ASSISTED SUICIDE TASK FORCE

Report outline

I. Mandate and goals

Synod 2023 appointed the Assisted Suicide Task Force "to make a definitive and comprehensive report on the practice of assisted suicide in all its forms" (*Acts of Synod 2023*, p. 981). The task force was assigned to shape its work according to the premise that there is a unique value to all human life and that humans have a special relationship with God as we bear God's image. Synod asked that the report be in concert with prior synodical work that "condemn[s] the wanton or arbitrary destruction of any human being at any stage of its development from the point of conception to the point of death" (*Acts of Synod 1972*, pp. 63-64). Before we launch into the main portion of our report, we want to explain how we understand our mandate and goal as a task force.

First, we are writing about medically assisted suicide (MAS).[1] The act of assisted suicide involves the situation in which the health-care system uses medicines to intentionally cause death, to which a capable individual has

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[1] In this report we have chosen to use the term "medically assisted suicide" because it is deemed to be clear in describing the act, and without tying it to a particular jurisdiction. Some jurisdictions call it "physician-assisted death," "death with dignity," or "medical assistance in dying"; however, none of these phrases are as clear, or accurate, in describing the act to which it refers. In addition, we reject the term Medical Assistance in Dying (MaiD), despite its popularity—particularly in Canada—because it is a euphemism that conflates medical killing with the medical assistance that is given to people in the natural dying process.

consented. MAS has been legalized in Canada and in many states in the United States. It remains illegal for anyone to help someone commit suicide outside of the prescribed processes in these jurisdictions, thus we will limit our discussion to pastoral care and end-of-life decisions in situations in which people are legally able to request that their life be ended with the help of an authorized health-care worker.

Second, we understand that by quoting the 1972 report on abortion, synod has asked us to write a report that is against medically assisted suicide. We focus our work on pastoral care and guidance from the position that a medically assisted suicide is not congruent with a biblical, Christian understanding of life and death.

Third, in its overture requesting that synod "make a statement on assisted suicide" (*Agenda for Synod 2023,* pp. 354-56), Classis Zeeland notes that the phrase from the 1972 report on abortion condemning "the wanton or arbitrary destruction of any human being . . ." does not describe the situation of medically assisted suicide, which is legislated with regard to the principle of patient autonomy and an approval process that includes waiting periods and is thus not arbitrary per se. We agree that a clearer statement on the value of human life would be helpful. We aim to provide a theological and pastoral framework that will help churches support and care for suffering people at the end of their lives or facing difficult life circumstances.

As of 2024, there are some 650 Christian Reformed pastors and chaplains who are doing ministry in jurisdictions where medically assisted suicide is legal. While writing this report, we engaged pastors and chaplains on their experience of providing pastoral care in the context of legalized medically assisted suicide. From our engagement with this group, we learned that MAS is an issue and decision that members of their congregations and communities face, and that some are choosing MAS. Church members hold a range of opinions about MAS. Pastors want people to feel safe to wrestle in community with the issue of suffering and to understand the difference between palliative care and MAS. They desire resources to support individuals and their loved ones in nuanced and difficult situations.

Taking all of this into consideration, we understand that the main question posed to the Assisted Suicide Task Force is as follows: *Given the growing availability and endorsement of medically assisted suicide, how should Christians think about this matter biblically, within the medical context, and in support of practical Christian living?*

In this report we will argue that Christian theology and pastoral-care practices encourage compassionate palliative care and support of suffering, disabled, and/or dying people and their families instead of acting to cause death.

II. Current Context

A. Map of Access to MAS

(*Note:* Medical Assistance in Dying (MAiD) is available in all provinces and territories in Canada.

Key

Medium gray—Bills are in place allowing euthanasia or assisted suicide (California, Colorado, District of Columbia, Hawaii, Maine, Montana, New Jersey, New Mexico, Oregon, Vermont, Washington).

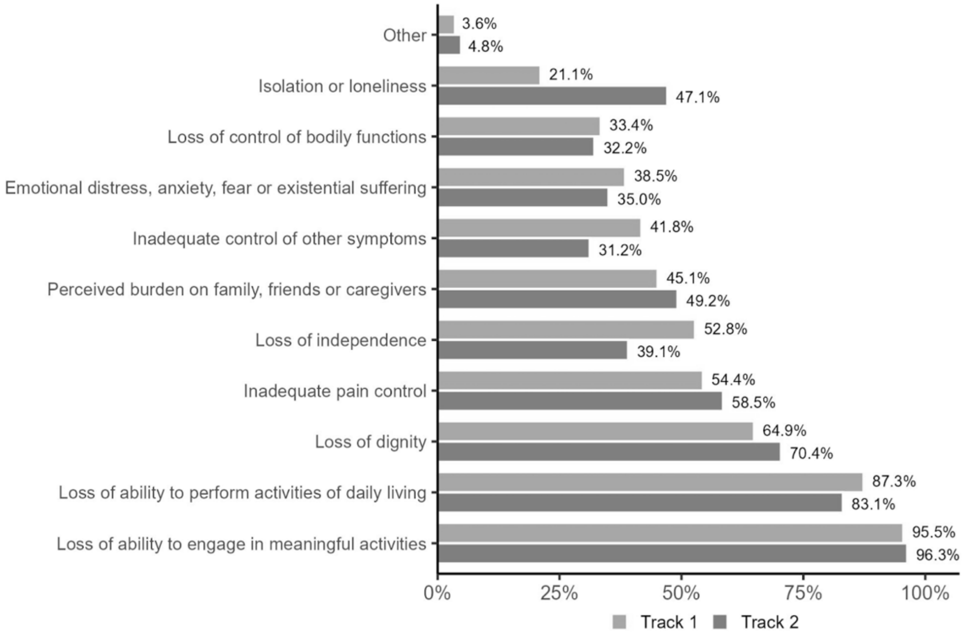
Black—Bills are in place allowing or proposing euthanasia or assisted suicide, but pro-life bills have been introduced (Connecticut, Montana, New Jersey).

Dark gray—Bills allowing euthanasia or assisted suicide are pending (Arizona, Connecticut, Delaware, Illinois, Indiana, Massachusetts, Missouri, New Hampshire, New York).

Note: Oregon allows people from out of state to travel to Oregon to receive euthanasia/assisted suicide.

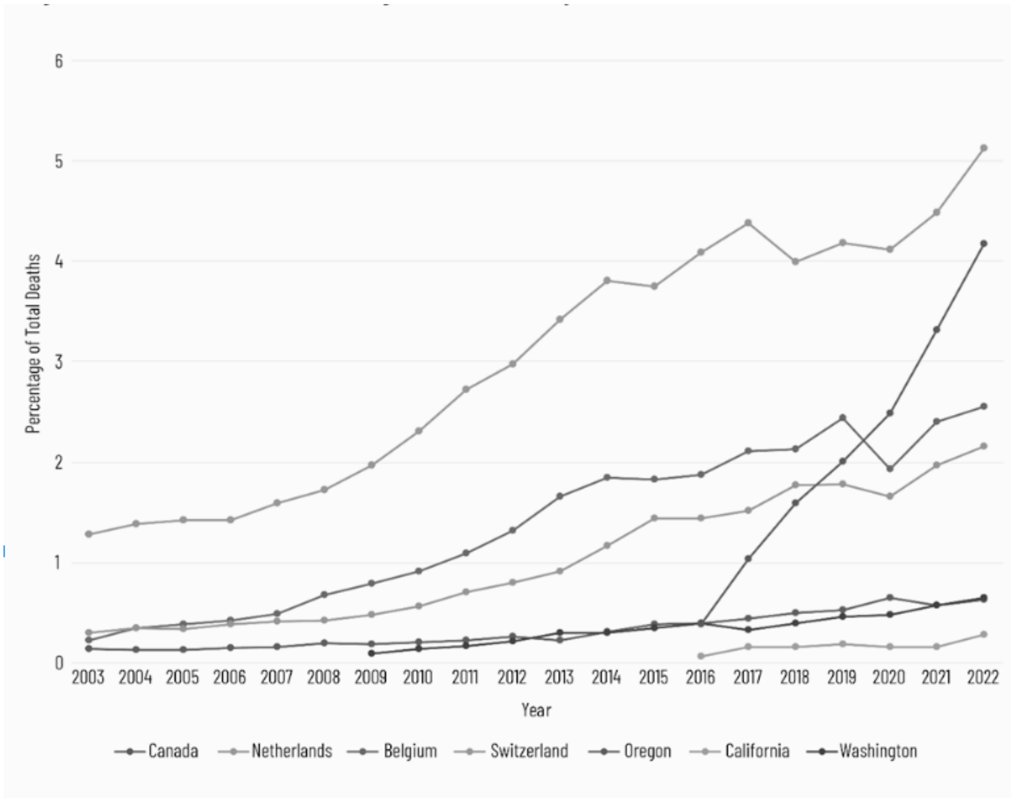
Source: deathwithdignity.org/states (accessed Jan. 22, 2025)

B. Chart showing reasons given for requesting MAiD (MAS in Canada), 2023



Notes: Track 1 MAiD is when a death is reasonably foreseeable.
Track 2 is when a death is not reasonably foreseeable but the patient has a disability, illness, or disease and is experiencing unbearable suffering that cannot be relieved under conditions that the patient considers acceptable.
For more information of the development of MAiD in Canada, see Appendix A.
Source: Fifth Annual Report on Medical Assistance in Dying in Canada, 2023. Stats Canada. (canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2023.html#f3.6a)

C. Graph showing assisted deaths as a percentage of total deaths in the eligible population, by jurisdiction[2]



This graph was originally published in color and is available on the Cardus website (see link in footnote). To distinguish the jurisdictions in this grayscale version, we include the percentage of total deaths for 2022: Netherlands, 5.1%; Canada, 4.1%; Belgium, 2.5%; Switzerland, 2.1%; Washington (state), 0.6%; Oregon, 0.6%; California, 0.3%. Note from author of table:

> This graph uses the most recent reported annual number of deaths. While jurisdictions have varying legislation and definitions of euthanasia and medical assistance in dying, the numbers reported here are official government accounts relating broadly to assisted death. The number of deaths recorded in Washington are the number of participants who are known to have died specifically after ingesting the requested lethal doses of medication. Since MAiD is not currently legal in Canada for persons under the age of 18, this Cardus paper calculates MAiD deaths as a percentage of all deaths of persons age 18 and above. Health Canada, however, calculates MAiD deaths as a percentage of all deaths over zero years of age. Consequently, Health Canada data and Cardus's own calculations show minor differences. For example, the 2022 percentage is 4.2 percent in this Cardus report, while for Health Canada it is 4.1 percent.

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[2] "From Exceptional to Routine" Cardus, 2024 (cardus.ca/research/health/reports/from-exceptional-to-routine/).

These three diagrams demonstrate that MAS is available and endorsed in Canada and the United States. MAS is legally available in Canada and in a growing number of states in the U.S. In Oregon the allowance for nonresidents means that people can travel to Oregon for MAS. There are various reasons people give for choosing MAS. Deaths by MAS are increasing as a percentage of total deaths year over year, most notably in Canada. Given the growing availability and endorsement of medically assisted suicide, how should Christians think about this matter biblically, within the medical context, and in support of practical Christian living?

III. Reformed Theological Framework

A. Imago Dei and the preciousness of life

Life is a gift from God, and human life is especially precious to God, our Creator. From the beginning of Scripture to the end, God is the giver and sustainer of life. While all life comes from God, human life is given particular value. In their report "Regarding Responsibility and Community at the End of Life," submitted to Synod 2000, the Committee for Contact with the Government (CCG) wrote that "both humankind and animals are referred to in Genesis as 'living beings,' but only of humankind is it said that God 'breathed into his nostrils the breath of life' (Gen. 2:7)."[3] There is something warmly personal and intimate in this picture. God did not just give us life; he gave us something of himself.

Dignity and meaning are not derived from one's cognitive or physical ability and therefore cannot be lost by age, injury, or disease. Dignity and meaning come from God, who created the whole world ex nihilo "out of nothing,"[4] imbued humankind with his image, and declared humanity "very good" (Gen. 1:31; Heidelberg Catechism Q&A 6). All persons have inherent worth and dignity, and all people are invited, in ways respective of their unique gifts, to be caretakers of the world and to reflect God's image in the world (Our World Belongs to God, para. 10).

The preciousness of human life is emphasized in Genesis 9:1-7. This passage begins and ends with the command to be "fruitful and multiply." In between this reiterated command to fill the earth comes a strong warning about extinguishing the life of another person: Genesis 9:6 says, "Whoever sheds the blood of a human, by a human shall that person's blood be shed, for in his own image God made humankind" (NRSV). Taking the life of another person is very serious.

This is also emphasized in the sixth commandment. Exodus 20:13 says "You shall not murder." The sixth commandment forbids any wrongful taking of life and affirms that we honor God when we honor and protect

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[3] *Agenda for Synod 2000*, p. 430. Note that this report is heartily endorsed by our task force as an important statement on responsibility and community at the end of life and worthy of review.

[4] St. Athanasius, *On The Incarnation: De Incarnatione Verdi Dei* (New York: St. Vladimir's Seminary, 1996).

the lives of fellow human beings. In Matthew 5:21-23, Jesus expands this command to include any harboring of anger against a neighbor as well. So we understand that the sixth commandment not only forbids the taking of physical life but also prohibits anything that harms, endangers, or even belittles other people. Further, the sixth commandment in its prohibition of killing is also a call to promote the well-being and flourishing of others. John Calvin, in writing on the sixth commandment, said,

> The purpose of this commandment is: the Lord has bound mankind together by a certain unity; hence each man ought to concern himself with the safety of all. To sum up, then, all violence, injury, and any harmful thing at all that may injure our neighbor's body are forbidden to us. We are accordingly commanded, if we find anything of use to us in saving our neighbors' lives, faithfully to employ it; if there is anything that makes for their peace, to see to it; if anything harmful, to ward it off; if they are in any danger, to lend a helping hand.[5]

As Calvin illustrates, this command is not just about not ending life; it is also about protecting, promoting, and helping life, in whatever ways we can, to flourish.

The Christian value of life is distinct from that perceived by contemporary culture, where the value of one's life is self-reported and assessed on a rubric of quality of life that prioritizes autonomy, ability, wealth, and health. We, however, believe that the value of human life is intrinsic and enduring. The Anglican theologian Rowan Williams writes, "For the Christian disciple, human dignity—and therefore any notion of human rights—depends upon the recognition that every person is related to God before they are related to anything or anyone else."[6] So Christians are to honor all lives, our own and others, even when they look different or seem weak. The CCG writes that the value of human life "is not diminished by the physical or mental ravages of old age, disability, disease, accident, or deformity. We may not terminate life on the basis of any of these things, for doing so places us on a slippery slope of treating life as a disposable commodity when its apparent usefulness is lost" (*Agenda for Synod 2000,* pp. 444-45). We care for others, we receive care when we need it, and we make every effort to protect the lives of all people—especially those whom our culture may deem as less valuable, weak, or unworthy.

The inherent dignity and value of humanity is made most clear in the incarnation and the bodily resurrection of Jesus Christ. Jesus took on flesh and lived among us. Jesus was made like humanity in every way except that he was without sin (Heb. 2:17-18; 4:15). Jesus suffered pain, grieved loss, and experienced suffering in body and soul. Jesus died and was buried. And Jesus' bodily resurrection both affirms the goodness of the body and indicates

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[5] *Institutes of the Christian Religion,* 2.8.39.

[6] Rowan Williams, *Being Disciples: Essentials of the Christian Life* (Grand Rapids, Mich.: Eerdmans, 2016), p. 65.

that death is not the end. Indeed, Jesus' death and resurrection secured our redemption, affirmed the goodness of humanity, and sealed the promise that we belong—body and soul, in life and in death—to our faithful Savior, Jesus Christ (see Heidelberg Catechism, Q&A 1). The incarnation also shows us that we are not alone in our difficulties; Jesus is intimately aware of the suffering and challenges of being human.

B. Suffering

Trouble and suffering are part of being human, and our Lord Jesus is "a man of sorrows, and acquainted with grief" (Isa. 53:3, RSV). He knows suffering. Our good bodies, created by God, can be a source of pleasure and joy, but they also bring us trouble. Disability, disease, and pain change our bodies and the way we live our lives. In our lifespan we grow and develop, and we experience mortal and physical limits that are different for each person—for reasons that may be unclear to us. Suffering involves physical, psychological, and spiritual parts of ourselves, at many times and for many reasons throughout our lives—and often it accompanies the dying process.

We live in a world that urges us to avoid suffering at all costs. Our cultural impulse to flee or eliminate suffering can cause us to miss out on its formative work in our lives. We certainly don't pursue suffering for its sake, but suffering isn't meaningless. Suffering develops character and deepens our dependence on our heavenly Father and on each other. The apostle Paul states that "suffering produces perseverance; perseverance, character; and character, hope" (Rom. 5:3-4). This passage is not a celebration of pain but, rather, a recognition that even in suffering God is accomplishing his purposes in us. Indeed, Paul writes, at times we are "hard pressed on every side, but not crushed; perplexed, but not in despair; persecuted, but not abandoned; struck down, but not destroyed. We always carry around in our body the death of Jesus, so that the life of Jesus may also be revealed in our body" (2 Cor. 4:8-10).

Considering the issue of medically assisted suicide, the loss of autonomy is a significant source of suffering for many people. Ewan Goligher, a Christian physician in Canada, suggests that the suffering that most often leads people to seek out MAS is existential pain, loss of meaning, or other, nonphysical reasons—which government statistics confirm.[7] People wrestle with the loss of autonomy that illness, disability, and aging can bring. People fear being a burden to family or friends. Loved ones may find themselves uncomfortable witnessing the suffering of others, and they may project that concern on those who are suffering in a way that makes them consider ending life. People worry about how the end may come about, and they want control over the time and manner of their death. Understanding the reasons that people consider MAS can help us respond to their concerns.

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[7] aaronrenn.com/p/dr-ewan-goligher-a-christian-response (accessed Dec. 6, 2024) and canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2023.html#a3.6 (accessed Jan. 3, 2025).

C. Addressing suffering: love, lament, liturgy

As Christians, we are called to respond to human suffering with compassion and care. We are called to *love one another*. Together, young and old, able-bodied and disabled, full of life and nearing death, we fix our eyes on Jesus, who "for the joy set before him . . . endured the cross, scorning its shame, and sat down at the right hand of the throne of God"; in our suffering we "consider him who endured such opposition from sinners, so that [we] will not grow weary and lose heart" (Heb. 12:1-3). We are members of the body of Christ: we belong to God, and we belong to one another. This "belonging to one another" is emphasized in the New Testament through "one another" commands:

- love one another (John 13:34)
- honor one another above yourselves (Rom. 12:10)
- care for one another (1 Cor. 12:25)
- be kind and compassionate to one another (Eph. 4:32)
- bear with one another (Col. 3:13)
- encourage one another (1 Thess. 5:11)
- bear one another's burdens (Gal. 6:2)

We may not be able to alleviate a particular cause of suffering or provide an explanation for the cause of suffering, but God invites us to find personal and practical ways to "carry each other's burdens and in this way . . . fulfill the law of Christ" (Gal. 6:2).[8] The love and help of community play a vital role in helping people who are suffering to persevere in faith. Providing presence and accompaniment can be a source of strength and encouragement, as this story from a CRC congregation demonstrates:

> When Mary was diagnosed with terminal cancer, she was concerned, especially because she did not have family members living locally. When her church family learned of her need, they stepped in, providing people with various skills to walk with her in her final weeks. The list of ready-to-help individuals included drivers who took her to doctor appointments, and nurses who helped trouble-shoot medical needs like bandaging and medication. There were people who loved to read who visited and read books to her when she became too weak to read on her own, and lifelong church friends who held her hand, wiped her brow, and sat with her in her final days.

Receiving a terminal diagnosis is very difficult. So is asking for help. It takes courage and confidence in the community to be vulnerable about needing support. When a person's needs and requests are heard and answered, the church lives into its calling to love one another. Unfortunately, in many situations that doesn't happen. Either those who are suffering are unable or unwilling to share their needs, or the community doesn't hear

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[8] The CCG chose Galatians 6:2 as the guiding verse for its report on end-of-life issues. We strongly recommend this report for its explanation of how the church can build communities of care for people at the end of life (see *Agenda for Synod 2000*, pp. 425-48).

and respond. This can bring pain, loneliness, and isolation. We know that some readers will have experienced situations in which they have not cared for or been cared for by their brothers and sisters in Christ. We must pause, recognize, and repent of our individual and collective failures to love each other. And we must begin again, hearing God's call to love one another.

God's people are called to respond with compassion, presence, help, and action to correct unjust situations to alleviate suffering. As followers of Jesus, we care for the vulnerable and for people whom our society devalues or ignores (James 1:27). Christians address suffering by loving one another at a relational level, and we work to alleviate situations like poverty or disasters that bring about suffering. This is of particular importance concerning the issue of MAS because some people may pursue it due to a lack of access to resources that are needed in order to live with a diagnosis or disability. Suffering can be the result of unjust systems and cycles of poverty. Christians work tirelessly to break these oppressive systems to bring about shalom in society.

Our love and care for each other are crucial but inadequate responses to human suffering. When life is a burden and full of suffering, our situations warrant *lament*. Psalms of lament express pain that is physical or psychological, sharing an honest desire for suffering to end and showing trust in God's sovereign care. Lament shows us that God and God's people can hold space for deep feelings; suffering is not to be repressed or hidden. Psalm 13 says, "How long, LORD? Will you forget me forever? How long will you hide your face from me? How long must I wrestle with my thoughts and day after day have sorrow in my heart?. . . But I trust in your unfailing love; my heart rejoices in your salvation. I will sing the LORD's praise, for he has been good to me."

Psalm 88 is the darkest lament in the Bible. This particular psalm does not end with an expression of trust or praise but with the despair of the psalmist: "darkness is my closest friend" (Ps. 88:18). We do not always see the answers for our suffering or even an end to it, but we love and are loved by a God who welcomes even the darkest places of our lives into his presence in prayer. We cannot make another person's suffering meaningful to them, but we can urge them to persevere and encourage them when they despair, and through our presence we can remind them that our good God will not abandon them. Together we remember the promise "My heart and my flesh may fail, but God is the strength of my heart and my portion forever" (Ps. 73:26). Suffering and death do not have the last word, for "our light and momentary troubles are achieving for us a future glory that far outweighs them all" (2 Cor. 4:17).

Lament can be individual or communal, and churches should make space for both expressions of lament in the liturgy of their public worship services. Our weekly practice of communal worship gathers the community of believers who individually and collectively cry out in protest to God and ask for his mercy. Suffering, death, and the dying process can be frightening to people because it seems unfamiliar, but perhaps it isn't as unfamiliar as people think. Christian liturgy teaches us how to live and how to die. Every time we gather around the baptismal font, we rehearse dying and rising with Christ. This regular liturgical practice deepens our faith for this life, but it also readies us for the resurrection that is still to come: "For if we have been united with him in a death like his, we will certainly also be united with him in a resurrection like his" (Rom. 6:5).

D. Medical care in the dying process

Uncontrolled pain or suffering is a situation that all human beings want to avoid. When facing suffering that is likely to worsen, or unlikely to resolve, there is a strong need for compassionate care, and the health-care system seeks to provide such care to people who are suffering. Palliative care and medically assisted suicide are two different solutions offered for the problem of intolerable suffering. However, the intent behind these offered solutions is quite different: whereas palliative care provides medicines and caring resources to optimize quality of life until a natural death, medically assisted suicide uses medicines to purposefully cause the death of a suffering individual who has chosen to die.

Medically assisted suicide follows established protocols to bring about the ending of one's life. A consenting individual who is suffering and wants to end their life seeks the assistance of the health-care system to do so. Depending on what is legal in one's jurisdiction, there may be the option of assisted suicide or euthanasia. In assisted suicide, medicines are prescribed, dispensed by a pharmacy, and self-administered; in euthanasia, a health-care worker administers a lethal injection via an intravenous line. Medication protocols in use are designed to bring a quick-and-painless end to life. Proponents of medically assisted suicide see it as allowing one to maintain control in dealing with immense suffering when illness or disability cause chaos, uncertainty, and fear.

Palliative care, in contrast, focuses on caring for a suffering individual until the natural end of their life. Palliative care brings together expertise from physicians, nurses, chaplains, social workers, personal support workers, and more with intent to optimize quality of life. Hospice care is health care that is focused on the last stage of life, when death is reasonably foreseeable. Palliative/hospice care can be provided in various settings, such as one's own home, a hospital, or a temporary or long-term care facility. Regardless, medicines and tools can be used capably to help with various symptoms one may experience in their suffering, such as pain, depression/anxiety, nausea/vomiting, bowel/bladder dysfunction, fatigue, shortness of breath, lack of appetite, changing cognitive function, or declining ability to take in food or water.

Thankfully, with modern palliative care it is rare for one's physical pain to be inadequately addressed. However, if pain cannot be helped while maintaining conscious awareness, palliative sedation can be used. Here, palliative-care providers use medications skillfully to induce a loss of consciousness, in much the same way that an anesthetist prevents conscious awareness of pain during a surgery. Though this entails a loss of consciousness, the intent remains the relief of suffering—not the ending of life. To be clear, if an individual dies while unconscious from palliative sedation, the cause is the underlying illness, not the sedatives used to provide comfort. This distinction has already been made in the CCG report (see *Agenda for Synod 2000*, p. 446).

As an example of palliative sedation, consider a patient with ALS[9] who is supported by a ventilator. Her nervous system no longer has capacity to breathe, so a machine pushes air into her body. The disease has progressed, and she can no longer communicate or feed herself. She had previously decided that she would not accept a feeding tube. After experiencing neurological decline for months, she and her family decide she is ready to stop using her life-support system. To avoid the experience of suffocation, her palliative physician provides medications that reduce air hunger and anxiety. She is provided sedation while her body succumbs to death due to her inability to breathe. This is a natural death, in which a health-care worker provides compassionate palliative support without the intent to kill, respecting the wishes of patient and family to stop receiving life-sustaining measures.

When confronted with an illness in which suffering is increasing, without expectation of cure, decisions must be made about whether to continue with life-prolonging treatment. One of the realities of modern health care is medicine's ability to prolong life without enhancing quality of life. This can make decision making about care options very difficult. A positive view of the value of life within the context of a loving community would not typically lead to early abandonment of all medical care. However, believers who have entrusted their life to Christ should not feel the need to pursue medically futile interventions but are free to decline treatment that is intended to prolong but not enhance one's life.

It is difficult to know ahead of time how we will feel and what we will want when there is a change in our health or ability. We may imagine a certain situation to be unbearable—but when it arrives, we may perhaps realize we were wrong. It can be helpful for patients to ask questions in order to fully understand available supports and treatments and discuss those matters with family members. Support from family and community can make difficult situations bearable. Ultimately, as believers, we entrust our lives to our

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[9] Amyotrophic lateral sclerosis (ALS) is a disease in which the nervous system governing muscles progressively degenerates, commonly over months to years, leaving an individual fully conscious yet losing the ability to eat, speak, move, and, lastly, breathe.

heavenly Father, seeking his guidance each step of the way, knowing we have hope that extends into eternity.

IV. What about "passive euthanasia"?

Many people have the idea that euthanasia can be accomplished in two ways: first, by "active/voluntary euthanasia" and, second, by "passive euthanasia." This two-part categorization is inaccurate and can be misleading. To be clear, this task force understands *euthanasia* as synonymous with active/voluntary euthanasia: the health-care system's use of medicines to *intentionally cause death, to kill*. On the other hand, passive euthanasia is commonly used to denote *allowing one to die*, usually by declining some level of medical treatment and/or by accepting some level of palliative treatment. "Passive euthanasia" is therefore a misnomer. As a task force, we would unambiguously state that the health-care system should never euthanize people, whereas it should support a person in declining a certain level of medical treatment or in receiving palliative care, in which there is no intent to kill.

Another situation that is sometimes termed "passive euthanasia" and deserves comment is when an individual decides to end their life by declining food and water. In this kind of situation, the context matters. If the individual has accepted a terminal condition, and further nourishment holds little value in sustaining their life, it is quite acceptable to refrain from intake—as is common near the end of life. However, if an individual is overwhelmed by despair and suffering and seeks a means to end it, even without medicines—that is a time to turn to the Lord and his people and thereby find strength to carry on.

Certainly the distinctions described here may be considered a fine line, but the line is real, and most thoughtful Christians who wish to be obedient will, at some point in their lives, have to make decisions involving that fine line. This is not merely a theoretical matter. (See Appendix C for more information on making health-care decisions.)

V. Disability

Medically assisted suicide is not just an end-of-life issue, it is a disability issue. In Canada, "Track 2" MAS allows people whose death is not reasonably foreseeable to access MAS simply on the condition that they have a disability and are suffering. Since we view life as precious, a gift of God and not diminished by age, disability, and disease, "Track 2" MAS involves an alarming devaluation of people who are every bit as valuable as nondisabled people.

People with disabilities experience barriers to participation in community in various ways and situations. The added cost in time and resources to gain inclusion can be weighty, especially when not borne by the larger community/society. Wheelchair users, and those who use assistive devices like a walker or cane, are excluded from physical spaces without ramp or elevator access. People with a hearing impairment or sensory disabilities are largely excluded from social connection. People with disabilities have more medical and therapy appointments; they have higher costs for adaptive equipment and medication. People with cognitive disabilities are treated as children and experience prejudice based on their disability. In Canada 27 percent of people age 15 and above have a disability.[10] In the United States the CDC reports that 28.7 percent of adults have a disability.[11] Social isolation is a source of significant suffering for people with disabilities.

The church must respond prophetically in a society where people with disabilities are devalued and experience higher rates of social isolation and poverty. First, we must work to understand the disabled experience. Second, we must break down barriers to participation in our churches and across society to reduce social isolation. The work of accessibility and community will shape disabled and nondisabled people to be together in a practical and powerful demonstration of the preciousness of all human life. To be pro-life is to be pro-disabled people.

As Christians, we are called to care for one another. We are usually quite good at embracing this as a Christian duty: we serve and give generously to others. Active doers and fixers, however, can find it very challenging to receive care when they need it. This should spark an important reimagining of the dignity of care: we value life when we give *and* receive care. While disability will likely touch all of our lives, most people do not think about, or prepare for, becoming disabled. As people of faith, is our view of the preciousness of human life robust enough for us to love ourselves when we experience disability personally?

VI. Pastoral Care

When people experience suffering, they don't often need more answers or dogma, they need *people* who can be present with them in their distress, *people* who can hear their questions without becoming anxious, *fellow brothers and sisters in Christ* who can help them “find strength in God” (1 Sam. 23:16). As pastors and leaders in the church, we have the opportunity to walk with people in matters of life and death.

Each person’s situation is unique, informed by a person’s own experiences and resources, and therefore the pastoral response must also be deeply personal. People find themselves in all kinds of situations and for a variety of reasons may wonder about or even pursue MAS. The Christian community is uniquely gifted to respond to and care for people who are hurting. In life and in death we belong to God, and we also belong to one another. This belonging compels us to care well for those facing suffering, disability, end of life, and any other situation that may lead them to consider MAS.

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[10] statcan.gc.ca/o1/en/plus/5980-disability-rate-canada-increased-2022 (accessed Dec. 6, 2024)
[11] cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html (accessed Dec. 6, 2024)

A. The power of presence

The Bible teaches us the importance of being present with people who are suffering, spending time with them, giving them our full attention, listening without judgment, absorbing some of their pain. As the apostle Paul writes, "Praise be to the God and Father of our Lord Jesus Christ, the Father of compassion and the God of all comfort, who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves receive from God" (2 Cor. 1:3-4). The book *Compassion: A Reflection on the Christian Life* offers this reflection regarding the gift of Christian community:

> In Christian community we gather in the name of Christ and thus experience him in the midst of a suffering world [suffering people]. There our old, weak minds, which are unable to fully perceive the pains of the world, are transformed into the mind of Christ, to whom nothing human is alien. In community, we are no longer a mass of helpless individuals, but are transformed into one people of God.[12]

Visiting people is a crucial practice for the individual and the church. Pastoral presence can strengthen and encourage. A calm demeanor can help reduce anxiety in a room and connect people who are unable to attend church gatherings. We have provided a document in Appendix B that can be used to equip lay leaders in pastoral visits, especially to those who are suffering and dying.

B. Perseverance in suffering

God has a purpose for our suffering that is not always known to us. Whether or not we understand the purpose for our own or other people's suffering, we respond with love, lament, and liturgy, drawing people further into relationship with God and others.

The first question of the Heidelberg Catechism asks, "What is your only comfort in life and in death?" And the answer, of course, is belonging. In life and in death we belong to our faithful Savior, Jesus Christ. We are not the masters of our own destinies but beloved children, kept and cared for by our heavenly Father, who knows the number of our days and the hairs on our heads.

Even when we suffer, we can trust the Lord's timing with our lives, because we trust that he is good. We serve a Shepherd who promises never to leave us and who will surely be with us even in the valley of the shadow of death. God's pervasive and tender care gives comfort and courage for all seasons of life and enables us to persevere, even in the uncertainty or fear we may feel about dying.

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[12] Henri J. M. Nouwen, Donald P. McNeill, and Douglas A. Morrison, *Compassion: A Reflection on the Christian Life* (PRH Christian Publishing, 2006), p. 54

C. Protection of life
All people are created in the image of God. We are called to protect the lives of vulnerable people. Our bias ought always to be for life; however, we also acknowledge that sometimes harm is done when life is needlessly extended. In our protection of life we must walk compassionately with people as they consider whether or not they wish to begin or continue a treatment that may prolong life but also increase suffering—or merely prolong life but with diminished quality. As Christians, we can count it a privilege to walk with people through these hard places and to bear witness to the gift of life and the hope of our life to come.

D. Promise of the gospel
The Bible teaches that those who believe in Jesus as Savior will spend eternity with him. No distinction is made regarding the cause of a person's death. While the Bible affirms the goodness of this life, it also points us forward to the life yet to come. For many people, waiting for death is difficult, but we believe that the answer to such struggle is not an expedited death but an empowered perseverance, made possible by the sustaining hand of our loving heavenly Father and the hope of the resurrection (1 Cor. 15). We wait for death in hope, trusting that "the one who raised the Lord Jesus from the dead will also raise us with Jesus and present us . . . to himself" (2 Cor. 4:14). Peace is not found in controlling how or when the end comes about, but in the One who is with us always and who promises to receive us into his kingdom with this gracious invitation: "Well done, good and faithful servant! . . . Come and share your master's happiness!" (Matt. 25:21).

VII. What do I say/do when my parishioners ask about medically assisted suicide?

- Listen and then listen some more.
- Refrain from the need to give your own thoughts or answers right away.
- Help them explore their own feelings. What underlying fear may be at work?
- Ask about family involvement. Have they shared with family? Is there family pressure?
- Consider access to resources. Discern whether the decision being made is due to lack of financial resources or concern about the cost or burden of care.
- Encourage other options (hospice, palliative care).
- Share Christian perspective—honor the preciousness of life.
- Keep showing up and involve other people from the faith community to provide consistent presence/care.

VIII. After a death by medically assisted suicide has occurred

In many ways, a funeral after MAS will be like any other funeral and its planning. It will require sensitivity to different dynamics at play, attentiveness to how loved ones are processing the loss, and a commitment to pointing people to the hope of glory. Romans 8 makes clear that there is nothing in all creation that can separate us from the love of God: neither life nor death. When caring for grieving family members or preparing for a funeral for someone who died by MAS, we believe that all the promises of God are still true. We hold on to the promise that nothing in all creation can separate us from the love of God (Rom. 8:38-39); that God is gracious and compassionate, slow to anger, and plenteous in mercy (Ps. 103:8); and that salvation is by grace alone, through faith, and comes to us as a gift from God (Eph. 2:8-9). A funeral is not the time to cast judgment on a person who has died by MAS, or on their family. Rather, a funeral is a service intended to help a family give thanks to God for the earthly life of a person, to say goodbye and grieve their death, to commend or entrust a person to God's care, and to turn in hope to the promise of 1 Corinthians 15:54—that, because of Jesus, death has been swallowed up in victory.

With the prevalence of MAS in our culture, some people in your congregation may, despite their beliefs, be involved in caring for people who pursue MAS. Physicians have colleagues to whom they refer patients for MAS in order to avoid the moral conflict of participating in MAS. However, a referral is understood as facilitating or supporting the intended path of care for a patient; abstaining from even such limited participation is advisable. Conscientious objection must be protected and supported in spheres where MAS is legislated and supported. Health-care workers may experience moral injury, the emotional harm that comes from working with people who choose MAS. This harm may present itself as compassion fatigue or as desensitization to the dying process. The Christian community should provide support for persons experiencing moral injury. We should also support family members who disagree with a loved one's decision to pursue MAS and who feel hurt and helpless as they watch their loved one die by lethal means.

IX. Conclusion

Across North America many people can request help from a health-care worker to end their life. As medically assisted suicide is legalized in more jurisdictions, we see the number of deaths by MAS increase. Medically assisted suicide is often framed as a type of tragic yet beautiful choice, as a kind of compassionate protection for people—protection from suffering, pain, or disability. Given the growing availability and endorsement of medically assisted suicide, how should Christians think about this matter biblically, within the medical context, and in support of practical Christian living?

The Christian understanding of life is rooted in the incarnational vision given to us in Scripture and exemplified in Christ: life is a gift by the grace of God. Made in his image, human beings are bestowed special honor by God, who deeply desires to be close to us. We view our lives and all human life as precious. "Do you not know that your bodies are temples of the Holy Spirit, who is in you, whom you have received from God? You are not your own; you were bought at a price. Therefore honor God with your bodies" (1 Cor. 6:19-20). Receiving a terminal diagnosis is very difficult; the decisions for care and treatment are individual and challenging. In these difficult moments, we affirm that life is precious, so we should not act to end life. Human dignity and value are enduring and intrinsic. Disease and disability do not diminish our value—and in all stages of our lives, we belong to God and to each other. We ask for help, and we give and receive care as our Lord Jesus has shown us.

Our commitment to honoring the preciousness of life is a communal practice. We commit to love one another. Someone who is suffering remains a temple of the Holy Spirit—that is, someone to care for, to comfort, and to love, not to kill. Just as the Lord ministered to Job, Moses, and Elijah in their despair, uniquely providing for each of their needs when they wished to die, so we should minister to people who have lost the will to live. By our loving presence and caring for their practical needs, we can remind suffering souls of their worth as creatures loved by God, with whom God is *actually*—not metaphorically—present.

Though we do not always understand the purpose of suffering, the Christian response to suffering is love, lament, and liturgy. Our inclination is toward life, and we do not act to end a life intentionally—yet we do not idolize life as if this life is all there is. We do not fear death; we wait for death in hope, trusting that "the one who raised Jesus from the dead will also raise us with Jesus. . . . Though outwardly we are wasting away, yet inwardly we are being renewed day by day" (2 Cor. 4:14, 16).

X. Recommendations

A. That synod affirm the value of human life as a gift from God, intrinsic and enduring, recognizing that, as Christians, we are to honor and care for all lives—our own and others—especially in suffering and despair.

B. That synod remind CRC members, churches, and classes, in accordance with prior synodical reflections, that the appropriate Christian response to suffering, disability, and/or dying people (and their families) is pastoral, including compassionate palliative care instead of acting to cause death (*Acts of Synod 2000*, pp. 686, 707-8).

C. That synod instruct all CRC members to make every effort to ensure that meeting spaces and programming are accessible so that our churches are prophetic witnesses that disability, disease, and deformity do not diminish the value and dignity of every human (*Acts of Synod 1985*, pp. 348-52, 490, 702-3, 825; *Acts of Synod 1993*, pp. 381-405, 539, 542-43; *Acts of Synod 2011*, p. 817).

D. That synod encourage classes to occasionally provide workshops and training on end-of-life issues such as palliative/hospice care, estate planning, and communicating one's values for care to their health-care proxy.

E. That synod recommend the list of resources appended to this report as helpful resources for members and leaders navigating suffering and/or the end of life.

F. That synod encourage pastors and church leadership teams to develop and share with local CRC churches a list of reputable local palliative/hospice-care organizations so that they can better support the members in their community in the dying process.

G. That synod encourage the churches to provide training and resources to people involved in pastoral care for congregations and communities, such as found in Appendix B of this report.

H. That synod remind CRC members to give generously of their time, treasure, and talents to work that supports people who are vulnerable and suffering, and to support the work of civil government to provide compassionate care so that those who are suffering and vulnerable do not feel pressured to end their lives.

I. That synod recommit to engagement with public policy makers in advocating for hospice and palliative care that is readily available for every person in their jurisdiction.

J. That synod commend to the churches the report of this task force as a faithful response to the reality of medically assisted suicide in our time.

Assisted Suicide Task Force

Sarah Albers
Brian Dijkema
Deb Fennema
David Shin
Caroline Short (reporter)
Doug Vande Griend
Stephen Vander Klippe (chair)
David van der Woerd
Zachary King (ex officio)

APPENDIX A

Medically Assisted Suicide Today

Opinions on euthanasia in Canada have altered significantly in the past forty years, and this is true within various legal, medical, and other bodies. In 1983 the Law Reform Commission of Canada concluded that neither active euthanasia nor aiding suicide should be legalized, and it recommended retention of the present law (which deemed such actions criminal).[13] Likewise, in 1995, the Canadian Medical Association (which represents doctors in Canada) issued a summary of its policy, saying that CMA members "should not participate in euthanasia and assisted suicide," a policy that was withheld as recently as 2014.[14] However, while both of these major institutions rejected euthanasia and assisted suicide, a review of legal bills and media showed a concerted effort to legalize these practices, as well as an increasing push to normalize them through law and public discourse.[15] In public opinion polls, there has also been a gradual shift toward greater acceptance of euthanasia, some of which was informed by negative experiences regarding the quality of care received by loved ones at their death.[16]

The shift in Canada was driven by a powerful lobby group called Death with Dignity. Individual patients who wanted a medically assisted death put forward legal challenges, with support from some physicians. There were numerous court cases in various jurisdictions that called for the decriminalization of the killing of terminally ill patients. A landmark decision in Canada involved the case of Sue Rodriguez, a British Columbia woman suffering from ALS, who sought to end her life with the assistance of a physician. This activity was deemed criminal under s. 241(b) of the Criminal Code that prohibited assisting someone to die by suicide. Rodriguez claimed the section was unconstitutional, but this claim was defeated by the court. The September 1993 decision upheld the constitutionality of s. 241(b), and assisted suicide remained a criminal act.[17]

While that law was upheld nationally in Canada at that time, various subnational jurisdictions introduced commissions and eventually laws, which attempted to allow for physicians to end the lives of patients who meet certain criteria. After various commissions and committees studied the issue, the Quebec National Assembly introduced (in June 2013) and passed (in June 2014) Bill 52. Despite the existing criminal prohibitions, the province's legislation established rights and rules for "end-of-life care," which included—although not exclusively—"medical aid in dying." MAiD, under

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[13] canada.ca/content/dam/lcc-cdc/documents/lrcc-reports/J31-40-1983-eng.pdf

[14] consciencelaws.org/archive/documents/cma-cmaj/2014-06-CMA-euthanasia-policy-correct.pdf

[15] publications.gc.ca/Pilot/LoPBdP/CIR/919-e.htm

[16] angusreid.org/assisted-suicide/

[17] publications.gc.ca/Collection-R/LoPBdP/BP/bp349-e.htm

Bill 52, was restricted to those "at the end of life" but required all provincially funded hospitals and nursing homes to provide MAiD and required physicians unwilling to perform MAiD to provide referrals.

This national expansion is also present in Canada where a Supreme Court decision in February 2015 (the Carter decision) unanimously ruled that two sections of the Criminal Code (which applies in all jurisdictions) related to consenting to death (s. 14) and aiding suicide (s. 241(1)(b)) were unconstitutional because they prevented competent adults from being able to die with the assistance of a clinician. The court's ruling effectively required that physician-assisted death be permitted in some form, and the court gave federal and provincial governments a total of 16 months to determine the legislative and regulatory details.[18] The Carter decision limited its consideration to those suffering intolerably from a "grievous and irremediable medical condition (including an illness, disease, or disability)." The decision explicitly excluded considerations of assisted death for minors, mental illness, and less serious medical issues.[19]

In effect, this decision required Parliament to decriminalize, for those administering MAiD, the otherwise criminal limitations that prevent murderers from claiming that their victims consented to dying and that prevent individuals from aiding someone to die by suicide. It is critical to note that the Supreme Court of Canada decision did not recognize a blanket, or basic human, right to euthanasia or MAiD but limited it to the conditions noted above.

Since that time, some restrictions on MAiD have been removed. This has occurred through the Trunchon decision in September 2019, and the subsequent legislation, Bill C-7, which introduced Track 2 MaiD. This new track removed the limit that restricted MAiD to a "reasonably foreseeable natural death" in some situations. People with disabilities and serious medical conditions who are suffering can apply for Track 2 MAiD when their death is not reasonably foreseeable. While the court challenges that paved the way for Track 2 were brought by individuals with disabilities, there has been an outcry from the disabled community[20] in Canada and the United Nations Special Rapporteur on the rights of persons with disabilities.[21] Unfortunately this outcry was diminished by the outbreak of COVID-19 and the ensuing health crisis that disproportionately affected disabled people. Track 2 MAiD devalues disabled persons' lives because it supports and facilitates their suicide—not because their death is reasonably foreseeable but because they have a disability. For a suffering person whose death is not reasonably foreseeable, they will not qualify for MAiD in Canada.

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[18] justice.gc.ca/eng/cj-jp/ad-am/scc-csc.html

[19] justice.gc.ca/eng/rp-pr/other-autre/ad-am/p1.html#fn7 (Carter, supra note 1 at para. 127)

[20] For a detailed overview of the response from the disabled community to MAiD, see Catherine Frazee, "MAID resistance in Canada: Sounding the Five-Minute Entreaty."

[21] documents.un.org/doc/undoc/gen/g19/348/81/pdf/g1934881.pdf (p. 13)

The Canadian federal government is also set to expand MAiD in 2027 to those whose sole condition is mental illness,[22] and there are calls for MAiD to be expanded to allow for "mature minors" who are children under the age of 18 to be euthanized.[23]

Several American states have passed various forms of physician-assisted suicide or euthanasia, with various levels of restrictions and allowances, including Oregon (1997), Washington (2009), Montana (2009), California (2016), Colorado (2016), New Mexico (2021), Vermont (2013), Maine (2019), Hawaii (2018), and New Jersey (2019). At the time of this writing, there are also other states with pending bills seeking to legalize physician-assisted suicide or euthanasia.

While policy surrounding this issue is worked out at the state level in the United States, a 2022 settlement of a federal lawsuit has effectively removed restrictions that limit physician-assisted suicide to residents of Oregon, and MAS is therefore now accessible to those who are not residents of the state.

In short, the legal, legislative, and policy environment surrounding euthanasia has drastically changed since the synodical study of 2000. In addition, the cultural acceptance of euthanasia has also widened, with one Canadian study showing that "four-in-five" Canadians (80%) now say it should be easier to make their own end-of-life decisions, compared to nearly three-quarters (73%) in 2016. This is in comparison to one in five who say there should be greater restrictions to doctor-assisted dying procedures.[24] This relatively strong support is also mirrored in American society.[25]

The theoretical support for euthanasia changes significantly, however, when it is described in greater detail,[26] when it applies to persons with mental illness, or when it is understood as a replacement for palliative care or for greater investment in health care.[27] It is notable that "62% of Canadians attach a lot of importance to the possibility that the public health-care system will begin to ignore long-term care and chronic disease in elderly people as MAiD becomes more available."[28] Canadians were also deeply concerned that MAiD would deprioritize, or even replace, funding for palliative care and other medical investments.[29]

These concerns appear to be legitimate, as government authorities have studied and found significant cost savings to the medical system as a result

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[22] justice.gc.ca/eng/cj-jp/ad-am/bk-di.html

[23] dyingwithdignity.ca/advocacy/mature-minors/#:~:text=Canada's%20law%20on%20medical%20assistance,or%20refuse%20lifesaving%20medical%20treatment

[24] angusreid.org/social-values-canada/

[25] news.gallup.com/poll/235145/americans-strong-support-euthanasia-persists.aspx

[26] ropercenter.cornell.edu/polling-choices-end-life

[27] cardus.ca/research/health/reports/broad-support-for-maid-in-canada-has-caveats-and-concerns/

[28] cardus.ca/research/health/reports/broad-support-for-maid-in-canada-has-caveats-and-concerns/

[29] *Ibid*.

of the expansion of MAiD, and there are already calls for MAiD expansion to relieve the burden of care for elderly, disabled, and other suffering people.[30]

In Canada, MAiD has quickly risen to become the fourth leading cause of death,[31] and the trend in the proportion of MAID requests considered ineligible continues to drop, year over year. In 2019, Health Canada reported 8 percent of requests were found ineligible,[32] dropping to 4.1 percent in 2021 and just 3.5 percent in 2022.[33] While some might point to the fact that California (a state whose population is almost the same as Canada's), where restrictions on who is eligible for euthanasia are stricter and which has one-tenth the death rate by euthanasia of Canada,[34] suggests that it is possible to "manage" these deaths, advocates consider Canada's permissive regime to be ideal.[35]

Our current context is very different from the context at the turn of the century. With some difference in eligibility and process in Canada and in some U.S. states, a medically assisted suicide is accessible to nearly all people in Canada and the U.S. In Canada, MAiD is not limited to a reasonably foreseeable death, people with disabilities can access a medically assisted suicide, and people are choosing to end their lives with the help of physicians at a shocking rate. Further, public attitude and dialogue have accepted medically assisted suicide as an understandable and acceptable choice.

APPENDIX B

Pastoral Care and the Dying Process: Bible Verses, Hymns, and Prayers for Visiting

Note: We have developed this appendix as a tool to equip lay leaders and persons who have limited experienced with pastoral care at the end of life. Pastoral care is the practical outpouring of our theological commitment to the preciousness of life, the acknowledgement that life can be very difficult and that lament and compassionate action are the correct responses to the difficulties of life. Our dream is that all churches may be filled with skilled pastoral caregivers who accompany and strengthen those who are suffering

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[30] "Cost Estimate for Bill C-7 'Medical Assistance in Dying,'" Office of the Parliamentary Budget Officer, October 20, 2020; pbo-dpb.gc.ca/web/default/files/Documents/Reports/RP-2021-025-M/RP-2021-025-M_en.pdf.

[31] canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2022.html

[32] *Ibid.*

[33] cardus.ca/in-the-news/media-coverage/skyrocketing-maid-deaths-must-prompt-urgent-reassessment/

[34] tandfonline.com/doi/full/10.1080/15265161.2023.2201190

[35] See deathwithdignity.org/about, which states, "Our goal is to ensure people with terminal illness can *decide for themselves what a good death means* in accordance with their values and beliefs."

and dying. We suggest adding a list of hospices and grief and patient support groups that are available in your community context.

Introduction

When people experience suffering, they usually don't need more answers or dogma. *They need people* who can be present with them in their distress. They need people who can hear their questions without becoming anxious. They need brothers and sisters in Christ who can help them "find strength in God" (1 Sam. 23:16). As pastors and leaders in the church, we have the opportunity to walk with people in matters of life and death. Pastoral care is about the power of presence, perseverance in suffering, the protection of life, and the promise of the gospel (see section VI of this report).

As spiritual caregivers, we have the remarkable privilege of walking with people through many seasons of life. This includes the end of earthly life. God calls us to carry each other's burdens and invites us to make Christ's presence known through our presence with people. This is a joyful and holy calling, but it can be painful and difficult at times. Words may fail, and we may struggle to know what to do in response to a person's suffering. As spiritual caregivers, we may hear people speak of their desire to die, a desire that is especially common among the elderly and persons who are suffering. We cannot, however, support the taking of life.

People in your congregation may choose not to share their medical conditions with you, so it may be difficult to figure out how to be helpful. If you visit often, they may be more willing to take you into their confidence. You could ask, however, "Given what you know now, when you think about the future, what matters to you? What is most important for us to focus on?" People may have goals of attending weddings or graduations, saying final goodbyes to certain family members, asking for or offering forgiveness, reaching milestone birthdays or anniversaries. Some people just want to revisit an old family farm, or to go to see a lake one last time. Your congregation may be able to facilitate reaching some of those goals. People who are dying often wish to feel closure about various aspects of their lives. If you have developed a close relationship with the person, you may try exploring some of these thoughts with them.

Understanding the dying process

Sometimes death comes abruptly. However, in many cases death is a slow process. It is helpful for elders, deacons, and other visitors to understand the dying process. Common symptoms at the end of life may include pain, nausea/vomiting, difficulties with bowel and bladder function, fatigue, shortness of breath, reduced appetite, depression/anxiety, reduced cognitive function, and/or changing abilities to take in food or water. Health-care workers care for such symptoms by using devices (feeding tube, IV-line, bladder catheter) and medications (pain reliever, antinauseant, laxative, antidepressant) to optimize function and to relieve suffering. These tools may come with side effects and secondary outcomes that may or may not be desired. There are a series of decisions to be made in this process. It is important to ask questions and to fully understand the treatment and symptom management options, especially as some interventions (like a long-term feeding tube) can prolong life significantly when that may not be helpful or desirable.

At a certain point, providing further nourishment or hydration to a body that is dying is no longer fruitful, so an IV-line or feeding tube can be discontinued. Medications that have been taken for long-term prevention or for the management of a chronic illness can be stopped. When someone can no longer swallow, medications are often administered directly under the skin (subcutaneously) or as a suppository. Decisions to refuse treatment are difficult—often more difficult for family members and caring community members than for the patient. Open and clear communication is important.

Where pain figures prominently, various medications can be used. After optimizing the environment (positioning, pillows, temperature, noise, lighting, etc.), medications targeting the type of pain experienced should be offered (nerve pain, bone pain, joint pain, organ pain). Narcotic pain relievers work by blocking pain signals from the body's receptors. When used carefully, narcotics are very helpful to relieve pain—but may have side effects such as nausea, sedation, or constipation. If one becomes anxious or agitated, a sedative can be helpful.

As a person dies, their organs gradually shut down. The process can occur rapidly over minutes or hours, or it can take days—even weeks. There are periods of reduced consciousness when there may be little to no responsiveness to external stimuli. Often there are also "rally" periods in which an individual may seem to improve or even partially recover. Loved ones can use such times for making meaningful connections. As this time of "twilight" progresses, limbs may become cool, swollen, and "mottled." Breathing can speed up, then slow, with longer pauses between breaths. An individual may reach out as if to connect with someone or something. Maintaining physical presence and speaking to the person dying are encouraged because a person's sense of hearing often remains intact until the end. Singing or reading of Scripture can be particularly comforting. Death is confirmed when a health-care worker determines that breathing and a heartbeat are no longer present.

Suggestions for visiting aging, terminally ill, and critically injured persons

- Check in on and tend to your own feelings prior to the visit so that you can be a nonanxious presence during your visit.
- Prepare to share a couple of Scriptures ahead of time that may fit for the particular situation. Trust the Holy Spirit to lead you in sharing those Scriptures appropriately, and don't be driven by your own agenda.

- Be respectful of the person's bed or chair; they are an extension of the person's personal space. Be mindful that they have lost control of most aspects of their lives and long to control some small things. If possible, sit in a chair that will bring your eye level below theirs; this gives them a feeling of more control.
- If you know your visit must be short, sit down briefly if you can, because the visit is likely to feel longer that way.
- Acknowledge the person's fears, pain, or uncertainty and offer your presence with them in it. A person's pain is what they say it is, so do not try to diminish their experience.
- Listen attentively and without judgment. We often feel the need to comment or give advice; staying silent requires self-discipline. If you feel that you need to comment, words such as "That must be so difficult" or "I wish I could make it all go away" might be helpful responses.
- Consider whether the person is able to communicate their wishes.
- If you pray with them, name their fears/laments in prayer, reminding them that they can bring all things to God in prayer, including their desire to die and for their suffering to end. Remember that when you pray, you are modeling how they and their supporters can pray.
- If family members are present while you visit, invite them to join you in praying, singing, or reading Scripture. Acknowledge their concerns. A comment that may elicit discussion: "It's really hard to hear your loved one talk about dying, isn't it?" Sometimes a family member may use your visit as an opportunity for respite, which can also be a gift/encouragement to them. Don't be offended if they leave the room for a break.
- When the visit draws to a close, ask if there is anything the person needs. Sometimes moving some dirty dishes out of sight or getting a book from across the room can be a great help. Little courtesies, such as leaving the door ajar to their liking, show your care.
- Commit to continuing to walk with the person on regular visits, and follow through on that promise. If you are unable to provide regular visits, consider connecting the person with another church member who is able to show up on a regular basis. It may be helpful for both you and the other visitor to meet together with the person a time or two during the transition.
- Remember that your visit is confidential. Be careful not to share with others any personal details about your visit.
- Don't overstay your welcome. People may want to please you by maintaining a welcome posture, but they may tire easily and need to rest.

Helpful Scriptures to use when visiting someone who is suffering

Deuteronomy 31:8
Deuteronomy 33:27
Joshua 1:8-9
Job 19:23-27
Psalm 34:18
Psalm 56:3-8
Psalm 57:1
Psalm 61:1-2
Psalm 62:1-6
Psalm 70:5
Psalm 73:23-26
Psalm 90
Psalm 91
Psalm 116:1-7
Psalm 121
Isaiah 40:31
Isaiah 41:8-10
Isaiah 43:1-3
Matthew 5:4
Matthew 11:28-30
John 14:26-27
Romans 5:1-5
Romans 8:37-39
1 Corinthians 15: 51-58
2 Corinthians 1:3-4
2 Corinthians 4:7-11
2 Corinthians 4:16-18
Philippians 1:19-29
Hebrews 6:19
Hebrews 10:22-23
Hebrews 12:1-3
James 1:2-4
1 Peter 5:6-10:6
Revelation 21:1-4

Hymns

Hymns bring spiritual encouragement. Their lyrics and the melody call us to faith and can connect us to the worshiping body when we cannot attend worship services. When words fail, sing a song or simply play the music. The songs below are some options that may be appropriate.

Be Still, My Soul
By the Sea of Crystal
Children of the Heavenly Father
For All the Saints
Great Is Thy Faithfulness
He Leadeth Me
How Firm a Foundation
In Christ Alone
I Sought the Lord, and Afterward I Knew
Nearer, Still Nearer
Praise God, from Whom All Blessings Flow
Precious Lord, Take My Hand
The Lord's My Shepherd
When Peace like a River

APPENDIX C

Information about Making Health-Care Decisions

Who Decides?

At present, state governments in the United States and provincial governments in Canada generally allow only an individual person, whether directly or by proxy when the individual lacks capacity, to make nearly all end-of-life decisions.

There are exceptions, of course. Parents are legally designated to make such decisions for minor children. And adults are granted the legal right to name proxies to make decisions for them when they are incapacitated. Where no proxies have been designated (or no designated proxy is willing and able), most various governments have passed differing laws that designate which relatives (in what priority) can make the decisions. And finally, when an individual has made no proxy designations and there is no willing/able family member, the court can appoint a guardian (who is really an agent of the government) to make decisions.

Special note should be made that, at present, at least, and in most if not all jurisdictions, the right to request medically assisted death (or "death with dignity") must be made by the individual while competent and cannot be made by a proxy. The laws on this issue may change in the future.

How Are Decisions Made?

As indicated above, in all U.S. states and Canadian provinces, a competent adult is the presumed decision maker as to his/her own health (medical) care, whether those questions involve end-of-life issues or otherwise, and a parent is presumed the decision maker as to his/her minor child's health (medical) care, although there is a growing list of exceptions to that rule (e.g., abortion, gender-change surgery, etc., where some jurisdictions allow minors to make decisions without consent or even their parents' knowledge).

However, the specific means by which an adult designates a proxy to make such decisions for them varies by state and province.

In some U.S. states, the legislature has created specific written forms for use to name a proxy. In other U.S. states, the legislatures have allowed for the designations of proxies but have not provided any particular form for doing so, leaving it up to individuals (or attorneys or some internet site) to provide the form. And yet in other U.S. states, the designation of a proxy can also be verbal (not a method to be advised). In Canadian provinces, the governments publish forms as resources but generally do not require the use of those forms.

There is also the matter of terminology. Depending on the state/province, the phrase "health-care proxy" may be replaced by "health-care representative" or "health-care decision maker" or "holder of a health-care power of attorney" or some other phrase, like "attorney for personal care."

The name of the document used to appoint a proxy also may differ according to the state or province. Names used include "advance directive" (perhaps the most common), "power of attorney for health care," "medical power of attorney," and "powers of attorney for personal care."

There is also a document called a Physician's Orders for Life Sustaining Treatment (POLST), usually used as one's end of life is imminent (beyond just a possibility). Do Not Resuscitate (DNR) orders are often part of the POLST provisions.

It is important to note that a “general power of attorney” (sometimes called a “financial power of attorney” or “continuing power of attorney for property”) is usually not regarded as a document that gives medical proxy authority, even if the language used in such a document may seem to be an all-inclusive grant of power from the person signing the document to the person being granted the power. It is typical that medical/health making power must be granted by a document that only deals with medical/health matters. Certainly that would be the case in those jurisdictions that prescribe the specific form to be used to designate medical/health proxies.

Use of Advanced Requests in Medically Assisted Deaths in Canada

In Canada the legal framework for the use of advanced requests in medical assistance in dying (MAiD) is continually evolving. Some provinces are taking steps to implement these requests under specific conditions. Advanced requests allow individuals to outline their wishes for MAiD in the event they lose the capacity to consent at the time of administration, which is the current federal standard.

Canada’s federal MAiD law, amended in March 2021, allows for two main pathways:

1. For those whose natural death is reasonably foreseeable, a simplified process applies.
2. For those whose death is not foreseeable, additional safeguards are required.

However, at present, the federal law does not explicitly permit advanced requests for MAiD except under Quebec's new regulations or in specific, provincially legislated cases. Most provinces, such as British Columbia, Ontario, and Alberta, continue to follow the federal guidelines, which do not yet encompass advanced requests. However, those provinces are closely monitoring Quebec’s framework and the broader national dialogue on the issue.

Quebec is the first Canadian jurisdiction to allow for the use of advanced requests for MAiD. An advance request for MAiD is different from an advance medical directive. Advance medical directives allow individuals to state what medical care they would accept or refuse in specific situations if they become incapable, but those directives do not cover MAiD. In order to utilize an advanced request, the person must have a serious and incurable illness that will lead to incapacity to consent to care. At the time of the request, the individual must be of full age and capable of giving consent to care, meaning they understand their medical situation and can clearly communicate their wishes. The request must be made freely, without external pressure, and must be fully informed.

The individual must consult with a physician or specialized nurse practitioner to obtain the advance request form, which is available only through these professionals. While not mandatory, individuals may designate one or two trusted persons to ensure that their wishes are known and respected when they become incapable of consenting. The request must detail specific clinical manifestations associated with the illness. These manifestations will serve as indicators for when MAiD should be administered after the individual loses capacity. The completed request must be signed in the presence of the physician or specialized nurse practitioner, two witnesses (unless made by notarial act), and any designated trusted third persons. The advance request must be recorded in a legally provided register by the physician, specialized nurse practitioner, or notary. Only the registered request is considered valid.

An individual who remains capable of consenting to care can also withdraw or modify their advance request at any time by consulting with a physician or specialized nurse practitioner, who will ensure that the changes are properly documented and updated in the register.

For MAiD to be administered on the basis of an advance request, several conditions must be met, including the following:

- The individual must exhibit, on a recurring basis, the clinical manifestations related to their illness as described in their request.
- They must be in a state of advanced, irreversible decline in capability.
- A competent professional must determine that the individual is experiencing enduring and unbearable physical or psychological suffering that cannot be relieved under conditions considered tolerable.
- A second independent physician or specialized nurse practitioner must also confirm that all criteria are met.