

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

## 3 4 **In Support of Physician Assistance in Dying**

5  
6 (A Resolution of Witness)

7  
8 **Submitted by:** The Central Atlantic Conference  
9

### 10 11 **Background**

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

17  
18 Suffering is just a word until it happens to you or to someone you love. We can afford to  
19 theorize about death when it is not immediately before us. Suffering is one thing when it is an  
20 abstraction, but quite another when it is our own.

21  
22 In a Harris Interactive Poll conducted in April 2005, 70% of the American public indicated their  
23 support for assistance in dying. In a poll of 1,000 physicians, conducted by the Finkelstein  
24 Institute and HCD Research in February 2005, 57% of those polled believe that it is ethical to  
25 assist an individual who has made a rational choice to die due to unbearable suffering.

26  
27 The claim is sometimes made that a terminally ill person who elects to take lethal medication is  
28 not acting freely, but is responding to a variety of subtle pressures (from family members or  
29 society; concerns may be financial or otherwise). However, the terminally ill patient who is  
30 considering a hastened death by refusal of life support is just as vulnerable.

31  
32 It is often the fortunate patient who can tell physicians to “pull the plug” - - for those who do not  
33 have a plug, assistance in dying is the humane and ethically equivalent solution.

34  
35 Some people have difficulty in accepting physician assistance in dying since they feel this  
36 amounts to suicide, which is condemned by their religious beliefs. But, doesn't the person who  
37 can legally ask to be unhooked from a ventilator or feeding tube, knowing that he or she will die,  
38 in effect commit suicide? The word “suicide” is incorrectly used when applied to dying patients.  
39 A terminally ill patient who asks for medicine to help him or her die does not initiate the dying  
40 process. It is already underway and death cannot be prevented.

41  
42 “Terminal sedation” is a procedure doctors legally use whose primary purpose is to relieve the  
43 suffering of a dying patient. With terminal sedation, the suffering patient is sedated to  
44 unconsciousness and all life-sustaining interventions, including nutrition and hydration are  
45 withheld. Generally, the patient then dies of dehydration, starvation, or some other intervening  
46 complication. Although death is inevitable, it usually does not take place for days or even

47 weeks, depending on clinical circumstances. In the opinion of many, this is no different than a  
48 physician writing a prescription for a lethal dose of barbiturates for a terminally ill patient.  
49

50 With respect to the argument that human life is sacred, and therefore should not be snuffed out  
51 under any circumstances, there is the counter argument that it is a desecration to needlessly let a  
52 dying human being continue to suffer. We must sanctify life to its natural end, but when we use  
53 medical technology to extend lives beyond their natural ends we must be careful of what we  
54 sanctify.  
55

56 Dying is one part of the normal life process. That we die is certain. When and how we die is  
57 not. An individual on the threshold of death no longer has a choice between living and dying,  
58 but only the choice of how to die. We die only once, so we should choose to die well.  
59

60 Some say that suffering is ennobling, as a way God sometimes tests and educates us (a sharing in  
61 Christ's passion and a union with the redeeming sacrifice which he offered), and is a natural part  
62 of dying that prepares the soul for the afterlife. These individuals would argue that only God  
63 should select the moment of death. But, perhaps, they need to ask two questions: Do they  
64 believe in a loving God? Do they believe their loving God would want them to suffer like that?  
65 The clear precedent of Jesus' countless efforts to alleviate suffering through his healing ministry,  
66 makes clear that there is no obligation incumbent upon us to endure suffering for its own sake.  
67

68 It does not seem to be fear of death itself, but fear of what one might experience before death that  
69 terrifies most individuals who are terminally ill. Experiences of late-stage terminal illness  
70 include such things as panic attacks, loss of autonomy, severe body wasting, intractable  
71 vomiting, urinary and bowel incontinence, general lack of bodily control, failing memory,  
72 difficulties coping with domestic chores, the inability to eat/speak/or read, total dependence, and  
73 no longer being able to recognize or interact with loved ones. Plus, the fear of lingering on, fear  
74 of bankrupting one's family with medical costs, fear of burdening others, fear of abandonment,  
75 fear of the unknown, etc. These things clearly affect dignity, self-respect and personhood, and  
76 collectively contribute to questions about the meaning, value and purpose of life. They are  
77 recognized as more important than pain in the desire for a hastened death.  
78

79 In November 1997, Oregon became the first State to adopt a physician assistance in dying law.  
80 As of the end of the year 2007 (more than ten years after the law took effect), there have been  
81 only 341 cases of physician assistance in dying (there were 49 deaths in 2007; that equates to  
82 15.6 Death With Dignity Act deaths per 10,000 total deaths). Oregon has very specific  
83 guidelines in place to regulate the practice of physician assistance in dying. In short, physician  
84 assistance in dying is presented as an option that no one need exercise - - it remains a matter of  
85 individual choice. A decision to live may be the direct result of having the option to die. So, in  
86 Oregon, a prescription for a lethal dose of barbiturates is a dying patient's security blanket.  
87

88 A study published in October 2007, in the Journal of Medical Ethics found physician assistance  
89 in dying does not lead to a "slippery slope" that disproportionately affects vulnerable people.  
90 The report debunks opponent arguments that claim the law targets at-risk groups. Drawing on  
91 the experiences in Oregon and Netherlands, where the practice is legal, the five researchers

92 concluded that there was no evidence of heightened risk for the elderly, women, the uninsured,  
93 persons with low educational status, the poor, racial or ethnic minorities, or the disabled.

94  
95 In general, the studies from Oregon portray the individuals opting for assistance in dying as very  
96 concerned about loss of independence and control over their lives. The Oregon Death with  
97 Dignity 2007 report reflected that, of the individuals who chose physician assistance in dying in  
98 dying in 2007, all were covered by some form of health insurance, 88% were enrolled in hospice  
99 care, 90% were able to die at home, 69% had some college, and cancer was the most common  
100 diagnosis in 86% of the cases.

101  
102 Anonymous surveys suggest that physicians in most states already act at the request of terminally  
103 ill patients to speed their death, albeit clandestinely and without regulation. Legalizing the  
104 practice could prevent any problems associated with secrecy.

105  
106 On September 9, 2007, the American Medical Women's Association announced that it supports  
107 the right of terminally ill patients to hasten what might otherwise be a protracted, undignified, or  
108 extremely painful death; that it believes physicians should have the right to provide a terminally  
109 ill patient with, but not administer, a lethal dose of medication so that the patient can hasten  
110 his/her death. The Association also supports the passage of assistance in dying laws, such as that  
111 passed in Oregon, which empower mentally competent, terminally ill patients and protects  
112 participating physicians.

113  
114 On March 25, 2008, the American Medical Student Association adopted an aid in dying policy  
115 which states: "Terminally ill, mentally competent patients should have a measure of control over  
116 their death when faced with suffering which the patient finds intolerable. Doctors should have  
117 the right to provide such a patient with the means and/or knowledge to use medication to bring  
118 about a peaceful death.

### 119 **Theological Statement**

120  
121 God intends that created life be more than simply the existence of a human organism. The  
122 Gospel of John reports Jesus as saying, "I came that you might have life, life in all its fullness,"  
123 (John 10:10). Life is also a perishable gift. Mortality is universal. There is a time to be born  
124 and a time to die.

125  
126 When medical science shifts from expanding the length and quality of life and begins simply to  
127 postpone the reality of death, the sacredness of life is no longer being served. Such prolongation  
128 may cause unnecessary suffering and/or loss of dignity while providing little or nothing of  
129 benefit to the individual.

130  
131 God's will does not involve suffering beyond limits of human endurance. It does not honor God  
132 to cling to an existence that has become an empty shell. The continuance of a mere physical  
133 existence is neither morally defensible nor is it God's will.

134  
135 When illness takes away those abilities we associate with full personhood, leaving one so  
136 impaired that what is most valuable and precious is gone, the mere continuance of the body by  
137 medicine or drugs is a violation of the person.

138  
139 Many persons, because of their religious beliefs or for other reasons, will choose to draw the last  
140 possible breath, no-matter-what. That choice will remain for every person who wants it. Some  
141 others, when end-of-life suffering becomes unbearable, will decide that continued existence on  
142 earth without hope or meaning is no longer “life in all its fullness,” in fact, it is no longer  
143 tolerable. They may ask to have the choice of a peaceful release.

144  
145 God has granted humanity the right of personal choice, which must include the end of life. The  
146 gift of abundant life is more than the avoidance of death, and over-regard for the body, without  
147 proper concern for the needs of the person, or the human spirit, can become a kind of biological  
148 idolatry. What is required is a balanced appreciation of the whole person. At some point, an  
149 individual has the right to die and not be simply maintained.

150  
151 We are co-creators with God, given free will, and the ability to make compassionate choices.  
152 The proposed Resolution, on grounds of compassion and choice, would permit physician  
153 assistance in dying to be legal if strict safeguards to prevent abuse are provided.

154  
155 Since God has made human beings responsible for the very beginning of human life, it is  
156 consistent to assume that the same God has made the end of human life a human responsibility.  
157 Thus, the principle of the sanctity of human life must yield to the principle of self-determination  
158 when someone is terminally ill.

159  
160 Choosing death with dignity over a life that has become either hopelessly painful and  
161 dysfunctional or empty and devoid of all meaning allows us to honor the God  
162 in whose image we were created.

### 163 164 **The Resolution**

165  
166 WHEREAS life is both a sacred and a perishable gift from God; and

167  
168 WHEREAS medical technology, pain management and palliative care have made great  
169 advances, yet some persons still face intolerable suffering during a terminal illness; and

170  
171 WHEREAS the purpose of medicine is to alleviate suffering, and sometimes ending a life is the  
172 only way to do it; and

173  
174 WHEREAS by establishing a set of procedures for legal assistance in dying, each State can  
175 ensure that only people who are truly terminally ill and of sound mind qualify for physician  
176 assistance in ending their lives, and can get out of an insufferable state if it comes to that; and

177  
178 WHEREAS the crucial question for dying patients is whether they are living or existing; and

179  
180 WHEREAS if the intent in withholding or with-drawing life sustaining treatment is to cause a  
181 merciful death, this purpose can be accomplished faster and more humanely, and at the time of  
182 the patient’s choosing, by physician assistance in dying; and

183

184 WHEREAS a terminally ill person no more commits suicide in taking a physician prescribed  
185 lethal dose of barbiturates then does a terminally ill person who asks to be unhooked from a  
186 ventilator or feeding tube, knowing he/she will die; and

187  
188 WHEREAS life's very sacredness means that it should not be allowed to linger in suffering or  
189 indignity, and that physician assistance in dying can be a greater form or respect for human life's  
190 sanctify; and

191  
192 WHEREAS it is clear that our loving God would not want anyone to suffer needlessly; and

193  
194 WHEREAS permitting a hopelessly ill person to die by not imposing extraordinary measures is  
195 widely accepted today by religious groups as being part of God's will; and

196  
197 WHEREAS physician assistance in dying is a last resort for those few cases in which Hospice  
198 care becomes ineffective or unacceptable to dying patients; and

199  
200 WHEREAS assistance in dying is well within the physician's role, since resorting to extreme  
201 measures to try to keep alive the terminally ill at all costs does not respect the patient; and

202  
203 WHEREAS denial of physician assistance in dying is, in fact, doing harm, when it perpetuates a  
204 patient's continued suffering; and

205  
206 WHEREAS in order to restore the balance between a physician's obligation to prolong life and  
207 the obligation to relieve suffering, a peaceful death to end such suffering must be acknowledged  
208 as a legitimate goal of medicine and as an integral part of a physician's responsibility; and

209  
210 WHEREAS individuals who don't want physicians to ease their pain in dying are free to follow  
211 that path, but they should not be allowed to require anyone else to die a painful, protracted and  
212 agonizing death; and

213  
214 WHEREAS current law, by prohibiting physician assistance in dying, favors those who believe it  
215 is immoral, legalization would give equal (not preferential) treatment to those who believe  
216 physician assistance in dying can be a principled moral choice.

217  
218 **THEREFORE LET IT BE RESOLVED**, that the Twenty-seventh General Synod supports  
219 physician assistance in dying, under very specific guidelines as determined by each State, when  
220 for an adult patient:

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

227  
228 **FUNDING**  
229

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

232

233

234 **IMPLEMENTATION**

235

236 Justice and Witness Ministries is requested to implement this resolution.

237

238