



Church of Ireland
Church and Society Commission

Discussion paper
Euthanasia and
Assisted Suicide

Terminology

Physician-assisted suicide is the voluntary and intentional termination of one's life by administration of a lethal substance with the direct or indirect assistance of a physician.

Assisted suicide is the intentional act of providing an individual with information, guidance, and/or the means for him or her, voluntarily and intentionally, to terminate his or her own life. This is to be distinguished from withholding or withdrawing futile treatment by the medical profession, or from individuals choosing not to accept life-prolonging treatment, through an advance healthcare directive known as a 'living will', which is a statement about the type and extent of medical or surgical treatment you want in the future, on the assumption that you will not be able to make that decision at the relevant time.

Involuntary euthanasia is the intentional killing of a dependent person for his or her perceived benefit against his or her consent.

Non-voluntary euthanasia is the intentional killing of a dependent person for his or her perceived benefit without his or her consent.

Voluntary euthanasia is the intentional killing of a dependent person for his or her perceived benefit following his or her consent.

Palliative care is the active holistic care of individuals with advanced progressive illness. It includes management of pain and other symptoms as well as the provision of psychological, social and spiritual support in order to achieve the best experience of life possible for individuals and family.

Affirming life

The prospect of euthanasia/assisted suicide continues to be a source of debate in the Republic of Ireland and Northern Ireland, and the Church of Ireland remains resolute that there should not be a right to euthanasia/assisted suicide in this society and suggests no grounds for introducing policy on euthanasia/assisted suicide.

At the centre of our theology lie certain core beliefs from which we get guiding principles that promote our decision-making, and from which, in turn, we get our policies and practices. One of these 'core beliefs' is the conviction that God is the life-giver. To believe that each and every human life is intrinsically valuable is to accept that every life has a purpose, a significance and meaning from its beginning to end. In this context, it is difficult to see how even the most sensitive legislation can do anything other than devalue this.

Protecting the vulnerable

There is a fundamental concern for the vulnerable and weak and a belief in the necessity to protect and cherish those less able to care for themselves. One marker of a society's compassion is how it deals with the most vulnerable. Legislating for euthanasia/assisted suicide poses the serious risk of devaluing the life of the individual when most vulnerable.

Approach to end of life care

There is perhaps no worse news to receive in life than that of a terminal diagnosis. The Church of Ireland, along with other Christian denominations, sees its clergy and chaplains minister to those who have received such diagnoses daily, with pastoral sensitivity and compassion.

It is our belief that one of the most important solutions to the end of life issues is that of freely available, professionally delivered, palliative care. This needs to be available in hospital, hospice and home. This is especially true of the latter, but there are increased demands for the final event to take place in a hospice, where patients have had care during the latter stages of their disease and have got to know the staff. So often this is not achieved due to lack of services, and appropriate personnel. Good end of life care helps patients with life-limiting conditions to live as well as possible until they die, and to die with dignity.

We note that the experience in Oregon where physician-assisted suicide has been introduced legally, there has been minimal uptake. It has been suggested that this was due to a considerable increase in the supply and standard of palliative care at the same time.

Medical profession

The medical profession has been given the skills to heal, sometimes to cure, and to care, and that it should continue to do, but at the same time remembering that there does come a right time to allow death to occur. We feel it is important in this debate to remember that there is a significant difference between requests for 'not to be resuscitated' or for treatment not to be initiated and for euthanasia/assisted suicide.

Slippery slope

There are considerable arguments of how often euthanasia/assisted suicide has been an involuntary procedure in the Netherlands, and in Oregon it is argued that because physician-assisted suicide is very rarely used, there is no risk of slippage or misuse. We would suggest that this should be looked at in the reverse, and that is that if there is good palliative care then there is no need for these other options.

In February 2014, Belgium became the first country in the world to abolish all age restrictions on the right to die after the Parliament approved legislation to extend euthanasia to terminally ill children. Many people, including Church leaders and

some paediatricians, questioned whether children would be able to make such a difficult choice.

In October 2016, the Dutch Minister of Health, Welfare and Sports advanced a proposal to legalise assisted dying for older people who are considered healthy but believe their life is complete. This could increase social pressure on older people and reinforce negative ideas surrounding old age.

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