Lecture #20: Euthanasia (Part 2)
(Detailed Notes)

"Give beer to those who are perishing, wine to those who are in anguish; let them drink and forget their poverty and remember their misery no more." (Prov 31:6-7)

Purpose of this Lecture: Discuss some practical considerations and concerns that we will face with those who may be dying

- o Definitions that help differentiate the situation
- o What about living wills and alternatives?
- o Some discussion questions to think about
- o A possible decision matrix to guide our decisions

1. There's great differences between "ending life", "prolonging death" and "allowing to die"

a. "Ending life (killing)"

- o The ending of a person's life by withholding routine or normal medical care
  - o Care needed to suppress infection, illness etc., normally secondary to the underlying illness or condition that is life threatening - thus bringing about death
  - o Care routinely applied to arrest further debilitation of the body and leading towards death - removal thus accelerating the dying process and is a direct contributor to it
- o The ending of a person's life by withholding essentials needed for life (food, water, air (oxygen), shelter); thus causing the death of the patient
- o Administering a lethal dose of medication, toxic element or poison (Dr. Kevorkian) that results (or brings about directly) the death of the patient
- o Allowing the means for the patient to take their own lives
- o This is never justified Biblically (see previous session); however, pain is to be relieved **(Prov 31:6-7)**

b. "Prolonging Death"

- o The action of using extraordinary means to keep the body alive at all costs with no expectation of improvement (or recovery); death is imminent; the patient is terminal (short time left)
  - o "Brain dead" patients? However, this is not foolproof - some have recovered
  - o The underlying illness or condition cannot be arrested, only slowed down
- o "Terminal patients", "Dying patients" and "imminent death"
  - o Terminal patients will eventually die, but may live active lives until the dying process overcomes them. This could be years
  - o Dying patients are those that are in the process of dying and continued treatment has no worthwhile benefit (other than comfort)
  - o Imminent death - those patients expected to die very soon, and even if extraordinary measures are applied to extend life, it will not extend it for long
  - o These terms vary in definition across the medical community!
- o This may not be justifiable Biblically **(see Session #19)**, great wisdom is needed to discern what is the proper decision to make; however, pain is to be relieved **(Prov 31:6-7)**
  - o If the patient is conscience and requests extraordinary care, it should be given
  - o If the patient is not conscience, what would be consistent with their desires and the benefit of measures potentially taken

c. "Allowing to (letting) die"

- o This involves the withdrawing (or removal) of extraordinary medical measures that have no hope of restoring to a better level of health, or not administering them in the first place
  - o This is not the same as refusing to give aid at an accident site, where readily available (ordinary) medical help can save a life
  - o Not same as forced to help only one of two facing certain death otherwise (ex: two fall into river, you have one rope, can save only one - which one?)
  - o Also different than triage, such as in battlefields or ER's where patients are separated into: those with no hope no matter how much care is provided; those who will survive and do not need immediate care; those who require significant care and there is hope

of survival (resource limiting conditions)
- Cases where the patient is near death and there is no hope of recovery
- For those that are conscience, hope remains until final death for ministering to others; for non-believers, hope of conversion remains until the end.
- For those not conscience, allowing the disease to take its natural course

- Patients should be made comfortable, with a minimum amount of medication to allow communication as much as possible
- Remember the famous quote: “As long as the Lord has a task for me to do, I cannot die”

d. What would you define "extraordinary" methods to be? (taken from note (3))

- Ordinary care:
  - Care that is customarily performed (changes with advances and availability)
  - Care that is obligatory (food, water, oxygen, shelter, pain relief)
- Palliative Care: care given to make a patient comfortable (meeting their physical, spiritual, and psychological needs)
- DNR = Do Not Resuscitate. Generally, orders to prevent any aggressive medical intervention should the patient stop breathing or suffer a cardiac arrest. Can be defined narrowly
- Extraordinary (heroic measures) care:
  - Any care that is beyond ordinary care
  - Optional treatment that is not likely to be beneficial or may impose burdens that outweigh the benefits offered

2. Planning ahead is wise, but limited - the best approach is to talk about your desires with your family

a. Living wills

- Definition: A legal document where a person stipulates what should be done if they are incompetent or unable to make his wishes known in life and death situations. Applies while a person is alive vice a normal will that applies only after a person is dead
- Advantages
  - It makes known under what conditions extraordinary care should or should not be undertaken to keep the person alive
  - By being written down it is not subject to the memory of someone else
  - Can prevent unduly extending the dying process
  - It can prevent enormous expenses from occurring from continuing medical treatment with no hope of recovery
  - It prevents excessive emotional trauma resulting from drawing out the dying process
- Disadvantages
  - Difficult to define a clear line between "ordinary" and "extraordinary" medical care; this also changes as technology changes (blood transfusion 100 years ago...)
  - "Hope of recover" term is used commonly, this term is imprecise (restoration of consciousness or quality of life?)
  - Actual care depends upon the nature of the illness or injury and may not be able to be anticipated in advance
  - A document created with a high degree of precision may actually inhibit the flexibility of the doctor to respond to a particular situation
  - The doctor's religious beliefs and/or philosophical framework may differ significantly from the patients, so that differences in interpretation may occur
  - A patients intentions when creating the living will may differ from their desires during an actual crisis - or they may have changed but the "will" was not updated
  - Litigation issues may be created requiring court rulings, thus delaying the process and affecting use of sound judgment
  - Advances in medical care may not be accounted for, thus use could be jeopardized
  - Like any legal document - it should be kept up to date and not done once then ignored

b. Alternative: Durable power of attorney

- o Definition: a legal document that gives legal authority to a designated proxy in addition to moral authority that the proxy has by virtue of family ties, church ties, etc.
- o Advantages
  - o Greatly increased power is resident in the proxy to deal with the physicians because of the legal sanction
  - o The proxy has opportunity to interpret his own words, while a legal document must be interpreted by others - thus there is greater potential for understanding
  - o The proxy can adapt to the circumstances (particulars of the medical treatment then available and/or the illness) while a legal document may not
- o Disadvantages
  - o The proxy may not know the current concerns or wishes of the patient
  - o (Be sure to keep on good terms with your relatives!)

c. Alternative: Any combination of:

- o Durable power of attorney
- o Living will with specific desires, what is allowed and not allowed etc.
- o "Values history" listing of what is important to you that will guide a proxy in better understanding what your decision would have been
- o "Advance Directives" which specify what your goals are in governing what health care is to be provided, i.e., being able to respond to others, being able to live without machines, etc.

d. Other considerations

- o Talking about our eventual death with family, relatives and/or others we are close to so that our desires are known and understood
- o When medical authority indicates that the continuation of extraordinary medical treatment cannot succeed in preventing death, they may be discontinued. However, treatments to maintain the patient's comfort and normal functioning must continue **(Prov 31:6-7)**
  - o Be willing to openly discuss the situation with the Doctor
  - o Do not assume the hospital or its staff has the same respect for life that you do
  - o Ask to see the instructions provided to the nurses on duty should a crisis occur
- o It is not right to require someone else to sacrifice their life for others (to minimize the economic burden on family, quality of life etc.)
- o Believing patients should have the fullest possible access to the ministry of the saints:
  - o Reading of the word
  - o Prayer together
  - o Fellowship, company, council by friends and family
- o Non-believing patients should have the fullest possible access to be ministered to since they are facing an eternity without Christ **(Job 33:19-30)**
- o We must be careful of our own motives if we are facing a close relatives imminent death
  - o Must make the decision in the best interest of the patient
  - o Must make the decision that brings the greatest glory to God
- o Hospital verses home or hospices
  - o Hospitals isolate persons from their family and friends and tend to be cold/clinical
  - o Hospitals minimize opportunity to minister spiritually to believers and non-believers
  - o Hospitals Tend to drug/sedate a person or distract by TV instead of the person facing their situation on the threshold of eternity!
  - o Death in homes can result in hard to overcome associations with familiar things, however, death at home provides a comfortable environment for the dying and greatly expanded opportunity to minister
  - o Hospice care can either be a facility to die in or care provided directly to a home

3. Bottom Line Thoughts

a. This society continues to make an idol of youth and want to destroy the weakest amongst us (unborn babies; infants with severe birth defects; the elderly and infirm; etc.)

b. We are to value life (no matter what the condition)

- o **Gen 1:27** - We are created in God's image
- o **Exodus 20:13 (Gen 9:4-6)** - We are not to take a life unnecessarily!

- o **Prov 31:6-7** - We are to give comfort to those that are dying

c. If facing life/death situations seek wise counsel, Biblical truths and principles, and pray fervently

- o **Matt 6:27** - God is sovereign over our lives, there is no untimely death (worry does not help)
- o **2 Cor 4:11-18** - Our hope is in Christ and the life to come
- o **2 Cor 12:7-10** - God's grace is sufficient for us, and will see us through to the end
- o **1 Cor 15:54-57** - We have the victory over death through Jesus Christ

d. In all of this - seek what will bring the greatest glory to Christ **(Phil 1:9-10)**

4. What can we realistically do as a testimony to this society?

a. Resist "Death with Dignity" laws which can cheapen life - write legislators and representatives
b. Write letters to the editor with well thought out arguments
c. Discuss with family and friends, relying upon Biblical principles more, and opinion less
d. Volunteer at hospitals, hospices, nursing homes, etc.
e. Take care of our own affairs as an example to others

5. Discussion Questions (as time allows)

a. "Is there Biblical warrant (or an absolute moral obligation) for a person to always accept treatment that would sustain life artificially?"

- o Biblically, life can justifiably be placed at risk for God's glory or for other people - but not with the intent to end our own lives **(2 Sam 23:13-17; Rom 5:7)**
- o Extending life is not the ultimate goal of our lives (one may accept death simply because it is inevitable or to prevent inordinate burden on his family **(1 Tim 5:8)**)
- o This "never say die" attitude can be making an idol of "life" itself (cryogenics; etc.)

*b. " Since "death" is the last enemy **(1 Cor 15:26)** should it always be resisted?"*

- o For believers, we know where we are headed - however, while in this body we can still be a testimony to God's glory **(Phil 1:20-26)**
- o We need not resist death at all costs - God gives comfort in knowing we are His **(Rom 14:7-8)**

c. "What about comatose patients?"

- o Coma is not the same as death or dying - and examples exist of those who have recovered
- o Comatose patients should receive the care needed just as those that are dying, as well as any treatment intended to try and bring them out of their comas (some have been successful)

d. "How about decisions concerning unbelieving, terminally ill persons?"

- o Treatment should allow the broadest opportunity for evangelism (isolation and mind-numbing drugs interfere with this opportunity)
- o As long as there is physical life there is hope

e. "How should research money or medical care be spent - how should priorities be determined?" (cancer verses AIDS research!)

- o Broad application of more routine medical care vice investment in expensive, advanced new treatments
- o Research and care for life-style induced medical conditions vice those that are not a result of a person's decisions
- o Resources applied for more common ailments (but less life threatening) vice less common but highly life threatening conditions)
- o Who receives organ transplants?

f. "Can a person decide for themselves to refuse "maximal" care in order to prevent others from suffering great burdens and expenses?" (self-sacrificial) **(John 15:13; Rom 5:7-8; 2 Cor 4:7-18; 12:7-10; Heb 11; 1 John 3:16)**

g. "Can a person justifiably choose a treatment to minimize suffering rather than one which lengthens their life?"

- o Pain medication can relax the body which hastens death in some circumstances
- o Relieving pain may increase the patients opportunity to minister to others
- o Pain medication itself is not the cause of death, the underlying terminal condition is

h. "Does a severely handicapped person who is a believer have a higher quality of life than a "normal" unbeliever?"

- o In a very real sense - Yes! Their lives speak to the glory of God **(1 Cor 10:31; Col 3:17,23)**
- o They can testify that they will be going to a far better place for eternity through

Christ **(1 Cor 15)**

- o Even a handicapped person has purpose to their lives, while a non-believer does not have an eternal perspective that is God honoring

6. See Handout: Decision Guiding Matrix

a. General guidance relating to decisions either by the patient or the care-giver
b. Obviously, each situation will be different
c. Provide feedback on applicability