Dying well: A challenge to Christian compassion

by Richard M. Gula in the May 5, 1999 issue

The fear of enduring unceasing pain, of being trapped by medical machines, of losing bodily integrity and personal dignity and of being an emotional and financial drain on one's loved ones--such fear lends strength to the movement for euthanasia and for physician-assisted suicide (PAS). Support for euthanasia/PAS has been spurred on by the Hemlock Society, founded by former journalist Derek Humphry and based in Eugene, Oregon. The society's political arm helped draft initiatives aimed at legalizing euthanasia. Ballot initiatives in the states of Washington (1991) and California (1992) were both narrowly defeated by a 54 to 46 percent margin. The defeat of these "euthanasia" initiatives shifted the focus to "assisted suicide," which gives more control to the dying patient.

In 1994 Oregon passed its Death with Dignity Act by a 51 to 49 percent margin, becoming the first state to legalize PAS. The statutes of Washington and New York prohibiting PAS were subjected to constitutional review. In June 1997 the Supreme Court ruled on *Washington v. Glucksberg* and *Vacco v. Quill*, declaring that PAS is not a constitutional right. This ruling left each state free to make its own decision about whether PAS and euthanasia should be legally permitted within its borders. The Supreme Court ruling recognized that our nation is already engaged in an intense debate about the morality, legality and practicality of PAS, and it encouraged the debate to continue.

Michael Manning, a physician and a Roman Catholic priest, reviews the arguments and takes a stand against euthanasia/PAS. While giving unequivocal support to the Roman Catholic position, his book is fair in its treatment of opposing views. Edward Larson and Darrell Amundsen also oppose euthanasia/PAS. Larson, a professor of history and law at the University of Georgia, has a special interest in the theory and law of modern health care. Amundsen, a professor of classics at Western Washington University, focuses on medical practice and ethics in ancient and medieval times. By tracing attitudes toward euthanasia and suicide from antiquity to

the present, the authors offer the historical perspective that has been missing in the debate. They argue that while both Greco-Roman and Enlightenment thinkers accepted the idea of suicide, the Judeo-Christian tradition does not. Charles McKhann, professor of surgery at Yale Medical School, joins the increasingly vocal minority within the medical community who have begun to question the profession's traditional opposition to PAS. He argues that PAS is acceptable as a last resort.

Richard A. McCormick, dean of Catholic moral theologians, once said that we can easily soften resistance to the unacceptable if we confuse it with the acceptable. The easiest way to skew the euthanasia/PAS debate is to see it as a "pulling the plug" issue. But forgoing useless or disproportionately burdensome treatment--which is what we generally mean by "pulling the plug"--is not the same as euthanasia or PAS. Standard medical, moral and legal practices allow competent patients or the surrogate of incompetent patients to select from proposed treatments or to refuse treatment altogether.

The terms voluntary active euthanasia and physician-assisted suicide sometimes are used interchangeably, confusing the two practices. Voluntary active euthanasia means a deliberate intervention, by someone other than the person whose life is at stake, directly intended to end that life. The patient must be competent and terminally ill, and must make a fully voluntary and persistent request for aid in dying. A common way to think about euthanasia is that a physician gives a lethal injection to the patient who wants to die. The term "mercy killing" is often used in place of "euthanasia" to emphasize that such an act is directly intended as an act of kindness to end suffering.

In PAS (or what McKhann prefers to call "assisted dying") a physician helps to bring on the patient's death by providing the means to do it or by giving the necessary information on how to do it, but the patient performs the lethal act. The typical procedure is for the patient to take a lethal dose of poison (by swallowing pills, by injecting himself or by inhaling a gas, for example) that the patient has asked the physician to prescribe for that purpose. In such a case, as in euthanasia, both the physician and patient are responsible for bringing about death.

The ethical arguments for and against euthanasia/PAS have remained largely unchanged for centuries. These arguments can be organized under three themes: autonomy, killing vs. allowing to die, and beneficence. Autonomy is the central issue for euthanasia advocates. "Death with dignity" and the so-called "right to die" are

familiar banners in this argument. These expressions are taken to mean that each person has the right to control his or her body and life and so should be able to determine at what time, in what way and by whose hand he or she will die. Jack Kevorkian is the symbolic cheerleader for promoting absolute autonomy as the fundamental moral value.

While everyone agrees that autonomy is an important value, the question is, Just how far does autonomy extend? A counterargument to autonomy as a justification for euthanasia/PAS can be made on the basis of religious beliefs and moral philosophy. While Enlightenment ideas about freedom led rationalists to question the traditional religious strictures against euthanasia and suicide, the Christian opposition to these practices did not weaken.

According to Christian beliefs, the sovereignty of God and the human responsibility for stewardship limit our freedom to control life. God has absolute dominion over life, and we share in that dominion only as limited creatures. Larson and Amundsen convincingly show that the Judeo-Christian perspective rejects the idea that one's life is like a possession--one's own to control, to use and to dispose of as one sees fit. The Judeo-Christian opposition to euthanasia/PAS is a part of its general opposition to making autonomy an absolute value. Freedom lies not just in having control but also in submitting to what cannot be controlled. We exercise freedom by accepting ourselves as creatures of God and by admitting our powerlessness before death.

The social nature of being human also limits our freedom. We cannot properly classify euthanasia/PAS only an exercise of individual autonomy. Such acts also involve the one doing or aiding the killing and a complying society. Therefore, euthanasia/PAS must be assessed for its social impact on care for the dying and on our general attitude toward life. While a concern for the common good respects and serves the interests of individuals, it upholds the collective good as more important than the good of any one individual. A commitment to the common good stands in constant tension with autonomy because it forces us to ask whether we should forgo some of the things which we want for ourselves so that the good of the whole might better be served.

Manning appeals to our responsibility for the common good in assessing the euthanasia/PAS movement. If we introduce euthanasia/PAS as a legal, medical option, would we risk discriminating against vulnerable groups--such as those with

AIDS, Alzheimer's or spinal cord injuries--that are perceived as burdens on the system and on society? Would legalizing euthanasia/PAS affect the way we think about mental and physical decline, about suffering, about the obligations of adult children to their parents or of how parents needing care feel toward their children? How would this practice affect the self-understanding of the disabled and their relation to society? How would it affect physicians' attitudes toward their failing patients? How would it affect the way we distribute our resources? Would those who did not choose euthanasia/PAS be forced to justify their refusal?

Closely related to the argument from the common good is the slippery-slope argument. Drawing on examples of what is happening in the Netherlands, where the practice of PAS and euthanasia (voluntary and involuntary) has increased even though not formally legal, Manning, Larson and Amundsen suggest that the policy and practice of euthanasia/PAS would weaken the general prohibition against killing.

An important dividing line in the debate is whether one sees a significant moral difference between killing by euthanasia/PAS and allowing to die by withdrawing useless, cure-oriented, life-sustaining treatment. Advocates of euthanasia/PAS such as McKhann see no moral difference between these two acts. If we are to respect autonomous, informed patients' request to end treatment, so the argument goes, then we ought to respect their request for aid in dying. Opponents of euthanasia/PAS insist that there is a moral difference between withholding treatment when nothing more can be done to reverse significantly the physical deterioration, and intervening to put the patient to death.

The distinction pivots on the way we understand causality and culpability. In killing, the cause of death is the lethal intervention. In allowing to die, the cause of death is the natural biological process. When the cause of death is the impersonal force of nature, no one can be held responsible. But if death results from the human action of injecting or ingesting lethal medication, then someone can be held culpable. Daniel Callahan, one of America's foremost bioethicists, has argued that failing to hold to this distinction perpetuates the illusion that we can control everything, that we can be masters of nature and death.

The argument from beneficence arises from the desire to relieve pain and suffering and to show compassion and mercy. Three dimensions of beneficence have played a prominent role in the debate: the "character" of medicine as a profession; the "suffering" that is to be relieved; and the "mercy" that is to be shown. That we

cannot reach a moral consensus reflects disagreement on the role of the physician and of the very aim of medicine. In wanting to license physicians to kill, McKhann and other advocates of euthanasia/PAS are calling into question the expectation that physicians will be healers committed to preventing, diagnosing and treating disease and to promoting wholeness. Manning and other opponents of euthanasia/PAS argue that "killing a patient" is contrary to the aim of medicine and the responsibilities of the physician.

The obligation to relieve suffering is the context for McKhann's argument, but he is typical in that he does not address the issue of suffering as such. Suffering remains one of the most neglected end-of-life issues, perhaps because we don't know what to do about it, how to explain it or how to make use of it. The argument from suffering reaches beyond medicine's responsibility and competence; it extends into metaphysical questions about the nature of human happiness and of what constitutes a meaningful life. To enlist a physician to achieve release from a meaningless life of suffering presumes that the physician is competent to judge what kinds of life are worth living. Perhaps this would be true if suffering had only medical causes. As physician-philosopher Eric Cassell has shown, while physical pain may be the major physical cause of suffering, the roots of suffering are more than physical. The degree to which people suffer and whether they find life empty or meaningful depend more on their attitude than on their physical condition.

Christian tradition teaches that suffering, while not a value in itself, is not an unqualified evil. It can be transforming. But if one begins with the assumption, as advocates of euthanasia/PAS seem to do, that no one ought to suffer, then the solution to suffering is to remove the sufferer. The Christian imagination, informed by its Jewish roots, presents the possibility of another response. Suffering can become the vehicle for learning to hold lightly to life, for coming to grips with our own creatureliness, and for realizing our ultimate dependence on God. While we should not glorify suffering or bring it on ourselves or others, we need not oppose it at all costs. The story of the life, death and resurrection of Jesus tells us that the tragedy of suffering, dying and death cannot, and will not, be stronger than God's love.

Larson and Amundsen show that the Christian opposition to suicide makes sense in the context of a firm belief in God's sovereignty and the humble trust that God makes all things work together for good. God's love, revealed in the resurrection of Jesus, gives us the courage to enter into suffering and death, knowing that life

ultimately triumphs. Beneficence is ultimately about mercy; that is, it is about how we fulfill the demands of covenantal fidelity to one another. What kind of mercy toward the dying fits the commitment first to be faithful and then, whenever possible, to heal? While it may be inappropriate to speak of killing as healing, may killing be compatible with mercy toward those who are dying painfully and find life empty, oppressive and meaningless? Those who argue in support of euthanasia/PAS think so. Those who oppose it fear that granting physicians the license to kill will erode our confidence in them at the very time we need them most.

For the Bible we learn that mercy and compassion are the ways that God loves, provides for and protects God's people. Out of mercy and compassion Jesus restored the broken to wholeness. He healed the blind, taught the ignorant, raised the dead and fed the hungry. The merciful are faithful to those who suffer by compassionately accompanying them, not by killing them. Mercy keeps us from abandoning hope when life is hard. Resorting to euthanasia/PAS is failing to embody the trust that sustains life and the commitment to be companions to one another.

Opinion polls taken during the past 25 years have shown a steady increase in the number of people of all ages and religious affiliations who support legalizing euthanasia/PAS. This popular support has been generated not by ethical arguments but by emotional reactions to the horrifying ways some people are dying. McKhann's experience of his own father's slow death, prolonged by hopeless, cure-oriented treatments, prompted him to write his book.

To counter the movement to legalize euthanasia/PAC, we need to offer a vision of dying well and provide better end-of-life care. Witness is more compelling than argument. Through the ways we live our lives, take care of our health, face our limits, let go of control, bear suffering, relate to others, make room for the weak and unsuccessful, and care for the sick, the elderly and the dying, we can be credible witnesses to our beliefs. We must counter the kinds of stories of poor end-of-life care that McKhann tells with stories of dying well.

For example, Cardinal Joseph Bernardin's courageous death touched the hearts of many. When he spoke about suffering, fear, pain and humiliation, he spoke out of his own experience. He showed that we can exercise freedom not just by being in control but also by consenting to our limits and surrendering to what is beyond human control. He joined his suffering with the paschal mystery of Jesus and trusted in the goodness of God.

In addition to personal virtue, we also need communal virtue. Our communal life must witness to those fundamental religious and moral convictions that nurture a vision of life that includes death as an inevitable outcome. A virtuous community provides the structures and develops the skills that enable us to provide companionship, sympathy and support in the time of trial. Already a movement is under way to improve end-of-life care by educating health-care providers to respond better to the needs of dying patients, by creating new care settings or improving existing ones, by seeking changes in methods of paying for appropriate care, by educating the public through conferences, town meetings, television programming, and even Web sites (see www.careproject.net), by providing adequate relief of pain, by withholding or withdrawing treatments that only prolong dying, by keeping company with those who are lonely, and by being a resource of meaning and hope for those tempted to despair.

Facing pain, suffering and death in ourselves and in others is the price of being human. While this fact is biologically determined, there is nothing fixed about how we will respond to it. What sickness and the threat of death do to us is one thing; what we make of them is another. If life has no particular meaning when everything is going well, then what can life mean when everything goes wrong? Only if we can compellingly witness to our religious convictions about life, suffering and death will we be able to shape public attitudes toward death.