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Dignity and Dying: A Christian Appraisal **“Definitions of Death”**

by **B. Holly Vautier**

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Definitions and Declarations

Modern technology has compelled society to re-evaluate classical definitions of death. Now that it is possible to mechanically sustain cardiac and respiratory functions, traditional criteria for determining death no longer retain their previous meaning. New ambiguities have necessitated new definitions.

While the Danish Council of Ethics has opted to retain the classical cardiac activity standard,¹ most contemporary criteria for death involve some form of brain death determination.² Two major versions of brain death — whole-brain and higher-brain (neocortical) — have been proposed.

The Uniform Determination of Death Act is representative of the whole-brain definition. Based on the 1981 President's Commission Report, it has now been endorsed legislatively or judicially by forty-five states.³ The UDDA defines death as follows:

either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.⁴

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In the United Kingdom, on the other hand, official criteria for death leave room for higher-brain interpretations. The current indicators of death — irreversible unconsciousness and irreversible apnoea — are considered controversial and unacceptable by many religious groups and some physicians. Nevertheless, a person who physiologically fits this description can be declared legally dead.⁵

The choice of either the whole-brain or higher-brain definition is significant, since it involves a philosophical position as well as an empirical formulation.⁶ While establishing the criterion for death is primarily a medical concern, defining death may be regarded as a philosophical task.⁷ When a patient is determined to be ‘dead’, for example, may depend more on the observer's definition of such terms as ‘person’, ‘human being’, and ‘alive’ than on specific biological indications. Advocates of the whole-brain perspective tend to hold inclusive views of personhood, pointing out that what is essential to being a person varies widely both within individual societies and interculturally.⁸ Alexander Capron cites only one requirement for personhood — ‘live birth of the product of a human conception’.⁹ On the other hand, proponents of the neocortical position restrict personhood to human beings whose cognitive functioning is intact. John Lizza argues that to be a person one must be conscious and sentient.¹⁰ Robert Veatch proposes that an individual's moral standing within the human community should end ‘when it is reasonable to deduce that there has been a break-down of the link between bodily integrity and mental and social capacity’.¹¹ It is evident, then, that one's definition of death involves one's declaration of the meaning of ‘personhood’.

Roots and Fruits

Divergent views of the meaning of personhood are not new. Origins of both the inclusive (whole-brain) and the cognitive (higher brain) understandings of personhood are apparent in history and philosophy.

At the root of the inclusive declaration of personhood is a tradition which acknowledges the human being as a single entity having both a material body and an immaterial soul. This unified concept is evident in the Torah and the New Testament, as well as in the writings of Aristotle.¹² The Judeo-Christian perspective points to the Genesis account of creation (Gen. 2:7) as indicative of this unity. Berkhof describes the twofold complex of personhood as follows:

Every act of man is seen as an act of the whole man. It is not the soul but man that sins; it is not the body but man that dies; and it is not merely the soul, but man, body and soul, that is redeemed by Christ.¹³

In *De Anima*, Aristotle affirms the unity of body and soul.¹⁴

On the other hand, the roots of the cognitive declaration of personhood are evident in the writings of Plato and Descartes. Unlike Aristotle, Plato regards the body as evil — merely an impediment to the progress of the soul. Descartes retains a mind/body dualism that reduces the status of the human body to that of a disposable piece of machinery.¹⁵ While the unified concept attributes goodness to the body, this view robs the body of all significance.

These two dissimilar traditions naturally yield fruits in keeping with their roots. The fruit of the unified concept of personhood is the acknowledgment that all human beings are persons. In traditional western society, this assumption of inclusivism has resulted in a linkage of justice and the value of human life. There has been a prevalent conviction that regardless of an individual's condition, characteristics, or merits, every human being ought to be granted equal right to and protection of one's life.¹⁶ On the other hand, the fruit of the fragmented concept of personhood is the acknowledgment that only certain human beings qualify as persons. In current pluralistic society, this assumption of exclusivism has resulted in indifference with regard to the value of some human life. There is confusion about which categories of human beings are morally entitled to rights to and protection of their lives.¹⁷

The Past: Perils of Non-Personhood

In *Ethics at the Edges of Life*, Paul Ramsey warns his readers that a nation's social policy will ultimately be based on its institutional assumption of who has moral standing within the human community. He convincingly demonstrates how legal, medical, and ethical decisions intersect to determine who will (and who will not) receive legal protection and life-saving or life-sustaining medical care. The treatment one receives will be contingent on the moral ethos prevalent within the society.¹⁸

The prevailing moral ethos includes the value a culture places on individual human life. Where a strong Judeo-

Christian ethic is evident, for example, life is regarded as a gift and a trust.¹⁹ It is seen as an intrinsic rather than merely an instrumental good. This is why, according to Bleich, '... it is possible to discern a reinforcement of values in the preservation and prolongation of life even if that life appears to be bereft of value in conventional or social terms.'²⁰ This sense of the sanctity or dignity of all human life has been influential in maintaining traditional western prohibitions against abortion, suicide, euthanasia, and hazardous medical experimentation on human subjects.

When an ethic which endorses life for all persons is replaced by an ethic of selective personhood, people are valued on conditional terms. Those who qualify for personhood (such as healthy, competent adults) retain their valued status in society. But those who fail to qualify for personhood (fetal life, disabled infants, incompetent adults, individuals who have lost their neocortical functions, for example) lose their status as valued members of the society. When loss of personhood is equated with worthlessness, depersonalization can too easily constitute a license to kill.

The 'euthanasia' murders in Germany (1920s-1940s) were a heinous example of the result of depersonalization. This killing of an estimated 275,000 mental patients was deliberately planned and enthusiastically executed by the psychiatric elite — within the context of a technologically advanced, 'humane' medical community.²¹

The scientific rationale for these outrageous acts was the concept of 'life devoid of value'. This idea, published in the writings of Professor Karl Binding and Doctor Alfred Hoche in 1920, served to justify the destruction of lives 'not worth living'.²² Binding included social factors (such as the burdens 'worthless persons' place on their families) as reasons for killing.²³ Hoche used economics as a rationale for murder. He categorized 'worthless persons' according to their disabilities in order to demonstrate how much the continued existence of each group would cost society. His calculating fiscal argument included the statement that '... it is easy to estimate what incredible capital is withdrawn from the nation's wealth for food, clothing, and heating — for an unproductive purpose.'²⁴

The Present: Failing The Personhood Test

What, one may ask, do the past perils of non-personhood have to do with current America? Wildes has observed that the once-dominant moral ethos of western society is 'fundamentally broken'. Considerable controversy already exists about who has moral standing within the community.²⁵

Abortion is legal. The fiction of non-personhood, as urged by Marks, has reached even beyond *Roe v Wade*.²⁶ It has extended into the special care nursery, where Drs. Duff and Campbell have practiced involuntary euthanasia for disabled newborns. These physicians have publicly justified allowing death as a 'management option' when 'the hope of meaningful personhood' is absent.²⁷ Fetal life has failed the personhood test. No legal statute has removed the Fourteenth Amendment rights of disabled

infants. They have simply failed the personhood test by default.

At the opposite edge of life, Dr Jack Kevorkian has continued to resist the law and persist in 'assisted suicides'. Is he preparing the terminally ill to fail the personhood test?

Writers in American journals are proposing that the designation of 'dead' be applied to persons whose potential for cognitive functioning has ceased.²³ This idea sounds strangely similar to a British statement that a PVS patient 'cannot be a person'²⁹ and the Danish position that loss of cognitive functioning means 'the extinction of the person'.³⁰ A recent article in the *Annals of Internal Medicine* carries this proposition to its practical conclusion. Halevy and Brody state:

We feel that medical care, including artificial nutrition and hydration, can be unilaterally withdrawn from vegetative patients. Organs may be harvested from eligible donors when the standard clinical tests are satisfied.

Their rationale is economic — 'the appropriate use of social resources'.³¹ PVS patients are beginning to fail the personhood test.

The Future: Inclusivity or Utility?

As our medical technology advances, there will be increasing temptation to depersonalize individuals and groups under the aegis of social needs. How we resolve the issue of personhood will determine when our social obligations to individuals begin and end. A social policy that reinforces the inclusive view of personhood will strive to deal justly with the distribution of limited resources; it will recognize both the intrinsic value of human life and the right of individuals to live. On the other hand, the classification of human beings as non-persons opens the door to a utilitarian ethics in which medical treatment is granted or denied on the basis of quality of life or economic criteria. Since a non-personhood policy implies that individual life is dispensable, it could also lead to the sanctioning of the procurement of donor organs from dying patients,³² the legalization of mercy killing, and the eventuality of involuntary euthanasia. St Martin has noted that the designation of certain groups as non-persons can predispose them to death selection.³³

As noted above, tacit legal, ethical, and medical policies have already converged to predispose Americans to accept non-personhood status for several groups within society. Ramsey has warned that 'talking about a non-personhood policy in a normless context is a way to promote its sooner actualization'.³⁴ Daniel Callahan, for example, has already strongly stated his intention to change social consensus to adopt 'a new policy that would refuse reimbursement' for comatose patients who are not likely to regain consciousness.³⁵ In our increasingly normless culture, we cannot afford to ignore the admonition of Arthur Dyck:

If a society withdraws its defenses of its most defenseless members, the question arises whether it is in the interest of persons to enter into covenant with such a society.³⁶

Death, Personhood, and Life

There is a sobering interconnection between definitions of death, the meaning of personhood, and the value of human life. For this reason, it is vital that societies continue to endorse a single, uniform definition of death which retains the status of all human beings as persons. Any designation of non-personhood invites revisions in medical and legal standards which lead to the devaluing of human life.

There is still some uncertainty as to when the moment of death occurs.³⁷ Hans Jonas has observed that 'since we do not know the exact borderline between life and death, nothing less than the maximal definition of death will do'.³⁸ And Helmut Thielicke thoughtfully concludes:

It is conceivable that a person who is dying may stand in a passageway where human communication has long since been left behind, but which nevertheless contains a self-consciousness different from any other which we know.³⁹

Criteria for death should be based on the state of the patient and not on the need for transplantable organs or the cost of continued therapy.⁴⁰ People must not allow a combination of Cartesian thinking and increasing cost/ratio panic to legitimize society's disposing of human beings in the same way that we dispose of material objects. Barry Bostrom has insightfully stated:

... law, medicine and health care should be designed to err, if at all, on the side of the preservation of life and the establishment of rational principles for the protection of the most vulnerable persons in society — those who are medically dependent and disabled.⁴¹

Jewish law astutely recognizes that the worth of every human being:

... is the indispensable foundation of a moral society.⁴²
... One seemingly innocuous inroad into the inviolate sanctuary of human life may threaten the entire ethical structure of society.⁴³

Aware of the past perils of non-personhood, alliances of German citizens are now protesting against what they see as the potential for future bioethical crimes against humanity.⁴⁴ Yet other Western nations remain complacent — seemingly indifferent to the moral and ethical danger signals.

The issues of the sanctity of life and the right to live have particular relevance in the field of gerontology. America is ageing. Public policy in such areas as resource allocation, cost containment, organ transplantation, and euthanasia will directly impact the increasing population of 'oldest old' (aged 85+). On the other hand, if they are knowledgeable

and motivated, older persons may have the political potential to influence public policy.

Attitudes that are merely theoretical today can become the laws, ethics, and medical practice of tomorrow. Paul Ramsey reminds us:

Eternal vigilance is the price public conscience must pay for law that sustains and does not further erode the moral fabric of this nation.⁴⁵

For most of America's history the 'moral fabric of this nation' has been fashioned by the Hippocratic tradition and supported by the biblical ethic of covenant. This outlook upholds the value of human life, produces the fruit of compassion, reinforces the related theological concepts of charity, mercy, and agape, and culminates in care based on need. The Mount Sinai covenant, for example, requires the Israelites to accept compassionate responsibility for widows, orphans, strangers, and the poor. In the New Testament, Jesus attributes worth to the most marginalized persons in society and equates righteousness with the provision of their care.⁴⁶ Biblical passages such as Psalm 139:14-16 and Matthew 10:29-31 speak eloquently of the uniqueness and dignity of each human being.

Indeed, 'eternal vigilance' is required in order to prevent further erosion of traditional moral and ethical foundations. The health plan proposed by U. S. President Clinton is an example of how changing attitudes toward the care of society's most vulnerable members can influence national health policy. At the core of the Health Security Act is a philosophical shift away from the ethic of giving treatment priority to seriously ill individuals and toward a policy of the greatest good for the greatest number. Instead of care based on need and motivated by covenant values and Christian virtues, the new model is care based on social utility (including quality of life criteria) and motivated by the bottom line. 'For too long,' the Act contends, 'public health funds have been sapped to pay for individual care.'⁴⁷

As the Clinton Plan demonstrates, today's theory can all too easily become tomorrow's practice. In the United States, neocortical definitions of death may currently be only theoretical. But if higher-brain declarations become socially acceptable, increasing categories of human beings are likely to fail the personhood test. In a social climate obsessed by cost containment and captivated by utilitarian thinking, it would be tempting to depersonalize those whose care is the most expensive. Higher-brain definitions of death are compatible with exclusive views of personhood. Non-personhood policies open the door to revisions in medical and legal standards which are conducive to the further devaluing of human life.

Arthur Dyck summarizes the pivotal ethical issue as follows:

All of us in our daily lives are confronted by arguments based on expediency, and appeals to the greatest good for the greatest number, to the most desirable results, to a new ethic, and the like. The limitations of these simple and superficially plausible modes of reasoning

need to be recognized and alternatives proposed and understood. A community that fails to do this will fail properly to distinguish good and evil in thought, and also in practice.⁴⁸

The future of medical ethics will be shaped by the way in which public policy defines death. Such definition will in turn depend on how we understand the meaning of personhood and the intrinsic value of human life.

NOTES

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33. Thomas St Martin, 'Euthanasia: The Three-In-One Issue', in Dennis J Horan and David Mall (eds.), *Death, Dying, And Euthanasia*, p. 600.
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A "New Day," or Journey Into Night?

*A Review of the Presbyterian Church (USA) Study Guide on Euthanasia and Assisted Death**

by B. Holly Vautier

Scripture tells us that there is a time for everything. In 1995 our denomination decided that it was time to take a new look at life and death. The result was a study document on euthanasia and assisted death which is currently available for our review.

While well-intentioned and informative, the study materials tend to obscure essential distinctives of the Christian faith. At certain points unorthodox theological notions are coupled with cultural assumptions to suggest conclusions that seem to be strangely at odds with the plain and historic meaning of Scripture. These conclusions are subsequently applied to the practical issues of life and death.

On p. 13 of the study guide we find an unusual rendition of a familiar biblical passage. We are asked to "reflect upon what it means to be given dominion over God's creation, including our lives and the lives of others." The idea that God gave people dominion over one another in matters of life and death is unorthodox. Human beings are created in the image of God (Genesis 1:26). The unique nature of humanity — resemblance to God and relationship with God — is the determining factor in dominion. This truth is eloquently presented in Psalm 8:5-8, where people are described as being made "a little lower than the heavenly beings," "crowned with glory and honor," and "made ruler" over the rest of creation. Our commission to rule is a consequence of our status as God's image-bearer. Since only God is inherently sovereign, humanity acts as God's representative and steward over nature, but human beings always remain accountable to God. The sovereignty that God delegated to people in Genesis 1 involves rulership over the non-human world. It is certainly not a license for one human being to take the life of another.

Very early in the study materials the biblical "sanctity of life" ethic is challenged by a replacement ethic in which choosing death can be an acceptable or even desirable option. Candidates for death are persons whose "quality of

life" is judged to be so low that their lives are not worth living. On p. 6 of the study guide, for example, disabled newborns are referred to as children whose "very existence seems more a biological mischance than a genuine life." These infants, as well as persons in extended unconscious states, are called "these living-dead or dead-living." They are referred to as existing "in the crevice." According to Scripture such persons bear the image of God despite their circumstances and are worthy of the gift of life. The study guide, however, appears to abandon the biblical perspective and appeals instead to cultural criteria as the basis for evaluating the lives of these human beings. The statement that "our laws and our ethics have not yet managed to bridge this crevice" (p. 6) implies that (1) moral decisions concerning the life and death of persons in the crevice should be made on the basis of newly emerging secular ethics and law instead of on Scripture and (2) the lives of the most vulnerable members of society have not been protected in the past.

The "crevice" language used in the study guide is similar to the "edge of life" terminology employed by Princeton theologian Paul Ramsey almost twenty years ago. Ramsey warned that if we fail to protect the lives of persons at the edges of life we open the formidable door to the killing of human beings and increase the likelihood that parameters for death eligibility will continue to widen. For centuries Western culture has applied a sanctity of life ethic in combination with the legal principle that the state has an interest in the life of its citizens to safeguard the lives of all people. The "crevice" statement implies that this traditional life-based ethic is outmoded and that a new ethic is needed. It is significant to note that the quality of life standard is not new. The writings of Binding and Hoche (scientists in Nazi Germany) are shocking reminders that such social criteria as quality of life, economics, and burden to families have already been relentlessly used in other societies as a rationalization to kill.

At one point in the study material there is a bizarre attempt to associate the death of Jesus with suicide. We are asked, "Did Jesus choose to end his life? If you believe that he did, do you see parallels to people considering euthanasia or assisted suicide?" (p. 33)

Scripture teaches that Jesus, the sinless Son of God, came to die for the sins of the world. As God Incarnate, his mission in life and death was unique. People demand euthanasia and assisted death in order (1) to avoid or escape some form of suffering and (2) to control the time and manner of one's death. The intent of Jesus' death was neither autonomous self-destruction nor the avoidance of pain. Jesus anticipated and agonized over the prospect of intense suffering, yet he placed God's will above his own (Mark 14:33-36). The real parallel between the death of Jesus and the circumstance of suffering Christians is that they, like Jesus, choose in their pain to trust themselves to the larger purposes of God and allow God to remain sovereign over life and death.

Christians are called to alleviate suffering, but not at the expense of human life. The cultural assumption that suffering is an unqualified evil that must be removed at any cost is based on a utilitarian ethic in which (1) the end justifies the means and (2) human happiness is the highest good. Some utilitarians would even consider euthanasia to be morally obligatory if one's self-sacrifice would benefit someone else. This is apparently the thinking behind the question, (p. 11) "Can we ever become such a burden to the community that it has the obligation to let go of us for the common good?" The biblical perspective of suffering is very different from the emerging cultural view. Isaiah 55:8 tells us that what seems good to human beings may not seem good to God, and what appears to us as evil may not be evil.

On p. 47 of the study guide we are asked, "Do you think that euthanasia or assisted suicide can be a faithful decision?" The questions guide the reader to the conclusion that euthanasia and assisted suicide can be a faithful act in certain situations. But, the truth is, Scripture teaches that euthanasia and assisted suicide should never be the Christian response to suffering. There are many reasons why these practices are unacceptable for Christians. (1) Euthanasia and assisted death are contrary to the Word of God, which prohibits the intentional taking of innocent human life (Exodus 20:13; Matthew 5:21; 19:18; Romans 13:9). God, who created us, owns our lives (Psalm 24:1; 1 Corinthians 6:19-20). "In life and in death we belong to God" (Brief Statement of Faith). As Christians, we realize that our freedom is limited by God's sovereignty, and that we cannot rightfully destroy that which is not ours. To act willfully to end one's life is to align oneself with disobedience by embracing an unnatural enemy (death - 1 Corinthians 15:20-26) and undermining the significance of one's life from God's perspective. (2) Euthanasia and assisted death deny God the opportunity to work creatively in the lives of sufferers and rob people of the spiritual fruit that suffering can produce in their lives. It is in our pain that we learn, like Job, that we can trust God even when our circumstances look hopeless. Even Jesus learned obedience from the things he suffered (Hebrews 5:8). Indeed,

suffering could be the most effective means by which God seeks to conform us to the likeness of his Son (Romans 8:29). (3) Euthanasia and assisted death are inconsistent with what people in the Bible perceived to be a good and righteous death. Balaam (Numbers 23:10) and Simeon (Luke 2:26, 29), for example, did nothing to shorten their lives. The deliverance which suffering or dying people sought was not escape through self-destruction, but rather restoration to active life.¹ This yearning to be restored by God is particularly evident in such Psalms as 22 and 88. (4) Euthanasia and assisted death short-circuit human obligation both to God and to one's community. Since our times are in God's hands (Psalm 31:15), deserting one's position in the world by assuming ultimate responsibility for one's life is rebellion against God and an affront to the human community. (5) Euthanasia and assisted death result in a finality in which all options are lost and all future freedom forfeited.² The possibility of a cure no longer exists; neither does the opportunity to be reconciled to God or with people. (6) Euthanasia and assisted death are not the only solutions available to persons who are suffering and dying. A faithful biblical response to those who suffer is never to kill, but always to care. This is possible in a setting such as hospice, where people are made comfortable and their pain is effectively managed. From a biblical perspective, killing a human being in order to alleviate suffering is not an option. The real question is, "How does one live while dying?"

A positive characteristic of the Reformed tradition has been its attempt to transform culture with the Gospel. Although the study material states that this is still the case (p. 43), in reality the Word of God seems to have become subservient to the culture. On p. 45 it is suggested that we "still need time for consensus to emerge both in the church and in society." Presumably the "complexity" of the issue negates Scripture, leaving Christians directionless as they seek to address questions of life and death.

As in the "crevice" statement considered earlier, the "consensus" quote implies either that previous generations have failed to address the issue of killing suffering or helpless people, or that the wisdom of the past is now outmoded. Such reasoning is false. For two thousand years of Western medicine there has been a clear consensus which prohibited the destruction of human life. Although non-Christian in origin, the Hippocratic tradition is in striking agreement with the biblical view of the sacredness of life.³ With regard to the specific question of euthanasia the Hippocratic Oath states, "I will not give poison to anyone though asked to do so, nor will I suggest such a plan."

For Christians who hold orthodox views of Scripture, the plea for new social consensus can have dangerous ramifications. The moral climate in the United States is becoming increasingly pluralistic, cost conscious, and utilitarian. Christians need to be aware that new consensus on the issue of euthanasia and assisted death is likely to blatantly contradict biblical teaching in such vital areas as the sovereignty of God, the nature of humanity and the meaning of the Sixth Commandment.

On p. 5 of the study guide participants are asked to “list the concerns that make our era a new day (or night) in relation to euthanasia, assisted suicide, and end of life issues.” This exercise again suggests that technology has placed us in a new situation which renders traditional wisdom (including Scripture) obsolete. One might ask what exactly it is about current culture that justifies replacing the ethic of life with an ethic of death. The experience of suffering is certainly not new, and the character of God and the nature of humanity have not changed. Throughout many generations people have suffered, yet neither the Church nor ethical medical practice have resorted to euthanasia and assisted death. The Bible has been foundational in upholding the prohibition against the killing of human beings. When pertinent Scripture is presented in the study materials, however, it is sometimes distorted, questioned, or assigned to a position subordinate to culture. The Word of God is

normative and relevant for all people, times, and circumstances. Departure from the biblical standard is certainly not a “new day” in any positive or enlightening sense. Accommodation to the culture at the expense of Scripture is more appropriately defined as a journey into night.

NOTES

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* Editor’s note: “In Life and Death We Belong to God: Euthanasia, Assisted Suicide, and End of Life Issues” A Study Guide by Congregational Ministries Division PC(USA) available through DMS, PDS 70-420-95-100.

Wishing People Dead

by Nancy L. Harvey

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Christine Busalacchi, a Missouri woman suffering from serious brain damage, died on the 8th of March, 1993. The cause of death was starvation. Her case was not a nationally famous one, but it does serve to raise certain disturbing questions—questions that must confront the families of anyone who is helpless and unable to communicate effectively and that will also continue to confront not only medical care givers but judges and law enforcers as well. For Christine’s death followed the deliberate decision of the state’s attorney general to allow those involved in her medical treatment to withhold food and water on the grounds that life support was no longer beneficial to her.

This decision and its outcome stirred a good deal of local protest from people who felt that Christine’s family and doctors had made a dangerous decision—tantamount, at least in the eyes of some, to murder. In answer to this protest, the director of the Center for Health Care Ethics at the St. Louis University Medical Center, a Dominican priest named Kevin O’Rourke, published a piece in the March 19, 1993 *St. Louis Post Dispatch* entitled “When Life Support Doesn’t Help.”

In this piece Father O’Rourke examines what he calls the “assumptions” of the protesters, and in the course of doing

so reveals certain assumptions of his own, assumptions that are important, not because they are his, but because they lie at the heart of the whole debate about life support for the helpless.

Father O’Rourke’s first assumption, and the basis of all the others, is that a severely brain-damaged person is better off dead. He does not, of course, put the case quite so bluntly. He writes, “No benefit to the patient results if mere physiological function is prolonged. Does it help people to continue their physiological function . . . if they will never regain the ability to think, talk, love, or relate to other people?”

Now, there may be no question when such words are used to apply to a person who is brain-dead. Medical science simply cannot resurrect dead tissue. But, as it happened, Christine was not brain-dead. And living brain cells can learn some of the tasks that the dead cells once performed. The first question, then, is whether brain-damaged people should be treated as if they were brain-dead. This is where the term Persistent Vegetative State comes in. A person in PVS is supposedly someone whose cerebral cortex does not function, and who consequently feels neither pleasure nor pain. Even if it should appear that such a person is responding, such responses are purely random.

Father O’Rourke is convinced that Christine was in PVS because the doctors said so. At least six board-certified

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neurospecialists made this diagnosis, basing their opinions on “PET scans” and “thorough clinical studies.” But several of her long-term caretakers, including at least one doctor, testified in court that she was not in PVS, basing their opinion on observations extending over months or even years. Since brain cells can learn other tasks, it is possible that a severely brain-damaged person like Christine could regain at least some ability to feel pleasure and pain, and to relate to other people. But obviously, only long-term observation could answer such a question. Only those who were in close daily contact with Christine could watch her responses to see if they were meaningful. Those who had actually been taking care of her did watch her and did notice that certain responses kept recurring in the same situations. They concluded that the responses had meaning. If, for example, she smiled at jokes, they concluded that she was responding meaningfully, perhaps to the joke, perhaps to the caretaker’s tone of voice or smile. Had she smiled at jokes, and at sad stories, and at the stock market report, it would have been reasonable to conclude that her smiles were random. Her long-term caretakers testified that she felt pleasure and pain, that she responded to music, and that she did, indeed, smile at jokes.

Why was such testimony ignored by the legal and medical authorities? It would not have been ignored in a court of law. If PVS were a crime, Christine would still be alive, for there would be far too much reasonable doubt to allow a guilty verdict, let alone a death sentence. It is hard not to think that some people did not care whether Christine was in PVS or only had a very limited ability to respond.

Father O’Rourke, like most of us, assumes that doctors know best. But medical science has its limits. A doctor can use a scan to see which areas of the brain are badly damaged, and he knows what functions go with which areas. But without long-term observation he cannot tell if brain cells are relearning other tasks. Furthermore, he cannot assume that a brain-damaged person will respond to a strange doctor in the same way that she would respond to a familiar caretaker. Perhaps she did not respond when the doctor called her name, but this does not mean that she was unable to respond. We understand this point better when we are dealing with those whose cerebral cortexes are not yet fully developed. We know that a baby may choose to smile at Mama and not at us. We have all met a two-year-old who counts to ten for Grandma, but not for us. No scan or clinical study can measure a person’s willingness to respond.

And what of the quality of the response? How much ability to “think, love, talk, or relate to other people” must there be before a brain-damaged person’s life will be legally protected? To whom must this ability be demonstrated? Who will establish the criteria? What will these criteria be? Father O’Rourke does not say, but he is perfectly prepared to speak of the need to assess the economic and psychic burdens on the family and society represented by helpless people.

There are certainly plenty of burdens out there to assess. All of us are helpless burdens when we are very young. Some of us will be burdens when we grow old. Cancer and AIDS

can turn us into burdens at any age. And those with physical disabilities are not the only burdens. In an economic sense, everyone in prison or on welfare is a burden. Is it wise to allow those who are burdened to dispose of those who burden them? Should individual families have the right to define “beneficial” and “burdensome” however they please, so that one brain-damaged daughter gets food and water while another gets the “benefit” of death by dehydration?

But Father O’Rourke does not think this case will set a precedent. He finds such reasoning misleading “because it fails to recognize the vital ethical issue: Life support may be withdrawn only if it is ineffective or extremely burdensome. We must distinguish between life support that is beneficial for a person and life support that is not beneficial.” He says that the family that withdraws food and water does not necessarily intend to kill the patient, but only to “stop doing things that are ineffective or futile.”

Now the words “ineffective,” “futile,” or “burdensome” have a certain medical meaning. A treatment is futile or ineffective if it does not cure or arrest the problem. No one will say that antibiotics are futile if they are killing the staph germs. That is their job. No one will say that radiation therapy is futile if it is shrinking the cancer. Such treatments can be considered burdensome if they cause more problems than they solve—the antibiotics are destroying the patient’s kidneys, or the radiation is causing pancreatitis. In such cases the patient may have to stop treatment. But to my knowledge, these are the only instances in which medical therapy is considered ineffective, futile, or burdensome—either it is not stopping the disease, or it is causing life-threatening side effects or extreme suffering.

Were these things happening with Christine? Were her food and water failing to arrest a disease or causing her serious side effects or extreme suffering? On the contrary, her food and water were giving her the only benefit they have to offer. They were keeping her alive in a fairly comfortable, healthy state. This is all food and water can do for anybody; they do not cure brain damage. How, then, could Christine’s food and water be considered “futile,” “ineffective,” “excessively burdensome,” and “not beneficial”? We do not stop radiation therapy for a cancer patient because it doesn’t cure her arthritis, and we do not stop administering antibiotics because the patient still has cataracts. We do not call a treatment ineffective or futile if it does not cure something it was never supposed to cure.

Why is all this stood on its head when the patient in question is severely brain-damaged? Why were the meanings of “beneficial” and “not beneficial” reversed for Christine so that keeping her alive was “not beneficial” and giving her food and water was “futile” and “burdensome”? True, the chances were slim that Christine’s condition would improve, but no one (yet) suggests that it is acceptable to withhold food and water from quadriplegics, though their chances of recovering are about as likely as Christine’s were. No one says that food and water are “futile” for people with muscular dystrophy or multiple sclerosis. Some of these people cannot feed themselves, and

food and water will not cure them. But since they are mentally alert, there is no movement to consider their food and water futile and withdraw them.

But such examples do not mean that no one else is in danger. The brain-damaged are not the only people who cannot “think, love, talk, or relate to other people.” There are autistic children. Stroke victims. People with Alzheimer’s. And my Aunt Helen. She was an elderly woman, single, no children or husband, living on social security disability. She had some health problems, but she was able to care for herself until about ten years ago, when she became so confused that she had to be hospitalized. Severe Alzheimer’s was the diagnosis. She refused to eat because she was afraid of poison. A nose tube was used until her throat became raw. Then doctors told us that they could put in a stomach tube, although they seemed reluctant to do so. Or they could do nothing, and we were told that in three or four days it would all be over. Helen was able to feel pain and had some ability to talk and relate to other people. But her ability to think rationally was not there. Obviously, her doctors had enlarged Father O’Rourke’s criteria. We could have chosen to let a confused elderly woman die of thirst. We did not. We demanded that her medications be carefully evaluated. Some were stopped and some were changed. The confusion cleared up and my aunt was again able to feed herself. It’s hard to believe that Aunt Helen was the only person with Alzheimer’s ever to have her food and water considered “not beneficial” by doctors.

We can see the same thing happening when surgery that would not be questioned for a normal newborn has suddenly become “not beneficial” for a Down’s Syndrome child. Of course, in such cases as Christine’s and Aunt Helen’s, we try to fool our consciences by saying that we are merely stopping treatment and that it is the “underlying pathology the life support has been circumventing” that really kills the patient. However, Alzheimer’s and severe brain damage do not affect the digestive system. They merely render the patient helpless. If I take away milk from a baby, does it die because it has an underdeveloped neuro-muscular-skeletal system? I myself happen to be living on artificial life support and I know the difference between food and water and “medical therapy.” There is a medical difference, and although Father O’Rourke says not, there is an ethical difference as well.

“Medical therapy” is something added. Something that a normal, healthy person does not need. And medical therapy is not neutral. If given unnecessarily, it will upset a person’s normal functioning. This upset may be quite mild, as it would be if we were to treat a normal person for shock. Or it could be fatal, as it would be if we gave a normal person injections of insulin.

My artificial life support which is necessary to treat short bowel syndrome, would damage a normal person, since it bypasses the digestive system entirely. If the person continued to eat, he would become obese; if he stopped eating, he would be at risk for bile duct obstruction. My life support, parenteral nutrition, allows dextrose, amino acids, and electrolytes to go directly into the bloodstream. But Christine’s and Aunt Helen’s food and water went directly

to the stomach and were digested. In neither case was there an “underlying pathology” that was preventing the digestive system from working. And while it is true that a stomach tube is not a natural method of delivering food, it is not in the same category as parenteral nutrition. To make such a comparison would be like comparing a patient who has a urinary catheter to one on kidney dialysis. The stomach tube and the catheter help the body to perform its natural functions—they do not replace major organs. Since I have no intestine to speak of, food and water are indeed futile for me. No matter how much I eat and drink I cannot keep myself alive. This was not the case with Christine. Food and water were beneficial for her, but only if we consider that her life was still a benefit.

Calling food and water medical treatment eases the consciences of those who request and those who decree that they can be turned off. After all, if a cancer patient elects to stop treatment, we are not murderers if we decide to let him do so, since the treatment being stopped is either causing intense suffering or failing to arrest the disease. But Christine was not suffering from any disease. How, then, could food and water be considered a cure? Everyone needs food and water, but only sick or injured people need treatment—and as we know, some of these do survive without treatment. But no one has ever been able to break the body’s absolute need for food and water. The only result of withdrawing them is death, always and everywhere, with no exceptions. Father O’Rourke says that family members do “not necessarily intend to kill the patient” when they withdraw food and water. This is confusing desire with motive. If a person is brain-dead, most of us do not want him to linger on and on. Some of us are glad when AIDS or cancer patients who have gone through months or years of pain die. We feel great loss, but we are not ashamed to say that we are glad that the suffering is over.

Therefore we can understand Father O’Rourke, and others who honestly believed that Christine was no different from a brain-dead person, desiring her death. The thought of a mere body, living with no awareness of its surroundings, no ability to exchange a smile with another person, no ability to enjoy the feeling of clean sheets on a bed—it does not seem wrong to wish such a person dead, set free from the broken body that stubbornly refuses even to get sick. But to deny that this is what we want when we take away the food and water is merely self-delusion. There is no other reason to take away a healthy but helpless person’s food and water. There is no other possible outcome. Such denial is like pouring water on someone while saying we don’t intend for him to be wet. We may have good reasons for drenching him—his clothes were on fire, he was starting to faint, or perhaps he was dirty. But whatever our reason for doing it, he must be wet in order to receive the benefit, and we are not afraid to say that we intend for him to be very wet indeed.

What benefit does a person like Christine receive from death? We don’t know. We cannot contrast the limited life she had here with some “benefit” in her life hereafter, because we know nothing about it. Her body is now rotting;

this is the only “benefit” which we know for certain that death has given her.

Father O’Rourke says that allowing her this “benefit” is not opposed to Catholic doctrine. Catholic doctrine admits life after death, and purgatory too, along with eternal torment for those who have not pleased God. There is, however, no hint (I would like to be corrected if I am wrong) either in Scripture or Church tradition that death is such a good thing that we may allow those who are burdensome to us to die so that they can go on and be happy in heaven—this despite the fact that there were many more such “burdens” in the world back when the New Testament was being recorded and throughout the centuries as Church doctrine developed. Perhaps we have forgotten just how much human wreckage there was, burdening families and society. More children were born brain-damaged because there were almost no Caesarians. A simple cut could cause a brain-damaging staph infection. Those who succumbed to smallpox, diphtheria, tetanus, scarlet fever, and other such diseases didn’t all die. Many of them lived on as cripples—brain-damaged, disfigured, or both. We seem to have forgotten what back-breaking work was needed to care for a helpless person when everything had to be washed by hand, when water had to be carried from a well, when an invalid’s food had to be prepared completely from scratch and spoon-fed.

Yet the Church championed those who were burdens and ministered to them, considering that in caring for the helpless, one was really caring for Christ Himself.

It is evident that to Father O’Rourke, and to those who agreed with the decision to let her starve, Christine did not have this value. To them, her life was useless. The simple pleasures that she could and did enjoy—ice cream, music, a trip outside in a wheelchair—were not enough, not deserving of legal protection or even the benefit of the doubt. Therefore her food and water were taken away, forever ending the possibility that improvement might be observed or that medical science might discover ways to help her. Is it “beneficial” to a society that wants to preserve individual liberty that people’s lives should depend on how burdensome or beneficial they are? “Burden” and “benefit” can be defined in many different ways, and will vary from family to family and from doctor to doctor. Even medical ethicists disagree with each other. Ultimately, these definitions depend on one’s deepest beliefs about the nature of God and man. There is the potential for terrible cruelty and injustice if a person’s life hangs on the definition of a word. Such a thing is far too frail to bear the weight of something that cannot be replaced.

‘Dignity, always dignity’

by Frederica Mathewes-Green

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When Oregon passed “Measure 16” last November, it became the first state in the nation to give doctors permission to prescribe poisonous drugs in order to kill dying patients. According to the National Conference of Catholic Bishops, Oregon is “the first jurisdiction in the world to legalize assisted suicide by popular vote.” Oregon was a well-chosen test site; it has the lowest church attendance in the nation, and pro-euthanasia messages played on bias against the pro-life Catholic leadership (it’s been said that “Anti-Catholicism is the anti-Semitism of the elite class”).

The lines don’t split precisely between Christians and non-believers, however. Many Christians feel an innate revulsion for legalized killing of the sick, but some do not. A recent letter in our Mailbag column proclaimed, “Thank God for Dr. Kevorkian.” It’s human nature to feel panic at the thought of dying in misery, and to long to circumvent the possibility.

There are really two concerns here. One is the awful specter of dying out-of-control, of ending one’s days voiceless, in a humiliating tableau of tubes and soiled sheets. No one

wants to go through such embarrassment. We want to die with dignity.

The other fear is of dying in someone else’s control, of missing God’s timing and ending up a cadaver irrigated by pumps, while loved ones battle a faceless bureaucracy. This is a reasonable desire for a natural death, much like a pregnant woman’s desire for a natural birth. The difficulty is that the horror stories often begin with a gamble that intervention would bring healing, and only if one could predict the future would these decisions be easy. In these tough situations it’s ethical to either accept or refuse treatment, but not to refuse care: basic food and water. Nor is it right to kill swiftly rather than take a chance on “undignified” death.

The more I thought about these fears, the more the word “dignity” began to grate. A few years ago, Brown University professor Felicia Ackerman published an essay titled “No thanks, I Don’t Want to Die with Dignity.” In it Ms. Ackerman questioned several popular “lines” about death, finding in the noble protestations (e.g., “I fear being a burden to my loved ones”) a subtle pressure on the dying

to, well, lie down and die. She concludes, “The notion that terminally ill people should be . . . ready to bow out gracefully as soon as they become burdensome, hardly serves their interests. It serves the interests of those who want sick people to be as little trouble and expense as possible.”

About the D word she says, “Personally, I’ve always considered dignified people stuffed shirts. So I can’t help doubting that a fatal illness would suddenly make me find dignity more precious than life.”

A Christian worldview can build on this perception. Where indeed did we get the idea that dignity is better than life? Were we ever promised in Scripture that we can die, or do anything else, with dignity? Is God so mindful of our pride?

Clinging to rags of dignity can make us look more absurd. In “Singin’ in the Rain,” Gene Kelly intones grandly, “I’ve had one motto which I’ve always lived by: ‘Dignity, always dignity.’” While his character recounts the fictitious story of a noble career in fine theater, the viewer sees reality: Kelly in a checked suit, strumming a ukulele and taking pratfalls. The joke’s on him: Behind the posturing, he’s not dignified at all.

In the Lord’s plan, the joke could be on us. How dignified did Ezekiel look eating a scroll? Was Hosea’s dignity

enhanced by being wed to a prostitute? A friend once contrasted his current trials with that of a different prophet: “Well, the Lord made Isaiah go naked for three years. I’m grateful at least that he hasn’t made me do that.” “Believe me,” I agreed, “A lot of us are grateful.”

We want our deaths to be free from pain, mess, embarrassment. But there is a long Christian tradition of “holy death,” that is, of allowing even a hard death to be a witness to God’s grace. We’re nowhere invited to ring down the curtain early to preserve our pride. How dignified did Jesus look on the way to the cross? Spattered with blood and spit, despised and rejected, he carried his own instrument of torture up a hill. Was this a death with dignity?

Ironically, it was. The Latin root for *dignity* is *dignus*, which means worthy. The most worthy death in history was shorn of all dignity. Yet it was the death that transformed death, changing it from a wall to a door.

It hardly matters whether we cross that door with stately serenity, or get shoved through in a buffoonish pratfall. There are many things more to be feared in life — sin, for example — than a foolish death. Getting through that door is the thing; we do so trusting in his *dignus*, not our own.

Bioethics: A Primer for Christians **“Suicide and Euthanasia”**

by Gilbert Meilaender

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Here is a recent story from the newspaper.¹ A man named George Delury helped his wife of twenty-two years, Myrna Lebov, to commit suicide. Ms. Lebov was suffering from multiple sclerosis and near the end of her life was able only to wash her face and hands, feed herself if the food had already been cut, apply her makeup, and brush her teeth. In addition, her memory had begun to be affected. When she asked her husband if he would help her end her life, he reports that “I said, of course I’d help. I also said in effect that I was astonished she’d fought so hard and so long to keep going. I would have quit a lot sooner.”

He learned that one of the medications his wife was taking could prove fatal if taken in a sufficiently large dose, so over several months she cut back on her dosage, saving

enough of the medicine to kill herself. Then on Independence Day they shared their traditional celebrative meal of chicken and wine, and he diluted the pills to provide a drinkable mixture. She drank it and was dead the next morning.

“The primary project in her life was to be independent,” Mr. Delury said, and so she exercised that independence one last time on July 4. He, for his part, hopes to write a book about death and, especially, about what he calls the “considerate hero” — an elderly person, for example, “who, facing serious illness, says, ‘this money would be better spent elsewhere.’”

Here, in short, is the story of a woman whose suffering evokes our sympathy—and also our fears, since we are uncertain what we would do in her circumstances. She is a woman whose “primary project” in life is to be

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independent, a project that surely calls for scrutiny, however great our sympathy for her. And her story, at least as told by her husband, invites us to consider whether we might be obligated to act “heroically” at some point in the future, ending our life in order to save resources that could be better spent on others. This is the sort of case that today makes news, and it turns our attention to two considerations—autonomy and suffering.

Christians have held that suicide is morally wrong because they have seen in it a contradiction of our nature as creatures, an unwillingness to receive life moment by moment from the hand of God without ever regarding it as simply “our” possession. We might think of ourselves as characters in a story of which God is the author. Dorothy L. Sayers ingeniously developed this analogy of artistic creation in *The Mind of the Maker*. Of the “work” produced by the artist Sayers writes:

For the satisfaction of its will to life it depends utterly upon the sustained and perpetually renewed will to creation of its maker. The work can live and grow on the sole condition of the maker’s untiring energy; to satisfy its will to die, he has only to stop working. In him it lives and moves and has its being, and it may say to him with literal truth, “Thou art my life, if thou withdraw, I die.” If the unselfconscious creature could be moved to worship, its thanks and praise would be due, not so much for any incidents of its structure, but primarily for its being and identity.²

Characters in a story do, of course, have a real, if limited, freedom, and a good author will not simply compel them to do what is contrary to the nature he himself has given them. But at the same time characters do not determine the plot of their life’s story, and it is a contradiction of their very being if they attempt to bring the story to its conclusion. We are dependent beings, and to think otherwise—to make independence our project, however sincerely—is to live a lie, to fly in the face of reality.

Thus, suicide as a rational project expresses a desire to be only free and not also finite—a desire to be more like Creator than creature. Of course, suicide may often result from depression or other emotional illness. In such cases it is not a rational undertaking, and we do not regard a person in such a state as a responsible agent. But there is no reason to deny that suicide can sometimes be undertaken by those who are not emotionally ill and who are responsible for their actions. Such suicide has about it a Promethean quality, a rejection of our status as creatures. Precisely because this is true, it is important to state that, contrary to what Christians have often believed, such rational suicide does not necessarily damn one. The suicide dies, so to speak, in the moment of sinning, without opportunity to repent. But then, so may I be killed instantly in a car accident while plotting revenge against an enemy of mine. God judges persons, not individual deeds, and the moment in one’s life when a sinful deed occurs does not determine one’s fate. Even if I try to reject God and keep the light of his presence from my life, there is no guarantee that my creaturely action will be able to overcome his authorial ingenuity. Thus the psalmist writes:

Whither shall I go from thy Spirit?
Or whither shall I flee from thy presence?
If I ascend to heaven, thou art there!
If I make my bed in Sheol, thou are there!
If I take the wings of the morning
and dwell in the uttermost parts of the sea,
even there thy hand shall lead me,
and thy right hand shall hold me.
If I say, “Let only darkness cover me,
and the light about me be night,”
even the darkness is not dark to thee,
the night is bright as the day;
for darkness is as light with thee. (Ps. 139:7-12)

Ultimate judgments about the person are not therefore ours to make, and we can condemn the act of suicide without claiming to render such a verdict.

What should be clear, though, is that Christians do not approach this issue by first thinking in terms of a “right to life” or a “right to die with dignity.” That is to say, we do not start with the language of independence. Within the story of my life I have the relative freedom of a creature, but it is not simply “my” life to do with as I please. I am free to end it, of course, but not free to do so without risking something as important to my nature as freedom: namely, the sense of myself as one who always exists in relation to God.

For a society as much in love with individual autonomy as ours, this view may seem not only objectionable but also peculiar—and peculiarly religious. As such it will seem to be simply a quirky view held for private reasons by some people, but hardly a view that could have any public standing. We have taken autonomy so much for granted, have accepted it so much as the natural state of affairs, that we have lost our ability to question it or to see that—every bit as much as religion—it also presupposes a metaphysic and a view of human nature. When, in December 1964, an official of the Cuban revolutionary government named Augusto Martinez Sanchez committed suicide, Fidel Castro issued the following statement:

We are deeply sorry for this event, although in accordance with elemental revolutionary principles, we believe this conduct by a revolutionary is unjustifiable and improper. . . . We believe that Comrade Martinez could not consciously have committed this act, since every revolutionary knows that he does not have the right to deprive his cause of a life that does not belong to him, and that he can only sacrifice against an enemy.³

To take an illustration much closer to home, one of my students once described her cousin’s suicide and its continuing effects on his family by saying: “He didn’t just take his own life; he took part of theirs too.” Such examples from the political and familial spheres suggest how deceptive the language of autonomy may be. We do not have to approve Castro’s political aims to recognize that the lives of fellow citizens may be bound together in such a way that all are aggrieved by the death of one. And the familial example reminds us that our identity is not an individual achievement but is socially formed from the very

beginning. Christians simply extend that sociality of the self—believing that we exist always in relation to God, the author of our being who has authority over us. Not all will share that belief, of course, but there is nothing peculiar or unfamiliar about such an understanding of the self. It explains why we do not think our lives are our own, why we believe suicide to be morally wrong.

If my life is not simply my possession to dispose of as I see fit, as if the God-relation did not exist, the same is true of the lives of others. I have no authority to act as if I exercised lordship over another's life, and another has no authority to make me lord over his life and death. Hence, Christians should not request or cooperate in either assisted suicide or euthanasia.

In a chapter written a quarter century ago that remains to this day a classic discussion of the issues, Paul Ramsey sought to articulate an ethic of "(only) caring for the dying."⁴ Such an ethic, he suggested, would reject two opposite extremes: refusing to acknowledge death by continuing the struggle against it when that struggle is useless, or aiming to hasten the coming of death. Neither of these can count as *care* for one of our fellow human beings; each is a form of abandonment. We should always try to care for the dying person, but we should *only* care. To try to do more by seizing either of the extremes is always to give something other or less than care. In the next chapter we will look closely at the problem of treatment refusals, of determining when it is permissible to cease the struggle against illness and death. In this chapter we concentrate on the temptation to hasten the coming of death.

Why might we be tempted to ask for or to offer euthanasia? One of the reasons has already been suggested in the discussion of suicide: our commitment to autonomy or self-determination. I am tempted to believe that my life is my own to do with as I please—and tempted to believe that another's life is her own to do with as she pleases. A second reason, equally powerful and tempting, is our desire to bring relief to those who suffer greatly. The argument for euthanasia rests chiefly on these two points, taken either singly or together.

Usually in the public debates of our society these two reasons are presented as a package, as if they must be taken together. For the present, that is, advocates of euthanasia (or, as it is sometimes termed, assistance in dying) have tended to argue that it should be permitted only if the person euthanized both was suffering greatly and (while competent) had requested such assistance. One suspects, however, that this is a purely strategic maneuver aimed at keeping the argument for the time being a relatively narrow one. Whatever our judgment of motives, however, the fact is that, simply as a matter of logic, the two prongs of the argument will gradually become independent of each other.⁵

If self-determination is truly so significant that we have a right to help in ending our life, then how can we insist that such help can rightly be offered only to those who are suffering greatly? Others who are not suffering may still find life meaningless, the game not worth the candle. They,

too, are autonomous, and, if autonomy is as important as the argument claims it is, then their autonomous requests for euthanasia should also be honored, even if they are not suffering greatly. Similarly, if the suffering of others makes so powerful a claim upon us that we should kill them to bring it to an end, it is hard to believe that we ought to restrict such merciful relief only to those who are self-determining, who are competent to request it. Surely, fully autonomous people are not the only human beings who can suffer greatly. Thus, from both directions, from each prong of the argument, there will be pressure to expand the class of candidates for euthanasia. Those who suffer greatly but cannot request relief and those who request help even though their suffering is not great will begin to seem more suitable candidates. That is in fact the logic of the argument currently being played out in our public policy disputes.

Whatever the outcome of arguments in the public sphere, of course, Christians must form their own views. If assisted suicide and euthanasia continue to become increasingly accepted, we must dissent from that attitude. For neither prong of the argument in support of euthanasia grows out of Christian conviction. The autonomy argument has already been taken up in this chapter's discussion of suicide, where we noted its questionably individualistic understanding of the human person, but that does not exhaust the argument's difficulties. For Christians, each person's life is a divine gift and trust, taken up into God's own eternal life in Jesus, to be guarded and respected in others and in oneself. However, because we are inclined to overemphasize our freedom and forget the limits of our finite condition, inclined to forget that life comes to us as a gift, death becomes the great reminder of those limits. In *The Death of Ivan Ilyich* Tolstoy powerfully captures Ilyich's surprise that he—and not just others—should come up against this limit, that his own existence should be included in the truth that all men are mortal. But try as we may to forget it, death *is* the starkest reminder of our limits. It is therefore a peculiar moment at which to attempt to seize ultimate control of our life and pretend that we are independent self creators. That is simply one last way of living a lie.

Moreover, euthanasia is not simply an extension of personal autonomy; it is not simply "nonintervention" in another person's private choice. On the contrary, because it requires the participation of at least one other person, it becomes a communal act involving the larger society and giving its approval to an act of abandonment. If it becomes a permissible and acceptable practice, have our freedom and independence been enhanced? In one sense no doubt they have, since we are given a new option, the option to die when we wish. But it is also true that the pressure will build to exercise this option, to be the "considerate hero" who does not stay alive too long using resources that might better be spent elsewhere. If and when euthanasia receives social approval, what looks like more freedom is likely to turn out to be less. In short, there are good reasons not to acquiesce in the autonomy argument.

Christians are, I suspect, more likely to be drawn to the argument that describes euthanasia as compassionate relief of suffering. And, to be sure, we all know the fear of suffering and the frustration of being unable to relieve it

fully in those whom we love. The principle that governs Christian compassion, however, is not “minimize suffering.” It is “maximize care.” Were our goal only to minimize suffering, no doubt we could sometimes achieve it by eliminating *sufferers*. But then we refuse to understand suffering as a significant part of human life that can have meaning or purpose. We should not, of course, pretend that suffering in itself is a good thing, nor should we put forward claims about the benefits others can reap from their suffering. Jesus in Gethsemane—who shrinks from the suffering to come but accepts it as part of his calling and obedience—should be our model here. The suffering that comes is an evil, but the God who in Jesus has not abandoned us in that suffering can bring good from it for us as for Jesus. We are called simply to live out our personal histories—the stories of which God is author—as faithfully as we can.

Our task is therefore not to abandon those who suffer but to “maximize care” for them as they live out their own life’s story. We ought “always to care, never to kill.”⁶ And it has, in fact, been precisely our deep commitment not to abandon those who suffer that has, in large measure, been a powerful motive force in the development of modern medicine. Our continued task is not to eliminate sufferers but to find better ways of dealing with their suffering. If we cannot always fully relieve the suffering, when we cannot relieve it, we must remember that even God does not really “solve” or take away the problem of suffering; rather, God himself lives that problem and bears it. His way is steadfast love *through* suffering, and it is the mystery of God’s own being and power that this truly proves to be the way to maximize care for all who suffer.

Christian physicians will have their own special reasons as physicians to refuse involvement in the practice of euthanasia. They have found in medicine what we all seek—work that can truly be understood as a calling. Knowing themselves to be whole only by the grace of God, they can seek to impart a small measure of wholeness—healing and health—to their patients. For several millennia the tradition of Western medicine has followed the Hippocratic Oath’s injunction not to “give a deadly drug to anybody if asked for it, nor . . . make a suggestion to this

effect.” But physicians swim daily in a sea of human suffering, and they may be especially tempted, when all else has failed, to eliminate suffering by eliminating the sufferer. Christian physicians, who understand their life as a response to the grace God has extended to them in their perishing condition, should, in William F. May’s words, be set free “from the need to avoid ties to the perishing.”⁷

It should therefore become part of their calling—at least in this time and place—to bear witness to all of us that suffering and death “are *real* but not *ultimate*; [and that] they do not speak the last word about the human condition.”⁸ Good physicians will know the limits of their art, and they can help us avoid the notion that there is any ultimate “technological fix” for the fundamental human problems of suffering and death. This means, we should note, that for physicians as well as the rest of us there are limits to what we should do in our attempts to relieve suffering. A willingness to discern such limits as best we can—and, having discerned them, to act in accord with them—is deeply embedded in the Christian understanding of the moral life. Understanding compassion and care in this way, we seek to learn to stand with and beside those who suffer—with them as an equal, not as a lord over life and death, but determined not to abandon them as they live out their personal histories up against that limit of death which we all share. For us, therefore, the governing imperative should be, not “minimize suffering,” but “maximize care.”

NOTES

1. Carey Goldberg, “A Meal, a Bitter Potion, A Major Test of a Law,” *The New York Times*, 6 July 1995, p. A1.
2. Dorothy L. Sayers, *The Mind of the Maker* (1941; New York: Harper & Row, 1979), pp. 141-142.
3. Cited in Michael Walzer, *Obligations* (New York: Simon & Schuster, 1970), p. 172.
4. See chapter three of Paul Ramsey, *The Patient as Person* (New Haven and London: Yale University Press, 1970).
5. This argument has been pressed forcefully by Daniel Callahan in a number of places. See especially chapter three of *The Troubled Dream of Life* (New York: Simon & Schuster, 1993).
6. See “Always to Care, Never to Kill: A Declaration on Euthanasia,” *First Things*, February 1992, pp. 45-47.
7. William F. May, *The Physician’s Covenant* (Philadelphia: Westminster Press, 1983), p. 127.
8. May, *The Physician’s Covenant*, p. 127.

AN OUTSTANDING RESOURCE IN THE BATTLE AGAINST ASSISTED SUICIDE: The Christian Medical and Dental Society has available a “Battle for Life” kit put together by Christian doctors. The kit includes a video, leader’s guide and discussion questions, overhead transparencies, biblical principles, and research synopsis. To order a copy write to Christian Medical and Dental Society, P.O. Box 5, Bristol, TN 37621, (423) 844-1000.

Bible Study of the Gospel of Mark

CHAPTER 14

of THE GOSPEL OF MARK

(chapter 15 will follow in the next issue)

Observe the text to understand the author’s meaning:

Read 14:1-2. Read Exodus 12:1-14, 21-30 concerning the Passover. What was the sacrifice? How were the people saved? In Mark 14:1-2, who will perform the sacrifice? Who is to be the sacrifice.

Read 14:3-9. Whose home is Jesus at? How much was the perfume worth? What does Jesus say the act means?

What is the complaint of the disciples? What is Jesus answer? Why is Jesus answer appropriate in light of the fact that he is the incarnate God? Can Jesus provide resources for the poor? Can Jesus provide tenfold back to the woman for her generous gift? If Jesus were not divine, would this answer have been adequate? Do you see her act as a morose, depressing act--to prepare a living person for burial? Or is it worship? --recognizing the truth of Jesus teachings--that he will lay down his life just as he said he would, but that he would be raised up and victorious. Discuss.

Read 14:10-11. Judas has another way of raising money, what is it? Read Luke 23:3-6. Mark has been a story of “insiders” treatment of Jesus: religious leaders and disciples. Here Jesus’ betrayal is from among his own disciples in league with the religious leaders.

Jesus chose Judas as a disciple, want to speculate on why Jesus chose one who would betray him? Did he not know Judas would betray him? Was there another purpose in picking him?

Read 14:12-16. Who is in charge as the location of the passover is selected? Do you see the secrecy as a way of protecting their time together since they know the chief priests are looking for Jesus to kill him?

Is Jesus at the mercy of circumstances or is Jesus in control of the events? Notice again that Jesus fulfills God’s law--the perpetual ordinance God gave, regarding the passover.

Read 14:17-21. Again, who is on control of the events? Is Jesus taken by surprise? Or as a prophet does he foretell the future? Jesus prophesied that he would be betrayed by one of the twelve and then warns of the judgment that comes when one betrays Jesus. By not naming Judas how do the twelve respond?

Was this an opportunity for Judas to repent? Does he? Perhaps Jesus does not name Judas so that we can see we too are capable of betrayal. At the moment they are ratifying the covenant, Judas is ready to betray Jesus to have him killed and Peter will soon also deny him.

Read 14:22-25. Read Ex 24:1-11. This is the ratification of the covenant on Mt. Sinai. In Mark the covenant is ratified again, this time with the blood of the Lamb. The passover continues as God commanded but now it is celebrated in its fullness in the Lord’s Supper as Jesus commanded. Each of us personally ratifies the covenant each time we partake of the blood of the covenant. We not only “remember” our redemption as the passover was a reminder of the Israelites’ redemption, but we ratify the covenant, and eat with God.

Read 14:26-31. Again, are the events chaotic and out of control or is Jesus clearly in charge? What does Jesus prophesy will happen to him? and the disciples? The chief priest wanted to wait until the Passover was over so

as not to incite the crowds (vs1) but when does the crucifixion take place? Who is in control of events? Is Peter in control even of himself?

Jesus speaks the truth and Peter denies it. But Peter will come to see who speaks and knows the truth.

Who is Jesus saying will strike down the shepherd? What will happen to the sheep? Read Zechariah 13:1-9. Does this scattering have a purpose? Look back at Zechariah 9:9-12, 16. Notice that Jesus foretells that after he is struck down, he will be raised up and go before them....Not only will he be raised but he will continue as their leader by going before them. Is this reminiscent of another OT event where there was scattering of the people? Was that also in judgment?

Read 14: 32-42. How many times in 13:33-37 does Jesus tell the disciples to stay on the alert? How many times does he find them sleeping?

Can you explain Jesus’ suffering in light of his being fully divine, fully human? Did Christ rebel against his call? Was he emotionally tempted? Was his will and obedience firm in doing God’s will?

Read 14:43-52. Who is it that comes after Jesus? Notice the word “betrays” is used three times in vs 41,42,44. This is an “inside job.” One of the chief priests served each year as high priest and entered the “holy of holies” in the temple--God’s throne room. The scribes teach the law and the elders are the religious leaders of the people.

Who is in control? What verse in particular shows this?

Earlier Jesus had gone to the temple and said the chief priests and scribes had turned it into a robbers den. Now what does Jesus suggest they think of him?

How many people had come to get Jesus? What does one of the disciples do? Was this an act of courage? What does Jesus say that causes the disciples to flee? On the one hand the multitude comes with swords and clubs against 12 men. The disciples and Jesus seem greatly outnumbered by evil. Yet, if Jesus is divine and can call down a heavenly army, then we see their swords and clubs as totally inadequate against God and his power.

Read 14: 53-65. Does this seem like a fair trial? Why not? Read Deu 17:1-7. If they suspected someone of worshipping idols what were the chief priests to do?

In the Mark text the word “testimony” is used 5 times. Do they have two witnesses who give testimony? In fact what do they find? Who finally says that he is the Son of the Blessed One? What should the response of the chief priests have been to this one who claimed to be God and who had fulfilled the Scriptures(vs49)?

What is the crime that Jesus is accused of? Where does that law come from? See also Lev 24:16. What is one of the things they expect from one who claims to be the

Messiah, according to verse 65? Has Jesus done this? In fact wasn't Jesus doing this in vs 62? Do you see a blindness in the chief priests and elders? Discuss.

Notice that Jesus says, he will sit at the right hand of power and in fulfillment of Daniel, come with the clouds of heaven, yet the man who stands before them is beaten, alone, powerless, spit on. What we see, is not what God sees. "What we see is not what we get."

Notice that "high priest" is mentioned 6 times in this section. This is a confrontation between the "high priest" and The High Priest! Who is the true high priest? How do we know? Can you discuss this in terms of fruits.

Read 14:66-72. The chief priests and elders just mocked Jesus saying if he was the son of God he would prophesy. As they mock him, his prophecy of Peter is being fulfilled.

Peter had given a loud, sure rebuttal to Jesus earlier that he would not deny Christ. Who is it that now confronts Peter and causes him to deny Christ? Soldiers? chief priests? Pilate? Who? Do you see an escalation in Peter's denials? When confronted with his denial of Jesus, what does Peter do? When the chief priests were confronted with their denial of Jesus, what do they do?

Interpret the Text:

1. Who is in charge in this chapter as has been the case throughout the whole gospel of Mark? What comfort and hope does that give us? What does it say about the

meaningfulness of our lives? Are our lives out of control and meaningless?

2. What is the relationship between evil and good? Is evil more powerful? How does it serve God's purposes?

3. What is the difference between the disciples on the one hand and the chief priests, scribes, elders on the other? How does each respond to Jesus?

BIBLE STUDY NOTES

Mark 14:17-21. Calvin writes, "God bent the treachery of Judas to the fulfillment of His purpose." Yet that does not mean that Judas will not be judged for his wickedness.

Mark 14:32-42. Calvin reminds us that Jesus' fear of death was not just separation from life but knowing that he faced the judgment of God for all human sin.

Mark 14:43-52. Calvin says, "Outside violence only dragged Him to die in so far as evil men worked out God's secret design...Nothing occurred by chance."

Mark 14:53-65. Calvin suggests that the reason priests ignore Christ's claims to be the long awaited redeemer is that they feel they have no need for a redeemer.

Mark 14:66-72. Calvin says, "When a man, for fear of the cross, turns aside from the pure profession of the Gospel he goes further if he sees he has not satisfied his enemies." Discuss.

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