



In the Shadow of Death:

A Christian perspective on
euthanasia and
assisted suicide

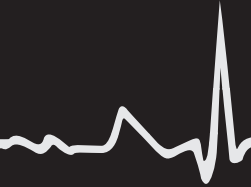


THE EVANGELICAL FELLOWSHIP OF CANADA



In the Shadow of Death:

A Christian perspective on
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Evangelical Fellowship of Canada

FAITH TODAY PUBLICATIONS
M.I.P Box 3745, Markham, ON L3R 0Y4
www.evangelicalfellowship.ca
Tel: 905-479-5885 or Fax: 905-479-4742

Printed in Canada

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Background discussion paper by
The Centre for Faith and Public Life of
the Evangelical Fellowship of Canada

ISBN 0-9730621-6-9

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I. Introduction

For I am already being poured out as a drink offering, and the time of my departure is at hand. I have fought the good fight, I have finished the race, I have kept the faith.”

2 Timothy 4:7¹

We all long to finish our lives well — living our final days with grace and dignity. We want this not only for ourselves but also for those we love. Yet the reality is that a whole host of illnesses and conditions can make the end of our life’s journey painful and difficult.

While advances in pain management have made it possible for most people to avoid unbearable pain, the same advances have also allowed life to be prolonged artificially — sometimes indefinitely. This can make healthcare decisions at the end of life difficult and complex.

When someone who is struggling with a terminal and debilitating illness pleads for death, the questions facing us, as family members, friends, neighbours and a society are: “What is the merciful response?” and “What does compassion require of us?” There is no way to set out rules that apply in all situations. However, we can seek to understand the guiding biblical principles and to try to apply them to individual cases.

We also need to ask what it means to live in a society that affirms the dignity of life and in which we accept a measure of responsibility for one another. Our society has become increasingly focused on individual choice and autonomy as a fundamental value. It is therefore not surprising that many groups and individuals are pushing to legalize euthanasia and assisted suicide in order to gain some measure of control over death.



As Christians, we believe that euthanasia and assisted suicide are contrary to God's sovereignty in our lives. As well, we are acutely concerned about the impact that legalizing euthanasia and assisted suicide may have on the most vulnerable in society: the elderly and the disabled.

“There is a time for everything, and a season for every activity under heaven: a time to be born and a time to die.”

Ecclesiastes 3:1-2 NIV

Those who are physically disabled and those who suffer from terminal illnesses are vulnerable for several reasons. They may experience feelings of uselessness and be concerned that they are burdening others. Sometimes, they hear members of the medical community describe them as a drain on the healthcare system.

The disabled and terminally ill are also vulnerable to manipulation by family members, who may not have their best interests at heart. If the door opens to legalized euthanasia and assisted suicide, it will be difficult to protect the vulnerable.

The purpose of this booklet is to set out the biblical principles regarding the sanctity of life and care of the vulnerable that Christians can apply both when making personal decisions and when seeking to understand and engage in public policy issues. In addition, we have provided a definition of terms, an outline of the current law in Canada and responses to arguments made by pro-euthanasia advocates.



II. Definitions

A. EUTHANASIA

In the current debates over this issue, much of the confusion about, and indeed support for, euthanasia comes from misunderstanding the term. Many people associate the term “euthanasia” with avoiding the artificial prolongation of life using sophisticated technology. To help make matters more clear, we define euthanasia as:

an action which directly and intentionally causes or hastens the death of another in order to put an end to a person’s suffering, with or without the person’s consent; or deliberate killing in order to put an end to a person’s suffering, with or without the person’s consent.²

Allowing a person to die of natural causes is not euthanasia. Thus, euthanasia does not include the decision to discontinue treatments that can no longer achieve their medical goals or are excessively burdensome to the patient. Such action does not cause death: it allows death to occur from natural causes. Respecting a person’s refusal of treatment or request to stop treatment that is medically useless or burdensome is not euthanasia. Under the current law in Canada, a person has the right to refuse any medical treatment, even life-saving treatment. Further, giving drugs to ease suffering during a terminal illness, even if the secondary effect is to shorten life, is not euthanasia. The intent is different. Where proper palliative pain care seeks to make a patient more comfortable, euthanasia seeks to hasten death.

Misunderstanding can arise around provision of basic necessities, such as food and water. Euthanasia can include withdrawing these necessities when doing so causes death through starvation and dehydration rather than by virtue of the underlying illness or condition.



Few would disagree that it is wrong to starve someone. However, there is a point at which artificial nutrition and hydration, including tube and intravenous feeding, actually artificially prolongs life and prevents the person from dying naturally. As people come close to the end of life, they often stop eating and drinking as bodily functions shut down. It is the intention behind the cessation of food and water that defines the act as euthanasia.

B. ASSISTED SUICIDE

We define assisted suicide as:

a person killing himself or herself with the help of another (the intentional taking of one's own life with the assistance of another person or persons).

Assisted suicide is not qualitatively different from euthanasia. It involves a person knowingly and intentionally arranging with someone else to provide that person with the means (e.g., a quantity of medications or some kind of machinery) whereby that person can kill himself or herself.



III. Biblical Principles

Canada is founded on and shaped by a vision of life that values human life as a precious resource. It is rooted in moral principles that support the sanctity of human life from both an individual and a societal perspective.

The preamble to the *Canadian Charter of Rights and Freedoms* (*Charter*) begins with the following statement: “Whereas Canada is

“That which fails to show respect for life, in particular human life, or puts at serious risk or harms the human spirit is inherently wrong.”

*Margaret Somerville,
The Ethical Canary, p. xiv*

founded upon principles that recognize the supremacy of God and the rule of law...” As Evangelicals, we appreciate the fact that our country’s guiding moral principles recognize both the supremacy of God and the rule of law. However, we must note that the clause recognizing the supremacy of God has been ignored by the courts.

The identification and interpretation of the principles that shape and guide our society is a task in which all Canadians

can participate. Various communities in our society are bringing their own perspectives to bear in this discussion, and religious communities have an important contribution to make.

The four principles we wish to address as evangelical Christians are the sanctity of life, the stewardship of life, care for the vulnerable and the communal responsibility in life.



A. THE SANCTITY OF LIFE

Then God said, “Let us make man in our image, in our likeness, and let them rule over the fish of the sea and the birds of the air, over the livestock, over all the earth, and over all the creatures that move along the ground.” So God created man in his own image, in the image of God he created him; male and female he created them.

Genesis 1:26-27

We believe that human beings, who are created in the image of God, have inherent dignity and worth. Life is sacred and should be cherished. There is no such thing as a “useless” life, because our worth is not determined by what we can do or the pleasure we experience, but rather by who we are in relation to God and to each other. We believe that human life must be valued, respected and protected throughout all its stages. This is not to say that physical life is of ultimate value and should be preserved at all costs. We understand physical death to be a transition into a new realm of existence.

“all humans are sacred, whatever their culture, race, religion, whatever their capacities or incapacities, and whatever their weaknesses or strengths may be.”

*Jean Vanier,
Becoming Human, p. 14*

Life is a gift from God. We are stewards of what God has entrusted to us. All human life, being of equal value in the sight of God, is to be cared for and nurtured physically, emotionally and spiritually.

The sanctity of life is a core principle in Canadian society. The Supreme Court has recognized that Canadian society is “based



upon respect for the intrinsic value of human life and on the inherent dignity of every human being...”³ This is how the Court interpreted the value of “life” found in section 7 of the *Charter*. Likewise, the Law Reform Commission has identified the sanctity of life as an essential value (see page 14).

Is allowing people to ask a doctor to kill them consistent with a life affirming society?

B. STEWARDSHIP OF LIFE

From everyone who has been given much, much will be demanded; and from the one who has been entrusted with much, much more will be asked.

Luke 12:48b

We believe that life is a gift of God and that we each have a unique responsibility for our own life. This understanding is captured in the concept “of life, liberty and the security of the person” in section 7 of the *Charter*. While people might differ in whether they understand life to be God’s or our own, our society affirms that we each have the responsibility to manage our lives well.

As a society, we affirm the liberty of each person to live life as he or she will. We seek to provide what is basic and essential to the exercise of that liberty through education, social assistance and health care. We do this not only to enhance individual freedom but also to enable individuals to steward the gifts God has given them.

As a society, we also have a corporate notion of what constitutes good stewardship of life. We discourage, either by moral suasion or by law, behaviour that is destructive to life, be it one’s own life or that of another. We seek to help people to enjoy fulfilling and enriching lives.



Can we consider euthanasia and assisted suicide to be consistent with good stewardship of our person?

C. CARE FOR THE VULNERABLE

Love your neighbour as yourself. Leviticus 19:18 and Luke 10:27

Because people are created in the image of God and are the objects of God's love and grace, our lives are inherently valuable. Jesus affirms that we should love others as we love ourselves. In both the Old and New Testaments, the people of Israel and the followers of Jesus were commanded to care for the alien, the widow, the orphan, and the poor. In short, we are to care for the vulnerable in our society.

In as much as we serve the vulnerable of our society, we are serving Christ. When we respond to those who cannot help themselves, we are acknowledging our own dependence on Christ's grace. As Jesus explained:

Then the King will say to those on his right, "Come, you who are blessed by my Father; take your inheritance, the kingdom prepared for you since the creation of the world. 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... I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me."

Matthew 25:34-36,40

Will legalizing euthanasia going to make the vulnerable in our society vulnerable to pressure to end their own lives?



D. COMMUNAL RESPONSIBILITY IN LIFE

Am I my brother's keeper? Genesis 4:9

Being created in the image of God means that we humans, unlike other creatures, have a unique relationship with him and with one another. We are loved and cared for by God in a special way. In Psalm 139, for example, God calls us into being. He is our Creator. Ideally, we are born of our parents' loving union. We are dependent upon our parents for a much longer time after birth than animals. We are raised and nurtured by families and communities. We are not self-sufficient; we live in relation to others as a child, a sibling, a spouse, a neighbour, a friend, a co-worker, a citizen. From birth until death, we live in community and are interdependent. It is God himself who requires us to be our brother's and our sister's keeper and have a measure of responsibility for one another.

Our interdependence and communal nature are reflected in all aspects of societal life, and they both give shape to and are the reason for our various institutions and associations. For example, the legal system recognizes the responsibility and interrelatedness of the community and the person. In law, the individual person is responsible to the community, because the community punishes criminal acts. Likewise, the community's responsibility for the individual is reflected in social welfare programs and provision of medical care. Our actions, and how we live our lives, affect others.

Thus, the death of a person affects an entire community. The argument for autonomy in life and death decisions runs the risk of presuming a narrow understanding of life and community. Our lives are, and ought to be, lived in community. How then can we claim absolute autonomy when it comes to the timing and method of our deaths?



IV. A Life-Affirming Ethos

We believe the principles that the evangelical Christian community brings to bear in the issue of euthanasia and assisted suicide are the same as or similar to those widely shared in Canadian society. These principles have an influence on the way we live.

We realize that people may face hard choices and heartbreaking situations when making end-of-life decisions, where things do not appear at all black and white. We have therefore set out the principles that we urge you to apply in individual cases. However, these principles also lead us, as Evangelicals, to advocate against certain public policy choices, such as legalizing euthanasia and assisted suicide.

Our legal system and our institutions are characterized by a life-affirming ethos, which is grounded in principles such as those we have articulated above. The Law Reform Commission has stated:

In truth the criminal law is a moral system. It may be crude, it may have faults. It may be rough and ready, but basically it is a system of applied morality and justice. It serves to underline those values necessary and important to society. When acts occur that seriously transgress essential values, like the sanctity of life, society must speak out and reaffirm those values. This is the true role of criminal law.⁴

The legalization of assisted suicide or euthanasia will call into question the life-affirming ethos that characterizes our health system. Will we continue to treat those who attempt suicide as though we really want them to live? In an atmosphere where euthanasia is acceptable, patients may be placed in the untenable position of having to justify their continued existence.



V. What does Canada's Law Say?

While people may refuse consent to any medical treatment or procedure, under current law in Canada, they cannot have a treatment or procedure for the purposes of ending their lives. We would argue that this distinction is important and should be maintained in law.

The changes in laws regarding suicide do not support euthanasia. The decision to decriminalize suicide in 1973 was not motivated by a change in attitude towards suicide.⁵ It did not indicate that suicide was to be condoned. Rather, Parliament believed that the appropriate response to those who had attempted to take their own lives was not punishment but compassionate help. Mental health professionals still treat suicidal tendencies as a cry for help or a symptom of despair. Thus, when a person attempts suicide, everything is done to maintain life. Once life is stabilized, the person is treated to find and resolve the cause of the suicidal tendencies. Doing away with laws punishing those who attempt to commit suicide did not empower people to commit suicide or give people an enforceable right to choose to commit suicide.

The following cases illustrate the way Canadian courts have dealt with issues of euthanasia and assisted suicide. The courts have consistently affirmed that Canadian law affirms the sanctity of life.

A. CRIMINAL CODE PROHIBITIONS

While Canada's *Criminal Code* contains no specific reference to "euthanasia," this practice is considered an act of murder, as captured in Section 14 of the *Criminal Code*, which states:

No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of



any person by whom death may be inflicted on the person by whom consent is given.

While the offender's intention to murder is relevant for determining what charges are laid and what sentence is given, the motive for the offence (for example, compassion, anger, greed) is not taken into consideration. Consent to death does not affect the criminal responsibility of the one who inflicts death.

Counselling or assisting a suicide is also prohibited in the *Criminal Code*. Section 241 of the *Criminal Code* reads:

Everyone who (a) counsels a person to commit suicide, or (b) aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable for a term of imprisonment not exceeding fourteen years.

B. COURT CASES

1. *Rodriguez v. Canada*⁶

British Columbia resident Sue Rodriguez was diagnosed with ALS (amyotrophic lateral sclerosis), a debilitating, terminal disease. She brought a challenge to the *Criminal Code* prohibitions against assisting someone to commit suicide on the basis that it violated her rights under the *Charter*. Rodriguez argued that section 7 of the *Charter*, which guarantees the right to life, also includes

“Canadian society is “based upon respect for the intrinsic value of human life and on the inherent dignity of every human being...”

*Mr. Justice Sopinka,
Rodriguez v. Canada*



the right to choose death. She also argued that it violated section 15 of the *Charter*, which guarantees equal treatment and benefit of the law without discrimination. She argued that it is discriminatory to disallow the benefit of a physician to those who are too disabled to commit suicide without assistance, since it is not a criminal offence for an able-bodied person to commit suicide.

In 1993, the Supreme Court of Canada, in a 5-4 split decision, ruled against Rodriguez. The majority of the judges affirmed that the prohibition against physician-assisted suicide is rooted in the interest of the state to protect and maintain respect for human life. They went on to say that to effectively protect life and those who are vulnerable in society, a prohibition without exception on the giving of assistance to commit suicide is the best approach.

2. **R. v. Latimer** ⁷

In 1993, Saskatchewan father and farmer Robert Latimer placed his severely disabled 12-year-old daughter, Tracy, in the family vehicle and ended her life by way of carbon monoxide poisoning. In 2001, following several years of complex court proceedings and appeals, the Supreme Court of Canada upheld Robert Latimer's second-degree murder conviction and sentence. Latimer argued, among other things, that he should have

“So many people with disabilities are seen by their parents and families only as a tragedy.”

*Jean Vanier,
Becoming Human, p. 26*



been able to argue the defence of necessity before the lower court — essentially, that he had no choice but to kill his daughter Tracy. He also argued that as Tracy's substitute decision-maker, he consented to her death. The court rejected these arguments.

3. Marielle Houle

Charles Fariala's mother, Marielle Houle, assisted his suicide in Quebec in October 2004. Because both mother and son worked in the local hospital they were well aware of the treatment received by people suffering from debilitating illness. Therefore, when he was diagnosed with multiple sclerosis, Fariala became extremely depressed and came to believe that his life was no longer worth living. When he asked his mother to help him end his life she agreed to do so. Marielle Houle was charged with aiding and abetting in the suicide of her son. It is important to note that Houle was not charged with first- or second-degree murder, but the lesser charge of aiding and abetting suicide. This case is pending.

4. R. v. Martens

In 2004, Evelyn Martens, an elderly woman from British Columbia and member of the Right to Die Society, was charged in the deaths of Monique Charest, a former nun, and of school-teacher Leyanne Burchell for counselling and assisting them in suicide. However, she was acquitted because the jury did not think there was enough evidence, although she did admit to an undercover police officer that she had been present when Charest died.



VI. What Does the Law of Other Countries Say?

A. THE NETHERLANDS

Assisted suicide and euthanasia have been legal under certain conditions in the Netherlands since 1984. There is evidence however that those conditions — safeguards which are in place on paper — are simply not being followed in practice. Many elderly are afraid to enter hospitals as their lives may be ended for them. Many are euthanized without their knowledge or consent.⁸

The Netherlands has taken the lead in legalizing physician-assisted death on a national scale, having effectively tolerated it for more than twenty years. Formal passage of legislation expressly permitting it took place in April 2001. Under the legislation, no evidence of terminal illness is required, but the physician is expected to be of the opinion that a candidate for assistance in dying is facing “unremitting and unbearable suffering,” for which there is no reasonable alternative solution. Active euthanasia by lethal injection has historically accounted for many more assisted deaths in the Netherlands than has assisted suicide. There is also evidence that a significant number of such deaths (in the order of 1,000 cases per year) take place without the personal consent of the individual, and that more than half of all cases of assisted death are not reported at all.⁹

According to a 2000 study on euthanasia and assisted suicide in the Netherlands, in 86 percent of so-called assisted suicides, the person assisting the suicide took a more active role, so the assisted suicides in fact became acts of euthanasia. The study also found that a third of lethal injections were given without patient consent, and that physicians frequently falsified death certificates.¹⁰



There is much to learn from the Dutch experience with euthanasia. “First, the slippery slope is very real... the Dutch have proved that once killing is accepted as a solution for one problem, it will be seen as the solution for many problems. Once we accept the killing of terminally ill patients... we will invariably accept the killing of chronically ill and depressed patients, and ultimately, even children.”¹¹

Lest one doubt the slippery slope argument, the Associated Press recently reported, “The Dutch government intends to expand its current euthanasia policy, setting guidelines for when doctors may end the lives of terminally ill newborns with the parents’ consent.”¹²

B. THE UNITED STATES OF AMERICA

Michigan doctor Jack Kevorkian has been instrumental in furthering the cause of voluntary euthanasia, both in Canada and in the U.S. Dr. Kevorkian continually challenged the law prohibiting assisted suicide by providing people with the means to die. In 1998, the program *60 Minutes* aired a tape showing Dr. Kevorkian giving Thomas Youk, upon his request, a lethal injection. As a result of the broadcast, Kevorkian was sentenced to 10 to 25 years imprisonment for the misuse of controlled substances. At the time of his incarceration, Dr. Kevorkian said he had decided to euthanize the man rather than assist him in suicide in order to push euthanasia onto the public agenda.

In 1997, the state of Oregon passed the Death with Dignity Act; it allows physicians whose primary responsibility is to manage a patient’s terminal illness to prescribe lethal doses of medication. A prognosis of death within six months must be confirmed by a second doctor, and the patient has to make two oral and one written request over the course of 15 days.¹³ Although several other states have had referenda on euthanasia and assisted suicide, Oregon is currently the only state in the U.S. to have legalized the practices.



The case of Terri Schindler-Schiavo received a great deal of attention both in the U.S. and internationally. Terri suffered severe brain damage in 1990 at the age of 26, as a result of a heart attack. In 2005, after many court cases and hearings — the result of a prolonged battle between her husband and parents — a state court in Florida granted her husband’s request that Terri’s feeding tube be removed. Terri was not dying, was not on life support and was not terminally ill. She was able to eat certain foods before she was given a feeding tube, which conditioned her to need it in order to eat. The courts consistently ruled that Terri, who was severely disabled, was in a persistent vegetative state (PVS) and that prolonging her life was essentially “futile treatment.” The debate polarized people depending on whether they agreed with the PVS diagnosis (her parents did not).

C. BELGIUM

Belgium legalized euthanasia in 2002; however, the legislation created a complicated process, which critics have called a “bureaucracy of death.” The practice was legalized primarily in an effort to try to stop or decrease the number of acts of euthanasia, because several thousand people were being illegally euthanized each year.¹⁴



VII. Impact of Euthanasia and Assisted Suicide on Vulnerable Persons

If assisted suicide or euthanasia were legalized, persons who are disabled, terminally ill or elderly would be at risk because, as Mr. Justice Sopinka stated in *Rodriguez v. Canada*, assisted suicide is ungovernable. It is not possible to devise safeguards that would adequately protect the vulnerable.¹⁵ We would extend this statement to euthanasia in general. If euthanasia is available, there could very well be some who will be pressured to “just end it all.”

Not surprisingly, those with disabilities feel especially vulnerable in this debate. Orville Endicott writes:

Having a disability often leads to the devaluation of the life of an individual, and consequently makes other people think that he or she would be better off dead. Although the individual might value his or her own life as much as anyone else would, knowing that others assign diminished value to one's life can affect the voluntariness of any decision to seek assistance in dying. Substitute decision makers are likewise influenced by the pervading view that the life of a person with a disability is a life not worth living...

The notion that a person with a disability has an unacceptably poor “quality of life” influences people's judgment as to whether such a person ought to receive needed medical care. “Do Not Resuscitate” orders are often made, not because a person's medical condition is untreatable, but because their disability is regarded as having made their life of negative value.¹⁶

Mark Pickup, the founder of HumanLifeMatters and a Canadian disability activist who has multiple sclerosis, stated:

This is the terror I referred to in the title of this address:
Terror in a Brave New World. It is frightening to live with



serious degenerative disability in the Brave New World of the 21st Century where the sanctity of human life ethos has been replaced by the quality of life.

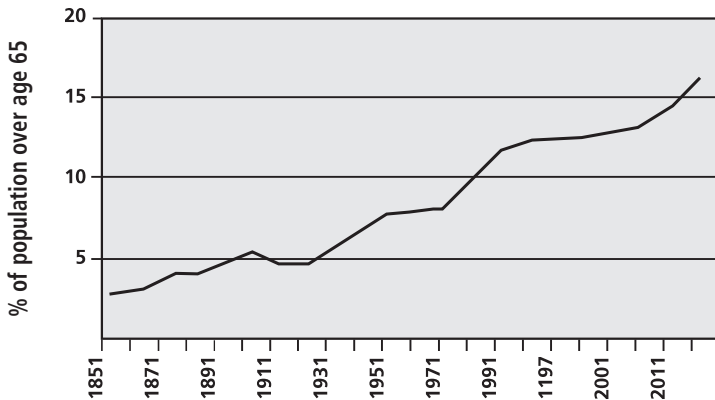
Quality of life is a moving target.

I am convinced that love is the final arbiter of life's value. Even when people are not recipients of human love — they are still loved by the author of love and life: God!¹⁷

Elderly persons are also at risk and vulnerable, even to their own families. There are reports of elder abuse, both physical and emotional, by family members.¹⁸ Family members caring for an elderly person often experience great frustration and exhaustion and may wish that the elderly person would die. Elderly persons might be pressured by family members to transfer assets or revise a will in favour of a particular family member. The implication is that the assets are more important than the person.

CANADA'S AGING POPULATION

The graph below shows the number of Canadians over age 65 as a percentage of the total population.



Source: Statistics Canada, CANSIM



The option of legalized euthanasia may help build resentment against those who continue to live with chronic illness or disability, as they will be using precious health care resources.

We are concerned as well that legalizing assisted suicide will change the way those who attempt suicide are treated. In the same way that Sue Rodriguez challenged the prohibition

on assisted suicide under section 15 of the *Charter*, on the basis that it treated disabled persons differently than able-bodied persons, so an able-bodied person could challenge the way the police and medical professionals deal with suicide. Thus, it might become illegal to intervene to save life when someone attempts suicide.

Why do so many polls show that Canadians are in favour of euthanasia? As a society, we fear dependence. Euthanasia is seen as a way of taking control over death or illness. We also do not value elderly and disabled persons as we should. In cultures and societies where elders are valued, they are respected and play significant roles in child rearing and in the community; in contrast, in our society, they have no particular function.

We must ask ourselves if calls for legalized euthanasia result from our failure to give adequate support to vulnerable persons and our failure to develop adequate palliative care for those who are dying. Our society has been labelled a throwaway society. We dispose of things when they are no longer useful, desirable or fashionable. Will this extend to people, too? Will we simply throw people away when they are no longer deemed useful, desirable or fashionable? We must ensure that the vulnerable are treated with compassion and as valued members of our community.

“Ever since dying came into fashion, life hasn’t been safe.”

- Anonymous



VIII. Impact of Euthanasia and Assisted Suicide on Health Care Professionals and on the Health Care System

The health care profession has, to this point, had a life-affirming ethos. Health care professionals are not trained in administering death. A change in the law, therefore, will necessitate either creating a “killer class” in the medical community or changing the training of health care professionals so that all are trained in administering death.

Physician-assisted suicide would impair the physician/patient relationship. Patients view a physician as one who is working to preserve life. If physicians can cause death, will patients trust their physicians? They may hesitate to express feelings of depression or suicidal thoughts for fear that it may be taken as a request for suicide. Other health care professionals would also be affected since they are frequently the ones who carry out the physician’s orders. Assisting in a suicide or participating in euthanasia might bring upon health care professionals the anger or lawsuit of a bereaved family.

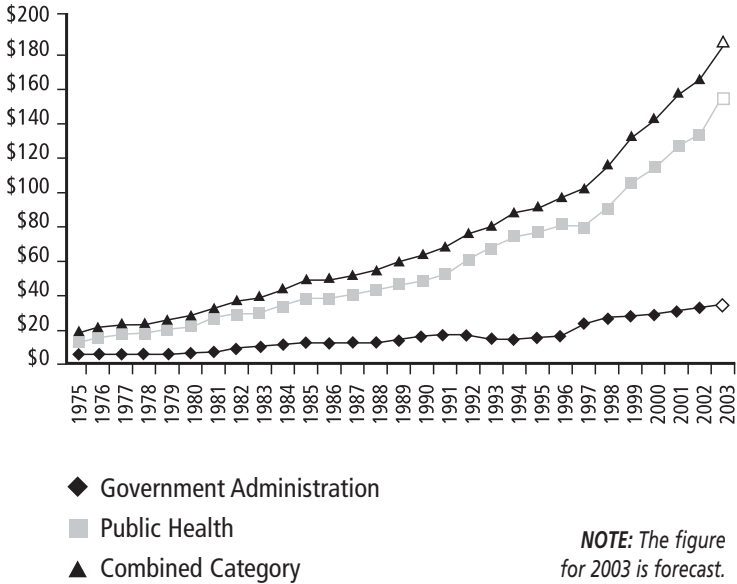
“I will give no deadly medicine to any one if asked, nor suggest any such counsel.”

The Hippocratic Oath



SPENDING PER PERSON

In 2003, provincial government spending on public health reached \$151 per capita; spending on government administration was \$33 per person.



Source: National Health Expenditure Database, CIHI

In an era of concern over health costs, euthanasia may seem like an easy answer to the high costs of treating terminally ill persons. The medical community is under tremendous pressure to cut costs, there are more patients than available hospital beds, and long wait times for certain critical diagnostic tests. The person who is terminally ill and for whom the medical arts can do very little may be put at risk. Some may reason that if they are going to die anyway it would be more economical to allocate limited resources to the patients most likely to recover. We advocate instead that more resources be put to palliative care.



IX. Palliative Care: What Compassion Requires

Persons facing death do not need help in dying; they need support to live in the face of suffering. They need good palliative care in all its facets. Advances in palliative care and pain control have reduced support for the argument that euthanasia is needed to end unbearable pain. In addition, these advances in care offer viable alternatives to the depersonalization of hospital care. Our resources and our power ought to be used to enable individuals to live with dignity in the face of death.

We believe that a strong and unqualified commitment to the sanctity of life by the major institutions of our society is required, particularly when our culture is fascinated by, and exposed to, death and marked by an erosion of the value of life.

“Tell them not to be afraid of the dying. It is very simple. The dying need tender loving, nothing more.”

Mother Teresa

A. UNDERSTANDING PALLIATIVE CARE

Palliative care was developed during the 1960s by medical professionals who recognized that traditional symptom and disease-focused health care was not meeting many significant needs of patients facing death. Palliative and hospice care is a holistic approach to a person's symptoms, concerned with relieving not just patients' physical suffering, but also their psychological, emotional and spiritual suffering. The care involves a team of health professionals from different disciplines and volunteers who provide care and support for patients and their families. Its focus is managing pain and alleviating symptoms, and most importantly, on providing comfort and care for patients together with their families.



Dr. Balfour Mount, a pioneer of the hospice movement, describes hospice care in the following way:

Several features characterize hospice care as being distinct from traditional health care programmes. There is a concern for the family and other loved ones as well as the patient. The fears and doubts of all involved, the strain on relationships and financial resources, the need for spiritual care, are all considered in addition to the more traditional issues relating to the disease itself. There is also a relaxation of the institutional regulations concerning visitors, food, pets, and other details of daily life. When the length of remaining life is recognized as lying outside the influence of further treatment, the focus is not on curing or prolonging life but on its quality each day; not on death, but on life and on living in the moment!¹⁹

In 2000, the Senate Subcommittee report, *Quality End-of-Life Care: The Right of Every Canadian*, in part, recommended:

Quality end-of-life care must become an entrenched core value of Canada's health care system. Each person is entitled to die in relative comfort, as free as possible from physical, emotional, psychosocial, and spiritual distress. Each Canadian is entitled to access skilled, compassionate, and respectful care at the end of life. This Subcommittee sees care for the dying as an entitlement for all.

Calls for a more compassionate and comprehensive approach to end-of-life seem to be assigned a low priority in the existing health care system. Thus, in spite of statistical evidence indicating an increase in the numbers of total deaths and acknowledged changes in demographics, disease patterns, and health care institutions, there has not yet been the required shift of resources to end-of-life care.²⁰



Medical treatment should never be for the purposes of causing death. It should always be life affirming. Good medical care seeks to restore health and to continue to care for those whose health cannot be restored. Palliative care protects the vulnerable, protects sanctity of life, is compassionate, involves a dying person's community and is good stewardship of resources and of the dying person's life. Palliative care eases the path from life to death by helping people who are dying to live out their last days in the fullest way possible.

B. ENSURING A WELL-RESOURCED COMPREHENSIVE HEALTHCARE SYSTEM

We affirm providing resources for both good curative care and palliative care. With restrained health care budgets, there are gaps in the level of care across Canada. This should not be used as an excuse to destroy the life-affirming ethos in Canadian medicine. Instead of sanctioning euthanasia and assisted suicide, governments should be ensuring good medical care, including palliative care.

- Over 220,000 Canadians die each year
- 75% of all deaths occur in people over 65 years of age
- 75% of the deaths take place in hospitals and long-term care facilities
- An estimated 5% of dying Canadians receive integrated and interdisciplinary palliative care

*Senate Sub-Committee Report, Quality End-of-Life Care:
The Right of Every Canadian, June 2000*



C. OFFERING COMPASSION AND SUPPORT

Scripture teaches that Christians are to be known by their acts of love. Jesus himself calls on his followers to visit the sick. This act of Christian service offers great comfort to those whom we visit, as well as immeasurable and intangible rewards for us. But, it can also be an intimidating task.

So often, people who are not accustomed to being with people who are disabled, sick or dying do not know what to say or do. We may feel uncomfortable in the presence of such suffering, or feel at a loss for those “right words” to ease the person’s pain. While feeling this way is quite natural, it is helpful to remember that often the most important thing we can do is to see beyond the ailment to the person, the child God loves.

As we do this, we can become present in the lives of the sick and the elderly and sensitive to their needs. At times, simply sitting quietly and prayerfully with someone will be a great comfort to them. At other times, they may need practical help: a meal, a ride to the doctor, or someone to care for the cat while they are in hospital. When we visit and help the sick and the elderly, in whatever form it takes, we become the presence of Christ in their lives. We also need to encourage good programs, such as those provided by hospitals and palliative care associations, that train people to be skilled visitors.

*“We are all healers
who can reach out
and offer health,
and we are all
patients in constant
need of help.”*

*Henri Nouwen,
The Wounded Healer, p. 27*



D. AFFIRMING WORTH AND MEANING

It is tragic that in many ways our society reinforces the message that those who are disabled or ill are not, or are no longer, valuable members of our society. In spite of the growing movement to have accessible workplaces, shops and restaurants, many places still exist where those using wheelchairs and walkers cannot go.

Every pregnant woman is offered pre-natal genetic testing for certain genetic anomalies that can lead to disability. It is now widely acceptable — and sometimes expected — for positive test results to end in abortion. What message does this send to members of our society living with disability?

Those living with disability or long-term illness need to hear the life-affirming message of Christ: your value is not dependent on what you can do, feel or experience. Your value comes from who you are in relation to God — his child, His precious, unique creation — independent of society's standards or expectations. As Christians, therefore, we must affirm the inherent value of every person, regardless of their condition or circumstances.

“... the greatest suffering is being lonely, feeling unloved, having no one. I have come more and more to realize that being unwanted is the worst disease that any human being can ever experience.”

Mother Teresa

E. PREPARING OURSELVES FOR END-OF-LIFE DECISIONS

We never know in advance when we will face making end-of-life decisions for ourselves or for those dear to us. Terri Schindler-



Schiavo, for example, was only 26 years old when she suffered a heart attack that rendered her incapacitated. It is never too early to think and pray through these issues and to discuss them with those close to you. Quite often, people are forced to make these decisions under traumatic circumstances. It will help if you have prayerfully considered the biblical principles and are prepared to apply them.

Some people advocate having a living will, also called an “advance health care directive” or a “power of attorney over health care.” This document allows you to name a person (called a “proxy”) who will make medical decisions for you if you become incapable of making them for yourself. It permits you to give direction to that person as to what medical intervention you wish or would refuse. You can do either of the above or both. However, there are some problems with living wills. If you give an official advanced direction as to future medical treatment, it must be followed, no matter what the circumstances. You cannot anticipate all possible situations so what you have written may not be the best course of action in the circumstances. As an alternative, you can set out a statement of principles that you give directly to your health care proxy, which might be helpful to him or her in making decisions on your behalf.

If you become incapacitated and do not have a living will, the law generally sets out who will make medical decisions on your behalf. If you are married, it is your spouse. If you have children and no spouse, it will be your children. If you are not married and have no children, it will be your parents. If you are not sure who would make these decisions, if your decision-maker lives far away, or if you do not trust your decision-maker, it is wise to have a living will and assign someone to do this (and tell them about it). Make sure that whoever will be making medical decisions on your behalf knows your principles and what kinds of treatment you would wish in various circumstances. Your life may be in their hands some day.



X. How Christians Can Respond with Compassion

As Christians, we have a message of hope and compassion. In all we do we must act in ways that bring Christ's compassion into the lives of suffering people. We must communicate our compassion to those who suffer and find their lives to be meaningless so they would rather die than live. Furthermore, we must be prepared to offer more than words in response to those who say that they have no hope in life and wish to die. We cannot proclaim the truth of God's law without bringing Christ's compassion and love in a real way. If we truly reflect Christ in our lives, we will take action to show that God suffers with the suffering and offers hope to those who despair. We must equip ourselves to minister to the disabled, the elderly and those who are terminally ill in informal ways and more structured ways, especially when opportunities arise to participate in hospice care or palliative care.

“Give a person tender love and care. Your radiating concern, your radiating joy will give that person great hope.”

- Mother Teresa

A. AS INDIVIDUALS

- Be informed, and willing to inform others. Be prepared for your own end-of-life decisions and those for people you love.
- Know your rights as a patient. If appropriate, designate a proxy in writing, someone to speak for you when you can't.
- Talk with those who will be making medical decisions for you in case you become incapable of making them yourself. Make



sure your proxy decision-maker knows your views on end-of-life decisions.

- Be a source of encouragement to those in your church or community who are disabled or suffering from terminal illness.
- Reach out to those who are depressed or struggling. Many times, they want to die because they cannot cope, and support at these times can make a huge difference in their desire to live.
- Consider supporting palliative care and hospice programs with your time and/or resources.

B. AS CITIZENS

- Urge your Member of Parliament to do the following:
 - Support palliative care programs and establish national standards for palliative care.
 - Uphold the current prohibitions against euthanasia and assisted suicide.
- Urge your provincial representative to do the following:
 - Increase financial support for palliative care and hospice programs.

“Unfortunately, in end-of-life care, we do not have a vocal constituency: The dead are no longer here to speak, the dying often cannot speak, and the bereaved are often too overcome by their loss to speak.”

*Dr. Harvey Chochinov,
University of Manitoba,
Canada Research Chair
in Palliative Care*



- Encourage greater awareness of and training in palliative care among medical practitioners.
- Insist on the full inclusion of spiritual caregivers in palliative care.

C. AS FAMILY MEMBERS

- Reassure the older members of your family of their value and the meaning in their lives.
- Involve the older members of your family in the regular routines of your life.
- Have regular contact with the seniors in your family. Try to alleviate any loneliness they may feel. Don't make them feel burdensome or forgotten.

D. AS CHURCHES

- Pray for those who feel life is not worth living and for those who are suffering.
- Remind church members of God's love for each person, of the value God places on each person, and of God's compassion for the suffering. Counter the idea that some lives are not worth living.
- Find ways to express love to seniors and the disabled. Consider ministries such as holding services in nursing homes and care facilities, or visiting the elderly and the disabled.
- Be sure not to marginalize seniors or the disabled, but take steps to involve them in the life of the church.
- Make church facilities accessible for the elderly and disabled so that they feel welcome to attend services.



- Offer concrete and practical assistance to seniors, terminally ill or disabled adults and to families caring for disabled or terminally ill children.
- Provide good teaching about death, dying and illness, understood within a Christian worldview
- Normalize grieving and provide access to proper pastoral care for those who are grieving and mourning.

XI. Conclusion

The legalization of euthanasia and assisted suicide would undermine the life-affirming ethos that currently shapes our legal system. We would legitimize suicide by implying that in some situations it is acceptable. We would be saying that murder is permissible even when the victim poses no threat to anyone else. It would suggest that life is at times optional and that our society at times sanctions the choice for death.

“The care of human life and happiness, and not their destruction, is the first and only legitimate object of good government.”

Thomas Jefferson

Public and legal acceptance of these practices would put at risk those members of

our society who are most deserving of respect and protection. As believers, we must resist the call for legalization of these forms of



killing, and urge our legislators to do likewise. Instead, we must affirm that the answer to relieving the suffering of those living with inevitably progressing illness and to providing “death with dignity,” is competent palliative and hospice care. Whenever possible we should support efforts in this area and be ready to offer our own services to meet the needs of those who require palliative care.

Wesley J. Smith identifies our dilemma:

As we chart the early years of the new millennium, we are at a crossroads that forces us to choose between two mutually exclusive value systems. Will we remain on the trail that leads ultimately to the full realization of the equality-of-human-life ethic and with it the tremendous potential for the creation of a true community, or do we take a hard turn down the slippery slope toward a coarsening of our views of the afflicted, the dying, the chronically ill, the disabled, and those in pain or depression, to the point where we feel they have a duty to die and get out of the way?²³

Those living with terminal illnesses need help in living their final days with dignity. Members of our communities living with disability deserve to be recognized for the valuable, contributing members of our society that they are. All those who are vulnerable due to illness or disability have the right to meaningful life, and certainly should not ever have to justify that right to live to anyone, not their doctor, their families or their friends.

As believers, we must by our words and our deeds counter the trend in our culture to subjectively assess the value of a person’s life based on what they can do, contribute, experience or feel. We must affirm the inherent value and worth of every person — regardless of health or ability — as a unique, loved child of God.



Appendix A: Further resources

The Canadian Hospice Palliative Care Association, the national, non-profit association that provides leadership in hospice palliative care in Canada.

Contact: Annex B, Saint-Vincent Hospital
60 Cambridge Street North, Ottawa, ON K1R 7A5
Tel: 1-800-668-2785, Fax: 613-241-3986
Hospice Palliative Care Info Line: 1-877-203-4636
Web: www.chpca.net.

The Christian Medical and Dental Society (Canada), a national organization of Christian physicians, dentists, and students who, through God's grace, honour Him by integrating faith with professional practice.

Contact: 30 - 5155 Spectrum Way, Mississauga, ON L4W 5A1
Tel: 1-888-256-8653, Fax: 905-625-1812
E-mail: main@cmds-emas.ca; Web: www.cmds-emas.ca

The Euthanasia Prevention Coalition was established to prepare a well-informed, broadly based, network of groups and individuals who support measures that will create an effective social barrier to euthanasia and assisted suicide.

Contact: PO Box 25033, London, ON N6C 6A8
Tel: 1-877-439-3348; Fax: 519-439-7053
E-mail: euthanasiaprevention@on.aibn.com; Web: www.epcc.ca

Evangelical Fellowship of Canada, the national association of evangelical Christians, has a variety of resources related to euthanasia:

Contact: Box MIP 3745, Markham, ON L3R 0Y4
Tel: 905-479-5885; Fax: 905-479-4742
E-mail: efc@efc-canada.com; Web: www.evangelicalfellowship.ca



Health Canada, a department of the federal government. Palliative and End-of-Life Care:

Contact: www.hc-sc.gc.ca/hcs-sss/palliat/index_e.html

Human Life Matters, a ministry for helping local churches effectively share the gospel with people with disabilities, integrate them into church-life, and develop opportunities for them to actively serve God.

Contact: 4417-51 Street, Beaumont, AB T4X 1C8
Tel./Fax: 780-929-9231, E-mail: humanlifematters@shaw.ca
Web: www.humanlifematters.com

Physicians for Life, a non-profit, charitable organization of Canadian physicians dedicated to the respect and ethical treatment of every human being, regardless of age or infirmity.

Contact: 29 Moore Street, R.R. #2, Richmond ON K0A 2Z0
Tel./Fax: 613-728-LIFE (5433); E-mail: info@physiciansforlife.ca
Web: www.physiciansforlife.ca

The Salvation Army Ethics Centre has positional statements on issues such as euthanasia, physician assisted suicide, and advance health care directives.

Contact: 447 Webb Place, Winnipeg, MB R3B 2P2
Tel: 204-957-2412; Fax: 204-957-2418
E-mail: Ethics_Centre@can.salvationarmy.org
Web: <http://ethics.salvationarmy.ca>



Appendix B: Responding to Arguments in Favour of Euthanasia

A. SELF-DETERMINATION

People naturally want to determine for themselves what is good and what is not and do not take into consideration that some things are rightly beyond their control. This concept of self-determination is increasingly prevalent in Canadian society and is one of the main arguments for the status quo on abortion. Self-determination and arguing for the right to choose the timing of our own death will become more frequent as our population grows older. People consider “life to be [their] property, to be disposed of as [they] see fit,” without realizing there is an after life in which each person gives an account to God for their actions on earth.

The Bible teaches us that God is sovereign over our lives. This contradicts the idea that we humans are in control of our lives and makes it much more difficult to argue that we should control the circumstances of our death as an extension of controlling our lives. As well, God made us stewards of our lives not owners, which is affirmed in Deuteronomy 32:39 when God said, “There is no God besides me. I put to death and I bring to life.” God is not only sovereign over life, but his sovereignty extends to death as well. The Bible teaches that God gives and takes life, and it is not a decision rightly ours to make (see Psalm 104:29).

B. ESCAPE FROM A LIFE OF SUFFERING

It is natural to want the joy of living without sorrow or pain. If it were legal to choose euthanasia or assisted suicide, people might respond to their fear of pain and dying by controlling when and how they die. Sue Rodriguez, for example, sought permission from



the courts to have a doctor assist her in suicide, once her disease caused her to experience more suffering than she was willing to accept.

With advances in palliative care and end-of-life treatment, pain and suffering can be mitigated by medication and treatment. Palliative care provides comfort, care and nurturing, to ease people during the departure from this life into the next. Palliative care welcomes family and friends in coming together in support and to remember a life lived. Gathering around a loved one is an important part of the process of grieving and coming to terms with death.

As Christians, we believe that God is able to sustain us and bring us through our suffering. In 2 Corinthians 4:17 it says, “For our light and momentary troubles are achieving for us an eternal glory that far outweighs them all.” Suffering may be real, but in it, God gives us the strength to endure. Sometimes we experience suffering in order that we might give glory to God when he provides a miracle, for instance when Lazarus died and Jesus brought him back to life. Sometimes God allows us to suffer in order for the growth and development of our character, and sometimes we do not know why we suffer, as Job, who never learned the reason for his troubles. What we do know for certain is that suffering is a part of life, and that God is able to turn suffering into blessing, not only for the suffering individual but for many around them.

C. LOW QUALITY OF LIFE

Quality of life has come to be associated with the welfare of the individual in terms of satisfaction, contentment, happiness, social harmony and fulfillment. Today, quality of life is synonymous with autonomous living — can the person feed and look after him or herself? “Autonomy” and “quality of life” are used to further the



argument for euthanasia. These are the measures used to condemn babies with disabilities to death because they would never have a high quality life. This dangerous view of quality of life can be used to suggest euthanasia for the mentally or physically disabled as well as the elderly.

As Christians, we know that all people are of equal worth and value in the eyes of God, because he formed each of us and knew us before we were born. Created by God, our lives have intrinsic worth and an eternal purpose. Proponents of euthanasia advocate that older people should end their life when they are no longer socially useful or are no longer able to enjoy life as they once did. The Bible suggests that old age is something to look forward to: “Honour your father and mother, so that you may live long.” (Exodus 20:12). The very notion of quality of life exists only at a subjective level, and as such no one, whether a parent, spouse, caregiver, or physician, can evaluate another person’s quality of life.

D. BEING A BURDEN FOR RELATIVES AND SOCIETY

The Bible teaches that older people are of great significance and importance, and that older men and women should teach the younger men and women, so the younger generation will be well equipped to face the challenges of life. However, the tendency today is to assert that children have a right to their own lives, and therefore that when parents are no longer capable of looking after themselves, they should not become a burden to their children. This argument is becoming increasingly prevalent in Canada as the aging population continues to grow without a corresponding growth in the younger generations. In general, people are living longer, and as a result, there is increased pressure on already scarce medical and social service personnel and facilities. Proponents of euthanasia argue that the enormous cost of caring for elderly citizens will call for “[a] larger and larger tax-bite from a smaller and smaller



group of taxpayers.” Some argue that if these individuals have already enjoyed a long life, why should large sums of money be spent to prolong their lives artificially?

In 1 Timothy 5:4, Paul said to Timothy, “...if a widow has children or grandchildren, these should learn first of all to put their religion into practice by caring for their own family and so repaying their parents and grandparents, for this is pleasing to God.” The fifth commandment says “honour your father and mother.” This implies some responsibility for looking after them in their old age. God, therefore, considers it an important role and responsibility for us to care for family members and the needy in society, including the elderly, orphans, widows and the sick.

The Bible places significant value on the elderly because they are to be wise mentors and teachers for the younger men and women around them. Especially in today’s fast paced society, learning not to resent the claims on our time and energy is likely to be the work of a lifetime. If we decline to learn the lesson, however, we cease to live in the kind of community that deserves to be called a family, and we are ill prepared to live in the community for which God has redeemed us — a community in which no one stands on the basis of his or her rights, and all live by the shared love Christians call charity.²⁷

E. AUTONOMY/INDIVIDUALISM

Today a great deal of emphasis is placed on personal autonomy, and “secular humanists... assert that the rights of the individual are paramount and that a person has a right to choose the time and nature of their own death.”²⁸ Combined with the utilitarian view that the value of life is based on what one can contribute to society, euthanasia would seem to be a reasonable and logical option when one no longer has a “valuable” life.



For the Enlightenment and its adherents what makes us human is autonomy — the ability to make a decision and act. But this is its very weakness, since — if we're honest — none of us is fully autonomous... ever. The autonomous human person is a theoretical construct at best and, when it comes down to it, little more than a delusion.²⁹

There is a tension between community and autonomy but it is community that “promotes mutual care, concern, and support between persons. The government and society promote community when they prevent harm to the weak and vulnerable — for example, by stopping suicides — not out of paternalism, but as a fulfillment of our obligation to protect, care for, and love one another.”³⁰

Humans are born dependent on others for their care, and as they mature, they in turn provide care for others, and toward the end of life, are once again, recipients of care. Virtually our every act throughout life is done in community. How can anyone then claim to reject community and claim autonomy when it concerns the timing and method of one's death? And since euthanasia and assisted suicide both involve aiding another person to hasten his or her death, isn't that more an argument for involving community, than for autonomy and individualism?



Endnotes

¹ All biblical quotations are taken from the NIV unless otherwise noted. The Thompson Chain-Reference Bible, New International Version. Copyright 1983 by the B.B. Kirkbride Bible Company, Inc. and the Zondervan Corporation.

² Catholic Health Association of Canada, *Euthanasia* (2004) [brochure].

³ *Rodriguez v. Canada*, [1993] 3 S.C.R. 519.

⁴ Law Reform Commission of Canada, Report No. 3 “Our Criminal Law: (1976), p. 16. Emphasis added.

⁵ “The decriminalization of attempted suicide, in 1973, did not have the effect of legitimizing suicide or of creating a true “right” to suicide in the classical sense of that word. The Commission feels that suicide remains an act which is fundamentally contrary to human nature.” Law Reform Commission of Canada, Report No. 28, “Some Aspects of Medical Treatment and Criminal Law” (1986), p. 13.

⁶ Note 3.

⁷ *Rodriguez*, [2001] 1 S.C.R. 3.

⁸ A study on medical decisions to end life in the Netherlands estimated that 0.8 percent of all deaths per year were the result of intentional life terminating acts without an explicit and persistent request from the patient. In the 1990 when the total number of deaths was 128,786, this represents approximately 1,030 persons.

The study also indicated that in another 13,522 cases a decision was made to increase dosages to alleviate pain and symptoms which involved the risk of shortening the patient’s life where the patient was not consulted. As well, in at least 12,494 cases, treatment was forgone which would have prolonged life without the patient being consulted. The study was published in *The Lancet* vol. 338: September 14, 1991, pp. 669-674.

⁹ Orville R. Endicott, “Legalizing Physician-Assisted Death: Can Safeguards Protect the Interest of Vulnerable Persons?” Prepared for the Council of Canadians with Disabilities under the sponsorship of the Canadian Bar Association “Law for the Future Fund” (2003), p. viii.

¹⁰ J.H. Groenewoud et al., “Clinical Problems with Euthanasia and Physician assisted-suicide in the Netherlands,” *Massachusetts Medical Society* (2000): 552.

¹¹ Wesley J. Smith, *Forced Exit* (Dallas: Spence Publishing Company, 2003) p. 133–134. *Globe and Mail*, September 30, 2005 A11.

¹² *Globe and Mail*, September 30, 2005 A11.

¹³ J.H. Groenewoud et al., p.558. Note 10.



¹⁴ Francois P. Retief and Louise Cilliers, “Medicina Antiqua: Poisons, Poisoning and Poisoners in Rome,” (2001) http://www.medicinaantiqua.org/uk/sa_poisons.html.

¹⁵ *Rodriguez*, p. 582 and 608. Note 7.

¹⁶ Orville R. Endicott, p. iv. Note 9.

¹⁷ Mark Pickup, Address to the 2005 U.S. National Right to Life Prayer Breakfast, Bloomington, MN, June 17, 2005. <http://www.humanlifematters.com/june17prayer.html>

¹⁸ Statistics Canada, *Family Violence in Canada: a statistical profile 2005*, reports that in 2003, 46 percent of violent crimes against seniors were by family members.

¹⁹ Balfour M. Mount, M.D., “Palliative Care of the Dying, Care for the Dying and Bereaved, ed. Ian Gentles (Toronto: Anglican Book Centre, 1982), pp. 7, 18.

²⁰ Senate of Canada, Final report of the Subcommittee to update “Of Life and Death” of the Standing Senate Committee on Social Affairs, Science and Technology, *Quality End-Of-Life Care: The Right of Every Canadian*, June 2000. http://www.parl.gc.ca/36/2/parlbus/commbus/senate/Com-e/upda-e/rep-e/repfinjun00_e.htm#THE%20SUBCOMMITTEE'S%20CONCLUSIONS

²¹ Matt. 25:36. Note 1.

²² This is the subject of debate in some provinces.

²³ Wesley J Smith, p. 316. Note 11.

²⁴ Senate of Canada, Senate Committee on Euthanasia and Assisted Suicide, *Of Life and Death: Report of the Special Senate Committee on Euthanasia and Assisted Suicide*, (Ottawa: Ministry of Supply and Service Canada, 1997), 17. http://www.parl.gc.ca/common/Committee_SenRep.asp?Language=E&Parl=35&Ses=1&comm_id=6

²⁵ Jane Campbell, *Get A Life!-Euthanasia and human value*, Independent Living Institute (12 May 2005) <<http://www.independentliving.org/docs6/campbell20030526.html> >[26 May 2005].

²⁶ Exodus 20:12. Note 1.

²⁷ Dr. H. Robert C. Pankratz and Dr. Richard M. Welsh, *A Christian Response to Euthanasia* (2001) <http://www.tkc.com/resources/resources-pages/euthanasia.html>.

²⁸ National Public Affairs Office Campaign Life Coalition, *Euthanasia and Assisted Suicide: A Briefing Book for Canadian Legislators*, (2004), p. 2:1. http://www.campaignlifecoalition.com/documents/Euthanasia_Briefing_Book.pdf

²⁹ Russ Kuykendall, *The Burkean Canuck*, <http://burkeancanuck.blogspot.com/2005/03/imago-dei-autonomous-person-and-value.html>, March 24, 2005.

³⁰ Wesley J. Smith, p. 7. Note 11.





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efc@efc-canada.com • www.evangelicalfellowship.ca





EFC

The Evangelical Fellowship
of Canada

M.I.P. Box 3745, Markham, ON L3R 0Y4
Tel: (905) 479-5885 • Fax: (905) 479-4742
efc@efc-canada.com
www.evangelicalfellowship.ca