**MINUTE FROM 19TH SYNOD IN 1996**

## *SYNOD BIO-ETHICS COMMITTEE*

It was resolved -

That the Synod -

***96.100*** ***(a)*** Receives the report of the Synod Bio-Ethics Committee, (Volume 1, pp 47-53); and the Supplementary Report (Volume 2, p 51)

(consensus)

***(b)*** Recommends the report, "A Christian Ethical Response to Euthanasia", as a contribution to the discussion on euthanasia within and beyond the Synod;

(consensus)

***(c)*** Informs the Department for Community Service about its opposition to the legalisation of active voluntary euthanasia and encourages Divisions to use the Report as the basis for ongoing discussions and policy making with staff and volunteers; and

(formal majority)

***(d)*** Requests the Moderator to -

***(i)*** inform the State Attorney General of the Synod's opposition to the legalisation of active voluntary euthanasia; and

***(ii)*** request the State Health Minister to prepare and distribute appropriate guidelines which affirm the right of patients to refuse treatment and not to expect the active intervention by medical and associated staff to end their lives.

(formal majority)

**REPORT RECEIVED BY THE 19TH SYNOD IN 1996**

**APPENDIX I**

# SYNOD BIO-ETHICS COMMITTEE

# "A CHRISTIAN RESPONSE TO EUTHANASIA"

### 1. Context and Methodology

The ethics of euthanasia has been a constant, though not always prominent, concern of Uniting Church ethicists, health care staff and agencies since Union. Policy making in the councils of the church has generally been confined to individual submissions and enquiries (for example, assignments for theology and ethics courses), discussion groups within Presbytery and Parish Social Responsibility Committees, and forums within the Department for Community Service. The passing of legislation in the Northern Territory (the Rights of the Terminally Ill Act 1995) - and the consideration of similar proposed legislation in South Australia, New South Wales, and the ACT - has brought the issue firmly to the forefront of ethical discernment and debate, both amongst UC agencies' staff and within parishes.

The Moderator issued a statement on May 26th, 1995, in response to the passing of the Northern Territory legislation on euthanasia. The statement was circulated through UC Information. In it, he said:

"The legalisation of euthanasia should not be seen or used as a quick fix to the complex question of dying with dignity. The euthanasia debate raises a complex network of issues - medical, legal, sociological, personal, religious and ethical. Our first responsibility, as Christians, is to recognise this complexity by being suspicious of instant simple answers. Our second responsibility is to locate and identify the specifically ethical questions within this debate...Participation by patients (and those supporting them) in decisions about medical treatment is an important part of respecting people's dignity - and is a crucial principle to remind ourselves in all areas of our caring. I am not convinced that there has been a sufficient exploration of the significance and implications of palliative care, technological change and human dignity which precede the major legal discussions of authority and procedure."

The Committee has tried to draw upon the expertise and experience of its members, as well as gather submissions from parishes, agencies and individuals, in the preparation of this report.

## 2. Theological and Traditional Insights

The committee looked for insights from Christian theology and tradition to undergird policy principles that could be expressed in a commonly-understood manner in the broader society. In pursuing this task, we felt the need to contribute something from the distinctive tradition and ethos of the Uniting Church, rather than merely provide another sampling of opinion from the general community. Consequently, the committee identified some initial principles for applying the New Testament ethic to the dilemma of euthanasia:

**(a)** To define love as the will to act out of one's total concern for the total good of the other;

**(b)** To make the best possible decision that one can in response to God's demand for integrity and faithfulness to one's duty;

**(c)** To understand that when we decide that we ought to act in ways which fall short of the full demands of love, we do so on our own responsibility, not God's;

**(d)** Having done what we must do, having done all we can do, we still know we fall short of God's perfect will for us, and that we must rely on His grace (undeserved loving-kindness);

**(e)** To act and live in the spirit of Micah 6: 8 - to do justly (to do what is right and fair), to love mercy (to share Christ-like compassion), and to walk humbly with God (to live in the presence of the all-pervading spirit of the Redeemer and Creator God).

These principles are permeated by a sense of solidarity and empathy - that is, a desire to enter into and identify with the experience of those who are suffering and vulnerable. The challenge in applying these principles involves hearing those who seek euthanasia, but also understanding the vulnerability of those who might be endangered by any legislation allowing euthanasia. We noted the advocacy commitment of the Uniting Church Community Services Australia which stated: In its social action, the Uniting Church stands alongside and in solidarity with those who suffer in any way and seeks to restore and empower those who fall within its influence. (CSA Foundation Document Section II - Page 3)

The Committee recognised early in its deliberations that some significant theological reflection needed to be done to make the connection between such initial principles and a Christian ethical response to euthanasia which might emerge theologically from such principles. The Committee noted that particular attention needed to be given to the relevant theological questions of -

- the Christian view of human life and the so-called `sanctity of life';
- the meaning of freedom (especially in light of the heavy emphasis placed upon the `voluntary' component of this action);
- from whose perspective should one enter into situations of extreme suffering? (in other words, to what extent can the voices of those who are suffering in this situation be deemed authoritative in ethical deliberation?)

The Committee was alerted early in its deliberations about the danger of falling quickly into an understanding of, or approach to, ethical decision-making which ignored the communal and relational dimension of human life. It would be very easy for our monthly meetings to become preoccupied with

discussions of the ethics of particular `hard' decisions of individual cases. Rev Dr Chris Budden has written:

The Christian tradition has generally held that we are essentially social creatures, that community is not accidental and does not arise simply as a way for selfish people to gain what they cannot on their own. We are only properly human as we are social, communal creatures - in relationship to God and to other people. Community is one of the ways in which God continues to sustain human life.

Budden asks the questions, arising from this supposition:

What impact would support for euthanasia have on the fabric of society? How would it impact on the basic assumption of society that medical practitioners do not kill people? What vision of society, and the place of the weak and vulnerable in that society, would we be supporting? What would we be saying about the way we see those who are sick, old, or unable to control their bodies and the way they should see themselves?

Will the ethos created by euthanasia tend towards the `duty to die'? Will we signal that those who are a burden to society have a duty to die and not be a burden. For example, there is some indication that women are more likely to access euthanasia than men. Is this because women are more likely to see themselves as a burden? The social context in which elderly people see their lives is often one of doubt and uncertainty about their future and about their being a significant burden on their relatives or on society? If euthanasia is an acceptable option, will they feel pressure to take it? (SR & J Document No. 96.23, p. 5)

The Committee moved from this particular understanding of the ethical context of the Uniting Church's tradition to articulate the implications of an ethic of responsible love: how does the church uphold and explore a caring justice in its ministry with the sick, the elderly, the disabled and the alienated? In responding to this question, the Committee noted the comments by one of its members, Rev Dr Gordon Watson, in his lecture, "The context of Christian ethics", to the Presbytery of Brisbane in April:

...Christian ethics is first of all and primarily not concerned with justice, though Christians obviously seek justice, but rather their primary concern is to be faithful disciples of Jesus Christ. This may entail that Christian ethics, instead of making Christians functional within the mores of liberal democracy, will make them dysfunctional! (Lecture No. 1, p. 7)

Thus, in trying to express a Christian ethic within, and emerging from, the context of human dying, the Committee is challenged, alongside the rest of the Church, to aspire to greater maturity in the Christian life. Christian maturity, writes Watson, can be defined as "the integrity of relationships within the koinonia which allows each member to be who they are in relationship to Christ and to each other." (p. 9) Who we are in relationship to Christ is, of course, characterised by a distinctive understanding of death and dying which is illuminated by the light of Christ's redeeming action. In this regard, Rev. Ann Wansbrough (from the NSW Synod Board of Social Responsibility) writes that:

The redemption which Christ offers us does not take away physical death. Rather it takes away the fear of death - we know that in death we are in the hands of a God of love and mercy, and do not need to fear death. We believe that physical death is not the end, and therefore do not need to cling to this life when the time has come to die." (from the BSR discussion paper, Euthanasia - Hearing the People in the Situation, Understanding the Dilemmas)

Rev Ian Kerr (from the Presbytery of Central Queensland) made similar points at an ecumenical forum in Rockhampton:

Certainly Christian faith urges us to be life-affirming because God created life and each life has a unique purpose in God's plan for the universe. Indeed each life is profoundly loved by this Creator-God. On the other hand, the Christian believes death is not the great end point to our individual lives. Our physical lives come to an end; but not the real person who inhabits these earthly bodies!

Of course this Christian convictions is based on faith which cannot be proved conclusively to others. But this Christian conviction of life beyond death is not based on wishful thinking or self-delusion. Christians interpret the Easter experience of Jesus' resurrection as also a sign that they too

will be raised from death to a new, spiritual life in the nearer presence of our loving God. The apostle Paul expressed it this way. "No wonder we do not lose heart! Though our outward humanity is in decay, yet day by day we are inward renewed - provided our eyes are not on the things that are seen, but on the things that are unseen; for what is seen is transient, what is unseen is eternal. We know that if the earthly frame that houses us today is demolished, we possess a building which God has provided - a house not made by human hands, eternal and in heaven." (2 Cor.4:16,18, 5:1)

"Therefore, in the debate on euthanasia, the Christian can confidently claim death is not the worst thing that can happen to a person. Life does not need to be preserved at all costs. And especially Christians need to give positive content to death and eternal life. Through death one is released from those damaged bonds of the flesh and set free for life with God, a life of love and growing fulfilment.

"Perhaps the question needs to be asked whether the development in modern medical technology that can keep "brain dead" people breathing artificially is the product of a society that is terrified in letting go of life and greeting the God who comes to us in death."

**3. Definition of terms**

Active voluntary euthanasia - the giving of treatment, on considered request by the patient, with the aim of hastening the death of the patient.

Patient assisted suicide - the making available to patients the means which they can use, if and when they so choose, to end their own lives.

(Peter Baume in "Voluntary Euthanasia - Mercy or Sin?", New Doctor, Winter 1995, p. 13)

Hospice and palliative care - "a concept of care which provides coordinated medical, nursing and allied services for people who are terminally ill, delivered where possible in the environment of the person's choice, and which provides physical, psychological, emotional and spiritual support for patients, and support for patients' families and friends. The provision of hospice and palliative care services includes grief and bereavement support for the family and other carers during the life of the patient and continuing after death." (The Australian Association for Hospice and Palliative Care - quoted in Roger Hunt, "Palliative Care - the Rhetoric-Reality Gap", in Willing to Listen, Wanting to Die, ed. by Helga Kuhse, Penguin, 1994)

Non-voluntary euthanasia - when a patient cannot give consent to having his or her life terminated because he or she is physically and/or mentally unable (e.g. unconscious, stroke victim, or person with dementia).

Involuntary euthanasia - when the act of euthanasia is in direct contravention to the patient's wishes.

Advance directive - a written instruction, such as a living will, describing the medical care a person would want in the event that he or she became unable to make and/or communicate their own health care decisions. Living wills are currently not legally binding anywhere in Australia.

**4. What are the key ethical questions which the church needs to address?**

**What are the issues confronting our Community Service agencies?**

In the categorisation of six levels of medical intervention (listed below), there seems to be greatest ethical contention over numbers 5 and 6. The first four are sometimes described as `passive euthanasia' - that is, the act of withholding or withdrawing treatment so that the patient's life is not prolonged -

**(i)** turning off a life support system (e.g. a ventilator);

**(ii)** discontinuing feeding and hydration for a comatose patient;

**(iii)** withholding, at a patient's request, treatment that can extend life but not cure the ailment;

**(iv)** providing pain relief knowing that the treatment or medication might hasten death;

**(v)** patient given means to kill themselves;

**(vi)** doctor administering a lethal injection at the patient's request.

Some members of the Committee felt that the distinction between `active' and `passive' was not as clear-cut nor as helpful as is often assumed in schematic representations of the ethics of euthanasia. The distinction between, for example, switching off a machine and increasing a drug dosage has sometimes been addressed by the so-called law of `double effect' whereby it is asserted that an action may have two consequences, the first an `intended' consequence and the second an `unintended' consequence. The Committee recognised that the common usage of such terminology could be helpful in addressing the overall situation, but limited in its capacity to communicate the complex ambiguities of every case study.

The crux of the matter appears to rest within the disagreement amongst health care practitioners, ethicists, and religious leaders about the extent to which pain can be controlled. For example, on the one hand Cardinal Clancy (the Roman Catholic Archbishop of Sydney) has written that "the science of palliative care has, in our day, achieved such sophistication in controlling and reducing pain that in most cases pain is no longer a significant problem." (The last right?, ed. by Chapman and Leeder, 1995, p. 46) On the other, Michael Car-Gregg, Founder of CanTeen (the Australian Teenage Cancer Patients Society), has written that "I am yet to meet a physician who can categorically state that all terminal pain can be controlled." (The last right?, 1995, p. 36) The Australian Association for Hospice and Palliative Care, in their draft policy statement on voluntary active euthanasia, have acknowledged that "while all pain and symptoms can be treated, complete relief is not always possible in all cases, even with optimal palliative care."

Beyond this significant debate (which requires further investigation and education), however, are repeated calls for palliative care to be improved, made more available (especially in regional and remote areas), and more greatly understood by the wider public. Dr Peter Ravenscroft, a medical expert in palliative care, has said that "The care of the dying is the responsibility of the whole community, not just the health professionals and those with a special interest." Dr Elizabeth Hepburn, Director of the Queensland Bioethics Centre and a Loreto Sister, has also noted that "palliative care seems to be a more compassionate and beneficient practice than euthanasia. It is also more demanding since it requires a commitment to journeying with the patient rather than simply offering a way out, a `final exit'." (Life and Death, Melbourne: Dove Publications, 1996, p. 42)

Jennifer Fitzgerald, an advocacy worker with Queensland Advocacy Incorporated, has reflected on this `journeying' in relation to people with a disability. She writes:

Our immediate understanding of, and willingness to assist with, a person with disability's wish to die is often actually the cause of their desire. Instead of euthanasia being a powerful act of self-determination, I believe it can also be seen as an expression of extreme powerlessness against a State or society which is unresponsive to its citizens' needs...As a community, we need to go beyond autonomy. We need to understand why a person wishes to die. And if, as a community, we have contributed to that desire, we need a much more appropriate response than assisting them to kill themselves. ("Legalized Euthanasia: Its Implication for People with Disability", April 11, 1996, p. 7)

In relation to palliative care, the Moderator, at the request of the Council of Synod (Minute 95.47.2), wrote to the State and Federal Ministers for Health urging (a) that an increased range of palliative care services be made accessible and affordable to all in the community; and (b) that increased resources be made available for specialist training in palliative care for health care professionals.
The Council of Synod also encouraged -

**(a)** appropriate agencies of the Uniting Church to prioritise the importance of palliative care in their strategic planning with regard to local needs and resources;

**(b)** members of the Uniting Church to offer strong pastoral support for doctors, nurses, chaplains and others who care for terminally ill patients and their relatives and friends; and

**(c)** the Committee to explore some of the ways in which the Uniting Church can give appropriate pastoral care to people who express a preference for active voluntary euthanasia in particular circumstances (95.47.3).

**5. What is the legal situation in Queensland and the rest of Australia? What law reform options are being considered?**

The revised Queensland Criminal Code, which was passed by Parliament in 1995 and was to have come into effect in 1996, attempted to give doctors and nurses increased protection (under section 82) against criminal charges if patients died during medical treatment. Section 82, according to the State Attorney-General's department, would not excuse a doctor who performed active euthanasia. At the time of the Criminal Code Bill's passage through Parliament, the then Attorney-General read into the record of Parliament a statement which declared that the Government was not introducing a euthanasia provision. This statement would have been used in the interpretation of section 82.

The revised Criminal Code also contained the offence of aiding suicide (section 108) as well as a provision that the consent of a person to the person's own death does not affect the criminal responsibility of another person who causes the first person's death (section 101). It is not entirely clear why the Goss Government abandoned an earlier draft provision in its proposed Criminal Code which stated, in somewhat more clearer terms that: A person is not criminally responsible if he or she gives such palliative care as is reasonable in the circumstances for the control or elimination of a person's pain and suffering even if such care shortens that person's life, unless the patient refuses such care.

The change in State Governments has put the revised Criminal Code on hold. While the Goss Government elaborated in some detail its intentions regarding the revised Criminal Code, there remained a number of specific legal and ethical issues within the legislation that needed further examination - especially given that there were complementary pieces of legislation planned to accompany its implementation in 1996. For example, what constitutes "benefit for the patient" of the cessation of treatment (for example, stopping nutrition or hydration) requires further examination, preferably by someone well versed in Criminal law.

Other Australian states (at the time of writing) also make it an offence to assist a dying person to commit suicide and/or to intentionally kill a dying person. The public debate about whether people have a legal `right' to die continues. However, some states make a common law provision for a person appointed by a patient to make decisions about treatment, including refusing treatment, if and when they become incompetent to make these decisions for themselves. The role and future of these so-called `advance directives' needs greater consideration.

Some options for law reform have been presented as follows -

- No change in the law, that is, retaining the act as criminal and punishable accordingly;
- Retaining mercy killing as a criminal offence with modifications (i.e. making mercy killing a defence reducing the charge from murder to manslaughter or creating a separate offence of mercy killing - in both instances, euthanasia is still regarded as a crime);
- Decriminalise euthanasia in certain circumstances (in order to protect doctors from criminal prosecution for practising euthanasia in certain circumstances, where specific requirements have been met and to protect those most vulnerable from exploitation) (an extract from the Royal College of Nursing's paper "Euthanasia: An Issue for Nurses" in New Doctor, Winter 1995, pp. 19-23).

Most members of the Committee have argued that there is a sound case for legislators to be conservative on this issue - as have other churches in Australia. The Anglican Primate of Australia after the passing of the Northern Territory legislation warned that: I think we need to look down the years and see the way in which the killing of the ill shall extend. The NT legislation has also been criticised by the National Assembly of the Australian Conference of the Leaders of (Catholic) Religious Institutes.

They noted, at their July 7th meeting in 1995, "that the bill was passed in a Territory where palliative care and hospice services are virtually unavailable, and where the services of only an occasional visiting oncologist are provided." (quoted in National Outlook, September 1995, p. 21) The task of drafting a euthanasia law with adequate safeguards appears extremely difficult. Practitioners of palliative care have pointed out that the law is "a blunt instrument and unsuited to regulate the highly personal dimensions of the doctor-patient relationship." ("Euthanasia and Palliative Care", Anglican Diocese of Brisbane SR Committee, p. 5) There is also a real fear that such legislation

would have the effect of `normalising' euthanasia, so that euthanasia would eventually become a routine procedure rather than something reserved for the most extreme situations (Elizabeth Hepburn, 1996, p. 52). Whatever the outcome of the challenges to the Northern Territory Legislation, the Uniting Church (Qld Synod) should continue to monitor the proposals of legislatures in States and Territories around Australia. Although this would necessarily be a responsibility of the national Assembly, there are implications for Queenslanders who may wish to travel interstate to avail themselves of particular legislation.

## 6. What have other churches/councils said and done?

The Executive of the National Council of Churches in Australia, at its meeting of 24-25 July 1995, issued the following public statement which was subsequently endorsed by the heads of member churches:

The churches recognise that there is considerable community debate and discussion about euthanasia. We recognise that there is in Australian society a wide range or meanings attached to the tern euthanasia and thus there is considerable confusion of views. We recognise too that most families have experienced grief at the suffering of a loved one. We share in the concern of all Australians seeking to love and care for and alleviate the suffering of the terminally ill.

The churches affirm the following principles as they apply to euthanasia -

**(a)** Euthanasia - understood as deliberately causing the death of a terminally ill person in order to bring that person's suffering to an end - we reject as contrary to God's law and the values of a civilised society.

**(b)** Life is a gift from God and as such is to be cherished; it should be the primary intent of law to sustain and enhance life, not to destroy it.

**(c)** Dying is an integral part of the cycle of life and death; while we naturally cling to life, at some point death must be accepted as inevitable.

**(d**) The withdrawal of excessively burdensome or futile medical interventions does not constitute euthanasia; to describe it as "passive euthanasia" causes confusion in the public debate.

**(e)** Optimal palliative care should be available to all people regardless of their age, or economic or social circumstances. Economic expediency, must not become the occasion for the introduction of euthanasia.

**(f)** People should never be made to feel they are a burden, that they have a "duty to die" and that they need to take measures to cause their own death.

To condone the deliberate killing of the most vulnerable is potentially to risk the status of all human life in our community.

We therefore urge the parliaments of Australia to show commitment to their people by opting for care, not killing, and to resist any moves to substitute euthanasia for effective palliative care.

## 7. Summary Statement

At this stage, the Queensland Synod Bioethics Committee is agreed that active voluntary euthanasia and patient assisted suicide present substantial moral problems. It recognises the dilemmas and stresses facing many caring staff employed in Uniting Church agencies, as well as the distress often experienced by the sick, the infirm, the disabled and their loved ones. While some members of the Committee acknowledge that there are individual cases in which active voluntary euthanasia may be appropriate, such cases do not readily form the basis for the legalisation of euthanasia in Queensland at this time. The Committee is committed to monitoring any changes in legislation proposed by the Queensland Government or individual Members of the Legislative Assembly to ensure that the processes of consultation and the establishment of safeguards are both rigorous and compassionate. There was a consensual position within the Committee in opposition to the practice of involuntary euthanasia.

**July 1996**