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LEGALIZATION OF EUTHANASIA: CRITICS AND FALSE THEOLOGICAL ARGUMENTS

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Abstract

Inspired by compassion for the suffering and with the best of intentions, a number of contemporary theologians, especially Anglican, have initiated a campaign to legalize euthanasia and physician-assisted suicide, bringing both principled and practical arguments which, however, come in contradiction with the official position of the Christian Churches. Their campaign directly undermines the sanctity of life, one of the fundamental principles of Christian ethics, medical ethics and criminal law. It is a principle that recognizes and affirms the fundamental equality of people in dignity, protecting in particular the most vulnerable members of society.

Keywords: euthanasia; dignity; Christianity

1. Introduction

Throughout history the Christian Churches have strongly opposed the intentional killing of persons. This opposition played a key role in the formation of international criminal law which interprets as a serious crime the intentional administration of a lethal injection at the request of the patient suffering from an incurable disease (voluntary euthanasia) or when someone provides the necessary information, guidance and means to a person who wants to commit suicide (assisted suicide). When a doctor provides this "*help*" it is physician-assisted suicide. Euthanasia can be achieved by action, active euthanasia (intentionally causing a person's death by performing an action such as administering a lethal injection) or by omission, passive euthanasia (intentionally causing a person's death by withholding treatment or by not providing food and water) .

One cannot speak of euthanasia unless the death is caused intentionally. Therefore, certain medical practices, labeled as passive euthanasia, do not represent a form of euthanasia since there is no intention to take the person's life. Among them are: not starting a treatment that would not benefit the patient, withdrawing a treatment that proved ineffective and difficult to bear or that the patient does not want, but also the administration of large doses of palliatives, when they have proven to be necessary, but which may endanger the patient's life. All of these examples represent correct medical practice supported by law.

Over the last 30 years we have seen the initiation of campaigns, even aggressive sometimes, to relax the law, led by pressure groups using the slogans "*Compassion and Choices*" in the United States and "*Dignity in Dying*" in the United Kingdom, inspired by the "*service provider model*" that requires doctors and nurses to use medical technologies that bring patient well-being.

Of course, how can a patient be said to have well-being if he is living when he wants to die, especially when he clearly has a degraded quality of life and is in continuous deterioration (Keown, 2021).

Inspired by compassion for the suffering and with the best of intentions, a number of contemporary theologians, particularly Anglican, have joined the campaign to legalize euthanasia and physician-assisted suicide, making both principled and practical arguments that come in contradiction with the official position of the Christian Churches.

2. False theological arguments pro-euthanasia

The best-known theologians who have joined pro-euthanasia groups are Desmond Tutu (1931-2021), Nobel Peace Prize laureate Archbishop of CapeTown (Tutu, 2014) and Lord George Carey, former Archbishop of Canterbury (Carey, 2015).

Archbishop Tutu's arguments include references to quality of life and resource use. Why, he wondered, should a life that is nearing its end be extended, usually at great financial cost, when the money could be used for mothers giving birth to children or for an organ transplant in a young person? In other words, it suggested that resources are used early in life or during the active period (Tutu, 2014). Speaking about dignity, he cited the case of Craig Schonegevel, a 28-year-old South African who, being diagnosed with Neurofibromatosis, ended up taking 12 sleeping pills and using plastic bags on his head due to the suffering and degradation of his quality of life, because the doctors refused to euthanize him. The patient had wanted to end his life with legal assistance, listening to his favorite music surrounded by the loved ones, but the law "*denied him and his family that dignity*". Craig's thinking was clear: he wanted autonomy and dignity. Objections to this line of thinking relate to palliative care, which if it exists and is of good quality, prevents people from legally requesting a lethal dose of medication. The option has been taken up and legislated in the Netherlands, Oregon and Switzerland (Keown, 2018).

On the occasion of his 85th birthday, Archbishop Tutu renewed his call for the legalization of euthanasia arguing that the sick should be treated with the same compassion and fairness both in their youth and near death because every human being must be given the right to leave the earthly life at their own will. Although he believed in the sanctity of life and that death is a part of life, Archbishop Tutu wondered why if the terminally ill could have control over their lives, they could not have control over death, being forced to endure terrible suffering against their own will? (Tutu, 2016)

Archbishop George Carey's pro-euthanasia speech, expressed in two articles published in 2014 and 2015 respectively, started from the observation that advances in medical science have led to an amazing extension of life (Carey, 2014). Over time, however, people have found that sometimes long life is excruciating and engendering suffering, and palliative care has not always proven effective. This has led some to decide their own lives, spending huge sums to travel to Switzerland for euthanasia. Suggesting that there are "*shadow cases*" where doctors or relatives of the suffering person have committed mercy killings using large doses of the drug, the archbishop wonders if the practice is not better brought out into a legal framework. Reconsidering the issue of euthanasia from the point of view of Christian Theology, Archbishop Carey came to the conclusion that God gives more importance to benevolence than to observance of dogmas. Suggesting the initiation of a draft law to protect both patients and doctors involved in an act of euthanasia, he argues that legalization would not change the role of doctors used to accompanying people on the journey from birth to death. Criticizing those who have opposed the legalization of euthanasia for fear of abuses, such as unscrupulous relatives who could push the elderly to premature deaths, the archbishop argues that love, compassion and justice should rule politics and not fear.

What confuses the two bishops is the delimitation of the terms quality of life and sanctity of life. From this perspective, human life is considered by its very nature to be sacred, it is intrinsically good and always deserves respect and protection. Its value is not dependent on any condition or attribute that could characterize it. Secondly, all human lives have the same value at any point in development from conception to death, undiminished by illness or disability. This implies that all human beings have the same right to life.

From the perspective of the sanctity of the human person, there is no real conflict between the sanctity of life and its quality. The two become complementary, from the first to the last moments of human existence, even more since the second, well understood, traces the

path that leads from earthly life to the Kingdom of God (Breck, 2010) . This complementarity between the *quality* and *sanctity* of life is possible because human life is sacred in its very nature. The origin, purpose and finality are given and determined by God.

So that there is no theoretical confusion, sacredness and holiness must be differentiated in the sense that the first refers to the essential goodness and infinite value of the life of the human being, created in the image of God, and the second refers to the arduous but blessed struggle of the human being for the acquisition of likeness to God. In this perspective, we have a lot to learn from the Holy Fathers, because in them we find a Christianity that is not alienated from its origins and a complete and balanced vision of man, in his relations with himself, with his peers and with God.

3. The role of faith in palliative care

The approach to the ethical issues specific to palliative care is based on the acceptance of the fact that the incurable and/or terminal patient is not a biological residue for which nothing can be done, a being that only needs anesthesia and whose life should not be prolonged pointlessly , but a person, a human being capable of making his life an experience of living and achieving, provided that he is bio-psycho-socially and spiritually integrated.

When from a therapeutic point of view it is no longer possible to effectively intervene to stop or improve the disease, medicine still possesses resources that can be used, not so much with the aim of curing or prolonging life, but out of respect for the patient and his quality of life . These resources are represented by palliative treatments.

In medicine, palliative care is complementary to curative treatments. It is about hygiene, cleaning bedsores, suctioning secretions from the respiratory tract, nutrition and hydration.

It appeared a few years ago in the USA, and now also in Romania, the controversy of extraordinary therapies, still not fully understood, divides the medical world. It is about no longer needing to care for dying patients, in the intensive care units, the only ones prepared for this kind of activity for now. Moreover, the partisans of this idea tend to consider hydration and artificial nutrition as therapeutic interventions, even more, as having an extraordinary character and consequently their application to patients does not constitute a duty. In reality, these interventions contribute, in most cases, not so much to prolonging life, as to making death less painful.

By palliative treatments, we generally mean those cares offered to patients with incurable diseases, which aim to control their symptoms, by applying procedures that allow the patient a good quality of life.

Palliative treatments include, for example: palliative oncotherapy (surgery, radiotherapy, chemotherapy) applied to patients whose symptoms are treated, but also supportive treatments such as: non-casual antalgic therapies aimed at reducing or eliminating the perception of pain; nutritional assessment and hydro-electrolytic regulation; treatment of opportunistic infections; rehabilitation physiotherapeutic procedures; psychological support of the patient and the family; the psychological supervision of the care team whose emotional performance is the basis of therapeutic optimization.

This strategy led to the emergence of experimental concepts, such as "*Hospices*" and/or home treatments.

In the practice of palliative care, we face certain situations in which the sick seek their pain for the purpose of salvation, as an imitation or a participation in the sufferings of Christ. This poses the problem of refusing anti-algesic medication and a difficult pain management as a symptom. However, it must be borne in mind that the person who considers his pain as redemption by itself and accepts it as such, is the one who bears it with stoicism and who rarely complains.

We identify in this situation a phenomenon, which we tend to qualify as psycho-somatic, and it is essentially along the lines of ascetic experience. There is in asceticism a capacity to dominate the passions, to dominate the body, the physiological needs such as hunger, thirst, fatigue, sleep and which has an extraordinary spiritual resonance, witness of the unity and synergy of the soul with the body. The fight against pain can be included here, and Christians have as an example all those martyrs who endured torture, mutilation, burning, and who manifested their joy as a total gift of their being to God. This reminds us of the exclamations of the martyrs: "*at this moment, someone else will be in me, Who will suffer for me*".

The use of analgesics in the care of dying patients is integrated into the of palliative treatments. These practices of accompanying and using analgesics and opiates can go as far as artificial sleep when the moral and physical suffering is too great or if the patient requests it. This is not about causing death, but waiting for it in less painful conditions.

When the use of painkillers will lead to loss of consciousness, their use is permitted provided that the patient has had time to fulfill his religious and moral duties, both to himself and to his family and society. It is not allowed to deprive the dying person of self-awareness without a serious reason.

On the other hand, it is to be avoided that by using suprathreshold doses of analgesics, especially opium-based, euthanasia is practiced knowingly and in hidden ways. That is why care must be taken that the dose of analgesics is proportional to the pain.

In daily practice, we find an interaction between palliative care and living the faith. Thus, after an anti-algesic and/or anxiolytic treatment, we create the optimal conditions for the patient to live his faith until its perfection in death. On the other hand, a confessional faith has a beneficial effect on pain and anguish, and experience shows us that the need for medication is much lower.

Returning to the experience of death, we find questions about what? about how? about the loss of the image, about degradation, about dependence, etc., in which the Christian faith, lived as a practical experience, brings balance, hope and self-satisfaction, making us exclaim with total confidence: "*Father, into Your hands I place my spirit* ". (Luke 23-46).

The role of the Christian community is to place the suffering man in a relationship between human and divine help, which he represents in his capacity as a member of the body of Christ.

One of the sufferings of the sick man is that of his social marginalization. For a professing Christian, however, this cannot exist in the Church, because it represents the realization of the unity of the body of Christ, from which no healthy or sick being is excluded.

Most of the time, physical and/or mental degradation is perceived as decay and humiliation. Of course, this loss of self-image in front of others or of one's own person can be restored by looking for inner beauty or in other words by contemplating the image of God.

4. Conclusions

The issue of euthanasia raises, first of all, questions of a religious and ethical nature. People's attitude towards euthanasia is usually determined by the vision they have about life and death, being also put into play by social and political considerations. Our social relationships are largely determined by the fact that we are not allowed to intentionally kill another person, just as society protects us from being killed. In this situation, however, several questions arise. What will happen if we give up this protection? Why should "*acceptable killing*" be restricted to euthanasia? Why should we not allow suicide to become morally valid? Thirdly, the nature of the medical profession is called into question. Doctors should be the ones who treat people's diseases, who relieve their suffering, and the "*administration*" of death

represents the exact opposite and completely changes the relationship between the doctor and the patient.

Most often the law is very strict regarding euthanasia. It is simply considered premeditated murder, punishable by death or hard labor for life. Indeed, the law fears that less noble feelings might be hidden under the pretext of mercy. It does not trust consents, even written ones, and especially the contamination effect which, by authorizing the shortening of a dying person's life, would extend to the incurables, then to the normal, to the alienated and finally to all undesirable persons.

Doctors have just as many reservations. Their duty is to sustain life, even when they cannot relieve suffering. They know better than anyone how difficult it is sometimes to recognize an incurable disease and that, if they are not in the eyes of all their peers, the defenders of life in principle, they will no longer enjoy people's trust and esteem. There are situations in which doctors can only avoid therapeutic rigor, which does nothing but artificially keep alive a few cells from an already dead body, and in other cases, substitute a slow and painful death, a euphoric death, which in accidental mode is faster.

The Christian Church totally rejects euthanasia, whether it is accepted by the patient or not. It believes that life is the gift of God, the only one who decides when it begins and ends. That is why euthanasia appears as a particular form of killing and/or suicide and is considered a reprehensible thing (Breck, 1990; Harakas, 1990).

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