The Executive Council has recommended this resolution be considered in the study process established by the Twenty-sixth General Synod in the resolution, “Legalization of Physician Aid in Dying (07-GA-37).

In Support of Physician Assistance in Dying

(A Resolution of Witness)

Submitted by: The Central Atlantic Conference

Background
There is nothing idyllic about dying. It is often bound up with pain, being alone, anxiety, anger, helplessness, resignation, denial and despair. Individuals who are dying slowly often go through severe, unrelenting and intolerable physical discomfort or pain, and laws prohibiting physician assistance in dying have the effect of forcing them to endure that suffering. These conditions clearly affect attitudes about living and dying.

Suffering is just a word until it happens to you or to someone you love. We can afford to theorize about death when it is not immediately before us. Suffering is one thing when it is an abstraction, but quite another when it is our own.

In a Harris Interactive Poll conducted in April 2005, 70% of the American public indicated their support for assistance in dying. In a poll of 1,000 physicians, conducted by the Finkelstein Institute and HCD Research in February 2005, 57% of those polled believe that it is ethical to assist an individual who has made a rational choice to die due to unbearable suffering.

The claim is sometimes made that a terminally ill person who elects to take lethal medication is not acting freely, but is responding to a variety of subtle pressures (from family members or society; concerns may be financial or otherwise). However, the terminally ill patient who is considering a hastened death by refusal of life support is just as vulnerable.

It is often the fortunate patient who can tell physicians to “pull the plug” - - for those who do not have a plug, assistance in dying is the humane and ethically equivalent solution.

Some people have difficulty in accepting physician assistance in dying since they feel this amounts to suicide, which is condemned by their religious beliefs. But, doesn’t the person who can legally ask to be unhooked from a ventilator or feeding tube, knowing that he or she will die, in effect commit suicide? The word “suicide” is incorrectly used when applied to dying patients. A terminally ill patient who asks for medicine to help him or her die does not initiate the dying process. It is already underway and death cannot be prevented.

“Terminal sedation” is a procedure doctors legally use whose primary purpose is to relieve the suffering of a dying patient. With terminal sedation, the suffering patient is sedated to unconsciousness and all life-sustaining interventions, including nutrition and hydration are withheld. Generally, the patient then dies of dehydration, starvation, or some other intervening complication. Although death is inevitable, it usually does not take place for days or even
weeks, depending on clinical circumstances. In the opinion of many, this is no different than a physician writing a prescription for a lethal dose of barbiturates for a terminally ill patient.

With respect to the argument that human life is sacred, and therefore should not be snuffed out under any circumstances, there is the counter argument that it is a desecration to needlessly let a dying human being continue to suffer. We must sanctify life to its natural end, but when we use medical technology to extend lives beyond their natural ends we must be careful of what we sanctify.

Dying is one part of the normal life process. That we die is certain. When and how we die is not. An individual on the threshold of death no longer has a choice between living and dying, but only the choice of how to die. We die only once, so we should choose to die well.

Some say that suffering is ennobling, as a way God sometimes tests and educates us (a sharing in Christ’s passion and a union with the redeeming sacrifice which he offered), and is a natural part of dying that prepares the soul for the afterlife. These individuals would argue that only God should select the moment of death. But, perhaps, they need to ask two questions: Do they believe in a loving God? Do they believe their loving God would want them to suffer like that? The clear precedent of Jesus’ countless efforts to alleviate suffering through his healing ministry, makes clear that there is no obligation incumbent upon us to endure suffering for its own sake.

It does not seem to be fear of death itself, but fear of what one might experience before death that terrifies most individuals who are terminally ill. Experiences of late-stage terminal illness include such things as panic attacks, loss of autonomy, severe body wasting, intractable vomiting, urinary and bowel incontinence, general lack of bodily control, failing memory, difficulties coping with domestic chores, the inability to eat/speak/or read, total dependence, and no longer being able to recognize or interact with loved ones. Plus, the fear of lingering on, fear of bankrupting one’s family with medical costs, fear of burdening others, fear of abandonment, fear of the unknown, etc. These things clearly affect dignity, self-respect and personhood, and collectively contribute to questions about the meaning, value and purpose of life. They are recognized as more important than pain in the desire for a hastened death.

In November 1997, Oregon became the first State to adopt a physician assistance in dying law. As of the end of the year 2007 (more than ten years after the law took effect), there have been only 341 cases of physician assistance in dying (there were 49 deaths in 2007; that equates to 15.6 Death With Dignity Act deaths per 10,000 total deaths). Oregon has very specific guidelines in place to regulate the practice of physician assistance in dying. In short, physician assistance in dying is presented as an option that no one need exercise - - it remains a matter of individual choice. A decision to live may be the direct result of having the option to die. So, in Oregon, a prescription for a lethal dose of barbiturates is a dying patient’s security blanket.

A study published in October 2007, in the Journal of Medical Ethics found physician assistance in dying does not lead to a “slippery slope” that disproportionately affects vulnerable people. The report debunks opponent arguments that claim the law targets at-risk groups. Drawing on the experiences in Oregon and Netherlands, where the practice is legal, the five researchers
concluded that there was no evidence of heightened risk for the elderly, women, the uninsured, persons with low educational status, the poor, racial or ethnic minorities, or the disabled.

In general, the studies from Oregon portray the individuals opting for assistance in dying as very concerned about loss of independence and control over their lives. The Oregon Death with Dignity 2007 report reflected that, of the individuals who chose physician assistance in dying in 2007, all were covered by some form of health insurance, 88% were enrolled in hospice care, 90% were able to die at home, 69% had some college, and cancer was the most common diagnosis in 86% of the cases.

Anonymous surveys suggest that physicians in most states already act at the request of terminally ill patients to speed their death, albeit clandestinely and without regulation. Legalizing the practice could prevent any problems associated with secrecy.

On September 9, 2007, the American Medical Women’s Association announced that it supports the right of terminally ill patients to hasten what might otherwise be a protracted, undignified, or extremely painful death; that it believes physicians should have the right to provide a terminally ill patient with, but not administer, a lethal dose of medication so that the patient can hasten his/her death. The Association also supports the passage of assistance in dying laws, such as that passed in Oregon, which empower mentally competent, terminally ill patients and protects participating physicians.

On March 25, 2008, the American Medical Student Association adopted an aid in dying policy which states: “Terminally ill, mentally competent patients should have a measure of control over their death when faced with suffering which the patient finds intolerable. Doctors should have the right to provide such a patient with the means and/or knowledge to use medication to bring about a peaceful death.

**Theological Statement**

God intends that created life be more than simply the existence of a human organism. The Gospel of John reports Jesus as saying, "I came that you might have life, life in all its fullness," (John 10:10). Life is also a perishable gift. Mortality is universal. There is a time to be born and a time to die.

When medical science shifts from expanding the length and quality of life and begins simply to postpone the reality of death, the sacredness of life is no longer being served. Such prolongation may cause unnecessary suffering and/or loss of dignity while providing little or nothing of benefit to the individual.

God’s will does not involve suffering beyond limits of human endurance. It does not honor God to cling to an existence that has become an empty shell. The continuance of a mere physical existence is neither morally defensible nor is it God’s will.

When illness takes away those abilities we associate with full personhood, leaving one so impaired that what is most valuable and precious is gone, the mere continuance of the body by medicine or drugs is a violation of the person.
Many persons, because of their religious beliefs or for other reasons, will choose to draw the last possible breath, no-matter-what. That choice will remain for every person who wants it. Some others, when end-of-life suffering becomes unbearable, will decide that continued existence on earth without hope or meaning is no longer “life in all its fullness,” in fact, it is no longer tolerable. They may ask to have the choice of a peaceful release.

God has granted humanity the right of personal choice, which must include the end of life. The gift of abundant life is more than the avoidance of death, and over-regard for the body, without proper concern for the needs of the person, or the human spirit, can become a kind of biological idolatry. What is required is a balanced appreciation of the whole person. At some point, an individual has the right to die and not be simply maintained.

We are co-creators with God, given free will, and the ability to make compassionate choices. The proposed Resolution, on grounds of compassion and choice, would permit physician assistance in dying to be legal if strict safeguards to prevent abuse are provided.

Since God has made human beings responsible for the very beginning of human life, it is consistent to assume that the same God has made the end of human life a human responsibility. Thus, the principle of the sanctity of human life must yield to the principle of self-determination when someone is terminally ill.

Choosing death with dignity over a life that has become either hopelessly painful and dysfunctional or empty and devoid of all meaning allows us to honor the God in whose image we were created.

The Resolution

WHEREAS life is both a sacred and a perishable gift from God; and

WHEREAS medical technology, pain management and palliative care have made great advances, yet some persons still face intolerable suffering during a terminal illness; and

WHEREAS the purpose of medicine is to alleviate suffering, and sometimes ending a life is the only way to do it; and

WHEREAS by establishing a set of procedures for legal assistance in dying, each State can ensure that only people who are truly terminally ill and of sound mind qualify for physician assistance in ending their lives, and can get out of an insufferable state if it comes to that; and

WHEREAS the crucial question for dying patients is whether they are living or existing; and

WHEREAS if the intent in withholding or with-drawing life sustaining treatment is to cause a merciful death, this purpose can be accomplished faster and more humanely, and at the time of the patient’s choosing, by physician assistance in dying; and
WHEREAS a terminally ill person no more commits suicide in taking a physician prescribed lethal dose of barbiturates then does a terminally ill person who asks to be unhooked from a ventilator or feeding tube, knowing he/she will die; and

WHEREAS life’s very sacredness means that it should not be allowed to linger in suffering or indignity, and that physician assistance in dying can be a greater form or respect for human life’s sanctify; and

WHEREAS it is clear that our loving God would not want anyone to suffer needlessly; and

WHEREAS permitting a hopelessly ill person to die by not imposing extraordinary measures is widely accepted today by religious groups as being part of God’s will; and

WHEREAS physician assistance in dying is a last resort for those few cases in which Hospice care becomes ineffective or unacceptable to dying patients; and

WHEREAS assistance in dying is well within the physician’s role, since resorting to extreme measures to try to keep alive the terminally ill at all costs does not respect the patient; and

WHEREAS denial of physician assistance in dying is, in fact, doing harm, when it perpetuates a patient’s continued suffering; and

WHEREAS in order to restore the balance between a physician’s obligation to prolong life and the obligation to relieve suffering, a peaceful death to end such suffering must be acknowledged as a legitimate goal of medicine and as an integral part of a physician’s responsibility; and

WHEREAS individuals who don’t want physicians to ease their pain in dying are free to follow that path, but they should not be allowed to require anyone else to die a painful, protracted and agonizing death; and

WHEREAS current law, by prohibiting physician assistance in dying, favors those who believe it is immoral, legalization would give equal (not preferential) treatment to those who believe physician assistance in dying can be a principled moral choice.

THEREFORE LET IT BE RESOLVED, that the Twenty-seventh General Synod supports physician assistance in dying, under very specific guidelines as determined by each State, when for an adult patient:

1. who has a terminal/incurable debilitating illness or condition
2. is expected to die within six months
3. who has periods of severe, unrelenting and intolerable physical discomfort or pain, without prospect of significant improvement, which is unacceptable to the patient
4. who is legally competent to make medical decisions and
5. is expressing a voluntary and personal choice to die

FUNDING
Funding for the implementation of this resolution will be made in accordance with the overall mandates of the affected agencies and the funds available.

**IMPLEMENTATION**

Justice and Witness Ministries is requested to implement this resolution.