Death Be Not Proud: Christian Reflections on Physician Assisted Suicide/Euthanasia

Disclaimer: this is an automatically generated machine transcription - there may be small errors or mistranscriptions. Please refer to the original audio if you are in any doubt.

Date: 30 October 2016

Preacher: Rev. Roger Revell

[0:00] Thank you. Good morning to all and to all a good morning. Great to be here again. We need to start with prayer today. We always need to do that, but we especially need it today. As we enter into this discussion, which is live, intense, and personal, deals with issues that get to the very core of what it means to be human, we pray that you would give us your spirit and ground us in the reality of Christ.

We might see you and seek to know your ways and follow in them with hearts that are obedient and joyful. We pray this in Jesus' name. Amen.

There's a handout which is basically an outline. I didn't do a PowerPoint today, did a handout. We can get that to you if you didn't get one. If you're not having a handout, then be a good Christian and share with the person beside you.

So we want to conserve trees and also promote the virtue of sharing. That's why I didn't print a lot of handouts. We've got some ground to cover, so I'm going to make a start and I'm going to keep a brisk pace.

We'll hopefully have a few minutes for questions and discussion at the end. So as you well know, the topic for reflection this morning, I've titled this Talk Death, Be Not Proud, Christian Reflections on Physician-Assisted Suicide, Euthanasia.

[1:23] This is a live and sensitive topic. It's also a topic that brings us to the crossroads between worldviews shaped by the Judeo-Christian inheritance and worldviews which consciously, but perhaps also unwittingly, part paths from the Judeo-Christian inheritance.

In treating this topic, I'm going to try not to take a polemical tone. Flannery O'Connor once said, quote, conviction without experience makes for harshness.

I agree. So if it's possible to be firm and adamant while yet empathic and kind, that's my aim, even if it's achieved imperfectly. Further to this, it is my intention to engage the question in a manner that avoids imputing nefarious motives to those who advocate physician-assisted suicide and those who seek it or request it.

I want to avoid the ad hominem fallacy in the arguments that I wish to make today. On the topic of physician-assisted suicide, which I will hereafter refer to as PAS, to save air and time, we must be ready to recognize that what some humans find merciful and humane, others find deeply troubling and misguided.

But in the same instant, we must also see that sometimes mercy and compassion take forms that are surprisingly and initially unrecognizable to us. I must also acknowledge certain depths for this talk.

[2:50] My remarks this morning represent a synthesis that has been funded by the thoughtful deliberation of many others. The list includes Ellen Weaver, M.D., Professor John Patrick, formerly of the University of Ottawa, Professor Nigel Bigger at Oxford University, Daniel Kalper, a lawyer here in town, and Richard Sandlin, a Ph.D. candidate in philosophy at the University of British Columbia, as well as many journalists and others who have written on this.

I may also say that my work here is a, my rumination here is a work in progress, so I pray that feedback and input that maybe comes from discussion, and would it serve to enrich and propel both my argumentation and my conviction on this topic.

A note on structure. I'm going to begin by giving a brief overview of what's happening with regard to the issue in Canada just now. Then I'm going to highlight key features of the case for PAS. And thirdly, I will offer a response which is critical in nature to the legalization of PAS.

PAS. It's important to note that I have crafted the response in a manner that avoids direct appeal to biblical revelation. Right? That is not, my instincts, of course, are deeply Christian and theological, but the argument I wish to advance is going to avoid direct appeal to biblical revelation.

That is done so as to help us envision and also commend avenues for engaging this issue with those who do not inhabit a biblical and Christian perspective on reality. Introducing the issue.

[4:19] Let me give you a very concise history of the issue in Canada. In 1892, the federal parliament, which has exclusive jurisdiction over matters of criminal law in this country, enacted the criminal code.

In that codification, which reflected prior common law consensus, attempting to commit suicide as well as aiding or counseling suicide were criminalized.

In 1972, the offense of attempting suicide was repealed, but the offense of counseling or aiding another to commit suicide remained in place. That's found in Section 241 of the criminal code.

Concomitant with this, in Canada, it was also the case that you could not consent to death or bodily harm in such situations. That is specified in Section 14 of the criminal code.

That provision, until recently, reinforced the criminalization of euthanasia in all circumstances. Now, this status quo underwent notable alteration in 2015 with the Supreme Court case Carter beat Canada.

[5:23] And in that case, the Supreme Court took issue with the two aforementioned provisions of the criminal code, S14 and S241. The Supreme Court did not strike them down altogether, but found that their application to, quote, grievously suffering people seeking to die was unconstitutional, so that those provisions were of no force or effect with respect to such people.

To quote, The effect of that decision, KCV Canada was that the government had 12 months to enact a regulatory framework for euthanasia in the form of physician-assisted suicide as qualifying.

Based on what's happened, the government has declined to expand the scope within which euthanasia would be permitted, according to the Carter v. Canada ruling. Moreover, the government included a significant requirement that natural death be, quote, reasonably foreseeable.

This additional requirement, the requirement of imminent death, drastically reduces the scope within which PAS, active euthanasia, could be available. It effectively eliminates the possibility of death for those driven by mental illness or grief.

The importance of that provision cannot be overstated. However, since that aspect of the legislation was not mentioned by the Supreme Court in its own decision, its constitutionality will likely be challenged in due course.

[7:10] In passing, I should also note that the bill was sent to the Senate in advance of its passage for consideration and input, and in the Senate deliberations, it was recommended that the requirement for foreseeable natural death, imminent death, that that requirement be eliminated.

That's what the Senate recommended, though it didn't make it into the bill. This may be indicative of what's to come. Now, at this point, so as to ensure accurate and clear communication, let me pause to identify and unpack some of the terms which are used surrounding PAS.

First is the word euthanasia. Literally, it's a Greek derivative of Greek, which means good death. Euthanasia, in turn, can be either passive or active. Its passive form involves simply allowing a person to die rather than either by withholding treatment or discontinuing treatment that's necessary to keep them alive, i.e. turning off the ventilator.

Active euthanasia involves taking some positive step to terminate life, such as the administration of a toxic substance. Active euthanasia, in turn, can either be voluntary or involuntary.

In a voluntary case, the subject has indicated a desire to end his or her life, and, of course, in an involuntary situation, the subject has indicated no such choice. I want to turn now to the second task of this morning's enterprise, which is understanding some of the rationale for the legalization of PAS.

[8:39] Here I want to begin by paraphrasing the argumentation of Vancouver GP, Dr. Ellen Weaver. You may have heard of her. Dr. Weaver is a high-profile advocate and practitioner of PAS.

She conducted the first court-approved active euthanasia case in Canada. Dr. Weaver has been a strong proponent of having physicians involved in euthanasia. The thought of depriving a patient of support from their primary care doctor in the situation of euthanasia is, quote, unthinkable to her.

For that very reason, she pursued training in the procedures. According to Dr. Weaver, euthanasia is about, quote, taking control back. Palliative care, while effective for 95% of cases, is always and often unable to restore human autonomy.

When autonomy is lost due to acute illness, it creates a tremendous burden on the patient. This is, to quote Dr. Weaver, the worst form of suffering, the loss of autonomy.

In such a situation, giving a patient a good death, she says, is among the most satisfying tasks that a doctor can perform. It's for that very reason that with reference to PAS, Dr. Weaver, in the cases with which she has assisted, she refers to the terminal dosage as medication, giving the medication, which of course is a deviation from the normative use of that term in the context of medical practice.

[10:05] Dr. Weaver helped Hannah Schaefer die. It was a high-profile case. You can read about that on the internet. In response to Schaefer's struggle with ALS, because of PAS, Schaefer did not choke to death, which is the way that she may have died otherwise.

Remarking on that situation, Weaver says that in the last moment, Schaefer looked at her with, quote, a wonderful smile of triumph. She was so sure, not sad. Through her euthanasia, Schaefer was, quote, in charge, and it felt really, really good.

These are Dr. Weaver's words reflecting on that situation. When asked about governmental safeguards against unwanted, unsolicited euthanasia, Dr. Weaver had this to say, quote, I think we can trust our society not to be vastly different from all those other societies which have enjoyed legalized euthanasia for a while now.

As we'll see shortly, that sentiment is under-informed. Further to this, Weaver does not believe that PAS will be an attractive option for the masses of people.

The people who seek this form of death, she says, are people like us. Wealthy, well-educated, white. They're used to being in charge of their lives. When asked about family pressures that may result in PAS that goes against the deeper will of the patient, Dr. Weaver has this to say, quote, Families are filled with such pressures.

[11:25] There are forces of love and guilt, and most families have all sorts of bizarre entanglements. Those things cannot be legislated. To further understand the rationale for PAS, which lands without much difficulty in our cultural context, it's important to hone in on one aspect of Weaver's argumentation.

To this end, I want to briefly reflect on autonomy. Autonomy. Our English word is derived from the Greek autonomas. Some of you may know what that means.

Self-law. Self-law. Autonomy thus refers to being a law unto oneself. Under the auspices of our civic and personal liberty traditions, ours is a culture which places a premium on individual autonomy.

It's worth noting that in this sense, our culture is quite distinct from many other cultures in the world. In the public square, the expression of individual autonomy is governed by what is known as the harm principle.

This principle dates to the British philosopher John Stuart Mill. In his theories of freedom and liberty, Mill argued that the potential harm of another person is the necessary, though not always sufficient, condition to curtail individual autonomy.

[12:43] And that reasoning harm is generally understood in a sort of direct and personal sense. Mill also concluded that personal harm is not an infringement of one's liberty and autonomy if consent is given by the person who would otherwise be harmed.

Thus, the autonomy of a boxer is not violated while he's in the ring. The core features of Mill's thought, which remains vastly influential in Western public ethics, is that individual autonomy is curtailed only by the risk of harming another unless there is consensual agreement otherwise to encapsulate.

Needless to say, while Mill's principle has been widely appropriated and is a tacit assumption in most of our minds, probably, it is notoriously ambiguous and does not engage with how certain human actions might harm wider culture in intangible but nonetheless real ways.

It's very individualistic, which is a bit odd given that Mill's also the father of utilitarianism, philosophy that prides itself on pursuing actions which serve the greatest good for the greatest number of people.

against the backdrop of Mill's harm principle, PAS is ethically intelligible and permissible. Euthanasia is fine because it doesn't hurt anyone since the patient has given full consent to his or her termination.

[14:06] Any following? With the foregoing survey in mind, I want to now mount a critical response to the legalization of PAS. So as to avoid confusion, please note that what I'm targeting here is voluntary active euthanasia of which PAS is one instantiation.

Before launching in to the argumentation there, I do, however, want to pause briefly here and just reflect on what scripture teaches that may be relevant to this subject, right? So a little bit of an excursus because the argumentation itself is not going to explicitly reference scripture and theology.

What does the Bible say about euthanasia? Same thing the Bible says about dating. Nothing. More than one Christian has looked at the sixth commandment as the basis for a rejection of euthanasia.

That commandment, of course, prohibits homicide. Within the more detailed portions of the Old Testament law, homicide is varyingly distinguished. Here's on the one hand, willful premeditated murder, right?

That is always condemned and set for punishment. Then there are cases of accidental manslaughter. That includes death as a result of a fit of rage, a crime of passion that leads one to strike down another. Or it might also include, for example, throwing a rock.

[15:28] You're cleaning out the yard and you throw a rock over your head to get it out of your garden and it hits someone else on the head and they die. That's another example of accidental manslaughter. And then there's the fact that the Old Testament law actually mandates certain forms of killing, namely capital execution for particular offenses.

So the very data of the Old Testament indicates that the taking of human life is not simply lumped into one homogenous class. There is differentiation and distinction. When the wider teaching of the Old Testament is taken into account, several key principles surface so as to define murder.

The elements of the biblical concept of murder seem to be it is intentional, it's premeditated, it's malicious, it's contrary to the desire of the victim, and it is against someone who has done nothing to deserve capital punishment.

Those are the criteria. Volunteer active euthanasia fits several of those, but not two of them. It doesn't fit the malicious criteria, and it doesn't fit the criteria of being contrary to the desire of the person who's going to be killed.

Right. What that means is that biblical law teaching on murder is not directly applicable to the issue of euthanasia, so we must look elsewhere. For that very reason, Christians have looked to several overarching theological principles as the basis and source for Christian misgivings towards euthanasia and physician-assisted suicide.

[16:53] The first of those, just to mention a few that are very important. The first is the sovereignty of God. Human life is inherently valuable and good because God says so. Because God says so.

In other words, human worth and significance are not, therefore, dependent on human usefulness and functionality. Listen to the words of Dietrich Bonhoeffer on this, to quote, In the sight of God, there is no life that is not valued and is not worth living, for life itself is valued by God, and where, if not in God, should lie the criterion for the ultimate value of life.

A second thing, a second theological principle is the recognition that God's mercy cannot be neatly equated with the alleviation of pain. This is tough for us. Sometimes God's mercy involves more than just physical comfort.

That is not its only driving concern. God's mercy also entails redemption, salvation, and even chastisement as an element therein. Sometimes God's mercy is severe, but nonetheless it is merciful.

In short, one can hardly conclude that for God, physical comfort is the primary goal of humans. Suffering, according to Scripture, is identified as an evil but not as an unqualified evil.

[18:06] It serves, as the Scriptures teach us, purifying or strengthening purposes. We see this in the events of Job, St. Paul's ministry, St. Peter's remarks on the outcomes of suffering trials in 1 Peter 1.

It's precisely what C.S. Lewis is getting at in his book, The Problem of Pain, where he equips pain as a megaphone which God uses, though not creates, to rouse a deaf world. These principles, of course, have formed my appraisal and the appraisal of other Christians on the topic of PAS.

Moving forward, however, you'll see I've opted not to give them explicit reference in the argument that I wish to advance against physician-assisted suicide. So let's turn now to the third and chief task today is making the case in public resisting physician-assisted suicide.

The ethics director of the CMDA, Christian Medical and Dental Association, which has a presence in Canada and also south of the Canadian border, says this, nobody has the monopoly on rationality and the debate about physician-assisted suicide.

I agree. On the one hand, this statement protects against a hasty or ideological dismissal of dissenting views, the views of Christians, for example, that will probably be increasingly the case.

[19:25] But on the other hand, that statement puts the onus on people like us and people like me today to approach this issue with coherent and cogent argumentation that is not alienatingly theological in its construction.

It's got to be, we have to be able to communicate. There can be multiple reasons for doing the truth, even if our awareness of truth is informed in the first place by God's revelation.

Those familiar with St. Augustine will be able to see that my ethos here is shaped by the legacy of his political theology. It's good to find common ground and build bridges. And it's also good to plunder the Egyptians from time to time.

If you know Augustine, you'll know what I mean there. In the next few minutes, I want to introduce five counterpoints. Five counterpoints as a critique of physician-assisted suicide.

And as you'll see, these points encompass not just a critical but also constructive dimension. Sarcastic isn't just to say that's wrong but also to offer alternatives. That's part of the church's prophetic vocation.

[20:36] So first, this one's, this is a, the first point is sort of a multi-step point so try to track with me if you can. The legalization of PAS will plausibly result in an increase in the practice.

And such an increase is something to be avoided for a variety of reasons. So let me unpack those two assertions which are connected to each other in turn. Do we think that euthanasia once legalized would remain rare?

Comparative study would indicate the opposite. The legalization of abortion by way of comparison was originally proposed to merely be the process of legalizing what was already happening. In other words, the rationale was to avoid abortions that endangered the mother owing to a need for secrecy.

Right? It was assumed when legalization happened that the practice would remain rare. Here we can hear Bill Clinton's words abortion should be legal, safe, and rare. Alas, that did not come to pass. In fact, the opposite has.

Abortion has become a preferred mode of birth control. According to one briefing filed with the Canadian Senate, abortion is the most frequent medical procedure in Canada. By this precedent, it's naive to deny the effect of legalization on normalization.

[21:53] You tracking with me? Okay. The former leads to the latter. The latter entails an overall increase. But we don't need to stick with the abortion trend as a rose bush at the end of the arbor.

The data is increasingly there for euthanasia itself. Consider some of the key findings of the Lancet study from the Netherlands published in 2012. You can Google this too. The number of euthanasia deaths increased significantly from 2005 to 2010.

Since 2010, and since, it almost doubled in fact. And since 2010, the death, the death number has increased by more than 77%.

Given precedents like that, it's plausible to assume that legalization will result in proliferation. In turn, proliferation leads to normalization.

And normalization is to be avoided for several compelling reasons. In the first place, the obvious reason, death is death. And it forestalls options.

[22:54] Right? PAS negates the possibility of recovery. And that is risky given the chances for misdiagnosis. Misdiagnosis can lead to the wrong judgment about the fatalism of the illness.

It can therefore result in an unmatched and therefore ineffective treatment. Medical science is a constantly evolving field. Doctors in this church will tell you that. My father's a medical practitioner and he'll tell you that as well.

Many others. Their breakthrough is happening. I mean, just consider what's happening with HIV right now. Right? Medical remedies that were unthinkable even six or seven years ago.

In the second place, I want to press this quite firmly, normalization can be plausibly connected to forms of what I call youth abuse. Euthanasia abuse.

Youth abuse. That applies to elders and also those who struggle with mental health issues. One forecaster says this, the legalization of active voluntary euthanasia should be expected to, quote, lead to forms of killing which have no necessary connection with either mercy or dignity.

[24:01] The Dutch precedent again shows that regulations surrounding euthanasia are nearly unenforceable. A well-known study of Dr. Carl Gunning, for instance, indicated that within a few months of the legalization of euthanasia of physician-assisted suicide, the guidelines were, quote, systematically breached with impunity.

Or consider a conclusory statement taken from oncology today with regard to euthanasia in Europe. There was a study done by this journal on that. There's ample evidence that, quote, laws and safeguards put in place have been regularly ignored and transgressed in all the jurisdictions and that transgressions are not prosecuted.

For example, about 900 people annually are administered lethal substances without having given explicit consent. And in one jurisdiction, almost 50% of cases of euthanasia are not reported.

Increased tolerance of transgressions in societies with such laws represents a social slippery slope. Washington Post article from this month has this to say in response to the latest biennial report from Belgium's Federal Commission on the Control and Evaluation of Euthanasia.

Quote, in the 2014-15 period, the report says that 124 of the nearly 4,000 euthanasia cases in Belgium involved persons diagnosed with a mental or behavioral disorder.

[25:20] Tiny Belgium's population is 11.4 million. 124 euthanasias over that time period is the equivalent of about 3,500 in the United States.

That figure is 3.1% of all the cases and a remarkable 20.8% of the 594 non-terminal patients whom Belgium doctors administered lethal injections in that period.

And then, of course, I'm very sad to mention this, there are also the cases of neonatal youth abuse. A 2005 study indicated that 22 newborns were euthanized.

After being born, they all had spina bifida or hydrocephalus conditions, which many adults live with today. That's under the auspices of the Groeningham Law.

You can look that up, too. Closer to home, Canadian Medical Association Journal conducted their own study of euthanasia in Belgium. What they discovered is harrowing.

[26:24] Just shy of one-third of the cases of PAS lacked an explicit request from the patient. And in about 80% of those cases, the issue was never even discussed with the patient.

Same results hold in the Netherlands. You'll find similar studies. Oddly, the Canadian Supreme Court in KCV Canada, listen up to this, rejected that study from the Canadian Medical Association Journal.

I'm not talking about the CMDA, Christian Medicals. I'm talking about the Canadian Medicals. They rejected that study. Why? Because, look up the precedent, Europeans are allegedly more paternalistic than Canadians.

Therefore, such abuses are not likely to occur in Canada. Are we going to be so insufferably arrogant to surmise that we would be morally superior to the Dutch in this arena?

Remember, it was the Dutch who valiantly resisted Hitler. But how much has changed in Dutch culture since then? We're hardly immune in Canada from such changes like that. In some, where PAS is normalized, youth abuse should be anticipated.

[27:35] There's a danger of abuse and the perversion of euthanasia with a voluntary becoming the involuntary. In situations where there are no family members to take decisions, it's not hard to imagine administrative pressures to quickly take patients on out.

Or in situations where there are family around, it's not hard to imagine situations. We all know this from experience where there's pressure on older people to hasten the end of their life as an act of responsibility. Would shame be involved?

The application of shame? According to Dr. Alan Weaver, such matters cannot be legislated. I would disagree. Are these prognostications far out and alarmist?

I think not, especially in a society where self-gratification, consumerism, and the relentless pursuit of individual happiness wars against any solid vision of the common good.

In such a setting, it's not hard to imagine PAS being conscripted into the service of wider economic interests. In all of this, I believe that the normalization and increase of PAS as a byproduct of its legalization makes our culture less humane.

[28:46] What may be perceived as a gain for a particular person, circumstances of great pain or at the end of their life, comes at a wider cost to the culture. Such a cost, of course, can't readily be accounted for by Mill's harm principle.

But just because something can't be accounted for doesn't mean it's not real. For this reason, I think individuals have to embrace responsibility to forego the right to PAS.

And I think the law should reinforce that. Against Dr. Weaver, I would contend that it's not enough simply to look at the patient right in front of you and to make big determinations in this area.

It's not enough simply to account for the autonomy of a particular individual person. If that is deemed compassionate, then I would say it's a form of compassion that is myopic and meager.

It's a compassion that works against the common good. And the absence of a robust vision of the common good lends itself to a society that is less rather than more humane. Franklin Delano Roosevelt once said this, the test of our progress is not whether we add to the abundance of those who have much, but whether we provide enough for those who have little.

[30:03] That's a sign of a humane society. A humane society is one that foregoes personal interest and advantage for the wider well-being. I think as we contemplate, PAS, we must not lose sight of this.

As I see it, we should not do things for personal comfort that potentially threaten the lives of others, even if that threat is in an indirect and not direct manner. Things should not be permitted, whereby one person's much desired rights soon become other people's unwanted duties as the culture shifts.

These convictions are part of a long tradition of unwritten obligations, which the individual has towards wider society. It's about counterbalancing individual rights and autonomy with the common good.

I believe that PAS is a seminal test case for this right now in our culture. When the balance is off, society becomes less humane, even if it tells itself early on that it is becoming more humane, which is what's happening right now.

That's the first point. The other four aren't quite as long. Second, side by side with what I've just said, this point may seem a bit contrary, so bear with me.

[31:15] Here I want to suggest that the legalization of PAS actually stands to undermine a healthy esteem and protection for the individual autonomy that we so prize and cherish in our culture. Let me explain.

Autonomy is not just about choice. It's about choice, and my philosopher friends have helped me to articulate, it's about choice that is fully informed, rational, and freely made. Are sick patients in tons and tons of pain able to exercise what we would call full and whole autonomy?

Depression, confusion, chronic pain, some of which we struggle with in this room, and we know how it affects us, a sense of being a burden, can indeed invalidate healthy autonomy.

Given that those types of things are often experienced at moments surrounding requests for PAS, I think it's sensible and even responsible to nip that possibility in the bud.

Anything else is an assault on true human autonomy. Let me give you an illustration here taken from a Senate briefing written by my former professor. Mrs. L was a 32-year-old married woman with two children.

[32:21] She was being treated for acute myeloid leukemia. Her first round of chemotherapy led to remission. During the second round, she became infected with adult respiratory distress syndrome requiring ventilator support.

Prior to the second round, Mrs. L and her husband had agreed to do whatever was needed to possibly beat the cancer. Over the next two weeks, the staff at the hospital predicted imminent death on a daily basis.

In the midst of this, Mrs. L was on five antibiotics and numerous other drugs, including sedatives and narcotics. Whenever sedation was withheld, and she was somewhat sentient, she would try to remove her endotracheal tube.

She would write please on a notepad asking that the ventilator be stopped and that she be let alone to die. Her husband and the doctor agreed to disregard those requests. For that, they were accused by others in the hospital of living in denial of reality.

Those other people who were accusing them appealed to Mrs. L's autonomy and her right to refuse treatment. Twenty-eight days later, Mrs. L was weaned from the ventilator.

[33:27] She left the ICU five days after that. She has no memory of her time in the ICU. She does not recall her request to have the tube removed and be allowed to die, and she is shocked that anyone might have acted on those requests rather than recognizing them as expressions of fear and frustration of compromised, unhealthy autonomy.

Mrs. L's situation reflects familiar circumstances when PAS may be requested, yet it allows us to see that the autonomy which we prize and which we should respect can easily be very impaired in such moments.

To embrace PAS and the culture that comes with it, therefore, is to enter a posture whereby proper autonomy can be dishonored. Point number three.

The legalization of PAS threatens to sabotage one of the great achievements of Western medicine, and this is not to be taken for granted. To put it another way, the legalization and proliferation of PAS could precipitate a disruption to one of the seminal virtues of our medical tradition.

The Canadian Medical Association Code of Ethics says this, Honor your profession and its traditions. What are said traditions? For one, there's the traditions that doctors are to do no harm and not to kill, and that's not purely a Christian conviction.

[34:48] It has its roots in the legacy of Hippocrates, a pre-Christian, non-Jewish, Greek doctor. His legacy is aptly represented by the French aphorism, translated here, the doctor is to cure sometimes, to relieve often, and to comfort always.

You may have heard this. Dr. Ellen Weaver, incidentally, sees PAS as an act of comfort, to comfort always. She said, that's what I'm doing. She champions this understanding of comfort out of her, quote, 41 years of practice as a doctor.

Sadly, Dr. Weaver's 41 years simply cannot be allowed to countermand a multi-central Western medical tradition that has brought great profit. I want to be firm on that. Though less than notable, sometimes controversial among Christians, social anthropologist Margaret Mead defends this principle.

Expounding the origins of Western medicine, Mead notes that it was, quote, the first instance of a complete separation between killing and curing. In the primitive world, she says, the doctor and the sorcerer tended to be the same person.

The one with the power to kill also had the power to cure, especially cure the undoing of his own killing activities. The Greeks, were their cultural heirs in this arena, made a clear distinction on that point.

[36:06] Early Greek doctors, the followers of Cephalus, were to be dedicated completely to life. Under all circumstances, regardless of age, rank, intellect, the life of a slave or an emperor, of a foreign man, or of a defective child, that was their mantra.

It has come down the ages to us. This is a priceless possession, a tradition which we cannot afford to tarnish. At last, as Margaret Mead herself laments, society is always, quote, attempting to make the physician into a killer, whether to the defected child at birth or leaving pills beside the bed of a cancer patient.

Close quote. Says Mead again, it is, quote, the duty of society to protect the physician from such requests. If euthanasia is legalized, it will affect the medical profession.

Doctors will see pressure to be agents of PAS when requested, just as they are now in Canada with regard to abortion. Talk to my friend Cameron, who's in your church, about his own training. Here again, the Dutch status quo is telling.

One minister of health in the Netherlands is on public record supporting, quote, the removal of licensure of any doctor refusing to assist in suicide. All of this is about turning the healer into the killer.

[37:22] Or to echo my friend Dr. Tim Mullen, oncology professor at Oxford, turning the National Health Service is just that, a health service, not a death service. Such confusion about the role of the physician is bad for our medical culture and bad for the doctors at the center of it.

It's good to notice here that there are both transitive and intransitive effects, both of which are deleterious. With regard to the medical culture, this could lead to a breakdown of trust.

The legalization of PAS, right? That begins to be seen as right and normal, right? And if your doctor is swept up into such thinking, will you be at peace and rest under his or her care?

That's the transitive effect, the negative transitive effect, right? Very undesirable consequence. But with regard to the individual doctrine, this is also important, and coming from a family of medical practitioners, very sensitive to this, I am.

The culture that permits PAS easily morphs into a culture that requires doctors to do it. That's the intransitive effect. When doctors start killing people, as with any human, it can have an adverse effect on their character.

[38:37] Should this be foisted upon doctors? Have they no right of conscience? In an age of constantly multiplying rights, this right seems to be increasingly becoming a luxury.

Moreover, do we want medical practitioners, the ones in whose hands we find ourselves being cared for in the most vulnerable moments, to lose a robust commitment to the sanctity of life?

I think not. Fourth, and here I turn to the constructive dimension, offering some alternatives. From a clinical perspective, the perceived need and requests for PAS are mitigated when palliative care is properly prioritized, funded, and administered.

I've sought to highlight some of the dangers and the cost of legalization of PAS. Now I want to bring a constructive alternative, right? Behind the PAS movement is a very sincere concern to alleviate pain.

We can all appreciate that. the solution has been framed by that movement as changing the law so as to put a new option on the table. We can alleviate that pain by your elimination, right?

[39:52] That's not necessary if we have an increase in good palliative resources. A professor of mine talked a lot about this. He's a Christian ethicist at Oxford, Nigel Bigger, and his wife is a palliative care nurse and specialist.

Good palliative care, he says, can relieve most suffering. The hospice movement has taught us this. Dr. Weaver herself admits that this is true in 95% of the cases.

With the right allocation of resources and skill, this percentage can climb even higher. That is what people have argued. Moreover, palliative care, if you want to come at it from an economic angle, does address the high cost of the overall medical system associated with people who are at the end of their lives.

The option of enhanced palliative care shatters the simplistic dichotomy that is often used by the pro-euthanasia movement. Advocates of PAS often speak about dying with dignity.

We've heard that turn of phrase, we want to die with dignity, right? That suggests that the alternative to euthanasia is death with indignity. It leads people to think that the choice is between a death writhing in agony or euthanasia.

[40:57] That's naive, and it comes from underhanded and dishonest presentations of the issue. In truth, it's caring, good caring, seasoned caring, well-resourced caring, rather than killing that best honors the dignity of the human.

Now, palliative care, one aspect of it is something called palliative sedation. Have I ever heard of palliative sedation? Palliative sedation may speed up someone's death.

Talk to people who work at end-of-life issues, right? But palliative sedation, this is very important, is distinct and different from active, voluntary euthanasia.

This is something that Nigel Bigger has vigorously argued, and I am in agreement with him. The goal and aim of palliative sedation is not to kill a patient, but it is to comfort and relieve.

The intention is not to kill, but to comfort and relieve. Palliative sedation may and often does result in death, but that is not the intention of the doctor. Have you ever seen the movie Master and Commander?

[42:03] There is a scene in that movie, I think, which is instructive here. The ship is in a terrible storm and the great central mast has been splintered and fallen into the water. The captain calls one of the sailors and says you need to cut the ropes that are holding that mast to the ship because if we don't cut them, it is going to sink the whole thing.

We are all going to die. The guy who has been called to cut the ropes, his best friend is out on the other end of the mast, out in the water. And he knows in that situation his intent is not to kill his friend.

It is to save the ship. We would never look at him and say you're a murderer. You murder your friend. That's not what's going on. That's a byproduct of what happens.

That distinction is very important. That's an analogy for palliative sedation. According to many experts, including Christians in the medical profession, death that comes as a byproduct of palliative sedation is not to be confused with euthanasia or PAS.

And arguments that blur this distinction should be resisted on grounds of intellectual honesty. That's a quote. To put it another way, there is a proper and fundamental ethical distinction between that which is intended and that which is foreseen but unintended.

[43:22] There's an important distinction between that which is intended and that which is foreseen but unintended. Palliative sedation. Way to comfort and care for people in great pain.

And fifth, and I added this point last night after pondering the remarks of a hospital chaplain here in Vancouver. From an intrapersonal perspective, what's going on inside of us? Intrapersonal.

The desire for euthanasia, the request for PAS, can be mitigated by a strengthened sense of purpose and hope in a patient. It's very important.

Some of you may know Viktor Frankel. He wrote a very famous book, Man's Search for Meaning. In his study of concentration camp survival, he concluded that those with hope and purpose persevered in the concentration camps to a greater degree than those who had forsaken or lost hope and purpose in living.

people. This conclusion suggests that while good palliative care can be an apt substitute for PAS, something more may be required in certain cases, especially those 5% of cases, for example.

[44:29] We take that figure where palliative care's limitations come to the fore. When face-to-face with chronic and intense suffering, as Dr. Edwin Hui at Regent College has said, biomedical intervention is not always enough.

In such situations, however, we must not underestimate the power of purpose and hope in sustaining the will to live, even amidst acute pain. Dr. Hui discusses this case study in relation to his own form of clinical work, one of the rare situations where the option of PAS seemed reasonable and compassionate to him.

The patient actually sustained acute and intense pain with remarkable buoyancy because purpose and hope were mediated to her by family and loved ones. And in this context, the pain actually receded, or at least the patient's experience of the pain.

Indeed, here in Canada, we have a picture of the living power of purpose and the events of Terry Fox in the Marathon for Hope. As this plays out, it means that the alternative to PAS is not just enhanced palliative care, though certainly we should do that, but attentiveness to purpose and hope.

And this pertains not so much to giving people hope, but helping people to find hope. And Christians of all people should be well-suited for this task. We can do this not only in an interpersonal sense, but also, you know, one-on-one with people, being present with them in suffering.

[45:59] We can do it that way, but we can do it another important way too I want to mention here, by resisting and fighting against the current in our society that nefariously reduces human worth and value to capability, capacity, performance, and achievement.

Where those types of values reign and where they set the measure of a life worth living, then PAS is hardly an unreasonable request. Let's be honest. But where the value of life is otherwise located and affirmed, euthanasia, I think, cannot but lose its appeal.

Consummation, palliative care, and sedation together with commitment to nurture hope and purpose, their reconfigured outlook on human worth, can relieve us from all the unsavory repercussions of PAS.

Doctors are protected from becoming agents of death, shielded from procedures that violate their conscience and potentially taint our medical culture. Keeping active euthanasia, PAS, off the table also preserves a vital respect for healthy autonomy.

It ensures that radical liberalism's addiction to unbridled individual autonomy does not get morphed into killing on demand.

[47:13] It protects and promotes the humane character of our society, and that humanity, of course, does come at a cost economically, personally, cost to individuals, cost to systems, yet I think it's a cost worth bearing because our refusal to do so would come at even a greater cost.

So it's not a question of cost or no cost, it's a question of which cost, which is often how it is in life, isn't it? Again, you'll notice in these five points that I refrain from any highly explicit references to scripture, Jesus, God, or the life to come.

It doesn't mean, however, that my reasoning is that my instincts here are non-Christian. To the contrary, everything I've said is informed and in fact spurred by my faith. But my faith is also a faith which seeks the wider good and is willing to avoid explicit appeals to the language of faith in pursuing that.

Perhaps that's part of the innocent shrewdness to which Jesus calls his people. And it's here that I conclude. We'll have 10 or 15 minutes for questions.

Thank you for your time. Okay, if you'll say your question and just so everyone can hear, I'll kind of repeat it and then we'll move. It's kind of a bit of a question, a bit of an agreement, like with not remembering, I was in intensive care at EGH for a week and I didn't remember the whole thing.

[48:28] Who knows what I could have requested? The doctor said yes. And when your energy level is drained, you can get suicidal thoughts but you have no desire. And then if a person requested that to a doctor and the doctor said yes, oh geez, then later on, you don't, you know, should you not die, you're feeling fine.

So again, your experience parallels the example of Mrs. L that I gave. Yeah. Thank you for sharing that. Yes, ma'am. Has anyone seen the Physicians for Life website also on Facebook where recently this past week an MP from Alberta Gardner, Genu, so it looks like Genius, G-E-N-G-U-I-N-S is his last name.

That's right. Garrett, Genu, who spoke in Parliament about a 32-year-old man saying who was depressed unbeknownst to his wife requested to suicide and his own doctor said no, but he found a doctor in Vancouver who without any medical examination from afar granted it and killed him and his wife is completely devastated.

You can look at the MP giving his remarks in the House of Commons online. Wow. Which is an example too of how the protocols that have been put in place at this time can be easily breached.

No protocol, nothing that the Canadian law said would hold everything in place. It was all ignored when he had said he was 32. Yeah. I think it's an assault on courage really.

[50:06] That's when, you know, fatigue makes cowards of us all. Pain makes even more cowards of us all. But that's not a true self. That's right. It's an abandonment of caring for the true person as opposed to the one who comes forward in pain asking for help.

And that's a guy to ask for help. It's not a request for death. It's a request for life. It's a request for help. Pass that. Pass that power to into courage again. I don't know.

Yeah. Yes, sir. Challenging the notion that physician-assisted suicide promotes dignity.

There's a researcher in Winnipeg, working at the Winnipeg Cancer Center, Dr. Harvey Chokinow, done some really informative research on what attacks a person's sense of dignity with an illness and how health care staff can promote an experience of dignity.

For example, you know, a person saying they need to be changed, you know, when they soil themselves, would undermine a sense of dignity. A staff person comes along and says, you know, we're all going to be at this stage at some point in our life where we're going to need this kind of dependence on others to help us through life.

[51:31] You know, and the staff care person might say, this is a privilege for me. This is my sense of calling to be able to care for you. So Dr. Chokinow has developed what he calls dignity therapy.

And if you Google it, his articles and his research will come up online. And that's just one example for me of a very sound research. and this is great challenging that whole notion of what is dignity, how do we preserve dignity.

He's a psychiatrist by training. Okay. Thank you so much for sharing that. That's tremendous. Yes, sir. I appreciate that your entire talk was focused on PAS.

but I'm a little puzzled as to why you said nothing about the difference between S and PAS, suicide, and physician-assisted suicide with respect to autonomy.

It seems to me that the whole PAS thing is about displacing autonomy and personal responsibility.

[52:49] And my question is, how many of the people who purportedly seek PAS are unwilling to exercise the autonomy of S, suicide?

Can you explain that a bit more? Yeah. Killing themselves. Doing it themselves. Oh, just doing it themselves. Yes. Yes. Yeah. That's kind of where you start.

Yeah. Good question. I think the reason that people don't just opt for, let's say, SS instead of PAS, self-suicide, instead of physician-assisted suicide, again, I'll just borrow from Dr. Weaver's remarks, is that there's the fear that SS will actually be painful and uncomfortable.

And so they want a professional to come in and ease them into death in a way that's mild and pleasant. So you see there, right, it's also, it's on the one hand, it's the drive for autonomy, right?

I'm in control of my life. And on the other hand, it's that very natural human aversion to pain, right? You know, if you put your hand in the fire, it gets burnt, so you don't do that again, right?

[54:04] We don't like that. But in a sense, PAS is absolutely a denial of autonomy. Yeah, in a sense, yeah. Unless someone is in a fairly rare state of being paralyzed and on life support.

Because you're saying you're farming out this aspect, right? And if it was true autonomy, you should do it, you know, you should do it like Socrates. Pick up the chalice yourself.

I think, yeah. That's a good point. Yeah. Yeah. Yes, sir. Just thinking about your fifth point, I mean, there are two aspects to that in a sense. I mean, the first you alluded earlier to just the Bible doesn't say much about, you know, this.

I mean, there are stories. I thought about the story of Saul, you know, when he was mortally wounded and he turned to his armor bearer and said, kill me or these uncircumcised will abuse me.

And he said, but he would not for he was afraid. What are you afraid of? Yeah. Because after Saul took his own life, then the armor bearer took his own life. But they both knew they were going to have to stand before God and give it out.

[55:14] Yeah. I mean, the Bible doesn't say what he was afraid of. Right. Yeah. He would not touch the king. Right. And then, you know, David's reaction. The same way. David took. The crowd was brought and he said, look, some liar boasting that he had killed Saul says, you know, look, I've got this.

You put your hand on the way you did. Yeah. Right. So there was a fear there because they knew that this was not just the king, but obviously somebody made in God's image.

Mm-hmm. There was that aspect of things. But the positive side to number five is also that, you know, without the gospel in society, without that hope, that sense that we all have a focus that this is, this is happening to me because of God's sovereignty, as you're saying.

Mm-hmm. I mean, as that has waned in our society, it's not surprising that we're now embracing this because we have the diminishment of the image of God in man, elevation of things like environment and bringing us down rather than exulting.

Yes. And now we have no hope in the gospel as a society. Mm-hmm. We're embracing this because what is there after this? Mm-hmm. Oblivion. Yeah. Once the society believes that, it becomes a difficult thing to just manufacture hope.

[56:29] Yes. That's great. Yeah, of course, these, and you're exactly right, these questions, this question, and other kind of contentious ethical questions that are in our society right now, all taking place in a certain context against a certain backdrop.

You know, I think Charles Taylor has probably done some of the best work in mapping that for us, the Canadian philosopher and theologian who had a career at McGill. And to understand why PAS is, you know, a plausible and compelling practice in our society, you have to understand that backdrop in a sense.

When you engage with people, though, you know, and try to make a persuasive case, it can be, it takes a lot of time to do that, right? So you look to try to identify common ground spaces which will allow for sort of engagement that that's just effective at promoting certain ends.

You know, we're in an, like Taylor would say, we live in an imminent frame because we don't have any sense of transcendence much anymore. And by the way, we live in that too. Like we're all, you know, we're kind of like, we're in it, but we're sort of God's pulling us out of it, but we're still in it, right?

If you really exegete your life, you'll see how much of what you do reflects the fact that you're, so no sense of transcendence. So this idea that you don't do that because you're going to be held to account one day, that's, that's like totally implausible in the context of an imminent frame, right?

[58:00] And pastorally, I can say a lot of Christians actually struggle with that because that cultural current is so, you know, this, if we're fish, that's the water in which we swim. Um, you know, so see, like it just gives us a sense of how radical conversion actually is.

Yes, ma'am. There doesn't seem to be any sensitivity to the fact that having a doctor involved in this is going to change his humanity.

No. And, you know, the other thing is that we are a society that some years ago overturned capital punishment.

It's an entirely different sort of thing, but it's just the idea of killing somebody. We overturned this and now we're, we're embracing, you know, PAS.

It's, it seems so contradictory. Mm-hmm. The, um, part, part of the reason that we, that there's not a lot of sensitivity to, uh, to, I guess what we would call the, what's it, the intransitive effects?

[59:11] How certain activity, you know, how, what we do shapes who we are. It's because as a culture we don't really deal on the cards of virtue anymore. Virtue ethics, you know, which is concerned with how what we do is forming us into certain, our character, right?

We deal more with the protocols and regulations and just follow those. So, you know, again, there's a, part of the backdrop is a big shift in paradigm there. And what we're asking for is an attentiveness to how what we do impacts us.

And I think that totally makes sense for someone who's a Christian, but I think you can make a strong case for that with someone who's not a Christian as well. There's a lot of psychologists who are working in that area right now. Yeah, we're just looking at what happens to these, these physicians, you know, over time.

Right. Yes, ma'am. I'll come back to you. What do you do? And more of a comment, I wondered about this myself. I'm glad you mentioned the palliative care and palliative sedation.

I'm not a medical person, but we're all aware that that is available to doctors and it is used with, you know, imminent death and it's used compassionately and carefully.

[60:17] And so to have the care that they need at the end of their life is available there already, you know, why we need something else to legislate this and make doctors do, as we've said, the opposite of what they're trained to do and go against their hypocritical and everything else.

Yeah. You know, this is already available to people at the end of their life. Again, for many medical, the Hippocratic Oath is optional now for, you know, if you go to a medical school commencement, you'll see it's optional and there are people who choose not to take that anymore.

It's kind of a relic from the past that some people like to honor for the sake of tradition or custom. So it's optional and many, it's the real threat there, I think, is just the consumerism of our culture, right?

And the way that that comes into the medical profession is, you know, you're just to deliver whatever service we want. That's your job. And whenever we want. You know, you're just sort of a technocrat. Again, no emphasis on virtue, not attentive to all of that.

And there will be consequences for this long term, I think. Okay. Yes, so we'll go with that. Yeah, just the comment around the impact on doctors. I just want to lift up the impact of the other healthcare professionals, nurses, respiratory technologists, the people who operate the respirators in an ICU, for example.

[61:44] Mm-hmm. Social workers, chaplains, physiotherapists, occupational therapists. So healthcare, the trend in healthcare is to provide holistic care. So that means you've got five to ten people looking after a patient in an ICU ward or a palliative ward for that matter.

You've got a physician who's sort of in charge of that and ultimately responsible. But the other professionals, and this is no criticism on the physician, but the other professionals are spending quite a bit more time often with the patient and therefore establishing an emotional relationship, a bond.

So the potential for moral distress around that healthcare team is quite significant. And potentially you've got healthcare team members not agreeing with the patient's decision and or the doctor's agreement to go along with that.

So you don't necessarily have a complete agreement, 100%, as I've seen. So the potential for moral distress is significant.

Yes, thank you. We'll do two more, you and then you. So go ahead. Yes, sir. Have you studies done in Holland about PTSD in doctors who are required? And in Holland and Belgium where they've done years of study on this is that indeed there has been a slippery slope in both countries where first they were requested and now they're forced.

[63:11] And as you said, it's coming where they'll be disbarred if they are not allowed to practice if they're not. But there have been studies in Holland where PTSD in doctors is occurring.

And I can see two things. One is, do you want a doctor who doesn't care if he kills you? Or do you want a doctor who falls apart because he kills you? It's really the issue of the person administering to death that is a completely, almost a silent aspect of this.

You cannot, you know, as somebody said, you know, say capital punishment, killing a person for doing an evil thing like killing another person is wrong. But let's put a hangman on every corner now and kill people who underneath their real person would want to live if, or that they have worth to the end of their life.

Right. Not where somebody says, well, suddenly now you're not worth it. Right. They're worth it. And that's the whole basis of kind of care in my view. And that when a group of people cares, the distress amongst medical professionals is very real.

Yeah. And there is a lot of confusion. I was joking with my wife a few weeks ago. In this year, we have legislation that legalizes PAS, and that's now a valid request.

[64:28] And if you satisfy these criteria and fill out this paperwork, which according to Dr. Weaver is actually, it's a pretty quick process. You know, you can essentially exercise your autonomy to take your own life and involve someone else to help you do that so it's not painful.

On the other hand, our city has just allocated $3.5 million to add suicide barriers on the Barard Bridge. So you can't take your life that way.

You know, so it's just, you see, even there is this moral tension in our society, right? That's still, no, we can't let people do that. You know, so you see, we're in this place of tension culturally. Yes, and you'll be the last one.

Yes, sir. Now, is this any way they have intentions to save money? Because I've heard hospitals, it's $1,000 a day. If they intend, this will save money with the physician-assisted suicide, then they don't have to pay, you can be paying $1,000 for this alive person to still be in the hospital.

Is that any intentions there at all, to save money? Well, if it was, I don't think anyone would admit it. Oh, yeah. Yeah. Yeah. So, the Prophet Jeremiah would probably have something to say about that.

[65:41] I'm not saving. Oh, yeah. Oh, yeah. Sorry. Forever. Come on. tän■ to have 5.