

Christian Care *at Life's End*

A Report of the
Commission on Theology and Church Relations
of The Lutheran Church—Missouri Synod

February 1993

CONTENTS

Introduction.....	3
I. At Life's End: Christian Care or Mercy-Killing?	4
II. Advance Directives	16
III. Spiritual Care at Life's End.....	17
IV. End-of-Life Decisions and Justification by Grace.....	21
V. The Christian Community's Responsibilities in Public Debate.....	22
Conclusion.....	25
Christian Care at Life's End: A Bible Study.....	26
Appendix: <i>Report on Euthanasia With Guiding Principles</i>	33
Bibliography.....	45

Scripture quotations in this publication are from the Revised Standard Version of the Bible, copyrighted 1946, 1952, © 1971, 1973 (except when otherwise noted). Used by permission.

Christian Care at Life's End

Introduction

The Commission on Theology and Church Relations began its 1979 *Report on Euthanasia With Guiding Principles* by stating that “our culture lives in the stormcenter of a biomedical revolution whose consequences defy description.” The Commission noted the advances in medical technology that have made it possible to extend life beyond previously expected limits and at the same time “to curtail life abruptly and almost painlessly at will and within the context of the discipline itself.”¹ In the decade that followed this report, new developments in this technology and accompanying efforts to manipulate the boundary between life and death have complicated end-of-life decisions and have intensified debate.

To the dismay and fear of many, the advocates of euthanasia, as well as of assisted suicide, have sought to justify the taking of human life on moral grounds by describing it as a truly compassionate act aimed at the relief of human suffering. In light of what the Scriptures say about the kind of care God wills that we provide to those who suffer and are facing death, we reject such claims as neither compassionate nor caring. Christians aim *always to care, never to kill*.

This does not mean, however, that Christians themselves are not faced with difficult end-of-life decisions occasioned by the use of modern technology to prolong life beyond previously known limits. The “biomedical revolution” has touched the lives of us all, and this means that as the end of our life or that of our loved ones approaches, increasing numbers of us will be called upon at some point to apply the principles of God’s Word to this issue.

The Lutheran Church—Missouri Synod at its 1992 convention recognized the growing need “to counteract a false understanding of compassion in our culture which claims that terminating the lives of those who are weak and helpless is a compassionate act” and to provide spiritual care and support to those who must help to bear the burdens of those who suffer. The Synod noted that a large number of developments in medical science and practice have occurred since the CTCR’s 1979 report and urged the Commission to complete its update of this report as soon as possible. It specifically commended to the members of the Synod for reference and guidance the twelve principles presented in the 1979 report as they address ethical questions related to euthanasia and assisted suicide.²

The Commission has now completed its update of its 1979 report. To assist the members of the Synod in applying the principles contained in this report to current dilemmas facing those who struggle to show Christian care at life’s end, the Commission has made use of a number of case studies. The principles are presented in groups according to the interrelationships among them and pertinent case studies follow. For those wishing to explore in more detail the biblical perspective on this issue, a Bible study has been included.

¹ *Report on Euthanasia With Guiding Principles*, A Report of the Commission on Theology and Church Relations of The Lutheran Church—Missouri Synod as prepared by its Social Concerns Committee, 1979, 4. An excerpted version of this report has been included as an appendix to this document (pp. 33-44). All subsequent references to the 1979 *Report* will be made both to this excerpted version and also to the original *Report*.

² Resolution 3-11A “To Reaffirm Synod’s Position on Euthanasia and Assisted Suicide,” 1992 *Proceedings*, 116-117.

I. At Life's End: Christian Care or Mercy-Killing?

Principle 1: *Euthanasia, in its proper sense, is a synonym for mercy killing, which involves suicide and/or murder. It is, therefore, contrary to God's Law.*

Principle 2: *As Creator, God alone knows with certainty whether a disease or an injury is incurable.*

Principle 3: *When the God-given powers of the body to sustain its own life can no longer function and doctors in their professional judgment conclude that there is no real hope for recovery even with life-support instruments, a Christian may in good conscience "let nature take its course."*

Principle 4: *Administering pain-killing medications, even at the risk of shortening life, is permissible, since this does not entail the choice of death as either a means or an end.³*

Case A: *Consider the death of Diane, a fifty-year-old woman who refused treatment for leukemia. (The treatment is rigorous and painful and offers only 25 percent chance of recovery.) She told the physician that she had gotten information on suicide from the Hemlock Society, and she requested a prescription for barbiturates for sleep. She was in fact having some trouble with insomnia, but the barbiturates are an essential ingredient in the Hemlock Society recipe. The doctor says, "It was extraordinarily important to Diane to maintain control of herself and her own dignity during the time remaining to her. When this was no longer possible, she clearly wanted to die." The doctor was convinced that she would not take her life until the disease reached the point at which "bone pain, weakness, fatigue, and fevers" began to dominate. He also believed that "the security of having enough barbiturates available to commit suicide when and if the time came would leave her secure enough to live fully and concentrate on the present I wrote the prescription with an uneasy feeling about the boundaries I was exploring" She reached the point "she feared the most—increasing discomfort, dependence, and hard choices between pain and sedation." She said her final goodbyes to her husband and college-age son, asked them to leave for an hour, and ended her life. The doctor reports, "I called the medical examiner to inform him that a hospice patient had died. When asked about the cause of death, I said, 'acute leukemia' any mention of suicide would have given rise to a police investigation The family or I could have been subject to criminal prosecution, and I to professional review, for our roles in support of Diane's choices Although I know we have measures to help control pain and lessen suffering, to think that people do not suffer in the process of dying is an illusion. Prolonged dying can occasionally be peaceful, but more*

³ See Appendix, pages 42-44, for explanatory paragraphs which accompany these principles (*Report on Euthanasia*, 28-29).

often the role of the physician and family is limited to lessening but not eliminating severe suffering.”⁴

Principles 1 and 2 oppose both Diane’s and the physician’s actions in this case. Christians never aim at death as a “solution” to the problems of dying. Christians aim *always to care, never to kill.*⁵ Care does not include subjecting patients to treatments that only prolong dying and increase suffering (Principles 3 and 4), but Christian care also never aims at the death of a fellow human being.

Principles 1 and 2 reject the decision for suicide, because in the choice of suicide Diane and her physician have presumed to take into their own hands the disposal of a human life. Life is God’s gift and trust. God gives and God takes away. We have no authority to decide for ourselves when life shall end nor to make the judgment whether the quality of someone’s life makes life no longer worth living. Diane’s emphasis is on maintaining “control of herself and her own dignity” even to the point of defying God’s decision about her time. A Christian recognizes that God has given us our time in this life and only He knows His full intention concerning our death (Principle 2). The Psalmist says, “My times are in thy hand” (Psalm 31:15). St. Paul asserts that “whether we live or whether we die, we are the Lord’s” (Rom. 14:8) and “for to me to live is Christ, and to die is gain” (Phil. 1:21). Clearly, the Christian accepts God’s gift of life and never aims to destroy the life He gives.

In this light consider a related case described in response to Diane’s.

Case B: *James Czysz’s wife Cindy died at age 40 from an acute leukemia; they experienced three years of intensive chemotherapy and a failed bone marrow transplant. James says, “Having walked with her every step of the way over the years, I can state unequivocally, she died as dignified a death as any queen or princess. Yes, there was suffering and much of it. No, it was not easy nor was it always pretty, but never was she not in control and never was her suffering ‘unspeakable.’ And always, even to the very end, she not only possessed but also projected a dignity and a special elegance that inspired all those who came to know her over the last three years In the examination of the ‘doctor-aided suicide’ issue, let’s not casually inject phrases such as unspeakable suffering and undignified death when describing eventualities. For my wife and me, each day was perceived as a special blessing, and in spite of the mental and physical anguish, there was never a morning we did not greet with a special type of quiet joy and hope.”⁶*

We include this alternative description for its different perspective on “control” and “dignity.” We need not necessarily agree with Cindy’s decision to undergo the rigorous treatments of chemotherapy and a bone marrow transplant. What draws our attention is that this

⁴ From *The New England Journal of Medicine* 324 (7 March 1991): 691-94.

⁵ Under the Creator, no human being should aim at the death of one who is suffering. See the excellent statement “Always to Care, Never to Kill: A Declaration on Euthanasia” produced by the Ramsey Colloquium of the Institute on Religion and Public Life. This group of Jewish and Christian theologians, ethicists, philosophers, and scholars has ably stated the case against mercy killing. An abbreviated statement was printed in the November 27, 1991, issue of the *Wall Street Journal*. The full statement can be found in *First Things* (February 1992): 45-47.

⁶ James Czysz, “Special blessing of death with dignity,” letter in “Voice of the People” column, *Chicago Tribune*, Section 1, 6 April 1991, 16.

couple, out of whatever resources God provided them, came to see that “control” and “dignity” are not a matter of avoiding suffering and the aspects of dying that are not “pretty.”⁷ Human dignity arises in a community of shared commitment to life and to the provision of appropriate care for those facing our common enemy, death. James speaks of “having walked with her every step of the way over the years.” What is controlled is our fear and anguish in the face of death. Loved ones and health care professionals help us overcome such fear and anguish when they are committed without qualification to our well-being by standing with us in our time of suffering.

Death confronts us with its threat of annihilation. Only God has demonstrated in Christ both the power and the love to overcome this final enemy. When we or other human beings presume directly to take death into our own hands, we find that we can only effect the destruction, not the salvation, of the dying person’s life. Thus, genuine human dignity follows the course pioneered by Christ in His true humanity. He worked only to heal and to save. In His own battle with death He did not take matters into His own hands, but in solidarity with the Psalmist before Him, committed His life into His Father’s hands (Psalm 31:5; Luke 23:46). Baptized into Christ, we therefore die as He died, committing the ultimate end of our lives neither into our own hands nor into the hands of others. We commend ourselves only and completely into the hands of the God whom Jesus taught us to call Father.

By refusing to usurp God’s role we safeguard our relationships with one another as human beings. Each of us knows, therefore, that neither you nor I nor anyone else, will ever rightly decide that someone is no longer to be included in the circle of human care.⁸ When we come to Principles 11 and 12 (see pp. 22-25), the central significance of this refusal to usurp God’s role will be seen to motivate continuing vigorous opposition to political initiatives whose goal is to legalize the killing of innocent life through an approach to “solving” the problem of human suffering that dangerously usurps God’s prerogatives.⁹

Case C: *Jacqueline Daniels is a fifty-two-year-old alcoholic ‘bag lady’ discovered at the foot of a stairwell in which she had apparently spent the night. She had evidently collapsed and fallen down the metal stairs, causing a severe head injury. Taken to the hospital, she survived the head injury but was rendered permanently incompetent. She requires nasogastric tube feeding. She also suffers from emphysema and requires supplemental oxygen (administered by face mask) to survive. An infection damaged her kidneys and she now requires dialysis once every two weeks to survive. Jackie has no health insurance and no known living relatives. She is subsequently diagnosed to have terminal bone cancer. Her physician does not believe that she should “prolong her painful dying process,” and she asks if it is ethically required to: (1) continue nasogastric feeding? (2) continue oxygen supplementation? or (3) continue kidney dialysis? Analgesics are*

⁷ In this paragraph we are reminded of resources for moral living that God has made available to all people through the gifts of His creation. In the next paragraph we draw on resources of faithful trust given through God’s unique revelation in our Lord Jesus Christ. Like Christ we commit our lives into the Father’s hands.

⁸ Many thoughtful non-Christians give witness to the significance of human refusal to usurp God’s role. (See, for example, footnote 5 of this document.) We, who through Baptism are living temples of God’s Holy Spirit (1 Cor. 6:19-20), have within us the strongest testimony to the call always to care for and never to kill anyone in need.

⁹ Derek Humphry, a leading proponent of suicide for the terminally ill and author of *Final Exit* (Eugene, OR: The Hemlock Society, 1991), gives terrible testimony in his treatment of his first two wives concerning the self-deception and brutalization that come with usurping God’s role. See Case J below and a brief account of his uncaring ways in a review of *Final Exit* in the *Lutheran Witness*, May 1992, 5.

*available to abolish any pain suffered by Jackie should the feeding, oxygen, or dialysis be withdrawn, but Jackie will certainly experience periodic, intractable pain from her bone cancer.*¹⁰

Christians aim *always to care, never to kill*. The goal in this case is to provide appropriate care to a patient who is clearly dying. Principle 3 is based on a distinction between “ordinary” medical care that provides “all the help a patient can obtain and undergo without imposing an excessive burden on himself and others” and “extraordinary” medical treatment “whose good effects are not deemed to be proportionate to the difficulty and inconvenience involved.” “Ordinary” care is required of us; “extraordinary” care is not.¹¹

Care requires respecting Jackie’s life while attending also to her suffering. We respect her life by not aiming at effecting her death (Principles 1 and 2), while we consider how best to minimize her suffering. Principle 3 suggests that Christians can in good conscience omit medical interventions that are “extraordinary” in the sense that their good effects appear not to be proportionate to the difficulty and inconvenience involved.

If Jackie were not dying from bone cancer, we might consider that nasogastric feeding, oxygen supplementation, and kidney dialysis all together fall within the realm of ordinary care. However, because Jackie is dying from bone cancer, we must ask with her physician whether we would be wise to put off death from kidney failure, only so that soon after she would die from cancer. If it is true that she would suffer less from kidney failure than from the pain of bone cancer, then we might show more care by “letting nature take its course” through kidney failure.

If it is decided that kidney dialysis is no longer appropriate, however, then feeding by nasogastric tube may also be seen to be “pointless.”¹² There is little point in providing nutrients when Jackie’s body cannot rid itself of poisonous wastes. We could be confident that in not feeding her we were doing our best to care for her and were not aiming at her death.”¹³

The question of continuing oxygen supplementation would turn on how to minimize Jackie’s suffering. The case description indicates that any pain involved could be dealt with. “But what about her *suffering* (which is a considerably more complicated concept than *pain*) while she struggles to breathe? Were this not a concern, we would be morally required to discontinue oxygen supplementation. It is in most respects as pointless as the other treatments.

¹⁰ Case adapted from Robert Barry, “Facing Hard Cases: The Ethics of Assisted Feeding,” in *Issues in Law & Medicine 2* (1986): 107-108.

¹¹ The distinction between “ordinary” and “extraordinary” care has been called into question in a variety of ways and should not be used as though it is self-evident. The distinction is developed by reference to words such as “burden,” “difficulty,” and “inconvenience.” The definition of such words includes a “human reaction” component. Thus, in their application these words require assessment of human feelings and behavior. And, assessments of feelings and behavior necessarily involve an element of subjectivity. Nevertheless, ways must be found to label and discuss the difference between medical interventions that constitute genuine care and are therefore required, and medical interventions whose value as care for a patient can be significantly questioned and whose use may therefore be omitted. The CTCR’s *Report on Euthanasia* uses the words “ordinary” and “extraordinary” to develop this distinction, and we continue to find the document’s use of the distinction serviceable. (See Appendix, 37; *Report on Euthanasia*, 15-16.)

¹² Gilbert Meilaender uses this expression in his discussion of this case in “The Confused, the Voiceless, the Perverse: Shall We Give Them Food and Drink?” *Issues in Law & Medicine 2* (1986): 144-45. Meilaender is a respected Lutheran ethicist who contributed many insights to the 1979 *Report on Euthanasia*. Throughout the discussion of this case we are following his helpful lead.

¹³ *Ibid.*, 145.

But this *is* a concern, and it suggests a reason for hesitating before discontinuing support for her breathing.”¹⁴

Case D: *This case is the same as Case C, but we omit the circumstance that Jackie has terminal bone cancer. Her physician asks if it is ethically required to: (1) continue nasogastric feeding? (2) continue oxygen supplementation? or (3) continue kidney dialysis?*

Again we apply the distinction between “ordinary” medical care that provides “all the help a patient can obtain and undergo without imposing an excessive burden on himself and others” and “extraordinary” medical treatment “whose good effects are not deemed to be proportionate to the difficulty and inconvenience involved.”¹⁵

Because Jackie is not dying from bone cancer we may find that nasogastric feeding, oxygen supplementation, and kidney dialysis all fall within the realm of ordinary care. The problem is to determine whether these treatments fall into the required class of “all the help a patient can obtain and undergo without imposing an excessive burden.” There is in fact disagreement among medical professionals and informed observers regarding cases of this kind. Some would argue that Jackie’s treatments are ordinary and required. Others would hold that Jackie is dying and that the treatments do not have sufficient good effects “proportionate to the difficulty and inconvenience involved.” These people would say that such treatments are optional and can be discontinued both for Jackie’s good and for society’s.

We note that Jackie is unable to speak for herself and, furthermore, that no one who really knew her can be found to speak for her. We cannot reliably know how she would assess the benefits and burdens of these treatments for herself. In light of the disagreement concerning whether such care is ordinary or extraordinary, and in light of the danger that society might be tempted simply to aim at the death of a person like Jackie rather than to care for her, we consider the wisest course to be to continue these treatments in her case.

But what if Jackie could speak for herself and argued that for her the good effects of all these interventions were not proportionate to the difficulty and the inconvenience involved in them? Could she rightly request that these interventions be discontinued? American law has recognized the right of competent patients to refuse such treatments. How will the church advise on these matters?

Consider again Cases A and B. Diane’s decision for suicide is rightly rejected on the basis of Biblical principle. But what about her decision to forego treatment for her leukemia? The treatment was described by the medical professionals as rigorous and painful and was said to offer only a 25 percent chance of recovery. Scripture advises us to seek and to support life, but it does not give a ready answer to the question whether the possible good effects of a specific treatment are proportional to the difficulty and inconvenience involved. We may admire Cindy Czynsz’s courage in undergoing the treatment, but we may also respect a Christian’s carefully considered decision to live his or her remaining days to the glory of God without undergoing this type of treatment.

Special questions are raised concerning refusal and/or withdrawal of medically provided nutrition and hydration. We have already seen in the discussion of Jackie’s terminal bone cancer (Case C) that medical provision of nutrition by means of a nasogastric tube might sensibly and

¹⁴ Ibid.

¹⁵ Appendix, 37 (*Report on Euthanasia*, 15).

morally be withdrawn if the patient is dying of cancer and kidney failure. Other cases in which providing food and water are clearly futile and only promote suffering have been described in the literature.¹⁶

A more difficult kind of case appears in situations in which not everyone would agree whether provision of food and water is a mode of care disproportionate to the burdens it brings.

Case E: *Dr. Kathleen Nolan of the Hastings Center recounts being deeply moved by the plight of an 84-year-old man who was being sustained by tube feeding. He believed that this intervention was only prolonging his dying, and he repeatedly pulled out the tube. Those caring for him resorted to restraints to prevent his removing the tubes. Dr. Nolan reports that in her rounds she discussed these matters with the man, and he pleaded, “Kat-te please, . . . it’s not right a man should die tied.”*¹⁷

Dr. Nolan is sympathetic to the man’s plight. In another context she speaks of technology that disrupts a person’s “death work” at the end of life. In her view, “death work” involves coming to terms with our dying rather than simply postponing death by technological means. She recognizes “the possibility of a larger role for spiritual or psychological counseling as a part of or as a supplement to usual medical discussions of these issues.”¹⁸

The problem for a Christian lies in determining whether provision of food and water by tube in this man’s case disproportionately burdens him and prolongs his dying, or whether such provision constitutes ordinary care that neither he nor any one else should consider optional. Roman Catholic theologian and ethicist David Thomasma puts the problem this way: “The technology overwhelms all of us at times. Even the most sophisticated physician or ethicist has difficulty judging when it’s time to use it. People don’t die all at once anymore. They die in pieces, and you’re never sure which piece to stop at.”¹⁹

Commenting on a similar case, Gilbert Meilaender says that such “feeding is certainly not useless, since without it he must soon die. But it is—or is perceived by him to be—very burdensome.”²⁰ He suggests that “we should not at the outset decide not to feed,” and he recommends experimenting with sedation and temporary restraints to permit effective feeding. But “if it turns out that effective sedation and restraint deprive [Grandpa Doe] of the few pleasures left him, we would be wrong to deprive him of his liberty.”²¹ Meilaender here seems to suggest that we owe careful attention to the patient’s own perception that provision of food and water is a burdensome prolongation of the dying process. As we will see shortly, however, he believes such a patient to be wrong about the burdens and therefore to be wrong in resisting treatment. We will return to Meilaender’s position on this matter in discussing Case F below.

We see up to this point a complex wrestling with questions concerning how one might rightly distinguish between care whose good effects outweigh the burdens it imposes and care that seems mainly to impose a prolonged dying upon an individual who has clearly expressed a

¹⁶ See, for example, Joanne Lynn and James F. Childress, “Must Patients Always Be Given Food and Water?”, chap. in *By No Extraordinary Means*, ed. Joanne Lynn (Bloomington: Indiana University Press, 1986), 51.

¹⁷ Kathleen Nolan, “At the Center,” column on cover of *Hastings Center Report* (October/November 1987).

¹⁸ Kathleen Nolan, “In Death’s Shadow: The Meanings of Withholding Resuscitation,” *Hastings Center Report* 17 (October/November 1987): 14.

¹⁹ David Thomasma, quoted in Jessica Seigel, “Deciding when to let life end,” *Chicago Tribune*, Section 5, 10 February 1992, 2.

²⁰ Meilaender, 142.

²¹ *Ibid.*, 143.

desire to let nature take its course. As we wrestle with such cases we need to remember that we are making decisions in a creation that has, because of sin, been subjected to futility (Romans 8) and that we ourselves are creatures subject to that futility. Consequently, we should not necessarily expect in our limited human wisdom always to be able to come to decisions with which all thoughtful Christians would agree.

We are considering cases in which Christians may disagree as to whether a treatment is “ordinary” and should be accepted, or “extraordinary” and may be refused. One of the most vexing questions in this area concerns whether medical provision of nutrition and hydration may be refused in cases of a “persistent vegetative state.”²² In these cases higher brain function and conscious awareness appear to have been permanently destroyed, yet the basic bodily functions can in some cases be sustained for many years by the relatively simple provision of food and water.

In cases where it is not possible in any way to determine a patient’s own assessments concerning the burdens and benefits of the treatment, the wisest choice is to continue provision of nutrition and hydration. In light of continuing disagreement in society and in the church concerning whether such treatment is required or optional, continued feeding is wise because, even if it errs, it plainly errs in an attempt to care and not to kill. Furthermore, in these circumstances continued feeding is wise because it effectively blocks the temptation society may have solely to aim at the death of patients whose “biological tenacity”²³ has become inconvenient and troublesome.

Thomas Kennedy, an ethicist working in a Lutheran context, has warned that our society may not currently support the requisite virtues that would give us confidence that decisions made on behalf of the incompetent would aim at care for them rather than simply at their elimination. “Without a discussion of the virtues and their sustenance and inculcation the case for a permissible foregoing of artificial nutrition and hydration will remain incomplete, for we know well the moral abuse which results from a public discussion which focuses upon legal rights and excludes consideration of moral integrity, character and duties to others.” He refers to “the behavior that has followed the *Roe v. Wade* decision” and warns that no matter how careful our reasoning is concerning required and optional care, this reasoning might too easily be abused in a society that is too little careful about virtue and character.²⁴

We turn now to consider those cases in which the patient’s point of view can be reliably ascertained, either from an advance directive, or from the testimony of trusted loved ones, physicians or pastors. Consider the following case:

²² Ronald E. Cranford, M.D., in an article titled “Patients with Permanent Loss of Consciousness,” provides a helpful discussion of different types of loss of consciousness. The essay is found in *By No Extraordinary Means*, ed. J. Lynn, 186-194. He writes, “The persistent vegetative state is probably the most common, as well as the most widely discussed form of permanent unconsciousness. Such patients perceive neither themselves nor their environment. Neurological examination reveals no neocortical functions. Yet these patients do have sleep-wake cycles, and at times their eyes open. From a neurologic standpoint, they simply do not experience pain, suffering, or cognition” (187). He reports estimates that between 5,000 and 10,000 Americans are currently being maintained in a persistent vegetative state (189).

²³ The phrase is Daniel Callahan’s coined in the context of an argument warning us that society too easily moves from permitting to requiring certain practices, such as the withdrawal of nutrition and hydration. See Daniel Callahan, “Public Policy and the Cessation of Nutrition,” chap. in *By No Extraordinary Means*, ed. J. Lynn, 61.

²⁴ Thomas D. Kennedy, “Eating, Drinking, and Dying Well,” *Christian Scholar’s Review* 20 (March 1991): 349.

Case F: *Martha is a 49-year-old American from a large Midwestern city. A successful real estate agent, she is married to Joe and is the mother of one grown son, Larry, who lives in another state. Martha has always viewed herself as a spiritual person. She attends a Lutheran church, the same one she and Joe have attended since they met in Walther League 30 years ago.*

Martha has had a history of hypertension, and she recently quit smoking. She was brought into the emergency room of a private hospital near her home after suffering a stroke while reading the paper. The effects of the episode on Martha were slight, and she was discharged from the hospital after a week. A degree of facial paralysis caused her to slur her words. She had some motor difficulty, but was able to care for herself. She did take a leave of absence from her job.

Following the stroke Martha became depressed and uncertain about her future. Concerned about another possible episode, she completed a living will, which in her state is nonbinding. She declared that she would want all artificial supports withdrawn in the case of an irreversible coma. She was reluctant to discuss her fears with her pastor, but she once told both him and Joe that though she was anxious about death she did not want to linger unconscious for years.

A second massive stroke left her in a coma. She was unresponsive to deep pain and showed no purposeful movement. Initially intubated as a precaution, she had been successfully weaned from the respirator. She was sustained, however, by a nasogastric feeding tube. Treatment continued for all complications: infections were treated with antibiotics, and gastro-intestinal bleeding with blood transfusions. Her occasional respiratory distress was not serious enough for her to be placed back on the respirator. After two weeks the consulting neurologist diagnosed Martha's condition as probably pervasive, permanent, and irreversible—commonly called a persistent vegetative state (PVS)—pending a confirming examination one week later. The subsequent neurological exam confirmed the PVS diagnosis, and she was transferred from the coronary care unit to a floor, while the hospital social worker sought placement in a nursing home or an extended care facility.

In an ethics consultation held with their pastor, their family lawyer, Martha's consulting and attending physicians, and the hospital's lawyer, Joe states that plainly Martha is dying and he wants the feeding tube removed and all treatment stopped. The hospital representatives suggest that a DNR (Do Not Resuscitate) order be entered in her medical records and the feeding tube maintained. The hospital lawyer points out that the state's Living Will Act forbids the removal of the tube if death would result "solely" from the withdrawal rather than from an existing terminal condition which could be interpreted to mean imminent death. The family lawyer, however, argues that the act defines as "terminal" a condition in which (1) death is imminent, and (2) death-delaying procedures serve only to prolong the dying process. Because the physicians believe that Martha's condition is permanent and that she could live on for another 20 years with careful management, Joe is adamant that the use of the feeding tube be

discontinued. Joe's pastor is inclined to agree that the feeding tube is only prolonging Martha's dying.

After lengthy debate, and in light of Martha's advance directive, the legal precedent of a patient's right to refuse medical treatment, and the argument that death was imminent without the tube, the physicians agree to discontinue nutrition and hydration. The hospital lawyer concurs with the decision. The tube is removed on the following day.²⁵

The participants in this decision argue that they are not aiming at Martha's death but at eliminating a burdensome intervention that is prolonging the dying process. Martha is dying because she has suffered a massive stroke. She has clearly indicated that she does not wish to be maintained in permanent unconsciousness and that she desires all artificial supports withdrawn in the event of her reaching this state. The persons favoring withdrawal of the feeding tube appear to be in agreement with David Thomasma's comment that as a result of modern medical technology "people don't die all at once anymore. They die in pieces" Thomasma adds that "you're never sure which piece to stop at."²⁶ Persons agreeing with the decision in Martha's case argue that Martha is sufficiently far into an irreversible process of dying so that this is the place to stop in the use of any further death-prolonging technology.

Gilbert Meilaender comes to a different conclusion about cases such as Martha's. He writes that

much of the time when we cease to provide nourishment for the permanently unconscious but biologically tenacious patient, we will not be stopping treatment aimed at disease. We will simply be withholding the nourishment that sustains all human beings whether healthy or ill, and the only result of our action can be death. At what, other than that death, could we be aiming?²⁷

Meilaender disagrees with the position that medical provision of food and water is a medical intervention aimed at the pathology that has rendered her unconscious. In his view, to provide food and water is not to fight a rear-guard, death-prolonging battle against the disease that has brought Martha irreversibly into the process of dying. Therefore, to remove the feeding tube does not aim at ending a futile or disproportionately burdensome medical treatment but simply and solely aims at her death. Because Christians are agreed in a commitment never to aim at death, we are obligated to overrule her understandable but morally misguided wishes and to continue providing food and water.

Meilaender's position is seen clearly in his advice in a case like that described in Case E. Recall that in the case of a patient who is vigorously resisting feeding he advised that if sedation and restraints deprived the man "of the few pleasures left him, we would be wrong to deprive him of his liberty."²⁸ He affirms that reasons can be given for respecting a patient's vigorous refusal of food and water that seem to the patient to be prolonging dying in a burdensome way.

²⁵ Adapted from a case prepared by E. R. DuBose and presented in *Active Euthanasia, Religion, and the Public Debate*, A Publication of the Park Ridge Center for the Study of Health, Faith, and Ethics, 1991, 13-14. A further step in the case is presented at Case G.

²⁶ Thomasma, 2.

²⁷ Meilaender, 140.

²⁸ *Ibid.*, 143.

But if an individual like this lapses into a coma and becomes “voiceless,” Meilaender argues that “matters change considerably. The nursing home staff can now insert a feeding tube without overriding the liberty of a conscious, resisting patient, and they should do so.”²⁹ The reason they should do so is that, in Meilaender’s view, the patient was simply in error to think that provision of food and water involves a burdensome prolongation of the dying process. When the patient is conscious and struggling against the feeding, a less evil course may be to avoid sedation and restraints, but the patient is nonetheless plainly wrong. Patients may understandably think that being effectively fed is a burdensome prolongation of the dying process, but Meilaender argues that they are wrong.

We see in this discussion of Martha’s case that Christians disagree about what should be done. But we should not misinterpret these disagreements, because they do not involve fundamental principles. Both those who think that artificial feeding should be discontinued and those who think it should be continued are trying to determine how to show Christian care without aiming at killing. They are trying to determine when the point has been reached at which medical interventions are no longer effective expressions of care but instead involve burdensome prolongation of a person’s dying. What these Christians (and others who approach the end of life similarly) have in common can be brought out by reflecting on the conclusion to Martha’s story.

Case G: *Conclusion to Martha’s story. One day after the feeding tube was removed, Joe, in the presence of his pastor, asks the physician to “do something” to hasten his wife’s dying. He sees no point in “stretching things out.” The physician replies that this lies beyond his professional responsibilities. Joe again asks him to do something, saying, “I’d do it myself, but I don’t know how.”*³⁰

Joe has moved beyond asking that a burdensome treatment be ended. He now asks the physician to aim directly at Martha’s death. The Guiding Principles in the CTCR’s 1979 *Report on Euthanasia* show Joe’s request to be wrong and strongly warn against society or the church ever supporting such a course of action. Joe’s pastor owes him a careful discussion of Martha’s situation in light of the fundamental obligation *always to care, never to kill*.

It might be argued that Joe is only consistently demonstrating that the decision to remove the feeding tube already aimed solely at Martha’s death. The physician in the case, however, evidently believes that in removing the tube he was aiming at appropriate care, but that in aiming at death we would go beyond our professional and human responsibilities.

The terrible difficulty of reaching agreement in these matters can be seen by reflecting on an objection Meilaender raises against his own position. He notes that the reasoning he has used concerning provision of food and water might be thought to be equally applicable to the question of “turning off a respirator.” He does not consider it a duty to turn a respirator back on, even if the patient “may die.”

. . . it is certainly true that air to breathe is as essential to life as food for eating. Yet, there are also important differences. Remove a person from a respirator and he may die—but, then, he may also continue to breathe spontaneously. Hence the common practice of trying to wean a person from the respirator is a sensible one; we can understand its point, and that point is not that we aim to kill But

²⁹ Ibid.

³⁰ See note 25.

*deprive a person of nourishment and he will die as surely as if we had administered a lethal drug, and it is harder to claim that we did not aim at his death.*³¹

Meilaender apparently agrees that in a variety of difficult cases we may morally remove a respirator even though the removal may end in the patient's death. The respirator is addressing a sickness in the patient, and if the respirator comes to be seen as optional, extraordinary care, we may remove it. We are not aiming at death but rather aiming at removing a burdensome or futile intervention.

Ronald Cranford reports that "one poll of physicians showed that, for a patient in a persistent vegetative state, 90 percent would discontinue a respirator, 80 percent would discontinue antibiotic treatment for pneumonia, and only 50 percent would stop nasogastric feedings."³² The differences of opinion here probably reflect in part the difference in law that obtained in the mid-eighties when the poll was taken: the Quinlan Case (1976) clarified legal responsibilities concerning turning off respirators; the Cruzan Case (1990) concerning feeding was still in the future.

Cranford also suggests, however, that the difference of opinion reflects the problem (to which Meilaender also points) before us: removal of all fluids and nutrition means death "inevitably and invariably." He asks, "So, is stopping fluids to be considered an acceptable instance of allowing nature to take its course, or is it actually causing death? Perhaps there is no one answer . . ."³³ He thinks that "some of the certainty [of death] can be reduced by continuing oral feedings whenever possible."³⁴ If the main concern is that removing nutrition and hydration inevitably leads to death, perhaps some of the moral difference between turning off respirators and discontinuing feeding would be lessened if discontinuance of artificial feeding were accompanied by attempts to feed orally whenever this is possible. The patient may likely still die, but attempts to feed orally would demonstrate that we are not aiming at the patient's death. In this light consider the following case:

Case H: *Joseph was a bachelor in good and close relationship with his brother Lester. After age 75 his health declined and by age 80 Joseph was in a nursing home suffering from severe senile dementia. He was generally oblivious to his surroundings, could not control his basic bodily functions, and remained in bed in a semi-fetal position. Because he could not swallow he was fed through a nasogastric tube which caused him obvious discomfort. Four months after the tube was inserted Lester requested that it be removed. He said that it was prolonging Joseph's life unreasonably and was very uncomfortable. As nearly as could be determined, Joseph had never indicated his own understanding of the appropriateness of prolonged feeding in a situation like his. Lester and his wife had spoken about the matter with their pastor, and they had agreed that they did not want Joseph to suffer any longer from such extraordinary means. They believed that he had reached the "time to die" spoken of in Ecclesiastes (3:2). The physician removed the tube, and Joseph was placed on "supportive care only." When the nursing staff began to feed him by inserting liquified food into*

³¹ Meilaender, 140.

³² Cranford, 194.

³³ Ibid., 191.

³⁴ Ibid.

*his mouth with a syringe, Lester became very upset because Joseph choked. He requested that Joseph be fed only with a cup and spoon. This was done. Joseph was sedated and kept comfortable. He died a few weeks later.*³⁵

This case is provided for pastors and people to discuss with one another the application of the Guiding Principles to yet another case. The following important new elements are present in this case: the patient suffers from senile dementia rather than persistent vegetative state, and the substitution of spoon feeding for tube feeding is explicitly considered. Also, this case differs from Martha's (Case F) in that no direct statement concerning the burdens and benefits of his treatment is available from Joseph. But the case also differs from Jackie's (Cases C and D) in that Lester and his wife have shared a common way of life with Joseph for many years and are trying to address the situation on the basis of the way of life they shared.

Summary of Illustrations and Applications of Principles 1–4

The basic guiding principles concerning euthanasia are clear. We are never in our decision-making to aim at death either for ourselves or for others, because that is contrary to God's Law (Principles 1 & 2). In respect for our relationship with God and with one another, we are required to give and to receive "ordinary" care in which the good effects of the treatment are proportionate to the difficulty and inconvenience involved, care that can be provided without imposing an excessive burden on the patient and on others. We may, and perhaps should, reject "extraordinary" care and in such cases "let nature take its course" (Principle 3).

The principles are clear, but wise application of them requires careful attention to specific circumstances. End-of-life issues require us to make decisions in an area where both we and all creation are subjected to futility. St. Paul writes that "the whole creation has been groaning in travail until now; and not only the creation, but we ourselves, who have the first fruits of the Spirit, groan inwardly as we wait for adoption as sons, the redemption of our bodies" (Rom. 8:22-23). As we together with creation groan and eagerly await the redemption of our bodies, we should expect that Christians who have had different specific experiences may at times disagree concerning application of principles to specific cases. And, in fact, we do find Christians respecting fundamental biblical principles and yet coming to different decisions concerning medical care. Responsible commentators in the Roman Catholic community, for example, agree on fundamental principles and yet disagree on the application of principles to specific types of cases.³⁶ Also within The Lutheran Church—Missouri Synod, agreement exists on the fundamental guiding principles and yet disagreement is present regarding the application of principles to specific types of cases.³⁷

³⁵ Adapted from "Too Sick to Eat: The Case of Joseph," in *Casebook on the Termination of Life Sustaining Treatment and the Care of the Dying*, ed. Cynthia B. Cohen (Bloomington: Indiana University Press, 1988), 55-56.

³⁶ See, for example, the differing views on withdrawal of nutrition and hydration found in the statements of the Oregon and Washington Bishops and the Pennsylvania Bishops in *Origins* 21 (November 7, 1991): 349-50 and *Origins* 21 (January 20, 1992): 547-549. The Oregon and Washington Bishops write, "Conscientious Catholic moral theologians and many others in our society have not achieved consensus about this point" (November 1991, 349-50).

³⁷ At a 1991 Think Tank on end-of-life issues convened by the President of The Lutheran Church—Missouri Synod, Dr. Ralph A. Bohlmann, participants were in agreement in affirmation of the 1979 *Report on Euthanasia*. But some argued that decisions regarding removal of nutrition and hydration in cases of persistent vegetative state might, in appropriate circumstances, be defended on the basis of the Guiding Principles contained in

We believe that our agreements enable us to present a strong and united front on the basis of the Scriptures against the temptation toward euthanasia in our society. We further believe that our disagreements over the details of application to extremely difficult cases neither discredit the principles nor threaten our common commitment to God's Word. We owe to each other and to our society a united witness against euthanasia. (See Principles 11 and 12.) We also owe to each other continuing dialog on difficult points, a dialog that respects the consciences of persons who are seeking to live God-pleasing lives in the context of sincere and careful attention to God's Word on the basis of accepted principles of interpretation. (See Principle 10.)

II. Advance Directives

Principle 5: *It is good ethical procedure for the doctor to request and receive a statement signed by the patient, if competent to consent, or by the nearest of kin, agreeing to the uselessness of further "heroic efforts" and consenting to termination of treatments.*³⁸

The U.S. government has put its influence behind the practice of asking patients to consider executing an advance directive. As of December 1991 the government has effectively mandated that nearly all health care facilities must bring to the attention of most patients their right to indicate what treatments they do or do not wish to receive in the event they are unable to advise their health care team.

Christians have numerous reasons to seek effective ways to assist their loved ones and their health care team in determining their wishes concerning medical care. The principles governing a Christian's choices concerning medical care are precisely those that were discussed and presented in the CTCR's *Report on Euthanasia* and that are being illustrated and discussed in this document.

The laws governing advance directives vary throughout the United States and Canada. Two main possibilities are usually made available. One is that persons may indicate in writing how they want health care personnel to proceed in their care should they become unable to participate in the decision-making process. The other is that persons may designate a trusted friend or loved one to act in their stead as a decision-maker, through a durable power of attorney for health care, should they become unable to make decisions for themselves.

Because laws vary and change from place to place we recommend that pastors and lay people become acquainted with the specific laws that govern advance directives in their communities. Health care professionals tend to favor the durable power of attorney for health care as the more effective of the two types of advance directive. They argue that instructions written in advance of a specific crisis tend often not to be sufficiently detailed and precise to help the health care team in decisions about care.³⁹

Whatever the laws may permit, Christians will seek prayerfully to prepare advance directives in ways that will express their commitment never to aim at death. Disagreements exist among Christians concerning difficult questions involving the application of fundamental principles to specific circumstances (see pp. 12-16 above). Therefore, we can expect to find Christians conscientiously taking different positions on what can and should be included in an advance directive that prescribes what medical interventions should or should not be used. We

this report. Others argued that providing food and water, by whatever means, should always be considered "ordinary" care and therefore, in light of the Guiding Principles, should always be required.

³⁸ Appendix, 43 (*Report on Euthanasia*, 29).

³⁹ See Gilbert Meilaender, "I Want To Burden My Loved Ones," *First Things* 16 (October 1991): 12-14.

advise pastors and lay people both to focus on fundamental principles and to be careful not to burden Christian consciences unnecessarily.

III. Spiritual Care at Life's End

Principle 6: *Each person, no matter how infirm and socially useless he or she may appear to be, deserves to be accepted as a being created in the image of God.*

Principle 7: *While suffering is an intrusion into life, it provides the opportunity for Christian witness and service.*

Principle 8: *Often the time prior to death is so wrapped in mystery that no one ought forcibly to interrupt the movement of a man's spirit as it may be communicating through God's Spirit with his Creator and Redeemer by way of responding in trust and inner yearning.*

Principle 9: *Death is not merely a physical but a crucial spiritual event for each person.*⁴⁰

In application of the above principles consider the following:

Case I: *Henri Nouwen, priest and author, describes his experiences as a primary caregiver for Adam, a resident in Daybreak Home in Toronto: Adam is the weakest person of our family. He is a 25-year-old man who cannot speak, dress himself, walk or eat without help. His back is curved, and his arm and leg movements are spastic. He suffers from severe epilepsy, and even with heavy medication he has few days without grandmal seizures. It takes me about an hour and a half to wake Adam, give him his medication, undress him, carry him into his bath, wash him, shave him, clean his teeth, dress him, walk him to the kitchen, give him breakfast, put him in his wheelchair and bring him to the place where he spends most of the day doing therapeutic exercises. After a month of working with Adam something started to happen to me that never had happened before. This severely handicapped young man, whom outsiders sometimes describe with very hurtful words, started to become my dearest companion. As my fears of entering Adam's unfamiliar world gradually decreased, I began to feel a profound tenderness and affection toward him. Before this, I had come to believe that what makes us human is our mind. But Adam keeps showing me that what makes us human is our heart, the center of our being, where God has hidden trust, hope and love. Deep speaks to deep, spirit speaks to spirit, heart speaks to heart. If Adam wants anything of me, it is that I simply be with him.*⁴¹

At least three different approaches to people who are suffering recommend themselves to people who seek to care: 1) we can care by attempting to eliminate or alleviate the suffering; 2) we can care by attempting to help the sufferer explain and understand the suffering; and 3) we can care simply by being with the person in need.

⁴⁰ Appendix, 44 (*Report on Euthanasia*, 29-30).

⁴¹ From *Weavings: A Journal of the Christian Spiritual Life* (March/April 1988), excerpted in *Reader's Digest* (January 1990): 114-116.

God has blessed us in these modern times with great power actually to heal, to eliminate and alleviate suffering. We also possess a variety of philosophical and theological perspectives for attempting to explain and understand suffering. But Nouwen reminds us that first and always we can care by “being with” another who is in need of our presence.

The temptation to mercy killing is nourished in part by a too narrowly focused definition of care. People of good will commit themselves to care, but they often think that care means *only* alleviation and/or explanation. If pain and suffering persistently defeat attempts to alleviate and explain, then they are tempted to do something further that looks like a final solution. Mercy killing then appears to be the most effective type of care possible. The sufferer’s life is “explained” as no longer worth living and the sufferer’s pain is “alleviated” through the taking of life.

Case J: *Derek Humphry, founder of the Hemlock Society and author of Final Exit (1991),⁴² a book of recipes for suicide, first encountered the temptation of mercy killing for the terminally ill in 1975 when his wife Jean was losing a battle with breast cancer. In Jean’s Way (1978)⁴³ Humphry recounts his first wife’s illness and suicide. Jean’s Way shows a modern person’s panic and flight in the face of suffering that will not yield to alleviation and explanation. Humphry reports that he could barely stand to be confined in the car with his wife as she struggled with her illness. “As we sat in silence, the horror of it all began to hit me in such a way that parts of me started to go out of control” (41). Turning from the insoluble problem of his wife’s illness, Humphry reports that he “was riddled with anxiety and doubt” concerning the significance of his own life. He worried “whether I could ever be attractive to another female” (74), and he fled to an affair with an old acquaintance. The affair “did wonders for my ego and I no longer felt condemned to a life of utter desolation and solitude” (80). Jean was contemplating suicide, and Humphry was tempted to kill Jean in her sleep without even consulting her. “I debated whether I should slip the overdose to Jean that night...but I realized that I could not administer it without her knowing” (104). In the end she drank the poison he gave her on the Saturday before Easter in 1975. Humphry’s way reasserted itself in his second wife’s suicide in October 1991. In 1989 Ann Humphry learned that she, like Jean before her, had breast cancer. Within a month of learning that Ann had cancer, Humphry left a message on their phone answering machine saying he was filing for divorce. Even though Ann’s cancer was being successfully treated, her despair over Humphry’s abandonment brought her to suicide at age 49.*

Henri Nouwen (Case I) counsels us not to follow Humphry’s way. In Christ we discover that we need not flee from the sufferer whose suffering resists alleviation and explanation. Our baptism concretely witnesses to Christ’s presence with us and gives us strength in the presence of suffering. Nouwen recognizes and has experienced the fears that come from entering the “unfamiliar world” of profound suffering. But he witnesses to how these fears “gradually decreased” as he cared for Adam in the most routine of ways. Indeed, “a profound tenderness and affection” grew up in him. Such a response to suffering does not arise naturally in us,

⁴² See note 9 above for reference.

⁴³ Derek Humphry, with Ann Wickett, *Jean’s Way* (New York: Quartet Books, Inc., 1978). See text for pages from which quotes are taken.

especially if we share the modern world's fixation on remedying and explaining everything. But as we return to God's strength in our baptism, we can learn to respond with a compassionate presence.

Contemporary Americans often feel an idolatrous need to assert their own abilities to control by fixing all problems and to prove their own mastery by explaining all dilemmas. Through Word and sacrament the Holy Spirit draws believers out of this idolatry to trust in their loving God. By faith we learn to put our caring into the context of God's caring. God's promise is that He will finally heal and wipe away every tear. Meanwhile, even when we only stand and wait, we are privileged to participate in such care.

Nouwen reminds us that those who suffer are often grateful for this most simple, but most profound form of care: "If Adam wants anything of me, it is that I simply be with him." Much earlier in *Out of Solitude* Nouwen wrote: "When we honestly ask ourselves which persons in our lives mean the most to us, we often find that it is those who, instead of giving much advice, solutions, or cures, have chosen rather to share our pain and touch our wounds with a gentle and tender hand."⁴⁴

The Christian community is called to cultivate the faith that enables sisters and brothers to share pain and touch wounds in the simple "ministry of presence." Our hands are to be the loving hands of Christ that reach out to those in need. Experienced Christians will be aware of many examples of lay people and pastors who clearly understand how important it is to be present to people in need.

Case K: *Joyce was, for thirty years, a pastor's wife. Over a five-year period, until her death, she struggled with heart trouble and a decision whether or not to have surgery. Out of her experience she wrote that, in the face of a person's physical and spiritual struggle, people are tempted to "seek to halt the struggle, to apply the band-aid of a religious answer rather than providing the continued support that is needed. Our 'quick-fix' society does not like the 'unresolved.' We want to 'get back to normal' or 'get on with our lives,' whatever that means spiritually. We do not want to struggle indefinitely, or watch others do so. But there is no 'quick fix' for spiritual dilemmas." She advised ministers and persons in the helping professions that, often, answers are not what people need, "but presence and permission to confront their dilemma verbally in that presence, as well as permission to struggle without being inhibited by the imposed timetables of busy professionals or the hoped-for 'result' of the 'helper.'" At one particularly difficult moment "help arrived in the form of a young nun who stayed with me, allowing me the release of tears, the expression of anger, the unloading of all the questions and responses I had dealt with during the night as well as more issues that confronted me in her presence. She did not try to sell me her religious ideology. She made no judgments on my thinking. She did not supply one pious 'answer' for my dilemma. Instead, she gave me what I needed most—her presence and her support." The nun "was both a religious professional and a trained counselor. But she did not need to be either to listen and to care."⁴⁵*

⁴⁴ Henri J. M. Nouwen, *Out of Solitude* (Notre Dame, IN: Ave Maria Press, 1974; large reprint edition, New York: Walker and Company, 1986), 34-35 (page references are to reprint edition).

⁴⁵ Joyce Otten, "The Spiritual Dilemma," *Illness, Crises and Loss; Multi-disciplinary Linkages* 1 (Summer 1991): 23, 25.

Concerned Christian caregivers will not always agree with everything Joyce has said. They wrestle with Scripture and in prayer to know and discern the times when for the sake of the sufferer they must pass judgment on a person's thinking and speak God's decisive, forgiving Word. But in many cases pastors and experienced lay people care for people like Joyce with a ministry of presence and prayer that is slow to offer pious explanations. They should work to increase this ministry of presence and prayer by initiating members of their congregations into the methods of "being there" for people in need.⁴⁶ We who have been united as one in the body of Christ through baptism and who continually have the oneness strengthened through the Sacrament of the Altar, will be moved by the love of Christ to serve other members of the body when they hurt.

Wherever this Christian approach to care is readily and visibly known to people at the end of life, the temptation on the part of the terminally ill to seek suicide is lessened. When this kind of supportive care is available, Christian people tempted by suicide can be reminded that the call to be "little Christs" has two sides to it. God often calls us to be caregivers, but He also at times calls each of us to be carereceivers. When we are seriously or terminally ill, we ought not reject God's call to be a "little Christ"—"one of the least of these"—, providing opportunities for others to serve God in caring for us. Richard Neuhaus observes that "to entrust ourselves to the care of others, is to abandon preoccupation with our own dignity and to allow to others the greatest human dignity, which is caring for those who have no claim upon us other than the claim of human need."⁴⁷ We need not only to have the courage to care for others, but also to have the courage to let others care for us.

Yielding ourselves to the care of others can teach us in turn how better to care for others. Daniel Foster, a Christian physician, observes that "sometimes one first learns to care in the midst of one's own need for caring. It is a life-expanding experience."⁴⁸ Our God-given humanity emerges in the complementary relationships of serving and of being served, of caring and of yielding to care.

Christ calls each of us to take up the cross and follow Him. He bore the cross for us. His grief over Lazarus' death brought tears. His own pain and agony were real. He fully shared dying and death. And so, His presence with us in our suffering and dying is the fully compassionate presence of one who suffers with us. But beyond that, by His cross Christ conquered sin and suffering and death. He has won the right to wipe away every tear from our eyes. In His eternal kingdom "death shall be no more, neither shall there be mourning nor crying nor pain any more" (Rev. 21:4).

Christians then are comforted by Christ Himself in the midst of their trials and cross-bearing. And His comforting presence equips us to serve others. St. Paul reminded the Corinthians that our heavenly Father "comforts us in all our affliction, so that we may be able to comfort those who are in any affliction, with the comfort with which we ourselves are comforted by God. For as we share abundantly in Christ's sufferings, so through Christ we share abundantly in comfort too" (2 Cor. 1:4-5).

⁴⁶ For a resource to help members of the Christian congregation learn and practice caregiving see Kenneth C. Haugk, *Christian Caregiving: A Way of Life* (Minneapolis: Augsburg Publishing House, 1984). A companion Leader's Guide is also available for congregations that may wish to offer courses in Christian care-giving.

⁴⁷ Richard John Neuhaus. "Dignity, Death, and Dependence," *The Religion and Society Report* 5 (August 1988): 2.

⁴⁸ Daniel W. Foster, "Religion and Medicine: The Physician's Perspective," chap. in *Health/Medicine and Faith Traditions*, ed. Martin Marty and K. Vaux (Philadelphia: Fortress Press, 1982), 267.

Principles 8 and 9 remind us in yet another way that we are not alone in our suffering and in our care for those who suffer. Principle 8 is rooted in Rom. 8:26-28: “Likewise the Spirit helps us in our weakness; for we do not know how to pray as we ought, but the Spirit himself intercedes for us with sighs too deep for words. And he who searches the hearts of men knows what is the mind of the Spirit, because the Spirit intercedes for the saints according to the will of God.

We know that in everything God works for good with those who love him, who are called according to his purpose.” Therefore with St. Paul we “consider that the sufferings of this present time are not worth comparing with the glory that is to be revealed to us” (Rom. 8:18).

IV. End-of-Life Decisions and Justification by Grace

Principle 10: *Any decisions made in this highly complex area, and any actions taken that may later appear to have been wrong, have been redeemed by that forgiveness which is available to all who put their trust in the work and merits of mankind’s Savior and Redeemer.*⁴⁹

Case L: *In November 1991 the President of The Lutheran Church—Missouri Synod, Dr. Ralph Bohlmann, convened a “think tank” meeting on end-of-life issues in St. Louis. At that meeting one pastor cautioned that “even well-meaning ‘principles’ in a CTCR document ought not be our final word to the Church, . . . as if to help up make the ‘right’ rather than the ‘wrong’ decisions. In such matters it is not always clear what is right or wrong and we live by grace entirely. Medical ethics is an opportunity to preach the Gospel of Jesus Christ.”*⁵⁰

This observation reflects features of the Christian life that prompted inclusion of Principle 10 in the original *Report on Euthanasia*. The church’s final word to sinners oppressed and threatened by the Law is ever and always the Word of grace, the Gospel of Jesus Christ. Guiding Principle 10 explicitly recognizes that disagreement concerning the application of principles will arise from time to time within the community of the faithful. This document has provided examples of such disagreement within the Synod in the discussion of Cases C, D, E, F, and G. (See the Summary of Illustrations and Applications of Principles 1–4, pp. 15-16.)

Disagreement reminds us that sometimes even our best efforts may yet lead to error. In retrospect we may come to wonder whether our decisions and actions were, after all, wrong. But whether we were right or wrong, God’s Word witnesses that all our righteousness comes from Christ. Luther asks, “Are we to rate the price of [Christ’s] blood so low as to say that it has redeemed only what is lowest in man, and that what is most excellent in man can take care of itself and has no need of Christ?”⁵¹ In recognition that we need Christ at all times and in all situations we pray as Luther advised a troubled soldier to pray:

Dear Lord, you see that I have to go to war, though I would rather not. I do not trust, however, in the justice of my cause, but in your grace and mercy, for I know that if I were to rely on the justness of my cause and were confident because of it,

⁴⁹ Appendix, 44 (*Report on Euthanasia*, 30).

⁵⁰ Richard C. Eyer, Think Tank presentation, 13 November 1991, 3.

⁵¹ Martin Luther, *Luther’s Works*, American Edition, (Philadelphia: Fortress Press, 1972), 33: 227.

you would rightly let me fall as one whose fall was just, because I relied upon my being right and not upon your sheer grace and kindness.⁵²

Our living “by grace entirely” (see Case L) does not, however, exempt us from seeking God’s guidance as we work out our callings to care for neighbors in this world. People who know themselves to be redeemed by Christ seek to make the right rather than the wrong decisions for His sake and for the benefit of their neighbor. How else should we seek to bring God’s love and care to our neighbors? Right or wrong ethical decisions, of course, do not make us right or wrong with God—we live by grace—but people who live by grace ponder God’s guidance and seek principled ways to apply that guidance to the complexities of life in a world made difficult by sin. The CTCR has offered these Guiding Principles to the Synod precisely for this purpose. Guiding Principle 10 is included to remind us that while the principles are meant to help us make God-pleasing decisions, such decisions do not and cannot make us right with God. Likewise, decisions that continue to trouble us cannot keep us from His forgiveness and grace.

V. The Christian Community’s Responsibilities in Public Debate

Principle 11: *The spiritual and moral questions raised by the issue of euthanasia are of such a nature that their evaluation is an enterprise touching on the very survival of the basic principles which undergird the integrity of our Christian faith and the survival of our cultural heritage. They constitute the primary spiritual and moral crucible of this age.*

Principle 12: *Christians are obligated to make their position known, by whatever means possible, as a way of helping to shape public opinion on the question of euthanasia.⁵³*

Case M: *Susan Williams, 52, died May 15, 1992, of carbon monoxide poisoning, inhaling the gas from a mask through a canister provided by Jack Kevorkian, a retired pathologist, and attached by him to her bed. He was present at the time of her death. She was one of many persons whose suicides have been witnessed and assisted since 1990 by Kevorkian.*

Kevorkian’s promotion of assisted suicide as a response to human suffering has been widely publicized and discussed. Some have aptly called him “Dr. Death.” In 1991 the people of the State of Washington confronted the issue of assisted suicide in Initiative 119. California had the issue on the ballot in November 1992. Both initiatives were defeated, but similar attempts to make assisted suicide legal are under way in many parts of our country. Derek Humphry’s book of recipes for suicide, *Final Exit*, sold over half a million copies in 1991.

Some of the fascination with assisted suicide may be due to the irony that the success of medical science in prolonging life has also led to many examples of death being too much resisted by powerful technologies. But mercy killing and assisted suicide have appeared to some in all centuries to be choices that can be rationally defended. As we argued above, the temptation to mercy killing is nourished in part by a too narrowly focused understanding of what it means to care (p. 17). Care is understood to require either the solving of the problem or the explaining of it. If pain and suffering persistently defeat attempts to eliminate them and explain them, then

⁵² *Luther’s Works*, 46: 123.

⁵³ Appendix, 44 (*Report on Euthanasia*, 30).

people are tempted to do something that looks like a final solution and explanation. Mercy killing is claimed to be the most effective type of care possible. The sufferer's life is "explained" as no longer worth living and his or her pain is "alleviated" through the taking of life. Christians, by contrast, witness to another profound aspect of care that involves their being present with one another in the presence of the One who alone can finally heal and explain.

In reviewing Carlos Gomez' book *Regulating Death: Euthanasia and the Case of the Netherlands* Martin Marty observes that "there seems to be in our culture what Carlos F. Gomez, a physician, calls an 'inexorable' motion toward easing moral and legal strictures against physician-aided death."⁵⁴ The church has a responsibility not only to teach the followers of Christ concerning the evils of euthanasia but also to work on behalf of neighbors whose lives are put at risk by public support for legalizing euthanasia.

We have reviewed in detail the Christian principles for opposing euthanasia. We should also be prepared as citizens in a democracy to advance other more general arguments against legalizing the practice. Two arguments are developed regularly by nonreligious people along with the religious. One is that "mercy killing" is hardly ever needed when competent and compassionate care is provided. Medical mismanagement of the end of life frightens people into thinking euthanasia is necessary. But the health care community is listening to our fears and should be encouraged to make care at the end of life more humane. Sadly, a turn to mercy killing would undercut the pressure that is leading the health care community to develop more humane methods of care at the end of life.

Ronald Cranford is an associate physician in neurology in Hennepin County Medical Center in Minneapolis and he is somewhat tempted by the arguments for physician-assisted suicide and mercy killing. Yet, he says, "the need for it isn't that great." What is needed is that we "develop much more humane policies toward letting people die and minimizing suffering, so they won't be driven toward the desperate move toward active euthanasia." He cites the alternative of hospice. "Hospice is having a very positive effect. You don't see active euthanasia in a hospice setting because you don't see unnecessary suffering and pain; you don't see the ruthless initiation of artificial feeding tubes, and you don't see people concerned about losing control. People in the hospice setting don't worry [about] resort to active euthanasia because they know they're going to be in control and know their pain is going to be relieved."⁵⁵

We should also remind our fellow citizens that while the popular press keeps us focused on a few sensational cases, studies show that most people at the end of life do not experience the medical mismanagement we all have grown to fear. Pastor David Mahsman summarized the results of such studies in the *Lutheran Witness* by stating, "In spite of popular misconceptions about the likelihood of lying 'hooked up to a machine' for weeks and months on end, not being allowed to die, the fact is that most Americans die peacefully, painlessly and amid family. Most people do *not* die hooked up to life-support equipment."⁵⁶ The Christian community has an obligation to remain informed about the actual circumstances of medical care so that fellow Americans are not stampeded by groundless fears into the far worse danger of legalized euthanasia.

The second main public argument against legalizing euthanasia concerns the sobering consequences that seem certain to follow. Two well-known bioethicists, Thomas Beauchamp and James Childress, along with the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, "have argued that it may be necessary to

⁵⁴ Martin Marty, "Death in Holland," *Commonweal* 118 (November 8, 1991): 665.

⁵⁵ Ronald Cranford, *Medical Ethics Advisor* (January 1991): 15.

⁵⁶ David L. Mahsman, "Questions at Life's End," *Lutheran Witness* 111 (May 1992):4.

have a policy restricting the taking of life in extreme circumstances—even when the action does not appear to be wrong—to avoid the undesirable consequences of the unjustified taking of life in less extreme circumstances.”⁵⁷

Euthanasia, in the form of physician-assisted suicide, is practiced more widely in the Netherlands than in any other nation. Advocates of euthanasia point to the Netherlands as they argue for legalization. Christians would do well to examine the actual evidence. In *Regulating Death: Euthanasia and the Case of the Netherlands*, as Martin Marty points out, physician Carlos Gomez of the University of Virginia brings the following problems to our attention: 1) The legal status of euthanasia in the Netherlands is unclear; “euthanasia turns out to be a matter more winked at by the courts (since 1973) than formally legitimated by law”; 2) no clear definition of euthanasia appears to be shared among responsible medical professionals; 3) policy is supposed to protect the dying person’s freedom of choice, but “though [public hospitals] desire to carve a ‘private space’ to assist individuals in dying, their staffs gradually develop policies which compromise the whole notion of voluntariness”; 4) the covenant of trust between physician and patient breaks down in the presence of legalized euthanasia; and 5) “...something important to the community and integral to definitions of human dignity tends to be lost in the blur of Netherlandish practices.”⁵⁸

The stories of suicides of the first two wives of the Hemlock Society’s Derek Humphry (Case J, p. 18 above) provide vivid examples of the breakdown of human community, dignity, and trust in the face of a commitment to euthanasia. Humphry provides another chilling example in *Final Exit*. On page 106 he realizes that some might think that his advocacy for euthanasia subtly coerces the elderly. He says, “I am not for one moment advocating that elderly people, or patients with degenerative diseases should take their lives.” But still on that same page he does suggest that the option of assisted suicide could certainly help with “what I call ‘terminal old age.’”⁵⁹

Subtle coercion of the elderly and the handicapped is one of the most inhuman consequences likely to follow upon legalized euthanasia. Guiding Principles 11 and 12 urge Christians to be in the forefront of those who keep before our society a vision of the consequences that promise to follow in the train of legalized euthanasia.

Christians are well positioned to recognize how the terrible sin and evil that infects our world defies simple and reasonable explanations. Part of the tragedy of the euthanasia movement is that people who are trying to “do the best” end up contending for something radically evil, the killing of another human being. Contemporary philosopher Hannah Arendt has argued that while sinful human selfishness often abuses people by using them as a means to an end, something

⁵⁷ Richard Gula, “Moral Principles Shaping Public Policy on Euthanasia,” *Second Opinion* 14 (1990): 78.

⁵⁸ The above five-point summary is taken from Marty’s review, 665. Euthanasia continues to be illegal in the Netherlands. In February 1993 Parliament codified existing medical guidelines, the so-called “Carefulness Requirements,” that are meant to protect physicians against criminal liability for practicing euthanasia. The official standing of physicians who follow the guidelines is that they have violated the law but will be guaranteed immunity from prosecution (*The Associated Press Online*, 2/9/93).

One week after the Parliament of the Netherlands codified the guidelines for voluntary euthanasia in February 1993 a statement released by the government’s Justice Department read as follows: “The government is proposing to extend the reporting procedure to include active medical intervention to cut short life without an express request.” A ministry spokeswoman, Liesbeth Rensman, said that could be a first step toward guidelines sanctioning involuntary euthanasia in certain cases, such as those involving some psychiatric patients and newborns with severe defects (*The Associated Press Online*, 2/16/93).

⁵⁹ Humphry, 106.

worse than selfishness emerges when people presume, even with the best of motives, to make other people “superfluous as human beings.”⁶⁰

Christians who in all humility are guided by God’s Word have an urgent responsibility to expose such radical evil for what it truly is.

Conclusion

Christians always aim to care and not to kill at life’s end. The 1979 *Report on Euthanasia With Guiding Principles* discusses in detail the complicated questions that arise as we seek to care and not to kill. The Guiding Principles are continuing to serve well as markers on the way to compassionate Christian care. We believe that there is fundamental agreement of these principles throughout The Lutheran Church—Missouri Synod.

In this update we have provided additional illustrations and discussions of the guiding principles. We have probed the significant difficulties that confront Christians as they try faithfully to show care at life’s end. We have urged that Christians who share a common commitment to faithful Christian care at the end of life should respect each other’s consciences when disagreements arise over the application of principle to difficult cases.

Christians in North America face strong forces contending for mercy killing and assisted suicide. We must lay a sound foundation for our own understanding of what it really means to care at the end of life and then work together to oppose the terribly distorted image of care that is projected by the “mercy” killers. We hope that this document can help pastors and lay people establish a sound understanding of the issues, and as a further resource we include with this document a four-part Bible study.

⁶⁰ From a letter to Karl Jaspers excerpted in a review by Kevin Ray of *Hannah Arendt—Karl Jaspers: Correspondence 1926-1969*, *St. Louis Post-Dispatch*, 24 January 1993, 9C.

Christian Care at Life's End

A Bible Study

What is the key end-of-life issue? Many will tell you that the key issue has to do with letting die and/or mercy killing. But the key issue for Christians is care. How do we care for one another at life's end? How do we receive care at life's end?

By reflecting on how God cares for us and how He guides us in our caring at life's end we find how He would guide us also in questions about letting die and mercy killing. Accordingly, this study of God's Word begins with a study of biblical resources concerning care, and then turns to resources concerning death.

Part One: Always to Care

In the document on "Christian Care at Life's End" the discussion of Principles 6-9 in Part III distinguishes three approaches to care:

- 1) caring by attempting to alleviate suffering;
- 2) caring by attempting to explain suffering; and
- 3) caring by being present with one who suffers.

Resources in God's Word:

We begin by reflecting on how Jesus' words and deeds reported in the Gospels illustrate all three approaches to care:

- Help each other remember and find several accounts in the Gospels of Jesus' alleviating people's suffering in all kinds of need.
- Read John 9:1-7 and Luke 13:1-5. What is Jesus saying about some human attempts to explain suffering?
- Read Mark 2:1-12. On this occasion Jesus both alleviates the person's physical problem and through forgiveness restores a healing relationship between the man and God. Discuss how God's forgiveness in Christ, His reconciling us to Himself, connects with His care for people's physical needs.
- Read Luke 23:39-43. Note the one criminal's plea for immediate alleviation of the suffering and the other criminal's explanation of why they suffer. The main focus, however, is on the relationship the one criminal seeks with Jesus: "Remember me . . ."
- Read Luke 7:36-50. Here is a connection between forgiven sins and how one who is forgiven cares. Read also Mark 14:3-9. Some people thought that the woman's actions showed an uncaring forgetfulness about people in need. What does Jesus say?
- Read Matt. 25:31-46. We usually focus on how the caregiver is having an opportunity to serve Christ as the brother or sister is served. But consider how Jesus' teaching also invites us to see that the person who receives care is playing a significant role. Christ says

that when His brothers and sisters in need are served, He Himself is being served. Thus he indicates that we image Christ even or especially in our times of need. Read also Phil. 4:10-20, Matt. 10:42 and Mark 9:41.

For additional study and reflection:

- Read 2 Cor. 12:7-9. How does God's response to St. Paul's need fit into the picture of three different ways to care?
- How does Rom. 8:35-39 echo and elaborate on Psalm 23:4?
- Read Is. 55:8-9 and Rom. 8:26-28. How might these passages help us see why sometimes neither alleviation nor explanation are avenues of care open to us?

In summary, discuss how in Christ the three aspects of care—alleviation, explanation, and presence—all come together.

Resources in our hymns and prayers:

- Find and share together favorite hymns from the "Trust" section of our hymnal. In *Lutheran Worship* (LW): Hymns 406-419 (*The Lutheran Hymnal* [TLH]: 425-437; *Lutheran Book of Worship* [LBW]: 445-485). See also "Cross and Comfort," LW: Hymns 420-429 (TLH: 513-535; LBW: 313-323). See also "Death and Burial," LW: Hymns 264-269 (TLH: 585-602; LBW 324-352). Look also for other hymns that speak to you of God's care and strengthen you in your care for others.
- Look for prayers in the front of LW, pp. 124-133, that may help you pray in your own and others' times of need (TLH, pp. 102-110; LBW, pp. 42-53).
- Study "Prayer at the Close of the Day" on pp. 263-269 of LW to see the resources about God's care that are used in this liturgy (TLH, pp. 110-119; LBW, pp. 154-160).

In light of God's Word and of the ways we sing and pray,

- Consider the document's discussions of Cases I, J and K (p. 17 ff.).
- Discuss the suggestion that those who are tempted by mercy killing have too narrow a notion of what genuine human care involves, because they focus only on alleviation and explanation.
- Share with one another your experiences, whether positive or negative, in trying to give Christian care to a person who was in deep need, perhaps at the end of life.
- Today there is much discussion of unhealthy dependencies ("co-dependence") in human relationships. Our study of God's Word suggests that not all dependencies are unhealthy. God has created us to be in interdependent community with each other. We both give and receive care regularly with many people. Discuss differences between healthy and unhealthy relationships of dependence and care.

- Discuss physician Daniel Foster’s observation, quoted in “Christian Care at Life’s End,” that “sometimes one first learns to care in the midst of one’s own need for caring. It is a life-expanding experience” (p. 20). Can you relate examples in your own or others’ experiences that shed light on this observation? Relate this observation to 2 Cor. 1:1-7.
- When we are very young and when we are very sick or weak, we have no choice but to depend on the care of others. Note how wonderfully Christ dignifies these times of dependency by speaking of us as His sisters and brothers and as persons through whom others may offer care as to Christ Himself.
- The document says, “When we are seriously or terminally ill, we ought not reject God’s call to be a “little Christ”—“one of the least of these”—providing opportunities for others to serve God in caring for us” (p. 20). Discuss this suggestion especially in light of Matt. 25:31-46.

Part Two: Never to Kill

In the document discussion of Principles 1-2 in Part I asserts that “Christians never aim at death as a ‘solution’ to the problems of dying” (p. 5).

Resources in God’s Word:

- Read Job 1-2, especially 1:21 and 2:9-10. The book of Job is a rich, though difficult, part of God’s Word that deserves careful study. Discuss Job’s confession that God is the One who both gives and takes life and Job’s refusal to “curse God and die.”
- Read Psalm 31, especially verses 5 and 14-16. Notice how Jesus’ prayer at His own death (Luke 23:46) repeats Psalm 31:5. What does it mean that “my times are in your hands”? How did Jesus put His life into His Father’s hands? Discuss how suicide and mercy killing are acts that contradict the prayer “into thy hands I commit my spirit.”
- Read Rom. 14:7-9 and Phil. 1:20-24. These passages indicate that both our living and our dying are to be done to God’s glory. Discuss how a decision to aim at death robs God of the glory that is His due. A decision to aim at death seems to be based on the notion that human beings can understand and control the mystery of sin and death. How can we help one another approach dying as Jesus did, wrestling in prayer, faithfully affirming “nevertheless, not as I will, but as thou wilt”? See Matt. 26:36-45.
- Read Mark 8:34, 1 Cor. 2:1-2, Gal. 3:1, and Col. 1:24. Discuss the significance of the cross for our living to God’s glory in our times of suffering.
- Read Is. 38:1-5 (2 Kings 20:1-5) and discuss the significance of praying that the terminally ill might be healed. Hezekiah had learned that he was terminally ill, not from medical tests, but from a word of God’s prophet Isaiah. Still, he prayed and God chose to restore him to continued earthly life. Keep in mind also, however, what we learned in Part One from Is. 55:8-9, 2 Cor. 12:7-9, and Rom. 8:26-28.
- Some people object that if God’s Word permits the government to take life in punishment of certain crimes, that seems to contradict the principle that only God is the

Lord of life and death. Read Rom. 13:1-7. St. Paul says that through the government God's wrath against crime is being carried out. But is there any passage in God's Word that would in a similar way say that God has appointed to certain persons the task of ending lives through mercy killing?

Resources in our hymns and prayers:

- Return again to some of the hymns and prayers you studied in Part One and look for ways in which these resources focus on God's will and His glory in our coming to terms with suffering and with death.
- Review the liturgies used by the church for funerals and memorial services. Examine how they embody biblical principles concerning faithful attention to God's will and glory in the midst of our sorrows and fears over death.
- Discuss with your pastor the complicated questions that arise in ministry to those who attempt suicide and to families that have experienced the suicide of a loved one.

In light of God's Word and of the ways we sing and pray,

- Consider the document's discussions of Cases A and B (pp. 4-5).
- The document says, "By refusing to usurp God's role we safeguard our relationships with one another as human beings. Each of us knows that neither you nor I nor anyone else, will ever rightly decide that someone is no longer to be included in the circle of human care" (p. 6). Discuss how weak, aged, handicapped, or other difficult-to-care-for people might especially be put at risk if our society begins to usurp God's role in the ending of lives. Further evidence about the risks involved can be seen in the following excerpts from a popular news magazine.

"A Gentle Way to Die" (Newsweek [March 2, 1992, 14]) begins by recommending that we "care" for those who are terminally ill in the way the author, Katie Lyle, cared for her cat—by administering "swift, merciful death." In Lyle's view terminal illness is an "easy case." She proceeds to discuss "the difficult case," whether we ought not apply the same "care" to "Henry, 40, six feet tall, strong, affectionate, loves action movies, his IQ in the profoundly retarded range." Her concluding paragraph: "I don't like the conclusion I'm forced to. But is a gentle death for a human being always the worst answer? Laws can be implemented to prevent abuses. It seems patently untrue to me that any life is always preferable to no life. I wish, more than I can say, that there were some place on this earth where Henry could live happily and freely and be loved and understood. But since there isn't, I find it disgraceful, as well as ironic, that we cannot bring ourselves to treat our fellow humans as humanely as we treat our pets."

Bear in mind that Lyle "is actively involved as a volunteer on three boards advocating on behalf of the handicapped." Note how insidiously "care" has been reduced to alleviation. Discuss how the "solution" of "gentle death" would remove all motive to provide "some place on earth

where Henry could live happily and freely and be loved and understood.” A sampling of letters in response to this essay can be found in *Newsweek*, March 23, 1992. The majority see that something is terribly wrong in Lyle’s reasoning, but, sadly, a significant percentage of our fellow Americans share her sentiments.

- Consider the document’s discussion of Case M (p. 22). Discuss together why Christians must be prepared to work together to oppose the legalization of mercy killing in our country. Discuss what kinds of arguments will likely be most effective in a public debate. How can we use our understanding of the full notion of Christian care to combat the shrunken notion of care that so-called “mercy” killers claim they have for the dying?
- Discuss the document’s use of Hannah Arendt’s suggestion that “radical evil” has to do with making people “superfluous as human beings” (p. 25). Consider how people who are suffering and vulnerable will be made to feel “superfluous” if mercy killing and assisted suicide come to be widely accepted in our society.

Part Three: Not To Prolong Dying

In the document the discussion of Principles 3-4 in Part I asserts that while Christians agree always to care and never to kill, still there are difficult cases in which Christians and others disagree concerning whether certain “medical interventions are no longer effective expressions of care but instead involve burdensome prolongation of a person’s dying” (p. 13).

Resources in God’s Word:

- Read Luke 2:25-32. Discuss Simeon’s prayer now to depart in peace.
- Compare Simeon’s prayer to St. Paul’s words that we have previously examined in Phil. 1:20-24.
- Read another example of St. Paul’s consideration of the tension between living in Christ and dying in Christ: 2 Cor. 5:1-9.
- Read Rom. 8:18-27, 1 Cor. 8:2-3, 1 Cor. 13:8-13, and Is. 55:8-9. Discuss the significance for our ethical decision-making of our incomplete knowledge and of our living in a world infected by sin.

Resources in our hymns and prayers:

- Discuss the sixth stanza from LW Hymn 436 (LBW 527):

And you, most kind and gentle death,
Waiting to hush our final breath,
Oh, praise him! Alleluia!
You lead to heav’n the child of God,
Where Christ our Lord the way has trod.
Oh, praise him! Oh, praise him!
Alleluia, alleluia, alleluia!

- Return again to some of the hymns and prayers you studied in Part One and look for ways in which these resources reflect a Christian's joyful tension between a willingness to live to God's glory here and yet also to die in His grace.
- Study the Propers for All Saints' Day on p. 116 in LW (TLH, p. 93; LBW, p. 36 and the liturgy on pp. 206-214).
- Discuss with your pastor and other caregivers the complicated questions that arise in ministry to patients and families who find themselves in the gray area where distinctions between effective care and burdensome prolongation of dying are difficult to make.

In light of God's Word and of the ways we sing and pray,

- Consider the document's discussions of Cases C, D, E, F and G (p. 6 ff.).
- The document leaves Case H for your study group to work through together (pp. 14-15).
- Discuss the document's suggestion that if a patient's own view of the burdens and benefits of continued medical treatment is not known, then "continued feeding is wise because, even if it errs, it plainly errs in an attempt to care and not to kill . . . and because it effectively blocks the temptation society may have solely to aim at the death of patients whose 'biological tenacity' has become inconvenient and troublesome" (p. 10).
- Discuss the differences and similarities between turning off a respirator and removing medically provided food and water.
- Invite health care professionals whom you know to dialog with you both about the "difficult cases" and about the claim that "most Americans die peacefully."
- Consider the document's claim that disagreement among Christians about what constitutes genuine care in difficult cases does not necessarily involve disagreement over basic Christian principles concerning care at the end of life. In particular, the document claims that "both those who think that artificial feeding should be discontinued and those who think it should be continued are trying to determine how to show Christian care without aiming at killing" (p. 13). Give examples and discuss ways in which people do agree on basic Christian principles and yet disagree about applications of them to difficult cases.
- From time to time Christians disagree about applications of basic principles to difficult cases. The document suggests that we nevertheless still can "present a strong and united front on the basis of the Scriptures against the temptation toward euthanasia in our society" (p. 16). Discuss ways in which this strong and united front can be presented even while we also acknowledge our disagreements.
- Consider the document's discussion of Case L (p. 21). Review the wonderful good news that whether we are right or wrong in our decision-making, "all our righteousness comes from Christ." Discuss how this good news urges us also to note, as the document claims, that "our living 'by grace entirely' does not, however, exempt us from seeking God's guidance as we work out our callings to care for neighbors in this world" (p. 22).

Part Four: Advance Directives for Health Care

In the document the discussion of Principle 5 in Part IV says that “Christians will seek prayerfully to prepare advance directives in ways that will express our commitment never to aim at death” (p. 16). The document also asserts that “disagreements exist among Christians concerning difficult questions involving the application of fundamental principles to specific circumstances. Therefore, we will expect to find Christians conscientiously taking different positions on what can and should be included in an advance directive. . . .” (p. 16).

In light of your study of God’s Word and of your discussions of the issues in the preceding parts of this study,

- Ask health care and legal professionals to acquaint you with typical examples of advance directives in use in your community and with the laws that govern them.
- Review together the materials that you receive and assess them in the light of your group’s understanding of the basic biblical principles governing a Christian’s decisions concerning the end of life.
- Discuss the ways in which disagreement about the application of principles may appear within your congregation concerning differing decisions about details to be included in advance directives.
- Help your congregation find or create legally and medically effective forms of advance directives that can be recommended to people who seek advice from your congregation.
- Discuss what educational activities might be appropriate for your congregation to undertake both among the members of the congregation and also in the community at large.
- Consider ways in which your congregation and its members can make an effective biblical witness concerning end-of-life issues in your local community and in the country’s public debates.

Conclusion

In this Bible Study we have probed resources in God’s Word and in the church’s life for addressing the significant difficulties that confront Christians as they try faithfully to show care at life’s end. We trust that God’s Spirit working through His Word will strengthen us all in a common commitment to faithful Christian care at the end of life. We also expect that we will be led to respect consciences when disagreements arise over the application of basic principles to difficult cases.

Our Father in heaven, Your will be done. Amen!

APPENDIX

Report on Euthanasia With Guiding Principles

Introduction

Our culture lives in the stormcenter of biomedical revolution whose consequences defy description. The cumulative results of countless discoveries and innovations in medical technology have made it possible for us to extend life beyond what were once considered to be its natural limits. Conversely, modern medical wizardry finds itself in a position that provides the know-how to curtail life abruptly and almost painlessly at will and within the context of the discipline itself.

In light of such awesome potentials there is talk about “dying with dignity,” “the right to die,” “merciful release” and “a good death.” Out of this way of speaking has developed a rather extensive use of the word “euthanasia,” with the innumerable spiritual and ethical problems attending the possibility of its more general practice. That “easeful death” of which the poet John Keats once wrote in “mused rhyme” is today being advocated for persons in great pain with terminal illnesses, for mentally retarded patients and for children with untreatable brain damage.

Under such circumstances the church would be remiss in her mission if she failed to seize the opportunity to help inform public opinion by dealing with the problems confronting individuals and society in the wake of massive advances in technology designed to deal with issues involving nothing less than life and death. For in the most profound sense the issue of euthanasia, like abortion, serves as a crucible to test the spiritual sensitivities and ethical fiber of contemporary life. The church, therefore, must attempt to offer some general guidelines especially for those who have an interest in conforming to God’s will as it applies to this area of concern. In point of fact, by the very nature of its responsibilities the church is expected to let itself be heard in terms of God’s law as this has been entrusted to His people for discussion, evaluation, teaching, preaching and proper application. Firm conviction and strong action have become particularly crucial at a time when a growing segment of humanity clamors even more loudly for legalizing the practice of mercy killing.

Over a decade ago The Lutheran Church—Missouri Synod, acting on a plea for “guidance to Christian people as they face . . . new dilemmas,” requested the Commission on Theology and Church Relations to initiate a comprehensive study of euthanasia (1967 Resolution 2-28). In response to this assignment the CTCR submits the following report as prepared by its Social Concerns Committee. It presents first of all a series of essential definitions. This report then takes up a consideration of the major aspects of the issues of life and death as seen in the light of God’s will and work as Creator, Redeemer and Sanctifier. It concludes with a statement of some basic principles which may prove helpful in reaching spiritual and moral decisions that bear the stamp of validity in terms of God’s Word.

I. SOME ESSENTIAL DEFINITIONS

1. Euthanasia

The ethical questions raised by the issue of euthanasia are rendered more complex and confusing by various adjectives applied to the word itself. The medical profession uses the word “euthanasia” with considerable hesitation and only in the sense of deliberately shortening life. But persons and groups devoted primarily to “social engineering” have popularized this term and have devised such euphemistic definitions for it as “death with dignity,” “assisting nature” and “choosing the moment.”

Within a context of this kind it is necessary to set forth some basic definitions of the term “euthanasia” as well as the modifications of the word created by the addition of the adjectives “active,” “passive,” “direct,” “indirect,” “positive,” “negative,” “voluntary,” “involuntary” and “compulsory,” and also to review its legal status.

a. Definition of “Euthanasia”

The word “*euthanasia*” literally means “*beautiful death*.” As its derivation from two Greek words would suggest, such a concept of dying developed quite logically in a culture that looked upon death in terms of being a “friend,” as in the case of Socrates committing suicide by drinking hemlock. In the Judaeo-Christian tradition, however, dying was and is generally seen to be inimical to man’s destiny, since the Scriptures make it very clear that man was created for life. As a result of this influence from the biblical past at work in our culture, euthanasia is understood in medical circles as an act of killing a human being and is often taken to be akin to murder. While *Dorland’s Medical Dictionary* speaks of euthanasia as “an easy and painless death,” its second statement calls it “putting to death a person suffering from an incurable disease.” The 1975 edition of *The American Heritage Dictionary* speaks of it as “the act of inducing the painless death of a person for reasons assumed to be merciful.”

The issue becomes confused when a distinction is made between “active” or “positive” and “passive” or “negative” euthanasia. The former is defined as taking direct steps to end the life of persons who are not necessarily dying but who, in the opinion of some, are better off dead. It is also described as the deliberate easing into death of a patient suffering from a painful and fatal disease. The terms “passive” or “negative” euthanasia, on the other hand, are sometimes used—incorrectly—to refer to the discontinuance or avoidance of extraordinary means of preserving life when there is no prospect of recovery. This practice does not, in a proper medical sense, signify euthanasia. Instead, it normally belongs to the responsible care that medical personnel exhibit toward patients that appear to have irrevocably entered the process of dying. . . .

To confound the whole field of definitions still more, the term “euthanasia” is sometimes modified by such adjectives as “voluntary,” “involuntary” and “compulsory.” If euthanasia is voluntarily administered by and to oneself, it is a form of suicide. If applied by another with the deceased’s consent or cooperation, it is both suicide and murder. If the application of a death-accelerating measure is administered by someone else without the consent of the patient or his family, it is called involuntary. If administered in violation of the wishes of the patient and/or the family, it is known as compulsory euthanasia. In an involuntary and/or a compulsory situation it is a form of murder. It is a patient-killer, not a pain-killer. In any form, it is illegal at the present time in every state.

The various semantic distinctions which have been indicated here, especially the use of “passive” or “active” and “positive” or “negative,” serve to confuse the unwary and to desensitize those who oppose the legalization of mercy killing disguised as “happy death.” In some cases the differentiations made may be well-intentioned. Yet the use of various qualifiers in connection with the term “euthanasia” has created great confusion, thereby raising unnecessary hazards for persons committed to a God-pleasing attitude regarding the issues of life and death.

Properly speaking euthanasia entails direct intervention, the killing of a human being, with or without his knowledge or consent. It may be briefly defined as the administration of a lethal dose to the patient or the deliberate refusal to use even the ordinary means of sustaining life. It is in this “active” sense that the word “euthanasia” will be used in the present study.

b. Legal Status of Euthanasia

Presently euthanasia is not legal in the United States, despite the efforts of such groups as Concern for Dying (formerly the Euthanasia Educational Council), the Society for the Right to Die (formerly the Euthanasia Society of America), the American Euthanasia Foundation, and the Good Death Fellowship to cultivate a climate of opinion favorable to the acceptance of legislation that would embody the use of this word and permit the practice of “mercy killing.” As a matter of fact, the legal status of euthanasia is more than a little ambiguous.

The fact that legislation regarding euthanasia is a matter of state rather than of federal law has produced significant disparities among the various proposals drawn up for legislative discussion and possible action

The complexities involved in the issues pertaining to life and death help to account for the ambiguity of existing legal formulations and opinions. Much of the current sentiment in favor of “liberalizing” the law with respect to mercy killing finds its source, to a large extent, in the thinking and plans of persons who oversimplify or even ignore the ethical questions raised both by advances in medical technology and by the changing definitions of death as well as the term euthanasia itself.

While the foregoing discussion characterizes the current legal climate with respect to euthanasia and the identification of some of the principal arguments adduced by proponents of change, our own position as Lutheran Christians who seek to bring our conduct into conformity with the divine will cannot, in the last analysis, be settled by purely secular sanctions or from considerations of public policy alone. It is appropriate at this time to include a reminder that resort to euthanasia would be sinful even if the time should come when mercy killing may no longer be defined by society as a crime.

2. Life and Death

In any evaluation of euthanasia it is essential to have at hand certain acceptable definitions of life and death, for euthanasia is a word that points to the end of the former and to the hastening of the latter. The problems arising from the contemporary and necessary attempts to redefine death, therefore, will be considered after some general statements on life have been set forth.

a. Life

There is a sense in which life, partly because it is God's creation, defies definition. There are dimensions and depths to living that can never be captured in any verbal formulation. Yet, in a study of this kind, certain definitions need to be set forth, if for no other reason than that they help to provide some general guidance for persons who deal in matters of life and death.

Life, for example, has been described as vitality. It is a state of existence characterized by active metabolism. Vegetative life, by way of distinction, is the simple metabolic and reproductive activity of a human being apart from the exercise of conscious mental or psychic processes.

Usually it is the fear of existing in a state of vegetative life that moves people to think of euthanasia as a way of abruptly ending a state of being devoid of conscious mental or psychic processes. In the fall of 1976 the State of California enacted legislation known as "The Living Will." This is a written, documented and witnessed instruction to the family or heirs of an individual that no extraordinary efforts be used to resuscitate or reestablish his or her respiration or heartbeat in case he or she is afflicted with an apparently fatal and terminal disease. Such a document, certified at a time when the person involved is presumed to be of sound mind, does not request destruction or killing. Instead, it constitutes a request that good medical judgment be exercised. It does not abjure the use of compassionate care and treatment. Euthanasia is not at issue in such cases, for no deliberate attempt to hasten death is involved. It is a matter of providing instruction not to undertake heroic or extraordinary measures in order to sustain some semblance of life

b. Death

The usual dictionaries, including *Dorland's Medical Dictionary*, define death as: (1) "the cessation of life"; (2) "the cessation of all vital functions without capability of resuscitation, either in animals or plants." The American Medical Association says that "death shall be determined by the clinical judgment of the physician using the necessary available and currently accepted criteria."

In this connection it should be noted that in some circles a new criterion for death is being used in medicine today. It is called irreversible coma or brain death and is determined by the following criteria: (1) unreceptivity and unresponsivity; (2) no movements or breathing; (3) no reflexes; and (4) flat electroencephalogram (brain-wave test). However, even in the case of the application of these criteria, it is not possible to be fully certain at all times that a patient is dead. Their validity, for example, is dependent on the exclusion of the following two conditions: hypothermia (that is, temperature below 90 degrees Fahrenheit, or 32.2 degrees Centigrade) and central nervous systems depressants such as barbiturates.

It is clear that euthanasia as the practice of deliberately ending life where some small possibility for continued existence still remains is killing, for total destruction is imposed from without on all body systems. These include the brain, the cerebral and neurological systems, the heart, the circulatory system, the kidneys, the excretory system, the liver, the detoxification system, and thus the entire metabolic system. In many instances recovery and rehabilitation can take place as a result of the administration of ordinary care, given for comfort and cleanliness.

3. Ordinary and Extraordinary Means

Some attention must be given to the distinction currently made between ordinary and extraordinary (or heroic) means of preserving life, for the difference between them throws some helpful light on very difficult aspects of the issue known as euthanasia.

Ordinary means are usually described as those measures which can be taken on the basis of the judgment that there is a demonstrable or recognizable proportion between the good effect sought and the degree of hurt or hardship involved in their use. They comprise all the help a patient can obtain and undergo without imposing an excessive burden on himself and others. They are considered to be imperative for the sustaining of life and are not, therefore, refusible.

By way of distinction, extraordinary treatment refers to the use of artificial means to prolong a patient's life once his vital processes have ceased their spontaneous functions. Furthermore, this term also embraces those measures which are very dangerous, difficult, painful or even costly, whose good effects are not deemed to be proportionate to the difficulty and inconvenience involved. They may, therefore, be refused. There are four major factors to be taken into consideration in extraordinary cases:

- (a) When irreversibility is established by more than one physician;
- (b) When a moment in the process of dying has been reached where nothing remains for medical science to do except to offer proper care;
- (c) When possible treatment involves grave burdens to oneself and to others; and
- (d) When there are no means left to relieve pain and no hope of recovery remains.

The very listing of these considerations indicates the degree to which medical judgment is involved in the decision as to whether or not to employ heroic measures in situations where no reasonable hope of benefit or of success appears to exist, or where, in addition, excessive discomfort and/or cost are involved. The facts in a given case do not always present themselves in a clear-cut fashion. If medical judgment indicates that a patient is irretrievably in the process of dying, it is possible for a physician licitly to choose, for example, not to treat new infections or emergencies, even those which are likely to hasten the death process.

II. ETHICS IN THEOLOGICAL FOCUS

Having discussed in some detail the definition of important terms, it is now necessary to turn to the major spiritual and moral considerations involved in discussing the question of euthanasia. In order to get a proper perspective on this vital matter which affects both faith and life, it will be helpful to examine it on the basis of the Apostles' Creed

1. Life Is the Creator's Gift

God created human beings to live and not to die. Death in any form is inimical to what God originally had in mind for His creation. Death is the last great enemy to be overcome by the power of the risen Lord (1 Cor. 15:26). To speak of "death with dignity" or "merciful release,"

therefore, consists of engaging in unholy rhetoric. Death entails destruction, separation and loss. None of these is part of the image in which God once created the human race (Gen. 1:26). Dying, therefore, is not just another point in the cosmic process or in the experience of living, as it is sometimes made out to be. Living is the only proper response on the part of a being created by the God of life. Death is the very negation of what God has given. Had it not been for man's own rebellion against the kind of intended relationship established by having been fashioned in God's image, there would be no death. In that case even the word "euthanasia" would never have occurred to anyone.

It is written of man in Gen. 2:7 that God breathed into him His very own spirit to turn him into a living being. When death, therefore, is described only in terms of the total stoppage of the circulation of blood and the cessation of the animal and vital functions, or even as irreversible coma, that may not say enough. For behind such a statement is a view of human life which identifies it solely with that of the animal kingdom. This does not do justice to the biblical revelation, which insists that people were not made to die like dogs in a ditch. While the Scriptures depict the animals as also having (or being) *nepesh* (soul), human beings are described as being unique in the sense that they are endowed with *ruach* (spirit). Dying, therefore, is called giving up one's spirit, as for example in John 19:30, where we read of Jesus' death on the cross (cf. also Eccl. 12:7).

The use of the criterion of "brain death" has contributed to a more constructive discussion in depth of the subject at hand. This yardstick is based on the death of the cortex, whose obliteration makes it virtually impossible to distinguish between a living patient and an unburied corpse. Such a person is dead in the most elementary sense of no longer being able to respond within the parameters established by the fact that he or she has been created in the image of God.

Death by every definition represents a defeat. It runs counter to every sustained expectation of each person as a living being. Having been made in the image of that God who is Life itself, human beings, even in their fallen estate, have within them a vague awareness that they are in this world not just for the purpose of leaving it by one of "death's thousand doors."

The psalmist's resistance to dying typifies the biblical view of death. He expressed his thanks to God in these words: "Thou has kept me alive, that I should not go down to the pit" (Ps. 30:3b). To be sure, the apostle Paul freely expressed the wish to depart and be with Christ as a status "far better" than remaining in the flesh (Phil. 1:23). At the same time, however, he realized that it was more necessary for him to carry on here in his mortal body on account of his converts to Christianity. At the end of his life, which had been full of suffering of every kind, he was quite ready to acknowledge that the time of his departure had come (2 Tim. 4:6). Yet he did so on the conviction that the moment of his violent death had been established in the counsels of his God and Lord. Unlike Seneca, the apostle gave no thought to taking his own life as a way of nobly leaving the hardships of this present existence.

Death is an intensely personal experience. For man is not just "a brother to the insensible clod," to quote William Cullen Bryant. Dying is nowhere described in Scripture as gentle absorption into the Great All. At the same time, death does not occur apart from considerations for the totality of all things. There is a sense in which the individual's death is intricately woven into the fabric of God's permissive will for the whole of His created order. By revelation the apostle Paul could hear the dark language of nature's pathos as it eagerly looked forward to the liberation of all creation from "the servitude of corruption" (Rom. 8:21). John Milton was indebted to the apostle for this insight, when he wrote:

Earth felt the wound, and Nature from her seat,
Sighing through all her works, gave signs of woe
That all was lost (*Paradise Lost*, IX, 780-782).

Hence the created world engages in that symphony of sound referred to by the apostle as groaning together in travail (Rom. 8:22). Death and corruption are alien powers that seem to triumph everywhere except for that destiny which is associated with the resurrection of the body to eternal life on the part of those who take God at His word.

It is within God's purview alone to decide on the moment when the individual is to share that life which lies beyond death in a world restored to a splendor even greater than that of its pristine purity. Within the context of this certain hope, mercy killing runs squarely against the grain of the will of a gracious Creator, who allows an alien power to fell man by way of death for the purpose of raising him up to the glory of eternal service and worship as a person belonging to a community of redeemed saints.

2. Life and Death in View of Redemption

God Himself has arranged for a super-victory over death by way of redemption. God the Creator chose to be the Redeemer by having His Son become incarnate in order to overcome the contradiction between what is and what ought to be. He did so by way of suffering and death, followed by His resurrection and exaltation.

In accomplishing this task of redemption Jesus Christ offers to all people not only a paradigm for meaningful suffering but also the opportunity to share in His distress (cf. Col. 1:24). By such identification men and women can transcend the agony, pain and decrepitude which attend life and are usually the lot of those very individuals whom others might be tempted to exterminate by way of "death with dignity." The suffering endured by God's saints can be turned into personal Good Fridays. By virtue of Jesus' own suffering these dark days will turn into the Easter of glorification for all those who love God. Euthanasia, mercy killing, as a way out of such human hurt, may well be a way of circumventing or negating God's will for His children. After all, our Lord did not suffer in order that His followers might escape such an ordeal but that they might learn from Him what pain and illness mean by way of God's dealings with His children.

This thought is exhibited in a document that is known as the Christian Affirmation of Life, adopted by the Board of Directors of the Catholic Hospital Association in 1974. It reads as follows:

I believe that Jesus Christ lived, suffered and died for me, and that His suffering, death and resurrection prefigure and make possible the death-resurrection process which I now anticipate.

But there is another side to all this. Suffering is an intrusion into human life. It "operates under another law," as H. Richard Niebuhr once put it, for, in the last analysis, man was not brought into being for the purpose of enduring infirmity and anguish. He was made to live, even to live fully. It was sin that brought on death with its attendant vultures that feed on life, defacing and devouring it. Redemption is the story of the way God has dealt, and is still dealing, with this issue, offering the blessings of eternal life.

Does not the prospect of everlasting bliss encourage abbreviating the course of the individual's existence here on earth so that he or she might more quickly reach his or her final

destiny? The assurance of life hereafter offers no excuse for ending life at will by euthanasia. God is Life and sent His Son into the world to be the Source of life (John 1:4).

The healing miracles of Jesus, particularly His raising of some persons from the dead, must be seen in this light. They indicate that illness and consequent death are strangers to God's primary intent for humankind. His purpose is to bring people to glory unending. As a foreshadowing of that destiny, Jesus healed a certain number of people to make the point that everlasting life could and did begin at the very moment of accepting Him as the embodiment of God's kingdom. In this way people were offered what He Himself called a more abundant life (John 10:10).

Even today an awareness of this divine intent offers the kind of motivation that persuades people to pursue the art of healing as a way of implementing the paradigm offered in the life and career of the Great Physician. This very fact has created one of the major paradoxes of history: namely, that the mightiest advances in medical care have been made in those cultures which have come most heavily under the influence of the Christian religion with its emphasis on the blessed hope of everlasting life. In fact, this progress has been so steady and unexpected that medical technology itself has become one element in what has been called the "terror of humanity." It can create the fear in people, as they grow older or become desperately ill, that they will be kept alive by extraordinary means without regard to the fact that they are persons rather than mere objects of medical experimentation and observation.

Contrary to the tenets of secularized medicine, the biblical revelation does not view the skill of prolonging life as constituting either the ultimate purpose or the last chapter of a person's life. Christian doctrine views the restoring miracles of Jesus as reminders that they are penultimate actions, designed to validate the expectation of the ultimate solution of all of life's problems in the resurrection of the dead, scheduled for the end of time. After all, the persons whom Jesus healed and those whom He brought back from the dead were "gathered to their fathers" in due time, and now, with all the rest of humanity, they await the sound of the last trumpet. Their experiences suggest that death need not be understood in terms of discontinuity. Even as the person who awakes from a night's slumber is the same one who went to sleep in the first place, so the person who lies down to die is the very one to be awakened to his eternal destiny in the resurrection of all people. Thoughts or actions associated with euthanasia, as man's way of deciding when this present life should end, may constitute the sin of *lèse majesté* against the Sovereign in whose hands alone lie the issues of life and death.

3. Life and Death in Light of Sanctification

Life is holy. This very conviction must take into account the consequences flowing from the work of the Holy Spirit, with whom individuals are endowed at Baptism. Of Him it is said that even now, during the time of our earthly existence, He serves as the down payment of the age to come. Hence the Nicene Creed speaks of Him as "the Lord and Giver of Life."

In terms of life as response, the Spirit's presence is of incalculable significance for an appreciation of what may go on in that dim region which lies between life and death. In some instances it is impossible to determine by ordinary means whether the patient has the capability of reacting to what goes on around him. In such a situation it is of crucial importance to keep in mind that, in a patient's relationship to God, the Spirit has been given the special task of formulating and articulating "sighs too deep for words" (Rom. 8:26) in such a way as to serve the purposes of intercession at the throne of grace. (This activity on the part of God's Spirit may help

to account for the fact that after they have come out of their unconscious state, some persons have been able to remember certain phrases from prayers said for them at their bedside by pastors or members of the family. They can recall such acts of kindness even though, at the time, there was no perceptible hint of comprehension.) Intentionally to bring about the death of an individual so engaged in communion with the heavenly Father would constitute a blasphemous intrusion into a sacred relationship prevailing quite beyond the farthest reaches of human knowledge and personal awareness.

The presence of the Spirit must also be taken into account for a fuller appreciation of the possibilities available to the patient suffering from those various infirmities which attend old age. Even an invalid, totally bedfast, can pray, and that is like the lifting up of holy hands at the evening sacrifice. Rather than considering such a person to be useless and an unnecessary burden, he or she ought to be thought of as precious in the sight of God, so valuable, in fact, that our heavenly Father was willing to arrange for his or her redemption in Jesus Christ and for a life in the Spirit that is ready to give expression to God's presence in a petition like the one that has become known as "A Prayer in Bed." It reads as follows:

Dear Lord, one day
I shall lie thus and pray
Stretched out upon my bed,
Within a few days or hours
Of being dead;
And I shall seek
Then for the words to speak
And scarce shall find them,
Being very weak;
There shall hardly be strength
To say the words, if they be found, at length.
Take then my now clear prayer,
Make it apply when shadowy words shall flee,
When the body, busy and dying,
May eclipse the soul.
I pray Thee now, while pray I can;
Then look, in mercy look
Upon my weakness—look and heed
When there can be no prayer
Except my need!

Such praying is the activity of a life that is appreciated as being sacred because it is intimately bound to God by His Spirit even when it is no longer possible to say the desired words. Who, then, with any feeling for the sanctity of life would want to cut short such holy conversation?

Cases of lingering and even painful illness provide the opportunity, instead, for the kind of service on the part of those who are well that will exhibit their care even by such everyday means as sick visitation. For of all the fears that haunt the ill and the aged few are more debilitating than the prospect of being left utterly alone with only the personal warmth and dedicated service of medical personnel to attend them amid the gadgetry and impersonal machines.

At this point the Christian community can render a number of valuable services. The general prayer in the traditional order of the Sunday service calls for special petitions on behalf of those who are lonely, afflicted and dying. Moreover, few tasks are more noble than that of regular visits to such as are ill and feel forsaken. Visiting the sick is one of the items listed in Matthew 25 as a criterion of judgment, especially when one of Christ's own is involved (cf. v. 40). For when these persons profess that they cannot recall doing such a thing, their heavenly King will say to them, "Verily I say to you, whatever you did to one of my brothers here, however humble, you did for me." An organized program of sick visitation within a congregation, therefore, comprises one of the most eloquent testimonies to the Christian faith even, and perhaps especially, to those who do not belong to the assembly of the faithful.

The church, moreover, must never neglect to prepare the dying for their journey into the life before them by the use of the means of grace. While these obviously do not work like magic, they do have a power that is sacramental. They offer strength for that experience which each individual must face all alone except for the One who has Himself gone ahead of us through the valley of the shadow

IV. GUIDING PRINCIPLES

The previous pages have set forth the major arguments against the practice of euthanasia as mercy killing. From this extensive discussion it is possible to formulate some general principles that will serve as guidelines for working one's way through the vast array of ethical questions raised not only by the very speed of advances made in the technology of medicine but also by forces at work in our culture which tend to relativize all moral considerations as they apply to the central issues of life. Accordingly, a set of guiding principles is here appended to help individual Christians and groups of the faithful in their response to the issues which confront us in this area:

- 1. Euthanasia, in its proper sense, is a synonym for mercy killing, which involves suicide and/or murder. It is, therefore, contrary to God's Law.***

Attempts have been and continue to be made to soften the impact of euthanasia as an evil by using modifiers such as "passive" or "negative" and proceeding from there to distinguish between active and passive euthanasia. These definitions tend to dull people's sensitivities to ethical considerations by relativizing moral principles as these apply to matters of life and death.

- 2. As Creator, God alone knows with certainty whether a disease or an injury is incurable.***

Instances have been cited in this study to show that medical personnel often have no way of being able to foretell the outcome of treatment administered under circumstances that seemed quite hopeless. The extraordinary advances made in medical technology provide new resources that are useful in making life and death decisions. Yet these decisions, too, fall within God's ultimate providence and grace. In the last analysis, He is the only healer.

3. ***When the God-given powers of the body to sustain its own life can no longer function and doctors in their professional judgment conclude that there is no real hope for recovery even with life-support instruments, a Christian may in good conscience “let nature take its course.”***

The power to sustain life refers to the period of time preceding the point in the process of dying when irreversibility has set in. When that moment of no return has been reached, the discontinuance of what have been called extraordinary or heroic means for prolonging life is not normally a violation of God’s Law. It belongs to the category of proper medical care rather than to the issue of euthanasia. In point of fact, the application of such unusual measures could be construed as a technological stretching of existence beyond the powers with which the Creator Himself endowed the patient in question.

In seeing a God-pleasing conclusion in this matter, the following persons should normally be involved in the final decision:

- a. The *patient* (if capable of discussing the facts) to help in determining the general reaction to bodily strength and suffering and in making a decision that is legally and morally acceptable;
 - b. The *doctor* to help determine whether support systems are still helpful and whether there is any hope for recovery;
 - c. The *nearest of kin* to gain concurrence in decisions reached;
 - d. The *pastor* to give spiritual guidance and counsel in reference to treatment and care and to provide spiritual assistance and comfort and support.
4. ***Administering pain-killing medications, even at the risk of shortening life, is permissible, since this does not entail the choice of death as either a means or an end.***
 5. ***It is good ethical procedure for the doctor to request and receive a statement signed by the patient, if competent to consent, or by the nearest of kin, agreeing to the uselessness of further “heroic efforts” and consenting to termination of treatments.***
 6. ***Each person, no matter how infirm and socially useless he or she may appear to be, deserves to be accepted as a being created in the image of God.***

Accordingly, medical personnel are expected not to treat a given patient as a mere case. They will, on the contrary, show concern and care in the treatment of even the most hopelessly ill. No person enjoys autonomy of existence. Patients may, therefore, not be treated as though they were units of matter, disposable either on their own terms or on the basis of the judgment of others who may be tempted to view an incurable patient in terms of convenience or utility.

- 7. *While suffering is an intrusion into life, it provides the opportunity for Christian witness and service.***

Suffering provides the occasion for others, particularly members of the family and of the Christian community, to attend the sick and the dying as a way of exhibiting the kind of care which will help the patient to retain a sense of worth. Such acts of kindness will help to relieve the kind of loneliness which may tempt one to ask that life be ended prematurely.

- 8. *Often the time prior to death is so wrapped in mystery that no one ought forcibly to interrupt the movement of man's spirit as it may be communicating through God's Spirit with his Creator and Redeemer by way of responding in trust and inner yearning.***

- 9. *Death is not merely a physical but a crucial spiritual event for each person.***

The church's means of grace, therefore, ought to be within easy availability for purposes of consoling the dying and preparing them for the high adventure of crossing over into life eternal. With proper consultation between pastor and doctor, arrangements can be made for receiving the full benefits of spiritual help also in the case of patients requiring heavy doses of drugs for medication. Doctors can arrange for periods of medical relaxation to make possible the proper administration of the means of grace.

- 10. *Any decisions made in this highly complex area, and any actions taken that may later appear to have been wrong, have been redeemed by that forgiveness which is available to all who put their trust in the work and merits of mankind's Savior and Redeemer.***

Such forgiveness, proclaimed by the church as it properly distinguishes between Law and Gospel, constitutes a potent cure for any feelings of guilt that may plague individuals making decisions in this very sensitive area of life as response to God's actions as Creator, Redeemer and Sanctifier.

- 11. *The spiritual and moral questions raised by the issue of euthanasia are of such a nature that their evaluation is an enterprise touching on the very survival of the basic principles which undergird the integrity of our Christian faith and the survival of our cultural heritage. They constitute the primary spiritual and moral crucible of this age.***

- 12. *Christians are obligated to make their position known, by whatever means possible, as a way of helping to shape public opinion on the question of euthanasia.***

The present confused state of affairs places a special burden on all persons of moral principle to use the "marketplace," giving expression to their convictions with a view to eliminating confusion for the purpose of formulating such legislation regarding medical practices as do not violate God's Law. In undertaking these responsibilities it is imperative to remain firm on the principles and clear in the use of terminology.

Bibliography

- Active Euthanasia, Religion, and the Public Debate*. Chicago: The Park Ridge Center, 1991.
- “Always to Care, Never to Kill: A Declaration on Euthanasia.” The Ramsey Colloquium of the Institute on Religion and Public Life. In *First Things* (February 1992): 45-47.
- Callahan, Daniel. “Public Policy and the Cessation of Nutrition.” Chap. in *By No Extraordinary Means*, edited J. Lynn. Bloomington: Indiana University Press, 1986.
- Cohen, C., editor. *Casebook on the Termination of Life-Sustaining Treatment and the Care of the Dying*. Bloomington: Indiana University Press, 1988.
- Cranford, Ronald E. “Patients with Permanent Loss of Consciousness.” Chap. in *By No Extraordinary Means*, ed. J. Lynn. Bloomington: Indiana University Press, 1986.
- Euthanasia With Guiding Principles*. A Report of the Commission on Theology and Church Relations of The Lutheran Church—Missouri Synod as prepared by its Social Concerns Committee, 1979.
- Eyer, Richard C. “Ethical Decision-Making at the End of Life.” Presentation to End-of-Life Think Tank. St. Louis, 13 November 1991.
- Foster, Daniel W. “Religion & Medicine: The Physician’s Perspective.” Chap. in *Health/Medicine and the Faith Traditions*, ed. M. Marty & K. Vaux. Philadelphia: Fortress Press, 1982.
- Gabriel, Trip. “A Fight to the Death.” *New York Times Magazine*, 8 December 1991.
- Gula, Richard M. “Moral Principles Shaping Public Policy on Euthanasia.” *Second Opinion* 14 (1990): 72-83.
- Humphry, Derek. *Final Exit*. Eugene, OR: Hemlock Society, 1991.
- Humphry, Derek with Ann Wickett. *Jean’s Way*. New York: Quartet Books, 1978.
- Kennedy, Thomas D. “Eating, Drinking, and Dying Well.” *Christian Scholar’s Review* 20 (March 1991): 339-49.
- Joanne Lynn and James F. Childress. “Must Patients Always Be Given Food and Water?” Chap. in *By No Extraordinary Means*, edited by J. Lynn. Bloomington: Indiana University Press, 1986.
- Mary, Martin E. Review of *Regulating Death: Euthanasia and the Care of the Netherlands* by Carlos Gomez. In *Commonweal* 8 (8 November 1991): 665.

- Meilaender, Gilbert. "I Want to Burden My Loved Ones." *First Things* 16 (October 1991): 12-14.
- Meilaender, Gilbert. "The Confused, the Voiceless, the Perverse: Shall We Give Them Food and Drink?" *Issues in Law & Medicine* 2 (1986): 133-48.
- Neuhaus, Richard John. "Death and Dignity." *The Religion and Society Report* (Summer 1988).
- Nolan, Kathleen. "At the Center." *Hastings Center Report* (October/November 1987).
- Nolan, Kathleen. "In Death's Shadow: The Meanings of Withholding Resuscitation." *Hastings Center Report* (November 1987): 9-14.
- Nouwen, Henri J. M. "Adam." *Weavings: A Journal of the Christian Spiritual Life* (March/April 1988), excerpted in *Reader's Digest* (January 1990): 114-116.
- Nouwen, Henri J. M. *Out of Solitude*. Notre Dame, IN: Ave Maria Press, 1974.
- Otten, Joyce. "The Spiritual Dilemma." *Illness, Crises and Loss; Multidisciplinary Linkages* 1 (Summer 1991): 22-26.

Additional Readings

- Abortion in Perspective*. A Report of the Commission on Theology and Church Relations as prepared by its Social Concerns Committee, 1984.
- Kadai, Heino. "Luther's Theology of the Cross." Chap. in *Accents in Luther's Theology: Essays in Commemoration of the 450th Anniversary of the Reformation*. St. Louis: Concordia Publishing House, 1967.
- Klotz, John. *Life Choices; Who Decides? Following God's Word in Life and Death Decisions*. St. Louis: Concordia Publishing House, 1991.
- Marty, Martin E. *Health and Medicine in the Lutheran Tradition*. New York: The Crossroad Publishing Company, 1983.
- Norbert Mueller and George Kraus. "Applying Word and Sacrament to the Dying and Bereaved." Chap. in *Pastoral Theology*. St. Louis: Concordia Publishing House, 1990.