

The Euthanasia Debate: Importance of Spiritual Care in End of Life

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Euthanasia is presented by its advocates as the panacea for all pain and suffering. The terminally ill who struggle with multiple symptoms of their illness were assured of relief, but what that relief translates into is the termination of life in what is known as mercy killing. So, there would be an end to pain and suffering. But, could we conclude there is an end (i.e., termination) to pain and suffering with the advocates of euthanasia when all that are done is taking out the individual who is the subject of that experiential reality and goes beyond that one individual to affecting countless lives? Besides, there are terminally ill people who decide to end their lives but would not have made that choice except for the offer put before them by the euthanasia advocates. However, that very reality is responsible for pain and suffering, either terminal illness or loss persists. It is for this reason that this paper adopts a contrary view from the above. I argue that terminally ill individuals grappling with symptoms of their condition do not need termination of life, but an intervention that strongly underscores being present to the individual in need. In other words, a care-giver must be present before there can be any meaningful care given to the patient. And I am using the pastoral care model in elaborating the notion of presence, as I equally elaborate the notion of healing presence that stresses the spiritual element of the human person whereby through our presence to the other, we thrive in times of adversity and illness by drawing strengths and courage from our connectedness, which is what the presence of pastoral care offers and equally assures the terminally ill in those moments of need.

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Introduction

The euthanasia debate dates to the ancient times. Right through the different ages, there have been many interpretations given to the concept. The word itself is derived from two Greek words, which mean “good death”. It is generally referred to as “mercy killing”, which could be attributed to the fact that it signifies an action through which a person is put to death primarily to relieve the person from pain caused by an incurable illness (Ashley & O’Rourke 1997, p. 417). It is crucial to understand that the purpose of ending life is to terminate an individual’s suffering. And the method used in terminating suffering, and which is crucial to the concept of euthanasia, is by putting the individual to death. The explanation of euthanasia above is a standard one given. However, there have been so many distinctions made regarding types of euthanasia, which has been part of the debate in order to capture the various situations in which euthanasia occurs.

Some authors have made attempts to specify the categories of people who are often affected by euthanasia. Others have tried to indicate situations in which euthanasia frequently occurs. What has been observed,

however, is that all these attempts at specifying those affected or situations in which euthanasia is more common have failed to address how the debate impacts the context of care¹ at the end of life, which is increasingly being transformed by the advancement of medical technology. The euthanasia debate has introduced the active/passive distinction, whereby active euthanasia is described as an act through which a person is deliberately or actively put to death by another. Passive euthanasia, on the other hand, is termed “letting nature take its course” given how medicine or treatment is no longer effective (Onimhawa, 1998, p. 8). From this description of passive euthanasia, one could conclude that the withdrawal of treatments that are of no therapeutic benefits to a patient would indeed be considered the ultimate cause of death eventually. For example, a respirator is often used to improve the condition of patients with respiratory problem.

What I disagree with is presenting the withdrawal of an ineffective therapy as passive euthanasia. The term “passive euthanasia” in the literature gives an allusion of complicity. To reduce the withdrawal of ineffective therapy to passive euthanasia is simplistic, since it only focuses on the reality of death as a result without having carefully analyzed the moral factors of the situation. I would hereby argue that the idea of passive euthanasia totally misconstrues the problem, and that the active/passive distinction in the euthanasia debate is both misleading and inappropriate. Instead of this distinction, which is confusing, I suggest that the killing/allowing to die distinction should be considered a better alternative in this debate. This latter distinction does not only give a more adequate description of a situation in which euthanasia might be an issue, but also recognizes the difference between an act which is aimed at killing and one that simply recognizes the futility of medical intervention, and consequently withholds or withdraws such means that are no longer of therapeutic benefit to the patient.

I would first discuss the concept of euthanasia. Here, I would do an analysis of the so-called active/passive distinction, which is the bone of contention for us in this paper. Following this, I would discuss the issue of forgoing treatment, which is ordinarily an issue in cases where a patient’s condition is terminal. Considering modern medical technology, people can be kept alive indefinitely. However, there are times when it is realized that the purpose of the medical technology being used in providing therapy, namely, health is not being met. I would argue that either withholding or withdrawing such ineffective therapy does not constitute the killing of a patient, which is often understood as euthanasia, but simply allowing nature to take its course, which ordinarily results in death. While some have described this withdrawal of ineffective care as an act of omission, thereby labeling it passive euthanasia, I would argue that it is neither an omission nor a deliberate act intended to kill. The intention of the acting agent is of great importance with regards to the issue of allowing a patient to die, and this too will be addressed later in this paper.

Here, it is important to understand that there is nothing morally wrong with the termination of a therapy that has clearly failed to meet its intended goal, namely, restoration of health. This is described as futile therapy, which no one is under any moral obligation to receive or be forced to receive. It is in this context that I will introduce the distinction between killing and allowing a patient to die, arguing that this is a more appropriate distinction which fully captures the reality of what the euthanasia debate involves, and equally acknowledges the futility of a treatment which one is not morally obliged to continue. In this instance, we would talk of allowing the natural process of dying to take place. As part of this discussion, I would introduce the principle of

¹ By care here, I do not simply mean medical care but wholistic care of the person, which includes, spiritual, mental/psychological, physical, and social in addition to the basic medical and nursing care of the dying.

double effect to further analyze the distinction between killing and allowing to die, thereby emphasizing the effectiveness of this distinction over the active/passive distinction in the euthanasia debate. Finally, I would like to highlight how pastoral care-givers can make use of the killing/allowing to die distinction in providing spiritual and emotional support to patients, family members, and health care professionals when end of life decisions are being made. This assistance, I believe, would help many from confusing euthanasia with other legitimate acts that could be embarked upon in the process of making end of life decisions when treatment has become futile.

Active & Passive Euthanasia

The word “euthanasia” was coined from two Greek words meaning “good death”. However, it has been defined differently through the centuries. The *Webster’s New Collegiate Dictionary* defines it as “the act of or practice of killing individuals that are hopelessly sick or injured for reasons of mercy”. This definition suggests that, for a killing to be qualified as euthanasia, it must be that the person killed is gravely ill and there is no possibility of recovery. Hence, rather than watching the individual waste away in pain, he or she is killed to put an end to suffering. Since the goal is to put an end to suffering, emphasis is often placed on how the means adopted must be pain-free. This is important if the justification for the killing, which is mercy, was to stand. Another implication of this definition is that euthanasia is an act that is performed by an individual on another, not an omission of action. However, some other definitions have suggested that euthanasia could involve omission of actions because of which death occurs. This latter definition is attributed to the *New Columbia Encyclopedia* in which euthanasia is defined as “either painlessly putting to death or failing to prevent death from natural causes in cases of terminal illness (Beauchamp & Walters, 1994, p. 434). In the current literature on the euthanasia debate, a distinction is often made between active and passive euthanasia, and this could rightly be attributed to the second definition above.

Active euthanasia is described as an act which brings about the death of another in order to put an end to suffering, while passive euthanasia is described as the omission of an act intended to cause the death of a gravely ill person (Sullivan, 1994, p. 132). While a distinction is made between active and passive euthanasia, it could also be pointed out that the very essence of euthanasia requires actively putting a gravely ill person to death in order to end suffering. This very notion requires performing an action. Such action aims at putting an end to suffering in the absence of any remedy. This specific goal of ending suffering is deemed preferable than watching the ill person waste away in pain while waiting for death to occur. Now, given there is a strong emphasis on making sure that the means to be used in terminating life must be pain-free, the idea of passive euthanasia would negate the very goal of euthanasia. This, for me, would strongly suggest that euthanasia, *per se*, would be a positive act rather than the omission of an act.

As mentioned above, passive euthanasia is also described as “letting nature take its course”. This, I contend, is a misrepresentation of another issue. Considering how James Rachels equates the distinctions between active and passive euthanasia and killing and allowing to die, not only he does deny there is any moral relevance between the two distinctions, but also he argues that letting nature take its course, i.e., allowing to die, is as morally reprehensible as actually performing an action that would kill a person (Rachels, 1975, p. 116). What is described as passive euthanasia, I would contend, is an action which is being analyzed solely from a consequentialist perspective. In other words, the mere fact that a person is not given a treatment or therapy, and the fact that the person subsequently dies, may not necessarily be as a direct result of the lack of therapy; the

person is simply said to have died from the lack of treatment. And the agent who would have provided treatment is also said to be the direct cause of death. What is not being examined in this scenario is the type of treatment concerned, if it has benefits for the patient or not, or if such benefit would contribute to the restoration of health and wellness for the patient, as well as the intention of the acting agent. Given this, I would say no wonder that when the issue of “allowing to die” is analyzed without considering the quality of the act in a given circumstance, as well as the intention of the acting agent, it is obvious that the only remaining element with which a moral analysis is done is the consequence (Sullivan, 1994), which greatly obscures the nature of the act. Rachels, in analyzing “allowing to die”, focuses only on the consequence of an intervention and because of that, he concludes that it is morally indifferent from killing.

There is another opinion contrary to the above, which holds that the active/passive distinction in the euthanasia public debate simply reflects how confused some authors are. According to this opinion, while euthanasia could result from the commission of an act or an omission, it could only be justifiably attributed to an omission if the “intention” of the omission is to “cause death in order that all suffering may be eliminated” (Ashley & O’Rourke, 1997, p. 417). In this case, euthanasia is essentially a human act, which by its very nature, deliberately intends to end the suffering of another through the death of the individual. But the omission of an act with regards to the care of a terminally ill person is neither necessarily nor ordinarily aimed at causing the death of the person. This is where the intention of the moral agent, among others, becomes a crucial factor in determining the morality of an act. For instance, if a treatment or therapy is deemed non-beneficial and probably burdensome to a patient dying of cancer, to either withhold or withdraw that treatment from the patient cannot be termed the cause of the patient’s death when death finally occurs. The direct cause of death would be the underlying disease, i.e., cancer. In this same example, the reason, i.e., intention of the acting agent, for terminating treatment is to actually prevent prolonging the suffering being induced by the continuation of such futile treatment.² However, if the patient were not terminally ill and not actively dying, terminating a treatment with potential benefits without the consent of the individual would not only be seen as killing, neither could such be described as “allowing to die”. One implication of this is that the decision to terminate a treatment deemed futile is either the individual patient or that of a surrogate in cases where the patient is no longer competent to make decisions. The care-givers’ professional judgment is also required in order to have an informed decision. Hence, while death could result from different types of medical (acts) interventions, it is not all deaths that could be described as killing. This is because the intention of the acting agent is crucial to making a distinction between killing and simply allowing a person who can no longer benefit from a therapy to die from the natural disease process. I think that the failure to consider the intention of the acting agent, while analyzing cases of withholding or withdrawing a treatment that is considered futile, is a major reason why “allowing to die” is often characterized as “killing”. Once the intention of the acting agent is brought into the moral picture, euthanasia would then be understood as either a positive act, or an omission with the specific “intention” to cause death. The death resulting from an omission then is the essence of the agent’s action. Also, just as the intention behind the termination of treatment helps to ascertain that the death is either “killing” or

² While treatment is terminated because of its futility, and in order to prevent prolonging the suffering of a dying patient, the care-giver equally administers medication to palliate pain and make the patient comfortable. So, while it could be said that treatment is terminated, some treatment is still being given with the comfort of the patient as the goal of such care being provided in that instance. In this case, it could not be said that there is an omission but rather a change in the care being provided. That change is necessitated by what is deemed beneficial to the patient. Hence, if death should occur after this change in treatment, it is only foreseen rather than intended. Such is only an unfortunate outcome that is foreseen, but which could not be prevented.

“allowing to die”, it equally assigns a moral quality to the agent’s action. Hence, I would argue that neither the active/passive distinction is morally appropriate for analyzing treatment decisions concerning end of life care, nor it is tenable to consider “killing” and “allowing to die” moral equivalents as Rachels claims.

Furthermore, Rachels (1975) contended that, for someone who is in a painful terminal condition, allowing to die is a cruel and slow death, while administering a lethal injection would be quick and painless. The misconception of what “allowing to die” entails is probably why Rachels sees it as killing essentially. For him, allowing a patient who is terminally ill to die without intervening to sustain life is essentially what passive euthanasia is. This idea, however, distorts the essence of what it means to allow the natural process of dying to proceed if treatment becomes futile. The basis for this idea is the notion that allowing to die is failing to act, which results in a patient’s death. This omission could also be understood as abandonment, in which case the omission is a deliberate act intended to kill. As such, the omission is not really an “omission” but a neglect of a patient, which is considered highly unethical in medical practice ordinarily. With this, no doubt Rachels finds making a distinction between killing and allowing to die difficult. Hence, not only he does claim that the distinction between active and passive euthanasia, which he unwittingly subscribed to lacking moral importance, but he equally thinks that active euthanasia is much preferable (Rachels, 1975) since the so-called passive approach unnecessarily inflicts pain and hardship on someone who is dying. This is another reason why I think that the active/passive distinction fails when it is employed in analyzing the termination of a treatment deemed futile at the end of life. Also, the confusion that is intrinsic to the active/passive distinction, and which further claims that passive euthanasia and allowing to die are morally equivalent, would render an intervention that is ordinarily a morally permissible act in the care of the dying a questionable act. This confusion that is often encountered when attempts are made to analyze the issue of withholding or withdrawing futile care at the end of life, has made it imperative not only to clearly distinguish killing from allowing to die, but also to discuss what each entail. Hence, I will now examine in the next section the issue of forgoing treatment in end of life cases.

Forgoing Treatment

The discussion in this section would focus on two main areas. One is the type of treatment that is often involved when medical care is withheld or withdrawn. Here, a distinction would be made between ordinary and extraordinary means of treatment. The second would focus specifically on making a distinction between killing and allowing to die. Here, I would introduce the Catholic principle of double effect, which is the traditional basis for distinguishing an act that essentially constitutes the taking of life, and another which is simply allowing the natural process of dying to proceed when nothing else could be done to sustain life.

Ordinary & Extraordinary Means

The distinction between ordinary and extraordinary means is traditionally a Catholic approach to decision-making regarding end of life care. According to this distinction, individuals who are making health care decisions are expected to use ordinary or proportionate means to preserve their lives but are not under any obligation, moral or otherwise, to use unreasonable or extraordinary means if a person is gravely ill and has a bleak prognosis (Ashley & O’Rourke 1994, p. 223). There are, however, a couple of things to note in this distinction. First, the distinction is moral, not medical. In other words, the basis upon which a distinction is to be made regarding types of care is moral rather than medical grounds. This distinction could easily be

construed as a medical one since there is a comparison between ordinary and extraordinary means of treatment, which are ordinarily medical stuff. Besides, the distinction essentially deals with the treatment of a patient, and so there is professional medical involvement. However, this is a moral distinction since it solely revolves around the patient, and what the patient would do in terms of whether he or she (or the patient's surrogate as the case may be) would decide on using the ordinary available means of preserving life or not.

Furthermore, when the patient decides on using ordinary means to preserve life, the obligation for such action lies with the individual person himself or herself. This is because of the distinction mentioned above. This distinction is said to be moral and it consists in the burdens posed by the treatment, which may or may not be bearable for the individual who is involved in that treatment situation. Also, the distinction is moral since it is ultimately determined by the individual whose life is to be affected by the treatment. This is because it is the patient who makes the decision to either accept the treatment or refuse it, and this also depends on what he or she has determined the treatment's outcome to be, if this is considered acceptable or not. It is the patient alone who, for instance, can adequately judge what impact certain factors, such as expense, pain, and inconvenience will have on him or her during treatment. In other words, the expert knowledge of the physician does not necessarily translate into the value or religious belief system of the patient in his care. Consequently, it is the individual patient alone and not the physician who can make the determination on what treatment constitutes ordinary or extraordinary means (Ashley & O'Rourke, 1994). Evident from this moral distinction are certain moral principles which are the guiding principles in health care. One is the principle of respect for human dignity. This principle underscores the basic tenet that the moral worth or value of each human person lies in none other than the self. Another is the principle of informed consent, which emphasizes that the professional gives information to the patient and allows the patient to make decisions about his/her care (Ashley & O'Rourke, 1994). Both principles underscore the deference given by the professional to the patient who is the focus of attention in the distinction above.

Having stated that this distinction is moral and that out of it comes an obligation with which an individual decides on using ordinary means to preserve one's life, the way an individual proceeds in determining ordinary means of care as opposed to extraordinary means is by making an analysis of benefits and burdens of the options as they are available to one in that particular context, in conjunction with the individual's diagnosis and prognosis. In other words, to come to that decision of what ordinary means of care is cannot be done in abstraction. Besides, there is a fact that someone with a reasonable chance of recovery is obliged to use ordinary or reasonable means of treatment to preserve their health; it is important to note that choosing an ordinary means to preserve life is a subjective matter for individuals since there could hardly be two situations that are the same (Kelly, 2007, p. 9).

There are several factors in everyone's case that make it unique, and that is partly the reason why the distinction is a moral choice by an individual and not medical.

When an individual tries to determine what a medical treatment has to offer him or her by way of benefits or the burdens to avoid, the person is essentially making a moral distinction between ordinary and extraordinary means of care. This process of weighing the benefits and burdens of a treatment is a subjective act for individuals in that a person must consider how tolerant one can be to painful treatment which is often a personal matter. There is no objective standard for measuring pain. Also, one must consider all the benefits of the treatment and whether potential benefits could become real benefits during treatment. These are all the things to be considered in making an analysis of the benefits and burdens of a treatment decision. What is

important here is that a patient makes a decision that is in accord with the goal of one's life, and not merely balancing comfort with suffering. In other words, contrary to what some have argued that life must be sustained at all costs given it is the ultimate good (Ashley & O'Rourke, 1997), it is evident that the individual patient who is analyzing the benefits and burdens of particular treatment options would have to view those options in light of his or her ultimate goal in life, which is not simply one's physical life but rather of the whole person, which is body and soul together. A clear benefit of treatment which has been indicated and which I also support, going by the whole person approach, is the cognitive affective function (Ashley & O'Rourke, 1997). This means that the benefit of the treatment should be measured not just in relation to a physical body, but as it affects the whole person who is a union of body and soul. This consideration of the benefits of treatment in relation to one who is not merely a physical entity but body and soul together would be one reason why a treatment that is non-beneficial may be withheld or withdrawn. And when this is done, the individual person should be able to recognize and engage his/her environment and be actively involved in his/her care as well. The individual patient should not be an object of the treatment but rather as the subject who is intellectually engaged in interacting with others. The goal of that interaction is the well-being of the patient which focuses on the person, namely body and soul.

At this juncture, I would like to establish a correlation between ordinary and extraordinary means of care and the concept of the goal of life which, in the Christian perspective, stresses the spiritual purpose of a person's life. This spiritual element is one of the many dimensions of the human person, which many authors seem to have ignored in their conclusions and which are primarily ethical and legal in nature. I would consider it rather safe to say that the issues many authors address in their discussion on the care of the terminally ill are often shaped by ethical and legal concepts. While these concepts raise important issues that are meant to safeguard the rights of the patient, they fail to grasp an aspect of the patient's life not subject to verifiable scrutiny. Therefore, I consider it pertinent to introduce an important aspect of the human person into this discussion, which is the spiritual element. According to the Christian view of what constitutes the goal of life, the decision to choose a treatment as a means for preserving life or forgoing it may actually be measured by the desire to have eternal life with God (Ashley & O'Rourke, 1997). A Christian whose faith tradition teaches that life with God is the goal of life would probably put that in consideration when making a treatment decision in the face of a chronic debilitating illness. Besides, considering how futile certain treatments may be and the hardship it does impose, not only on the patient, but also the loved ones, it is Christian faith that does inform the decision-making in those moments to realize that such situations do not point at finality. Hence, when a decision is made not to seek extraordinary means of preserving life, it is a decision informed not just by the condition of physical health but the whole person, i.e., body and soul, and the union with God, which eternal life promises according to the Christian faith. Considering this spiritual dimension of the human person and the goal of life, it would be a gross misunderstanding of individual values if a person's decision to either reject or discontinue a treatment that is excessively burdensome if such were simply characterized as killing.

Killing & Allowing to Die

In discussing the distinction between killing and allowing to die, I want to introduce the principle of double effect, which is often invoked in cases where an action yields two effects, both of which are not necessarily intended by the acting agent. This principle is attributed to the Catholic moral tradition, which states that an action with both good and bad effects is right if four conditions are met. The conditions are as follows:

- (1) The act-in-itself must not be morally wrong.
- (2) The bad effect must not cause the good effect.
- (3) The agent must not intend the bad effect.
- (4) The bad effect must not outweigh the good effect (Kelly, 2004).

Of these four conditions, the third condition is of paramount importance in light of the distinction between killing and allowing to die. As I have already mentioned above that the intention of the acting agent is crucial to determining the difference between killing and allowing to die, here the principle of double effect underscores intention as the end being sought by the acting agent. In other words, the agent may not deliberately and consciously seek something bad (which in this case is death of a person who is incurably ill), just so as to end the suffering (which is deemed a good thing) that the person is undergoing.

There are certain types of actions where the intention is nothing other than killing. Examples of this are physician assisted suicide and direct euthanasia. In these cases, a patient may wish to die and get help from a health care practitioner, who provides the lethal drug with which the patient ends one's own life. It could also be that the health care practitioner initiates an action that terminates a patient's life. In both cases, the action is a classic example of killing for the very fact that the intention of the actors is to cause death. Stated otherwise, death is the end being sought and this type of action, regardless of how much effort is made to sugarcoat it and make it appear to be something different, it is simply killing, which is morally wrong.

However, there are other types of actions in which the intention of the acting agent is not to kill, but notwithstanding, a death is still associated with the agent's conduct. Again, it is important to note here that intention (according to the principle of double effect) is not to be taken as a means toward an end but rather an end. Examples of such acts are withholding of life-sustaining treatment, withdrawing of life-sustaining treatment, and pain relief that quickens death. In all these instances listed, the health care practitioner initiates an action specifically aimed at the comfort of a patient who is terminally ill. Crucial to this is the fact that the patient's condition is such that all available treatments are of no therapeutic value to the patient. In addition to this, further subjecting the patient to such futile therapy may be causing more pain and discomfort. Hence, that is the reason for the withdrawal or withholding of such care. The administration of opiate in addition may be such that while it provides relief from pain because of the advanced stage of an illness, it may also suppress respiration whereby it hastens death. Here, the act of administering opiate for the purpose or pain relief must be examined as such. Pain relief, as such, cannot be labeled a "bad" act. Hence, the death resulting from such treatment is an example of how, in our conduct, we may not be able to prevent certain "other" effects from coming to be, which does not necessarily mean that the acting agent has willed such.

Going back to the root of the word, euthanasia means "happy death" and its specific aim is to terminate life to put an end to pain. How ironical though that to achieve what is deemed happiness, the individual has to sacrifice one's existence which now raises a poignant question about euthanasia's goal. Whose happiness determines death? Is it that of the patient or that of proponents of euthanasia? What the proponents of euthanasia have not openly acknowledged is that once there is no life (i.e., all sensation ceases), there would be no more pain. But this is precisely where the distinction between killing and allowing to die lies. Euthanasia, which seeks to end life to put an end to pain, intends death, not even as accidental consequence of a decisions making process but as an end. This is simply because one cannot claim to be seeking an end in a logical sense, which in this instance is happiness as proponents of euthanasia claim, when the human person has ceased to exist. It is only a living person who can be the proof that there is no more pain and once life is terminated, they

are deprived of that objective basis of individual decision making crucial to every human life especially those at the end of life.

The Slippery Slope

Slippery slope argument essentially tries to justify a claim on the basis of an established position. However, in addition to an initial claim, other conclusion might be equally inferred from that first premise (Wrenn, 2019). Opponents of euthanasia are accused of slippery slope fallacy for arguing that encouraging euthanasia would essentially promote suicide rates. Proponents of euthanasia have responded with arguments pointing at why individuals made the choice to die, and have relied mostly on statistics to justify their position that where euthanasia has been legalized, it has not necessarily resulted in an increase in number of deaths through such means as people ordinarily fear it would (Young, 2019). Needless to say, that just as no study can claim to be perfect in representing painful human realities of life that are neither fully grasped by any scientific concept nor can it be represented by such inadequate statistical figures generally driven by ordinary intellectual exercise. So, the attempt that is made using the slippery slope argument only succeeds in taking the focus of the opponents of euthanasia away from the issue for a moment which does not change what the truth is, that euthanasia simply deprives the individual of being, it neither heals nor comforts. The proponents of euthanasia aim at securing a “happy death” for these individuals who are terminally ill with pain and are suffering. However, not only their actions do result in deaths of these individuals, but also they equally leave us with questions as to whose happiness they seek. Obviously, it could hardly be the happiness of one who is dead since happiness requires one in a state of being. But, once death occurs, happiness as we know and experience is no longer attainable and it would be false to claim such is possible.³

Of all who have died “benefitting” from the legalization of euthanasia, how many could probably be alive and well, had they not thought the law meant the choice before them was the right thing, the moral thing or perhaps the only option when in fact most believed all lifelong the contrary? Hence, the real slippery slope is not about any abstract argument but the state of mind regarding the consciousness of vulnerable individuals we ought to be caring for. The issue at stake here fails to recognize real needs of the human person, which is not about statistical figures but human well-being. Pain and suffering in either chronic or terminal illness is subjective and requires individual and wholistic care. When we are being presented with realistic views of human need, this is the story of how we are connected and called upon to respond to those who are critically and terminally ill among us, and to journey with them. It is indeed a story of humanity, but the meaning of euthanasia is a denial of our common response to that “person” in need by offering the hand of “death” in the legislation of either euthanasia or assisted suicide. Each time someone drinks the “hemlock”, we justify their action claiming they are exercising their autonomy. What we do not address is the role we play, individually or socially, in being responsible for the choice that some do make to die simply because of that sense of isolation. So, could we have failed in our collective responsibility? What would have happened is that while the “so-called” slippery slope argument goes back and forth; the real slippery slope would have occurred considering how the atmosphere created by society would have injected a lethargic dose of reality into the consciousness of those vulnerable individuals in our care leaving them nothing to hope for. This is clearly demonstrated by *The Belgian Act on Euthanasia* which not only allows euthanasia in cases of terminally ill

³ Plato, Sophiste, 262e-263d.

individual but goes on to permit same in instances of those whose illness is not terminal, but pain and suffering is deemed unbearable. The Act states certain conditions to be in place for this to happen (*The Belgian Act on Euthanasia*, 2002, pp. 3, 4). By permitting euthanasia even in those instances, the real slippery slope is obvious and within lies the greatest threat to those who are society's weakest.

Given how it is not every aspect of life that could be bound by laws of reason, I am not going to focus on the choice made by the terminally ill to die as a competent act. The fact remains that I do not think this individual has been well-served. What I intend to do here is to offer other means than euthanasia in comforting individuals with pain in chronic and terminal condition. This approach recognizes the individuality of the one going through such hardship and their right to have their pain better managed with all the means available, medically, socially, psychologically, and with human support. In addition, such individuals should also be given spiritual support to the extent that each one dictates. This enhances comfort and only the individual can decide when such is enough, since it is not something quantifiable.

Spiritual Care

There is a distinction between organized religion and spirituality. It is a thin line which can easily be ignored and perhaps be mistakenly taken one for the other. That one regularly observes religious practices as stipulated by a faith tradition may not necessarily mean one is equally spiritually connected. In fact, spirituality is what is needed for the human person to truly be in touch with the self and relate to the other. Spirituality is that inner desire to relate to another. Ultimately, that other is the Supreme Being. It is there in everyone, and in theological sense would be referred to as the source of our being. Therefore, there is a longing or yearning, which is part of the pain experienced in end of life suffering. That pain as we may witness at times is spiritual and depending on where the individual may be in life's journey, it may only be alleviated by offering spiritual support that assures human connection, which nothing material can offer. This connectedness that is deeply rooted within the human person is at the heart of spiritual care. Ashley and O'Rourke (1997) outlined four roles of spiritual support in health care: to heal, to sustain, to guide, and to reconcile (p. 233). For the purpose of this discussion, my focus will only be on two of these roles, namely, to heal and to reconcile. Just as the medical profession seeks to restore health and wellness to the individual, which, in other words, is the physiological healing, spiritual care is provided to patients for their wholistic healing. Such healing is neither quantifiable for it to be measured in hours of visits by Chaplains, nor it could be measured simply by spiritual care providers' encounters with patients despite all attempts being made to do just this. Rather, it is about the level of individual's need and the availability of pastoral ministers to journey with one effectively. There would be times when all the spiritual care-givers can offer is their presence because there is simply no "word" to say that can effectively communicate the human support other than being there. That presence is often what many lack in the afflictions brought on by the pain and suffering that tend to want to make them end life. And in such instances, there is hardly anyway that someone can claim to want to quantify the "presence" offered to the patient and its effectiveness. Apart from trained chaplains, others who equally provide this presence to terminally ill patients are palliative care nurses since they are constantly working with individuals at the end stage of life. In a study done among some of these nurses in Belgium, it was discovered that majority of study participants do not actually have any preference for or against euthanasia "a priori" despite the fact that some of the patients they care for do request for it. However, the strong opinion which seems to prevail among them is that first, prudence requires that there should be no rush in arriving at euthanasia as the only solution. Also,

they stress how important it is to listen to those whose views are shaped by real life experiences (Verpoort, Gastmans & Dierckx de Casterlé, 2004, p. 598). This group of nurses, given their role in caring for terminally ill patients and how committed they are to what they do, stress the importance of this presence and one might add, “healing presence” which provides more than just therapeutic or comforting or palliative care; it also brings with it an element of the spiritual care simply because these care-givers have come to know their patients well and become so dedicated to them. In some instances, patients would share their “soul” with devoted care-givers who stand by them and that gives the comfort needed which no other can offer. That might as well be what helps the individual find the desired healing when the moment comes.

The second role of spiritual care I am highlighting is to reconcile. Several years ago, I worked as a staff chaplain at a university hospital. The Palliative Care Team had a patient for whom they did everything possible in trying to control his pain but to no avail. Then, the nurse on the team referred the patient to pastoral care and asked that I visit with him. When I sat with the patient, he narrated his story and the one regret he had, something he wished he could have done differently. That was his pain. That one decision had led to a misunderstanding in the family, but he did what was in the best interest of the son and this was only a second guessing. What I did was to affirm his decision and to help him to realize he did nothing wrong and that he did not have to worry about going back to do anything over. He asked me over again and I affirmed him once more that he did nothing wrong. The patient was in pain which the Palliative Care Team could not help him with simply because it was of a spiritual nature. His pain emanated from the fact that he was in doubt if his past deed was right or if he may have been cut off from the other. This other is to be understood spiritually in the sense of the ultimate being to whom each one is accountable, but this other is also encountered in every neighbor, which would make sense that the patient feels the need to be spiritually grounded. Worth mentioning here is one of the reasons cited by proponents of euthanasia why people chose to die which is psychological distress,⁴ and it is not different from what the patient in the example given above also experienced. For this patient however, the spiritual care that was provided made the difference.

It is doubtful if, on the one hand, the arguments put forward by proponents of euthanasia would have considered spiritual needs of such patients, or if they would have even thought of making provision to give patients that option by either providing the care or making the information available that patients need in crisis moment. Their emphasis rather seems to be more on the patient’s claim or demand but what this demand is presenting could be properly interpreted as a “cry for help” which calls for interpretation. It requires working with the patient to better understand the individual’s story in order to appreciate the full extent of one’s pain and suffering, and this might sometimes require allowing the spiritual care-giver to be vulnerable in order to have a trust relationship with the patient. This truly means connecting with the patient, which in most cases helps the spiritual care-giver to appreciate the individual’s pain. It is only then the patient’s healing could begin in the peace that is felt within as one journeys with the other assuring the patient that he or she is not alone in their pain and suffering. That comforting presence of the other who supports and helps lifts so much burden off the patient who finally experiences love in the bond that is formed with the other helping him or her. What euthanasia or assisted suicide does is rob the patient of “knowing” such is indeed possible and relating to that final peace.

⁴ Summer 2018 (minor correction).

Conclusion

Euthanasia is presented as a relief to many who are in pain and are suffering. For what it is, it is deemed as that happy medium that sets one free from all that ails the individual according to proponents of euthanasia. However, to be truly free of something, one would have had to fully recognize it and concluded such is a burden which must be expunged. This is usually a free act, done willingly and with full knowledge of what the action is about. This cannot be said of many and perhaps most of those who took the decision to end their lives by euthanasia, and now who are doing so by assisted suicide. I say this for that simple reason that many simply hold on to what has been presented to them as a happy death, which I dare say is a misnomer. Life is good and while terminal illness brings with it pain and suffering which culminate in death, the spiritual care approach in end of life strives to help patients have a peaceful transition where they can recognize what the issues are and a care-giver journeys with the patient in helping to address and resolve them. This gives a wholistic care which helps patients be at peace in embracing the inevitable with solace.

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