BIOETHICAL COMMITTEE

OF THE BAPTIST, METHODIST AND WALDENSIAN CHURCHES IN ITALY

"This is the end. For me the beginning of life"

Euthanasia and Assisted suicide: a Protestant Perspective.

Document n. 18

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"This is the end. For me the beginning of life"[1]

Euthanasia and assisted suicide: a Protestant perspective

1.Introduction[2]

"*Over the past few years, the debate on euthanasia and assisted suicide has progressively widened, involving both the broad public and health care professionals supporting and treating terminal patients"*. Such was the beginning of the 1998 document on euthanasia and assisted suicide by the 'Working group on ethical issues raised by science' appointed by the Waldensian Executive Board[3]. It was published at a time when in Italy these topics were hardly debated, if at all. In many ways the document pioneered some issues which were going to play a key role in the Italian public debate in the following years , such as the role of medical science, able to extend life, often without improving its quality, the changing meaning and social role of the medical profession and the respect for patients' will (decisional autonomy) in their end-of-life decisions.

Nearly twenty years later, as members of the Bioethical Committee of the Baptist, Methodist and Waldensian Churches in Italy, we felt it was time to return to the subject, not only because the debate is still going on in the country, in fact having become even more important, (as proven by the debate first started in Parliament in March 2016), but also because, with time, the *status quaestionis* has undergone major changes.

First of all, the *involved subjects have changed:* in 1998 most cases concerned cancer or other terminally ill patients. Since we first started discussion, the debate has progressively included other conditions – from degenerative neurological diseases to permanent traumas of the nervous system, to mental conditions and persistent vegetative states. As well as involving a wider range of patients, the discussion currently also encompasses issues such as euthanasia for minors and for people not suffering from any of the aforementioned conditions, who simply wish to end their lives. The end of life debate is no longer limited to so called terminal patients, nor to the meaning of the medical profession and of care, but has widened to an extent that questions the basal anthropological categories of Western society.

The second issue concerns the *development of medical and pharmacological techniques*. Progress and higher standards of palliative care have deeply affected end of life settings in Western societies. Some believe that the new treatments may have decreased the urgency of euthanasia debate, others that help in death hastening is essentially a matter of freedom, the ethical statute of which is unrelated to technological development.

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1 The title refers to Dietrich Bonhoeffer's last known words before being executed in the Flossenbürg concentration camp on April the 9th 1945. See E. Bethge, *Dietrich Bonhoeffer. Eine Biographie*, Gütersloh, Gütersloher Verlagshaus, 1993.

2 The present document is the result of a discussion which lasted more than two years, with the participation of all the members of the Committee and which was approved by majority with three dissenting votes. Anita Ammenti, Ilenya Goss, Anna Rollier, Silvia Rostain and Luca Savarino all contributed to the drafting of the document which was finished in April 2017.

3 See the WG on the Ethical Problems Raised by Science, *L'eutanasia e il suicido assistito (*Euthanasia and assisted suicide), 1998, now available at http://www.chiesavaldese.org/documents/eutanasia.pdf

The third aspect concerns *available data:* it is now possible to debate on the basis of the statistics of the countries that have legalised euthanasia and assisted suicide over the past 20 years.
Fourthly, *the attitude of the Churches* on these topics has not changed: unlike what the 1998 authors had hoped for,[4] now as then, the Christian including Protestant judgement on euthanasia and assisted suicide is negative[5].

2.Definitions

End of life discussions often fail to distinguish the different situations they are dealing with. Thus, the difference between withholding or withdrawing treatment on one hand, and euthanasia and assisted suicide on the other, should be clarified. This will help to gain a better understanding of the terms being used both in a scientific and in a philosophical context.
The most common and comprehensive definition of euthanasia is: " a physician (or other person) intentionally killing a person by the administration of drugs, at that person's voluntary and competent request".
Assisted suicide is defined as: " a person intentionally helping another person to terminate his or her life, at that person's voluntary and competent request".
Euthanasia and assisted suicide differ from withholding or withdrawing treatment, the latter implying the physician's decision to withhold or to interrupt treatment, on the patient's explicit and voluntary request, even in the event that this decision may result in the death of the person.
When speaking about euthanasia and assisted suicide we are therefore referring to a *voluntary medical act* by which the life of a competent person (or a person who has given advanced directives stating their will) is terminated. In accordance with the guidelines of the main international scientific societies, we will not use the ambiguous definition of passive euthanasia.

3.Palliative Medicine

According to WHO "*palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering, by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual"*.

In the above described terminal phases, doctors and the care team are called to involve patients and their family members and to explain, in a shared way, what the procedure means and what the appropriate clinical and ethical treatments under the specific circumstances are. This stems from the awareness that care and therapy cannot only be aimed at the treatment of the disease or of the symptom, but implies caring activities

4 See *Ibid*: "Unquestionably the experience from other countries and especially Holland, which legalised euthanasia, must be cautiously studied if it is to be transferred to other social contexts. We believe that Italy has reached the time to deal with the topic and start the legal debate to stimulate public opinion as well as health professionals and churches".
5 See the CPCE *A time to live and a time to die*, http://www.leuenberg.net/time-live-and-time-die (In Italian *Un tempo per vivere, un tempo per morire*, edited by L. Savarino, Turin, Claudiana, 2012).

for the suffering person as a whole. The treatment of the disease is only useful as long as it benefits the person. When it does not fulfil this purpose any more, especially if it is invasive and intensive, care must be directed to the introduction or increase of palliative treatment.

WHO estimates that each year, in Europe, every 100.000 adults there are about 560 deaths of persons needing palliative care (40% with an oncologic disease and 60% with diseases other than cancer). Thirty to forty-five per cent of these patients require specialist palliative care. The remaining should receive general palliative treatment offered by all doctors, predominantly in primary care settings.

There are two possible scenarios for palliative treatment:

- an *alternative* approach, with end-of-life palliative care starting after therapeutic treatment has been stopped, that is to say when the disease does not respond any longer to specific treatments, and where controlling pain and other symptoms, as well as dealing with the psychological, social and spiritual problems of the patient become the focus.

- a s*imultaneous* approach: a recent development; it is used for an incurable and advanced but not yet terminal disease, in which palliative care is administered together with specialist treatment against the disease.

4.Continuous Deep Palliative Sedation (CDPS)

In the opinion issued on January 29th, 2016 the Italian National Committee for Bioethics (NBC *Comitato Nazionale di Bioetica* CNB) defined CDPS as "*the intentional administration of drugs, in the required dosage, to induce a state of reduced or absent consciousness, in order to alleviate pain and the physical and/or psychological refractory symptom which has become intolerable for the patient in the imminence of death"*.

Palliative medicine has been practiced for years in several European Countries and has led to the possibility of adopting a protocol of deep and continuous sedation, given a number of clear criteria, that is the patient's informed consent, an incurable disease in an advanced stage, death expected within a few hours or days, the presence of one or more refractory symptoms – i.e. not responding to treatment – or acute terminal events with intolerable suffering for the patients. Ethical approval of the treatment requires all the circumstances to be present at the same time.

The NBC's statement confirms the ethical nature of the procedure, rightly defined as a medical act, and rules out the possibility that it should be considered as a form of euthanasia. In fact, the medical literature shows that the average life expectancy of sedated patients does not differ from that of non sedated ones.

Like WHO, the NBC considers CDPS as a fundamental right for dying adults and minors because it fulfils the will of the dying person, even if underage. The person's will can be expressed through a living will or through advanced directives. The Italian NBC also accepts that the withdrawal of treatment – such as artificial nutrition and hydration – is ethically legitimate.

5. The Legal Framework

Laws in countries such as France and Italy allow CDPS, while banning euthanasia and assisted suicide.

In Italy Law 38 (approved in 2010) regulates palliative care. Article 1 states that: "a citizen holds the right to palliative care and to pain relief treatment". The Law also identifies two separate care networks (for pain relief and for CDPS) for adults and a single network covering both aspects for paediatric patients. A 2015 Parliamentary Report on the implementation of Law 38/2010 highlighted a mismatch between legal provisions and current practice. It suggests it is a basic right of every citizen to receive adequate support to control suffering and that the means should be supplied.

In France the Claeys Leonetti Law on the End of Life was approved on February 2nd,2016, after a yearlong Parliamentary debate. It establishes the right of patients with a short *quod vitam* prognosis to ask, or allow a relative to ask, for continuous deep sedation until death, allowing health staff to discontinue nutrition, hydration and life prolonging treatments. The Law also states the right of the patient to be fully informed by medical professionals of their state of health, treatment options and the right to refuse a given treatment through a trusted person or with advanced directives. At the same time, new palliative care centres have been scheduled across the country with a heavy investment in resources, and training in palliative medicine for all health care professionals has been programmed.

Other countries have decriminalised or legalised euthanasia or assisted suicide. New legal provisions on euthanasia and assisted suicide were approved in the United States in the late Nineteen Nineties (in Oregon in 1997). In the years that followed several western countries approved a range of provisions: Holland, Belgium and Luxembourg legalised euthanasia and assisted suicide; euthanasia was legalised in Columbia; a number of US States - Oregon, Washington, Vermont, California, and Colorado – did so, while in Canada assisted suicide was legalised. In other US states, such as Montana and New Mexico, euthanasia and assisted suicide were decriminalised but not legalised, and any medical staff assisting the process can no longer be persecuted. In Switzerland euthanasia is illegal, but assisted suicide is practiced regularly, as the law states that only persons assisting for 'selfish reasons' can be prosecuted[6]. Lastly, in Belgium and Holland there are also provisions for euthanasia in minors, though exclusively for children who show judgement and are conscious when euthanasia is requested. In Holland euthanasia can be performed on newborns and babies suffering from severe incurable diseases.

Access to such provisions is a very delicate issue: Switzerland is an extreme case, as the request for assisted suicide can be granted to any competent person. Furthermore, assisted suicide is also available to foreign citizens; it is a fee-paying service which is performed in cooperation with NGOs. In most other countries access is limited to nationals and follows very strict medical requirements: the patient's condition and suffering has to be certified by doctors, suffering must be unbearable and the condition fatal. In this respect, European and US legislation differ substantially: in Holland, Belgium and Luxembourg access criteria include the notion of unbearable suffering, while in the US legislation refers mostly to a more objective medical state, that is a ter-

6 For a more up to date overview on Europe (up to 2011), see *A time to live, a time to die,* especially Chapters 7 &8.

minal one. For this reason European legislation states that all applications and papers should be seen by a supervisory board, which checks the consistency of the procedures with the criteria laid out by law and has the power to reject the patient's application.

Other features are more fragmentary and country based: however, on the whole it can be said that in all countries with legal euthanasia and/or assisted suicide the number of cases has progressively increased and, for the time being, has not reached a plateau. The majority of cases is represented by cancer patients (70-80%) or patients suffering from neurodegenerative diseases (about 15%) or from heart and pulmonary conditions. As for the age groups, most, that is 30% of cases, are 65 to 80 years-old, a figure which drops to 15% thereafter. US literature also refers to the level of education: nearly 50% of persons requesting euthanasia or assisted suicide are graduates.

6. The Ethical and Theological Point of View

When debating end of life situations, a distinction should be made between the theological, ethical and legal points of view: above all, a preliminary and necessary agreement among them should not be presumed.

'Acts against the Faith' may be morally legitimate and vice versa: for instance, according to Bonhoeffer, suicide is a sin, but not an immoral action; according to Kierkegaard, Abraham's choice of agreeing to sacrifice Isaac makes him a model of faith but also a bad father for many.

Furthermore, there are morally problematic choices which we do not believe should be punished by law and vice versa there are morally legitimate actions which laws ban: for instance, no liberal democracy punishes adultery any more, but may punish pregnancies for others, not because it is inherently immoral, but because of issues of social justice or possible health risks.

As highlighted in the aforementioned document of the *Council of the Community of Protestant Churches in Europe*, European Protestant Churches admit the voluntary choice of a competent patient to withdraw or withhold treatment. This also applies to debatable situations such as withdrawing hydration and artificial nourishment in patients in a persistent vegetative state, who had given advanced directives for that interruption. Protestant churches are also in favour of extending and developing the palliative care system accepting, where necessary, the possibility of CDPS. On the other side, they maintain a firm and virtually unanimous condemnation of euthanasia and assisted suicide.

That said, the first question this paper raises concerns precisely the legitimacy of euthanasia and assisted suicide from the point of view of Christian ethics.

The arguments used to reject both euthanasia and assisted suicide often refer to the inviolability of human dignity, which believers consider to flow from the relationship with God the Creator and Redeemer. The value of individual life is not to be found in performance, functionality or even in autonomy: even a vulnerable and disadvantaged life is loved by and supported by God. Regardless of the conditions he or she is experiencing at the time, human dignity is what determines the right each individual has to be protected by any form of destruction, violation and exploitation. Human dignity is what determines the duty to care for those who are suffering; an efficient palliative care system fulfils this principle. Human dignity is what determines

the legitimacy of withdrawing or withholding a treatment in patients who believe that such measures will not contribute to their wellbeing and the quality of life.

Human dignity is also what determines the rejection of the two main arguments which the supporters of euthanasia and assisted suicide refer to: individual self-determination and the principle of beneficence.

As for autonomy, its absolutization is not compatible with the Christian view on human beings: such view is not based on autonomy as subjective freedom, but on the idea of a creatural freedom defined and made possible by the relationship with God and other human beings. There are many arguments which contrast absolute autonomy: the fact that even the secular idea of individual autonomy in its Kantian version can lead to the rejection of euthanasia and assisted suicide; the self-contradiction of a faculty or capability which leads to self-destruction; the difficulty of determining the level of autonomy of vulnerable, weak or terminally ill people with a good degree of certainty; and the idea of holding responsibility for a life received as a gift and not self-generated.

As for beneficence, it should be remembered that most of the requests for help to die are not determined exclusively by physical, but by psychological and existential needs. Our society is called to try and limit them through: i) efficient palliative care; ii) psychological support; iii) pastoral accompaniment, and iv) striving to offer a greater economic and social fairness.

We share the principles underlying the above: the thesis that the main task of Churches is to fight a public battle for palliative care and accompanying to death, thus limiting the requests for euthanasia and assisted suicide to a minimum. Likewise, we also believe Churches are called to promote cultural awareness to question the idea that the only worthy life is an autonomous and independent one, which does not require the care and assistance of others. The specific nature of Christian thought on end of life means raising awareness on issues such as life, death, suffering, disease and care. The secular and Roman Catholic points of view too often over-focus unilaterally on the legalistic and normative perspectives.

At the same time one wonders whether the request to have one's life ended must always be considered as opposed to a morally responsible life lived in Faith. In other words, one wonders whether such a request must always be classified as the rejection of one's life as a divine gift, as the misappropriation of a right which does not belong to humans, and condemned as a form of practical atheism[7]; or if, alternatively, under specific circumstances, it could be seen as a responsible answer to the Commandment, expressing love for God and for thy neighbour.

To avoid the dangers of ethics being legalistic, excessively unyielding in normative terms, most of the Twentieth century Protestant theology thought it preferable to deal with the specific contexts and the contingent situations in which decisions were made. This meant relinquishing the absolute theological and rational principles and the inflexible and literal interpretation of the biblical norm[8].

Our thoughts on euthanasia and assisted suicide refer to specific situations, the hallmarks of which are the central role of the medical context, the person's will, the unbearable suffering of a person who has no possib-

7 See D. Bonhoeffer, *Ethics*, pages 142 and following, Touchstone, 1955.

8 In this case reference is made to the hermeneutics of the Biblical text used by the Churches of the Reformation, far from a literalist approach to the Bible which is widespread in the Evangelical approach.

ility of recovering and the documented fatal outcome of its condition. The ethical reflection herein specifically concerns the meaning of helping someone to die within a very defined context: when care and every possible treatment, including an adequate palliative care , adequate psychological and spiritual and possibly pastoral care have been made available to the patient.

Euthanasia and assisted suicide can be considered from different points of view: the patient's, that of those who accompany the patient, and carers'. Although the situation is the same, the ethical and theological considerations vary according to the person's perspective. In this case, our focus is mainly on sufferers, their freedom and the choices they still have in an end of life situation.

To assume that the request to be helped to die is, inevitably, a rejection of the gift of God, and therefore of the bond with God, appears to us to be based on a unilateral, and barely justifiable, idea of the logic of gifting. Such logic does not necessarily imply that a gift is *inalienable* for those who receive it. Rather, it implies the idea of a *responsible* and grateful use of the received gift, in consideration of the bond this gift established In this sense, we believe that people in conditions of extreme suffering, requesting not to spend their last days in a state of drug induced unconsciousness, are not necessarily expressing a wish to turn their finite freedom into an absolute one, nor are they repudiating their relationship with God. It may be the will to deal with the gift of life in a responsible manner, trusting in the grace of harbouring the oppressed and the exhausted. It may mean confiding in a God who does not require a tribute of suffering, who does not impose conditions and obligations and does not subject humans to abstract principles.

In fact, God frees humans, giving the possibility of not continuing to live on earth in their hands. In some cases, the choice of death may be interpreted as a rejection of the gift, but in other cases it may be seen as a way of accepting it. It can be the awareness of the limits of human existence, understanding and thus accepting the finite measure of one's capacity to bear suffering. As discussed further in the text, [9] it may even be an expression of love towards others, one's neighbours.

A similar conclusion is not based on rejecting the idea that natural life is a gift which has to be preserved. It is based on the Christian tradition whereby natural life cannot be an absolute value. We think that nowadays such a belief can be usefully applied to a completely different historical and social context.

The relativization of the value of biological life recognizes a feature of the Gospel, witnessed in the text of the Bible. Some of Jesus's words give a meaning to life and death which go beyond our understanding[10]: Psalm 73 witnesses the prayer of the oppressed and exhausted, and trusts in the fact that when life ceases there will still be the relation with God ([11]). Paul's Epistles are also rich in words which suggest that life and

9 See for instance *infra*, note 13.

10 For instance see Jn . 11, 25-26: "those who believe in me, even though they die, they will live " New Revised Standard Version (for all quotations unless otherwise indicated).

11 See. Psalm. 73,26: «My flesh and my heart may fail: but God is the strength of my heart, and my portion forever ». The suicides the Scripture writes about do not seem to be guilty because they terminated their lives, but for the things that preceded their final tragic act. Abimelech who asked a servant to kill him (Hebrews 9:54), Samson who died taking the Philistines with him (Hebrews 16:26-31), Saul and his arm bearer (I Sam 31:4-6), Ahitophel hanging (2 Sam 17:23), Zimri dying in the fire that he had started (1 Kings 16:18) and Judas in the New Testament (Mt 27:5). Augustine condemns suicide in his *De civitate Dei*, IX, 17, and in the 6th century suicide was defined as a sin (for religion) and a crime (in a lay sense), but Augustine's very strong position can be explained as a reaction to the Donatist position that saw suicide as being close to the idea of martyrdom.

death have an intense meaning, able to overcome the level of physical experience[12]. It is possible to perceive that there a relationship between life's historical, contingent and eschatological meanings. According to the Scripture, the meaning of life cannot be understood within a 'penultimate or one-but-last' horizon, but opening one's self to a wider perspective, i.e,. in the context of Faith, to confidence in God when faced with the extreme limit of one's existence. In the physical experience, life and death are the "final" horizons, but they acquire their authentic value in their relativization when referred to God, able to transcend them.

The idea that the tenet of Christianity is the responsibility to God and our fellow humans, and not the respect for life is also consistent with an authoritative Twentieth century Protestant tradition[13], whereby the biological dimension of our existence is a good but not the ultimate good, that being devotion to God. This devotion implies a free and responsible answer, where human intelligence interprets the Commandment in the context of the existing historical situation. Exactly on this aspect the specificity of the Protestant ethical view emerges, with agreements and disagreements with some roman-catholic formulations: in the awareness that God does not require a tribute of suffering and that He embraces those who trust in Him, welcoming the announcement of Grace, all this making it *possible* to ask for help in dying.

This is why we believe that, under certain circumstances, voluntary termination of life can be admissible, albeit as an extreme solution. Where our position differs from that of non-believers is the idea that, ethically, this choice has to be made under exceptional circumstances, requiring specific motivations. In a Christian perspective, it cannot be seen only as the enactment of individual freedom and autonomy, expressed by the possibility to decide when one is going to die. It can be considered as a possibility which i) in some cases is legitimate, and ii) understandable in the framework of complex responsibility, to God, to others and to one's self.

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12 See Phil. 1, 20b-21 "It is my eager expectation and hope that I will not be put to shame in any way, but that by my speaking with all boldness, Christ will be exalted now and always in my body . whether by life or death", and Romans 8, 38-39: "For I am convinced that neither death nor life, neither angels nor demons neither the present nor things to come, nor powers, nor height nor depth, nor anything else in all creation, will be able to separate us from the love of God that is in Christ Jesus our Lord."

13 Even considering the historical distance and the specific context where these thoughts developed, marked by the tragedies of National Socialist Germany, Dietrich Bonhoeffer's and Karl Barth's thought follow along the same lines. "*If a sufferer from incurable disease cannot fail to see that his care must bring about the material and psychological ruin of his family, and if he therefore, by his own decision, frees them from his burden, then no doubt there are there are many objections to such unauthorized action, and yet a condemnation will be impossible*." (D. Bonhoeffer, *Ethics*, *op cit* p. 169). In a nutshell, Bonhoeffer's arguments could be summarized in three key points which all converge in the refusal of a legalistic interpretation of the choice for death. First of all, suggesting that suicide can be interpreted as a lack of faith, and therefore a sin, but not as an immoral act against the human or natural law. Furthermore, also in terms of the Christian faith, killing one's self does not always correspond to suicide and cannot therefore be considered a sin. Lastly, the idea that according to human criteria it would be impossible to distinguish an arbitrary and selfish act from the responsible sacrifice of one's life in the name of a greater good and answering an order of God's. Also Karl Barth, in *Dogmatica*, reaches similar conclusions on this argument: God's commandment, which lays down the rights of a natural life and which for a Christian is generally speaking valid, but which in some cases, the most extreme cases, can be overruled by greater or higher considerations such as an altruistic motif or to obey a Commandment of God's. Barth points out that this issue is especially important in the context of modern medical science: "One should consider how things will evolve in the context to have a clearer idea. However, it is possible that this may be one of those limit cases (*Grenzfall*) . In this event it would not be an arbitrary euthanasia, but respecting a life which is fading away, offering the respect it is owed." (K. Barth, *Die Kirkliche Dogmatik, III/4 – Die Lehre von der Schöpfung*, Zürich, Evangelischer Verlag Zöllikon, 1951, p. 488).

7. **The Social and Legal Point of View**

European Protestant Churches not only tend to deny the ethical legitimacy of euthanasia, but also oppose its legalisation.

Over the past few years, Western societies have become markedly pluralist: Churches can no longer think they are only addressing their members, but are called to think of how they can uphold and argue their positions on political and legal issues in a public sphere where there are believers of many denominations, as well as non-believers. Although these views cannot be outside the relationship with one's faith, it is also true that, being addressed to society as a whole, one has to try and develop it in more comprehensive terms. The balance between the options of faith and reasoning is always fragile and the object of many a discussion.

Although from a Christian point of view, euthanasia and assisted suicide can be considered legitimate only under certain circumstances, it has to be ascertained on which basis Churches argue against their legalization. In other words, a claim from Churches to extend their ethical views to the entire society has to be avoided, at the same time supporting the fact that they uphold their views on the basis of universal reasons.

From a legal point of view, the law must consider what to do when faced with a legitimate substantial interest and with other situations which may be just as worthy of consideration, but are in conflict with the former. In that case the judiciary would have to choose between two opposing worthy interests.

The reasons adopted to question the legitimacy of the legalisation of euthanasia and assisted suicide, even for people who do not share one's faith, mainly refer to two main categories of arguments:

First of all, it is claimed that the progress in palliative care, and in particular the introduction and improvement of CDPS are able to control the dying patient's pain in all cases, thus reducing the social demand for euthanasia. Terminal patients in their last days and hours of life suffer from a series of symptoms, including hallucinations, anxiety, restlessness, dyspnoea, pain, vomiting, physical and psychological distress. In the final stages of life, patients may become unresponsive to auxiliary and palliative treatment. CDPS is a possible solution to relieve those symptoms, which cannot otherwise be controlled. Sedatives such as benzodiazepines are used at increasing doses to obtain the required level of sedation; such level can easily be maintained and the effect is reversible. Unlike what was often said in the past, recent studies appear to indicate that in most cases CDPS does not shorten patients' life, on the contrary, it can extend it. However, it is also true that there appears not to be any scientific evidence on the effectiveness of CDPS on the quality of life and the control of *all* a dying person's symptoms[14]. Furthermore, neuro-scientific studies on the mental state in end of life situations do not allow us to rule out, with a good degree of certainty, that these people do not have hallucinations, in spite of being unconscious. Another point is that palliative care in some cases can stretch to days or even weeks, which makes it difficult to manage.

From a spiritual, psychological and pastoral point of view, it is certainly true that condemning euthanasia and assisted suicide on the one hand, while supporting the withdrawal/withholding of treatment on the other, may allow to guarantee a greater consistency with the rituals that pastoral work has always tried to stress, as an essential part of the human dying process.

14 See the Cochrane Library study entitled *Palliative Pharmacological Sedation for terminally ill Adults*, available on line.

That notwithstanding, the reasons and the possible limits of the difference between withdrawing/withholding a treatment – always considered legitimate – and the request of euthanasia and assisted suicide – which is thought should be banned-, have to be carefully reconsidered. The document of the Council of the Community of Protestant Churches in Europe makes this difference. The document rightly recalls that such a distinction cannot be sought in the results of the action, which is this case would be similar if not identical; nor can this distinction be understood in terms of intention, which cannot be easily defined and is controversial by definition. The real moral difference is the distinction between omitting and acting, or better said, between killing and letting die: a causal action is not like failing to prevent something from happening.

Ethically the line between killing and letting die does not always hold. On the one hand, killing is not always considered a morally reproachable act: over time, Western theological and philosophical traditions have defined a long list of exceptions to the principle of 'thou shalt not kill' which range from self-defence to capital punishment; from just war to abortion. On the other hand, letting die is sometimes considered reprehensible: a person who refused to help a newborn who had accidentally slipped into a bath tub would be seen to be as guilty as someone who had deliberately drowned the newborn. There are situations where allowing an event to take place means being an accessory to the crime.

With this, we do not wish to deny ethical and legal distinctions between killing and letting die: we are simply saying that it is not an absolute distinction. Let us take the case of a doctor asked to end the suffering of a competent patient, who does not want to spend his last days or hours unconscious. It is psychologically understandable and existentially legitimate for the doctor to refuse, so much so that in this case the law maintains the right to conscientious objection. However, it is difficult to uphold a position whereby in the first case *death is always due to the disease,* while in the second case the doctor's actions have arbitrarily put an end to an innocent person's life.

One therefore wonders whether, in the case of terminal illnesses with a very short time remaining to live, the difference between shortening life by a few hours or days or having palliative care with so called CPDS is ethically significant.

The more so for the cases where palliative care is unable to control all the symptoms that indicate suffering in the patient. As the Council's document reads, we have to consider that even an adequate system of palliative care may not be able to totally eliminate the social demand for euthanasia[15]. As a result, we ask ourselves how we can interpret this demand and what answers can be offered to it.

The second series of reasons adopted to question the legitimacy of legalising euthanasia and assisted suicide draws from a series of prudential arguments, based on the negative consequences of legalisation. First and foremost, the fear that the introduction of the legitimacy of euthanasia and assisted suicide into medical practice and legislation may lead to accelerating death even in unaware or non-consenting people. It might be a slippery slope at the end of which we could have the legal suppression of the elderly, disabled or maladjusted people. In Western societies with the severe cuts to health funding and an ageing population, euthanasia could be seen as a solution to the problem of allocating resources for the treatment and pain alleviation of

15 See *A time to live, a time to die,* especially Chapter 8

terminal patients. Secondly, the idea that legalisation of euthanasia could establish the principle whereby only an autonomous life is worthy.

The above are legitimate concerns, especially in a context such as the Italian one, where one must consider the cultural and health service specificity. Discussions on end of life, the dramatic cases debated in the media highlighted how, in Italy, it is extremely difficult to start a serious debate on these matters. In terms of what the health service can offer, palliative care is not available throughout the country and people often lack the necessary information on what is on offer.

In this context, as well as an ethical and theological debate, Churches are called to act civically and pastorally, in order to spread an informed and aware end of life culture, in cooperation with what is already happening among specialists in research and in health care professionals training.

8. Conclusions

Our hope is that a calm and peaceful in depth debate may develop on such a delicate topic, both within the faith communities, and in the wider Italian public . We believe that the main task of Churches is not to offer normative solutions but rather to contribute to a cultural debate, favouring the growth of a collective awareness on the matter. The debate should be carried out bearing in mind available scientific evidence based knowledge and the legislation of the countries which have followed a similar path over the past twenty-five years.

We are aware that it is a very controversial and divisive theme, which is why we have tried to separate the various levels of the debate, in spite of the fact that they often overlap and intertwine. This is especially true for the scientific, ethical and juridical aspects. Subsequently, we should distinguish Christian ethics mainly addressed to a community of faith from secular ethics which one expects will use universal arguments.

Our point of view is informed by Faith, but in no way wishes nor expects to generalise a specific moral, making it absolute. It carefully considers the context where individual choices and political dynamics take place. Within this framework we believe there are no universal arguments whereby one can consider the choice of a person to die as *morally* illegitimate. We do however recognise the need for a prudential approach, maintaining alertness on the possible negative social dynamics of the legalisation of euthanasia and assisted suicide.

We are aware that the legislative outcome of such a debate may differ greatly: there are countries such as France that ban euthanasia and assisted suicide but allow CDPS ; there are other countries that have legalised euthanasia or assisted suicide, and others that have opted for an intermediate solution, that is the decriminalisation of euthanasia and assisted suicide in very few selected and special cases[16].

16 While maintaining their position against legalization of euthanasia and assisted suicide, the Document of the Council of the Protestant Churches of Europe accepts the possibility of going against the law in extreme and rare cases as a need to consider both: "Most importantly, legalising euthanasia implies normalisation of a procedure to end the life of a seriously and irrevocably ill person with the approval of state and society. Irrespective of the claims by those who favour legalisation that there will be strict legal requirements and conditions, and it will be reserved for exceptional and rare cases only, this still implies introducing euthanasia as an element of ordinary legislation and juridical practice" (*A time to live, a time to die*, page 43).

Whatever solution will be adopted in Italy we believe that individual autonomy (not easily definable and even more difficult to measure in practice) cannot be the *only* socially acceptable criterion to legitimate the individual decision to end one's life. Autonomy is a necessary but not sufficient condition for a good end of life legislation: as well as autonomy, legislation should draw from beneficence (the need to answer to the request for euthanasia and assisted suicide to persons suffering from unbearable pain), non maleficence (avoiding social abuse in accessing programmes) and justice (death without pain should not only be a privilege of the wealthy).

Euthanasia and assisted suicide are seen as ethically one and the same: it is true that from a practical point of view they are two different paths leading to the same result. However, from the philosophical and symbolic point of view there are major differences in terms of the principles which inform the two actions. In the case of assisted suicide the autonomy of the patient is in the forefront: the patient is both the person making the request and the material executor of the action. In the case of euthanasia, beneficence (which justifies the doctor terminating the life of the patient) and in this case autonomy is a mere constraint, a necessary but not sufficient condition to justify the legitimacy of this practice. The case of euthanasia on minors is emblematic, that is to say euthanasia on people who are not legally able to express consent. In this case one resorts to substitute consent (for instance the parents) trying, as far as possible, to match it with the will of the minor.

However, from an ethical and anthropological point of view, voluntary death should be considered the lesser evil and not the supreme expression of human freedom. Our position stands for a reasonable and in-between anthropological ideal: we are not guided by the indiscriminate autonomy, but by mercy which is what leads us to respect the point of view of those who are suffering, to defend their right to choose and at the same time to try and limit their suffering. As believers, we would like to live in a society where the request for euthanasia is reduced to a minimum. This is why we favour the greatest extension of palliative care.

We would like to express our concern with legislations – such as the Swiss – which have *de facto* liberalised access to end of life programmes in an indiscriminate manner. We are also concerned with laws such as the Dutch one which intends to introduce formulations which in practice cannot be clearly defined ('*feel one's life is complete).* We believe that to avoid dangerous slippery slopes leading to abuse a legalisation or decriminalisation of help in dying should be linked to an objective criterion, that is to a medical diagnosis.

The principle underlying our remarks is *mercy*, a principle which cannot be exclusively understood on a general and abstract level – as in the case of legislation: it has to be seen in its practical use, in relation to people asked to carry difficult and debatable choices. This principle is one of the hallmarks of Christian ethics, but can reasonably be shared in a secular perspective. Given this premise, we do not believe there are sufficient reasons to disagree with the conclusions of the 1998 document, which expanded the notion of care so that in extreme cases it also included the help to die: "*One has to acknowledge that there are no definitive ethical nor pastoral justifications to oppose it in principle. We cannot avoid the question another person insistently puts and which I perceive as a serious one: on which side is the God of promise and life? On the side of the unpurposeful extreme pain of a terminal patient, or on the side of his/her human desire to die? Paradoxical as it may seem, in this case accepting the request for death means accepting the request for life, accepting that the person has the right to die aware of their own death. The doctor who accepts this request by a ter-*

minal patient does so within a treatment and care relational process. Doctors who assist suicide or euthanasia are not committing a crime, nor violating any divine law, they are performing a human act of deep respect, defending that life that has a name and a history of relationships"

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