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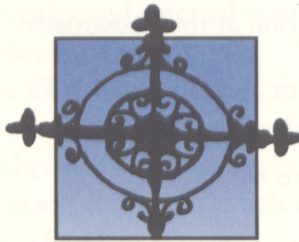
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The Santa Clara Lectures



“Issues in Contemporary Christian Ethics: The Choice of Death in a Medical Context”

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ISSUES IN CONTEMPORARY CHRISTIAN ETHICS:
THE CHOICE OF DEATH IN A MEDICAL CONTEXT

by Margaret A. Farley

All religious and cultural traditions have incorporated moral assessments of choices regarding human death. These choices appear in contexts of individual self-defense, war, criminal sanctions, debility and old age, and a variety of other situations where life and death appear to conflict and the balance between them threatens to tilt in the direction of death.

Though clear norms have governed many of these contexts, ambivalence and ambiguity have not always been overcome. Jewish and Christian traditions, so profoundly influential in western culture, have not escaped ambiguity and internal controversy regarding some questions of human life and death.

Ambivalence in the Christian tradition, for example, has in some respects increased over the centuries. In the first three hundred years of the life of the church, there was a strong prohibition against taking any human life, even in self-defense (though one could lay down one’s life in martyrdom, for there was not a corresponding absolute obligation to preserve life in every circumstance).¹ The attitude toward war was generally one of pacifism. Justin Martyr could write confidently that “The Christian must not resist attack.” Origen maintained that the Christian lawmaker must not allow killing at all. Ambrose, in the fourth century, taught that the Christian could not take the life of another even to save his own life. By the time Saint Augustine was writing and preaching, however, the prohibition against killing was less absolute. The fifth commandment still yielded a prohibition against private individuals killing either themselves or another; but now there could be justification for a Christian’s engaging in warfare. With the beginning of a Christian version of “just war” theory, Christians could be not only soldiers but magistrates leading armies to war; and they could be hangmen performing as agents of justifiable capital punishment. In the middle ages, the prohibition against murder (taking the life of innocent persons) was clear, as was a prohibition against suicide; but the right of the state to wage war and to impose capital punishment, and the right of individuals to self-defense, were now formulated and accepted. Indeed,

gradually there developed a full-scale casuistry regarding the meaning and application of the right to self-defense.

Today, questions about death and dying have become more than ever before complex and troubling. Apart from issues of war, revolution, capital punishment, and abortion, almost all of us in western culture are faced with multiple options regarding our own and our loved ones' dying. My topic this evening focuses primarily on issues regarding death in a medical context—issues that are raised for us in large part by developments in medical technology, technology whose possibilities have fueled a cultural need and pressure to expand the horizons of death through scientific power.

The range of moral options in response to the use of medical technology near the end of life perhaps needs no detailing here. It includes everything from preserving life as long as possible no matter what the cost, to ending life by our own hand before it becomes what we fear will be intolerable; from agreeing to Do Not Resuscitate orders in hospital settings, to specifying orders for Limitation of Treatment that extends to the use of ventilators, artificial modes of nutrition, etc.; from formulating Living Wills to granting Medical Durable Power of Attorney so that we will not be left without an arm of agency in the midst of the medical world. These options are all too familiar to us; we know them through various communications media and through direct experience in our personal lives and our professions.

To focus our considerations this evening, I am going to try to do three things: (1) to identify some of the larger issues that underlie the choices we may make regarding our own and others' deaths; (2) to indicate some of the ethical boundaries and distinctions that have traditionally been important in evaluating specific choices in relation to human death; (3) to probe arguments both for and against changes in the law that would extend the range of individual choices regarding our dying. In addressing these three tasks, I have a concern to resist the polarization and politicization of the issue of euthanasia in the manner we have experienced with the issue of abortion.

Underlying Issues

The issues I have in mind here are philosophical (and medical and legal) but finally religious (and hence theological) issues. They are is-

sues deep within both Judaism and Christianity, and they have analogues in other world religions. A way to identify them briefly is to reflect on two convictions that are lodged in our attitudes toward human dying. On the one hand, life is a fundamental good. It is a gift from God, to be held as a gift is held, with reverence and respect; it is to be stewarded, cared for as something that is our own yet not only our own to be done with simply as we please. A sign that life is this kind of a value for us, this kind of a gift, is God's command to us: "Thou shalt not kill" (Exodus 20:13). The command appears in legal and prophetic traditions in the Hebrew scriptures and in the teachings of Jesus in the Christian scriptures, articulated along with imperatives neither to kill or to be angry, and not to despair in the face of suffering. We interpret this command not only as a negative prohibition against killing but as a positive prescription—so that, for example, as Karl Barth expresses it: Thou shalt will to live, and even will to be healthy.² "The freedom for life to which the human is summoned by the command of God is the freedom to treat as a loan both the life of all persons with one's own and one's own with that of all human persons."³ Or, as the American Catholic bishops put it in their document on the provision of artificial nutrition and hydration:

The Judeo-Christian tradition celebrates life as the gift of a loving God and respects the life of each human being because each is made in the image and likeness of God. As Christians we also believe we are redeemed by Christ and called to share eternal life with him. . . . Our church views life as a sacred trust, a gift over which we are given stewardship and not absolute dominion.⁴

The value of human life, then, and its ultimate ownership, is revealed in God's command and in the story of God's relationship to humanity. And there are other indications that life is a fundamental value and a gift, our own but not only our own—that is, indications not provided directly through God's special revelation. For example, some have recognized in human "nature" itself a basic drive toward life, a desire to live, indicative of a moral "law," an obligation to preserve human life. Others have found this good of life in their love for one another, experiencing in relation to a beloved a revelation of the value of life such that an intention to kill cannot be a part of what love requires. Others have maintained that life is valuable at least as

the necessary condition for human persons to have and to enjoy other values. Still others have argued that respect for the life of each individual is necessary for the common good of the human community. On all of these counts, life is to be preserved—as a good that is precious to God, to the community, and to each person.

But if this is one conviction, religiously and philosophically affirmed, that human life is a fundamental good, there is a second: Life is not an absolute good, not the supreme value for humans. Thus, Karl Barth can qualify the command, “Thou shalt will to live,” with the paradoxical formulation, “[but] not will to live unconditionally... rather will to stake and surrender [one’s life], and perhaps be prepared to die.”⁵ And the Catholic bishops can write: “As conscientious stewards we have a duty to preserve life, while recognizing certain limits to that duty.”⁶ So that, as the ethicist and legal theorist Richard Stith has put it: There are these two intuitions: Life must not be destroyed, but it need not always be preserved. Every person is utterly valuable, and each one’s life is utterly valuable, yet things other than life are sometimes more valuable. Human life deserves respect; it even has sanctity; but death may sometimes be welcomed.⁷

We are therefore faced with serious questions: What are the limits to our obligation to preserve life? and, is the prohibition against taking life, against intending death, absolute? When we begin to reflect on these questions, we tend to do at least two things. First, we identify limits, boundaries, to our obligations regarding human life. In order to do so, we ask what are the conditions under which life must always be preserved? If physical life in this world is not an absolute good, to what other goods is it relative? What other values might, under what circumstances, take priority over life? And second (though relatedly), we consider distinctions. We differentiate between kinds of choices in order to see whether some of them may be morally justified though others may not. We distinguish, for example, between choices to kill and choices to let die. Let me say something briefly about each of these two strategies.

Limits and Distinctions

Limits to the Obligation to Preserve Life

While my focus this evening is on choices in a medical context, it is helpful to consider more generally the limitations that have been

proposed or acknowledged regarding the obligation to preserve human life. None of these is without controversy, but they indicate the willingness of most persons to relativize in some way the value of human life. It is, actually, difficult to find anyone who finally wants to make of life in this world an absolute value. For example, when it comes to questions of war, those who think that some wars can be justified are willing to relativize the lives of their enemies; those who are absolute pacifists are willing to relativize their own lives.

Some of the candidates for limits to the obligation to preserve life (which is not to be equated with limits to the obligation not to kill) include the following:

1. Personal integrity and moral or religious witness: For the martyr, life is less valuable than the integrity of her or his faith or moral commitments; it may also be of less value than witnessing to what is believed to be right and true.

2. Conflict between human lives: There are situations in which the value of one or more individuals’ lives comes into conflict with the value of another’s. Criteria have been developed to justify the limiting of efforts to preserve some lives when all cannot be preserved. Examples of situations where these apply include self-defense; scarcity of resources (as when triage methods are used or more general policies are developed for rationing access to medical treatments); conflict between individual and common good (as when capital punishment is justified as a deterrent to crime).

3. Individual autonomy: The free choice of an individual sets some limits to the obligation of another to preserve that individual’s life, as when an individual’s refusal of medical treatment takes priority over the beneficent wishes and actions of medical caregivers.

4. Quality of life: A conflict of values can occur for and within an individual person for whom there is a “totality” of value. Physical life is a condition for every other value enjoyed by the individual in this life, but as a condition it is for the sake of the person as a whole.

Thus, the loss of present and future conscious awareness, of the ability to relate with others, of the possibility of a life free from intractable and personality-changing pain, etc., may relativize the value of ongoing sheer biological existence and limit the obligation to preserve one's own or another's life under such circumstances.

5. Medical futility: The ineffectiveness of some forms of activity (for example, medical treatment) to extend the life of a patient (or to extend it with a reasonable quality of life for the person as a whole) sets a limit to the obligation to attempt to preserve that life.

To identify limits to the obligation to preserve life helps us see how life is a value but a relative value; it is a way of gaining clarity on what life is relative to; it provides us with a perspective from which we may ask whether or not we are truly obliged to preserve a particular life, our own or another's. Yet categories of "limits" in this sense do not by themselves resolve the questions about preserving life (and staving off death) that arise for us in the concrete. They are necessary but not sufficient for our moral discernment in this regard. We need additional conceptual tools such as descriptions of moral actions in terms of their intentions and their circumstances. Descriptions allow distinctions, and distinctions serve discernment.

Distinctions Among Choices Regarding Death

Some choices regarding death can be morally justified, some cannot; and among the choices that are potentially justifiable, some are more easily justified than others. So general a statement is hardly controversial, but a great deal of controversy surrounds every effort to specify it. Prior to its specification, therefore, a preliminary comment may be in order.

There is an ironic twofold problem with distinguishing the moral status of different choices regarding death. On the one hand, relying too strongly on such distinctions to solve our moral questions regarding death can obscure the real problems we face. I hope to show this in what follows. But on the other hand, blurring the distinctions among these choices can compound the problems we face. This is

most dangerous when we lump together all sorts of choices regarding death (in a medical context) under one category and call it "euthanasia."

This, I am afraid, is a temptation for advocates of the left and of the right on these issues. Even those who otherwise take distinctions seriously, such as the writers of official documents for the Roman Catholic community, contribute to confusion when they define euthanasia as "an action or omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated."⁸ Important distinctions are contained in this definition (based on concepts such as "intention" and "cause"), but they are all too often invisible under the large umbrella of the oversimplified category, "euthanasia."

The kinds of distinctions I have in mind appear at three levels. (1) The first is a distinction between so-called active and passive euthanasia, or more accurately, actively taking life (killing) on the one hand, and letting someone die (omitting what would otherwise preserve someone's life), on the other. (2) The second is a distinction that further divides the possibilities of passive euthanasia (or letting die); it is a distinction based on the circumstances of the patient, and it has traditionally been referred to in considerations of ordinary versus extraordinary means. (3) Finally, there is a distinction that divides the possibilities of active euthanasia; it is the distinction between what has traditionally been called direct versus indirect active causing of death. All of these distinctions have been in the tradition of Roman Catholic moral theology for a long time, and they have also functioned significantly in contemporary medical ethics. It is not necessary for me, therefore, to provide a full discussion of them, but only to point to them in a way that suggests my own conviction that they remain important to our discernment of choices regarding death.

First, then, the distinction between killing and letting die: It is a distinction that is today heavily challenged. In contexts where "letting die" means pulling a plug, it is not so simple to distinguish it from a lethal injection intended to kill. In either case, of course, the result is death. Those who conclude that there is, therefore, no moral distinction to be drawn between these choices, these "actions," charge that the distinction is speciously maintained in "bad faith" by those who want to escape the responsibility of their choices. What reasons can

be given, then, to preserve the distinction between active and passive euthanasia? The key elements in a distinguishing description of these two options are that to let die (as opposed to actively killing) need not be to intend death or actively to cause it, though it is to accept it (for the consequences of not-doing will indeed be death in most instances) and to be the occasion of it. A sign that one need not be intending death is that should the patient continue to live, despite the withholding or withdrawal of treatment, one would not consider one's aims frustrated; and the active cause of the death when it does take place is not immediately one's omission of treatment but the underlying disease process that brings the person to the brink of death in the first place.

But why would these distinguishing features change the moral status of one's choices? Here disagreement runs deep. Nonetheless, those who want to maintain this distinction (including myself) argue that to accept death, to allow it and provide an occasion for it by removing unreasonable barriers,⁹ is not to violate the value of human life—not to violate it as a divine gift, a fundamental drive within the heart of the human individual, a good of great importance to the human community. It is indeed to accept the inevitable process of dying that is a part of human living.

The descriptive difference between active and passive euthanasia is not trivial, even though each represents a choice whose consequence is death and each requires morally justifying reasons. Indeed, because the consequence (foreseen if not intended) of each is death, there can be no avoidance of moral responsibility for omitting treatment, any more than there can be for actively and directly killing someone. In other words, there must be justifying reasons if a choice to let someone die is to be a morally good choice. These reasons emerge in the further distinction to be drawn between ordinary and extraordinary means.

This second distinction has been signaled with a variety of terms ordinary/extraordinary, obligatory/optional, beneficial/burdensome, medically indicated/not indicated, etc.¹⁰ The point of the struggle for appropriate terminology is to express most clearly a concrete situational difference that yields either an obligation, or not an obligation, to treat in a particular way. The distinction is not one of customary versus unusual treatment, nor is it one that can be captured by identify-

ing general categories, kinds, of treatments. Its meaning is circumstantial, situational, in that it refers to the proportionate benefit and burden of a particular treatment relative to a particular patient. It is a matter of medical and personal discernment as to what counts morally as an "excessive" burden or what counts morally as an acceptable benefit.¹¹ The point of the distinction, however, is that some discernment of this sort is required if one is to justify omitting (withholding or withdrawing) some form of medical treatment.

To maintain that passive euthanasia can be justified in some situations is not to suggest that active euthanasia cannot also be justified. The third distinction I have noted, between direct and indirect active euthanasia, has offered a traditional way to allow for a morally justified limited form of action to hasten death. The distinction is often a subtle one, and it is not helpful in many cases. Its clearest application is in cases where action is taken to alleviate pain even though the medication given may hasten the process of dying. Here, too, the distinction rests upon clarification of what is directly intended (relief from pain) as opposed to what is foreseen as a consequence and hence held in a complex act of choice only by indirect intention (death).¹²

As I have said, it is not possible for me here to provide a full account of the meaning of these distinctions or the controversy that presently surrounds them. I am assuming some familiarity with them and raising them up because I believe in their continued importance for ethical discernment and for the forging of policies regarding choices of death. But let me here return to the question of why a distinction between active and passive euthanasia remains morally significant, and along with this, the question of why a distinction between direct and indirect active euthanasia is significant morally. The answer has two parts. First, there is a profound difference (at least for many persons) in the moral experience of letting someone die and the moral experience of actively killing someone; and there is a profound difference (at least for some persons) in the moral experience of giving an individual medication to alleviate pain and giving an individual medication with the precise and direct intention of killing her. It will not do to dismiss these differences in experience (in the perception, the judgment, the self-determined goal, of what one is doing) as illusory or self-deceptive, as the residue of a taboo morality that will disappear under critical scrutiny. Granted (and seriously and

acknowledged) that omission must have justifying reasons (just as commission), and that indirect causing of death must be justified by grave reasons (in some sense, just as direct killing must be), there is nonetheless a profound difference in the moral experience of letting life go and actively, directly, taking it. The grounds of this experience may be several, but it can be rationally described and supported.¹³ To reject it out of hand may be to change drastically the moral sensibilities of individuals and a culture. This is why disagreement about these moral experiences, experiences of moral obligation, run so deep. It is also why our debates about them require such respect and such care.

This leads me to the second part of an answer to the question of why the distinctions between active and passive euthanasia, and between direct and indirect active euthanasia, remain morally significant. They play an important role in our assessment of options in the realm of public policy. If the line is drawn against the active, direct, taking of life in a medical context, it secures a line against expanding the population of those for whom decisions of death can be made. It prevents us from making decisions of death for persons who are vulnerable by reason of poverty, age, race, mental acuity, or whatever status makes their life appear to be of less value to society than the lives of others. It limits our choices of death to populations whose death is inevitable when medical treatment is deemed unreasonably burdensome to them, and populations for whom the obligation to care in a medical context focuses on providing them comfort in the face of terrible pain.

I am, therefore, prepared to argue that choices for death may be more easily justified when they are choices to let a life go, under circumstances in which the burdens of preserving life outweigh the benefits (for the one who is dying); and when the hastening of death is the secondary and not directly intended result of reasoned decisions to provide positive remedies for pain. These choices need not be made in the kind of "bad faith" that slips out from under true moral responsibility. They require moral justification; they are the result of discernment; they draw on legitimate and significant distinctions among moral choices; they ratify the value of human life as gift and as responsibility.

Yet, as I have said, the application of such distinctions does not finally resolve all of our quandaries regarding the welcoming of death

in the context of sickness and debility. There remains the question of whether or not direct and active intervention with the intention to kill can ever be justified. Indeed, one of the most urgent issues that faces us as a society now is the issue of directly ending lives marked by great suffering and caught in a prolonged process of dying—issues, that is, of active euthanasia and of assisted suicide. Widespread and growing public support of the decriminalization of these options reflects a general cultural (and religious) shift in evaluations of suicide;¹⁴ it also represents deep fears in anticipation of the circumstances of sickness and death.

In large part, our fears are of being given too much medical treatment, being kept alive too long, dying not at peace but in a wild frenzy of efforts to give us a little more time to live. The radical possibilities introduced by modern medicine lead ironically to scenarios of dying that have become unacceptable to many individuals. To more and more persons, it appears that the only way to retain some control over our death—to die a death marked by conscious self-awareness, with knowledge of our ending, surrounded by those we love—is to take our death into our own hands. It begins to make sense that while science has made death an enemy (to be fought on the battlefield of medicine), so science must come to befriend death, to assist us scientifically in dying as we choose. This is part of the point of proposals for physician-assisted suicide and for voluntary active euthanasia.

The debate surrounding these proposals intensifies weekly in almost every state of our nation, and the polarization of positions threatens to become as intractable as our polarization over the issue of abortion. It is not possible for me tonight to address what is at stake in anything like an adequate manner; hence, it will not be surprising if what I offer is unsatisfying to persons presently on either side of the question. There may also be dissatisfaction on all sides because I will not shape what I say as an advocacy position for or against the proposals before us. What I want to do, briefly, is to reflect on the major arguments that surround these proposals and to do so against the background of the underlying principles and moral distinctions that I have just outlined.

Active Taking of Life in a Medical Context

The issues that surround the active taking of life in the context of

sickness and dying are most often joined, it seems to me, in three ways. First, individual choice (or individual autonomy) competes with community interests (or with perceptions of the common good). What is frequently identified as a “right to die” conflicts with a concern to protect society from a “slippery slope” of abuses that will ultimately violate the clearer and prior rights of the majority of citizens. Second, arguments for the moral legitimacy of a choice to die (by an active taking of life) conflict with arguments for a strong prohibition against such a choice. In other words, the issue is not joined merely over the right of the individual versus the good of the community, but over the evaluation of the moral goodness or evil intrinsic to active euthanasia and assisted suicide. Third, the issue is joined over competing assessments (competing predictions) of the social consequences of the legalization of a right to choose death. These three ways of joining the issues are obviously closely related.

I will not attempt here to adjudicate the three conflicts, but only to reflect in a particular way on the second and third. (This does not signal a judgment that the first issue—regarding the sheer right of choice on the part of the individual to choose death—is unimportant, but only that I am limited here in time. Moreover, the second and third sets of arguments have significant implications for adjudicating the first.) I will address the second and third within the context of a particular faith community, the Roman Catholic community. I do so both because of my audience here this evening and because the Catholic community is one whose voice promises to be significant in our national debate on these questions.

Moral Elements in the Choice to Take Life

Let me, then, consider for a moment arguments for and against the moral legitimacy of a choice to die. I have already pointed to the major reasons for maintaining that we ought not to take our own life or to ask another to take it for us. To repeat them quickly: (1) Our life is not our own; it belongs to God; it is God’s prerogative to decide when our life must end in this world. (2) It is the law of nature to preserve our life as long as we are able; while there are limits to our power to do so and to our reasonable obligation to do so, we must not give in too quickly to the forces of death, not refuse the burdens of our whole life or cut off prematurely its possibilities. (3) We are es-

entially social beings, and to take our life by our own decision is to injure the community (our family, our friends, and the wider communities to which we belong).

On the other side of this issue, specific counterarguments are mounted—for example, to characterize the free agency of the one who is to die as the only morally significant feature of the choice to die; to deny that God holds (or wants) complete control over our dying; to reject a notion of “natural law”; to construe community on the model of an ecosystem where the demise of some is nature’s way of making room for others. Perhaps most frequently it is argued that the suffering of the one dying overrides all other considerations that otherwise would make the active taking of human life immoral. All of these are extremely important arguments to assess, even within the Catholic tradition. But within this context they suggest questions of a particular sort, questions through which the issues may be seriously joined and strongly pressed either to resolution or to deeper levels of conflict.

For example, for those who believe that God is their ultimate destiny—their beginning and their end, their holder in life and savior in death—is it not conceivable that profound “acceptance” of death, acknowledgment of an ending that is indeed God’s will, can be expressed through action as well as through passion, through doing as well as being done unto? For those who believe that they are called to resist the forces of diminishment and death as long as they can, and to surrender in the end not to evil (or even to sickness) but to God, can this never take the form of an active decision to die? Or better, does it not always, at its most profound and radical level, take this form? But can “yielding” ever be expressed through an active ending of life by one’s own hand or another’s? Dying holds the mystery and the hope that (as Teilhard de Chardin put it¹⁵) our death will be truly a “communion” with God. But in communion, action and passion, giving and receiving, embracing and letting go, become two sides of the same reality.

I recently stood at the bedside of a young man dying of AIDS. He had fought his disease long and hard, with extraordinary intelligence and courage. The day came, however, when it was clear that no more could be done. Aggressive treatments, even technologies of sheer life support, were finally being overwhelmed by the forces of death. As his

family, friends, and physician were telling him of this dire situation, he said in what he could manage of a whisper, "You mean it's time to concede?" For him, conceding was an active surrender to God, and it entailed a decision to stop the technologies that were keeping him alive. He took no direct action (nor requested any) to end his life, though he chose to accept death and to cease prolonging his dying. Without erasing the difference between his form of letting go and a more active taking of his life, is it nonetheless possible that all the elements of religious acceptance could have been incorporated into one or the other?

Moreover, is it not possible, at least in exceptional circumstances, that the law of one's nature, the law of one's being, presses one to self-preservation in a manner whereby the whole of one's being must be saved? If it is possible that an individual can be in such dire straits that her very integrity as a self is threatened (by intractable pain, ravaging the spirit as well as the body), is it not justifiable in such circumstances to end one's life, to surrender it while it is still whole?

Finally, for those who believe in the Communion of Saints, is there a way in which membership in community is sustained no matter how death is accepted? Is it possible that, when death becomes inevitable and surrender to God is made in the face of it, then communal bonds can be preserved and not violated in an active as well as a passive dying-into-life?

I raise these questions not to suggest that it makes no moral difference if we refuse treatment or ask for a lethal dosage of medicine; for I am convinced that in most circumstances it does make a difference. I raise the questions, rather, in order to probe the possibility of exceptions to a rule. I raise them also in order to expand our understanding of perspectives on these issues that may be different from our own.

Now, however, let me move to the third set of issues I identified earlier. That is, let me consider competing assessments of the consequences of legalizing voluntary active euthanasia and assisted suicide.

Social Consequences of Changes in the Law

There are many persons who argue against a change in policy and law in these matters not because active euthanasia or suicide are intrinsically wrong (wrong "in principle") but because they will be injurious to society. Holders of this position point to several factors: We

will soon be on a very slippery slope, where what began as respect for some individuals' right of private choice becomes a violation of others' right to medical care; where we create an ethos in which individuals are pressured, socially coerced, to choose to die rather than to live as a burden to others; where voluntary active euthanasia slips into involuntary active euthanasia (as it has, according to some reports, in the Netherlands¹⁶); where the "easy way out" short-circuits the possibility of an individual and his or her family's resisting death to the end, companionship one another to the end, and only then surrendering into God. Moreover, risks of error, and pressures to expand the practice of euthanasia, are greater in a society such as ours where medical care is inequitably distributed according to factors of race, economic status, geography, gender, etc.; and where there is already a massive breakdown in trust between patients and physicians and a crisis of professional identity among medical care providers. In this view, then, the negative social consequences of decriminalizing voluntary active euthanasia and/or assisted suicide are serious indeed, and they weigh against any change in the law. The interests of society, not as a collectivity but as a community of many, finally should take priority over the interests of a few.

There are, however, responses to these concerns. For example, potential abuses may be limited if we craft careful safeguards against them (as has been attempted in legislative proposals for assisted suicide that require three requests, both oral and written, medical consultation, communication with family members, etc.). Besides, it is not as if we are currently invulnerable to abuses (for physicians are sometimes even now asked to write prescriptions or to provide injections that will, in a hidden way, end a patient's life; and if they respond out of compassion, there is no public scrutiny of their choices and actions).

Then, too, loss of spiritual depth among individuals in society is not inevitable should active direct taking of life in limited circumstances become possible; and in any case, one person's way to spiritual wisdom and courage is not necessarily the same as another's. There are other ways, besides holding the line against new legislation, for religious traditions to promote reverence for life, courage in the face of suffering, and religious meaning in death.

Moreover, of central importance to the good of society is tolerance

and respect for differing moral perceptions. If a prohibition against active euthanasia can only be sustained "in principle" by appeals to a certain belief in God, or a particular interpretation of the natural law, then it is sustained on sectarian appeals, not on reasons grounded in a universal morality. Insofar as this is the case, the basic values of a democratic pluralistic society may be violated—by the imposition of this prohibition on all without a sufficient achievement of moral or religious consensus. Hence, in this view, the negative social consequences of changes in the law are not grave enough to support an absolute prohibition against the active taking of life in a medical context, and there may be some consequences that argue positively for change.

Some Recommendations

How shall we weigh these arguments, these analyses, and the many more that I have not had time to identify? My goal, as I have said, has not been to reach a conclusion or to advocate a position. I have been, on this occasion, more concerned about the process of our societal and religious discourse than on its ending. Still, I will jump ahead of where I have come in my analysis thus far—for the sake of honesty—to signal four provisional conclusions and directions that seem to me defensible and important.

(1) The concerns on all sides about dying point to some things that can be done without moving to active voluntary euthanasia or assisted suicide. What we must do, first and foremost, is to clarify the meaning and the effectiveness of refusal of treatment. If this is truly legally safeguarded, and if there is wide and deep understanding of its medical as well as its moral and religious possibility and power, we shall be able to recognize that: (a) We do have decisions to make regarding our death, choices to live but choices finally to surrender to what must be and what can even be welcomed. And (b) as Paul Ramsey once wrote, "If the sting of death is sin, the sting of dying is solitude. . . . Desertion is more choking than death, and more feared. The chief problem of the dying is how not to die alone."¹⁷ To choose in the end to let go is a choice we should make with others. In the medical context, the most pressing need and the most effective safeguard against all that we fear is communication. It is to be structured by policy and nurtured by those who share our life.

(2) What we must also do is to press for medical progress in the management of pain. Along with this must come a clearer focus in the clinical setting on the goals of care for each individual patient—goals that are appropriate to the individual's medical condition and personal values. Only so can we determine whether aggressive treatments should be continued or withheld; only so can we be clear about the requirements of care and the possibilities of alleviating suffering. If we can manage these things, the situations in which there appears no way out but through active killing—situations that are already rare—will be almost nonexistent.

(3) Yet I do not dispute that there are and will be rare circumstances, exceptional cases, in which intractable suffering may threaten the very soul of the person, and in which the active taking of life may be justified. Such decisions must remain the exception, however, and not become the rule. Whatever we must do, in law and in policy, to allow but to limit these actions is worthy of our discernment and our efforts at agreement.

(4) The process of our discernment, whether in the political arena or in our own faith communities, is a process that holds a moral requirement of mutual respect. We must find the ways to secure this respect, and through it the hope for the fruits of a discernment that will ultimately injure neither the individual or society.

I end where I began: Human life has profound value; it is even holy. It therefore deserves utter respect. Yet death may sometimes be welcomed—if it is welcomed in a way that does not ignore or violate the requirement to respect and to value each person. The questions before us are questions of what that way means and what, from all of us, it demands.

END NOTES

¹For helpful historical accounts of valuations of human life in general and attitudes to euthanasia in particular, see Arthur J. Droge & James D. Tabor, *A Noble Death: Suicide and Martyrdom Among Christians and Jews in Antiquity* (San Francisco: Harper, 1991); Arthur S. Berger & Joyce Berger, eds., *To Die or Not to Die? Cross-disciplinary, Cultural, And Legal Perspectives on the Right to Choose Death* (New York: Praeger, 1990); Ron Hamel, ed., *Choosing Death: Active Euthanasia, Religion, and the Public Debate* (Philadelphia: Trinity Press International, 1991), chap. 2.

²Karl Barth, *Church Dogmatics*, trans. A.T. MacKay, et al., (Edinburgh: T. & T. Clark, 1961), III/4, 356.

³*Ibid.*, 335 (inclusive language added to translation).

⁴U.S. Bishops' Pro-Life Committee, *Nutrition and Hydration: Moral and Pastoral Reflections* (1992).

⁵Barth, *ibid.*, 334.

⁶U.S. Bishops' Pro-Life Committee, *ibid.*

⁷See Richard Stith, "Toward Freedom from Value," in Stephen E. Lammers & Allen Verhey, eds., *On Moral Medicine* (William B. Eerdmans Publishing Co., 1987), 127.

⁸Vatican Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (1980).

⁹For a careful and detailed discussion of this distinction, see Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics*, 4th edition (New York: Oxford Univ. Press, 1994), 219-35.

¹⁰For an assessment of this distinction that differs from the one I offer, see Beauchamp & Childress, *ibid.*, 200-202.

¹¹For the present, I prefer to use the terms "ordinary/extraordinary" for this distinction, not because I do not see the difficulties they carry, but because for those who understand their traditional criteria, they still hold a clearer content than the alternatives.

¹²Involved in this distinction is the Principle of Double Effect. I have opted here not to discuss this principle as such simply because time does not permit.

¹³I do not believe, obviously, that the important difference in these experiences has to do merely with the agent's own self-understanding as innocent or guilty.

¹⁴Signs of the shift I have in mind include contemporary willingness to provide a Catholic burial to individuals who have committed suicide.

¹⁵See Teilhard de Chardin, *The Divine Milieu* (Harper Torchbooks, 1965), 90.

¹⁶See Paul J. van der Maas, et al., "Euthanasia and Other Medical Decisions Concerning the End of Life," *The Lancet* 338 (Sept. 14, 1991), 669-74. The report is that voluntary euthanasia has expanded to include what incompetent patients "would have" chosen were they able.

¹⁷Paul Ramsey, *The Patient as Person* (New Haven: Yale Univ. Press, 1970), 134

