraculous healings have ceased.

Nonetheless, few though they may be, there are some accounts of miraculous healings and even the raising of the dead. Bede (673-735 AD) recorded in his *History of the English Church and People* an account of Cuthbert, Bishop of Lindisfarne, healing a man with a fractured skull sustained from falling from a horse. He also recorded John, Bishop of Hexham, healing a mute. What some Christians believe is that healing was so commonplace during the New Testament and early church fathers' times that they were not worth recording.

But what of all the healings that go on in the so-called signs-and-wonders churches like Anaheim Vineyard (John Wimber's church). In his book *Power Healing,* John Wimber writes about the weekly healing rallies that occur in his church, where thousands would claim to be healed. And there are pastors who call all doctors "conmen" and tell the sick to throw away their medications and depend on God alone to heal them. So the next question is: If God still heals supernaturally or miraculously

instead of through doctors, then does He do it frequently? Does He heal "on demand" through certain people to whom He has given the gift of healing?

Does God Heal Supernaturally *Frequently* Today?

A major problem with the claims of many of these miraculous healings at prayer rallies or healing services is that they are mainly anecdotal. Richard Mayhue reports his investigations into the faith healing movement in *The Healing Promise:*

- No faith healer can come up with consistently verified cases of healing of organic diseases instantly, totally, by word or by touch.
- No faith healer heals everybody (hundreds go away as sick or as crippled as they came).
- Faith healers appear to disallow God's own purpose in allowing His people to be sick.
- Faith healers seem to need a closed environment to operate. Faith healing sessions are often preceded by a time of worship and prayers. It is often an emotional event with great expectation. It is significant that some healers cannot work outside of this environment. John Wimber writes in *Power Healing* that he would send away unbelieving relatives before he could pray for a person.
- Faith healers are not known for going to hospitals to heal. Oral Roberts and his City of Faith Medical and Research Centre depend more on medical science than on miraculous healing.
- Faith healers get sick and die like everyone else.

Many instances of healings can be explained in many other ways. Professor Verna Wright, Consultant Rheumatologist at Leeds University Medical School, has this to say about miraculous healing:

- The language of doctors — doctors often try to simplify their language as they explain medical conditions to non-medically trained patients and their relatives. This often results in misunderstanding. A lump may be misunderstood as a tumour.
- How patients perceive their illness — one patient was told she had a minor illness and to come back in three months' time. Outside she told her friend she had only three months to live!
- Often, patients hear only what they want to hear. There was one incident in which the patient had completed a course of treatment and had recovered. Somewhere in the conversation, the doctor used the word "miracle". The next Sunday, the patient testified in church that the doctor had said that it was a miracle she was healed!
- Difficulty of measuring responses in healing, for example, it is difficult to measure leg length accurately. Often, in some areas, it is not possible to be precise. Yet there are many claims of leg lengthening.
- Mistakes in diagnosis — doctors may make a mistake in diagnosis. An infective enlarged lymph node may be mistakenly diagnosed to be a lymphoma.
- The variability of disease — there is a wide variability in the natural history of diseases. Syphilis (before the discovery of penicillin) was called the "Queen of Deception" because it could present in many manifestations.

- There are spontaneous remissions even in cancer. It has been documented that many diseases can go into remission of their own or disappear as the body regains its functions.
- Power of the psyche — the subconscious mind is very powerful and we have barely begun to understand it. Psychosomatic medicine is a whole field of diseases caused by the sick subconscious mind. Some of the physical illnesses that we suffer are the result of the subconscious mind and if the subconscious needs are fulfilled, the physical symptoms disappear. This may explain many of the "miraculous healings" that we hear about.

If we take all these into consideration, it appears that miraculous healing is not as frequent as we believe it to be. So, how then shall we live? Do we still pray for the sick? Yes, we do, because God still heals. James 5:14-16 tells us:

> *Is any one of you sick? He should call the elders of the church to pray over him and anoint him with oil in the name of the Lord. And the prayer offered in faith will make the sick person well; the Lord will raise him up. If he has sinned, he will be forgiven. Therefore confess your sins to each other and pray for each other so that you may be healed. The prayer of a righteous man is powerful and effective.*

But we must recognise the fact that He heals whom He will, as He wills. If God heals everybody, then there will be no more

suffering and pain. And no one will need to die, making this discussion on the right to die and euthanasia a moot one.

As it is, there is much suffering in the world. There are many sick people, some of whom are terminally ill. We can try to explain why God allows this; about the redemptive value of suffering; and about why God heals some but not all people from their illnesses. But, in the end, we need to accept that there are mysteries that we cannot understand this side of eternity. We have to take by faith that God is a loving and caring God. And we have to learn to accept living and dying as gifts from this God.

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1 D.B. Biebel, *If God Is So Good, Why Do I Hurt So Bad?* (Colorado Springs, CO: NavPress, 1989)

2 Stewart, op. cit., p.66

3 Peter Kreeft, *Making Sense Out of Suffering* (Ann Arbor, MI: Servant Books, 1986) p.12. See also Victor E. Frankl, *Man's Search for Meaning* (New York: Washington Square Press, 1984)

4 Mike Mason, *The Gospel According to Job* (Wheaton, IL: Crossway, 1994) gives "an honest look at pain and doubt from the life of one who lost everything".

5 N. Hanson, *School of Suffering in Moral Medicine: Theological Perspectives in Medical Ethics* (Grand Rapids, MI: Eerdmans, 1987) pp.249-54

6 Douglas Moo, *The Epistle to the Romans, NICNT* (Grand Rapids, MI: Eerdmans, 1996) pp.529-530

7 Stewart, op. cit., p.71

8 Albert Schweitzer, *Out of My Life and Thought* (Baltimore: The John Hopkins University Press, 1933, 1949, 1990, 1998) pp.244-245

Chapter Six

The Traditional Christian Response to Euthanasia and Suicide

"The Times They Are A' Changing"
— Bob Dylan

After considering pain, suffering, death, euthanasia and suicide from biblical and ethical perspectives, let us now approach the subject from a historical-traditional one. However, this perspective will have to be mainly from a Judeo-Christian point of view. Other cultures generally have not held such distinctly high views of human life and of man and woman based on divine revelation rather than natural revelation. Such cultures as Islam (which came after Christianity) and, later, modern Hinduism share some of the Judeo-Christian traditions on the subject due to their influence.[1] Some of these traditions subsequently became "global" traditions, practically, subtly and partly because of colonialism and imperialism. Christian missionary activities in the areas of education and social reforms also played an important role in this regard.

Euthanasia and Suicide in the Ancient Past

Suicide, euthanasia, infanticide and abortion were all widely practised in the ancient Greco-Roman world but suicide was more common among the elite. There was no dishonour associated with suicide. Slaves, however, were forbidden to take their own lives, as they were the property of their owners.[2] Two philosophers who argued against suicide, Aristotle (384–322 BC) and Plato (427–347 BC), based their arguments on natural laws. Aristotle's objection was economic and political in nature. The attainment of the human form was of great moral significance; the destruction of human life at any stage was thus naturally morally offensive. In committing suicide, a person was also committing an offence by robbing the State of one's civic and economic contribution. Plato's objection was more metaphysical and religious. His view was that, "we did not create ourselves, we are property of the gods; it is therefore presumptuous of us to desert our station before being relieved."[3] It appears that Plato's and Aristotle's views of suicide were exceptions rather than the rule, though they had significant influence later on.

Typical of the ancient views of suicide and euthanasia was that of Seneca, a first-century Roman philosopher:

> *Against all injuries of life I have the refuge of death. If I can choose between a death by torture and one that is simple and easy, why should I not select the latter? As I choose the ship in which I sail and the house in which I inhabit, so I will choose the death by which I leave life. In no matter more than in death should we act according to our desire…Why should I endure the*

> *agonies of disease when I can emancipate myself from my torments.*[4]

Seneca's approach to self-autonomy was similar to that of Kant, a philosopher who lived many centuries later. As persons, we have the capability and the freedom to choose our destiny, which includes choosing the mode and way of dying. Edward Larson, professor of history and law at the University of Georgia, and Darrel Amundsen, professor of classics and chair of the Department of Modern and Classical Languages at Western Washington University, undertook a study of suicide and euthanasia in classic antiquity, and came to the following conclusions:

1. There is no evidence of any train of ancient pagan thought and values that endorsed suicide as always appropriate and proper for anyone desiring to die under any and all circumstances with no qualifications, restrictions or limits.
2. It is highly questionable that any train of ancient pagan thought and values condemned all suicides irrespective of individual circumstances. Pythagoreanism[5] and some strains of Platonism were possible exceptions.
3. There is scant evidence that any train of ancient pagan thought and values condemned suicide by the hopelessly ill. Again Pythagoreanism and some strains of Platonism were possible exceptions.[6]

They added: "There is a plethora of evidence for the practice of euthanasia and physician-assisted suicide in the classical world. But

evidence for those who held that a physician should not be involved in such activities is painfully scarce."[7]

In ancient Judaism, suicide was a serious crime. The Hebrew phrase *pikku'ah nefash* means "regard for human life". It is used in rabbinical literature to express the duty to save human life (the life of a fellow Israelite) when it is in peril, which is one of the most sacred obligations in Judaism. This obligation included the sacred duty to preserve one's own life under most circumstances.[8] The Jewish historian Josephus tells us that the body of a suicide victim was not buried until after sunset and was then carried to the grave without the normal funeral rites.[9]

In their survey of Jewish literature, Larson and Edmundsen summarise:

> *In the entirety of Jewish literature from the Old Testament through the fifth century A.D., we know of not one case of a Jew taking his own life or having someone kill him in order to escape from illness. There is only one instance of which we are aware of anyone in the sources attempting suicide when he was ill, and that was Herod. According to Josephus, when Herod the Great was nearing death, "he was so tormented by lack of food and a racking cough that his sufferings mastered him and he made an effort to anticipate his appointed end. He took an apple and asked for a knife, it being his habit to cut up apples when he ate them; then looking round to make sure there was no one to stop him, he raised his hand to stab himself. But his cousin Achiab dashed up and stopped him by grasping his wrist."*[10]

Contrary to the Greco-Roman influence in their society, Jews did not embrace suicide because they regarded it as taking away the prerogative of life and death from God and damaging the body which is made in the image of God.

Euthanasia and Suicide in Early Christianity

The early church embraced many of the Jewish traditions in its attitude towards human life, suicide and euthanasia. It is not surprising to find that the early church fathers did not write much about it. The issue then was more of martyrdom. Some Christians took to flaunting their faith as a way of courting their own martyrdom. This came to be frowned upon and the Church accepted the position enunciated by Clement of Alexandria (ca. 155–220 AD) that honoured martyrdom proper but stressed the importance of doing all one could, short of betraying one's faith, to avoid it.[11]

Eusebius (ca. 260–341 AD) was the earliest church father to record any examples of Christians committing suicide. There were those (1) who killed themselves to avoid being arrested and tortured, (2) who had already been arrested but dramatically ended their lives before being executed, and (3) virgins and married women who committed suicide to avoid rape.[12]

There was no known reference in the patristic texts, or writings of the church fathers, of suicide by the ill in the Christian community.[13] Christianity did introduce a new concept into the Greek and Roman world of antiquity — an obligation to care. This was not an obligation to cure — but an obligation to care — a categorical imperative to extend compassion in both word and deed to the poor, the widowed, orphans and the sick. This was a truly revolutionary concept and we still feel its influence today.

It was Augustine (354–430 AD) who formalised and consolidated traditional Judeo-Christian opposition to suicide and euthanasia as an unacceptable form of murder. In Book 1 of the *City of God*, he outlined his defence of the traditional position:

1. Scripture neither commanded it nor expressly permitted it, either as a means of attaining immortality or as a way to avoid or escape any evil.
2. It must be understood to be forbidden by the sixth commandment: "You shall not murder".
3. If no one on his own authority has a right to kill even a guilty man, then one who kills himself is a homicide.
4. The act of suicide allowed no opportunity for repentance.[14]

He also denounced it as a cowardly way of escaping the pain and suffering of this life.[15]

Euthanasia and Suicide in the Middle Ages

In his *Summa Theologiae,* Thomas Aquinas (1225–1274) expressed the classical objection to suicide, arguing that it was absolutely prohibited because (1) it violated our natural self-love and inclination to preserve our being, (2) it offended the human community, of which each human being is a part, and (3) it offended God, who offers life as a gift.[16]

Aquinas was deeply impressed by the view of the Jewish scholar Maimonides that killing an innocent person, "whether he is healthy or about to die from natural causes", is wrong. Euthanasia for those in pain and suffering, Aquinas maintained, was contrary

to Christian tradition, natural law, and the well being of society. It violated the dominion of God over human life. Aquinas spelled out in some detail the Christian position that the only justification for taking the life of another is to protect innocent life. Three circumstances in which killing may be allowed are (1) self-defence, (2) the defence of the innocent from an unjust aggressor in war, and (3) the defence of society in the case of capital punishment.[17]

The influence of Augustine and Thomas Aquinas was so strong that their writings were accepted to be completely authoritative by the Church and, until recently, no one challenged their views.

Robert Barry, a medieval Roman-Catholic theologian, remarks:

> *The continuation of the ancient Christian prohibition of suicide into Medieval Christianity was extraordinarily effective. What is striking about the history of suicide in the Middle Ages is that there were few notable suicides between 400 and 1400 A.D. among the orthodox Christians. Catholic doctrines and attitudes had so permeated society during this era that individuals did not find suicide to be an efficient means of resolving personal, financial or political issues.*[18]

The only reference to euthanasia in the period of the late Middle Ages that Larson and Admundsen found in their research was in a plague treatise written by physician Sigmund Albichs in 1406: "The…physician should refrain from administering anything to the patient that will cause him to die quickly, for then he would be a murderer."[19]

Euthanasia and Suicide Since the Middle Ages

By the sixteenth century, some Christians explicitly discussed suicide and euthanasia in the face of illness. In an imaginary land named *Utopia* depicted by Thomas More, a Roman Catholic, suicide and euthanasia were encouraged for those suffering from incurable diseases accompanied by continuous pain. Speculation that the book provided satire, rather than serious argument, for suicide and euthanasia was supported by the fact that as More awaited his own execution in the tower of London, he wrote *A Dialogue of Comfort: Against Tribulation,* in which he argued against these acts.[20]

John Donne, the English poet and Anglican priest, wrote the first defence of suicide in English in *Biathanatos*. There, he defined suicide very broadly to include all cases of willing death, including Christ's death on the cross. Donne, however, did not permit suicide undertaken for self-interest.[21]

Neither Martin Luther, the great Reformer who endured great physical suffering due to numerous health problems,[22] and John Calvin, who was in fragile health, approved of euthanasia as a means of ending the misery brought on by illness. Both viewed sicknesses as an opportunity for gaining increased confidence in God's presence and power, and thus bringing about spiritual healing.[23]

In the *ars moriendi*, or the art of dying literature, the recommendation to those caring for the dying was to provide ease and comfort, rather than to cause their death. Works such as *The Rule and the Exercise of Holy Dying* by renowned Anglican Bishop Jeremy Taylor explained the importance of preparing for death, and maintained that we should not choose our cause of death.[24]

During the eighteenth century, Christian dominance over Western thought and ethics was weakened by the onslaught of the scientific revolution in offering rational, empirical explanations for natural phenomenon. The "Age of Reason" had begun. Reason and experience became more important than divine revelation. To many philosophers, individual freedom and autonomy became the rightful objectives of human society. They also reviewed the prevailing thinking on suicide. The leading apologists for suicide were the English philosophers, such as David Hume and John Locke. They drew opposing fire from the Roman Catholic Church, the Bishop of Norwich, John Wesley and Isaac Watts. The Christian orthodoxy remained firm in their opposition to suicide and euthanasia.

However, from the early twentieth century onwards, it was noted that "despite firm legal restrictions against assisted suicide and euthanasia that remained largely unchanged during the nineteenth and twentieth centuries, the judicial system tended to exhibit increasing leniency if the victim was terminally ill or severely incapacitated."[25]

What We Can Conclude from the Historical-Traditional Survey

In this brief historical survey of the trend towards euthanasia, we have seen that, initially, in the Greco-Roman world, euthanasia and suicide were acceptable. Only in ancient Judaism were they specifically forbidden. The early Christians carried forth this tradition of forbidding euthanasia and suicide through the Middle Ages and beyond, to the period of the Reformation. With the "Age of Reason" in the eighteenth and nineteenth century, Judeo-

Christian thinking began to lose some of its influence. In the early twentieth century, society began to boldly question the traditional thinking about euthanasia and suicide. Sensational cases reported by the press swayed public opinion while the relaxation of rulings against abortion weakened the belief in the sanctity of life. With the increasing costs of healthcare, the die was cast in favour of euthanasia under appropriate conditions. This, however, was not without continuing resistance from Christians and mainstream religious circles and pro-life movements.[26]

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1 Coward, Lipner, and Young, op. cit. The authors argue that British policies and laws have influenced modern Hinduism.

2 Russell Blacker, "Suicide Down the Ages: A Judeo-Christian Perspective" cited in Christian Medical and Dental Society website

3 Ibid.

4 Quoted in Francis Beckwith and Norman Geisler, *Matters of Life and Death* (Grand Rapids, MI: Baker Book House, 1991) p.158

5 The Pythagoreans were alleged to be instrumental in formulating the Hippocratic Oath. Contrary to popular belief, the Pythagoreans were a small group whose tenets included belief in reincarnation, the practice of vegetarianism and sexual purity, and a condemnation of abortion, suicide and the shedding of blood. They were unlikely to be of any great influence in their society.

6 Edward Larson is professor of history and law at the University of Georgia. Darrel Amundsen is professor of classics and chair of the Department of Modern and Classical Languages at Western Washington University, Washington. He is a recognised expert in the field of ancient and medieval medical history and ethics. See Larson and Admundsen, op. cit., pp.32-33

7 Ibid. p.35

8 Ibid. p.58

9 Blacker, op. cit.

10 Larson and Admundsen, op. cit., p.55

11 Blacker, op. cit.

12 Larson and Admundsen, op. cit., p.114

13 Ibid. p.101

14 Ibid. p.121

15 *The Washington Report* (1997) p.24

16 Ibid. p.24

17 Ibid. p.26

18 Barry, "The Development of Roman Catholic Teachings on Suicide" p.473-74 as quoted in Larson and Admundsen, op. cit., pp. 132-133

19 Larson and Admundsen, op. cit., p.155

[20] *The Washington Report* (1997) p.25

[21] Ibid. p.25. Also see Larson and Admundsen, op. cit., p.151. John Donne wrote *Biathanatos* before he became an Anglican priest and while he was still struggling with his own salvation.

[22] Luther had heart problems, kidney and bladder stones, an ulcerated leg, severe constipation, haemorrhoids, migraine headaches, depression and recurrent respiratory problems.

[23] *The Washington Report* (1997) p.27

[24] Ibid. p.27

[25] Larson and Admundsen, op. cit., p.161. In the 1920s and 1930s, in highly publicised criminal prosecution against family members or physicians for euthanasia, juries refused to indict, and judges suspended the sentences of those convicted.

Chapter Seven

The Euthanasia Debate

"The broad mass of a nation…will more easily fall victim to a big lie than to a small one."
— Adolf Hitler

Let us now consider the arguments for and against euthanasia in detail. While discussing the opposing arguments in a strictly "pros-and-cons" approach may give us a sense of which is the stronger side, it will not give us a sense of the subject as a whole. Often, the issues considered as crucial by proponents of euthanasia are different from those thought to be important by the opponents. Discussion about euthanasia and the right-to-die is also associated with much emotion, which could muddle our thinking. In the first part of this chapter, we shall look at why some opt for euthanasia to help us to understand their pain, suffering and needs. Then we will consider an alternative way of looking at the issue.

The Arguments for Euthanasia

Fear is a strong emotion. Any emotion that could drive anyone

to consider ending his own life must necessarily be strong. The postmodern society is a society built on fear — fear of uncertainty, insecurity and hopelessness. We are a society obsessed with the fear of dying and death. Because of this fear, we would go to great lengths to live in denial of death. We often organise our life as if we will live forever. Hence, the "worship" of youth and the measures we are willing to take — cosmetic surgery, biotoxin treatments and others — to look young. The underlying philosophy is that as long as we do not look old, we are not old and death is further away. Marketing and advertising agencies capitalise on this fear. Proponents of euthanasia, such as Derek Humphry of the Hemlock Society and ethicist Peter Singer, pick on this fear when they argue for euthanasia.

Derek Humphry, founder of the Hemlock Society, is a journalist and author who has spent the past 20 years campaigning for lawful physician-assisted dying to be an option for the terminally and hopelessly ill. He started this campaign in 1975 after the death of his first wife, Jean, from bone cancer. Her condition became so painful and distressing that she took her own life with his help. Since then, Humphry has been campaigning tirelessly for the right-to-die movement. In his books and speeches, Humphry often recalls the painful way in which Jean died.

Peter Singer was the director of the Centre for Human Bioethics at Monash University in Victoria, Australia, before he took up a teaching position at Princeton University in the United States. He was also a president of the International Society for Bioethics. Singer is a bioethicist who believes that all human beings should be given the absolute right to die if they want to, especially if they are terminally ill and want to avoid further pain and suffering. He also accords society the responsibility to end the

lives of individuals who are non-productive, such as the mentally and physically impaired.

Fear of Prolonged Dying

Medical progress has created an interesting phenomenon — dying in bits and pieces, and in stages. One of our fears is that medical technology and treatment methods will prolong our dying, long after it has been decided that our condition is terminal and hopeless.

Karen Ann Quinlan was 21 years old when she became comatose at a party after taking some drugs with alcohol. She stopped breathing and was put on a ventilator. She was diagnosed by her doctors as being in a persistent vegetative state (PVS) with no chance of recovery. Karen's family, after much discussion with their parish priest, decided to request the doctors to switch off the ventilator and let Karen die. The doctors refused and the Quinlans had to ask the courts to allow Karen to be unhooked from the ventilator. The lower court rejected their request and the Quinlans were forced to take their case to the New Jersey Supreme Court, which ruled in their favour. Karen Quinlan took seven years to die after she was taken off the ventilator. These were seven years in which she never regained consciousness. They were also seven years of emotional pain and financial burden on her family. All this could have been avoided, some said, by a single lethal injection. We dread to be helpless, to know that our bodies are deteriorating, our organs failing and we are becoming more dependent on others, especially after the best medical experts around tell us that there is no hope for recovery, only steady deterioration.

Nearer home, in Singapore, and more recently, in April 2005, *The Straits Times* reported that Goh Kok Hoe, 52, had Lou Gehring's

disease or amyotrophic lateral sclerosis (ALS). This is a progressive neuro-degenerative disease and sufferers will gradually lose control of their voluntary muscles. They will lose the ability to walk, talk, feed themselves and breathe. Then they will die unless they are hooked onto a ventilator that breathes for them. Mr Goh, who has led an active life, playing badminton and golf regularly, does not want to be put on a ventilator. The former human resource manager has left instructions that he be allowed to die when the time comes.

In 1996, a Task Force on Assisted Suicide presented this conclusion to a Convention of the Episcopal Diocese of Newark:

> *Unless an individual somehow understands suffering due to serious illness as a direct consequence of one's faithful response to the Gospel, endurance of such suffering cannot be seen as a mandate, either moral or theological, on the basis of scriptural witness. It is not a moral failing to view such suffering as devoid of purpose, and thus without redemptive value. This, coupled with the clear precedent of Jesus' countless efforts to alleviate suffering through his healing ministry, make clear that there is no obligation incumbent upon the Christian to endure suffering for its own sake.*[1]

The Task Force recognised the concept of purposeless, *unredemptive suffering*, that is, suffering that has no value or meaning. An example is an old lady suffering from terminal cancer of the cervix, in extreme pain, dying alone and forgotten in an obscure nursing home. Assisted suicide provided a way of ending

the unredemptive suffering of those who did not elect to undergo it, according to that report.[2]

Fear of Dying in the Cold

Another fear we have is the institutionalisation of dying. Dying has become *a cold, clinical process*. The overwhelming majority of Americans die in institutional settings, such as nursing homes and hospitals. While some of these offer care, safety and familiar personnel and surroundings, others represent sterile, indifferent and sometimes even hostile and unfriendly environments.[3] Unfortunately, this scenario is also becoming common in Asia. This inhuman side of medicine is frightening. The clinical sterility of the intensive care unit may make it an efficient environment for doctors and nurses to work in, but it can contribute to a scary experience for the patient. Often, patients complain that they are treated as an object rather than as a human being. Dying in such places can be a very lonely experience. Such death is comparable to dying "in the cold", by the roadside, uncared for and unloved, without dignity. This fear convinces many that the option for euthanasia should be available to them.

Fear of Uncontrolled Pain

In a letter to the Forum page of *The Straits Times* in April 2005, Dr George Wong, a retired plastic surgeon, described the death of his father from stomach cancer two decades ago. He said that his father was in such severe pain that he begged to die. Dr Wong wrote, "Some members of society don't want a painful ending and that option should be given to them. If they want to end their lives, let them go. Why prolong their suffering?"

Much pain accompanies many terminal illnesses, especially cancers. As the population ages, the incidence of cancers and degenerative disorders will increase. Though pain management in palliative care has improved tremendously in the past few years, it is still not ideal and has its limitations.

Effective pain management is dependent on the expertise, belief system and attitude of the attending physicians and supporting personnel. If they believe that suffering is, in some way, good for the soul, they may unconsciously fail to optimise the level of the analgesics prescribed. Physicians are trained to cure and some may have trouble accepting a case of terminal illness. They may feel a sense of failure in such a situation. How they then react to their feelings will affect the way they treat their patients. Some could be indifferent to the needs of their patients, including their pain, and even ignore them totally.

Another important point to note is that not all physicians are trained in pain management. The physicians who have training in pain management include anaesthetists, critical care internists and oncologists. Most general physicians do not have the specialised expertise for effective pain management. As a result, many patients suffer from inadequate pain control.

There is also a downside to pain control; a patient may be in a narcotic haze and have a "dopy" look. Many people are not willing to exchange their sense of awareness and dignity for control of their pain. There are many who have lived through life without dependence on narcotics. To them, it is an insult that, in their last days, they have to turn to drugs. As such, they may appreciate the option of euthanasia by which they can arrange for a quick, pain-free death.

Fear of Loss of Control

Personal autonomy or self-determination is the cornerstone of this postmodern world. We would like to have full control of our lives. This includes the desire to choose the time and manner of one's death. Betty Rollins writes in the foreword to Humphry's book: "Some people want to eke out every second of life — no matter how grim — and that is their right. But others so not. And that should be their right."[4]

In his book, *Tuesdays with Morrie*, Mitch Albom describes the last few months he spent with his old professor, Morrie Schwartz. Morrie, like Mr Goh, was suffering from amyotrophic lateral sclerosis (ALS), a slow unremitting degenerative disorder. The book started with a man who enjoyed dancing, and ended with one who was incontinent in bed before he died.[5]

This is a fear that many of us have, the fear of senility and embarrassing dependency. It is a fear of getting a disease like ALS or Alzheimer's and seeing ourselves deteriorate slowly, knowing that there is nothing we can do about it. Under such a condition, it might be better to kill oneself with a lethal overdose than to suffer the indignity of slow deterioration. At least we can choose when to die. The argument is that if we can no longer serve God or others by remaining alive, it is not wrong to exercise our freedom of choice to bring about our own death or to ask others to do it for us.

Fear of Being a Burden

Many of us are afraid of being a burden to others; it may be a financial, emotional, physical or spiritual burden. Hence, we would like to have the option to take away that burden at the right time and place.

"It costs too much to avoid death today."[6] Healthcare is expensive. Dying is expensive. The financial burden can be heavy for a reasonable quality of care. A Federal Court of Appeals in the United States acknowledged that some terminally ill patients could request for a lethal dose of medication in order to protect their family from the expense of prolonged treatment. The court indicated that this would not be unrealistic. It was, however, "reluctant to say that, in a society in which the costs of protracted health care can be so exorbitant, it is improper for competent, terminally-ill adults to take the economic welfare of their families and loved one into consideration" (*Compassion in Dying v. State of Washington, 1996*).

How many of us would want to be a physical and emotional burden to our spouses, children or relatives if we become chronically ill, debilitated and dependent? Malaysia is a rapidly developing country while Singapore is a developed one. Many young couples do not have the time or the resources to take care of the sick in their household. We hear of parents being shuttled between one child's home and that of another on a two-week rotation. And this is when they are well. What if they are very ill and dependent but do not need hospitalisation? Would they be made to feel welcome in their children's homes? Would their sense of self-worth still be intact? Would they consider euthanasia as an appropriate Christian act of love?

Fear of Isolation and Depression

Writing in *Between Life and Death*, Dr Kenneth Schemmer notes:

> Many aspects of dying produce loneliness for the patient.
> - The sickness itself usually causes both patient and visitor to withdraw from each other.

- The delivery of medical care, especially by high-tech procedures, often places physical barriers between the patient and the care-givers.
- For the patient, the whole process of dying is isolating. He or she quits working, quits social activities, spends less time with hobbies, hasn't the strength to maintain daily activities with family, and his or her time becomes continually more consumed with caring for himself or herself than for others.
- Friends find it increasingly more difficult to arrange times to visit the patient, and when they do, he or she is less interested in them. Friends lose interest in visiting. So the patient loses more interest in them and his or her surroundings.[7]

Many people who have chronic illness or are physically incapacitated will agree with Dr Schemmer's observation. Increasing loneliness is a reality when one has a chronic and terminal illness. In a society that fears loneliness, and where there are always noise, people and activity, being alone is a terrifying experience.

Depression is another fearsome emotion. This depression does not consist of the usual ups and downs we feel in our daily life, but is a persistent feeling of despair. The depressed mood may last weeks or months, and the depressed person may suffer loss of pleasure and interest in things previously enjoyed, and have feelings of worthlessness and excessive guilt. He may appear sluggish and slowed down (with psychomotor retardation) or chronically agitated, fatigued, troubled in thought and concentration, with changes in weight and sleep patterns, and be plagued by recurrent thoughts of death.[8]

Unfortunately, Christians do not have a good track record in dealing with depression. In the preface to his book *Why Do Christians Shoot Their Wounded?* Dwight Carlson writes:

> *In my experience Christians are intolerant, if not prejudiced, against individuals with emotional difficulties [depression]. Most view such problems as personal sin. Some well-known Christian authors have further fueled the fires of stigma and judgment toward those suffering with emotional illness.*[9]

For some strange reason, it is assumed that Christians will not suffer from emotion problems and depression. It is not surprising that the intense fear of loneliness and depression can drive some to seek relief through euthanasia.

The Arguments Against Euthanasia

Alternative Treatment

Some sick people receive sub-optimal care because palliative care facilities do not exist or local physicians lack proper training. If the sick receive the best care, they will be less inclined to opt for euthanasia; people are interested in getting rid of their pain — not their lives. The alternative treatments will be described more fully in the next chapter after we have considered the arguments against euthanasia.

Informed Consent

A study of terminally ill patients published in an issue of *The American Journal of Psychiatry* notes:

> *The striking feature of [our] results is that all of the patients who either desired premature death or contemplated suicide were judged to be suffering from clinical depressive illness; that is, none of those patients who did not have clinical depression had thoughts of suicide or wished that death will come early."*[10]

This study reports an important association between a request for euthanasia from a terminally ill patient and clinical depression. Based on this link, it is possible that if the depression is treated, the patient will not opt for euthanasia.

In his book, *Seduced by Death: Doctors, Patients and the Dutch Cure*, Herbert Hendin reports:

> *Patients who request euthanasia are usually asking in the strongest possible ways they know for mental and physical relief from suffering…When that request is made to a caring, sensitive, and knowledgeable physician who can assure them that he or she will remain with them to the end and relieve their suffering, most patients no longer want to die.*[11]

Another reason why some patients opt for euthanasia is that they do not have anyone to talk through the issue with and receive counsel from. Often, they are left to make a major decision on their own. This is where visitation and counselling, especially from pastors or Christian counsellors, are important. One good example is the approach adopted by Dr Pellegrino.

> *After the patient expressed his wish, Pellegrino sought to meet the real needs behind the wish. First he used the best methods of pain relief and increased the patient's sense of control by enabling the patient to self-administer the pain medication. This patient was also feeling guilty, clinically depressed, and concerned about being a burden to others. Pellegrino treated the depression, brought in a pastoral counsellor to address the guilt, and gathered the patient's family to help them see how their response to this man's illness was aggravating his sense of unworthiness. Once these needs were met, the patient thanked Pellegrino for not responding to his earlier request to die. "The most valuable days of my life have been the last days I have spent," he said.*[12]

Opponents of euthanasia maintain that many of those who request for euthanasia may not be in the proper frame of mind or have the sound value system to give informed consent. They may be suffering from depression, in severe pain or emotional or mental distress. After their underlying problems have been dealt with, they may not want to die.

Death a Part of Living

Like living, dying is a process. Some people would regard it as a journey. For those who do not die suddenly, the dying process can be quite frightening. Psychiatrist Elisabeth Kubler-Ross outlined five stages of dying — denial, anger, bargaining, depression and acceptance. These stages are similar to those in the grieving process. In the process of grieving the loss of a loved one, there is initially denial (No, it is a mistake. He is not dead). Then there

is anger (Why me, Lord?). The next stage is bargaining (What if I promise to be a missionary; will you bring him back?). Depression follows (I cannot live without him). The final stage is acceptance (He is gone. Nothing I do can bring him back. I need to move on with my life). We need to go through the entire process before we can be whole again. Being stuck in any stage of the grieving process is bad and can lead to mental and emotional dysfunction. The dying process has a similar progression. The word we commonly use for the completion of the dying process is "closure". In an interview, Dr Kubler-Ross comments:

> *Lots of my dying patients say they grow in bounds and leaps, and finish all the unfinished business. [But assisted suicide is] cheating them of these lessons, like taking a student out of school before final exams. That's not love, it's projecting your own unfinished business.*[13]

Euthanasia will short-circuit the dying process. We often emphasise living as a growth process. What many of us do not realise is that dying and death is part of that process. To opt to end the process prematurely means that we are truncating it, with the result that there may be no closure for the person involved and for his family.

In arguing against euthanasia, Peter Saunders highlights this issue of closure:

> *It is during the times of a terminal illness that people have a unique opportunity to reflect on the way they have lived their lives, to make amends for wrongs done, to provide for the future security of loved ones and to prepare mentally*

and spiritually for their own death. Not all make full use of this opportunity, but those involved in hospice work often observe a mending of family relationships and rediscovery of mutual love and responsibility that may not have been evident for years.

It is often through facing the hardship that terminal illness brings, and through learning to accept the practical help of others that human character and maturity develops most fully. Death if properly managed can be the final stage of growth. It can also be a time when words are spoken and strength imparted that will help sustain "those left behind" through the years ahead.[14]

Christians have always regarded life as a journey. Death is not the end but a gateway to a new, fuller, richer life with God. As pointed out by Peter Saunders, closure is important for those left behind.

Euthanasia Undermines Medical Research

Medical research has always been strong when there is an urgent need to find a cure or at least to control a medical condition. When death becomes the treatment or cure, as in euthanasia, medical research ceases. Pharmaceutical companies will not spend millions of dollars on research on neuro-degenerative disorders like Alzheimer's, ALS, traumatic paralysis and other medical conditions if there is no demand for their drugs. When the option to shorten a disease process is available, there is no need to spend further on treatment. While not often recognised, this is an important consideration.

Another effect of allowing euthanasia is that it will pave the way for "death treatment" to become more developed. It will encourage research into more efficient ways to bring about death. One notable example is Dr Karl Brandt, the only public official in modern times to develop an active euthanasia programme for a country.

In 1939, Dr Brandt was asked by Hitler to look into a request by a father to have his deformed and mentally retarded child killed. Dr Brandt approved the request. Later, in 1939, Hitler asked the doctor to initiate a secret euthanasia programme aimed at deformed children and the incurably insane. The programme was carried out with "great efficiency" and thousands of mental patients and children were "delivered from life". The programme's scope demanded new medical technologies and led to an invention that did the grisly task well — the first gas chamber.[15] This is a real danger of the dark side of medical research.[16]

Autonomy Is Never Absolute

A patient's right to autonomy is important, but the contention is that there is no absolute autonomous right to euthanasia. A report from the UK Christian Medical Fellowship to the House of Lords[17] included these words from Romans 14:7, "For none of us lives to himself alone and none of us dies to himself alone." As we have seen, theologically and ethically, man does not have absolute autonomy.

When we say, "We are Masters of our own lives, Captains of our own souls," even when arguing from agnostic, atheistic or social science contexts, we are talking about illusions. From the moment we are born to the moment we die, we are a product of our environment, upbringing, racial make-up, cultural conditioning, education and socio-economic moulding and sexual orientation.

We have never been free. We have always been guided by our own society's norms. Our society feeds us and protects us. Yet, when the going gets tough, we want to get out. The effect of euthanasia on society will be enormous.

A decision to end one's life does not operate in a vacuum. It will affect others — families and friends left behind, healthcare workers, a whole community and web of relationships.

Unlike suicide, euthanasia is not a private act. For the patient's autonomy to be exercised, the doctor's autonomy will be affected.[18] Daniel Callahan has argued along such a line, and suggests that permitting euthanasia will be "self-determination run amok".

> *[Euthanasia] cannot properly be classified as a private matter of self-determination or as an autonomous act of managing one's private affairs. Euthanasia is a social decision. It involves the one to be killed, the one doing the killing, and it requires a complying society to make it acceptable. Therefore euthanasia must be assessed in its social dimensions. Precisely for this reason, the appeal to autonomy to justify euthanasia for one individual does not adequately account for the social dimensions of that individual act nor the impact that sanctioning euthanasia will have on the common good. Any discussion on euthanasia, then, ought not to be limited to what helps or hinders individual well being. Rather, it must reach beyond the individual to include the impact that individual acts of euthanasia have on community welfare. Therefore, autonomy must be understood within the limits of the social responsibilities for the common good.*[19]

As autonomy is not absolute, it must be considered in a social, if not a religious, context. There is always a community aspect to human life.

A Slippery Slope

Society has always had a duty to protect the weak, the sick and the helpless. Society can only work if all its individual members are willing to submit their autonomy for the greater good. If, however, the members are not willing to submit, then the society will be destroyed. One good (but unfortunate) example is the allowing of abortion. When individual members of a society decide that a certain life is worthless (in this case the foetus) and works so that they change society's duty to protect, then the society is in trouble. Once it is accepted that a certain life is worthless, that a certain life is not worth living, the society will withdraw its protection. The allowing of abortion leads the way to euthanasia of the deformed infant, the mentally insane, those in a persistent vegetative state, the terminally ill and, eventually, the aged, the economically unproductive, the aesthetically ugly and, finally, the "politically unreliable". It is scary to contemplate where the path will lead.

There are strong and often emotive reasons to give a person the right to make a decision concerning his own welfare. But there are limitations when it comes to wanting to be allowed to make a right-to-die decision. As we have discussed, there are many sides to the coin. In the next chapter we shall look at a Christian response to euthanasia.

[1] *Report of the Task Force on Assisted Suicide to the 122nd Convention of the Episcopal Diocese of Newark*, January 27, 1996

[2] Ibid.

[3] *The Washington Report* (1997)

[4] Derek Humphry, *Final Exit: The Practicalities of Self–deliverance and Assisted Suicide for the Dying* (Eugene, OR: The Hemlock Society, 1991)

[5] Mitch Albom, *Tuesdays with Morrie* (London: Warner Books, 1997). In this book, Mitch Albom describes the slow deterioration of his friend and their conversations. It is notable that in spite of his disease, Morrie did not talk about euthanasia or request for a quick end to his life.

[6] *The Washington Report* (1997)

[7] Kenneth E. Schemmer, *Between Life and Death: The Life-Support Dilemma* (Wheaton, IL: Victor Books, 1988) p.148

[8] George P. Nichols, "Do Real Christians Get Depressed?" cited in the Christian Medical and Dental Society website

[9] Dwight L. Carlson, *Why Do Christians Shoot Their Wounded?* (Downers Grove, IL: InterVarsity, 1994) p.9

[10] James H. Brown, Paul Henteleff, Samai Barakat and Cheryl J. Rowe, "Is It Normal for Terminally Ill Patients to Desire Death?" in *American Journal of Psychiatry*, Vol. 143 No. 2, February 1986:210 [55]

[11] Herbert Hendin, *Seduced by Death: Doctors, Patients and the Dutch Cure* (New York: Norton, 1997) pp. 204, 211; Gary Thomas, "Deadly Compassion" in *Christianity Today*, June 16, 1997, p.17 quoted in Larson and Admundsen, op. cit., p.249

[12] Ibid. p. 249

[13] Leslie Miller, "Kubler-Ross, Loving Life, Easing Death" *USA Today*, November 30, 1992, quoted in Burke J. Balch and Randall K. O'Bannon, "Why We Shouldn't Legalise Suicide, Part III: What About the Terminally Ill?" Cited in http://www.nrlc.org/euthanasia/asisuid3.html

[14] Peter Saunders, "Twelve Reasons Why Euthanasia Should Not Be Legalised" cited in the Christian Medical Fellowship website http://www.cmf.org.uk/home.htm

[15] Gary E. Crum, "Dying Well: Death and Life in the '90s" in Richard D. Land and Louis A. Moore, (eds.), *Life at Risk: The Crisis in Medical Ethics* (Nashville: Southern Baptist Christian Life Commission, 1995) p.166-167

[16] One of the dangers of the Genome Project is that it is possible to identify specific genes belonging to a particular group of people. For example, the gene for sickle cell disease is specific to Africans. Thus, it is possible to create a virus that will be specifically destructive to that gene. It can then be released and will cause genocide among the Africans, a sort of biological "smart bomb".

[17] Submission from the Christian Medical Fellowship to the Select Committee of the House of Lords on Medical Ethics cited in http://www.cmf.org.uk/home.htm

[18] Saunders, op. cit.

[19] Daniel Callahan, "When Self-Determination Runs Amok" in *Hastings Center Report*, pp.22: 52-55

Chapter Eight

The Christian Response to Euthanasia

I ask for a natural death. No teeth on the ground,
no blood about the place. It is not death I fear,
but unspecified, unlimited pain
— Robert Lowell

The Christian response to euthanasia is a dignified death. A dignified death occurs when a person dies at his God-appointed time, with gratitude for and satisfaction with the life he has lived, and now waits with faith and hope for the next stage of his journey. Jesus spoke to Peter about the manner of his death, "I tell you the truth, when you were younger you dressed yourself and went where you wanted; but when you are old you will stretch out your hands, and someone else will dress you and lead you where you do not want to go" (John 21:18). The Lord said this to indicate the kind of death for Peter that would glorify Him. And there are some lessons we can learn from this.

When we are young and healthy, we can come and go as and when we like. However, when we are old, and particularly when we are sick, we are often at the mercy of others, especially doctors and

nurses who may prescribe treatments or impose medical, dietary and physical restrictions on us. What is important for us is to realise that there are stages or seasons in our life. Peter's death was remarkable in that when it was time for him to die, he went willingly to his death. Tradition has it that when the Roman authorities were looking for him in Rome, he managed to escape to the outskirts of the city. However, while there, he received the revelation that it was time for him to die. So he turned around and surrendered to the Roman authorities. Tradition also mentions that Peter requested to be crucified upside down. Here is an example of a man who accepted death, when it came, with dignity and grace. Dignified dying does not deny the reality of death or try to control it with denial, anger and depression, but accepts that death is inevitable, and allows and receives help from others to ease this stage of the life journey. Dignified dying and death allows for closure and growth. Dignified dying and death has no fear of death.

The dying of well-known Christian apologist and pastor, Francis Schaeffer, as recorded by his wife, Edith, offers a good example of a dignified death:

> *The decision came on Easter Sunday of 1984. Schaeffer, a world-famous champion of the Christian right-to-life movement, had been dying from cancer for several years. As his condition worsened, he had moved with his wife, Edith, from their long time residence in Switzerland to a new home near the Mayo Clinic in Minnesota. Extensive treatment allowed him to write and lecture to the very end. But when final treatment decisions had to be made, Schaeffer was no longer able to make them himself. A team of Mayo doctors called his wife aside, and the leading*

consultant asked her, "He is dying of advance cancer. Do you want him to be placed in intensive care on machines? Now is the time to make the choice."

Edith Schaeffer knew precisely what she and her husband wanted. "You men have already done great things during these last years and these last few weeks. You fought for life and gave Fran time to complete an amazing amount of work," she replied, reflecting on the distinction that her husband had drawn between preserving life at all costs and prolonging death. The time has come for her husband to go home, surrounded by the familiar things he loved. Soon he was home, in a bedroom with a large window overlooking colorful flowers put there everyday in pots because it was still winter in Minnesota. Treasured memorabilia from Switzerland filled the room, and his favorite music by the masters flooded the air. Ten days after leaving the hospital, amid the sounds of Handel's Messiah, Francis Schaeffer died without the treatment that could have prolonged his death. His wife had made their home into a hospice.[1]

This attitude towards dying is different from our society's perception of death. As Dylan Thomas put it so eloquently, our society's reaction to death is to fight it. He said, "Do not go gentle into that good night, Old age should burn and rage at the close of the day. Rage, rage against the dying of light." Death is regarded as something to struggle against and to control.

The thought of a slow and painful death is particularly worrying. That is why many want the choice of "opting out". It is their insurance policy to avoid a prolonged and arguably meaningless

death. But as we have seen from our discussion in the previous chapters, suicide is far from a good option. The better option is a dignified death, and there are a number of things we can do to make this a possibility.

Coping with Pain

Total pain management involves four areas: physical, emotional, social and spiritual pain.[2] Here, we shall deal with physical pain.

There has been much progress made in the management of pain. Today, we have "pain control" teams in many hospitals and "pain control" nurses whose job is to help patients cope with their pain. It has been claimed that, in the setting of widespread cancer, although more than half the patients will experience pain, it is manageable by oral administration of opioids alone in 70 to 80 per cent of cases.[3] Another author has claimed that adequate interventions exist to control pain in 90 to 99 per cent of patients.[4]

New pain control methods include radiation therapy, nerve blocks (including spino-thalamic tractotomy), non-steroidal anti-inflammatory drugs (NSAIDs), transcutaneous electric nerve stimulation and direct spinal cord (dorsal column) stimulation. There are also developments in non-pharmacological methods, such as distraction, art and music therapy and relaxation.

One of the most useful pain control technologies to date is the Patient-controlled Analgesia (PCA). The PCA consists of a pump which can deliver a continuous infusion of drugs, such as morphine. At the same time, it has a button that allows a patient to press for a single increased dose in the case of worsening pain. Studies have shown that PCA may lower the amount of medication administered to patients, while providing them with a safe and

effective way to have more control over their treatment. It is a great relief for patients to know that the means to ease their pain is available and that they are able to do something about it.

Other new treatment modes include a 72-hour analgesic patch which releases controlled amounts of the opioid fentanyl through the skin. This patch allows a patient to sleep through the night, thus avoiding the need to wake up to take more medicine.

A point about pain management that we should be aware of is the possible lethal effect of the medication used. Morphine, which is effective in relieving pain, can also cause respiratory depression. Hence, there are those who would object to its use. Here, the Roman Catholic moral thought — the Principle of Double Effect — might be useful. This principle addresses both the intention and the result of actions. If one action can have good and bad effects, it is ethically permissible to do the act with good intention (for example, use of morphine for pain relief), even if the bad effects (potential for respiratory depression leading to an earlier death) can be anticipated.[5]

Surprisingly, one group that opposes adequate pain control is Christians. The Scriptures teach that we live in a fallen world, and one of the results of "the fall" is the "curse" of pain (Genesis 3:16). Some Christians are vocal in their opposition to the use of analgesia or anaesthesia to relieve the pain of childbirth and control disease-related pain. They believe that pain must be tolerated.[6]

Palliative Care

The World Health Organisation has defined palliative care as being *"the active and appropriate care of patients whose disease is no longer curable. It affirms life…regards dying as a normal process…and…neither*

hastens nor postpones death."[7] The emphasis of palliative care is caring.

During the process of dying, many things may happen. A patient may have a heart attack, suffer from kidney failure, or have a stroke. Prior to the 1960s, the mode of treatment is usually decided by the doctor. This has changed because of the development of more treatment options, many of which are invasive, burdensome, and expensive, and some of which offer less than ideal efficacy; the emergence of the legal doctrine of "informed consent"; and the rise of individual rights. More and more people would like to have a greater say in their own treatment programme. And they should, because human stewardship means that they have to take care of their own bodies. As such, the terminally ill should have a say on the extent of the treatment they receive.

To guide us on limiting treatment, Dr Robert Orr, Director of Clinical Ethics at Loma Linda University Medical Centre and Clinical Co-Director of the Centre for Christian Bioethics at Loma Linda University in the United States, offers some advice:

1. Prepare in advance by thinking ahead about biblical principles, personal values, and other factors which might influence what you want for yourself or for loved ones. Talk with family members and your physician about these matters, and consider preparing a written advance directive.
2. When confronting these difficult decisions, gather as much information as possible from physicians, books, classes, etc. Request second opinions if there is significant uncertainty.

3. In some cases, it may be appropriate to seek an ethical opinion as well. Most hospitals have an ethics committee and an increasing number have ethics consultants to help in these situations.
4. Try to have realistic expectations. Medicine is part science, part art, and part ministry. But it is a human endeavour and, as such, is fraught with human limitations.
5. Do not try to make these decisions alone. Your own pain and stress may colour your thinking. Involve fellow believers, search the Scripture, use other Christian resources, and above all, pray earnestly for the guidance of the Holy Spirit.
6. Accept the fact that, even with one God, one Bible, and one Holy Spirit, Christians may honestly disagree about what is the proper course of action in a given situation, so others may not always agree with your decision.
7. If doubts arise about decisions already made, rest in the knowledge that before God and with the help of others you trust you made the most medically informed, morally responsible decision you could make at the time. No one can do any better than that.[8]

The results of this discussion can be written into a *Living Will*. This is a legal document that spells out what types of treatment should and should not be given. It may define treatment measures and specify when treatment must stop. Treatment can be roughly divided into ordinary and extraordinary categories. Ordinary medical treatment includes medications, operations, physiotherapy and other medical modalities that are generally accepted by doctors worldwide for the treatment of specific conditions. Extraordinary

treatment refers to modalities that are unusual, experimental or unproven in their efforts to prolong life.

The differentiation between ordinary and extraordinary measures is often not so clear-cut. One example is the use of artificial, mechanical ventilation. A 30-year-old man with meningitis who has stopped breathing is put on a ventilator to help him breathe. That is considered ordinary treatment. The chances of recovery with treatment with antibiotics and other supportive care are good. However, putting a 79-year-old woman with uncontrolled hypertensive and massive heart and kidney failure on a ventilator is considered extraordinary treatment. This is because she is already dying and the treatment only delays the inevitable. A living will, made up by the woman and her family (before she became so sick) may specify that if she should suffer a heart attack or other complications that make her unable to breathe, then everything possible to resuscitate her should be done, short of putting her on a ventilator. In this manner, a living will gives clear instructions on limiting treatment. It may also give instructions on ordering treatment. One could specify that treatment must go on and not stop. That will stop the removal of the feeding tube from a patient in a persistent vegetative state. Other types of instructions are *Advance Medical Directives*[9], *Medical Directives*[10] and *Value History Advance Directives*[11].

In Singapore, the Advance Medical Directive (AMD) Act was passed in 1996. It allows patients to decide in advance what medical treatment they want or do not want if they are unconscious and unable to make these decisions. The AMD is to be drawn up in the presence and with the advice of a patient's personal physician and will be lodged with the AMD Registry. Physicians treating patients will not know of this AMD except in cases when extraordinary

medical treatments are needed — the physicians will then have to consult the Registry. Patients are under no obligation to inform other physicians about the AMD. This is to safeguard their interests and ensure that the AMD will not unduly influence the medical care they receive. According to the Singapore Ministry of Health, 2,654 people have registered their AMD since the Act was passed but only one has used it to date.

Mr Goh, whom we met in the previous chapter, and who is suffering from amyotrophic lateral sclerosis (ALS), signed an Advance Medical Directive after consulting his wife. The AMD expresses his wish that he does not want to be hooked up to a ventilator when he is unable to breathe as a result of paralysis of the respiratory muscles. He said, "I do not want my wife to bear the burden of deciding when I should go and be blamed later for pulling the plug." It must be noted that the term Advance Medical Directive in Singapore is used to describe the living will or medical directive in other countries.

Outside Singapore, an advance medical directive is a legal document to appoint a healthcare personnel as a proxy. This proxy is authorised to make decisions for the patient if he is unconscious and unable to decide for himself. This directive has an advantage over the living will in that it is more flexible, and should thus obviate the need for legal intervention in an ambiguous situation.

In the case of a medical directive, the patient himself writes in the document which of the 12 treatment modalities he would or would not want to have if he should be incapacitated in four different clinical situations. The modalities listed are: cardiopulmonary resuscitation, mechanical breathing, artificial nutrition, artificial hydration, major surgery, kidney dialysis, chemotherapy, minor surgery, invasive diagnostic testing, and prescription of blood

and blood products, antibiotics, and pain medications. The four clinical situations are: permanent unconsciousness, persistent unconsciousness with a small chance of improvement, irreversible dementia accompanied by a terminal illness, and irreversible dementia without other illness.

In a value history advance directive, a person is appointed to make decision based on the values of the patient rather than the treatment modalities. It is an advance directive designed such that surrogates can make decisions for a patient after he has lost his competence. They propose that more important question, "What are the patient's values?" They then offer an alternative advance directive that focuses on the values rather than their desires about specific treatment modalities.

It is good Christian stewardship to lay out specific limiting treatment instructions. Then we can be sure that our wishes are known and that our physicians will not prolong our death when it is due. It is also good stewardship to have a will for our affairs in order, so that estate management will not be a hassle for our family.

Hospice Care

Modern hospice care is a remarkable, recent development. The movement started in London in 1967 with the founding of Saint Christopher's Hospice by Dr Cicely Saunders,[12] and was imported to the United States the following year by Florena Wald, then dean of Yale University's School of Nursing. Its subsequent rapid growth[13] is a testimony to the urgent need to ease the dying process as opposed to the use of medical technology to keep terminally ill patients alive. The all-encompassing nature of hospice care is summed up in its philosophy, as defined by the National Hospice Organisation in the United States:

> *Hospice affirms life. Hospice exists to provide support and care for persons in the last phases of incurable disease so that they might live as fully and as comfortably as possible. Hospice recognizes dying as a natural process whether or not resulting from disease. Hospice neither hastens nor postpones death. Hospice exists in the hope and belief that, through appropriate care and the promotion of a caring community sensitive to their needs, patients, families may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them.*[14]

The hospice philosophy goes far beyond standard medical palliative care. It includes physical, psychological, social, and spiritual therapies. Physicians, nurses, counsellors, clergy, social workers, occupational and physical therapists, and volunteers work as a team to provide various hospice services.

Financial Support

We are well aware of how important financial planning is. Many of us plan for our retirement, making sure we have enough money to see us through our "golden" years. Yet, few plan for medical treatment. Some of us do have a hospitalisation insurance plan that pays a certain sum of money if we are hospitalised for a certain number of days. Others have health benefits from their employers. But how many of us prepare for a long period of hospitalisation or a regime of treatment that will cost us a large sum of money? In Singapore, what can be withdrawn from the Central Provident

Fund for healthcare purposes is limited by the amount of money one has in the Fund.

Cancer treatment regimes may last for one to two years and cost around RM200,000 in Malaysia or S$250,000 in Singapore. A bone marrow transplant costs RM250,000 or S$350,000. Treatment costs of this nature can easily wipe out our retirement savings. We cannot depend on subsidised government healthcare. For example, if you are 55 years old, suffering from kidney failure and need daily haemodialysis, you may not get into a government dialysis programme because you may not have priority. A younger patient with a young family may get preference over you. Hence, there is a need to plan for major illnesses.

There are a number of insurance schemes that cover major illnesses; some cover up to 36 illnesses. Among them are cancer, heart attack, bypass surgery, stroke, kidney failure, pulmonary hypertension, brain surgery, major organ transplants, Parkinson's disease and Alzheimer's disease. A policy may pay a lump sum insured (10 per cent; 10 per cent; 80 per cent) over three years — enough to see to the medical expenses. It is good Christian stewardship to buy one of these policies. Then, in times of illness, we will not feel that we are a financial burden and think of euthanasia as a way to save on medical fees!

The Role of the Church

The Church is a caring community and has much to offer as alternatives to euthanasia. It is conceivable that people will not look to euthanasia as an option if their needs are being met, and the Church has a major role to play in meeting some of these needs.

A Biblical Mandate

The Church has a biblical mandate to care for the sick, the poor and the lonely. In His teaching on the parable of the sheep and goats, Jesus said that those who follow His mandate will be blessed by His Father and will receive an inheritance. The mandate is, "For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me" (Matthew 25:35-36).

It is in fulfilling this mandate that the Church will make a difference in the world. It is in following this mandate that the Church can offer viable alternatives to euthanasia for the terminally ill.

Power of Faith

The Church has the power of faith; faith to know that death is not the end but just a beginning of a new and wonderful experience. Hence, death is not to be feared. Yet, we are not to seek death but to continue our present life in faith until our allotted time is over. The Church also has power in the faith of a loving and caring God. The prophet Isaiah wrote, "For the LORD comforts his people and will have compassion on his afflicted ones" (Isaiah 49:13b). It is with this faith that the Church can help those suffering from terminal illness to bear their afflictions with fortitude.

Power of Prayer

The Church can draw on the power of prayer. James 5:14-16 states, "Is any one you sick? He should call the elders of the church to pray over him and anoint him with oil in the name of the Lord. And

the prayer offered in faith will make the sick person well; the Lord will raise him up. If he has sinned, he will be forgiven. Therefore confess your sins to each other and pray for each other so that you may be healed. The prayer of a righteous man is powerful and effective."

It is one of the great mysteries of the universe that God will listen and act upon the prayers of His people. The Church has a God-given role to pray for the sick and those facing death. The Church would have failed in its mission if it does not pray for and with the sick and dying.

Power of Compassion and Empathy

The Church has the power of compassion and empathy for the sick and the dying. This should encourage us to face the limits of our mortality at the critical moments of imminent death when we face hard choices of whether to ask for treatment or not. The Church should have more preaching on facing limits, living with mortality, suffering and death. It is too late to address these issues at a funeral. The Church should also have educational programmes that help people to stay well, cope with stress and face death. Teaching on death and dying should include the writing of living wills and discussion on the issues of euthanasia. In making a right-for-life stand, the Church has not always been successful in communicating to its members the reason for its stand.

The Church must be hospitable in the way it provides for members who can visit and communicate with the sick, the shut-ins (people who cannot leave their homes) and the dying. The sick and dying must be shown that they are worthy of respect, that their lives have meaning, and that they are not being isolated or abandoned. For those with chronic illnesses, suffering is exacerbated if they

are unable to sustain meaningful relationships. The loss of contact with others spawns hopelessness and despair. Hence, the ministry of visitation is especially important for the elderly, the sick and the dying. Those who have contact with them must be conspicuously visible and keep company with them, be willing to talk about what is important to them, and listen to their needs, fears, and questions. We must offer emotional support and, when necessary, call in professional help.

No one should have to die alone. Part of caregiving to the dying consists of simply sitting with them. It is a very difficult thing for us to do, but it is particularly meaningful for the dying person. He may not be conscious, but he will be aware of the presence of others in the dying process.

We must not forget to care for the caregivers: the pastors, the relatives and members of the family caring for the ill and dying. The heart of the issue in responding to debilitating, chronic and lingering disease is the human heart. We must help the caretakers to cope with their own fears and their needs. Caretakers need support emotionally and spiritually. When we deal with the mortality of another, we are also dealing with our own mortality.

Power of Community

The Church has the power of community life. As a community, the Church must take into account the social needs of the elderly, terminally ill and dying. It is easy to be too spiritual. The terminally ill and dying will need practical help to get to the hospital for their appointments, legal help to settle their affairs, and domestic help to get food and groceries. The Church should be involved in meeting these needs.

Power of the Church's Collective Resources and Network

Finally, but not least, the Church should use its collective resources and its network to champion hospice care. Many learned theologians, physicians and ethicists have said much on the rightness and wrongness of euthanasia. Proponents often discuss plans to legalise euthanasia and efforts to lobby for legislation in their favour. Opponents will write pages and pages on why euthanasia is morally wrong. Yet, when it comes to offering alternatives to euthanasia, there is silence! Only a handful of authors do this, and often in a cursory manner. How can we defend a position without offering solutions?

If the Church is to champion the right-to-life movement and stand against euthanasia, it must be proactive in promoting hospice care. It is in hospice care that we can offer a dignified death. It is in hospice care that we can overcome many of the fears that drive people to seek euthanasia. Yet, Herbert Hendin laments the Church's generally poor record in hospice care:

> *My experience with churches has been fairly grim. If I call up a minister of a church a person attended for 30-40 years in the prime of her life but now she's disabled, and I ask, "Is there anything you can do to help this person's burden?" I'd say I'm no better than 50-50 to get a favourable response. Lynn notes, "Take the last 20 members who have died in your congregation and ask their families how the church responded. I've had patients who were furious when they received cards telling them people were praying for them. 'Well, why don't they pray with me in person while holding my hand?'" Based on his intimate knowledge of people in pain, popular psychiatrist*

> *and theologian, M. Scott Peck concludes, "I submit that the answer to the problem of assisted suicide lies not in more euthanasia but in more hospice care. The first order of business should be to establish that dying patients have a constitutional right to competent hospice care."*[15]

The Church can set up hospice care in a centre (building) to serve the community with a group of nurses, physiotherapists, counsellors, physicians and volunteers, or offer hospice care to a patient in his own home. In Malaysia, the Church has not come forth to offer hospice care, even though it has the resources to do so.

The Hospice Council of Malaysia is a group of non-governmental organisations offering hospice care and, surprisingly, does not get much support from the Church in Malaysia. The author is also not aware of any churches offering hospice care in his home state of Johor Darul Takzim. It is the non-Christians who have taken the initiative and started a hospice programme. It is time for churches in Malaysia to take a hard look at themselves and see if they are indeed God's caring community in Malaysia. In Singapore, there is some church involvement in hospice care but more needs to be done.

Dying Well

The Christian response to euthanasia is to help the dying die with dignity. People seek euthanasia because they are afraid of dying, of pain, of being a financial burden and of dying alone. The Church has a mandate to care for the sick and dying. One aspect of that mandate is to educate people on their responsibilities, among which are the need to draw up wills and the need for sound financial planning. Another aspect is to provide good palliative and

hospice care where the dying can die with dignity. As the Church attends to these aspects, it is helping to provide a Christian counter to euthanasia.

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[1] Edith Schaeffer, *Forever Music* (Nashville: Nelson, 1986) p. 62-63. Quoted in Larson and Admundsen, op. cit., p.175

[2] A good overview of pain control is found in Cicely Saunders, Mary Baines and Robert Dunlop, *Living with Dying: A Guide to Palliative Care* (New York: Oxford University Press, 1995 Third Edition). Here, the authors share their experiences on pain control in their work at Saint Christopher's Hospice, the first modern hospice established in 1967. See also David Cundiff, *Euthanasia Is Not the Answer: A Hospice Physician's View* (Totowa, New Jersey: Humana Press, 1992) pp.104-132

[3] Robert Truong and Charles Berde, "Pain, Euthanasia and Anesthesiologists" in *Anesthesiology*, Vol. 78, February 1993:357

[4] Albert Einstein, "Overview of Cancer Pain Management" in Judy Kornell (ed), *Pain Management and Care of the Terminal Patient* (Washington: Washington State Medical Association, 1992) p.4

[5] Christian Medical and Dental Society Ethical Statement, "Pain Management" cited in the society's website

[6] Ibid.

[7] Gill, op. cit., p.98

[8] Robert D. Orr, "When It's Okay to Let Go" cited in Christian Medical and Dental Society website

[9] **Advance Medical Directives**. Orentlicher, "Advance Medical Directives" in *Journal of American Medical Association*, Vol. 263(17), 1990:2365-2376

[10] **Medical Directives**. Emanuel L.L. and Emanuel E.J., "The Medical Directives: A New Comprehensive Advance Care Document" in *Journal of American Medical Association*, Vol. 261, 1989:3288-3293

[11] **Values History.** Lamber P. and McIver-Gibson, Nathanson, "The Value History: An Innovation in Surrogate Medical Decision-Making" in *Law, Medicine and Health Care*, Vol. 18(3), 1990:202-212

[12] Dame Cicely Saunders studied under Oxford scholar C.S. Lewis before World War II and moved in Christian circles that included Dorothy L. Sayers. While serving as a nurse during the war and a social worker after it, Saunders become interested in the plight of the terminally ill and serving them became her ministry. She attended medical school to learn ways to control the pain of dying cancer patients and in 1967, founded the first modern hospice.

[13] For information on the Hospice Movement, see Dame Cicely Saunders and Robert Kastenbaum (eds.), *Hospice Care on the International Scene* (New York: Springer Publishing Company, 1997). For a personal account, see David Cundiff, op. cit.

[14] National Hospice Organization, "Standards of a Hospice Program of Care" 1982, p.1

[15] Hendin, op. cit., p.203; Gary, op. cit., p.21; M. Scott Peck, "Living Is a Mystery," *Newsweek*, March 10, 1997, p.18 quoted in Larson and Admundsen, op. cit., p.249

Chapter Nine

A Review and Personal Reflection

"We must take our theories with a serious playfulness and a playful seriousness."
— Erik Erikson

In this small volume, I have attempted to give an overview of the debate on euthanasia. Let me recapitulate on what we have discussed so far. Chapter One introduced us to euthanasia and the right to die, and asserted that these issues are relevant to all of us. We might think that we are far removed from the reality of euthanasia, but as the case studies have shown, nobody is excepted. We also examined the various trends that make euthanasia or mercy killing acceptable in some cultures.

In Chapter Two, we considered the meanings of suicide, euthanasia and death. When the word "euthanasia" is used, it refers to active euthanasia, which means "one person intentionally causes the death of another who is terminally or seriously ill, often to end the latter's pain and suffering". We differentiated it from passive euthanasia that is often used to mean the withholding

or withdrawal of treatment. However, I agree with the Christian Medical Fellowship that passive euthanasia is an inaccurate and unhelpful term. Withholding or withdrawing treatment when the mode of treatment is deemed ineffective does not constitute euthanasia but is good medical practice. We also differentiated between voluntary, involuntary and non-voluntary euthanasia. We accepted the definition of death as outlined in the Harvard brain death criteria and identified some difficulties that can arise in declaring someone dead. We also introduced the term "dignified death".

In Chapter Three, we started off with a historical perspective of the right-to-die movement and a brief survey of the state of euthanasia in the world today. We found that though repeated attempts at legislation have failed in many countries, euthanasia is legal in the Netherlands, Switzerland, Belgium, Colombia and the state of Michigan in the United States at the time of writing. Both the Roman Catholic Church and various Protestant denominations remain united in their stand against euthanasia. Nonetheless, it appears that it is just a matter of time before more countries and states relax their law on euthanasia. In the recent case of Terri Schiavo in the United States, a feeding tube was removed from a woman who had been in a persistent vegetative state for 15 years. The courts' ruling that tube feeding was a form of treatment and not a mode of nutrition generated much public interest in the case. It must not be forgotten that there are thousands of others in a persistent vegetative state in the United States and elsewhere in the world. One wonders what will happen to them now.

We know that an issue is in the news when Hollywood gets into the act. The 2004 award-winning movie directed by Clint Eastwood, *Million Dollar Baby,* has euthanasia written into its climatic ending.

While the movie has a boxing theme, it is basically a story about people struggling with their broken lives and making choices in an unkind, cold and often cruel world. Frankie Dunn (Clint Eastwood) is a boxing trainer. His family life is in shambles and though he attends Mass regularly, he has problems coping with his broken world. Maggie Fitzgerald (Hilary Swank) is a young woman who wants to be a boxing champion to escape her "white trash" family background. Frankie takes a gamble and agrees to train Maggie as a long shot to win a boxing title. Several powerful scenes in the movie remind us of the choices we often have to make in our own lives. Towards the end of the film, Maggie suffers an injury in the ring that makes her a quadriplegic. She decides that she does not want to spend the rest of her life in that condition and asks Frankie to pull the plug on the ventilator that is keeping her alive. Initially, Frankie refuses but after a series of events, he agrees to help her to die. In his direction of the movie, Eastwood manages to create in viewers much sympathy for Frankie and Maggie, thus making euthanasia (because of compassion) a logical end. It would appear that there is a strong lobby for euthanasia, and the general public in some countries seems to be sympathetic towards its legalisation.

As we moved on to Chapter Four, we looked to the Christian Scriptures to guide our discussion on suicide. It is from Scripture that we derived the principles of the sanctity of life. We also affirmed the stand against suicide from the principle of the sovereignty of God and the principle of stewardship. Human life is a gift from God and He has absolute dominion over it.

In Chapter Five, we examined the biblical perspective on suffering and healing. In a fallen world and with our fragile bodies, suffering is inevitable. We also looked at divine or supernatural healing and raised some tough questions about it. Sometimes, we

are so keen to give glory to God that we claim many "healings" in His name. God does heal today, but mainly through the natural healing facilities that He has incorporated into His creation and His instruments — doctors and nurses — who use natural knowledge to heal. Of course, God is the same yesterday, today and tomorrow, and we cannot discount the fact that He can intervene when He wants to. However, no one can predict when or why He does heal. We can only conclude that suffering and divine healing are mysteries we have to accept from a holy and loving God.

After looking at euthanasia from a theological and ethical perspective, we uncovered the historical and traditional perspective in Chapter Six. We noted that while the classical antiquity of ancient Greece and Rome did not have strong views against suicide and euthanasia, ancient Judaism condemned suicide and euthanasia. We also noted that the Pythagoreans who were associated with the Hippocratic Oath were a small and insignificant group during that time. The early Christians adopted most of the traditions of ancient Judaism, which included its attitude towards suicide and euthanasia. It was Augustine who formulated the Church's doctrine against suicide and euthanasia. He was later supported by Thomas Aquinas.

The Church was so strong politically, socially and economically that throughout the Middle Ages and beyond, there was no challenge to that doctrine. It was only during the "Age of Reason" in the eighteenth century that intellectuals dared to challenge the authority of church teachings. Insidiously, Western civilisation began to turn away from its Judeo-Christian roots. The first crack on the medical front came with the liberalisation of laws allowing "therapeutic abortions". This was followed by strong attacks on the Church's position on euthanasia.

In Chapter Seven, we presented the arguments for and against euthanasia. Unlike abortion, the issue of euthanasia is complex and has strong emotional, social and financial context. We see here that the argument for euthanasia was almost always consequentialist and if we do not refer to our deontological views for defence, we can be easily swayed. Chapter Eight offered a Christian alternative to euthanasia and also identified areas in which Christians, churches and parachurch organisations can play a role to make that alternative a reality.

It is always easy to discuss an issue but difficult to respond to its implications. The famous author, poet, literary critic and Nobel Laureate for Literature, T.S. Eliot, once pointed to this other level in ethics that gives us insight into a pastoral response to the euthanasia movement. After lecturing on a serious issue in American life, he was asked, "Mr Elliot, what are we going to do about the problem we have discussed?"

He replied, in effect:

> *You have asked the wrong question. You must understand that we face two types of problems in life. One kind of problem provokes the question, "What are we going to do about it?" The other kind poses a subtler question, "How do we behave towards it?"*[1]

As a Christian doctor and paediatrician, medicine, to me, is a divine vocation. I am called into it as much as another man is called into the ministry. The words that Thomas Syndenham, a Christian physician, uttered in 1668 still ring true:

> *Whoever applies himself to medicine should seriously weigh the following considerations. First that he will one day have to render an account to the Supreme Judge of the lives of sick people entrusted to his care. Next, by whatever skill or knowledge he may, by the divine favour become possessed of, should be devoted above all things to the glory of God and the welfare of the human race. Thirdly he must remember that it is no mean or ignoble creature that he deals with. We may ascertain the worth of the human race since for its sake God's only begotten Son became man and thereby ennobled the nature he took upon him. Finally, the physician should bear in mind that he himself is not exempt from the common lot but is subject to the same law of mortality and disease as his fellows and he will care for the sick with more diligence and tenderness if he remembers that he himself is their fellow sufferer.*

As a Christian physician who has had to deal with severely deformed infants and very sick and terminally ill patients, the issue of euthanasia is very real to me. Martin Luther once commented, "It is not by understanding, reading or speculating that one becomes a theologian, but through living, dying and being damned."[2]

I have sat with a young couple whose newborn is a baby boy with anencephaly.[3] I have talked with parents and relatives in the waiting room of the intensive care unit. I have stood by the bedside of a terminal patient after all available treatment has been tried and failed, and waited for the heartbeat to cease. I have had to calm emotionally distressed relatives in a cold hospital corridor at three in the morning. It is at times like these that one's theological and

pastoral convictions are severely tested. Doctors in such situations have to struggle with (1) their medical training which means doing everything possible not to give up or stop, (2) their theological persuasion or worldview which determines how highly they value the sanctity of human life, the sovereignty of God and stewardship and (3) their compassion towards their patients. All doctors, whatever their religious or lack of religious beliefs, struggle with these three areas.

The basic tenet of the medical profession has been challenged. The pillar of ethical medical practice has always been an alliance of Judeo-Christian values and the Hippocratic Oath. An adherent would pledge "*to use treatment to the sick according to my ability and judgment, but I will never use it to injure or wrong them. I will not give poison to anyone though asked to do so, nor will I suggest such a plan.*" The physician is a healer, not a killer.

As Nigel Cameron wrote in *The New Medicine: Life and Death After Hippocrates*, the fundamental tenet of Hippocratic medicine was always to heal, motivated by an unexpressed, but very real, compassion. Relief of suffering was a by-product of this commitment to help. Recently, the cure of disease and the relief of suffering have been accorded equal importance. The former is driven by a mechanistic view of human beings and the latter by a poorly defined sense of compassion, with patient autonomy the guiding principle and financial concerns lurking in the shadows.[4]

The emancipation from the Hippocratic tradition has led to a free-for-all in medical ethics:

> *Once freed from the Hippocratic obligation to confine his role to healing, the physician is fatally compromised. The idea that his freedom to take an open-ended view*

> *of his patient's interests can serve those interests better, since he is freed from a narrow obligation to heal and not to harm is illusory. His freedom in fact exposes him to competing pressures from which the Hippocratic commitment preserved him. The more diverse the range of moral options, the more complex the decision he faces, the more unpredictable their outcome…The tradition of healing and the sanctity of life is giving place to another, in which a malleable notion of respect does duty for sanctity, and healing itself is displaced by "relief of suffering" as the chief goal of the medical enterprise, all in the service of an undefined "compassion"…Suffering may best be served by acting or failing to act so as to bring about the death of the patient. Human life may be "respected" by being deliberately brought to a close. These are the radically new options being taken up in contemporary medicine.*[5]

The shift in the basic tenet of the medical profession was subtle but significant. It is the duty of a Christian physician in his teachings, writings and medical practice to bring the focus back to healing.

Another area of concern to me as a physician is the erosion of trust between patients and their physicians. There used to be a strong bond of trust between a sick person and his doctor. Unfortunately, with the commercialisation of medicine, this trust has steadily eroded. Some patients have become suspicious of the intentions of their physicians — do the doctors want to treat them or make money out of them? What will happen to this trust if, by legislation, doctors are allowed to offer euthanasia to patients who are "suffering unbearably" in the terminal stage of their illnesses?

Would there be suspicions that the doctor is not doing enough because he believes euthanasia is the better option for the patient?

In an editorial in the March/April 2005 issue of *Clinical Medicine*, the Journal of the Royal College of Physicians of London, Dr Peter Watkins wrote, "If doctors are perceived as potential harbingers of death, this delicate relationship with their patients, and with society at large, is permanently altered. Fear, after all, is the opposite of trust. Trust, once lost, cannot easily be regained." He went on to note that from several correspondences he received from Holland, "some patients with serious diseases or disabilities fear their doctors who may regularly offer euthanasia".

Underpinning my bioethics in my practice of medicine as a Christian physician is not the Hippocratic Oath but three principles of Scripture; (1) the principle of the sanctity of human life, (2) the principle of the sovereignty of God and (3) the principle of human stewardship.

The objective of my practice of medicine is to heal; it means to use all my knowledge, skills and prayers to cure, when possible. If that is not possible, then it is my responsibility to relieve pain. It is not my job to relieve suffering. I make the distinction between healing and the relief of suffering because I believe that suffering is a prophetic interaction between the sufferer and God. Pain can be treated by effective pain management. Suffering, on the other hand, is treated by building a deeper relationship with God and accepting death. This is where sound theological teaching, counselling, prayerful intercession and support by the community of faith come in. Suffering is easier to bear if someone walks with us through it. It is through faith in an ever-loving God and through knowing — by prayer — that this God is listening and responding that make suffering bearable and more meaningful. There is

adequate demonstration of the power of faith and the power of prayer.

In my medical practice, I shall withhold or withdraw treatment if I believe further treatment will not work or the prognosis is so poor that there is virtually no chance of improvement. Nonetheless, before I withhold or withdraw treatment, I will seek the opinion of another physician. I will not prolong dying. I do not consider the withholding or withdrawal of treatment to be euthanasia. I consider it good medical practice to know "when to let go". To know the limitations of medical care is an important aspect of medical practice.

However, I consider food and water to be basic needs of life and not a form of treatment. Hence, I do not consider the withholding or withdrawal of tube or oral feeding to be morally acceptable.

I am aware of the tremendous amount of suffering that my patients, their families and their communities go through. I empathise with them. I acknowledge that suffering is not always ennobling. But suffering can be made more bearable through the love and help of others. One of the lessons a suffering person must learn is to accept help from others, and the lesson for the rest of us is to offer help.

I have highlighted the calling of the Church to help the sick and the suffering, especially the terminally ill. For those who are terminally ill and are dying, I have suggested the Christian alternative to euthanasia, which is a dignified death. Recently, there has been talk of a culture of life, which simply means embracing all that life has to offer us with joy and love. It also follows that we respect all lives, all cultures, all ethnic groups and peoples, and enjoy the diversity of life. It suggests that we have to protect the environment from exploitation and reclaim the damaged environment. I believe

in the culture of life. I believe that we should embrace life with whatever we have been given. But I also believe the culture of life includes death. Everything dies. Death is part of life. And it is my sincere hope that Christians will take up the challenge of helping the terminally ill to have a dignified death, thus negating the desire for mercy killing.

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[1] Quoted in William F. May, *The Patient's Ordeal* (Bloomington: Indiana University Press, 1991) p.3

[2] Quoted in Larson and Admundsen, op. cit., p.147

[3] Literally "no brain". This is a severe congenital abnormality in which the baby is born without the cortex. As the brainstem is intact, the heart will beat and the baby will breathe. But he will not be able to do anything else. This is similar to being in a persistent vegetative state. What is the appropriate response? Leave the baby to die? Without fluids, the baby will die within a few days. Put in a feeding tube and offer milk? The baby may live for years. It has been "accepted practice" among the medical profession to leave the baby to die without feeding either milk or water. For comment on this practice, see David Short, "The Management of Handicapped Neonates – Why I Have Changed My Attitude" in *Respect for Life: A Symposium* (London: Christian Medical Fellowship, 1984) pp.41-47

[4] David B. Biebel, "The Impact of Suffering on End-of-Life Decisions" in Land and Moore, op. cit., p.179

[5] Nigel M. de S. Cameron, *The New Medicine: Life and Death After Hippocrates* (Wheaton IL: Crossway Books, 1991) pp.131-132

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"Today is a good day to die" is the rallying cry of the Klingons, a warrior race in the science fiction worlds of Star Trek. To the Klingons, what is important is glory and honour. To die in battle is to die with full honour and much glory. Hence the embracement of death, which is in direct contrast to our culture where there is a denial of death. Even Christians have assimilated this culture, and live in fear of death though the Bible teaches that there is nothing to fear. God in His sovereignty determines the time of our birth and of our death. If He has chosen that day for us to die, then it is a good day to die.

When we bring about our own death, however, the day of dying is not of God's choosing but of ours. Do we have the right to choose when we are to die? Do we have the right to determine the way we are to die? And do we have the right to ask someone to kill us?

"This book is the result of Dr Tang's own experience in facing life-and-death issues and in it he explores theological, medical, ethical, moral and legal issues. He takes the reader from historical perspectives to contemporary issues that defy black-and-white definitions. Dr Tang addresses some very thorny issues, including euthanasia which he approaches from various angles. He contends that being contemporary is not necessarily being right.

Dr Tang's extensively referenced book is timely indeed, at a time of rapidly increasing knowledge and understanding of the human body. It helps the Christian reader to make important decisions in an informed manner; decisions surrounding sickness and death."

— Datuk Dr Alex Mathews
Consultant Obstetrician and Gynaecologist
Chairman, Overseas Missionary Fellowship (OMF) Malaysia Home Council

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