



Is Physician Assisted Suicide the way to a good death?



RESOURCE PAPER 12 — revised 2021

The shadow of death falls over all of life. We can ignore it or suppress it, but never escape it. When it comes to the reality of death, the Bible is more honest than much of modern culture. Psalm 23 acknowledges the ‘valley of the shadow of death’ —and yet is confident that God is with his people even there. Debates about euthanasia and Physician Assisted Suicide force us to think about the reality of death. This paper aims to help you think from a biblical perspective about spiritual, ethical, medical, social and legal aspects of the discussion.

The heart-breaking case of Brittany Maynard

Brittany Maynard’s heart-breaking story captured world headlines in 2014 and put euthanasia onto the public agenda in a new way. Only 29 years old and newly married, she was diagnosed with a brain tumour on New Year’s Day. Despite immediate surgery the tumour returned and by April her prognosis was bleak: probably only six months to live with very limited options. Whole brain radiotherapy might slow the progress of the cancer but the side-effects would be awful. Instead, Brittany decided to have minimal treatment while she ticked off some of her ‘bucket-list’: Alaska, British Columbia, Yellowstone National Park, and a helicopter ride in the Grand Canyon. And she moved from her home state of California to Oregon where she could access legalised Physician Assisted Suicide (VAD).

She chose November 1 as the date for her death. That morning she had another small seizure, a reminder of what her condition held in store for her — blindness and paralysis. She and her husband, Dan Diaz, went for a hike in the morning with family, friends and their dogs. She posted a Facebook farewell: “Goodbye to all my dear friends and family that I love. Today is the day I have chosen to pass away with dignity in the face of my terminal illness, this terrible brain cancer that has taken so much from me ... but would have taken so much more”. She mixed the sedative she had been supplied and drank. For a few minutes she talked and joked with her friends and family and then fell unconscious. Her breathing slowed, then stopped. Her husband said, “It truly was the most peaceful experience that you could ever hope for when you talk

about a person's passing".¹

Brittany's story shows a great deal about the current discussion of euthanasia. It is immensely personal, and yet very public. Dan Diaz held back on many of the details of her final minutes saying they are 'sacred'. He is right. It is hard to think of a more intense or personal moment. The patient and family and friends deserve some privacy and protection. Hospitals and nursing homes close the door and draw the curtains around the dying.

Yet, euthanasia is also topic of public debate. To promote the cause, Brittany Maynard allowed herself to become the focus of intense interest. Her story hit the headlines and captivated social media. She gave several TV interviews, wrote an op-ed piece for CNN, kept a blog and had a series of you-tube clips with her and her family. Her case was highlighted by *Compassion and Choices*, an "end-of-life choice" organisation. Her beautiful wedding portraits, shots of adventure travel and happy informal snaps are just the kind thing that fill social media feeds. She was young and articulate. Many people felt connected with her and that gave the story punch. Her public advocacy helped to change the politics of euthanasia, bringing the millennial generation into the campaign.

Brittany's case aligned with the title of the organisation which promoted her story — *Compassion and Choices*. The horror of facing an awful, life-crushing disease at a young age stirs sympathy. How can you not feel compassion? It is also easy to understand that she wanted a choice about her death. We want control of our lives. Surely that should extend to death as well? The *Compassion and Choices* campaign succeeded a year later when California enacted the End of Life Option Act to allow Physician Assisted Suicide.

Many Christians and churches are opposed to legalised euthanasia. How do we respond to heartbreaking situations, like that faced by Brittany Maynard? What do we think about euthanasia? Can it be compassionate? How do we debate the issues in public? Should Christians oppose legislation like the California Act? What if we, or

someone in our family, faces a similar situation to Brittany? This paper will help you think about issues of life and death in the light of the gospel.

Life and death and the gospel

The gospel announces that, in Christ, God is Lord of life and death. He gives life to all, claims the love and service of everyone as his creatures, and he is the Lord over death.

God is the Creator of all life. It all depends on him and it all praises him (see Ps 104). God, the Creator, puts a boundary around human life, since humans are made in his image. So God says that murder is wrong (Ex 20:13; Gen 9:5-6). There is a particularly special value and sacredness about human life. God doesn't put the same limit on animal life (Lev 24:17-18). He allows us to cut down trees and mine the earth. Of course, we should be careful in the way we use the environment, but people can and should use it. Human life, however, receives a special protection from God.

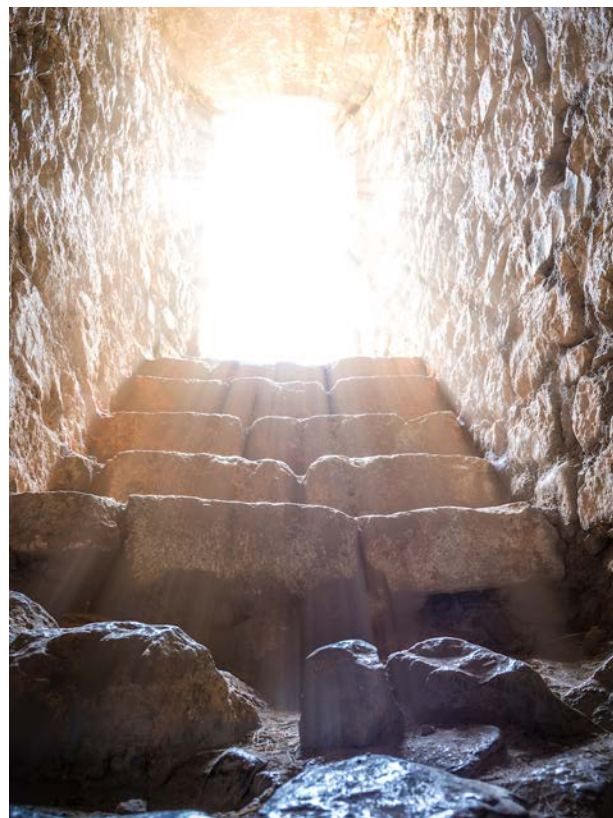
This protection extends to every human life. All people are made in God's image, so every person is valuable and every life counts. It is not just productive lives that matter, or those of the rich, strong, male, white and able bodied. It is an atrocity that people who claimed to follow Christ have allowed slavery or supported apartheid, because in doing so they robbed people of the dignity and protection they deserved as those in God's image.

The Christian commitment to the "sanctity of human life" is based on these truths. Every person is valuable and each human life is preserved for God. He determines life and death: we aren't free to do this. So, although the Bible does not *directly* address euthanasia, it clearly shows that human life is not ours to take.

God not only places his protection on human life, he also claims our lives for himself. Every human is made as someone who should know God and live for him. The Westminster Shorter Catechism famously says that our chief end (that is, our great purpose) is "to glorify God and enjoy him forever". This theological perspective on

life challenges many modern assumptions about a genuinely good life. Autonomy and choice are not the highest human aspirations. Yes, we have responsibilities and choices — but the goal is not merely to exercise that capacity, but rather to direct it toward God. Similarly, suffering is bad, but turning away from God is worse; so human suffering can serve the greater end of leading us to God. Paul speaks of this when he says that Christians “glory in our sufferings”, because we see that through God’s grace they can develop our character and direct us to God as our true hope (Romans 5:1–5). This challenges several of the assumptions that support the arguments for the legalisation of euthanasia. Freedom to choose to avoid suffering and to embrace death in our own timing do not make a well lived life. God often calls us to persevere through suffering for his sake.¹

Death and dying are inevitable because of sin. God warned Adam that if he ate from the tree of the knowledge of good and evil he would certainly die. When Adam ate, God declared that humanity would now return to the dust from which we are made. In God’s mercy, death did not come instantly, but it came. Human life is limited and there is no way that anyone can avoid the reality of death. Death is “the last enemy” (1Cor 15:26): that is, it continues its cruel dominion over humans throughout history. There is no escape from death until God brings human history to a close and puts all enemies under Christ’s feet. Death not only ends human life, it fills it with pain. Bodies ache, breath labours, disease spreads, organs fail — all of this is an inevitable reality of life in this present age. This is not, in itself, an argument against euthanasia. It is simply a reminder that until the Lord returns, we cannot entirely avoid pain and suffering. That said, we will consider the importance of pain relief later in this paper.

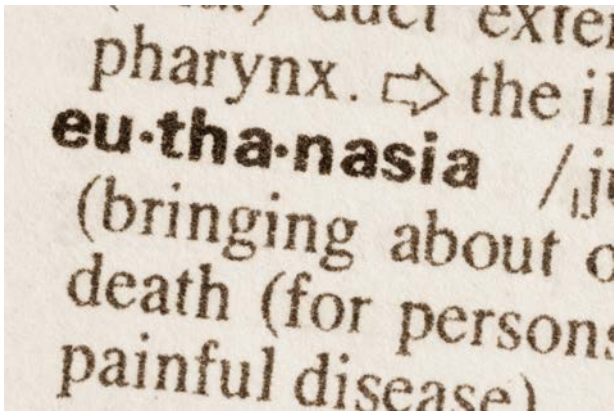


Death is inevitable but it does not have the final word. Jesus says, “I am the resurrection and the life. Those who believe in me, even though they die, will live, and everyone who lives and believes in me will never die” (John 11:25–26). The last enemy will, finally, be subdued. The end of 1 Corinthians 15 is filled with triumphant confidence springing from Jesus’ resurrection. Yes, death has come to all because of Adam, but Christ has now been raised and his resurrection ensures his final victory over death and the resurrection of all who are in him (1 Cor 15:20–26). Believers will be transformed in the resurrection to be like Christ. Before then, God’s people will be with him in death (Philippians 1:21).

Care for the sick and dying

Resurrection hope allows Christians to face death and dying with assurance. Yet because God is opposed to death and suffering, Chris-

¹ There are, however, two exceptions in which it is permissible to take a human life: capital punishment and warfare. Each of these raise some complex questions about how they apply to modern life, and Christians differ in their understanding. (For a summary of arguments for and against capital punishment see: <https://www.thegospel-coalition.org/article/why-i-oppose-capital-punishment>). At the very least we can say that these are exceptional circumstances, only permitted for certain authorities to punish wrongdoers and protect people.



tians do not merely resign and accept it. Death and suffering are inevitable, but they are not the whole story. Christians seek healing, where possible. The true and living God is “the Lord who heals” (Ex 15:26). The Bible celebrates healing as an element of God’s blessing and salvation (Ex 23:25-26; 2Ki 20:5; Ps 103:3; 107:20; Jer 30:17; Hos 11:3). Jesus’ miracles revealed the power of the kingdom over the interrelated realities of demons, disease and death, and he spoke of a kingdom in which all these effects of sin would finally be overthrown. Christians know suffering will come – they are realistic about it, but not passive. When healing is possible, we embrace that. When it isn’t, we should offer care and support for the sick and dying.

The Christian commitment to healing and care is the historical origin of public hospitals. Greek and Roman culture had medical services, but these were anything but philanthropic. Early Christian congregations cared for people in the surrounding community, irrespective of their status, and they established institutions to pro-

vide medical care.² From the third century, most urban Christian congregations had an arrangement to care for the poor and the sick; and during the fourth century they began to set up hospitals as distinct institutions. Since then, Christians have always had a commitment to providing medical care, often as part of their mission.

These great truths frame the Christian view of life and death: human life is God’s gift which no one is free to take; every life belongs to God and is meant to serve him even through suffering; in the face of inevitable disease and death Christians seek healing and offer care; and in Christ there is the promise of resurrection life beyond death. Together these mean that Christians oppose taking life, are realistic about death and but also refuse to live as if death is the end. This, then, determines how we think about euthanasia.

Getting the terms straight

When we turn to the question of euthanasia, it is important to be clear about terminology. Some of the terms are technical and quite specific, and can also influence our thinking and discussion.

Euthanasia literally means “good death”. The word is used to describe a wide range of actions might which lead to the ending of a person’s life and to situations in which deliberately refraining from acting leads to the someone’s death.

There is an important distinction between “active” euthanasia and “passive” euthanasia. Indeed, this is such an important distinction, that it is better not to use such terms (and gladly some



new terms have been developed). *Active euthanasia* involves an action, such as giving an injection, which is intended to cause a patient's death. In the past this has been called *mercy killing*. By contrast, *passive euthanasia* involves allowing a patient to die due to the effects of their disease. This may involve taking them off a ventilator which has been sustaining breathing. It is better to call this 'allowing to die', than to think of it as if it were another version of euthanasia.

However, in some circumstances, it is quite right to decide to no longer treat someone and to allow them to die of a condition which is clearly taking their life. That is, the expected course of the disease is such that the patient will die in the next hours, days or weeks. It is not a question of whether to try to cure the disease or even to reverse many of the symptoms; there is no effective treatment which is likely to bring substantial healing. It is not always easy to know if that is the case, but often the likely course is obvious. "Allowing to die" often means refraining from actions, such as not giving a patient renal dialysis (which maintains the chemical balance of the blood as a replacement for kidneys which have stopped functioning). A further example would be the decision not to resuscitate a patient who is in the end stage of a terminal disease and has a heart attack.

The *intentions* of actions are important in assessing them. God has made us as people who are able to plan our actions and set goals, so the morality of our actions depends significantly on our intentions. That is not the only relevant way in which we judge our actions, but it is an important one. It is wrong to treat a patient in a way which deliberately seeks to end their life; but usually it is very appropriate to seek to relieve pain and make the person as comfortable as possible.

We do not have a responsibility to extend a person's life as long as possible, irrespective of the condition of that life. Sometimes, we recognise that a patient will have greater comfort and dignity if they are not put through further treatment but helped to be comfortable and allowed to prepare for death. Our society likes to think

that medical prowess is stronger than death. Despite daily evidence to the contrary, we are told that we can always hold off death. This is a myth. There is a point at which the proper response is acceptance.

Clarifying the distinction between euthanasia and allowing to die does not solve all our ethical conundrums. There are still very difficult decisions to be made about how long and how aggressively to keep treating patients. These decisions need to be made carefully and, when possible, the patient and his or her family should be the ones who make decisions, on the basis of good information and with the support of the medical staff.

Recent discussion has made more use of the terms *Physician Assisted Suicide (PAS)* and, even more recently, *Voluntary Assisted Dying (VAD)*. This term applies to a situation, such as that of Brittany Maynard, in which the patient takes a prescribed drug to end their life. Using the word 'voluntary' emphasises the patient's agency. This may reduce fear about doctors acting arbitrarily to end the life of a vulnerable patient. It is often argued that the ability to end one's life voluntarily is a basic human right. This, it is said, is significantly different to a doctor taking a patient's life.³

Arguments for VAD often include the claim VAD often includes the claim that choosing to end one's life is the equivalent of refusing treatment. This is similar to the claim discussed previously regarding euthanasia—that allowing to die and killing are equivalent. But if those arguments are not convincing in the case of the doctor's action, then they are not convincing when applied to the patient's action. In neither case is allowing to die the same as taking life. What is more, Christian teaching has been that suicide — taking one's own life — is tragic. Western societies are increasingly concerned about suicide and are working to prevent it. In this, they recognise that life is valuable and should be preserved and protected. It is tragic that VAD is promoted alongside suicide prevention schemes.

The appeal of Physician Assisted Suicide

The debate about VAD highlights how we think about humans and what makes life worth living. Our society often assesses human life by how functional or useful it is. People whose minds or bodies do not seem to work well might be viewed as having come to the end of their (useful) lives. We also often assume that the goal of life is gaining pleasure and avoiding pain. So, when someone has enormous pain, then almost anything can be justified if it relieves the pain. Further, our society views people as autonomous—we believe that as far as possible we should make our own decision about our own lives and bodies according to our own right.

These views combine to give our society a perspective which is inclined to accept VAD. A poll taken in May 2015 suggests that 72% of Australians think that VAD should be allowed for people with incurable disease with severe pain.⁵

Ironically, medical advances have contributed to the increasing pressure for euthanasia. In the last century, our ability to understand and treat medical conditions has improved remarkably. Many people survive longer after being diagnosed with conditions that used to lead to death quickly. This means they may face prolonged pain, although in some cases, our ability to relieve pain or cure these conditions has also improved. Modern medicine is increasingly proficient at diagnosing and predicting the course of illnesses and what effect treatments will have. It is often possible to keep a person alive for months or years even when the disease will end their life eventu-

ally. One effect of medical improvements is that health care costs have soared. In 1960-61 health care cost 3.8% of the Australian GDP; in 2007-08 it cost 9.1% of GDP (figures from *The Australian Institute of Health and Welfare*). It is no surprise that we begin to wonder about the cost of treating people who are dying, and dying painfully. Christians should be sensitive to the issue of cost, but we shouldn't be willing to accept that these factors change the basic ethical goal of medical care—to preserve life. Nor should we measure the value of human lives by the dollar costs of caring for them.

A group of Australian doctors have argued that VAD and euthanasia are often attractive due to misunderstandings of patients, families and clinicians. Patients and their families often assume that the process of dying at the end of a terminal disease is “inherently painful, undignified, and traumatic for both patient and family”. They think that the only choice is between euthanasia and aggressive, intrusive, treatment, over which they have little control. They are not aware of the range of options available in palliative care.

Similarly, some physicians may not be aware of palliative care options. Studies show that some doctors focus entirely on questions of physical pain “while patients and families want a broader spiritual, psychological, and social focus”. Both physicians and patients can fail to distinguish between active euthanasia and allowing to die. This may have the effect of pushing people to two extremes: either they are loath to use pain relief because they view this as akin to ending



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life; or they pursue life-ending actions without exploring genuine palliative care.⁶

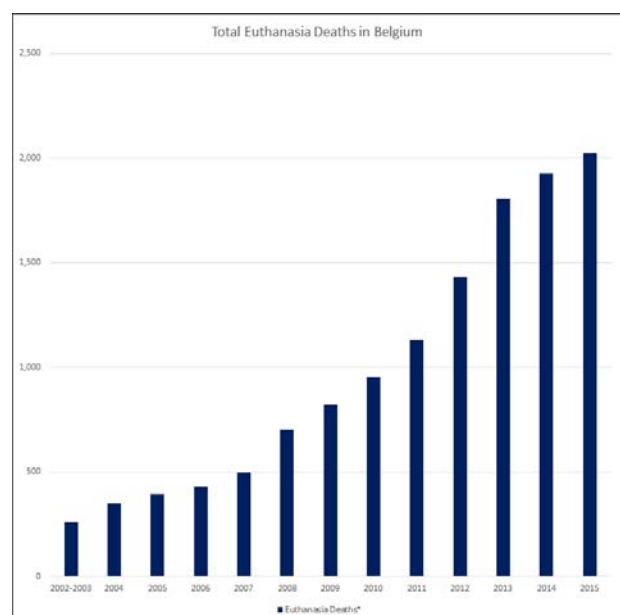
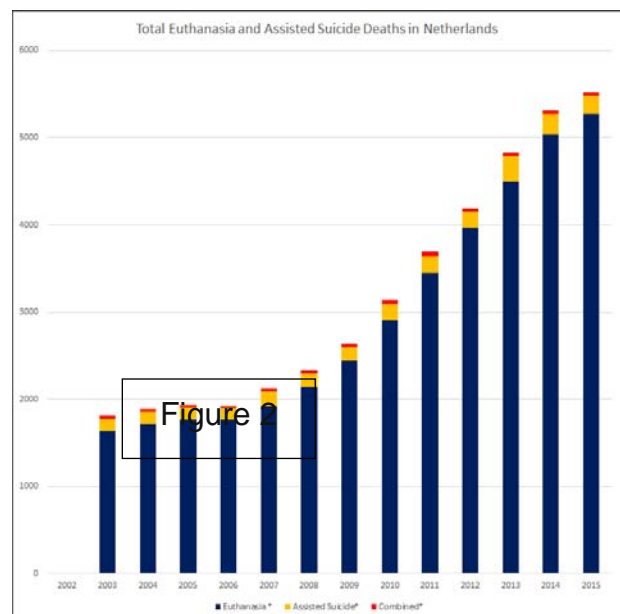
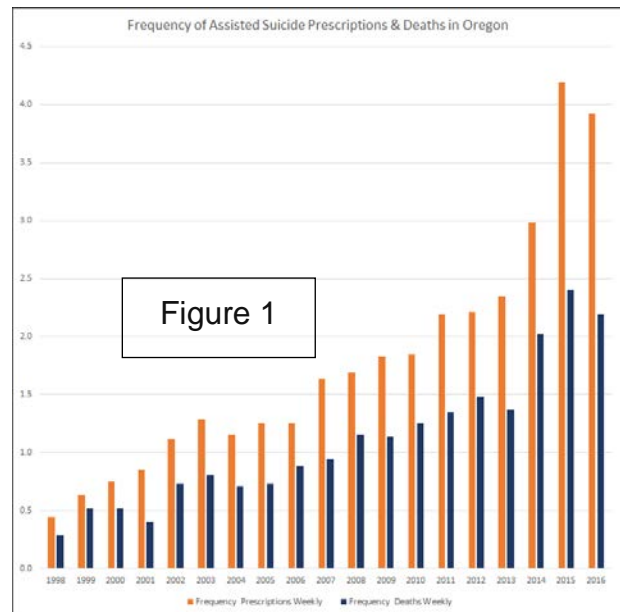
The Christian response

The Christian commitment to the sanctity of life — God’s protection of human life — should lead us to oppose the idea of killing people, or allowing them to take their own lives. A Christian view does not measure the value of a life by how pleasurable it is or by how useful the person is. What is more, we have responsibilities to God and each other which should shape our lives. We cannot view the great goal of life as avoiding suffering; our goal is to live for God and to care for others. God may call us to live with pain and to care for others while we, and they, suffer. Our Christian perspective is quite different to the point of view which focuses on utility, pleasure and autonomy.

Stanley Hauerhaus, a well-known Christian ethicist, gives four compelling reasons why a Christian perspective will not accept VAD.

- 1) We receive life as a gift from God even when it is distorted by illness, and God gives purpose to our lives even in pain and sickness.
- 2) Each of us has a duty to God and to the community to live and to encourage others to live, even when that means enduring in suffering.
- 3) If a life is taken this means the community has failed to care for a person God has put among it, and the person has failed to serve the community in which they have been placed. Individuals are called to be part of the community and it is called to care for them. VAD shortcuts those responsibilities.
- 4) We have given the medical professions the task of acting for our community by caring for people and sustaining life, and we cannot ask the same professions to be part of ending life.⁷

The legalisation of euthanasia or VAD brings a threat to vulnerable people. People with disabili-



ties, especially children, can become prime candidates for termination. If the value of life is assessed on the basis of intellectual and physical abilities, and freedom from pain and suffering, then it becomes easy to judge that it would be better to release a child from a difficult life with limited development. Similarly, elderly people who require a great deal of care, and who may have limited quality of life, might feel that they should relieve their families of their burden. People suffering from mental illness could see VAD as a solution, or as something which society encourages them to consider. A recent report to the New Zealand Parliament, which was very even-handed in its treatment of the cases for and against VAD, noted in its conclusion that the committee was “particularly concerned about protecting vulnerable people, such as individuals with dementia or reduced capacity”, and that some of the committee “remain unconvinced that the models seen overseas provide adequate protection for vulnerable people”.⁸

The fear that euthanasia will be extended to very vulnerable groups is illustrated by cases in Europe. Dr Theo A Boer, is a Christian and a professor of Health Care Ethics. He supported the legalisation of PAS and was on the Dutch government’s review committee for assisted dying. In 2016 he expressed growing concern over the situation in the Netherlands. The number of assisted deaths began increasing in 2007 “for no apparent reason”, tripling between 2002 and 2014 until VAD accounted for one in 25 deaths in the Netherlands. There were also 300 non-voluntary deaths annually, each of which was illegal but impossible to prosecute (this figure was derived from anonymous surveys). Along with the increasing numbers of cases, Boer became concerned about the very different type of patients seeking death. “Whereas in the first years the vast majority of patients—about 95 percent—were patients with a terminal disease who had their lives ended days or weeks before a natural death was expected, an increasing number of patients now seek assisted dying because of dementia, psychiatric illnesses, and accumulated age-related complaints.” Several reported cases involved patients whose suffering was due

to old age, loneliness and bereavement. He is also concerned about the normalisation of assisted dying, which was being treated as a preferred form of death, rather than an exception. Further, he is disturbed by the growing pressure to allow children access to assisted dying. Already, in the Netherlands, infants up to one year old can be euthanised by a physician with parental consent and a child over 12 can choose assisted dying.⁹ There is now a campaign to allow children of any age the right to choose their own death. Belgium brought in child assisted death legislation in 2016. Boer concludes:

“Neither the Netherlands nor Belgium has made a serious attempt to address the rising incidents of assisted dying and the shift from seeing assisted dying as a last resort to seeing it as a normal death. It appears that once legalization of assisted dying has occurred, critical reflection is difficult.”¹⁰

Working for the common good

The discussion so far in this paper gives a clear case for why Christians should be opposed to the legalisation of VAD. The two key reasons are: 1) Our basic commitment to the sanctity of life 2) That PAS puts vulnerable groups at risk. Christians should be advocating for better palliative care, not the legalisation of euthanasia.

The argument in the public square can be emotive, and often appeals to compassion and human rights. It is important for Christians to be clear that opposition to VAD is not due to lack of compassion. In fact, our opposition to this legislation is motivated by compassion. VAD will put vulnerable people at risk, especially people with disabilities, the elderly, and those struggling with mental illness.

In some Australian states, VAD is already legal. For NSW, the debate is live. Christians should consider contacting their parliamentary representatives to express their concerns. It is worth signing petitions, but it is even more powerful to make personal contact. [Click here to find your local representative.](#)



Caring for the dying

Engagement in the public square is important, but care for the dying is more important. Christians do not celebrate pain and suffering. Human beings are God's image bearers, so we will want to ease suffering where we can. This is why Christians have led the development of palliative care.

In the nineteenth century, the hospice movement began with Jeanne Garnier in France, Mary Aikenhead from the Irish Sisters of Charity, and Rose Hawthorne in the United States. Each of these women was motivated by her Christian faith to help care for the dying.¹¹ They each an institutions which "placed a strong emphasis on the cure of the soul, even when the life of the body was diminishing".¹²

Dame Cicely Saunders (1918 – 2005), a Christian, is generally credited with beginning the discipline of palliative care in modern medicine. She described a hospice as "a stopping place for pilgrims".

She thought her care could do something to relieve physical and mental burdens, but that "we can see so clearly that the real work is not ours at all but Our Lord's, Who by His saving death draws near to all the dying".¹³ While others have certainly been involved in the development of palliative care, its Christian origins highlight the Christian concern for the dying.

Good palliative care is concerned for the comfort of the patient, and seeks to provide for them physically, emotionally and spiritually. Physical comfort for the dying includes pain control and the management of other distressing symptoms. This kind of treatment does not promise to remove all physical suffering, but it can offer patients significant control over their pain and give them the capacity to deal with personal matters, including relational and spiritual issues. Emotional care begins with providing patients with warm human support, especially continued connection with family and friends, as well as with wider society. It allows a patient sufficient space and time alone to process thoughts and feelings, and provides opportunities for those thoughts and feelings to be shared with others. It requires carers to be aware of, and to seek to relieve, the anxiety and depression which sometimes accompanies a terminal disease. Spiritual care allows a patient to seek meaning in their life and death and to reflect on their situation. It should include opportunities to ask spiritual questions and to find peace with God in Christ.¹⁴

It is important that a patient and their family are involved in decisions about medical care at the end of life. Doctors and medical staff should explain the situation and treatment options as clearly as possible to the patient and family, and

allow them time to ask questions and process the information. It can be tempting for families to “protect” a patient by not telling them that they are likely to die soon, but it is far better to allow the person to know, and to talk through what they want to have happen in medical care and other matters.

Caring for people as they approach death should be part of the ministry of the church. We may not need to run hospices, but we should be attentive to those in our congregations and community who are dying. Often people feel they have been abandoned in the last stages of their lives, and dying then becomes an even more painful and lonely experience. Christians should be ready to visit and to offer care. Pastoral care of dying people is very taxing – it may not look like an efficient use of ministry time, and we can easily slip into focussing on more ‘strategic’ ministry. We must resist this tendency. The church can express Christ’s love at the bedside of the dying. Lots of Christians work in professions which care for the sick. We should encourage our brothers and sisters in this ministry, but not think that their work absolves us of being involved in some way in this ministry.

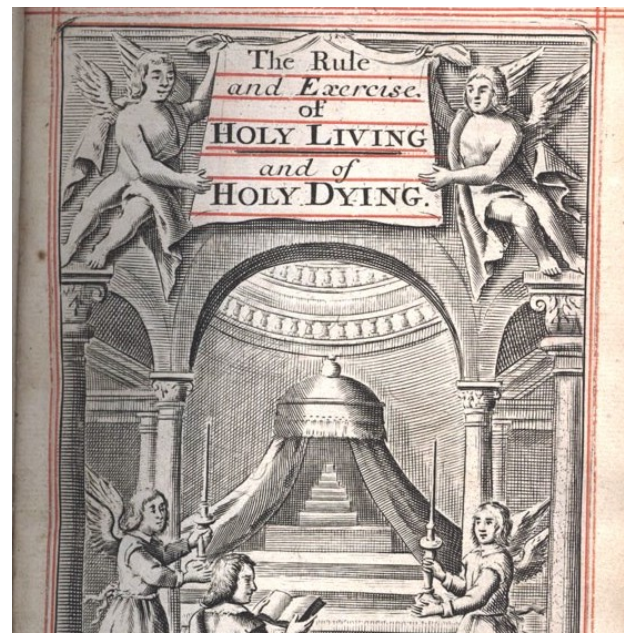
Churches can also support family members who are caring for a dying relative. Appropriate people in the church should make contact with the family and offer practical, emotional and spiritual support. Perhaps a friend from church could visit the dying person, to allow some respite time for family members. Maybe the family would benefit from the provision of meals or house cleaning. The church should offer to pray with and for them. Caring for a dying family member is difficult and exhausting, and church support is a very concrete expression of our commitment to the value of life and loving people.

Conclusion

Christians face life and death in the light of Christ’s death and resurrection. This looks very different to common views of death in our society. Many Australians wish to avoid death as far as possible and would prefer to die with little or no awareness of it, and no pain. In contrast, the litany of the Book of Common Prayer asks the

Lord to deliver believers from “sudden death”. Christian wisdom understands that we need time to prepare for death physically, emotionally and, most importantly, spiritually. While our society is terrified at the hint of death and pain, Christians can look it in the eye because it is an enemy which will not have the final word. John Donne, the 17th century English preacher and poet, wrote his hymn “To God, My God, In My Sickness” as preparation for death. The opening words are a Christian response to death:

*Since I am coming to that Holy room,
Where, with Thy choir of saints for evermore,
I shall be made Thy music; as I come
I tune the instrument here at the door,
And what I must do then, think here before.*



By God’s grace, Christians can face death like this. When they do, they display a far better alternative to the modern view of death. This is a testament to us all. Death can be a time to “tune the instrument at the door. It can be a time to “tune the instrument at the door”.

Resources

- D.J. Atkinson, "Life, Health and Death", 87-92 *New Dictionary of Ethics and Pastoral Care* IVP, 1995
An excellent overview of Christian ethics in the area of life, death and medical care.
- N. M. de Cameron, "Euthanasia", 357-9 *New Dictionary of Ethics and Pastoral Care* IVP, 1995
A specific discussion of euthanasia.
- D.P. Gushee, *The Sacredness of Human Life: Why an Ancient Biblical Vision Is Key to the World's Future*. Grand Rapids: Eerdmans, 2013
A presentation of why Christians hold that human life is "sacred", how that has been lost in Western thought and the implications of recovering this view. While some of Gushee's conclusions are open to debate, the book makes a powerful case that issue of end of life relate to the wider question of how we view human life.
- G. Meilaender, "Euthanasia and Christian vision" 655-62, S. E. Lammers and A. Verhey (eds) *On moral medicine: theological perspectives in medical ethics* Eerdmans, 1987
A careful discussion by a Christian ethicist arguing that acts which result in ending a life can not be simply redescribed as acts motivated by a desire to relieve pain.
- B.L. Peterson *Foundations of Pastoral Care* Kansas: Beacon Hill, 2007, 229-49
Some practical guidelines about pastoral care for people facing death, and their family and friends.
- B. Davis *Departing in Peace: biblical decision-making at the end of life*, Phillipsburg: P&R, 2017
A biblically informed and immensely practical guide to facing some of the difficult decision in end of life care, written for Christians facing issues in their own live, families and pastoral care. Some sections need a little translation from an American setting.
- M. Somerville *Death talk : the case against euthanasia and physician-assisted suicide*, Montreal: McGill-Queen's UP, 2104; 2nd ed.
A broad consideration of why the legalisation of euthanasia/VAD has gained support in Western culture, and how it will distort medical and the wider culture.

Other resources with information about legal provisions in New South Wales

<http://www.legalaid.nsw.gov.au/publications/factsheets-and-resources/who-will-decide-for-you-if-you-cant-decide-for-yourself-think-about-planning-ahead>
<http://www.tag.nsw.gov.au/what-is-a-power-of-attorney.html>
<http://www.tag.nsw.gov.au/advance-care-directives.html>
<http://www.tag.nsw.gov.au/what-is-an-enduring-guardian.html>
http://www0.health.nsw.gov.au/policies/gl/2005/pdf/GL2005_057.pdf

References

1. 'It was her time': Brittany Maynard's husband on letting her go: <http://www.today.com/health/brittany-maynards-husband-talks-about-letting-her-go-1D80424130>
 2. See G.B. Ferngren, *Medicine and Health care in early Christianity* (Baltimore: Johns Hopkins University, 2009).
 3. J. Bowes, "Live and let die: A case for death with dignity" (2015, Mar 30). University Wire <http://www.stanforddaily.com/2015/03/30/live-and-let-die-a-case-for-death-with-dignity/>
 4. Dixon, Nicholas. "On the Difference between Physician-Assisted Suicide and Active Euthanasia." *The Hastings Center Report* 28, no. 5 (1998): 25-29.
 5. <http://www.essentialvision.com.au/voluntary-euthanasia-3>
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 14. Holewa, Kathryn A., and John P. Higgins. "Palliative care — the empowering alternative: a Roman Catholic perspective." *Trinity Journal* 24, no. 2 (September 1, 2003): 207-219
 15. The "shadow of death" is a literal rendering of a single Hebrew word, which can also be translated as 'deep darkness' (see NIV). It is used for death in other Old Testament passages (Job 38:17; Jer 2:6). The LXX (the old Greek translation of the Old Testament) usually takes it to mean the shadow of death as does Matthew 4:16 translating Isa 9:2. See D. Kidner, *Psalms 1–72: An Introduction and Commentary*. IVP/Accordance electronic ed. (Downers Grove: InterVarsity Press, 1973.)
- Figure 1, page 8 : <http://www.consciencelaws.org/background/procedures/assist020.aspx#death-01>
- Figure 2, page 8 : <http://www.consciencelaws.org/background/procedures/assist019.aspx#death-01>
- Figure 3, page 8 : <http://www.consciencelaws.org/background/procedures/assist018.aspx#death-01>

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