Euthanasia means 'good death', not 'quick exit'

International Conference for Ageing and Spirituality, Auckland, 2 September 2009

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In his recent book *"Before We Say Goodbye",* Sean Davison provides a very moving and sensitively written diary of the last three months he spent with his late mother, Pat, leading up to her death in Dunedin in 2006. Terminal illness is a situation known sooner or later to us all, whether personally or within the whanau of family and friends. There are very stressful situations, and no easy answers

My mother died at age 90, frail, unable to communicate or do anything for herself. Although she did not contract pneumonia, our family was asked if in such a circumstance we would want the hospital to administer antibiotics, or keep her comfortable. We chose the latter. The question of euthanasia which such situations raise is a fraught one which most of us wrestle with personally. There is no simple answer, no hard-line ideological prescription.

I start from three principles :

1. Life should start, proceed and end as naturally as possible

2. With the aid of medicine and technology, we should take steps to maximise human wellbeing and minimise those factors that work against human wellbeing.

3. In the spiritual domain, we should facilitate the growth of a deeper sense of oneness with one's God (however defined), and the peace of mind and soul that comes with that.

In the case of someone in a terminal situation (which I know raises questions of definition of its own), I would define human well-being as :

4. Minimising pain and distress

5. Maximising the opportunity for human relationships, especially with those close to us, and promoting spiritual wellbeing.

The conclusions I draw from this with regard to those who are terminally ill are :

6. I see it as a matter of the patient's advance directives as to whether steps should be taken to artificially prolong life if in a terminal condition eg providing antibiotics to combat pneumonia, resuscitating someone after heart attack or stroke, or continuing with life support systems. The advance directives may be established by a Living Will or other statement of intent. For some in the medical profession, prolonging life may be seen as a question of professional pride.

7. The medical profession should use any medical means at their disposal to relieve pain and distress, and make the patient comfortable. If in the process this shortens the person's life, that is acceptable insofar as the intention is the relief of pain and distress. Again, I am aware that effective means of achieving this, eg by the use of morphine, are complex.

8. I am uncomfortable with any intervention to extinguish a person's life as a direct act by, for example, the injection or ingestion of chemicals having a lethal consequence. To me this has the

feeling of an execution, and contravenes the principle of allowing life to end as naturally as possible (see 1 above).

Euthanasia -Greek *eu* (good) *thanatos* (death) – is in common usage the situation outlined in (8), whether death be by the hand of others, or by others assisting a person to take his/her own life. *(See the final paragraph for a truer meaning of 'euthanasia').* There are several considerations here to note :

9. The period "before we say goodbye" can be rich with opportunities to deepen relationships, tie up loose ends from life, and say things we might not have the chance to otherwise say. This process is richly outlined in Sean Davison's book. The deepening of one's spiritual life can also be a central part of this process.

10. The euthanasia option could put pressure on the dying person to say "End it for me now, dear : I don't want to be a burden to you"

11. It might also lead to situations where a family conveys a message to a dying relative (even if only implicitly) : "Come on, Mum, do the decent thing".

12. The euthanasia option might be extended to people who are handicapped, depressed, or in some other situation which is not terminal, even although stressful. In such situations it is preferable to help people find new meaning and purpose in living, rather than make a quick exit.

13. The success of option 7 (making life comfortable for a dying person) is dependent on the availability of good palliative care facilities. A palliative care physician who has cared for large numbers of dying patients over many years reports never having been asked for assistance to die where effective palliative care facilities exist. But in rural areas such facilities may be slim or non-existent. This is a challenge to our health service.

14. We need to be aware of extensions of the euthanasia option. Australian euthanasia advocate, Dr Philip Nitschke, appears to favour voluntary euthanasia as a means to shorten the lives of the ailing aged as a means of reducing the fiscal burden on the nation's health budget. Nitschke writes : "So the next time you hear a government minister trying to argue why this or that payment or welfare programme for single mothers or war veterans must be cut, counter their argument with their fiscal irresponsibility on end-of-life choices." *(Killing me Softly, p 131, 2005).*

The choice is not easy. We are dealing with human life and death, pain and weakness, loving relationships that are central to our lives. On balance my view is that we need not artificially prolong life, nor terminate it by direct intervention. We should reframe our use of the word euthanasia using it not in the sense of a quick exit, but rather in its true meaning of 'a good death', one which values all life, seeks ways to make the ending of life as comfortable and pain-free as possible, while being enriched by the presence of family and friends, and the love of God.

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