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Compassion Requires Care, Not Killing

Debates over assisted suicide, often termed Medical Aid in Dying (MAiD) by proponents, are often portrayed as a clash between religious conservatives and secular progressives. In reality, a surprisingly broad coalition of Christian, secular, disability-rights, and other faith traditions raise similar objections rooted in the sanctity of life, the risks to vulnerable populations, and the structural vulnerabilities of modern healthcare systems.

Christian Perspectives (especially Catholic, Orthodox, and Evangelical)

Christian ethics emphasize that human life is uniquely dignified and is itself sacred. We often say, "from conception until natural death," and refer to the Fifth Commandment, "Thou Shall Not Kill," as making intentional taking innocent human life morally impermissible even in the face of suffering. It traces a core belief that we are stewards, not owners, of the life that God has entrusted to us, and it is therefore morally wrong to take innocent human life intentionally – whether it is that of another person (including an unborn child) or even our own.

In "Faithful at the End of Life" presentations, we often talk about the reality of suffering – both in the present moment and in the future. Christians emphasize the duty of accompaniment through palliative care, hospice, prayer, community support, and the avoidance of abandonment. Many also highlight a "slippery slope." Once the government and medical professionals accept intentional life-ending as a treatment method, categories of eligibility tend to broaden over time, as documented in several countries. It inevitably changes the nature of the relationship between patients, families, and healthcare professionals.

Secular Ethical Concerns

Nonreligious critics often focus on power imbalance and vulnerability, arguing that assisted suicide creates social pressure on the elderly, disabled, mentally ill, or economically distressed to view themselves as burdens. They emphasize that medical systems already struggle with bias, cost pressures, and understaffed palliative services. When assisted suicide is normalized, the "choice" to die may not remain free from coercion.

Non-Christian Religious Traditions

Many global traditions share reservations, though from different metaphysical frameworks. Hinduism stresses ahimsa (non-violence), karmic consequences for suicide, and the spiritual importance of natural death. Buddhism teaches that taking life, including one's own, creates harmful karma and disrupts mindful dying. Sikhism views life as a sacred gift, with death unfolding under Hukam (Divine Will). In major schools of Islamic law (Sunni and Shi'a), there is broad agreement that suicide is forbidden, assisting in suicide is also forbidden, and intention does not justify ending life, even out of compassion.

Though diverse, all these traditions share the belief that **compassion requires care, not killing**, and that broad societal permission to end life poses real moral dangers.

Background

In the last two decades, multiple countries: Canada, the Netherlands, Belgium, Luxembourg, several Australian states, New Zealand, and more, have legalized some form of assisted suicide or euthanasia. Eligibility in these jurisdictions has often expanded. The Netherlands permits euthanasia for psychiatric conditions and, in some circumstances, minors. Canada legalized MAiD in 2016 for terminal illness, expanded it in 2021 to chronic disabilities and non-terminal conditions, and debated further expansion to mental illness as a sole criterion.

Critics argue that these patterns demonstrate a predictable "ratchet effect": once assisted suicide is permitted, successive expansions occur due to legal challenges, activist pressure, or philosophical consistency.

Eleven U.S. states plus Washington, D.C. have legalized physician-assisted suicide. The programs have been fraught with problems:

- Safeguards such as waiting periods, psychological evaluations, or residency checks have been weakened or removed in some states.
- Advocacy organizations continue to push for broader eligibility and interstate telehealth access to assisted suicide prescriptions.
- Disability-rights organizations (for example, Not Dead Yet) remain among the most vocal opponents due to concerns about coercion, insurance incentives, and systemic inequities.

Ohio Legislation

Ohio law currently prohibits physician-assisted suicide. State law allows courts to intervene if individuals or organizations are believed to be preparing to assist in a suicide, reflecting a long-standing commitment to protecting vulnerable populations and enforcing ethical boundaries in medicine.

Nevertheless, organizations such as Compassion & Choices and Ohio End of Life Options are active in the state:

- They promote public education, legislative lobbying, and storytelling campaigns.
- Their frame assisted suicide as a compassionate expansion of patient autonomy, and they coordinate with national-level legal and public-relations campaigns.
- They have recently been successful in gaining some traction with the introduction of HB 835, legislation that would adopt an Oregon-style statute in Ohio.
- They, and likeminded groups, boast of increasing number of voters agreeing with the idea that assisted suicide should be an option.

Recent Headlines Illustrate the Fundamental Flaw in Assisted Suicide

To be clear, we do not object to assisted suicide because it sometimes results in bad outcomes. The bad outcomes spring from the fundamental nature of assisted suicide itself. There are simply no guardrails that can be put around the concept that eliminate this because it is fundamentally flawed.

It is a “choice” that is inextricably intertwined with social factors and coercion including loneliness, fear, vulnerability, poverty, disability, or inadequate mental-health care.

Eating Disorders and “Terminal Anorexia” - A widely discussed case involved a middle-aged woman with severe anorexia nervosa who pursued MAiD under Canada’s broad eligibility criteria. Clinicians and ethicists debated whether anorexia, a treatable psychiatric illness, could truly be “irremediable.” Critics warn that this normalizes death as a therapeutic response to suffering that should instead prompt intensive psychological care. This has also happened in Colorado in the United States, prompting intense debates among psychiatrists about if “terminal anorexia” should be recognized.

Poverty and Inadequate Social Supports - Reports have documented individuals requesting MAiD in Canada because they lacked accessible housing, disability supports, or financial stability. Disability advocates argue that a “choice” for death under such circumstances reflects social failure, not meaningful autonomy. The failures have been so egregious that the UN issued scathing language against Canadian “Track 2” MAiD in a recent report (See Art. 10).

Veterans Confronted with MAiD Recommendations - Canada’s Veterans Affairs ministry admitted that staff inappropriately raised MAiD with veterans seeking help for PTSD and Traumatic Brain Injury. This example is often cited by critics to show how systemic pressures can lead to harmful suggestions.

Mental Health and Disability – The effort of a young woman in Spain with longstanding mental health problems and past efforts to die by suicide causing her to become paraplegic made international headlines as a critical failure of the institutions supposedly safeguarding the so-called parameters of Spain’s law. The February 2026 death of the 25-year old was shocking to many around the earth.

These cases reinforce concerns that once MAiD/assisted suicide is normalized, it not only fundamentally rewrites the basic moral premise of not intentionally killing humans, it can be proposed to those who are not dying but are suffering socially, psychologically, or economically. **Compassion requires care, not killing.**

Related Concerns: Uniform Determination of Death Act (UDDA) and Brain-Death Standards

Assisted Suicide is a distinct issue, and the multitude of national and international horror stories along with legislative efforts have brought the topic back to some public prominence. A major and distinct but not unrelated, issue in end-of-life policy debates concerns how death itself is defined in U.S. law.

All states, including Ohio, use the UDDA’s twofold definition of death: Irreversible cessation of circulatory and respiratory functions, or irreversible cessation of all functions of the entire brain, including the brainstem.

From 2021–2023, the Uniform Law Commission considered revising the UDDA. The effort stalled amid concerns from disability-rights groups questioning diagnostic accuracy, religious organizations concerned about premature declarations of death, and some physicians warning that revised definitions might broaden who can legally be considered “dead.”

This debate matters because loosening or redefining brain-death criteria intersects with assisted suicide in public trust, medical authority, and end-of-life ethics. It is further complicated by recent U.S. investigations into organ procurement organizations (OPOs) that have revealed troubling

cases, such as instances in which patients exhibited neurological signs inconsistent with death during organ retrieval procedures, reports of poor neurological assessments, questionable consent processes, or pressure placed on families to authorize donation. It has resulted in Congressional scrutiny of certain OPOs for alleged misconduct.

These events are not representative of all organ procurement in the U.S., but they highlight the real-world risks of institutional failure in high-stakes medical decisions.

Advocates, especially those arguing against assisted suicide from a slippery-slope or risk-based approach, note that if systems sometimes fail in determining death for organ donation, an area governed by long-standing laws and norms, then even so-called safeguards around assisted death are also vulnerable to error, bias, or pressure.

To be clear, it is very important to note that in pro-life bioethics there is no absolute moral opposition to organ donation. For example, St. Pope John Paul II strongly supported organ donation, calling it a "noble and meritorious" act of love. He emphasized that donating organs after death should be encouraged, provided it is done with informed, explicit consent and adheres to strict ethical standards, such as the certain determination of death. We cover this issue in depth in *Faithful at the End of Life.*

Given these intersecting concerns, many Ohioans across religious, cultural, and philosophical backgrounds argue that the compassionate response to suffering is high-quality palliative care, mental-health support, family accompaniment, and social safety nets, not an expansion of legally sanctioned death. **Compassion Requires Care, Not Killing**

Next Steps

First and foremost, pro-life advocates need to learn how to be effective advocates for the defense of all life – the aged, the infirm, and those experiencing disability. It means acknowledging that suffering is real and that while it may have a spiritual element, there are also concrete measures that we can take to address the duty of accompaniment through palliative care, hospice, prayer, community support, and the avoidance of abandonment.

We've compiled this resource to provide some basic information, but we have more available.

1: Invite a GCRTL Speaker to talk to your church, school, or organization on end-of-life issues. We not only have our highly acclaimed "Faithful at the End of Life" program covering end-of-life bioethics and Advance Directives, but we have recently acquired the licenses to show the newest documentary put out by the Euthanasia Prevention Coalition, highlighting the lessons learned from Canada's "MAiD" program. There is no cost, and we are scheduling for Fall.

2: Contact your State Representative to ask, respectfully, that they oppose HB 835. You can identify your lawmaker here, and follow the provided link to send a short note to him or her. Remember that any information you provide will be part of the public record, so do not include sensitive or confidential information.

3: Consider a donation so that we can maintain our current work and also expand to take on this new challenge. Our team, and our budget, are pushed to their limit, and yet we have increasingly more to cover. We need your help. Making a one-time gift of $25, a monthly gift of $5, or by registering for our banquet, are powerful ways you can partner with us in this work.