Christian Decision-Making

AND THE

End of Life

APRIL 2023

An Update and Supplement to *Christian Care at Life's End*

Christian Decision-Making

AND THE

End of Life

An Update and Supplement to *Christian Care at Life's End*

COMMISSION ON THEOLOGY AND CHURCH RELATIONS

© 2023 The Lutheran Church—Missouri Synod 1333 S. Kirkwood Road St. Louis, MO 63122 888-THE LCMS • *lcms.org*

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without the prior written permission of The Lutheran Church—Missouri Synod. Unless otherwise indicated, all Scripture quotations are from the ESV® Bible (The Holy Bible, English Standard Version®), copyright © 2001 by Crossway, a publishing ministry of Good News Publishers. Used by permission. All rights reserved.

Cover Image: Lightstock

THE
LUTHERAN CHURCH
MISSOURI SYNOD

Contents

I. Introduction . . . 1
- A. Death, the Existential Reality . . . 2
- B. A Culture on the Move in Attitude and Legal Permissions . . . 4
- C. Dying in America . . . 5

II. Theological Foundations . . . 6
- A. Christian Basis for Human Dignity and the Sanctity of Life . . . 6
- B. Death with Dignity? . . . 10
- C. The Quest for Absolute Autonomy . . . 12
- D. The Question of Euthanasia and What It Really Means . . . 13

III. Medical-Ethical Considerations . . . 15
- A. Ventilators and Medical Prolongation of Life and Dying . . . 15
- B. Who Decides? . . . 17
- C. Advance Directives . . . 17
- D. The Question of When Enough Is "Enough" . . . 22
- E. Refusing or Withdrawing Treatment . . . 23
- F. Financial Matters . . . 24
- G. Necessary Distinctions and Helpful Terminology . . . 26
  - 1. Burdens of Treatment vs. Burdens of Life . . . 26
  - 2. Caring, But Only Caring . . . 26
  - 3. Irretrievably Dying vs. Terminally Ill . . . 27
  - 4. Intention or Aim of an Action vs. Result of an Action . . . 27
  - 5. Palliative Care vs. Palliative Sedation . . . 27
  - 6. Treatments Which May Be Refused vs. Care Which Should Never Be Denied . . . 28
  - 7. "Vegetable" vs. "Persistent Vegetative State" . . . 29
  - 8. What Do/Did They Want? vs. What Is Best for Them? . . . 29
- H. Hospice Care . . . 29

IV. Pastoral and Spiritual Dimensions . . . 32
- A. Dealing with Our Uncertainty and Sinfulness . . . 32
- B. The Reality of Death and Our Struggle with Helplessness . . . 33
  - 1. Fear of Helplessness and Lack of Control . . . 34
  - 2. Facing Helplessness Due to Suffering . . . 35
  - 3. Facing Helplessness as a School for Learning to Trust God . . . 35
- C. Christ's Comfort for the Dying . . . 36
- D. Christ's Comfort for the Grieving . . . 37

V. Concluding Remarks . . . 40

Appendix . . . 41

I. Introduction

In 1993, the Commission on Theology and Church Relations (CTCR) published *Christian Care at Life's End*. The report was an update of the CTCR's earlier (1979) *Report on Euthanasia with Guiding Principles*.[1] This report is, in turn, a further update on the CTCR's past work. In its introduction, the 1979 report said, "Our culture lives in the stormcenter of a biomedical revolution whose consequences defy description."[2] The 1993 report repeated that assessment, and it is still true. Thirty years later, the biomedical storm has not abated. As was true in 1979, those who promote euthanasia or assisted suicide continue "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."[3] The LCMS continues to reject such false compassion. Instead, we affirm that at the end of life the Christian's responsibility toward those who are suffering is, in the words of the Ramsey Colloquium, "*always to care, never to kill.*" [4]

This does not mean, however, that Christians themselves are not faced with difficult end-of-life decisions occasioned by the use of modern technology and medical advances to prolong life beyond previously known limits. As Helmut Thielicke observed already in the 1970s, "Medicine has made such tremendous advances in the modern period that there seems to be almost no limit to what it can do."[5] The "biomedical revolution" has touched the lives of us all, and as the end of our life or that of a loved one approaches, more of us will be called upon to apply the principles of God's Word in this difficult time.

The CTCR fully affirms its 1993 and 1979 reports. *Christian Care at Life's End* (1993) together with the principles of the 1979 report, which formed the basis of *Christian Care at Life's End*, remain valuable in addressing the sensitive questions about care for those at the end of life in a way that is robustly biblical, theologically sound and pastorally sensitive. This report therefore is not a substitute or revision of that previous work. Rather, it is intended as a supplement and informational resource to help concerned Christians better understand various new challenges that complicate an already delicate, difficult topic. We note especially that since *Christian Care at Life's End* was published, the legal environment has continued to move in the direction of greater personal autonomy and statutory permission to allow physicians to participate in assisted suicide. Together with these legal changes, the United States population has become increasingly supportive of physician-assisted suicide.

---

[1] Commission on Theology and Church Relations, *Christian Care at Life's End* (St. Louis: The Lutheran Church—Missouri Synod, 1993). The 1993 report includes as a supplement (pages 33–44) the CTCR's *Report on Euthanasia with Guiding Principles* (St. Louis: The Lutheran Church—Missouri Synod, 1979). The genesis of the 1993 update was the 1992 LCMS Convention Resolution 3-11A, "To Reaffirm Synod's Position on Euthanasia and Assisted Suicide." See *1992 Proceedings*, 116–117.

[2] CTCR, *Report on Euthanasia,* 33.

[3] CTCR, *Report on Euthanasia,* 33.

[4] The Ramsey Colloquium of the Institute on Religion and Public Life, "Always to Care, Never to Kill: A Declaration on Euthanasia," *First Things* (February 1992): 45–47.

[5] Helmut Thielicke, *The Doctor as Judge of Who Shall Live and Who Shall Die* (Minneapolis: Fortress, 1976), 1.

The framework of the report consists of four parts: Part I — a historical and contextual section, Part II — a theological section, Part III — a medical and ethical section, and Part IV — a pastoral and spiritual section. Individual parts may be of greater or lesser interest to different readers with different questions.[6]

A. Death, the Existential Reality

A rabbinic adage claims that it is impossible to look long into the sun or into death.[7] Since the rebellion of our first parents in the Garden, death has been the inescapable reality of human existence. People often approach the end of their earthly pilgrimage with a variety of regrets, expressed and unexpressed. A hospice social worker chronicled some of the most common:

1. They wish they had been more loving to the people who matter the most.
2. They wish they had been a better spouse, parent or child.
3. They wish they had not spent so much time working.
4. They wish they had taken more risks.
5. They wish they had been happier and enjoyed life more.
6. They wish they had lived their dream.
7. They wish they had taken better care of themselves.
8. They wish they had done more for others.
9. They wish they had chosen more meaningful work.[8]

Martin Luther dealt with death as a daily reality, not as a theoretical one. Living in times of high infant mortality, untreatable diseases, a lack of effective surgical interventions and recurrent outbreaks of plagues, he understood the existential threat death posed. Indeed, while others fled the most recent scourge of plague in Wittenberg in 1527, Martin and his pregnant wife, Katie, remained behind, opening their home to care for the dying. Some speculate that the death of his infant daughter Elizabeth a few months before her first birthday in 1528 was partly due to their ministrations to the dying the previous year. Another one of his children, his beloved daughter Magdalene, died in his arms in 1542. In 1524, Luther based his hymn "In the Very Midst of Life" on a Latin antiphon. Part of it reads: "In the very midst of life Snares of death surround us; Who shall help us in the strife Lest the foe confound us? … In the midst of death's dark vale Pow'rs of hell o'er take us. Who will help when they assail, Who secure will make us?"[9]

Christian theology does not support cultural notions of death as "natural," part of the "circle of life" or the way for a loved one to become an angel. Christian thinking about death is nuanced. Death, with sin and Satan, has been vanquished by the risen Lord, but the unholy triad continue to wield dangerous power while we still await the final advent of Christ.

Biblical theology has a similarly subtle understanding of suffering. Suffering marks a fallen world, but it cannot simply be equated with evil. In Luther's 1518 *Heidelberg Disputation*, he articulated a "theology of the cross." "A theologian of glory calls evil good and good evil. A theologian of the cross calls the thing what it actually is." Furthermore: "This is clear: He who does not know Christ does not know God hidden in suffering."[10] But in our culture where ease is valued and any

---

[6] The Commission has also developed a supplementary resource with definitions, timelines and other information, see appendix.

[7] Paul D. Steinke, "Comfort in the Face of Death," *The Lutheran Witness* (May 1998).

[8] Grace Bluerock, "The 9 Most Common Regrets People Have at the End of Life," *Mindfulness* (Feb. 24, 2020), *mindbodygreen.com/0-23024/the-9-most-common-regrets-people-have-at-the-end-of-life.html.*

[9] "In the Very Midst of Life," *Lutheran Service Book* (St. Louis: Concordia Publishing House, 2006), 755.

[10] *LW* 31:53. Quotations marked *LW* are from *Luther's Works, American Edition*, ed. Jaroslav Pelikan, Helmut T. Lehmann and Christopher Boyd Brown, 75 vols. (Philadelphia and St. Louis: Augsburg and Concordia Publishing House, 1955–).

discomfort viewed with alarm, we tend to default to our old Adamic nature in preferring our own "works to suffering, glory to the cross, strength to weakness, wisdom to folly."[11] The way of Christ is the way of the cross. Indeed, "God can be found only in suffering and the cross."[12] This view of suffering, however, is neither fatalistic nor masochistic. The Christian recognizes both a responsibility to care for those who suffer and a recognition that God is at work even while His children suffer.

Christians serve in myriad vocations where we are called to "fear, love, and trust" God and to love our neighbor. Loving our neighbor will often involve standing in solidarity with the neighbor and bearing his suffering as well. But Christian vocation never calls for a false "compassion" that would conclude that we may kill our neighbor, even in the name of mercy. The Christian is "always to care, never to kill."

In our increasingly secularized world, spiritual counsel in the face of death is given little attention. A growing number of our fellow citizens are availing themselves of a more direct course of action in order to deal with their most pressing existential reality: impending death. Aided by changing laws permitting their physician to prescribe medications to hasten death, they are resorting to assisted suicide.[13]

The firsthand account by physician Timothy Quill, originally published in the *New England Journal of Medicine* in 1991, famously articulated the rationale for physician-assisted suicide with respect to his patient Diane, who had been diagnosed with acute myelomonocyte leukemia.[14] "Knowing of her desire for independence and her decision to stay in control, I thought this request made perfect sense."[15] His case study has been much discussed as a model.[16] In a manner now common for arguments in favor of physician assistance in the death of patients, Dr. Quill lays out his steps: (1) assuring that the suicide would be effective and that a slow, lingering death would not occur; (2) avoiding a violent death of the patient; (3) providing the patient with the requisite information about organizations that might assist in the effort; (4) prescribing the dosages of the medications that would permit death to come as quickly and painlessly as possible; and (5) providing comfort to the family of the patient.[17] The actions by Quill eventually became the subject of landmark court rulings.[18]

Such hastening of death, as Quill advocates, is one problem. Another is desperately seeking to prolong life when a person is irretrievably dying. Gifford A. Grobien recently posed a pair of questions facing us as we navigate the waters of the brave new world of medical possibility and legal permission: "In considering caring for our mortal life, especially as it approaches its end, a couple questions may help us to sharpen our thinking: has our desire to delay or even eliminate death clouded or undermined faith in resurrection to immortal life after death? Does delaying death suggest a false hope for a 'quality' of life in advanced age that is not biologically feasible?" Grobien concludes, "The single greatest challenge in bioethics is living the natural life God has given us, with faith, thanksgiving, and love, while also recognizing the limits of this life when they come and hoping for the life of the world to come."[19]

---

[11] *LW* 31:53.

[12] *LW* 31:53.

[13] Assisted suicide of one form or another is also known as Physician-Assisted Suicide, Physician-Assisted Dying, Physician-Assisted Death, Physician Aid in Dying, Medically Assisted Dying (MAD), Medical Aid in Dying (MAID) or Patient-Administered Hastened Death.

[14] Timothy Quill, "Death and Dignity: A Case of Individualized Decision Making," *New England Journal of Medicine* 324, no. 10 (1991): 691–694.

[15] Quill, 693.

[16] Cf. Timothy E. Quill, "Death and Dignity," in Michael M. Uhlmann, *Last Rights?: Assisted Suicide and Euthanasia Debated* (Grand Rapids: Eerdmans, 1998), 319–42; Andrew J. Dyck, *Life's Worth: The Case Against Assisted Suicide* (Grand Rapids: Eerdmans, 2002), 12–28.

[17] See the summary of Quill's rationale in Dyck, 13.

[18] See the thorough discussion of the Quill arguments as they wound their way up through the courts, eventually resulting in a landmark 1997 ruling in Neil M. Gorsuch's *The Future of Assisted Suicide and Euthanasia* (Princeton: Princeton University Press, 2006). Quill contended that laws prohibiting physician-assisted suicide violate provisions of the Fourteenth Amendment.

[19] Gifford A. Grobien, "The Future of Bioethics," *For the Life of the World* 25, no. 3 (Fall 2021), 6.

Put simply, we are addressing this question: How should faithful Christians respond to the advance of medical possibilities and legal permissions, particularly in dealing with terminal illness? **The goal of this report is to provide theologically sound practical and pastoral guidance for Christian care at life's end. Since our goal is practical and pastoral, the discussions of medical terms and legal documents in this report related to end-of-life matters are for information only and should not be considered legal advice. We encourage all who need or desire legal counsel for a particular situation to consult an attorney familiar with the laws in their jurisdiction.**

All of our efforts in this arena, however, must be prefaced with a frank admission of humility in the face of the daunting challenges of understanding the array of specialized knowledge possessed by physicians, scientific researchers, attorneys, philosophers and theologians. Thielicke captured the challenge when he reminded us that "no one who is committed to the gospel—the message of the incarnation of the eternal Word—can claim to have some kind of supratemporal knowledge (a *philosophia perennis*). He knows that he is simply one of the many who have not yet arrived but are still on the way (*theologia viatorum*)."[20]

B. A Culture on the Move in Attitude and Legal Permissions

The relentless march toward "physician-assisted dying" has made major inroads into law and public acceptance in a growing number of places within the United States. Despite sometimes vigorous opposition by groups opposing physicians enabling the deaths of patients, the trend has been for jurisdictions to liberalize laws governing physician assistance with the death of terminally ill patients. One may reasonably assume that this trend will continue in the coming years in our increasingly secularized culture as "death with dignity" forces continue to mount sustained campaigns to change laws and litigate the matter in the courts.

For decades, polling in the United States has surveyed both the general public and the medical community on the topic of physician involvement in providing lethal medications to terminal patients. For instance, a 2020 Medscape Oncology Ethics Report found that when asked "Should physician assisted dying be made legal for terminally ill patients?" 55% of the more than 5,000 oncologists surveyed nationwide agreed, "compared with 49% in 2018." Of the doctors surveyed, 34% said "no," and 12% indicated that "it depends."[21] The report concluded: "Acceptance of this concept has grown over the decade. More specialists (57%) than primary care physicians (51%) are in favor of physician-assisted dying being legal."[22]

A May 2020 Gallup survey found that nearly 3 out of 4 Americans (74%) answered "Yes" to the question: "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his or her family request it?"[23] The majority support for physician-assisted dying included every demographic group surveyed. This was true among males (75%), females (73%), white people (77%), people of color (65%), college graduates (79%), high school graduates or less education (71%), Republicans (69%), Independents (72%), Democrats (85%), conservatives (57%), moderates (80%) and liberals (87%).[24]

---

[20] Thielicke, *The Doctor as Judge*, 2. Thielicke writes eloquently about the "ambiguity" created by living with the unintended, but predictable, consequences of so-called medical "advances." Each instance of progress carries with it a "price to be paid," 8.

[21] See Shelly Reese, "Medscape Oncology Ethics Report 2020," *Medscape* (Jan. 29, 2021), *medscape.com/slideshow/2020-ethics-rpt-oncology-6013582.*

[22] Leslie Kane, "Life, Death, and Painful Dilemmas: Ethics 2020," *Medscape* (Nov. 13, 2020), *medscape.com/slideshow/2020-ethics-report-life-death-6013311#2.*

[23] Published as "Gallup Poll Social Survey 2020" and cited by a prominent medical aid in dying group, "Polling on Medical Aid in Dying," *Compassion & Choices*, *https://compassionandchoices.org/resources/polling-medical-aid-dying.*

[24] "Polling on Medical Aid in Dying," *Compassion & Choices, https://compassionandchoices.org/resources/polling-medical-aid-dying.*

In 2016, LifeWay Research conducted a major study of American attitudes.[25] Their 1,000-person survey sample stratification mirrored the most recent U.S. Census data for gender, age, race/ethnicity, region, metro/non-metro, education and income. The following are among the most relevant findings: 67% agree that it is morally acceptable for a person to ask for a physician's aid in taking his or her own life, and 69% affirm permitting physicians to assist terminally ill patients in ending their life. Significantly, nonreligious persons are more likely to agree (84%) than Christians (59%) and other religions (70%). Those defined as having "evangelical beliefs" were less likely to agree than those without evangelical beliefs (38% vs. 73%).[26]

C. Dying in America

Death for most Americans will not take place in a hospital. A 2018 Harvard report stated that "although more than 700,000 people die in hospitals each year in the US, the trend is toward fewer in-hospital deaths" even during a time of increasing hospital admissions. In fact, between 2000 and 2015, a sharp turnabout occurred in the places where people died. In comparison with a 2000 survey, those who died in 2015 were more likely to die at home or in a community-based setting (31% vs. 40%) and less likely to die in an acute care hospital (20% vs. 33%).[27] Linda D. Bartlett and Karen Rehder claim that death for most Americans is "peaceful, painless, and with family."[28] They note that "most Americans spend their last days in their own homes with family and friends; most are alert and in control of their bodily functions; one-third die at home while one-half transfer to a hospital shortly before death; most maintain active interest in the world; most are not depressed; and many report a feeling of hope, believing they have something to live for."[29] M. Powell Lawton of the Philadelphia Geriatric Center reported that, "On the day of death 51 percent had no difficulty with orientation or recognition of family; 61 percent had no pain; and 52 percent could breathe freely."[30]

Nevertheless, despite the reality for the aggregate of persons, significant numbers of individuals do die in hospitals amid various technological interventions. The resulting emotional strains and financial costs of hospital care for dying patients are significant burdens. As a result, such factors continue to drive changes to law and custom that permit physicians to intervene in ways that ostensibly "relieve misery," but do so by hastening or even causing death.

Recent years have witnessed an explosion of debates in the literature on end-of-life issues. A wide variety of voices are heard: medical researchers and physicians, philosophers and ethicists, theologians, attorneys, journalists, disability activist groups, and even presidential commissions.

---

[25] "American Views on Assisted Suicide — Lifeway Research," *LifeWay Research, http://lifewayresearch.com/wp-content/uploads/2016/12/Sept-2016-American-Views-Assisted-Suicide.pdf.*

[26] Those with "evangelical beliefs" "strongly agree" with these statements: The Bible is the highest authority for what I believe; it is very important for me personally to encourage non-Christians to trust Jesus Christ as their Savior; Jesus Christ's death on the cross is the only sacrifice that could remove the penalty of my sin; and only those who trust in Jesus Christ alone as their Savior receive God's free gift of eternal salvation. These doctrinal markers are shared by faithful members of the LCMS. Polling organizations frequently identify the LCMS as "evangelical" because of such shared beliefs.

[27] Robert H. Shmerling, "Where People Die," *Harvard Health* (Oct. 31, 2018), *health.harvard.edu/blog/where-people-die-2018103115278.*

[28] Linda D. Bartlett and Karen Rehder, "Ventilators, Feeding Tubes, and Other End-of-Life Questions," *Lutherans for Life* (Feb. 28, 2020), *lutheransforlife.org/article/ventilators-feeding-tubes-and-other-end-of-life-questions/.* The study surveyed 4,000 people age 65 and older.

[29] Bartlett and Rehder, "Ventilators, Feeding Tubes, and Other End-of-Life Questions," 7.

[30] Quoted by Bartlett and Rehder, "Ventilators, Feeding Tubes, and Other End-of-Life Questions," 7.

II. Theological Foundations

A. Christian Basis for Human Dignity and the Sanctity of Life

Christian discussions of end-of-life issues must begin with the doctrine of creation.[31] Created by God, accountable to God, we live as perpetual recipients in relation to His perpetual giving. Secondly, Luther reminds us that the commandment against taking life also obligates us to be protectors and sustainers of life, for ourselves and for others. Lutheran theologians call this a theology of "receptivity and vocation."[32] All end-of-life conclusions are predicated on the premise of God's superior claim to us and are bounded by the limits of creation as He designed them. As Luther put it, "The First Article is given for the purpose that we should know and learn where we come from, what we are, and to whom we belong."[33] Indeed, Luther's comments on the First Article of the Apostles' Creed use a form of "all" nine times to emphasize God's role.

> *What does this mean?* I believe that God has made me and **ALL** creatures; that He has given me my body and soul, eyes, ears, and **ALL** my members, my reason and **ALL** my senses, and still takes care of them. He also gives me clothing and shoes, food and drink, house and home, wife and children, land, animals, and **ALL** I have. He richly and daily provides me with **ALL** that I need to support this body and life. He defends me against **ALL** danger and guards and protects me from **ALL** evil. **ALL** this He does only out of fatherly, divine goodness and mercy, without any merit or worthiness in me. For **ALL** this it is my duty to thank and praise, serve and obey Him. This is most certainly true.[34]

The doctrine of creation, specifically the teaching of creation out of nothing (*ex nihilo*), confesses that everything in the cosmos owes its existence to the divine will. This sets orthodox Christianity apart from pantheism, panentheism and open theism.[35] It also establishes the qualitative distinction between Creator and creature.

This idea of the primary differentiation between the Creator and the creature does not exist merely in the realm of dogma. It is central to the Genesis narrative, the Old Testament teachings about idolatry, and Paul's theology and soteriology. The language of Genesis reinforces the consistent teaching of radical differentiation. The verb "create" (*bara* — אָבָרָ) in the Hebrew Scriptures has God alone as its subject—only God creates.[36]

---

[31] While Christian discussions of this topic begin with a doctrine of creation, this is not to say that one can only mount a defense against suicide and euthanasia on Christian grounds. Arthur J. Dyck of the Harvard School of Public Health put forth a case based on "logic and facts" to demonstrate that one might argue for a natural and inalienable right to life, a natural love for life, and as a belief in life's sacredness or "incalculable worth" without committing oneself to the Christian faith tradition on the basis of "the moral structure of life's worth and protection." In his *Life's Worth: The Case against Assisted Suicide* (Grand Rapids: Eerdmans, 2002), before showing the importance of the "incalculable worth" of life in Christianity, he argues that such views are compatible with, but not dependent on, one's adherence to the Christian tradition or its doctrine, 73.

[32] Charles Arand, "Personal Autonomy versus Creaturely Contingency: The First Article and the Right to Die," *Concordia Journal* (October 1994), 388.

[33] Cited by Arand, "Personal Autonomy versus Creaturely Contingency," 388.

[34] *Luther's Small Catechism with Explanation* (St. Louis: Concordia Publishing House, 2017), 16, emphasis added.

[35] Simply defined: Pantheism identifies God with the universe; panentheism holds that God and the universe are distinguished, but the universe influences and changes God; open theism distinguishes God and the universe, but because of human freedom God's knowledge of the future is limited and His current governance is limited by human cooperation with Him.

[36] Thomas E. McComiskey, "278 אָבָרָ," ed. R. Laird Harris, Gleason L. Archer Jr. and Bruce K. Waltke, *Theological Wordbook of the Old Testament* (Chicago: Moody Press, 1999), 127.

Yet our history from the time of the Garden of Eden until the present has been marked by our rejection of God's rightful place as Creator and ourselves as His creation. As early as 1517, Luther declared: "Man is by nature unable to want God to be God. Indeed, he himself wants to be God, and does not want God to be God."[37] In the New Testament, Paul concludes his discussion in Romans 1:19–25 with the divine consequence of ignoring that created order: "Therefore God gave them up in the lusts of their hearts to impurity, to the dishonoring of their bodies among themselves, because they exchanged the truth about God for a lie and worshiped and served the creature rather than the Creator, who is blessed forever! Amen."

Finally, the truth of Scripture affirms more than this. Unlike a sculptor who would have an instrumental relationship between himself and what he fashioned or a painter who would leave something of his genius in the paintings he produced, God is related to His creation as "Absolute Giver to absolute receiver."[38] Put another way, God gives life; we receive life. We are stewards, not owners, of the lives God entrusts to us. If our lives are given from God, we certainly have no authority over the lives and deaths of others. Since God is the absolute Giver and our nature hardwires us to be receivers, "the most uncreaturely thing that a person could do is to refuse God's gift of life."[39] Oswald Bayer helpfully explains that human dignity lies in the "indissoluble intertwining of element and instituting word" by the One who has "bestowed, given on loan—by the One who promises and gives himself unconditionally to humankind: namely, God."[40] Because my human dignity does not develop out of my own works or merit, neither can any other human being rip it from me. It belongs neither to me nor to those in power in society. Rather, it remains that which is on loan from God. The relationship of Creator to creature as "Absolute Giver to absolute receiver," is developed biblically by Paul in 1 Corinthians 6 where he teaches that "you are not your own, for you were bought with a price. So glorify God in your body" (1 COR. 6:19–20).

Since we are both dependent and finite, necessarily creature rather than Creator, any effort to arrogate to ourselves rights that properly belong only to God (e.g., giving or taking life) can only be counted as foolish in the extreme or, more properly, an act of cosmic treason. Continuing Sayer's analogy of God's creation to human artistry, we have no reason to believe that our efforts to seize power from the Artist would be any more successful than if a painting refused to be painted. In Psalm 139, verses 7–12 reflect upon the impossibility of evading the searching presence of the Creator, regardless of the strategies or designs followed by the creature. David then explains:

> 13 For you formed my inward parts;
> you knitted me together in my mother's womb.
> 14 I praise you, for I am fearfully and wonderfully made.
> Wonderful are your works;
> my soul knows it very well.
> 15 My frame was not hidden from you,
> when I was being made in secret,
> intricately woven in the depths of the earth.
> 16 Your eyes saw my unformed substance;
> in your book were written, every one of them,
> the days that were formed for me,
> when as yet there was none of them.

[37] *LW* 31:10.

[38] Arand, "Personal Autonomy versus Creaturely Contingency," 380. See also Oswald Bayer, "Self-Creation? On the Dignity of Human Beings," *Modern Theology* 20, no. 2 (April 2004), 275–290. Bayer opens with the provocative sentence: "The absurd desire of humans to become self-creators — be it in an individual or a collective way — is as old as humanity itself," 275.

[39] Arand, "Personal Autonomy versus Creaturely Contingency," 392.

[40] Bayer, "Self-Creation?" 279. Bayer calls this an unconditional "categorical gratuity."

Thinking of ourselves as radically dependent on a Creator for our lives and identity bears critical implications for our understanding of the topic of human dignity, so much discussed by the advocates of "death with dignity." Charles Arand couples the First Article of the Creed with the assertion of *ex nihilo* creation as the radical counter-cultural confession of second-century orthodoxy. It confuted the idea that the material was intrinsically tainted with evil and notions of an imposed chaotic order of creation popular in such Greek philosophies as Stoicism, Epicureanism and Platonism.[41] Arand proffers this truth as a potent affirmation of our belief in the worth of human life. Created by God, we do not have life on our own nor are we free to dispose of it as we will.

Carl Trueman echoes these concerns in his discussion of dignity in *The Rise and Triumph of the Modern Self*.[42] The argument that we are created by God and radically dependent on Him has been eroded by the rise of what has been dubbed "expressive individualism." Philosophical trends from Rousseau through the Romantics, to Freud, and then to the New Left have altered the popular understanding of the relationship between Creator and creation. As the self-emerged triumphant, notions of volitional choice in countless arenas of life became the means for individuals to define themselves, thinking that their identity is the sum total of their choices. Even being a Christian is viewed as a personal choice, together with whatever "flavor" of Christian we elect to become. So also, morality is merely another choice. As Christians (and as confessional Lutherans), we are not exempt from this lamentable psychologizing of identity and dignity. As Trueman noted, "The general culture of expressive individualism and of choice of identity is ours too."[43]

We are not suggesting that the shift from rigidly hierarchical notions to the current emphasis on individual dignity was entirely wrong. The democratizing of government and society has certainly been beneficial in many ways. But such benefits are most firmly grounded in the fact that God has created and provided redemption for every person rather than in tenuous claims of human dignity. While human dignity is frequently ill-defined, it is certain that any authentic claim of human dignity must be centered in the worth and identity God gives by His creating, redeeming and sanctifying work. "The problem with expressive individualism is not its emphasis on the dignity or the individual value of every human being. That is what undergirded the fight against slavery in the nineteenth century and the civil rights movement of the 1950s and 1960s. Rather, it is the fact that expressive individualism has detached these concepts of individual dignity and value from any kind of grounding in a sacred order."[44] In place of dignity based on a universal human nature bestowed by God, today's psychologized expressive individualism grounds dignity in the sovereign right of every individual to determine his or her own identity and to act in ways that demand not mere tolerance but recognition by the society at large.

Lutherans do not stop with locating the nature of human dignity in the Creator-creature relationship. As Christ-centered and cross-focused disciples of Christ, we cannot fail to describe our human dignity in terms of redemption as well as creation. As such, dignity is a gift conferred by the Creator who is also the Redeemer. Luther's explanation of the First Article of the Creed in his Small Catechism defines human beings in terms of their original creation, but with a view to justification when he writes: "God protects me against all danger and shields and preserves me from all evil. And all this is done out of pure, fatherly, and divine goodness and mercy, without any merit or worthiness of mine at all!"[45] Our lives

[41] Arand, "Personal Autonomy versus Creaturely Contingency," 393.

[42] Carl R. Trueman, *The Rise and Triumph of the Modern Self: Cultural Amnesia, Expressive Individualism, and the Road to Sexual Revolution* (Wheaton: Crossway, 2020).

[43] Trueman, *The Rise and Triumph of the Modern Self,* 386. Trueman cites numerous authors, such as Michael Horton, Christian Smith and David Wells, who have demonstrated some of the ways expressive individualism and the choice of identity have had pernicious effects on the Christian church of our day. The descriptor "therapeutic" in the term made famous by Smith, "Therapeutic Moralistic Deism," describes this emphasis upon the shift from helping persons adjust to the demands of their duties toward God or their accountability to a larger society to an agenda that makes the self-determining individual primary.

[44] Trueman, *The Rise and Triumph of the Modern Self,* 387.

[45] Martin Luther, "Small Catechism," in *The Book of Concord*, Robert Kolb and Timothy J. Wengert, eds. (Minneapolis: Fortress Press, 2000), 354–355.

are never valued on the basis of our merits or even for our functional capabilities, but always an existence that is "merely owed."[46] Bayer puts it so well:

> This means that humankind — any human without exception — is, without any merit or any worth that he could grant himself or expect from other humans as recognition, unconditionally and absolutely recognized and valued by his creator, redeemer and perfecter. This means that he has an inviolable and indestructible dignity. Since this dignity is not conferred on him by any human person, no human being can deny it to him.[47]

This does not imply that a right view of human dignity flows only from a theology of creation. Lutherans, following Luther, base their view of the dignity of man in a theology centered in the cross and in a theology of justification. While it is "broadly anthropological" and equally applicable to all, we cannot escape the fact that it must also be seen through the lens of salvation and concerned with matters of eternity.[48]

We are and ever shall be creatures, made by our Creator. However, the basis for our dignity rests on an interconnectedness of what Bayer calls "three irreducible respects." In addition to being made by God, we are those who have become corrupted and lost our dignity (ROM. 3:23) and yet persons who have been redeemed by Jesus Christ and set free from the systemic corruption of our original creation. Viewed from the perspective of the cross, one might say that what makes us human is a universal need to be justified by faith.[49]

Rather than basing human dignity on something intrinsic to us, as if we owned it and were owed deferential treatment because of it, our dignity must always be viewed as a bestowed endowment. And because of the irrevocable and unconditional grant of dignity by the Triune God, it will always be extrinsic to our abilities, functional capacities and merits. This last point bridges the gap between creation and redemption. Lutheran theology views both creation in Eden and consummation in eternity through the lens of justification and the cross of Christ. Justification addresses the loss of our original dignity and secures it for all humankind, as those for whom Christ died, regardless of one's faith or lack thereof. In short, "According to Luther, human dignity … is warranted only by the triune God: the creator, redeemer and perfecter of humans and the world around them."[50]

But if we are radically and irrevocably dependent on God as our "creator, redeemer, and perfecter," then dependence on others cannot be seen as a necessary loss of dignity. Creaturely dependence marks and circumscribes the very meaning of our identity. To be creaturely is to know our true dignity as those created in the image of God. An embodied existence as creatures involves a dependence in faith upon the One who is Lord of life. It also means that we are placed in community where we willingly give aid to others and receive it from them. "When we act for the benefit of another, we do not simply act heroically or philanthropically. We are doing what we have been given to do. As co-workers with God in the ongoing work of creation, we are given the task of supporting and securing the life of others."[51]

Unlike arguments based on the instrumental value of a person (how much they can do, earn, contribute, their level of cognitive capacity or physical ability, and the like), Christians base their understanding of life's preciousness on the

---

[46] Oswald Bayer, "Martin Luther's Conception of Human Dignity," in *The Cambridge Handbook of Human Dignity: Interdisciplinary Perspectives,* ed. Marcus Düwell, Jens Braarvig, Roger Brownsword and Dietmar Mieth (Cambridge: Cambridge University Press, 2014), 103.

[47] Bayer, "Martin Luther's Conception of Human Dignity," 102. Bayer cites Luther's three seminal works on this topic of human dignity as *The Disputation Concerning Man* (1536), *On the Freedom of the Christian* (1520), and his dispute with Erasmus, *On the Bondage of the Will* (1525). See also Andrew Ronnevik, "Lutheran Conceptions of Human Dignity in a Global Context: A Conversation with Indian Dalits and European/Americans," *Dialog: A Journal of Theology* 59, no. 4 (December 2020): 325–333.

[48] Ronnevik, "Lutheran Conceptions of Human Dignity in a Global Context," 326.

[49] Bayer, "Martin Luther's Conception of Human Dignity," 102–103, referencing Luther's central thesis 32 of the *Disputation Concerning Man*.

[50] Bayer, "Martin Luther's Conception of Human Dignity," 106.

[51] Arand, "Personal Autonomy versus Creaturely Contingency," 397.

bestowed value of persons as created in the image of God and those for whom Christ died. As Bartlett and Rehder put it:

> Christians do well to build our responses on the Truth of God's Word, which says that:
>
> (1) human life is sacred regardless of condition or health,
>
> (2) God is Lord over all matters of life and death and we can trust Him to do what is right according to His will,
>
> (3) God has demonstrated His goodness and love for us in the cross of Jesus and nothing can separate us from His love,
>
> (4) God has a purpose for every life.[52]

B. Death with Dignity?

Driving the engine of the "death with dignity" crusade have been two central ideas: (1) an absolutist approach to human autonomy and its corollary of self-determination, and (2) an emotion-laden desire to limit or relieve suffering.[53] "Advocates of euthanasia and physician-assisted suicide believe that 'dignity' demands the freedom to call our own shots — when we can end our lives before we become 'helpless' and dependent on others to care for us."[54] Indeed, much of the literature in favor of physician assistance in the dying of patients takes for granted that patient "wishes" bear the weight of moral obligation.[55]

This emotional tilt toward autonomy does not always come packaged with coherent rational explanations. The same physician who would defend abortion on the grounds of the woman's right to determine what should happen to her body might ignore a suicide note pinned to the shirt of an ER admission with slashed wrists and proceed to attempt to save the person's life despite the patient's expressed intents.[56] Beyond that, one might legitimately question whether "doing what the patient wants" can truly escape the physician imposing his or her values on the patient at the end of life's journey.[57]

Behind the central arguments, however, stand a couple of additional factors. First, the 1960s and 1970s were an era of rebellion against authority that affected medical care. Physicians were no longer automatically trusted to act in a patient's best interests, almost as a parent. Their judgments were questioned, second opinions were sought, and patients became more consumerist in their desire to make their own choices and decisions for modalities of care. Second, despite the publicity attendant to laws respecting advance directives, patient wishes continued to be set aside for various reasons.[58] Some of the reasons for the success of efforts to legalize physician-assisted suicide, then, originate in a reaction to how patients have been treated in hospitals and by physicians. Pathologist turned physician-assisted-suicide crusader Jack Kevorkian summed it up on his way to jail: "If I have lost my freedom, I have lost something more valuable than life. Therefore, continuing life

---

[52] Bartlett and Rehder, "Ventilators, Feeding Tubes, and Other End-of-Life Questions," 1.

[53] Trueman, *The Rise and Triumph of the Modern Self,* especially 64–70, discusses the implications of "psychological man and expressive individualism" shaping the societal idea of what it means to be a "self" in the contemporary world. The absolutist approach to human autonomy accompanies the sociological and philosophical shifts chronicled by Philip Rieff and Charles Taylor that Trueman explains. Indeed, without these changes, a slogan such as "death with dignity" would be difficult to understand. A valuable analysis of the autonomy-based and utilitarian arguments for assisted suicide can be found in Neil M. Gorsuch's *The Future of Assisted Suicide and Euthanasia* (Princeton: Princeton University Press, 2006). The Supreme Court associate justice concludes: "After considering arguments from history, fairness, autonomy doctrine and theory, and utilitarianism, I suggested that courts and legislators may wish to consider a less frequently voiced perspective on the assisted suicide and euthanasia question, one grounded in the recognition of human life as a fundamental good. Under this view, private intentional acts of homicide are always wrong" (217–218).

[54] Bartlett and Rehder, "Ventilators, Feeding Tubes, and Other End-of-Life Questions," 1.

[55] See, for example, Tom Beauchamp and James F. Childress, *Principles of Bioethical Ethics*, 8th ed. (New York: Oxford University Press, 2019).

[56] Stanley Hauerwas, *Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped, and the Church* (Notre Dame: University of Notre Dame, 1986), develops this exact scenario in his discussion of suicide and the ethics of autonomy, 100–101.

[57] Dr. Patricia Wesley, a psychiatrist, observes (in Dyck, *Life's Worth,* 15): "It is frighteningly naïve to assume that when our guide to medical practice is 'doing what the patient wants,' we will escape the imposition of the physician's values on the clinical encounter. Personal values can be sequestered in the question not asked, or the gentle challenge not posed, when both should have been."

[58] Sometimes hospitals do not have a copy of the patient's advance directive on hand. Clinical circumstances may have changed to render obsolete the original intention of the author. There may be disagreements with a family about treatment decisions.

is pointless. It's as simple as that."[59]

Public arguments for euthanasia and physician-assisted suicide almost always conjoin these two factors: an absolutist approach to human autonomy and self-determination together with an emotional desire to limit or relieve suffering. We often hear pleas for allowing people who are suffering greatly to request assistance in "ending it all."[60] One may wonder how often this is "a purely strategic maneuver aimed at keeping the argument for the time being a relatively narrow one. Whatever our judgment of motives, however, the fact is that, simply as a matter of logic, the two prongs of the argument will gradually become independent of each other."[61]

Once we grant the overarching significance of self-determination, why does it matter whether one is suffering "greatly" or not? How does one's degree of suffering enter in as a factor in the moral equation? If self-determination is but one aspect to be considered and if it must be evaluated along with "great suffering," what kind of suffering is reason enough for ending one's life? Would a young athlete who sustained a career-ending injury have the right to claim that the loss of fame and financial security was sufficient justification for assisted suicide?

The other prong of the argument proves problematic as well. If the great suffering of a person makes such powerful moral claims on us that we should kill to end his agony, why would we insist that the person be self-determining or competent to request it? We readily ask veterinarians to intervene to "put down" our pets whose bodies are consumed with cancers and painful maladies. We consider it merciful to do so.

The conventional defense of a "right to die" advances by promoting two ideas, both of which can easily expand the class of candidates for such merciful ministrations. "Those who suffer greatly but cannot request relief and those who request help even though their physical pain is not great will begin to seem more suitable candidates."[62]

Evangelical writer Joni Eareckson Tada has lived for 55 years since suffering a fracture between the fourth and fifth cervical vertebrae at age 17 and becoming a quadriplegic, paralyzed from the shoulders down. Her years of living with the limitations of her condition have afforded her ample time to reflect on the questions of the quality-of-life ethic and end-of-life decisions. She wisely observes: "When we clamor about the sanctity of our individual rights, we may be reinforcing an all-too-human failing, and that is the tendency to place ourselves at the center of our moral universe. We label our desires 'rights' as if to give those willful determinations a showy kind of dignity."[63]

The doctrine of creation establishes the principle of partnering with God as co-regents called to exercise dominion over His creation. But this takes place in the context of our creaturely receptivity and response to God who is the Creator. In this context, the idea of self-determination can never be the defining value by which human lives are lived. Our dignity does not lie in our autonomy, but in our dependence.

---

[59] Quoted in Arand, "Personal Autonomy versus Creaturely Contingency," 387.

[60] Many arguments for PAS appear shaped more by the life experience of the writer rather than upon enduring principles. Famed Roman Catholic theologian Hans Küng, for instance, readily admits his argument in favor of PAS has been formed in the context of watching his brother die a very painful death from a brain tumor. Hans Küng, "A Dignified Dying," Section 145 in Therese M. Lysaught, *On Moral Medicine: Theological Perspectives in Medical Ethics,* 3rd ed. (Grand Rapids: Eerdmans, 2012).

[61] Meilaender, *Bioethics: A Primer for Christians*, 75.

[62] Meilaender, *Bioethics: A Primer for Christians*, 76.

[63] Joni Eareckson Tada, *When Is It Right to Die?* (Grand Rapids: Zondervan Publishing House, 1992), 73.

C. The Quest for Absolute Autonomy[64]

As Arand has observed, exalted notions of autonomy elevate isolation and separation, ultimately excluding relevant others from moral conversation and decisions; relationships become merely voluntary associations based on my absolute decision-making authority. Callahan shows that this leads to an atrophy of our sense of obligation toward others and their obligations to us.[65] Older cultures either grounded their claim to moral authority on myths (e.g., the oracle of Delphi demands it) or on a transcendent appeal to faith rather than fate (e.g., Christianity).[66] In both cases, they operated with a clear sense of the transcendent and the authority such an attitude toward a "higher power" had on the moral commands of the culture. In stark contrast with such approaches, our society increasingly exists without rooting its moral imperatives in anything sacred. That does not relieve us of the necessity to justify our norms, "but they cannot do so on the basis of something sacred or transcendent. Instead, they have to do so on the basis of themselves. Ethics, shorn of its reference to the transcendent, becomes little more than a statement of personal preferences and, increasingly in our therapeutic culture, of 'feeling.'"[67] The inherent moral instability and volatility of this approach should be obvious.[68]

Against this, biblical doctrine teaches us that our autonomy is circumscribed and bounded by our creaturely nature as those born into community, not into isolation. It holds that relationships are the currency of our creaturely existence, and that we are called to render and receive assistance to our fellow human beings. Where in this do we have an autonomous right to refuse life or refuse to help our sisters and brothers in their need?

First, Christians affirm the qualitative distinction between Creator and creation. As Creator, God does not cede His rights to the creation, but retains them. This is the thrust of St. Paul's affirmation in 1 Corinthians 6 when he declares: "Or do you not know that your body is a temple of the Holy Spirit within you, whom you have from God? You are not your own, for you were bought with a price. So glorify God in your body" (1 COR. 6:19–20). Christian doctrine insists that all other ideologies fail to grasp this central truth of existence that there is an infinite qualitative distinction between the Creator and the creation.

Second, the reality of our creatureliness includes an inescapably communal element. Meilaender recounts the lesson he learned from one of his students when discussing suicide. She "described her cousin's suicide and its continuing effects on his family by saying: 'He didn't just take his own life; he took part of theirs too.'"[69] We are never able to escape the import of the existential question: "Am I my brother's keeper?"

Third, Scripture repeatedly affirms that not only does God retain the rights to our life, but He determines the number of our days. "Your eyes saw my unformed substance; in your book were written, every one of them, the days that were formed for me, when as yet there was none of them" (PSALM 139:16). Not only is God infinitely higher than we are, and not only are we thrown into community with all of its joys and messy obligations, even the length of our sojourn on this planet remains properly with the One who is not only our Creator but also our Sustainer.

---

[64] In 1985, bioethicists Tom L. Beauchamp and James F. Childress produced their influential *Principles of Biomedical Ethics* (Oxford: Oxford University Press, 2019), now in its eighth edition. They put forth a four-principle approach to common medical morality: respect for autonomy, beneficence, non-maleficence and justice. They address the issue of autonomy by speaking of autonomy as creating both "negative" and "positive" duties. Negatively, "autonomous actions should not be subject to controlling constraints by others," while positively, autonomy requires "respectful treatment in disclosing information" so people can make their own decisions. The idea is that the decision-maker should be as free as possible under the constraints of the existing circumstances. In developing their other three points, they speak of the duty of non-maleficence: "first do no harm" ("avoiding anything which is unnecessarily or unjustifiably harmful"), beneficence: "do as much good as you can," and justice: distribute health resources fairly. As they apply the principles, "physician assistance in hastening death is best viewed as part of a continuum of medical care." They find no significant moral difference between "comfort-only care that hastens death and PAS and euthanasia," Dyck, 45.

[65] Arand, "Personal Autonomy versus Creaturely Contingency," 399.

[66] Trueman helpfully demonstrates the relevance of Rieff to this topic, *The Rise and Triumph of the Modern Self*, 74–82.

[67] Trueman, *The Rise and Triumph of the Modern Self*, 79.

[68] Trueman, *The Rise and Triumph of the Modern Self*, 76. Rieff refers to this by the nomenclature "third world," roughly equivalent to what Charles Taylor means by the "immanent frame." It denotes a culture where transcendence has collapsed into immanence and partakes of the kind of ethics Alasdair MacIntyre dubs emotivism.

[69] Meilaender, *Bioethics: A Primer for Christians*, 74.

D. The Question of Euthanasia and What It Really Means

Lutheran catechesis reinforces the truth that the Fifth Commandment calls upon us to "fear and love God so that we do not hurt or harm our neighbor in his body, but help and support him in every physical need."[70] The Ramsey Colloquium's directive "always to care, never to kill"[71] echoes this tradition. "For Christians, each person's life is a divine gift and trust, taken up into God's own eternal life in Jesus, to be guarded and respected in others and in oneself."[72]

Physician-assisted suicide may escape the technical meaning of euthanasia since it "only" involves the physician in prescribing the drugs that will end life when taken by the patient. Such specious logic cannot evade the fact that purposefully enabling an act is to participate in it. There is a difference, however, between enabling death and accepting its inevitability. "Deeply embedded in our moral and medical traditions is the distinction between *allowing to die*, on the one hand, and *killing* on the other."[73]

Christian ethicists have made a strong case for the right to refuse or withhold medical treatments if they are either "useless or excessively burdensome."[74] But, even here, to reject a treatment must never devolve into rejecting a life. It engages others in a conspiracy to abandon, to kill another human being. Only flights of sophistry can disguise the fact that despite all the language regarding choice and self-determination, euthanasia represents a license to kill.

The experience of the Netherlands may prove instructive. Euthanasia has been known to be regularly practiced in the Netherlands since 1973, even prior to the current more permissive law.[75] Indeed, one might argue that the 2001 law sought to make legal what had been practiced behind closed doors in the previous decades.[76] The official guidelines now require that the patient's decision is "voluntary, well considered and persistent, in the presence of unbearable pain without hope of improvement."[77] They mandate the consultation with more than one doctor and concurrence between the physician and the patient that euthanasia is the only reasonable option. Despite claims that the Dutch experience has been "virtually abuse-free," studies have consistently shown that cases of voluntary euthanasia have been underreported by less than half of the actual cases for a variety of reasons (e.g., fear of being challenged for how strictly one followed the guidelines in the law).[78] Since 2002, euthanasia is regulated by the Termination of Life on Request and Assisted Suicide (Review Procedures) Act. Rates for officially reported euthanasia have risen steadily in the Netherlands, from under 2% of all deaths in 2002 to more than 4% in 2019.[79] But major skepticism exists as to how accurate the official numbers are, given the incentive to avoid scrutiny, additional paperwork and the refusal by some physicians to report their euthanasia cases.

---

[70] *Luther's Small Catechism with Explanation*, 14.

[71] The Ramsey Colloquium, "Always to Care, Never to Kill," 45.

[72] Meilaender, *Bioethics: A Primer for Christians*, 76–77.

[73] The Ramsey Colloquium, "Always to Care, Never to Kill," 45.

[74] This distinction occurs repeatedly in the literature and is enshrined in Meilaender's influential work.

[75] Brian Pollard, "Current Euthanasia Law in the Netherlands," *Catholic Education Resource Center* (2003), *catholiceducation.org/en/controversy/euthanasia-and-assisted-suicide/current-euthanasia-law-in-the-netherlands.html.* Gorsuch recounts the much-celebrated 1984 assisted suicide that resulted in the Dutch Supreme Court siding with the physician on the grounds of "conflicting duties." Despite the nominally illegal nature of physician-assisted suicide in the Netherlands, the court found that the killing was justified by the doctor's professional judgment about the quality of his patient's life. Neil M. Gorsuch, *The Future of Assisted Suicide and Euthanasia* (Princeton: Princeton University Press, 2006), 104–105. This legal protection expanded considerably in 1994 when "the Dutch Supreme Court held that, for a request for assisted suicide or euthanasia to be justified on 'necessity' grounds, the patient's suffering need not be physical, the patient need not be terminally ill, and purely psychological suffering can qualify a patient for an act of euthanasia," 105.

[76] On this, see Ian Dowbiggin, *A Merciful End: The Euthanasia Movement in Modern America* (Oxford: Oxford University Press, 2003), 169.

[77] Gorsuch summarizes the law as permitting assisted suicide and euthanasia when the physician: "1. holds the conviction that the request by the patient was voluntary and well-considered, 2. holds the conviction that the patient's suffering was lasting and unbearable, 3. has informed the patient about the situation he was in and about his prospects, 4. and the patient [held] the conviction that there was no other reasonable solution for the situation he was in, 5. has consulted at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, referred to in parts 1–4, and, 6. has terminated a life or assisted in a suicide with due care," *The Future of Assisted Suicide and Euthanasia,* 106.

[78] Gorsuch devotes a major portion of Chapter 7 (103–116) to a thorough discussion of the Dutch experience with assisted suicide and euthanasia, including a critical review of major studies. He observes that "the Surveys have consistently found that a significant proportion of assisted suicides and acts of euthanasia go unreported, even though Dutch professional and legal guidelines allow the practices and expressly require them to be reported to public authorities," *The Future of Assisted Suicide and Euthanasia,* 113.

[79] See "A Critical Look at the Rising Euthanasia Rates in the Netherlands," as reported by *healthcare-in-europe.com* (Jan. 15, 2021), *https://healthcare-in-europe.com/en/news/a-critical-look-at-the-rising-euthanasia-rates-in-the-netherlands.html.*

The experience of the Netherlands with its permission to euthanize provides us with a warning about the trajectory of a society that surrenders the sanctity-of-life ethic and the protection of the weak and vulnerable. One suspects that in a world of limited resources, the permission to die will soon morph into a duty to die. Heads of nursing homes, eldercare attorneys and others in the senior living sector have reported dealing with greedy relatives trying to find a way to limit the expense of care for a frail relative.[80] Imagine if the person lived in a jurisdiction where the law permitted physician-assisted suicide. Would terminally ill seniors be pressured to become "compassionate heroes" for their families to preserve more of the inheritance? Common sense tells us that they would. The conjoining of legal permission with social acceptance would result not in more freedom, but in less.[81]

Unfortunately, the logic of providing euthanasia leaves us with a major dilemma exposed by the Netherlands experience. Typically, euthanasia policies say that we should offer it as a right both because of our claims to self-determination and in order to relieve suffering for the terminally ill. However, we have noted earlier (see "The Quest for Absolute Autonomy") that oftentimes these two criteria are separated in practice.

Meilaender has provided a strong defense of the rejection of euthanasia and affirmation of "double-effect" reasoning.[82] With respect to euthanasia, he offers four simple observations. First, physicians are obliged to do what they can to relieve the suffering of their patients. Here the "can" must be limited to "morally can." A physician would be prohibited from doing something that would relieve suffering but violate a moral code. Second, refusing to approve actions that are intended to kill the patient does not imply that we must do everything possible to keep the person alive (e.g., it is sound medicine and morally appropriate to refuse treatments that are useless or excessively burdensome). Third, the freedom to order one's own life is not absolute. We may not marry our sister, sell one of our kidneys to the highest bidder or take certain drugs. Fourth, genuine compassion must respect the boundaries established by the Creator-creature divide. Hence, "we cannot give ultimate authority over our life to another human being, nor are we authorized to exercise such authority over another."[83]

[80] Medicare in the United States, for instance, does not provide for "custodial care" in nursing homes and senior living communities. Some family members have objected to depleting their loved one's financial resources on "useless" care. In order to qualify for the government aid that may be available, some families enter into convoluted legal mechanisms for shielding assets. An entire specialty of law focuses on means to transfer assets into legal instruments that make a frail senior appear to be penniless and in need of government-provided nursing home care.

[81] Consider the arguments Meilaender makes regarding this in *Bioethics: A Primer for Christians*, 75–80.

[82] Gilbert Meilaender, *Bioethics and the Character of Human Life: Essays and Reflections* (Eugene, Ore.: Cascade Books, 2020), 121–132.

[83] Meilaender, *Bioethics and the Character of Human Life*, 123. It is important to note that Meilaender refers to "*ultimate* authority" and is not speaking against something such as a health POA.

III. Medical-Ethical Considerations

The Commission recognizes that a host of medical and ethical matters come to bear as we face the end of earthly life for ourselves or our loved ones. Many of the issues have to do with making decisions about treatment — what sort, how long, how do we decide and so forth. The following are some of the matters that must often be considered. What about matters such as the use of devices to help with breathing or procedures that provide hydration and nutrition? Is there sometimes an appropriate time to stop the use of such artificial means for prolonging a physical life? And who should make such decisions — patients, their family, doctors? Are advance directives advisable? Are they absolute?

There are many such questions. The items below seek to address some of them, in no particular order of priority or logical progression.

A. Ventilators and Medical Prolongation of Life and Dying

Elizabeth R. Skoglund observes, "If a respirator or ventilator can be a bridge back to life, then we have the obligation to try it. If, on the other hand, the respirator is used when death is inevitable, simply to slow the dying process, then it is wrongfully keeping us from being released to be with God."[84]

Do Not Resuscitate (DNR) orders often involve the issue of ventilators. A DNR designation refers to a medical order making clear an individual's request that no measures be taken to resuscitate him if his heart or breathing stops. The order is made while the individual is mentally capable and conscious, or by his health care proxy if he is not. DNR covers a wide range of specific instructions to health care providers. Some patients may choose to have "full code" with intubation and to be placed on a ventilator (short or long term). Another patient may decide not to be on a ventilator with a "DNR Select" code status, where the heart would be shocked if it stops but intubation/ventilation is not performed. Some in this category choose to permit use of a BIPAP (similar to a CPAP for sleep apnea) to assist with breathing. A third option involves a patient that chooses to have a status of Do Not Resuscitate (DNR). Various treatments (e.g., antibiotics, tube feeding) and other care preferences can be specified on some DNR forms in some jurisdictions to guide health team members.

As for medically assisted nutrition and hydration, Luther's words are on point when he reminds us in the Small Catechism that "we should fear and love God so that we do not hurt or harm our neighbor in his body, but help and support him in every physical need."[85] He expands on this in the Large Catechism by explaining "this commandment is violated not only when we do evil, but also when we have the opportunity to do good to our neighbors and to prevent, protect, and save them from suffering bodily harm or injury but fail to do so. … If you see anyone who is suffering from hunger and do not feed her, you have let her starve."[86] Even in a state of coma, patients are often aware of their surround-

[84] Bartlett and Rehder, "Ventilators, Feeding Tubes, and Other End-of-Life Questions," 2.

[85] *Luther's Small Catechism with Explanation*, 14.

[86] Kirsi I. Stjerna, "The Large Catechism of Dr. Martin Luther," in *Word and Faith*, ed. Hans J. Hillerbrand, Kirsi I. Stjerna and Timothy J. Wengert, vol. 2, *The Annotated Luther* (Minneapolis: Fortress Press, 2015), 329.

ings and of conversations that take place. "Patients are not blind. They see the offering or non-offering of appropriate food and fluids as an expression of love and concern or lack of love and concern."[87] Tube feeding should never be deemed useless or futile if it sustains life and prevents death by starvation or dehydration.[88] Since a patient's life is God-given, we will not deem a treatment futile that sustains the life, "even though we might all agree this is not the life anyone would choose for himself."[89]

The concern that oral tube feeding runs the risk of infection or that it may even lead to incidental aspiration that may result in pneumonia hardly stands up to scrutiny. If one method of delivering nutrition and hydration proves problematic, there are other means to do it. The so-called "G-tube," for instance, provides a long-term alternative to the short-term naso-gastric delivery of nutrition and hydration following a minor surgical procedure. Placement of a G-tube can be performed in three ways: surgically through making small incisions guided by a laparoscope, surgically by means of an open incision to the abdomen, or endoscopically employing a scope into the stomach to create the stoma from the inside.

One might reasonably ask if ever removing artificial nutrition and hydration represents a permissible act. Here the question revolves around whether one is "allowing a person to die" or is intending to cause death. This paper affirms the principle that withholding or withdrawing treatments may be done when it becomes useless or excessively burdensome. In many end-of-life situations, the continued administration of hydration and nutrition may create rather than ameliorate problems.[90] For instance, if the kidneys no longer process fluids for elimination, adding fluids artificially may result in painful edema (swelling). Yet, we are reminded that the burdensomeness is that of the treatment, not of life itself. We are called to care for other persons and do all that we can reasonably do to assist in sustaining their lives. Certainly, fulfilling the commandment not to kill, but to "fear and love God so that we do not hurt or harm our neighbor in his body, but help and support him in every physical need" ordinarily includes supplying food and water.[91]

Another question involves comatose patients. Are we morally obligated to sustain their lives by means of artificial nutrition and hydration when the very fact of being in a persistent vegetative state makes any return to normal life highly unlikely? But, even here, the annals of medical science are replete with examples of remarkable, even miraculous, recoveries from an unconscious or persistent vegetative state. For instance, Munira Abdulla (born 1959), an Emirati woman, lapsed into a coma following a car accident and regained consciousness after 27 years.[92] While for a conscious patient, the use of tube feeding may prove terrifying and lead to a state of extreme agitation, an unconscious person would (obviously) not experience treatment as excessively burdensome. This illustrates the distinction between a treatment imposing an excessive burden and family members wishing to be relieved of the burden of sustaining a person's life. Meilaender correctly notes that such care cannot be described as "useless, since it preserves the life of the embodied human being (who is not a dying patient)."[93] To withdraw or withhold nutrition and hydration from a person means certain death. Regardless of our professed motives, we would be aiming at the death of the person. For this reason, sensitive ethicists such as Meilaender conclude: "For the permanently unconscious person, feeding is neither useless nor excessively burdensome. It is ordinary

[87] Bartlett and Rehder, "Ventilators, Feeding Tubes, and Other End-of-Life Questions," 3.

[88] Bartlett and Rehder, "Ventilators, Feeding Tubes, and Other End-of-Life Questions," 3.

[89] Richard Eyer, *Holy People, Holy Lives* (St. Louis: Concordia Publishing House, 2014), Kindle Edition, locations 1202–1203.

[90] For a thorough discussion of the morality of withholding food and water, cf. Joanne Lynn and James F. Childress, "Must Patients Always Be Given Food and Water?" in *By No Extraordinary Means*, ed. Joanne Lynn (Bloomington: Indiana University Press, 1986), 47–60. "The question is whether the obligation to act in the patient's best interests was discharged by withholding or withdrawing particular medical treatments. All we have claimed is that nutrition and hydration by medical means need not always be provided," 59. In the same book, Daniel Callahan frets that mounting social and economic pressures will precipitate "prematurely terminating nutrition" rather than providing it for too long after it becomes burdensome. Callahan, "Public Policy and the Cessation of Nutrition," 65. Childress follows Callahan's chapter and cautions against self-deception. He argues that we should make these decisions with clear-eyed awareness, accepting moral responsibility for the lines we draw and limits we set. Childress, "What is Morally Justifiable to Discontinue Medical Nutrition and Hydration?" 67–83.

[91] See CTCR, *Christian Care at Life's End*, for further discussion of these kinds of difficult and challenging decisions.

[92] "UAE Woman Munira Abdulla Wakes Up After 27 Years in a Coma," *BBC News Service*, April 23, 2019, *bbc.com/news/world-middle-east-48020481*.

[93] Gilbert Meilaender, "On Removing Food and Water: Against the Stream," *The Hastings Center Report* 14, no. 6 (December 1984), 13.

human care and is not given as treatment for any life-threatening disease. Since this is true, a decision not to offer such care can enact only one intention: to take the life of the unconscious person."[94]

We do not know what spiritual communion God may or may not have with a person in a persistent vegetative state. That some have recovered and resumed relatively normal lives makes it dangerous to presume that we are merely sustaining a biological shell rather than keeping a person alive.[95] However, whether we are physicians or nurses attending to a patient, family members called to bear the infirmity of their loved one, or even the patient himself or herself in a persistent vegetative state, we are all still God's creatures, "the instruments by which he provides and preserves life."[96]

B. Who Decides?

The annals of medical ethics are full of accounts of debates over who should be the decider. The popularity of living wills, a topic we will consider in the next section, is in large part a reaction to the fear of physicians imposing their own values and ideas upon the end-of-life decisions. Some doctors will err on the side of determining that the patient is a "lost cause" and act accordingly. Others will opt for every treatment conceivable, whether it is prudent or not. Complicating this scene, we have questions regarding whether physicians may ethically object to performing particular procedures, even against their consciences and religious beliefs. An influential article in the *New England Journal of Medicine* argued that physicians freely chose to enter the field of medicine and that "conscience clauses" should not be permitted.[97]

Most people probably agree that patients are not obliged to submit themselves to every recommendation by a physician, even their own. Nor are doctors required to follow bad medicine or unethical practice no matter how strongly their patients plead for it. We would want patients and their physicians to discuss and deliberate on how to proceed with a course of treatment. This should include a candid disclosure of the potential risks and the rewards attendant to it. But what if the patient cannot participate in such a conversation due to the temporary effects of a traumatic injury or a chronic case of dementia? Case law has tried to answer that hypothetical case with advance directives and "substituted judgment" criteria. What would the patient have wanted us to do if she were of sound mind and capable of making her wishes known? But does this approach resolve the dilemma of decision-making?

C. Advance Directives

Much of contemporary thinking about end-of-life decision-making has accepted a rather simplistic resolution to a difficult problem. The solution is that the patient alone decides on the care to be received. Given this assumption, a further question is how a patient is to be treated if he is no longer capable of decision-making. The answer proposed is that individuals should write down their wishes regarding medical treatment in advance of the time treatment is needed — an "advance directive." The most commonly known form of advance directive is the so-called "living will." In a living will, a hypothetical patient — let's say, Mary — expresses the kind of care that she would want as she contemplates life's end. But this ignores the fact that patients eventually face an all-too-real end of life that is not hypothetical at all. Indeed, there is a real question

[94] Meilaender, "On Removing Food and Water," 13.

[95] Elsewhere in this document, we argue that one may refuse or withhold treatment from someone in certain circumstances. Sustaining the life of one who is not actively dying is not the same as removing nutrition and hydration for someone who is in end-stage renal failure and for whom the very continuation of hydration will increase the person's discomfort and distress.

[96] Robert Kolb and Charles P. Arand, *The Genius of Luther's Theology: A Wittenberg Way of Thinking for the Contemporary Church* (Grand Rapids: Baker Academic, 2008), 55. Kolb reminds us that "both human creatures and nonhuman creatures function as masks of God (Luther used the Latin term *larvae Dei*), behind which he remains the creative agent of life."

[97] Ronit Y. Stahl and Ezekiel J. Emanuel, "Physicians, Not Conscripts — Conscientious Objection in Health Care," *New England Journal of Medicine* 376 (2017): 1380–1385. Against this line of thinking, that when you enter a profession you voluntarily surrender your rights to certain kinds of decisions based on ethical values, Leon Kass makes a strong case for understanding the role of the physician as a professional one bound by the rule: Doctors must not kill. He mounts a strong case against physician-assisted suicide. He concludes that what dying people most need as the "treatment of choice is company and care," "I Will Give No Deadly Drug": Why Doctors Must Not Kill," in *The Case against Assisted Suicide: For the Right to End-of-Life Care*, ed. Kathleen Foley and Herbert Hendin (Baltimore: Johns Hopkins University Press, 2002), 38.

whether the Mary who articulated her preferences two decades ago in a living will would agree with them today in her particular situation and circumstances.[98]

In order to address the deficiencies of substituted judgment and living wills, many ethicists opt for the designation of a legal proxy to act in the best interests of the person. Activated in various forms, the Durable Power of Attorney for Healthcare (under a variety of names) empowers a proxy named by the patient to act in the best interests of the patient.

The living will was first proposed by attorney Luis Kutner and defended in the *Indiana Law Journal* in 1969.[99] Since then, much ink has been spilled over the wisdom of such an advance directive. It must be stated at the outset that there is no perfect and simple answer to the question of whether living wills are beneficial.[100] Thoughtful people will continue to disagree over the wisdom of using them.

The commonly identified arguments for drafting a living will may be summarized as follows:[101]

1. Living wills preserve self-determination. Given that the patient will be the one either to benefit or be burdened by future treatments, it stands to reason that he should offer informed consent before being subjected to medical interventions.
2. Living wills afford an opportunity for a person to declare his or her own wishes for the circumstances of death. The patient may not want to be kept alive by a machine.
3. Living wills offer some measure of protection against the twin dangers of over-treatment and under-treatment. Just as some people are adamant that they want to be resuscitated in the event of a cardiac event, others insist that they should have a DNR order attached to their files.[102]
4. Living wills can serve to relieve anxiety and to facilitate the process of avoiding procrastinated decision-making in this critical area of life.
5. Living wills help families by not burdening them with difficult decisions at times of emotional duress. Even if a family is exemplary in its functioning, watching a parent die is an overwhelming emotional burden, one that does not lend itself to calm and wise choice-making when the decision may need to be made almost instantly.
6. Living wills can safeguard family finances. The financial consequences of end-of-life care may be significant, squandering a family's resources on interventions that may have little benefit.
7. Living wills can reduce litigation risk. Physicians tend to prefer a legal safety net against torts brought by family members unhappy with the clinical outcome or experiencing guilt and second thoughts about the wisdom of a course of treatment.

---

[98] The Wisconsin Evangelical Lutheran Synod website offers two brief but helpful discussions of advance directives. See Christian Life Resources, "Living Wills vs. Medical Directive Statements: There Is a Difference," *https://christianliferesources.com/2012/09/09/living-wills-vs-medical-directive-statements-there-is-a-difference/* and Christian Life Resources, "A Basic Understanding of Medical Directives, *https://christianliferesources.com/2018/05/10/a-basic-understanding-of-medical-directives/*.

[99] Luis Kutner, "Due Process of Euthanasia: The Living Will, A Proposal," *Indiana Law Journal* 44, no. 4, Article 2 (1969), *repository.law.indiana.edu/ilj/vol44/iss4/2.*

[100] The terms "living will" and "advance directives" are used interchangeably herein.

[101] *Taking Care: Ethical Caregiving in Our Aging Society*. The President's Council on Bioethics, September 2005, 67–70.

[102] It might be noted that the survival to discharge after in-hospital CPR was 18.7% for patients between 70 and 79 years old, 15.4% for patients between 80 and 89 years old, and 11.6% for patients of 90 years and older according to a study reported in *Age and Aging.* Myke S. Gijn, et al., "Chance of Survival and the Functional Outcome after in-Hospital Cardiopulmonary Resuscitation in Older People: A Systematic Review," *OUP Academic*, Oxford University Press, April 22, 2014, *https://academic.oup.com/ageing/article/43/4/456/2812217.*

While many are persuaded by such arguments for living wills, particularly when taken cumulatively, there are also sound reasons, both practical and theological, to question the use of living wills.[103]

1. A minority of people actually utilize living wills. In 1976, California was the first state to legally sanction them, yet almost 45 years later, a 2020 survey by the Gallup organization revealed that only 45% of Americans have a living will (and only 46% have a will for their assets).
2. People who do complete living wills typically do so prior to when the living will would take effect. As noted earlier, what someone may or may not want can change significantly when the time of actual need arises. People are often confused when asked to sign a living will concerning what their actual end-of-life wishes might be. One study pointed to a third of preferences for life-sustaining treatment changing over periods as short as two years.[104]
3. Living wills are often unclear or even contradictory in the preferences they identify.
4. Living wills are frequently lost, misplaced or not transmitted to those making medical decisions. Despite efforts by physicians to get patient wishes into their electronic records, medical charts often do not contain the intentions of the patient, let alone the actual document.[105]
5. Living wills, even when transmitted, often do not correlate with the care decisions made by surrogates at the bedside of the dying person. While family members generally predict patient preferences more accurately than physicians, "these studies call into question whether living wills are likely to have a significant impact on the medical care received by an incompetent patient, at least in cases where surrogate decisions are made either by relatives of the patient or by physicians who know the patient."[106]

Another concern is vital for Christian consideration of living wills. We have warned that the biblical foundation for human dignity is not personal autonomy, but the reality that God has created each person, that He bestows human value and worth (or dignity), and that He determines the course of human life from conception to death. For these reasons, we cannot ignore the danger that some may seek to utilize a living will or another advance directive to project their autonomy into the territory of an unknown and uncertain future. Of course, there are other reasons why living wills may be appealing. They may serve simply to communicate an individual's thoughts and desires about medical care and death without any rejection of God's sovereignty over life or the gracious character of His wise decisions concerning our lives.

In addition, some who utilize living wills see them as a means for them to express loving concern for their family. They assume that a living will would minimize the pain and conflict their loved ones might face in trying to address difficult end-of-life decisions. Such a motivation, commendable as it is, requires further consideration. In contrast with those who wish to avoid burdening their family members, Gilbert Meilaender bluntly says, "I want to burden my loved ones."[107] By this, he addresses the desire to spare family members at the time of death.

Meilaender summarizes the comments he has heard frequently in seminars: "I'm afraid that if my children have to make decisions about my care, they won't be able to handle the pressure. They'll just argue with each other, and they'll

---

[103] *Taking Care*, 71–79. Laws governing the wording and execution of a General Durable Powers of Attorney, an Advance Medical Directive and other similar documents vary from state to state. It is beyond the purpose of this report to survey the various state laws; rather, readers are encouraged to seek competent legal advice from an attorney familiar with the laws in their state.

[104] *Taking Care*, 74.

[105] When the Presidential Council on Bioethics report was written in 2005, they reported that only 16% of patient charts contained the actual form. *Taking Care*, 75–76.

[106] *Taking Care*, 78.

[107] Gilbert Meilaender, "I Want to Burden My Loved Ones," *Things That Count* (Wilmington, Del.: Intercollegiate Institute, Inc., 1999). The essay is reproduced in *First Things* (March 2010), *firstthings.com/article/2010/03/i-want-to-burden-my-loved-ones.*

feel guilty, wondering whether they're really doing what I would want. I don't want to be a burden to them, and I will do whatever I can in advance to see that I'm not."[108]

Those who have served in pastoral ministries or in institutions caring for the elderly will recognize the sentiment Meilaender repeats. Not all families are intact, or cooperative, or even particularly stable. Dying seniors may have one or more estranged children with whom they have not spoken in years or even decades. Sometimes the relationships between the children become the crux of the dissension. The end-of-life crisis facing an aging mother or father will only exacerbate existing sibling issues that have never been resolved satisfactorily. At times, a child may question or mistrust a parent's decision-making on behalf of another parent. Would it not be better to prevent such conflict and relieve the burden of decision-making by simply drafting a living will that states what a patient's wishes for end-of-life care should be?

Meilaender rejects the underlying assumption that a family should be spared such burdens. To be a family is to bear one another's burdens. "Is this not in large measure what it means to belong to a family: to burden each other — and to find, almost miraculously, that others are willing, even happy, to carry such burdens? Families would not have the significance they do for us if they did not, in fact, give us a claim upon each other."[109]

The logic of living wills elevates personal autonomy and self-determination above any other ethical values. But if dying people nearing the end of life demonstrate anything, it is that they are neither autonomous nor self-determining. Whether attended to by physicians, nurses or willing family caregivers, the wishes and the needs of a person at the threshold of death may be quite different from those that were anticipated perhaps decades earlier while one was still a vigorous person. As death draws near, such a document is of far less importance than prayerful conversation between family members, medical caregivers and one's pastor.

Meilaender reminds us that living wills may cut short such conversations that should rightly occur about a loved one's care. He notes that the severely demented or unconscious loved one becomes a stranger of a sort. His very condition evokes enormously deep and painful emotions. We may experience guilt over things we should or should not have said, memories of acts we wish we could take back, and fear (even terror) that we might find ourselves in the same situation someday. Defaulting to the legal language of a living will permits us to turn away from these concerns and shield ourselves behind the excuse of "just doing what Mom wanted." More ominously, moved by our discomfort and personal fears for our own futures, we may be tempted to do less than we should to sustain the life of our loved one.[110] Against this, some object that this burdens the loved ones, exactly what the living will attempts to avoid. But if the language of countless sentimental greeting cards means anything, love is the kind of burden we freely accept. "For to burden one another is, in large measure, what it means to belong to a family — and to the new family into which we are brought in baptism."[111]

The living will, therefore, may be questioned from the standpoint of Christian theology and common sense for two reasons. First, the wish to specify all of the conditions of care at life's end from the perspective of an earlier time may represent an effort to assert an illegitimate "right" to autonomy and self-determination. As already noted, the Christian doctrine of creation prizes creaturely dependence and receptivity over an individualized quest for autonomy and self-assertion of rights.

Second, living wills are based on the false assumption that we can predict and fully understand future events. Because these assumptions are false, living wills have proven remarkably ineffective in accomplishing their intended purposes, as

[108] Meilaender, "I Want to Burden My Loved Ones."

[109] Meilaender, "I Want to Burden My Loved Ones."

[110] Meilaender, "I Want to Burden My Loved Ones."

[111] Meilaender, *Bioethics: A Primer for Christians*, 103.

we noted earlier.[112] For these reasons, we suggest that living wills do not represent the best means for loved ones to exercise their God-given responsibilities to provide compassionate care for their loved ones. "In the end, no legal instrument can substitute for wise and loving choices, made on the spot, when the precise treatment dilemma is clear and care decisions are needed."[113]

Rather than endorsing living wills, many sensitive ethicists, both Christian and non-Christian, have instead defended the use of proxy directives such as a durable power of attorney (POA) for health care. A POA for health care avoids the impossible task of guessing what a legally incompetent person might want given the particular clinical circumstances near the end of life. Instead, it rightfully burdens those who loved her with asking a far more relevant question: "What is best for her now?"[114]

Some might argue that durable POA documents share with living wills a desire to reach into a future beyond the scope of time when we are fully competent to direct our own care. But unlike the living will, which extends its reach by means of legal specifications to guarantee the patient's own wishes and autonomy, the proxy affirms the individual's creaturely dependence and his need to rely upon others.

A health care POA designates that an individual, as the principal, appoints another person to be his agent to make health care decisions if he is unable or unwilling to make them.[115] A POA for health care should not be confused with a POA for property or business transactions, which appoints a person to make business- or property-related decisions. Even though the health care POA may not necessarily be making decisions, the agent most often has access to applicable medical records. Many jurisdictions provide for the health care POA to be durable, which means the agency designation remains in place even though the principal no longer retains ability to make decisions for himself or herself.

The selection of a health care agent is a critical decision as the agent will have ultimate authority for decision-making even after the individual is no longer able to express their own wishes. The individual chosen to be the health care agent should be someone with the capability to make decisions even if other family members are not in agreement.

It is normally prudent to choose a single health care agent. Commonly, one or two successors can be named in a health care POA, but only in an order of priority. Naming two individuals as health care co-agents only provides an opportunity for conflicts and stalemates and, therefore, the possibility that no decision is made.

Many times in a health care POA, an individual expresses certain wishes for how they want end-of-life decisions to be made. It is important the health care agent chosen be an individual well-grounded in the principal's spiritual foundation as well as their personal wishes. This helps to ensure that the health care agent is well equipped to assimilate the medical and health care facts that are unfolding and make appropriate, timely decisions.

Rather than a living will, the health care POA offers a better option for directing end-of-life care. As Meilaender concludes, it makes a simple statement to health care providers: "Here is a person upon whom I have often been dependent

---

[112] See pages 41–42. The 2005 report *Taking Care* devotes an entire chapter, pages 55–93, to "The Limited Wisdom of Advance Directives." This report of the President's Commission on Bioethics articulates multiple reasons for rejecting the living will in favor of power of attorney proxies and legal surrogate instruments.

[113] *Taking Care*, 56.

[114] Cf. *Taking Care*, 55–93, where the legal rulings in landmark 20th-century cases are discussed in terms of various permutations of subjective and objective standards, including "substituted judgment" and "best interest" standards.

[115] Power of Attorney documents vary widely, yet many jurisdictions have their statutory Health Care POA formats available online through their health departments or they may be accessed through a party's legal counsel or health care provider. It is important to ensure that current documents reflecting a person's end-of-life wishes are readily available and locatable when they may be needed.

for love and care in the past. Now, when I can no longer participate in decisions about my medical care, I am content to continue to be dependent upon his love and care. Talk with him about what is best for me."[116]

D. The Question of When Enough Is "Enough"

When is a treatment useless? When is a treatment excessively burdensome? A commitment to the sanctity of life and a refusal to accept physician-assisted suicide does not involve an idealistic effort to sustain biological life at all costs. When all indications point to God calling the soul from the body, "there is no point in merely blowing wind through the empty tent with ventilators and machines."[117] When death appears imminent, the decision to withhold or withdraw food and hydration is not deciding to kill. Rather, it represents an important aspect of caring for the dying person. We do not wish to add burdens to the patient at such a time, but to relieve him of additional burdens.

While it may be appropriate to withdraw or withhold nutrition and hydration for someone who is imminently dying, that does not mean that we may act in this way because a patient is not dying fast enough. As fallible men and women with deceitful hearts (JER. 17:9), it is easy to deceive ourselves with faulty reasons for why we should hasten death. Hospital and skilled nursing facility nurses have all heard families use a patient's poor "quality of life" as a reason to suspend treatments. Others speak of the psychological toll that a prolonged dying process may have on a physically frail or emotionally unstable spouse or other family members to rationalize a speedier death. An adult child may protest that this "useless care" is sapping the limited savings that the surviving parent will need to "get by." No doubt selfishness motivates some heirs who would rather a patient die quickly so their inheritance will not be used for patient care.

Despite such specious reasoning, we acknowledge that there are times when it is inappropriate to provide nutrition and hydration artificially. Depending on the specific condition, when major organs begin to fail, nutrition and hydration may actually increase the discomfort the body experiences after it no longer accepts or processes such sustenance effectively. In the active stages of dying, deterioration of the digestive tract can lead to discomfort and bloating. Similarly, as the heart becomes weaker and less efficient in pumping blood, fluid overload creates several negative conditions including fluid backup in the lungs, respiratory distress and excessive swelling of the tissues.

The Christian Medical and Dental Associations promotes a four-option approach to dealing with the ethical issues presented by artificial nutrition and hydration (ANH):

- Strong indications for use of ANH include patients with an inability to take oral fluids and nutrition with a high probability of reversing it; a patient in a stable condition but who is unable to swallow; a patient with a newly diagnosed but not imminently fatal severe brain impairment; gastrointestinal tract failure or need for bowel rest; or a fully informed patient wishing to survive until an important life event.
- Allowable indications for use of ANH speak to a morally neutral situation where a patient or surrogate should make the best decision after consulting with appropriate medical personnel. Examples would include a patient wishing to prolong life despite a severe and progressive neurologic impairment (e.g., end-stage amyotrophic lateral sclerosis, also called Lou Gehrig's disease or ALS) and situations in which there is uncertainty whether the anticipated benefits versus burdens justify the intervention.
- Not recommended but allowable indications for ANH include when a patient or surrogate asks to overrule the patient's advance directive due to a specific or changing clinical context.

[116] Meilaender, *Bioethics: A Primer for Christians*, 104.

[117] Bartlett and Rehder, "Ventilators, Feeding Tubes, and Other End-of-Life Questions," 8.

- Unallowable indications where it is unethical to employ ANH include administering it against the patient's or surrogate's express wishes, compelling medical professionals to participate in ANH insertion in violation of their conscience, or utilizing ANH when the patient is declared brain dead. [118]

E. Refusing or Withdrawing Treatment

In discussing the ethics of refusing treatment, several authors cite a helpful metaphor, known as "the good host," first proffered by the Anglican David H. Smith.

> A couple invite friends to dinner. Food and drink are pleasant; the conversation bubbles. The good host is hospitable and courteous to his guest, no matter what his shifts in mood. But there comes a time when the party "winds down" — a time to acknowledge that the evening is over. At that point, not easily determined by clock, conversation or basal metabolism, the good host does not press his guest to stay but lets him go. Indeed he may have to signal that it is acceptable to leave. A good host will never be sure of his timing and will never kick out his guest. His jurisdiction over the guest is limited to taking care and permitting departure.[119]

The illustration compares end-of-life decisions to the hospitality offered by a good host. The good host neither pushes his guests out the door too early nor does he inveigh upon them to remain after the end of the party.[120] While a growing number of jurisdictions may permit physician assistance in facilitating the deaths of their patients (e.g., by prescribing the lethal medication for the terminal patient to take), Christian ethics does not choose death or aim at it. Here it must be stated that neither do we make a false idol out of biological life as if it were the only or highest good.[121]

Unlike those availing themselves of the permission in those states with physician assistance in suicide laws, we are not called to choose death or aim at it. However, refusing treatments, even life-saving ones, may be a correct Christian choice. At 86 years of age, Polycarp, the Bishop of Smyrna, was taken to the arena. The proconsul attempted to persuade him to curse Christ and he would be free to go. But Polycarp refused, saying: "For eighty-six years I have served him, and he has done me no evil. How can I curse my king, who saved me?"[122] While Polycarp freely answered the proconsul's questions, expecting that it would result in his death, he did not do so intending or aiming at death.[123] The same moral reasoning applies to the soldier who sacrifices his life willingly for the well-being of others. While one might reasonably know or suspect that making a charge against overwhelming odds will result in one's death, this is not an act of suicide. Dying may be the most likely outcome, but it is not part of the soldier's plan of action.

Many end-of-life treatments to reduce pain will carry negative, even possibly lethal, side effects. The narcotic morphine, for example, has become a commonly prescribed end-of-life medication to relieve severe pain that does not respond to other analgesics. As the patient's pain increases, caregivers typically administer larger doses of the

---

[118] "Position Statements," Christian Medical & Dental Associations® (CMDA), March 23, 2022, *https://cmda.org/policy-issues-home/position-statements/*.

[119] David H. Smith, *Health and Medicine in the Anglican Tradition* (New York: Crossroad, 1986), 52.

[120] Hauerwas cites Daniel Callahan's recapturing of the meaning of "natural death" with some qualified approval since the phrase itself may be too misleading to be of much help. Hauerwas instead opts for the description of a "good death." Hauerwas, *Suffering Presence*, 98. Callahan defines "natural death" as one when (1) one's life work has been accomplished; (2) one's moral obligations have been discharged; (3) one's death will not seem an offense to sense or sensibility; and (4) one's process of dying does not involve "unbearable and degrading pain," 97. Hauerwas quotes Eberhard Jungel as teaching that the Christian proclamation of Jesus Christ freeing us from the curse of death implies that "human life has a natural end which comes when the time allotted to life has expired. Man has a right to die this death and no other." Hauerwas, *Suffering Presence*, 97. Hauerwas concludes that we ought not allow the "symbol of brain death to tyrannize us by requiring that we delay death so long that we can no longer die a good death … it should not be used as a substitute for the responsibility each of us has to die our own death." Hauerwas, *Suffering Presence*, 98.

[121] Hauerwas asserts that "we should die in such a manner that others see that they are sustaining us and that correlatively due credit is given to God as the ultimate giver of life." Hauerwas, *Suffering Presence*, 96.

[122] Justo L. Gonzalez, *The Story of Christianity*, Vol. 1. (Peabody, Mass.: Prince Press, 1984), 43–45.

[123] This differentiation between intention and result plays a large role in Roman Catholic moral philosophy and has been credited to Thomas Aquinas. The so-called doctrine of "double effect" also comes into discussions of sedation, which may ease pain and may also hasten death. Note that while this notion becomes quite important in Roman Catholic medical ethics, there are some who dispute the appropriateness of it. David VanDrunen, for instance, refuses to employ the category as such because he deems the criteria not "always helpful" and argues that the use of it proves unhelpful as a rule to "determine the application of the principle on every occasion." Cf. VanDrunen, *Bioethics and the Christian Life*, 213–238.

drug.[124] Morphine not only deadens pain; it also suppresses respiration. The aim of the treatment, however, intends to mitigate pain and not to cause the death of the patient. If a caregiver deliberately overdoses the patient in order to euthanize him, we would say that he killed him since death was the physician's aim. If, however, a carefully adjusted dose of morphine to relieve pain suppressed respiration and the patient died, we would not reach the same determination since death was not the intent. This has led to the following guidelines for the moral answer to questions of refusing or withdrawing treatment.[125]

First, a treatment may be refused if it is useless for the person relative to his condition. Since there is no moral obligation to undergo treatments that hold little prospect of curing or even ameliorating the symptoms of a disease, refusing to accept a particular treatment does not equal the rejection of the gift of life.

In some cases, the refusal of treatment is more than "allowing to die," it is done in order that the individual will die. A parent who will not allow a baby with Down syndrome to receive a necessary surgery might be said to refuse the surgery so that the child will die. This kind of verbal trickery has become more popular in our era when we tend to think of personhood in terms of skill sets and cognitive abilities. For example, the evangelist and motivational speaker Nick Vujicic was born with tetra-amelia syndrome, leaving him without arms or legs. Had he also suffered from a blockage in his digestive system requiring surgery, one might easily have imagined his parents asking if he might be a candidate for euthanasia in a nation such as the Netherlands.

Second, treatments that are useful and perhaps even lifesaving may sometimes be excessively burdensome. In such cases, because life is not our god, we are not called upon to bear all burdens in order to stay alive. A variety of medical procedures, treatments and even medications may prolong life, but at an unwarranted burden. The patient chooses life, not death, simply not the life promised by the particular medical treatment. Elderly cancer patients, for instance, may choose not to accept the recommended chemotherapy because of the burden of the side effects.

As in the first guideline, this one may be abused quite readily. If we confuse the burdens of treatment with the burden of life, we move into an ethical danger zone. During the last several decades, for instance, the news has brought stories of Karen Quinlan and Terri Schiavo to our attention. None of us would wish for an unconscious existence in a persistent vegetative state, sustained by artificial nutrition and hydration. But, as Meilaender has wisely said, "if we act on such a thought and withdraw the feeding tube, the burden at which we are taking aim is not treatment but life itself."[126] Christian wisdom says that if the treatment will benefit the life the patient has (whether we would choose such a life for ourselves or not), we are called to choose life.

F. Financial Matters

Since insurance policies, government provisions for coverage and state-specific legislation vary greatly and change rapidly, it would not be possible to address all of the practical matters related to how finances intersect with the convictions of a faithful Christian end-of-life ethic. Nevertheless, a few observations must be made.

Given the growing acceptance of assisted suicide, it is almost certain that withholding medical care for the terminally ill and for those with cognitive and other functional deficits will increase, and that some of that increase will be for financial reasons. Rising medical costs for lifesaving or life-prolonging treatments come into sharp conflict with the strictures of

[124] Not only medical caregivers, but also family members may sometimes be authorized to administer morphine. It would be vital in such cases that there be instruction in the proper way to do so, as well as counsel concerning the distinction between caring and killing.

[125] The following points are so common to end-of-life books and articles that they hardly require detailed documentation, and are commonly identified by Roman Catholic, Reformed (e.g., VanDrunen) and Lutheran ethicists. Lutheran ethicist Meilaender, for instance, often lists these as helpful principles. The reader may be directed to Meilaender's *Bioethics: A Primer for Christians*, 84–87, for a summary in his section "Guidelines."

[126] Meilaender, *Bioethics: A Primer for Christians*, 87–88.

budgets and bottom-line considerations by insurance companies. This becomes particularly true in an era when a Christian value on life seems less "cost effective" to those who think only of human life in pragmatic and non-theistic terms. As long ago as 1984, Colorado Governor Richard D. Lamm argued that there simply would not be enough money to fund all of the possible technological interventions that medical science presents. Lamm, a former certified public accountant, earned the moniker "Governor Gloom" for suggesting that the elderly have "a duty to die and get out of the way with all of our machines and artificial hearts and everything else like that and let the other society, our kids, build a reasonable life."[127] John Kilner makes several solid criticisms of age-based rationing of life-sustaining medical care. After considering a variety of utilitarian considerations, he concludes, "Our elderly and aged deserve our respect and our protection. Rationing their health care because of their age is to treat them with disdain rather than with dignity."[128] As a variety of ethicists have observed, the unintended consequences of loosening the restrictions on physician-assisted dying and euthanasia may result in a rapid closing of the distance between personal preference and the morally obligatory. What may begin as a possible course of action based on the wishes of the terminally ill person may soon become a "duty to die and get out of the way." Such opinions seem even more persuasive when medical resources are scarce, and beds, medications, oxygen and other means of care are rationed and perhaps unavailable to those with a better chance of survival.

The selection of physician, hospital and hospice program directly impacts the approach to end-of-life treatments. Patients and their health care surrogates need to ask whatever questions are required in order to discover the approach their health care provider will take when faced with terminal conditions, incapacity and possibly prolonged custodial care. It would be better to change physicians than to have one who was reluctant to cooperate with the wishes of the patient or POA when determining next steps for the hospital or hospice. Remember also that hospice aims to support the family in offering palliative medication and emotional support, not provide restorative therapies. Doing one's due diligence in researching and contracting with the hospice organization that will fit your needs is paramount. Similarly, while dedicated hospice in-patient facilities offer much greater care, they also have their own policies and procedures that may not align with the convictions and concerns of the family for caring for their loved one. Inquiries with hospice programs and in-patient programs can determine what one may expect prior to signing up with the hospice.

The choice of the agent granted durable power of attorney for health care should similarly be considered seriously. Family dynamics may present the POA with decision-making in an unenviable environment. One child may feel guilty about how she treated mom and wants to do everything medically possible to prolong life, while another one may be struggling with financial reverses and secretly hopes that enough money will be available in the estate to rescue him from fiscal ruin. Those chosen to carry the responsibility of POA should be able to resist the temptations of competing voices and to decide based on what is best for the loved one.

One potential cause of conflict over patient care can occur when different individuals are given responsibility for the medical POA and the financial POA. For example, a parent may designate one child to handle the POA for finance and another to assume the POA for health care. This may seem advisable if one child has a health care background and another has a demonstrated skill in handling money. But the arrangement can also lead to unhappy consequences. The person responsible for managing the financial affairs could conceivably refuse to allow payment for a high "out of pocket" course of treatment endorsed by the child with the medical POA.

---

[127] "Gov. Lamm Asserts Elderly, If Very Ill, Have 'Duty to Die,'" *New York Times*, March 29, 1984. Lamm's view was endorsed by some ethicists, for example John Hardwig in "Is There a Duty to Die?" *The Hastings Center Report* 27, no. 2 (1997), 34–42.

[128] John F. Kilner, "Age-Based Rationing of Life-Sustaining Health Care," Section 74 in Therese M. Lysaught, *On Moral Medicine: Theological Perspectives in Medical Ethics,* 3rd ed. (Grand Rapids: Eerdmans, 2012).

As in most areas of life, advance planning can be extremely helpful. It is generally advisable for those who qualify and can afford it to carry long-term care insurance. However, with annual costs that can be significant, that option will not be practical for persons of lower income and/or savings. Additionally, many applicants for long-term care insurance will be rejected due to pre-existing conditions (including, among others, inability to pass a cognitive test, obesity and certain chronic conditions).

G. Necessary Distinctions and Helpful Terminology

1. Burdens of Treatment vs. Burdens of Life

Earlier we introduced the matter of medically useless or excessively burdensome treatments. Along with most Christian ethicists, we affirm that no one should be subjected to a treatment that would be useless. But beyond this, no one need agree to every treatment proposed by physicians, regardless of how lifesaving it may be, if the treatment is excessively burdensome. Many cancer chemotherapy regimens, for instance, may produce extremely difficult side effects, particularly for a very aged individual. Some patients may elect to spend time with family or friends rather than accepting a grueling course of chemotherapy with little possibility of extending life.

Refusing a particular course of medical treatment because it proves too burdensome on the patient is radically different from considering the very life of the dying person to be a burden. A person may suffer from the burden of frailty due to age, accident or chronic illness. In some cases, such conditions may cause us to pray for God's deliverance from them. They are nonetheless common to our human condition and not a ground for suicide or euthanasia. "We may reject a treatment; we must never reject a life."[129]

2. Caring, But Only Caring

The Ramsey Colloquium's declaration "always to care, never to kill" summarizes the Judeo-Christian tradition with respect to our obligations to our fellow creatures.[130] It also echoes the moral consensus of the Law of God written on every human heart (ROM. 2:15). The classic form of the Hippocratic Oath stated the duties of a physician clearly on this point: "I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion."[131] But the moral obligation to care for our fellow sisters and brothers so that we "do not hurt or harm our neighbor in his body, but help and support him in every physical need" does not require us to employ treatments that are useless or cause needless suffering.

The commitment "always to care, never to kill" does not mean that we should eliminate all those who suffer or that we glibly ignore their suffering. Instead, it requires that we find efficacious ways to mitigate suffering. Christian ethicists summarize the principle governing Christian compassion in realistic, not idealistic, ways. In the name of Christ, we show compassion most when we maximize care, not when we merely minimize suffering. Indeed, if compassion is the elimination of all suffering, we might achieve it by ridding the world of sufferers. This does not mean, however, that we support needless suffering. While we will continue to cite the sufferings of our Lord and their benefits, that does not require us to refuse remedies and analgesics that can make the suffering we are called upon to bear more bearable. Just as Scripture speaks of endurance in the midst of tribulation, not apart from it, so it also teaches love that remains steadfast through suffering.

---

[129] John T. Pless, *Mercy at Life's End: A Guide for Laity and Their Pastors* (St. Louis: The Lutheran Church—Missouri Synod, 2013), 13.

[130] The Ramsey Colloquium, "Always to Care, Never to Kill," 45–47.

[131] "Hippocratic Oath," *Encyclopædia Britannica*, Encyclopædia Britannica, Inc., *britannica.com/EBchecked/topic/266652/Hippocratic-oath.*

3. Irretrievably Dying vs. Terminally Ill

One may suffer from a condition the physician labels "terminal" without facing imminent death. Some prostate cancers may grow so slowly that eventually a different malady actually causes death. Doctors may then elect to treat such a cancer with benign neglect, since the consequences of the cures may be worse than the reasonable expectation of death in the near term. The fact remains that such a person has a "terminal disease" or a "terminal condition." However, that in and of itself does not fix an expiration date on the person's life.

Other people are irretrievably dying, and their body has begun to shut down.[132] Family members may be advised that a vital organ has begun to malfunction in a life-threatening way. Often efforts to shore up the function of one organ (e.g., the heart) will create additional problems for another one (e.g., kidneys). Some forms of advanced disease may be so progressed that only hours or days remain. Someone who is irretrievably dying may find few treatments that can be called "useful." Here the Christian duty of maximizing care comes into play.

4. Intention or Aim of an Action vs. Result of an Action

Elsewhere in this report, we cite the distinction between a "suicide mission" and an "act of suicide." The first does not aim at death; it is merely doing one's duty as a soldier. The second intends for the act to produce death. This can be true even when another agent may be involved. The so-called "death by cop" scenario describes a situation where a person uses a gun to provoke the police to respond with deadly force. Here, we say that the person was committing suicide by another's hand. Polycarp submitted to the death of a martyr; he did not aim to die. Sometimes legitimate medical treatments will result in death notwithstanding the care with which they are employed. A lifesaving but delicate surgery may lead to an unhappy outcome contrary to the wishes of the patient, family and surgeon. More commonly, the use of pain medication may have undesired side effects that are well known to the administering physician. We earlier noted that morphine effectively dulls unrelenting pain so that some call it a "godsend" to sufferers. Unfortunately, it also suppresses respiration and may result in death. However, pain relief and not death was the intention. Ethicists call this the "double effect" doctrine.[133]

Wesley Smith's *Culture of Death* deals with the operational reality of "double effect" as it applies to the care for the suffering. He cites attorney and ethicist Rita Marker's four guidelines:[134]

1. The action taken (in this case, treating pain and relieving suffering) is "good" or morally neutral.
2. The bad effect (in this case, the possibility of death) must not be intended, but only permitted.
3. The good effect cannot be brought about by means of the bad effect.
4. There is a proportionately grave reason to perform the act (in this case, the alleviation of severe pain) and thereby risk the bad effect.

5. Palliative Care vs. Palliative Sedation[135]

Palliative care describes the treatment of the discomfort, symptoms and stress of serious illness. Whether offered in a hospital or clinic, in hospice, or at home, the goal aims at relief from problematic symptoms such as pain, shortness of breath, fatigue, constipation, nausea, loss of appetite and sleep difficulties, among others. Some palliative care seeks to mitigate the side effects of medical treatments (e.g., chemotherapy). It holds forth the hope of improving the quality of life

---

[132] Meilaender makes this distinction: "Irretrievably dying is not the same as to be terminally ill. One can be terminally ill but still expected to live for months or even years. For the patient who is irretrievably dying, few if any treatments can really be useful." Meilaender, *Bioethics: A Primer for Christians*, 85.

[133] Widely credited to Aquinas, the doctrine of "double effect" has been much used in Roman Catholic moral literature. Protestants have sometimes employed the same idea by differentiating intention from result.

[134] Wesley Smith, *Culture of Death: The Assault on Medical Ethics in America* (San Francisco: Encounter Books, 2000), 106–107.

[135] Perhaps the most useful and succinct summary of the ethical issues related to palliative sedation can be found in Meilaender, *Bioethics and the Character of Human Life*, Chapter 11, "Comforting When We Cannot Heal," 121–132. This section relies heavily upon his points in that chapter.

for the patient and reducing the distress of family members. Since unwelcome symptoms exist on a spectrum from easily remedied to the most unmanageable, "palliative sedation" (PS), as defined here, denotes the intentional lowering of awareness toward pain, perhaps including unconsciousness, for patients with severe and unmanageable symptoms. Although being conscious and present to interact with family and friends remains a value that most people seek to retain as they near the end of life, for some the relief of symptoms may outweigh the desire to be conscious.

In some circles, this has been quite controversial. Imagine two scenarios. First, a dying patient suffers extreme pain for which there is no easy solution. The physician gradually increases the dosage of morphine until the person can tolerate the pain, even though it might also reduce the patient's level of consciousness. Double-effect reasoning would support this as a moral decision and good medical practice. But consider a twist to this scenario. What if the physician administers a barbiturate drip intended to leave the patient unconscious? Here the goal is not to mitigate the suffering but to eliminate the conscious experience in which the suffering is perceived. Does this constitute a treatment protocol that fails the moral test because it intends an arguably evil effect (that is, permanent unconsciousness)? We might argue that surgeons render patients unconscious routinely during surgical procedures. We call it anesthesia. But this argument proves too much. The medication producing unconsciousness during surgery is both limited in duration and intended to allow repairs that will restore the patient to health and return to somewhat normal function. The medication given to create a permanent state of unconsciousness aims at an evil effect (if you consider consciousness an important value). Meilaender demurs on the grounds that consciousness is not always a value that must or ought to be counted as supremely important. While we might say that it would not be morally correct to put a healthy young person into a state of permanent unconsciousness, the same might not be the case for a 95-year-old with hours left to live. Imagine that this elderly saint has prayed with her pastor and bid each member of her family and family circle good-bye. Faced with difficult-to-manage pain, we might agree with those who say, "Consciousness seems to me, if I may put it a little too brashly, not quite that big a deal."[136]

6. Treatments Which May Be Refused vs. Care Which Should Never Be Denied

Elsewhere in this document the point has been made that one may reasonably and responsibly refuse treatment when it is medically useless or excessively burdensome. The 1993 CTCR report proposed four factors to be considered as relevant for withholding or withdrawing treatment:

(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 palliative 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.[137]

While treatments may be refused, care must never be denied. Pless cites Wesley Smith's observation that "Futile Care Theory" has corrupted medical ethics such that some hospital protocols actually require that feeding tubes be withdrawn from patients in a persistent vegetative state, even over the objections of family decision-makers and in spite of explicit patient desires expressed in advance directives.[138] Pless concludes that "a treatment may be refused or discontinued if it is deemed futile, but care is never futile and is not to cease until natural death."[139]

---

[136] Meilaender, *Bioethics and the Character of Human Life: Essays and Reflections* (Eugene, Ore.: Cascade Books, 2020), 127. Meilaender allows that some cases may be more problematic. For instance, he balks at a blanket permission for palliative sedation where the patient's suffering is not a result of an underlying physical pathology causing extreme and unendurable pain but a result of feelings of loneliness, depression or disgust with the dependence occasioned by old age.

[137] CTCR, *Christian Care at Life's End*, 37.

[138] Pless, *Mercy at Life's End*, 12.

[139] Pless, *Mercy at Life's End*, 13.

7. "Vegetable" vs. "Persistent Vegetative State"

Lay use of the term "vegetable" for a person in a coma or a vegetative state represents a horrible misinterpretation of the meaning of the medical term "persistent vegetative state" (PVS). While the word may be acceptable within the scope of its clinical use, the casual use of it may mislead people greatly. The term "coma" refers to the lack of both awareness and wakefulness, whether in an open-eyed or closed-eyed coma state. Patients in a vegetative state may have regained consciousness from a coma, but still have not regained awareness. PVS represents a disorder of consciousness in which patients with severe brain damage are in a state of partial arousal rather than true awareness. Typically the classification of "vegetative state" (VS) gets applied to such persons in the first weeks with the classification "persistent vegetative state" coming after four weeks. While some commonly describe those in a persistent vegetative state as brain dead, that misunderstands the injury. Patients with PVS have a healthy and functioning lower brain stem.

Although very rare, PVS patients may sometimes regain full consciousness. One man, Conley Holbrook, was classified as "comatose" for eight years. On Feb. 25, 1991, he awakened. According to Bartlett and Rehder, 26-year-old Holbrook was not only able to call each of his relatives by name, but he was even able to identify the small children who had been born while he was unconscious.[140] Another person, Patti White Bull, emerged from her unconscious state on Christmas Eve in 1999 after 16 years.[141]

8. What Do/Did They Want? vs. What Is Best for Them?

As Christians, the question "What did he/she want?" should not be primary in our thinking. A better question for Christian surrogates at the bedside of a dying loved one should be, "What is best for this person?"[142]

H. Hospice Care

Hospice care, in-patient or at home, can become a valuable partner to both the family and the dying person. Unlike health restorative therapies and procedures common in hospitals, hospice aims at palliative relief of pain and symptoms of a terminally ill patient.[143] Hospice programs also incorporate attending to the emotional and spiritual needs of the patient. Note that the spiritual support provided by a secular organization that conceives of the idea of "spiritual" in the most generic and ecumenical way will be something quite different from pastoral care offered by a Lutheran clergyman.[144] Lutheran pastors will want to provide Word and Sacrament ministry to a terminally ill person on a regular basis. They will typically want to prepare the dying saint and his or her family for impending death with the use of the "Commendation of the Dying," found in the *Pastoral Care Companion*.[145]

Because of the focus on palliation of a terminally ill patient's pain and symptoms, the priority falls on comfort and quality of life through the reduction of pain and suffering. Hospice provides an alternative to therapies aimed at prolonging life through means of therapies and procedures. Current treatments for cancer, for instance, carry with them potential unwanted side effects and additional symptoms that may prove extremely burdensome to an elderly patient. Outside the

---

[140] Bartlett and Rehder, "Ventilators, Feeding Tubes, and Other End-of-Life Questions," 5. Conley Holbrook identified his cousin as his attacker following awakening from his semi-comatose state, resulting in the man facing trial for attempted murder. "Brain-Damaged Man's 'Miracle' Recovery Lands a Cousin in Jail: Tragedy: The Two Boyhood Chums Grew up to Be Drinking Buddies. A Head Injury Left One of Them Speechless for Eight Years. Was It Assault or Just Another Family Fight?" *Los Angeles Times*, April 21, 1991, *latimes.com/archives/la-xpm-1991-04-21-mn-846-story.html.*

[141] "Awakening from 16 Years in near-Coma." *Los Angeles Times*, Feb. 3, 2000, *latimes.com/archives/la-xpm-2000-feb-03-me-60571-story.html.*

[142] This point is discussed in more detail under the section on advance directives, particularly as related to the durable power for health care proxy (see pages 17–21).

[143] The very notion of hospice care stands against the ideology of suicide and euthanasia. As Dyck notes, "Hospice was founded to provide comfort-only care that would help prevent suicide and euthanasia. Hospice physicians repeatedly report that once they provide comfort-only care, patients who expressed a desire to end their lives, or have it ended, change their minds, or no longer pursue ending their lives as an option," *Life's Worth: The Case Against Assisted Suicide* (Grand Rapids: Eerdmans, 2002), 47.

[144] Hospice organizations may assume that they will be responsible for the spiritual care of the dying person. It may be necessary for the family to request that their pastor rather than the hospice chaplain provide spiritual care and counsel for the dying.

[145] "Commendation of the Dying," in *Lutheran Service Book: Pastoral Prayer Companion* (St. Louis: Concordia Publishing House, 2007), 81–94.

United States, the term "hospice" often denotes facilities and institutions. Usage in the United States applies to both in-patient and out-patient (home-based) programs that began to spring up and proliferate in the early 1970s. In 2017, almost 1.5 million patients took part in hospice in the United States.

At present, the United States Medicare program only covers hospice care if the hospice provider is Medicare-approved. One can determine if the hospice provider qualifies as Medicare-approved by inquiring with your physician, the hospice provider, the state hospice organization or the state health department.[146] If the hospice has been Medicare-approved, "once your hospice benefit starts, Original Medicare will cover everything you need related to your terminal illness."[147] Current law permits two 90-day benefit periods, followed by an unlimited number of 60-day benefit periods. This includes the right to change hospice providers once during each benefit period.

Depending on the specific needs of the terminally ill person, the number and quality of hospice programs in the area, and one's own ability to assist in the care of the dying loved one, a person may prefer to opt for receiving hospice in a nursing home or long-term care facility where hospice services are added onto the regular nursing, housekeeping and dietary services. Most people profess to prefer dying in "my own bed" rather than in a hospital, nursing home or other institutional setting. However, if the spouse may be too frail or impaired to assist the hospice team actively, an in-home program may not be practical. At times, the decision whether or not to use home-based hospice will hinge on the availability of family members (and/or hired help) to support the terminally ill person. A frail, elderly spouse suffering from early stages of dementia, for instance, would not be a suitable person to attend to an obese patient with uncontrolled incontinence.

Increasingly, patients are encouraged to become intelligent consumers of their usage of medical science and its myriad benefits. In the area of hospice, differences of practical pain and symptom management exist. For instance, some hospices may not perform glucose monitoring for diabetics as they see it as "treatment toward a cure," even though not monitoring glucose could cause hypoglycemia (critically low levels where a patient goes into coma and death) or hyperglycemia (critically high levels). Both are considered clinical emergencies. Other hospices recognize glucose monitoring is not curative, but that it prevents harm in maintaining acceptable levels and waiting for death from another condition (e.g., cancer, heart failure). Asking questions of the staff before entering into an agreement may assist patients and their families in making a wise selection. And while the Medicare website declares that "Original Medicare will cover everything you need related to your terminal illness," that should not be understood to mean that nothing is expected of the family. Different hospice providers carry out their duties in myriad ways, some handling most of the care needs, others expecting family members or the hospital or senior facility to shoulder some of the responsibilities. Again, asking enough questions in advance and probing to ensure a full understanding of how a particular organization operates will increase the likelihood of having a satisfying relationship with their services and support in a time of need. Note that a person is not obligated to accept the leads and recommendations from hospital discharge planners. While they may be invaluable in a search for a provider, their information should not substitute for one's own efforts to secure the hospice that will meet the family's expectations.

---

[146] Because Medicare Advantage programs must offer the same benefits as traditional Medicare, one may also take advantage of hospice through a Medicare Advantage program. However, the list of providers will be limited to those approved by the Advantage program. "How Hospice Works," Medicare, *medicare.gov/what-medicare-covers/what-part-a-covers/how-hospice-works.*

[147] Coverage may not be as complete as some expect. For more information about what Medicare considers "everything you need related to your terminal illness," see "How Hospice Works," above.

Medicare suggests that the following questions may aid families in the selection of a hospice provider:

- Is the hospice provider certified and licensed by the state or federal government?
- Does the hospice provider train caregivers to care for you at home?
- How will your doctor work with the doctor from the hospice provider?
- How many other patients are assigned to each member of the hospice care staff?
- Will the hospice staff meet regularly with you and your family to discuss care?
- How does the hospice staff respond to after-hour emergencies?
- What measures are in place to ensure hospice care quality?
- What services do hospice volunteers offer? Are they trained?[148]

[148] "How Hospice Works," *medicare.gov/what-medicare-covers/what-part-a-covers/how-hospice-works.*

IV. Pastoral and Spiritual Dimensions

A. Dealing with Our Uncertainty and Sinfulness

The discussion of end-of-life decision-making must also take account of the ambiguity inherent in all human experience. As fallible creatures with circumscribed consciousness, we must admit that we may not always know clearly what the "right thing to do" might be in a particular situation. More than one disciple of Christ has felt the force of St. Paul's phrase "we see in a mirror dimly" (1 COR. 13:12) when confronted with the uncertainties attending to bedside decision-making for a dying loved one. After opining that the unbroken tradition from "Genesis to Heidegger" differentiates animal life from human life by the presence of "human consciousness of self," Thielicke admits that there are no casuistic rules to offer us infallible direction on how to handle the bedside choices families and physicians must render. He resorts to the notion that "one must simply run the risk of making the decision — and be prepared in so doing to err, and thereby to incur guilt. As a Christian, I would say that whoever hopes to come through it all without illusions or repressions will have to live in the name of forgiveness."[149]

The 1993 document of the CTCR reminded us that "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."[150] To sinners burdened in conscience by the guilt of the Law, our final word must always be one of Gospel and forgiving grace in Jesus Christ. Whether hindsight reveals the inadequacy of our calculations here or not, we dare not stop with the penultimate word of Law but press on to the ultimate word of Gospel. As Luther wisely observed, "Are we to rate the price of his 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?[151]

At one level, such counsel should reassure those who confess that all human efforts carry the taint of sin and that motives can never be 100% pure. We all live by faith and in light of the forgiveness of God, after all. For faithful loved ones carrying a burden of guilt over the death of a loved one and torturing themselves over whether they could have "done more" or done it differently, this message may be an important part of sensitive pastoral care.

One can hardly gainsay the liberating promise of divine forgiveness and the blessed state of absolution. However, we are never permitted to substitute divine pardon for legitimate human agency. We dare not adopt a cavalier attitude that it does not really matter what we decide to do since we know that God will forgive us in the end anyway. Neither are families exempt from the difficult prayerful conversations that attend to living in Christ through faith as we serve our neighbor through love.[152]

---

[149] Thielicke, *The Doctor as Judge*, 21. See the entire section, 16–21, for his argument.

[150] CTCR, *Christian Care at Life's End*, 21.

[151] *LW* 33:227.

[152] In Luther's "The Freedom of the Christian," he writes: "We conclude, therefore, that a Christian lives not in himself, but in Christ and in his neighbor. Otherwise he is not a Christian. He lives in Christ through faith, in his neighbor through love," *LW* 31:371.

The principles and considerations laid out in this report provide concrete guidance for faithful end-of-life decisions amid the ambiguities of incomplete knowledge and often competing values. We all live under what Thielicke called that "alien dignity" that forbids us to be subjected to the "dictatorial rule" of our own technical capacities. We were created by a divine benevolence who bequeathed to us a value and dignity that remains, even this side of the fall. Whatever else we say about the value of God's creation of man and woman, it implies a sanctity that must not be trampled under or made subservient to what human ingenuity and inventiveness can design by way of medical interventions and treatment protocols. We do well to seek counsel from physicians and pastors, consider the relative merits of the options, pray to the One who is the source and Lord of life, and exercise our duties as the designated surrogates of a dying loved one. But along the way of the entire process, we joyfully acknowledge and believe the forgiveness of God in Christ Jesus and His Holy Spirit as our real and present Comforter in every circumstance.

B. The Reality of Death and Our Struggle with Helplessness

Christians affirm both the unnatural nature of death as the curse that fell upon a sinful human race and the hope held out for us in the death and resurrection of Jesus Christ who came that death may die.[153] Luther never flinched from dealing with the severity of sin's consequences. His handling of Psalm 90, for example, serves as a "corrective for therapeutic pastoral theologies."[154] For the reformer, "The entire human race fell so far away from God and is so thoroughly blinded by original sin that man knows neither himself nor God. Indeed, he does not even know his own sorry state, although he feels it and languishes under it. He neither understands its origin nor does he see its final outcome."[155] In his commentary, Luther rejects any minimizing of death as the "worst blindness" in the face of what one certainly knows and experiences to be the opposite.[156] Luther comments on Psalm 90: "First, Moses here stresses the tyranny of death and of God's wrath, since he shows that human nature is subject to eternal death; he does this for the purpose of terrifying hardened and unbelieving despisers of God. Secondly, Moses prays for a remedy against despair, that men might not succumb to despair."[157]

We cannot escape God's wrath and its inevitable consequences in death by wishing them away with flowery eulogies, which amount to little more than secular attempts at absolution by works and worthiness, or by exercising our self-determination by choosing when and how we will "die with dignity."[158] Self-determination is what got humanity into the problem of sin in the first place! Luther thunders that it "is wicked to invent a new god and in this way to escape God's wrath and so to attempt to avert something which we, because of sin, have justly deserved."[159] The law focuses like a laser on what death is and remains: our enemy. Werner Elert rightly observed that God's call deals a "destructive blow" to any notions of autonomous self-determination. But looked at "with the eyes of God," all of this autonomy shrinks to the "mathematical point," and we see that "the outer side of our life is death."[160]

---

[153] The short piece, "What About Death and Dying" by A.L. Barry in the Synod's "What about …" series, offers a succinct statement dealing with the types of questions laypersons often ask regarding death and dying. It can be downloaded online at The Lutheran Church—Missouri Synod's LCMS Document Library, *https://files.lcms.org/file/preview/4C9b1IpSFPRy18M2tCdDXhzJX-AEw1Azd.*

[154] John T. Pless, "Luther's Reading of Psalm 90: The Eschatology of Pastoral Theology," in *Take Courage: Essays in Honor of Harold Senkbeil* (Irvine: New Reformation Publications, 2016), Kindle Edition.

[155] Martin Luther, *Luther's Works*, Vol. 13: Selected Psalms II, ed. Jaroslav J. Pelikan, Hilton C. Oswald and Helmut T. Lehmann, vol. 13 (St. Louis: Concordia Publishing House, 1999), 76.

[156] *LW* 13:77.

[157] *LW* 13:78. The old Henry Cole translation of Luther's devotional thoughts on the Psalms, *A Manual on the Book of Psalms* (London: Seeley and Burnside, 1837), offers a wonderful summary of Luther's view of Psalm 90. "This Psalm contains a very great and important doctrine; in which Moses teaches what is the origin and cause of that death to which the whole human race is subject, and the reason why so horrible a punishment was inflicted on the whole race of mortals: the Psalmist saith, it was on account of sin: and the guilt and desert of sin are greater than can be conceived by the human mind, unless God touch the heart with a knowledge of it; and yet, in this sin and guilt, and under this wrath, all the sons of Adam are born."

[158] Pless, "Luther's Reading of Psalm 90," Kindle Edition.

[159] *LW* 13:96

[160] Werner Elert, *The Structure of Lutheranism*, electronic ed. (St. Louis: Concordia Publishing House, 2000), 26.

Reflecting upon Luther's handling of Psalm 90, Pless sees it as establishing both a foundation and a framework for pastoral care in the face of death.[161] With Luther, the pastor is called to face death squarely and name it for what it is. Death, the alien work of God's wrath, remains the last enemy and may only be overcome by the death and resurrection of the one "who was delivered up for our trespasses and raised for our justification" (ROM. 4:25). Secular notions of death as "natural" seek to keep it in the biology lab and treat it as merely another part of the "circle of life," and a rather natural one at that. Paul, like Luther much later, had a much more realistic view of death as our true enemy. "The sting of death is sin, and the power of sin is the law," Paul declares in 1 Corinthians 15:56. The trio of death, sin and the law are the unholy trinity of Luther's exposition of Psalm 90.

But just as Easter follows Good Friday, the resurrection comes after the cross. The same Christ who gave His life as a propitiatory sacrifice for our sins guarantees us a final victory. Our words to the dying and their grieving families does not end with a grave or with the months of wrenching grieving that may follow. We offer the promise and hope of God in Christ. Pless states it well:

> The one who died in our place gives us his indestructible life. The end of life's story is not the obituary; the final destination is not the cemetery. The end of the story is Christ Jesus crucified and risen from the dead. The end of the story is your resurrection. In light of this truth, we are set free to face the questions of mercy and care at life's end with the full confidence that the Lord who gives us life and who will one day recall this life to himself always has more to give. We will neither take our own lives or those of others, nor will we hold on to them selfishly when the Lord, who has already called us from death to life in Holy Baptism, calls us to die for that final time.[162]

Pastoral preparation for the various stages of life should involve at the very least an orientation to the joys and rewards of each season of life, including the final one, despite the discomfort with helplessness and loss of control as we await union with Christ in glory. Meilaender offers insight into the wisdom of aging and the notion of a complete life: "No longer imagining, if he ever did, that he goes to meet God on his own terms, it is the old person's 'special opportunity' to discover that the initiative always lies with God — and in this discovery to be an example for all who are younger."[163]

Thoughtful Christian leaders may consider the complexity of the issues that surround end-of-life care and despair of having a sure word from the Lord. Richard C. Eyer helpfully cuts through the clutter and affirms three key ideas: 1) The problem comes because we are afraid of being helpless and without control over our lives in a time of great ethical and relational crisis; 2) "It is only when we find ourselves helpless due to suffering and do NOT take matters into our own hands that we come to see God at work in our lives redeeming and remaking us through 'death and resurrection' of the spiritual self"; and 3) Part of the obedience of faith means that we use our sense of helplessness and inadequacy to learn to submit to God and trust Him despite the specific conditions and circumstances.[164] We may take each of these points in order.

1. Fear of Helplessness and Lack of Control

We fear helplessness and seek to project our own self-determination into the future's uncertainties. God, the Creator, makes us His creatures. Creaturely existence must, by definition, be receptive and dependent. Finding ourselves afraid of dying, unable to control the outcome of the medical care we receive, can never be a comfortable place to be. But it is precisely in extreme situations like these that we become the instruments of God for our family and caregivers. And in their care, they become God's instruments to us. We cannot forget that Jesus selected a helpless child to be emblematic of those who enter

[161] Pless, "Luther's Reading of Psalm 90," Kindle Edition.

[162] Pless, "Luther's Reading of Psalm 90," Kindle Edition.

[163] Gilbert Meilaender, *Should We Live Forever? The Ethical Ambiguities of Aging* (Grand Rapids: Eerdmans, 2013), Kindle Edition, location 1543.

[164] Richard C. Eyer, "A Christian Guide to End-of-Life Decisions" (Nevada, Iowa: Lutherans for Life), n.d.

into His kingdom (MATT. 18:3). We revel in the grace of infant Baptism partly because it reminds us that God gives His gift of faith precisely when we are unable to obtain it on our own. The Baptism of an infant reminds us that God rewards only the helpless with heaven; those seeking to control the outcomes of life spend eternity separated from Him.

2. Facing Helplessness Due to Suffering

St. Paul reminds us that God specializes in manifesting Himself at exactly the point of our deepest need and showing Himself sufficient for our every need. Romans 5:6 declares that "while we were still weak, at the right time Christ died for the ungodly." Luther similarly observes that "through persecution the Gospel and God's Word only advance and become stronger, and faith increases. This contradicts the way things work with worldly possessions, which decrease in misfortune and adversity and increase in prosperity and peace. Christ's kingdom increases in affliction and decreases in peace and luxury, as St. Paul says, 'My power is made stronger in weakness,' etc. (2 COR. 12[:9])."[165]

Our sinful nature ever seeks to become a theologian of glory rather than a theologian of the cross. Luther's words in his Heidelberg Disputation (1518) show our problem in stark relief when he writes, "This is clear: The person who does not know Christ does not know God hidden in suffering. Therefore, this person prefers works to suffering, glory to the cross, strength to weakness, wisdom to folly, and, in general, good to evil … However, God can be found only in suffering and the cross, as has already been said."[166]

3. Facing Helplessness as a School for Learning to Trust God

Part of the often painful pedagogy of discipleship involves learning to submit to God in the muddle of our helplessness and feelings of futility. This is not the same as the famous "stiff upper lip," nor is it a compliance through clenched teeth as would be unbefitting the Christian, "but a childlike, willing, glorious submission to God; even as the Christian in his entire life submits to God's ways and permits God to guide him."[167] We follow the Christ who is truly God but also truly one of us. His entire life was a life of faith, but His approach to His own end-of-life experience informs our understanding. In the Garden of Gethsemane, facing imminent death, He submitted to God's will and committed His life into the hands of the Father (LUKE 22:42; LUKE 23:46; CF. 1 PETER 4:19).[168] Now He intercedes for us in heaven and invites us to approach the "throne of grace, that we may receive mercy and find grace to help in time of need" (HEB. 4:14–16). Of all the discipleship challenges we face, none is more existentially pressing than our own death or that of a loved one.

In the last century, Dietrich Bonhoeffer similarly comprehended the uncertainties that faced him living as a follower of Christ, needing to learn the painful lessons of discipleship. For him those lessons came under the Nazi regime. Near the end of the war, Bonhoeffer wrote:

> "Having patience in days of trouble" — this has been the focus recently of nearly our entire inner concentration. How do we accomplish it? By submitting to God's blows and God's law and saying, Happy are those who experience this! This is what those who call God "dear Father" must say. Those whom God disciplines through difficult life experiences, through war and deprivation, learn that they can insist on nothing from God; so they wait patiently and humbly until God again turns toward them kindly, and they know that this hour is coming.[169]

---

[165] *LW* 76: 288.

[166] Dennis Bielfeldt, "Heidelberg Disputation," in *The Roots of Reform*, ed. Hans J. Hillerbrand, Kirsi I. Stjerna and Timothy J. Wengert, vol. 1, *The Annotated Luther* (Minneapolis: Fortress Press, 2015), 99–100.

[167] Francis Pieper, *Christian Dogmatics*, vol. 1 (St. Louis: Concordia Publishing House, 1953), 138.

[168] Samuel H. Nafzger et al., eds., *Confessing the Gospel: A Lutheran Approach to Systematic Theology*, vol. 1 (St. Louis: Concordia Publishing House, 2017), 182.

[169] Dietrich Bonhoeffer, *Conspiracy and Imprisonment: 1940–1945*, ed. Jørgen Glenthøj et al., trans. Lisa E. Dahill and Douglas W. Stott, vol. 16 (Minneapolis: Fortress Press, 2006), 627–628.

C. Christ's Comfort for the Dying

The comfort Christians offer those who are at the end of their earthly pilgrimage begins not in the hospital or hospice room, but at the cross.[170] The root for the English "comfort" comes from the Latin *com fortis*, with strength. While the farthest thing from the existential reality of a dying person may be said to be strength, that is exactly what Christian caregiving offers. We strengthen them because our God is the ultimate strength. Paul declares to the Corinthians, "Blessed be the God and Father of our Lord Jesus Christ, the Father of mercies and God of all comfort, who 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. 1:3–5).

But since this is no "whistling past the graveyard" kind of comfort, it does not ignore the ugly realities of the actual situation the person faces in the midst of suffering. Just as Jesus quoted the words of abandonment from Psalm 22 while He suffered on the cross, sometimes we may expect to hear words of bitter loneliness and even abandonment from those we minister to at their most dire moment. Our task does not involve looking the other way from their pain, their negative emotions or even their real doubts no matter how uncomfortable it makes us. As ministers of Christ, we represent the ultimate Suffering One. Hebrews reminds us that "we do not have a high priest who is unable to sympathize with our weaknesses, but one who in every respect has been tempted as we are, yet without sin. Let us then with confidence draw near to the throne of grace, that we may receive mercy and find grace to help in time of need" (HEB. 4:15–16). As one veteran chaplain put it after meeting with a struggling patient: "She was sustained by God and God's care-giver. She was comforted with the comfort of God."[171]

This was Luther's pastoral approach, pointing to Christ and His saving work and promises as our source of comfort in the face of death. Luther rejected much of the *ars moriendi* ("the art of dying") tradition of his times.[172] Unlike those who focused their attention on the works that a Christian should perform in order to ensure a "blessed death," Luther steadfastly held forth the promises of God in the Gospel. Reflecting on the finished work of his catechism, he observed, "Now it has come, praise God, to this: men and women, young and old, know the catechism. They know how to believe, live, pray, suffer, and die."[173] Luther began a 1522 Invocavit Sunday sermon with these words:

> The summons of death comes to us all, and no one can die for another. All must fight their own battle with death by themselves, alone. We can shout into one another's ears but everyone must individually be prepared for the time of death, for I will not be with you then nor you with me. Therefore each person must personally know and be armed with the chief things that concern a Christian.[174]

In May 1519, while Luther was engaged in preparing to debate John Eck, he received a request from Mark Schart, a counselor in Elector Frederick's court, to write on the topic of death and dying. Luther demurred due to the press of his debate preparation and other duties. Within weeks, Luther relented and promised to produce something on the topic if Schart would be patient. On Nov. 1, 1519, Luther's "A Sermon on Preparing to Die" was published.[175] He took aim against

---

[170] Steinke, "Comfort in the Face of Death," 126.

[171] Steinke, 126.

[172] Robert Kolb, "The Reformation of Dying and Burial: Preaching, Pastoral Care, and Ritual at Committal in Luther's Reform," *Concordia Theological Quarterly* 81 (2017): 77–93, especially 81–82.

[173] "Luther's Warning to His Dear German People," *LW* 47:52; quoted in Robert Kolb, "Introduction," *A Booklet of Comfort for the Sick & On the Christian Knight* by Johann Spangenberg, trans. Robert Kolb (Milwaukee: Marquette University Press, 2007), 9. "In contrast to Jean Gerson's *ars moriendi* and other forms of late-medieval death literature, Martin Luther found in his theological breakthrough a means of approaching death through what Oswald Bayer called *promissio,*" Jones, *Promissio and Death*, ii.

[174] Martin J. Lohrmann, "The Invocavit Sermons," in *Pastoral Writings*, ed. Hans J. Hillerbrand et al., vol. 4, *The Annotated Luther* (Minneapolis: Fortress Press, 1522), 14–15. The "chief things" Luther has in mind are that we are "children of wrath" under God's judgment, that God has given His Son so that whoever believes in Him is a child of God, and that we must love as God has loved us since true faith results in love.

[175] Martin Luther, "A Sermon on Preparing to Die," *LW* 42.

the spirit of the times with its teachings about how to prepare for a "blessed death." He warns that Satan would have us fix our gaze on death's terror and God's wrath, brooding over our sins.[176] Luther stressed that instead of looking to oneself and one's own works, "we must turn our eyes to God, to whom the path of death leads and directs us."[177] Specifically, he points to "the picture of Christ" or "the picture of grace" — the image of Christ suffering on the cross for the sins of the world.[178] Because of God's promise of the forgiveness of sins, believers are encouraged to focus on "the glowing picture of Christ" in the confidence that "death, sin, and hell will flee with all their might."[179] Or as Luther summarizes: "In Christ [God] offers you the image of life, of grace, and of salvation so that you may not be horrified by the images of sin, death, and hell."[180]

End-of-life issues at the bedside soon give way to those of the grieving ones left behind. The pastoral ministry at the point of death does not end with the one who died. Rather, it carries over into the ongoing ministry to the family and friends of the deceased. Here, too, the glorious promise of the Gospel needs to be heard. Perhaps no hymn captures the soaring truth of Christian hope based on the finished work of Christ and His promise to us better than the words of Hamburg pastor Erdmann Neumeister's "God's Own Child, I Gladly Say It" (1718). Every verse revels in the sacramental benefits of Christian Baptism as the believer's "great treasure of redemption and eternal salvation" and being baptized into Christ as "the shower from heaven."[181] Such strong and certain hope offers strength not only to the dying but also to those who grieve in the face of death and loss.

D. Christ's Comfort for the Grieving

The *Pastoral Care Companion* provides a number of liturgies, prayers and counsel for the aftermath of death. We have referenced the "Commendation of the Dying" liturgy as a tool to use with families as they surround the bedside of a dying loved one. The *Pastoral Care Companion* also includes helpful sections on "Comforting the Bereaved," "Entrance of the Body into the Church," the "Funeral Service" and the "Committal."[182] Pastors may find these resources appropriate for their hospital and hospice room ministry as well as the funeral and committal services.

Rather than offering pat answers and pious platitudes to deal with death's aftermath, pastoral care involves entering into the pain of the bereaved and helping them respond to it in a faithful Christian manner, including the use of lament.[183]

This document has emphasized the importance of learning to accept our helplessness — and to embrace our Father's merciful care and trustworthiness — in the face of death. Yet it is also true that the prayers of the faithful in the Scriptures, especially in the Psalms, teach us to cry out honestly, boldly and even impatiently to our faithful God. Our Lord Jesus Himself displayed such moments of raw lament when weeping over Jerusalem, when appealing to His Father in the Garden of Gethsemane and when crying out from the cross (in the words of a "lament" psalm), "My God, my God, why have you forsaken me?" (**MATT. 27:46; CF. PSALM 22:1**). After all, as Bayer reminds us, "It is part of God's own nature to let himself be petitioned … . God reveals himself not as inexorable fate, but as biddable."[184]

---

[176] *LW* 42:101.

[177] *LW* 42:99.

[178] *LW* 42:104–06.

[179] *LW* 42:106.

[180] *LW* 42:114.

[181] Joseph Herl, Peter C. Reske and Jon D. Vieker, eds. *Lutheran Service Book: Companion to the Hymns*, Vol. 1 (St. Louis: Concordia Publishing House, 2019), 594.

[182] *Lutheran Service Book Pastoral Care Companion*, "Comforting the Bereaved," 95–106; "Entrance of the Body into the Church," 107–109; "Funeral Service," 110–124; "Committal," 125–135; and "Burial for a Stillborn Child or Unbaptized Child," 136–147.

[183] Two helpful resources for Lutherans in this respect are Dennis Ngien, *Fruit for the Soul: Luther on the Lament Psalms* (Minneapolis: Fortress Press, 2015) and Ronald K. Rittgers, *A Widower's Lament: The Pious Meditations of Johann Christoph Oelhafen, Translated with an Introduction, Notes, and Epilogue* (Minneapolis: Fortress Press, 2021).

[184] Oswald Bayer, "Toward a Theology of Lament," in *Caritas et Reformatio. Essays on Church and Society in Honor of Carter Lindberg*, ed. David Whitford (St. Louis: Concordia Publishing House, 2002), 214.

Lutherans may particularly benefit from a consideration of lament as a way of living out our faith in times of crisis and grief. Luther's moving writings on his trials and afflictions, his *Anfechtungen* (variously translated as trials, temptations and assaults), coupled with his teaching on what it means to be a "theologian of the cross" speak eloquently to our pastoral task with the bereaved. Robert Kolb captures it well when he notes, "In the midst of *Anfechtungen* of various kinds, Luther recognized that he had no answer that would give him mastery over the question of the 'why' of sin and evil. Therefore, Luther let God be master and simply turned to him in days of trouble, often with the cry of lament."[185]

Luther likens the human heart to a ship on the seas driven by a storm. Sometimes the buffeting of circumstances and our particular experiences plunge us into the waters of despair. At other times, "the breezes of hope" bring us the prospect of potential happiness. Luther points to the biblical psalms as a rich resource for prayer in each of these seasons of life, including the darkest hours:

> Where does one find finer words of joy than in the psalms of praise and thanksgiving? There you look into the hearts of all the saints, as into fair and pleasant gardens, yes, as into heaven itself. There you see what fine and pleasant flowers of the heart spring up from all sorts of fair and happy thoughts toward God, because of his blessings. On the other hand, where do you find deeper, more sorrowful, more pitiful words of sadness than in the psalms of lamentation? There again you look into the hearts of all the saints, as into death, yes, as into hell itself. How gloomy and dark it is there, with all kinds of troubled forebodings about the wrath of God! So, too, when they speak of fear and hope, they use such words that no painter could so depict for you fear or hope, and no Cicero or other orator so portray them. And that they speak these words to God and with God, this, I repeat, is the best thing of all.[186]

It is instructive to consider even our Lord's own prayer with its seven petitions as a fitting prayer for the grieving and lamenting believer.[187] Each petition relates to the experience of a person in grief. In a world seemingly out of control with death stalking and then stealing from us those we love, we center our thinking by affirming from the depths of pain that God's name is holy, and we ask that it be kept holy, even in this hurt. Second, while our minds may race to questions that all seem to begin with "why," we petition our heavenly Father for the Spirit's grace that enables us to "believe His holy Word and lead godly lives here in time and there in eternity" as members of His kingdom. Third, we pray that in the midst of loss that leaves us reeling, God will superintend in such a way that He "breaks and hinders every evil plan" and enables us to hallow His name even when we hurt too much to care, and that He "strengthens and keeps us firm in His Word and faith until we [also] die." Fourth, we ask for God to give us all that we need, even in our days of grieving, and to receive it all with thanksgiving. Fifth, those who are grieving often fall prey to anger and to thoughts of recriminations. Not uncommonly, the families of those who have died sometimes lash out at the physicians and institutions that provided support for their loved one at the end of life. We pray that God will assist us as we "sincerely forgive and gladly do good to those who sin against us." Sixth, recognizing the emotional fragility of a person in grief, we petition the God of all comfort to "guard and keep us so that the devil, the world, and our sinful nature may not deceive us or mislead us into false belief, despair, and other great shame and vice." Finally, the Lord's Prayer captures the aspiration of the disciple for God to "rescue us from every evil of body and soul" and "when our last hour comes, give us a blessed end, and graciously take us from this valley of sorrow to Himself in heaven."

Lutheran theologian Oswald Bayer rightly draws attention to the faith that undergirds a Christian's lament. Rather than finding its voice in "a nihilistic vacuum of unbelief," lament only occurs because our God speaks to us and hears us

---

[185] Robert Kolb, Foreword, in Ngien, *Fruit for the Soul,* xiii-ix.

[186] *LW* 35:255–256.

[187] Notice how applicable the words of Luther's catechism are to the experience of the grieving Christian. His words sprinkle this section with the aspirations of one in grief and expressing lament. See "The Lord's Prayer," *Luther's Small Catechism with Explanation*, 19–22.

when we cry to Him. "Lament does not become silent in light of the promise of an answer; rather, it becomes louder and sharper. The distress articulated in the lament gains painful depth."[188]

One of the most remarkable features of prayers of lament is the way in which they hold tightly together the seemingly opposite poles of grief and joy, despair and hope. Psalm 13, for example, opens with the aching cries: "How long, O LORD? Will you forget me forever? How long will you hide your face from me? How long must I take counsel in my soul and have sorrow in my heart all the day?" (PSALM 13:1–2). Yet just a few verses later, the psalmist declares, "But I have trusted in your steadfast love; my heart shall rejoice in your salvation" (PSALM 13:5). On the one hand, this emotional ambiguity may be understood "not as … separate moments in the speaker's life, but as states that exist simultaneously in his heart."[189] On the other hand, there is a movement consistently exhibited by the biblical lament psalms, a movement from pain and lament to confidence, hope and praise. As Luther says regarding this psalm, "Hope itself despairs and despair nevertheless begins to hope."[190]

Psalm 22 is no different. As David concludes his convulsive paroxysm of pain, he breaks forth in praise of God:

22 I will tell of your name to my brothers;
in the midst of the congregation I will praise you:
23 You who fear the LORD, praise him!
All you offspring of Jacob, glorify him,
and stand in awe of him, all you offspring of Israel!
24 For he has not despised or abhorred
the affliction of the afflicted,
and he has not hidden his face from him,
but has heard, when he cried to him.
25 From you comes my praise in the great congregation;
my vows I will perform before those who fear him.
26 The afflicted shall eat and be satisfied;
those who seek him shall praise the LORD!
May your hearts live forever!

Lament offers a biblical template, then, for dealing with the bereaved, and it unites us together in the suffering, the prayer and the faithfulness of our Lord Jesus Himself. Glenn Packiam notes five additional aspects of such prayer. It expresses the anguish of the human heart in prayer, represents an act of praise of God, bears testimony to the dependence on Him even in sorrow, shows the way forward in our relationship with God, petitions Him as our dear Father to engage with us in our suffering, and takes us into the very midst of the broken hearts of God's people. Packiam concludes by noting the movement toward praise that undergirds the lament of believers.

Lament is not our final prayer. It is a prayer *in the meantime*. Most of the lament psalms end with a "vow to praise" — a promise to return thanksgiving to God for His deliverance. Because Jesus Christ is risen from the dead, we know that sorrow is not how the story ends. The song may be in a minor motif now, but one day it will resolve in a major chord. When every tear is wiped away, when death is swallowed up in victory, when heaven and earth are made new and joined as one, when the saints rise in glorious bodies … then we will sing at last a great, "Hallelujah!"[191]

---

[188] Bayer, "Toward a Theology of Lament," in *Caritas et Reformatio*, 212.

[189] Timothy E. Saleska, *Psalms 1–50* (Concordia Commentary; St. Louis: Concordia Publishing House, 2020), 285, citing J. Clinton McCann Jr., *The Book of Psalms* in *The New Interpreter's Bible,* ed. Leander E. Keck (Nashville: Abingdon, 1996), 727.

[190] Quoted by Saleska, *Psalms 1–50,* 288.

[191] Glenn Packiam, "Five Things to Know About Lament," *N.T. Wright Online*, April 2020, *ntwrightonline.org/five-things-to-know-about-lament/*.

V. Concluding Remarks

In concluding this report, we want to remind the reader once more of the CTCR's earlier reports, *Christian Care at Life's End* and *Euthanasia.* Those studies and their principles remain foundational for this report. As was the case with the Commission's previous reports on how Christians are called to care and never to kill, we have sought herein to be faithful to a distinctively Christian understanding of death. We do not seek to avoid death as if it were a natural or medical obstacle to be overcome. Instead, we acknowledge it as the right and meet punishment we must all face as the wages of sin. Yet we do so with the hope of eternal life through the death and resurrection of Jesus Christ.

"Precious in the sight of the LORD is the death of his saints" (PSALM 116:15).

"When the perishable puts on the imperishable, and the mortal puts on immortality, then shall come to pass the saying that is written:

'Death is swallowed up in victory.'
'O death, where is your victory?
O death, where is your sting?'

"The sting of death is sin, and the power of sin is the law. But thanks be to God, who gives us the victory through our Lord Jesus Christ" (1 COR. 15:54–57).

Appendix

APPROPRIATE QUESTIONS FOR DISCUSSION WITH MEDICAL PERSONNEL AND FAMILY

Richard C. Eyer helpfully offers guidance for how to deal with physician interactions in end-of-life situations.[192] He offers several questions for the family members being approached by the physician for input on either initiating or continuing life support interventions. He recommends that the family member ask to speak directly with the physician if approached by a nurse or other hospital staff person. Eyer's proposed questions have been modified and expanded to take into account some of the end-of-life discussions in this paper, particularly the suggestions by John T. Pless.[193] As such, they are also directed as points for discussion with family members and one's pastor as well as with medical professionals.

1. Ask the doctor: "What is the medical condition of the patient at this time?" (You are asking for an objective medical evaluation, not a philosophical opinion, of the patient's condition.)
2. Ask the doctor: "What is the prognosis?" Has a "second opinion" been sought? Does this opinion confirm or call into question the original prognosis? (You are asking whether the patient is expected to recover or not.)
3. Ask the doctor: "Is the patient dying at this time?" Have the patient's vital processes already begun to shut down, indicating that death is inevitable unless God intervenes? (If the patient is not dying, it would be morally wrong to aim at causing the death of the patient.)
4. Is treatment being discontinued to hasten death (hence "choosing death") or because the treatment itself has become burdensome on the patient with no realistic hope of recovery?
5. Ask the doctor: "Is the patient awake?" (If so, you will want to be supportive by discussing with the patient his condition and by praying with him for guidance before a decision is made.)
6. Ask the doctor: "Is the patient in any pain at this time?" (You are asking whether pain gives urgency to your decision.)
7. Is adequate physical care (e.g., artificial nutrition and hydration) provided for the dying person even when other treatments are discontinued or life support systems are withdrawn?
8. If a decision is needed immediately, err on the side of life, not death. If a decision is not needed momentarily, say, "I need time to talk with my family and/or pastor and I will call you within [a stated length of time]." (You are saying you need the input of others concerned for the patient.)
9. If the situation allows, leave the hospital and meet with your family and pastor at church in a prayerful environment. This distance from the hospital environment sometimes helps you think more clearly. Inform the nurse that you are leaving, where you will be and when you will return.

---

[192] Richard. C. Eyer, "Medical Directives and Some Misunderstandings" (Mequon, Wis.: Concordia University, n.d.). A helpful, but unfortunately out of print, resource for group studies of end-of-life decisions that includes descriptions, biblical texts for each issue, case studies, small-group questions and even "things to do" in follow up can be found in John Klotz, ed., *Life Choices Who Decides? Following God's Word in Life and Death Decisions* (St. Louis: Concordia Publishing House, 1991).

[193] Pless, *Mercy at Life's End*, 16, was invaluable for adding to the excellent questions by Eyer.

SUPPLEMENTARY MATERIALS

GLOSSARY: DEFINITIONS OF CURRENT END-OF-LIFE TERMS

Actively dying — The hours or days preceding imminent death during which time the patient's physiologic functions wane. Virtually all dying patients go through a stereotypical pattern of symptoms and signs in the days before death. This trajectory is often referred to as "actively dying" or "imminent death."

Advance directive — The most common types of advance directives are the living will and the power of attorney for health care. Called "advance" because such a document is prepared prior to a health crisis during which it would guide medical care, these directives vary by state and can include other documents, such as a dementia provision or a DNR ("do not resuscitate") order (see below). See also "living will" and "power of attorney for health care" below.

Artificial nutrition and hydration (AN&H/ANH) — ANH is most often delivered by means of a nasogastric (NG) or percutaneous endoscopic gastrostomy (PEG) tube (see below). It often involves a surgical procedure to place a flexible feeding tube through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and esophagus. Whether delivered by an NG or PEG tube, the purpose of ANH is to provide short-term support for patients who are acutely ill. When employed near the end of life, ANH will most likely not prolong life and can lead to medical complications that increase suffering for the patient.

Coma — While differences of physical presentation exist within the classification of "coma" (e.g., open-eyed vs. closed-eyed), the Mayo Clinic defines a coma as "a state of prolonged unconsciousness that can be caused by a variety of problems — traumatic head injury, stroke, brain tumor, drug or alcohol intoxication, or even an underlying illness, such as diabetes or an infection." A coma "seldom lasts longer than several weeks."

Death with dignity — The term used by proponents of physician-assisted suicide/dying to describe death where the patient is viewed as being in control (either by an advance directive or by electing to request lethal medications). It is also the name given to aid-in-dying laws that have advanced in a number of states over the years. Oregon's landmark aid-in-dying law, enacted in 1997, is called the Oregon Death With Dignity Act. The state of Washington's 2008 law is the Death with Dignity Act. It is a term of art and part of the political landscape (e.g., pro-choice, pro-abortion). People who speak of "death with dignity" are not employing the word "dignity" in its Christian sense but as part of their efforts to legalize physician-assisted dying and/or euthanasia.

Do not resuscitate (DNR) — A medical order that no measures be taken to resuscitate a patient whose heart or breathing stops. The order is made while the individual is mentally capable and conscious, or by that individual's healthcare proxy if he or she is not. A variety of interventions may be specified. Some patients may choose to have "full code" with intubation and to be placed on a ventilator (short or long term). Another patient may decide not to be on a ventilator with a "DNR Select" code status where the heart would be shocked if it stops, but intubation/ventilation is not performed. Some in this category choose to be placed on a BIPAP (bilevel positive airway pressure) machine (similar to a CPAP— continuous positive airway pressure — for sleep apnea). A third option involves a patient who chooses to have a status of "do not resuscitate" (DNR). Various "treatments" (i.e., antibiotics, tube feeding) and other care preferences desired/not desired can be specified on some DNR forms in some jurisdictions to guide health team members.

End of life — In clinical medicine, the "end of life" can be thought of as the period preceding an individual's natural death from a process that is unlikely to be arrested by medical care. For insurance purposes, the "end of life" has been operationalized to represent the last six months of a patient's life. It refers to a final period — hours, days, weeks, months — in a person's life in which it is medically obvious that death is imminent or a terminal moribund state cannot be prevented.

Euthanasia — Also known as "mercy killing." In the act of euthanasia, the physician — not the dying person — chooses and acts to cause the death of the patient.

Hospice — A program in which an interdisciplinary team of caregivers provides comfort, support and dignity to terminally ill people when medical treatment is no longer expected to cure the terminal disease or prolong life. Hospice service is provided wherever the person resides, most often at home. It is voluntary and also involves and supports the individual's family and/or loved ones.

Irretrievably dying — Irretrievably dying refers to the condition where a person's body has already begun to shut down and few, if any, medical treatments offer hope of healing. The term may be contrasted with "terminally ill," since one can be terminally ill but still expected to live for months or even years.

Living will — A document that expresses a person's end-of-life preferences if he or she becomes unable to speak. A living will is just one type of an advance directive (see above).

Medical aid in dying (MAID) — A provision that allows mentally capable, terminally ill adults to request a prescription from their physician for life-ending medication that the person may self-administer. The states that currently authorize MAID require that, prior to providing a prescription, doctors must confirm that a patient is fully informed about his or her prognosis and must provide the patient with information about additional end-of-life options, including comfort care, hospice and pain control. Other synonymous terms are commonly used: physician-assisted suicide, physician-assisted dying, physician-assisted death, physician aid in dying, medically-assisted dying, patient-administered hastened death. Advocates of the practice consider the term "physician-assisted suicide" to be a partisan description of the medical practice of aid in dying. They may cite the judgment of the American Psychological Association that suicide and aid in dying have "profound psychological differences." Lutheran ethicists have joined other Christians and non-Christians in opposing this as suicide or euthanasia under another name.

Medical (or physician) orders for life-sustaining treatment (MOLST/POLST) — A document available in some states that provides detailed guidance about an individual's wishes for end-of-life medical care. The order is part of advance health care planning and is prepared by a medical professional.

Nasogastric (NG) tube — A flexible tube inserted through the nose to deliver nutrition and medication to the stomach for those experiencing difficulty swallowing. NG tubes may administer nutrients and medication, remove liquids or air from the stomach, add contrast to the stomach for X-rays, or protect the bowel after surgery or during a bowel rest.

Palliative/total sedation — Also referred to as terminal sedation. The continuous administration of medication to relieve severe, unrelenting symptoms that cannot be controlled while keeping the person conscious. This state is maintained until death occurs.

Percutaneous endoscopic gastrostomy (PEG) tube — A PEG tube is an alternative to an NG tube for patient nutrition. The PEG tube is surgically placed through the abdomen directly into the stomach.

Persistent vegetative state (PVS) or Post-coma unresponsiveness — PVS represents a disorder of consciousness in which patients with severe brain damage are in a state of partial arousal rather than true awareness. Typically the VS classification gets applied to such persons, with the classification "persistent vegetative state" coming after four weeks. While some describe those in a persistent vegetative state as "brain dead," in fact, the lower brain stem in PVS patients is still healthy and fully functioning. This results in the person's ability to blink and otherwise move his or her eyes, breathe independently, cry or laugh, though not as an emotional response to external events. Those with PVS enjoy normal circulation, experience regular sleep-wake cycles, move their limbs, though purely as reflex (PVS patients can't hold their limbs nor move them on command), open their eyes, smile and track objects with their eyes.

Power of attorney for healthcare (POAH) — A legal document that grants someone the authority to make health care decisions on behalf of another individual when that individual cannot do so. Synonymous terms include durable power of attorney for health care, medical power of attorney, health care power of attorney and health care proxy.

Refusal of medical treatment — The legal right of competent adults to refuse medical treatment even if that treatment is necessary to sustain life. These life-sustaining interventions can include ventilators, feeding tubes and pacemakers. If an adult is judged to be mentally incompetent by a psychiatric professional, the person can be treated against his will.

Terminal care period — The period during which there is evidence of progressive malignancy, and in which therapy cannot realistically be expected to prolong survival significantly. Patients enter this period either at the time of diagnosis or following a period of active treatment. The onset of the terminal care period should not be confused with the point at which the expectation of life is estimated to be short. A patient might be expected to die within a few months but have a treatable malignancy. This patient would still be in the active treatment period.

Terminal condition — As held by at least two appellate courts, "dying" or a "terminal condition" is a condition resulting from injury,

disease or illness from which there likely can be no return to health, and which, without life-prolonging procedures, will lead to natural death. In other words, a person with a terminal condition is one for whom no medical cure exists.

Terminal prognosis, terminally ill — An illness for which the medical expectation is death within a few months. Aid-in-dying laws typically define a patient as terminal whose life expectancy is six months or less. Those suffering from a fatal pathology because medical treatment in their cases will not lead to a restoration of health and will prolong the dying process may be deemed terminally ill or have a terminal prognosis. People in an irreversible coma (IC) and/or a persistent vegetative state (PVS) are, ipso facto, terminally ill. For the sake of simplicity, most clinicians consider IC and PVS to belong to this same class of terminally ill people and refer to them as permanently unconscious, though each group has different, but related, neurological impairments. The Medicare hospice benefit is limited to persons whose physicians attest that the patient has "a terminal illness with a life expectancy of six months or less."

Transition of care — Transition of care during the end of life includes: 1) changing place of care, 2) changing goals of care, 3) changing teams of care. The term refers to support given to patients when they move from one phase of the disease or treatment to another, such as from hospital care to home care. It involves helping patients and families with medical, practical and emotional needs as they adjust to different levels and goals of care.

Voluntarily stopping eating and drinking (VSED) — VSED is a legal right for any individual who wishes to shorten the dying process by refusing nourishment orally or through a tube.

CHRONOLOGY OF ASSISTED DYING EFFORTS IN THE U.S.[194]

Ian Dowbiggin offers two of the most useful histories of the euthanasia movement in America.[195] Readers wishing to deal with the philosophical and historical factors leading to success and failure of the efforts to push for physician-assisted suicide/dying would be rewarded by reading his volumes. Dowbiggin roots the emergence of right-to-die agitation in a "combination of a fervent quest to maximize human freedom and the reformist urge to socialize individual identities in the service of utilitarian goals" within a larger mindset of progressivism in the early twentieth century.[196] The following chronology was compiled by noted physician-assisted dying advocate, Derek Humphry. Usage of this chronology for informational purposes does not, obviously, imply support for or agreement with Humphry's views or interpretations of these events.

Pre-1950s

1906 First euthanasia bill drafted in Ohio. It does not succeed.

1935 World's first euthanasia society is founded in London, England.

1938 The Euthanasia Society of America is founded in New York by Unitarian minister Rev. Charles Potter.

1950s

1954 American professor Joseph Fletcher publishes *Morals and Medicine*, predicting the coming controversy over the right to die.

1957 Pope Pius XII issues Catholic doctrine distinguishing ordinary from extraordinary means for sustaining life.

1958 Oxford law professor Glanville Williams publishes *The Sanctity of Life and the Criminal Law*, proposing that voluntary euthanasia be allowed for competent, terminally ill patients.

1960s

1967 The first living will is written by attorney Louis Kutner, and his arguments for it appear in the *Indiana Law Journal*.

1967 A right-to-die bill is introduced by Dr. Walter W. Sackett in Florida's legislature. It arouses extensive debate but is unsuccessful.

1968 Doctors at Harvard Medical School propose redefining death to include brain death as well as heart-lung death. Gradually this definition is accepted.

1969 A voluntary euthanasia bill is introduced in the Idaho legislature. It fails.

1969 Psychiatrist Elisabeth Kübler-Ross publishes *On Death and Dying*, in which she proposes the five-stages model for those facing death.

1970s

1970 The Euthanasia Society (U.S.) finishes distributing 60,000 living wills.

1973 The American Hospital Association creates the Patient Bill of Rights, which includes informed consent and the right to refuse treatment.

1973 Dr. Gertruida Postma, who gave her dying mother a lethal injection, receives a light sentence in the Netherlands. The furor launches the euthanasia movement in that country: The Dutch Association for a Voluntary End of Life (NVVE).

1974 The Euthanasia Society in New York is renamed the Society for the Right to Die. The first American hospice opens in New Haven, Conn.

1975 Henry P. Van Dusen, 77, and his wife, Elizabeth, 80, leaders of the Christian ecumenical movement, commit suicide rather than suffer from disabling conditions. Their note reads, "We still feel this is the best way and the right way to go."

1976 The New Jersey Supreme Court allows Karen Ann Quinlan's parents to disconnect her respirator, saying it is affirming the choice Karen herself would have made. The Quinlan case becomes a legal landmark. Quinlan lives another eight years.

1976 The California Natural Death Act is passed. The nation's first aid-in-dying statute gives legal standing to living wills and protects physicians from being sued for failing to treat incurable illnesses.

---

[194] The following chronology is taken from Derek Humphry's book *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying,* Delta, 2002. It is also available at *finalexit.org/chronology_right-to-die_events.html.*

[195] Ian Dowbiggin, *A Merciful End: The Euthanasia Movement in Modern America*. Oxford: Oxford University Press, 2003. From *A Concise History of Euthanasia: Life, Death, God, and Medicine* (Lanham, Md.: The Rowman & Littlefield Publishing Group, 2005).

[196] Dowbiggin, *A Merciful End*, xiii.

1976 Ten more U.S. states pass natural death laws.

1976 The first international meeting of right-to-die groups is held in Tokyo.

1977 A people's initiative asking the Swiss Federal Parliament to allow euthanasia for incurably ill people in the Swiss canton of Zurich is passed by a vote of 203,148 to 144,822, but the Federal Parliament does not follow the initiative.

1978 Doris Portwood publishes *Common Sense Suicide: The Final Right*. It argues that old people in poor health might justifiably kill themselves.

1978 *Whose Life Is It Anyway?*, a play about a young artist who becomes quadriplegic, is staged in London and on Broadway, raising questions about the right to die. A film version appears in 1982. Simultaneously, *Jean's Way* is published in England by Derek Humphry, describing how he helped his terminally ill wife to die.

1979 Two right-to-die organizations split. The Society for the Right to Die separates from Concern for Dying, a companion group that grew out of the Society's Euthanasia Education Council.

1980s

1980 The advice column "Dear Abby" publishes a letter from a reader agonizing over a dying loved one, after which the Society for the Right to Die receives 30,000 advance care directive requests.

1980 Pope John Paul II issues the "Declaration on Euthanasia," which opposes mercy killing but permits the greater use of painkillers to ease pain and the right to refuse extraordinary means for sustaining life.

1980 The Hemlock Society is founded in Santa Monica, Calif., by Derek Humphry. It advocates legal change and distributes how-to-die information. This launches the campaign for assisted dying in America. Hemlock's national membership grows to 50,000 within a decade. Right-to-die societies are formed in France, Germany and Canada.

1980 The World Federation of Right to Die Societies is formed in Oxford, England. It comprises 27 groups from 18 nations.

1981 Hemlock publishes a how-to suicide guide, *Let Me Die Before I Wake*.

1984 Advance care directives become recognized in 22 states and the District of Columbia.

1984 The Netherlands Supreme Court approves voluntary euthanasia and physician-assisted suicide under strict conditions.

1985 Karen Ann Quinlan dies.

1985 Betty Rollin publishes *Last Wish*, her account of helping her mother die after a long battle with breast cancer. The book becomes a bestseller.

1986 Roswell Gilbert, 76, is sentenced in Florida to 25 years without parole for shooting his terminally ill wife. He is granted clemency five years later.

1986 Elizabeth Bouvia is granted the right to refuse food by an appeals court but ultimately declines to take advantage of the permission. She was still alive in 2008.

1987 The California State Bar Conference passes Resolution #3-4-87 to become the first public body to approve of physician aid in dying.

1988 The Unitarian Universalist Association of Congregations passes a national resolution favoring aid in dying for the terminally ill, becoming the first religious body to affirm a right to die.

1990s

1990 The American Medical Association adopts the formal position that, with informed consent, a physician can withhold or withdraw treatment from a patient who is close to death and may also discontinue life support of a patient in a permanent coma.

1990 Dr. Jack Kevorkian assists in the death of Janet Adkins, a middle-aged woman with Alzheimer's disease. Kevorkian subsequently flaunts the Michigan legislature's attempts to stop him from assisting in additional suicides.

1990 The U.S. Supreme Court decides the Cruzan case, its first aid-in-dying ruling. The decision recognizes that competent adults have a constitutionally protected liberty interest that includes a right to refuse medical treatment; the court also allows a state to impose procedural safeguards to protect its interests.

1990 Congress passes the Patient Self-Determination Act, requiring hospitals that receive federal funds to tell patients that they have a right to demand or refuse treatment. It takes effect the next year.

1991 Dr. Timothy Quill writes about "Diane" in the New England Journal of Medicine, describing his provision of lethal drugs to a leukemia patient who chose to die at home by her own hand rather than undergo therapy that offered a 25% chance of survival.

1991 A nationwide Gallup poll finds that 75% of Americans approve of living wills.

1991 Derek Humphry publishes *Final Exit*, a how-to book on "self-deliverance." The book becomes a U.S. bestseller, with subsequent editions published in 1996 and 2002.

1991 Choice in Dying is formed by the merger of two aid-in-dying organizations, Concern for Dying and Society for the Right to Die. The new organization becomes known for defending patients' rights and promoting living wills, and grows in five years to 150,000 members.

1992 California voters defeat Proposition 161, which would have allowed physicians to hasten death by actively administering or prescribing medications for self-administration by suffering, terminally ill patients. The percentage vote is 54–46.

1993 Derek Humphry starts ERGO (Euthanasia Research and Guidance Organization), a nonprofit group to research and publish literature on the right to die.

1993 Compassion in Dying is founded in the state of Washington to counsel the terminally ill and provide information about how to die without suffering and "with personal assistance, if necessary, to intentionally hasten death." The group sponsors suits challenging state laws against assisted suicide.

1993 Oregon Right to Die, a political action committee, is founded. It writes and subsequently passes the Oregon Death with Dignity Act by way of a citizens ballot initiative.

1994 All 50 U.S. states and the District of Columbia now recognize some type of advance directive procedure.

1994 Washington's anti-suicide law is overturned. In *Compassion v. Washington*, a district court finds that a law outlawing assisted suicide violates the Fourteenth Amendment. Chief District Judge Barbara Rothstein writes, "The court does not believe that a distinction can be drawn between refusing life-sustaining medical treatment and physician-assisted suicide by an uncoerced, mentally competent, terminally ill adult."

1994 In New York State, the lawsuit *Quill et. al. v. Koppell* is filed to challenge the New York law prohibiting assisted suicide. Quill loses and files an appeal.

1994 Oregon voters approve Measure 16, a Death with Dignity Act ballot initiative that would permit terminally ill patients, under certain guidelines, to obtain a physician's prescription to end life. The vote percentage is 51–49. But U.S. District Court Judge Michael Hogan issues a temporary restraining order against the measure, followed by an injunction barring the state from putting the law into effect.

1995 Washington's Compassion ruling is overturned by the Ninth Circuit Court of Appeals, reinstating the anti-suicide law.

1995 U.S. District Judge Michael Hogan rules that Oregon Measure 16, the Death with Dignity Act, is unconstitutional on the grounds that it violates the equal protection clause of the U.S. Constitution. His ruling is immediately appealed.

1995 Surveys find that doctors disregard most advance directives. The *Journal of the American Medical Association* reports that physicians were unaware of the directives of three-fourths of all elderly patients admitted to a New York hospital; the California Medical Review reports that three-fourths of all advance directives are missing from Medicare records in that state.

1995 Oral arguments in the appeal of *Quill v. Vacco* contest the legality of New York's anti-suicide law before the Second Circuit Court of Appeals.

1995 The *Compassion* case is reconsidered in Washington by a Ninth Circuit Court of Appeals panel of 11 judges, the largest panel ever to hear a physician-assisted suicide case.

1996 The Ninth Circuit Court of Appeals reverses the *Compassion* finding in Washington, holding that "a liberty interest exists in the choice of how and when one dies, and that the provision of the Washington statute banning assisted suicide, as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors, violates the Due Process Clause." The ruling affects laws of nine states. It is stayed, pending appeal to the U.S. Supreme Court.

1996 A Michigan jury acquits Kevorkian of violating a state law banning assisted suicide.

1996 The Second Circuit Court of Appeals reverses the *Quill* finding, ruling that "The New York statutes criminalizing assisted suicide violate the Equal Protection Clause because, to the extent that they prohibit a physician from prescribing medications to be self-administered by a mentally competent, terminally ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest." The ruling affects laws in New York, Vermont and Connecticut. On April 17, the court stays enforcement of its ruling for 30 days pending an appeal to the U.S. Supreme Court.

1996 The U.S. Supreme Court announces that it will review both cases sponsored by Compassion in Dying, known now as *Washington v. Glucksberg* and *Quill v. Vacco*.

1997 On May 13, the Oregon House of Representatives votes 32–26 to return Measure 16 to the voters in November for repeal (H.B. 2954). On June 10, the Senate votes 20–10 to pass H.B. 2954 and return Measure 16 to the voters for repeal. No similar attempt to overturn the will of the voters has been tried in Oregon since 1908.

1997 On June 26, the U.S. Supreme Court reverses the decisions of the Ninth and Second Circuit Courts of Appeals in *Washington v. Glucksberg* and *Quill v. Vacco*, upholding as constitutional state statutes that bar assisted suicide. However, the court also validates the concept of "double effect," openly acknowledging that death hastened by increased palliative measures does not constitute prohibited conduct so long as the intent is the relief of pain and suffering. The majority opinion ends with the pronouncement: "Throughout the nation, Americans are engaged in an earnest and profound debate about the morality, legality and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."

1997 Britain's Parliament rejects, by 234 votes to 89, the seventh attempt in 60 years to change the law on assisted suicide, despite polls showing 82% of British people want change.

1997 On Nov. 4, the people of Oregon vote by a margin of 60–40% against Measure 51, which would have repealed the 1994 Oregon Death with Dignity Act. The law officially takes effect (ORS 127.800-897) on Oct. 27, when court challenges are disposed of. Actual implementation of the law starts on the first day of 1998.

1998 The Oregon Health Services Commission decides that payment for physician-assisted suicide can come from state funds under the Oregon Health Plan.

1998 Sixteen people die by making use of the Oregon Death with Dignity Act, receiving physician-assisted suicide in its first full year of implementation.

1998 Measure B on the Michigan ballot to legalize physician-assisted suicide is defeated by a margin of 70–30%.

1998 The Swiss association DIGNITAS is founded. It offers assisted suicide and accepts members from abroad.

1999 Kevorkian is sentenced to 10 to 25 years in prison for the second-degree murder of Thomas Youk after showing a video of Youk's death by injection on national television. His appeals are dismissed.

2000s

2002 A Dutch law allowing voluntary euthanasia and physician-assisted suicide — which had been permitted under certain guidelines for 20 years — takes effect on Feb. 1.

2002 Belgium passes a law similar to the Dutch law, allowing both voluntary euthanasia and physician-assisted suicide.

2003 U.S. Attorney General John Ashcroft asks the Ninth Circuit Court of Appeals to reverse the finding of a lower court judge that the Oregon Death with Dignity Act of 1994 does not contravene federal powers. Up to this point, 129 dying people have used the law to obtain physician-assisted suicide. The losers of this appeal ask the U.S. Supreme Court to rule, which it agrees to do.

2003 The British Parliament rejects the Patient (Assisted Dying) Bill introduced by Lord Joffe. Identical to the Oregon law, it was fiercely opposed by the churches. This was the eighth time in 60 years that a right to die bill was refused by Parliament.

2004 Hemlock Society USA is renamed End-of-Life Choices and within months is merged with Compassion in Dying to become Compassion & Choices (C&C). The Final Exit Network is formed to provide volunteers across America to help dying people who request assistance.

2004 Lesley Martin of New Zealand completes a seven-month prison sentence for the attempted murder by morphine overdose of her terminally ill mother. She vows to continue to work for lawful voluntary euthanasia.

2005 Terri Schiavo of Florida dies when her feeding tube is removed after she lived for 14 years in a persistent vegetative state. President George W. Bush, Florida Governor Jeb Bush, Schiavo's parents and right-to-life advocates had fought to keep her on life support, but her husband, Michael Schiavo, successfully used the legal system to have her feeding tube removed.

2006 The U.S. Supreme Court refuses the U.S. Attorney General's application to repeal the Oregon Death with Dignity Act. The George W. Bush administration wanted the law struck down on the grounds that states do not control lethal drugs, but Oregon successfully argued that states control medical practice and that the drugs required for this form of death were never meant to be banned.

2006 Dr. Philip Nitschke publishes *The Peaceful Pill Handbook*, outlining ways to bring one's own life to an end. It is immediately banned in his own country, Australia, as well as in New Zealand.

2007 Jack Kevorkian is released from prison on parole after serving nine years. He helped some 130 people to die, all within his home area.

2008 Voters in Washington approve, by 59-41%, a physician-assisted suicide law similar to that in Oregon. In the first year, 63 people are recorded as having used it.

2009 The Montana Supreme Court rules that physician-assisted suicide is not against the law in that state.

2010s

2011 After a two-week trial, an Arizona jury acquits Dr. Lawrence Egbert in the suicide of Jana Van Voorhis, whom prosecutors said he had assisted in killing herself. Egbert, who also is indicted in Georgia on charges that he helped a man with cancer kill himself, is one of four people charged by Arizona authorities in Van Voorhis' death. Jurors are unable to reach a verdict for a co-defendant, Frank Langsner. According to Maricopa County prosecutors, the other two defendants in the case, Wye Hale-Rowe and Roberta Massey, had pled guilty to one count of facilitation to commit manslaughter and had agreed to testify in the case.

2011 Sharlotte Hydorn, 92, a retired school teacher who was selling helium hood kits designed to help people commit suicide, pleads guilty in a San Diego federal court to a misdemeanor charge of failing to file a tax return. According to court records, Hydorn sold approximately 1,300 suicide kits since 2007.

2012 In *Final Exit Network, Inc., vs. State of Georgia* (S11A1960), the Georgia Supreme Court unanimously strikes down the state's assisted-suicide law, finding it violates the free speech clauses of the Georgia and U.S. Constitutions. The court's ruling means that four members of the Final Exit Network do not have to stand trial on felony charges in Forsyth County. They were charged in connection with the 2008 suicide of 58-year-old John Celmer, who killed himself two years after he had been diagnosed with cancer.

2012 The world's first mobile euthanasia unit begins to operate in the Netherlands.

2012 *In Search of Gentle Death: The Fight for Your Right to Die with Dignity* by Richard N. Côté (with a foreword by Derek Humphry) is published by Corinthian Books, South Carolina.

2012 The Georgia Senate passes a bill making assisting in a suicide a crime. The Senate bill was a reaction to the Supreme Court of Georgia's decision, on Feb. 6, declaring the existing law unconstitutional in violation of First Amendment free speech principles. The Georgia Supreme Court ruling terminated the prosecution of the "Georgia Four," Final Exit Network volunteers who had been arrested and charged in February 2009 under the old law. The Georgia House passed a similar bill on March 7.

2012 The International Congress of World Federation of Right-to-Die Societies is hosted in Zürich, Switzerland.

2013 Vermont becomes the first legislature in the U.S. to pass a physician-assisted suicide law. (Oregon and Washington passed their laws via citizen initiative vote; Montana's came about through a court case.)

2015 The Final Exit Network (FEN), Inc., is convicted in Minnesota on a charge of assisting in a suicide because FEN volunteers instructed a Minnesota resident on the process of "self-deliverance." The Supreme Court of Minnesota redefined the word "assist" to prohibit speech that enables a suicide. The U.S. Supreme Court declined to review the case.

2015 Vermont's legislature passes a bill removing "sunset" measures from the original Act 39, Patient Choice and Control at the End of Life Act.

2015 A death with dignity bill narrowly fails, by a single vote in the Senate, in Maine.

2015 The California legislature passes ABX-15, End of Life Option Act, a death with dignity law.

2016 The Washington D.C. Council passes the Death with Dignity Act.

2016 Colorado voters pass the End of Life Options Act on the November ballot.

2017 In February, the Washington D.C. Death with Dignity Act goes into effect; implementation begins in June.

2018 In April, Hawaii becomes the seventh U.S. jurisdiction to enact an assisted dying law similar to Oregon's original law.

2018 In May, the California End of Life Option Act is suspended for three weeks following a district court ruling. On June 15, an appellate court reinstates the law.

2019 The Our Care, Our Choice Act in Hawaii takes effect on Jan. 1.

Since Humphry's Chronology

2021 In April, New Mexico becomes the 10th jurisdiction to enact an assisted dying law. On April 9, New Mexico Governor Lujan Grisham signs AB47, the Elizabeth Whitefield End of Life Options Act, which goes into effect on June 18.

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. First Things (February 1992): 45–47.

Anderson, Kirby. *Euthanasia: A Christian Perspective*. Plano, Texas: Probe Ministries, 1998.

Arand, Charles. "Personal Autonomy versus Creaturely Contingency: The First Article and the Right to Die." *Concordia Journal* (October 1994): 385–401.

"Ars Moriendi." *The Lutheran Witness* (September 2020): full issue.

Bartlett, Linda D., and Karen Rehder. "Ventilators, Feeding Tubes, and Other End-of-Life Questions." *Lutherans for Life* (Feb. 28, 2020). *lutheransforlife.org/article/ventilators-feeding-tubes-and-other-end-of-life-questions*.

Barry, A.L. "What About … Death and Dying." St. Louis: The Lutheran Church—Missouri Synod, 1998. *https://files.lcms.org/file/preview/4C9b1IpSFPRy18M2tCdDXhzJXAEw1Azd?*.

Bayer, Oswald. "Toward a Theology of Lament." In *Caritas et Reformatio: Essays on Church and Society in Honor of Carter Lindberg*, edited by David Whitford, 211–20. St. Louis: Concordia Publishing House, 2002.

-----. "Self-Creation? On the Dignity of Human Beings." *Modern Theology* 20 (April 2004): 275–90.

-----. "Martin Luther's Conception of Human Dignity." In *The Cambridge Handbook of Human Dignity: Interdisciplinary Perspectives*, eds. Marcus Düwell, Jens Braarvig, Roger Brownsword and Dietmar Mieth. Cambridge: Cambridge University Press, 2014.

-----. *Martin Luther's Theology: A Contemporary Interpretation*. Grand Rapids: Eerdmans, 2003.

Beauchamp, Tom L., and James F. Childress. *Principles of Biomedical Ethics*, 8th ed. New York: Oxford University Press, 2019.

Bielfeldt, Dennis. "Heidelberg Disputation." In *The Roots of Reform*, vol. 1 (The Annotated Luther), edited by Hans J. Hillerbrand, Kirsi I. Stjerna and Timothy J. Wengert. Minneapolis: Fortress Press, 2015.

Biermann, Joel. *A Case for Character: Toward a Lutheran Virtue Ethics*. Minneapolis: Fortress Press, 2014.

Billings, J. Todd. *Rejoicing in Lament: Wrestling with Incurable Cancer and Life in Christ*. Grand Rapids: Brazos Press, 2015.

Bluerock, Grace. "The 9 Most Common Regrets at the End of Life." *Mindfulness* (Feb. 24, 2020). *mindbodygreen.com/0-23024/the-9-most-common-regrets-people-have-at-the-end-of-life.html*.

Britannica ProCon.org. "Euthanasia & Medical Aid in Dying (MAID) Around the World." *euthanasia.procon.org/euthanasia-physician-assisted-suicide-pas-around-the-world/*.

Brock, Peter. "A New Kind of Foundling: The Church's Life of Mercy in an Aging Nation." In *Toward a Theology of Mercy: Student Essays for 2007*. St. Louis: The Lutheran Church—Missouri Synod, 2007.

Callahan, Daniel. "Public Policy and the Cessation of Nutrition." In *By No Extraordinary Means*, edited by J. Lynn. Bloomington: Indiana University Press, 1986.

Cohen, C., ed. *Casebook on the Termination of Life-Sustaining Treatment and the Care of the Dying*. Bloomington: Indiana University Press, 1988.

"Commendation of the Dying." *Lutheran Service Book: Pastoral Prayer Companion*. St. Louis: Concordia Publishing House, 2007.

Commission on Theology and Church Relations. *Christian Care at Life's End*. St. Louis: The Lutheran Church—Missouri Synod, 1993. *https://files.lcms.org/file/preview/37664F4B-35B0-4FF2-A950-5C28F9BA20D0*.

-----. *Euthanasia With Guiding Principles*. St. Louis: The Lutheran Church—Missouri Synod, 1979.

Cranford, Ronald E. "Patients with Permanent Loss of Consciousness." In *By No Extraordinary Means*, edited by J. Lynn. Bloomington: Indiana University Press, 1986.

Davis, John Jefferson. *Evangelical Ethics*, 3rd ed. Phillipsburg, N.J.: P&R Publishing, 2004.

Dunlop, John. "A Physician's Advice to Spiritual Counselors of the Dying." *Trinity Journal* 14:2 (Fall 1993): 202–14.

Dowbiggin, Ian. *A Concise History of Euthanasia: Life, Death, God, and Medicine*. Oxford: Rowan & Littlefield, 2005.

-----. *A Merciful End: The Euthanasia Movement in Modern America*. New York: Oxford University Press, 2003.

Dyck, Arthur J. *Life's Worth: The Case Against Assisted Suicide*. Grand Rapids: Eerdmans, 2002.

Eyer, Richard C. "A Christian Guide to End of Life Decisions." *Lutherans for Life. https://lutheransforlife.org/article/a-christian-guide-to-end-of-life-decisions/*.

-----. "Ethical Decision-Making at the End of Life." Presentation to End-of-Life Think Tank. St. Louis: Nov. 13, 1991.

-----. *Holy People, Holy Lives: Law and Gospel in Bioethics*. St. Louis: Concordia Publishing House, 2000.

-----. *Medical Directive and Some Misunderstandings. https://files.lcms.org/file/preview/7F0B3AF8-7ED1-4267-B0A0-C029C58C8A78.*

Foley, Kathleen. *The Case against Assisted Suicide: For the Right to End-of-Life Care*, ed. Kathleen Foley, M.D., and Herbert Hendin. Baltimore: Johns Hopkins University Press, 2002.

Foster, Daniel W. "Religion & Medicine: The Physician's Perspective." In *Health/Medicine and the Faith Traditions*, edited by Martin Marty and Kenneth Vaux. Philadelphia: Fortress Press, 1982.

Fowler, Marsha D. "Christian Teaching and the Church's Authority." In *BioEngagement: Making a Christian Difference Through Bioethics Today*, edited by Nigel M. de S. Cameron, Scott E. Daniels and Barbara J. White, 235–48. Grand Rapids: Eerdmans, 2000.

Frame, John M. *Medical Ethics: Principles, Persons, and Problems*. Phillipsburg, N.J.: Presbyterian and Reformed Publishing, 1988.

Gabriel, Trip. "A Fight to the Death." *New York Times Magazine*, Dec. 8, 1991.

Gerhard, Johann. *Handbook of Consolations: For the Fears and Trials That Oppress Us in the Struggle with Death*, trans. Carl L. Beckwith. Eugene, Ore.: Wipf & Stock, 2009.

Gorsuch, Neil M. *The Future of Assisted Suicide*. Princeton: Princeton University Press, 2006.

"Gov. Lamm Asserts Elderly, If Very Ill, Have 'Duty to Die.'" *New York Times*. March 29, 1984.

Grobien, Gifford A. "The Future of Bioethics." *For the Life of the World* 25: 3 (Fall 2021): 4–6.

Gula, Richard M. "Moral Principles Shaping Public Policy on Euthanasia." *Second Opinion* 14 (1990): 72–83.

Hamel, Ronald P. *Choosing Death: Active Euthanasia, Religion, and the Public Debate.* Norcross, Ga.: Trinity Press International, 1991.

Hauerwas, Stanley. *Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped, and the Church*. South Bend: University of Notre Dame Press, 1986.

Herl, Joseph, Peter C. Reske and Jon D. Vieker, eds. *Lutheran Service Book: Companion to the Hymns*, Vol. 1. St. Louis: Concordia Publishing House, 2019.

"Hippocratic Oath." *Britannica Online. https://www.britannica.com/topic/Hippocratic-oath.*

"How Hospice Works." Medicare.gov. *https://www.medicare.gov/what-medicare-covers/what-part-a-covers/how-hospice-works.*

Humphry, Derek. "Chronology of Right-to-Die Events During the 20th Century and into the Millenium [sic], 1900–2019." *https://www.finalexit.org/chronology_right-to-die_events.html.*

-----. *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*. New York: Dell Publishing, 2002.

Humphry, Derek with Ann Wickett. *Jean's Way*. New York: Quartet Books, 1978.

Johnson, Anna Marie. Introduction to "A Sermon on Preparing to Die." *The Annotated Luther, Vol. 4: Pastoral Writings*, edited by Timothy J. Wengert et al. Minneapolis: Fortress Press, 2016.

Jones, Ken Sundet. "Death and Dying." In *Dictionary of Luther and the Lutheran Tradition*, edited by Timothy J. Wengert. Grand Rapids: Baker Academic, 2017.

-----. *Promissio and Death: Luther and God's Word for the End of Life*. Ph.D. Thesis, Luther Seminary, 2003.

Kamisar, Yale. "Some Non-Religious Views Against Proposed 'Mercy Killing' Legislation." *Minnesota Law Review* 42 (1958): 969–1042.

Kass, Leon R. *Life, Liberty and the Defense of Dignity: The Challenge for Bioethics*. San Francisco: Encounter Books, 2003.

Kaufman, Matthew. "Euthanasia and the Christian." Lutherans for Life. *https://lutheransforlife.org/article/euthanasia-and-the-christian/*.

Kennedy, Thomas D. "Eating, Drinking, and Dying Well." *Christian Scholar's Review* 20 (March 1991): 339–49.

Klotz, John. *Life Choices: Who Decides? Following God's Word in Life and Death Decisions*. St. Louis: Concordia Publishing House, 1991.

Kolb, Robert and Charles P. Arand, *The Genius of Luther's Theology: A Wittenberg Way of Thinking for the Contemporary Church*. Grand Rapids: Baker Academic, 2008.

Kolb, Robert, ed. *A Booklet of Comfort for the Sick, & On the Christian Knight* by Johann Spangenberg, trans. Robert Kolb. Milwaukee: Marquette University Press, 2007. Introduction.

-----. "The Reformation of Dying and Burial: Preaching, Pastoral Care, and Ritual at Committal in Luther's Reform." *Concordia Theological Quarterly* 81 (2017): 77–93.

Küng, Hans. "A Dignified Dying." In *On Moral Medicine: Theological Perspectives in Medical Ethics*, 3rd ed., edited by M. Therese Lysaught and Joseph J. Kotva Jr. Grand Rapids: Eerdmans, 2012.

-----. "Questions and Answers Concerning the End of Life." Lutherans for Life. *https://lutheransforlife.org/article/questions-and-answers-concerning-the-end-of-life/*.

-----. "The Other End of Life." Sermon. Lutherans for Life. *https://lutheransforlife.org/sermon/the-other-end-of-life/*.

Leroux, Neil. *Martin Luther as Comforter: Writings on Death*. Leiden: Brill, 2007.

Lifeway Research. American Views on Assisted Suicide. *http://research.lifeway.com/wp-content/uploads/2016/12/Sept-2016-American-Views-Assisted-Suicide.pdf*.

Lohrmann, Martin J. "The Invocavit Sermons." In *The Annotated Luther, Vol. 4: Pastoral Writings*, edited by Hans J. Hillerbrand et al., 14–15. Minneapolis: Fortress Press, 1522.

Luther, Martin. *A Manual on the Book of Psalms*. London: Seeley and Burnside, 1837.

-----."A Sermon on Preparing to Die." *The Annotated Luther, Vol. 4: Pastoral Writings*, edited by Timothy J. Wengert et al. Minneapolis: Fortress Press, 2016.

-----. "Disputation Against Scholastic Theology." *Luther's Works 31: Career of the Reformer I*, edited by Jaroslav Jan Pelikan, Hilton C. Oswald and Helmut T. Lehmann. Philadelphia: Fortress Press, 1999.

-----. "Gospel for the Fourth Sunday after Epiphany." *Luther's Works 76: Church Postil II*, edited by Benjamin T.G. Mayes, James L. Langebartels and Christopher Boyd Brown. St. Louis: Concordia Publishing House, 2013.

-----. *Letters of Spiritual Counsel (Library of Christian Classics)*, trans. Theodore G. Tappert. Reprint, Vancouver, B.C.: Regent College Publishing, 2003.

-----. *Luther's Small Catechism with Explanation*. St. Louis: Concordia Publishing House, 2017.

-----. "Preface to the Psalter," *Luther's Works 35:Word and Sacrament I*, edited by Jaroslav Jan Pelikan, Hilton C. Oswald and Helmut T. Lehmann. Philadelphia: Fortress Press, 1999.

-----. "Psalm 90" (1534), trans. Paul M. Bretscher. *Luther's Works* 13, edited by Jaroslav Pelikan. St. Louis: Concordia Publishing House, 1956.

Lutheran Service Book: Pastoral Care Companion. Commission on Worship of The Lutheran Church—Missouri Synod. St. Louis: Concordia Publishing House, 2007.

Lynn, Joanne and James F. Childress. "Must Patients Always Be Given Food and Water?" In *By No Extraordinary Means*, edited by J. Lynn. Bloomington: Indiana University Press, 1986.

Lysaught, M. Therese and Joseph J. Kotva Jr., eds. *On Moral Medicine: Theological Perspectives in Medical Ethics*, 3rd ed. Grand Rapids: Eerdmans, 2012.

Marty, Martin E. *Health and Medicine in the Lutheran Tradition*. New York: The Crossroad Publishing Company, 1983.

-----. Review of *Regulating Death: Euthanasia and the Care of the Netherlands* by Carlos Gomez. Commonweal 8 (Nov. 8, 1991): 665.

Meilaender, Gilbert. B*ioethics and the Character of Human Life*. Eugene: Cascade Books, 2020. Particularly see the following chapters: "How Not to Write (or Think) about Euthanasia" (103–08), "Gifts of the Body: Procuring Organs for Transplant" (109–20), "Comforting When We Cannot Heal: The Ethics of Palliative Sedation" (121–32), and "Christian Living Toward Dying" (133–43).

-----. *Bioethics: A Primer for Christians*, 4th ed. Grand Rapids: Eerdmans, 2020.

-----. "I Want to Burden My Loved Ones." *First Things* (Oct. 1991): 12–14. *https://www.firstthings.com/article/2010/03/i-want-to-burden-my-loved-ones*.

-----. "Living Life's End." *The Freedom of a Christian: Grace, Vocation, and the Meaning of Our Humanity*. Grand Rapids: Brazos Press, 2006. *www.firstthings.com/article/2005/05/living-lifes-end*.

-----. *Neither Beast Nor God: The Dignity of the Human Person*. San Francisco: Encounter Books, 2009.

-----. *Should We Live Forever? The Ethical Ambiguities of Aging*. Grand Rapids: Eerdmans, 2013.

-----. "The Confused, the Voiceless, the Perverse: Shall We Give Them Food and Drink?" *Issues in Law & Medicine* 2 (1986): 133–48.

-----. "Who Decides." *On Moral Medicine: Theological Perspectives in Medical Ethics*, 3rd ed., Section 154, edited by M. Therese Lysaught and Joseph J. Kotva Jr. Grand Rapids: Eerdmans, 2012.

Mueller, Norbert and George Kraus. "Applying Word and Sacrament to the Dying and Bereaved." In *Pastoral Theology*. St. Louis: Concordia Publishing House, 1990.

Neuhaus, Richard John. "Death and Dignity." *The Religion and Society Report* October/November 1987.

Ngien, Dennis. *Fruit for the Soul: Luther on the Lament Psalms*. Minneapolis: Fortress Press, 2015.

Nicolai, Philipp. *Freuden Spiegel des Ewigen Lebens*. Halle: Bertag von Richard Mühlmann, 1854.

-----. *The Joy of Eternal Life*. St. Louis: Concordia Publishing House, 2021.

Nolan, Kathleen. "In Death's Shadow: The Meanings of Withholding Resuscitation." *Hastings Center Report* (Nov. 1987): 9–14.

Otten, Joyce. "The Spiritual Dilemma." *Illness, Crises and Loss: Multidisciplinary Linkages* 1 (Summer 1991): 22–26.

Paulson, Steven. "Endings and Beginnings: Death and Resurrection." *Dialo*g 38 (Winter 1999): 26–34.

Pless, John T. and Jacob A. Corzine. *Faith in the Shadow of a Pandemic*. St. Louis: Concordia Publishing House, 2020.

Pless, John T. A *Small Catechism on Human Life*. St. Louis: LCMS World Relief and Human Care, 2006.

-----. "Luther's Answer to the Purpose Driven Death." In *Martin Luther: Preacher of the Cross*. St. Louis: Concordia Publishing House, 2013.

-----. "Luther's Reading of Psalm 90: The Eschatology of Pastoral Theology." In T*ake Courage: Essays in Honor of Harold Senkbeil*, edited by Timothy J. Pauls and Mark A. Pierson. Irvine: New Reformation Publications, 2020.

-----. *Mercy at Life's End: A Guide for Laity and Their Pastors*. St. Louis: The Lutheran Church—Missouri Synod, 2013.

Pollard, Brian, *Current Euthanasia Law in the Netherlands*. Catholic Education Resource Center, 2003. *https://www.catholiceducation.org/en/controversy/euthanasia-and-assisted-suicide/current-euthanasia-law-in-the-netherlands.html.*

"Polling on Medical Aid in Dying." Compassion & Choices. *https://www.compassionandchoices.org/resources/polling-medical-aid-dying.*

"Position Statements: Artificially-Administered Nutrition and Hydration." Christian Medical & Dental Associations® (CMDA), March 23, 2022. *https://cmda.org/policy-issues-home/position-statements/*.

Quill, Timothy E. "Death and Dignity." In *Last Rights? Assisted Suicide and Euthanasia Debated*, edited by Michael M. Uhlmann. Grand Rapids: Eerdmans, 1998.

-----. "Death with Dignity: A Case of Individualized Decision Making." *New England Journal of Medicine* 324, no. 10 (March 7, 1991): 691–94.

Rae, Scott B. and Paul M. Cox. *Bioethics: A Christian Approach in a Pluralistic Age*. Grand Rapids: Eerdmans, 1999.

Ramsey, Paul. "The Indignity of 'Death with Dignity.'" In *On Moral Medicine: Theological Perspectives in Medical Ethics, 3rd ed*, edited by M. Therese Lysaught and Joseph J. Kotva Jr. Grand Rapids: Eerdmans, 2012.

"Rare Diseases." PhRMA. *https://phrma.org/scientific-innovation/progress-in-fighting-rare-diseases?.*

Regional Euthanasia Review Committees. *https://english.euthanasiecommissie.nl/the-committees/documents/publications/annual-reports/2002/annual-reports/annual-reports.*

Reinis, Austra. R*eforming the Art of Dying: The Ars Moriendi in the German Reformation* (1519–1528). Aldershot, England: Ashgate, 2007.

Rittgers, Ronald K. *A Widower's Lament: The Pious Meditations of Johann Christoph Oelhafen*. Minneapolis: Fortress Press, 2021.

-----. *The Reformation of Suffering: Pastoral Theology and Lay Piety in Late Medieval and Early Modern Germany*. Oxford: Oxford University Press, 2012.

Ronnevik, Andrew. "Lutheran Conceptions of Human Dignity in a Global Context: A Conversation with Indian Dalits and European/Americans." *Dialog: A Journal of Theolog*y 59, no. 4 (December 2020): 325–33.

Salemink, Michael. *Going Gracefully*. Lutherans for Life. *https://lutheransforlife.org/article/going-gracefully/*.

Sauter, Gerhard. "Dying with Dignity?" In *God and Human Dignity*, edited by R.K. Soulen and Linda Woodhead. Grand Rapids: Eerdmans, 2006.

Schulz, Gregory P. *The Fellowship of His Sufferings: Four Briefings*. Gregory P. Schulz, 2020.

Shmerling, Robert H. "Where People Die." Harvard Health Blog Oct. 31, 2018. *https://www.health.harvard.edu/blog/where-people-die-2018103115278.*

Shuman, Joel and Volck. *Reclaiming the Body: Christians and the Faithful Use of Modern Medicine*. Grand Rapids: Brazos Press, 2006.

Smith, David H. H*ealth and Medicine in the Anglican Tradition*. New York: Crossroad, 1986.

Smith, Wesley J. *Culture of Death: The Assault on Medical Ethics in America*. San Francisco: Encounter Books, 2000.

Stahl, Ronit Y., and Ezekiel J. Emanuel. "Physicians, Not Conscripts — Conscientious Objection in Health Care." *New England Journal of Medicine* 376 (6 April 2017): 1380–85.

Steinke, Paul. "Comfort in the Face of Death." T*he Lutheran Witness* (May 1998).

Taking Care: Ethical Caregiving in Our Aging Society. President's Council on Bioethics. *https://repository.library.georgetown.edu/bitstream/handle/10822/559378/taking_care.pdf?sequence=1&isAllowed=y.*

"*The Basics on Advance Directives: Thy Will Be Done*." Lutherans for Life. *https://lutheransforlife.org/article/the-basics-on-advance-directives-thy-will-be-done/*.

Thielicke, Helmut. *Death and Life*. Trans. Edward Schroeder. Philadelphia: Fortress Press, 1970.

-----. *Living with Dying*. Trans. Geoffrey W. Bromiley. Grand Rapids: Eerdmans, 1983.

-----. *The Doctor as Judge of Who Shall Live and Who Shall Die*. Philadelphia: Fortress Press, 1976.

-----. *Theological Ethics, vol 1: Foundations*. Philadelphia: Fortress Press, 1966.

Trueman, Carl R., *The Rise and Triumph of the Modern Self: Cultural Amnesia, Expressive Individualism, and the Road to Sexual Revolution*. Wheaton, Ill.: Crossway, 2020.

"UAE Woman Munira Abdulla Wakes Up After 27 Years in a Coma." BBC News (April 23, 2019). *https://www.bbc.com/news/world-middle-east-48020481*.

"Unexplained 7-fold Variation in Euthanasia Rates Across Netherlands." *British Medical Journal*. *https://medicalxpress.com/news/2021-01-unexplained-fold-variation-euthanasia-netherlands.html.*

Uhlmann, Michael. Last Rights? Assisted Suicide and Euthanasia Debated. Grand Rapids: Eerdmans, 1998.

VanDrunen, David. *Bioethics and the Christian Life*. Wheaton, Ill.: Crossway, 2009. See especially "Suicide, Euthanasia, and the Distinction Between Killing and Letting Die."

Van Gijn, Dionne Frijns, Esther M. M. van de Glind, Barbara C. van Munster and Marije E. Hamaker. "The Chance of Survival and the Functional Outcome After In-Hospital Cardiopulmonary Resuscitation in Older People: A Systematic Review." *Age and Ageing* 43.4 (July 2014): 456–63. *https://doi.org/10.1093/ageing/afu035*.

Warneck, Richard H. *Pastoral Ministry: Theology and Practice*. St. Louis: Concordia Publishing House, 2018.

Waters, Brent. *This Mortal Flesh: Incarnation and Bioethics*. Grand Rapids: Brazos Press, 2009.

ADDITIONAL RESOURCES

Christians for Life (WELS): *christianliferesources.com*

Concordia Bioethics Institute: *cuw.edu/departments/institutes/bioethics*

LCMS Life Ministries: *lcms.org/life*

Lutherans for Life: *lutheransforlife.org*

The Center for Bioethics and Human Dignity: *cbhd.org*

THE
LUTHERAN CHURCH
MISSOURI SYNOD