

MATTERS OF LIFE AND DEATH

End of life decisions in Christian tradition

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The Christian tradition has always upheld that human life is sacred from conception to death and must therefore be respected and preserved. This means not only that human life may not be deliberately taken (except perhaps in self-defence or in a just war) but also that we have a grave obligation to care for our life, cherish it and do what is within our reasonable power to maintain it. The question arises concerning the extent of this obligation of care and preservation. Are there limits to the duty to preserve life and if so how are these limits to be determined?

Euthanasia and Assisted Suicide

Today, more than ever perhaps in human history, questions are raised regarding the first arm of our obligations regarding human life, the prohibition against the deliberate termination of life. Are there any circumstances in which this obligation may be waived? May human life ever be taken when excess of pain and suffering render it extremely burdensome? This is the nub of the current debate over euthanasia and assisted suicide.

As it is presented in this debate, euthanasia means the deliberate intervention by another person than the terminally ill patient with the direct intention of causing death at the patient's request. This is commonly brought about by lethal injection or by drugs and is heralded as an act of mercy or kindness towards the person enduring extreme suffering. However, the Catholic tradition is clearly expressed in the words of Pope John Paul II in his 1995 encyclical *Evangelium Vitae* (the Gospel of Life), 'euthanasia must be called a false mercy, and indeed a disturbing "perversion" of mercy' (n.66).



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Physician-assisted suicide refers to the action on the part of the physician making available to the patient the necessary information or lethal drug or some other means to assist the patient in bringing about his/her own death. The physician does not actually do the killing but cooperates formally with the patient in causing death. Morally, therefore, assisted suicide is not essentially different from euthanasia.

The current push to have euthanasia legalised relies heavily on the claimed right-to-death-with-dignity, the right to terminate one's life when the intensity and inevitability of personal suffering render this course of action desirable. This right to die argument is ultimately based on every person's moral autonomy: 'it's my life. I can do what I like with it'. By the appeal to autonomy is meant that we all have a right to control our lives and what happens to us, to decide how we should live our lives and when to end them. Our autonomy is absolute. And when this is claimed, the mere fact that a choice is *my* choice is all that is needed to make that choice morally right.

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As Jack Kevorkian (‘Doctor Death’) maintains, ‘In my view the highest principle in medical ethics – in any kind of ethics – is personal autonomy, self-determination. What counts is what the patient wants and judges to be a benefit or a value in his or her own life. That’s primary’.¹ It also makes sense, it is contended, to ask for professional help from physicians or others in order that the exercise of this right may be effectively realised.

Autonomy and freedom of choice are undoubtedly among the most basic and important human values, but one must query the claim that autonomy is absolute. According to Christian tradition it certainly is not. Nor is our freedom unlimited.

Promoters of euthanasia and assisted suicide fail to realise that their argument from the right to die is a vicious circle. One cannot have a right to something that is immoral. Whether deliberate death or suicide can be a morally justified alternative has first to be proven before there can be any claim to a right in this matter. Merely claiming a right to it cannot be made the basis of the morality of such a course of action. As far as I can see, no convincing argument has been advanced to establish that suicide is a morally good action, whereas many arguments are raised to prove the contrary.

St. Thomas Aquinas, for example, argues:

Everything naturally loves itself, and it is for this reason that everything seeks to keep itself in being and to resist hostile forces. So suicide runs counter to *one’s natural inclination* [by this he means ‘runs counter to the spontaneous recognition we have that life is a good thing, and that we should not act in such a way as to destroy a good thing’], and also to that charity by which one ought to cherish oneself. Suicide is, therefore, always a mortal sin in so far as it is contrary to the natural law and to charity.²

For those who are familiar with and follow the natural law approach this is a very strong argument, but admittedly one cannot expect such familiarity and acceptance today.

Using a different philosophical approach, Kant reaches the same conclusion. For him there is a contradiction in a person, who is a moral being (and so subject to obligation), withdrawing himself from all obligation:

Man cannot renounce his personality as long as he is a subject of duty (morality), hence so long as he lives; and that he should have the moral title to withdraw from all obligation, i.e., freely to act as if he needed no moral title for his action, is a contradiction.³

Hence, in Kant’s view moral autonomy is exercised within a framework of duty (morality). Suicide introduces a unique element into the exercise of moral autonomy, shared by no other choice in our life-history of moral choices; and in its totality it represents a rupture of the framework within which moral autonomy remains moral.

The late moral theologian, William Daniel SJ, put this argument in religious terms:

Our moral life is to be lived out in responsibility to God. Whether God has given us dominion over our own bodies or only the use of them is a question that may not be approached as one question among many, for it involves in a singular way the whole person....The life of the body is the life of the person, and the life of the person is a moral life. The totality of the moral life is to be lived out in responsibility before God. What is singular in the decision to commit suicide is that the person withdraws from the sphere of moral decision and responsibility... So I believe that the act of suicide, whereby a person withdraws from this field of responsibility before God, is the ultimate rejection of life as gift-and-task-to be performed, and the ultimate in self-assertion. From this point of view it can be seen as a rejection of the creaturely condition, just

¹ Jack Kevorkian, *Free Inquiry* 92 (1991), p. 14.

² *Summa Theologiae*, II-II, 64, 5.

³ Immanuel Kant, *The Doctrine of Virtue* (Part II of *The Metaphysics of Morals*), trans. M.J. McGregor, (Harper Torchbooks: New York, 1964), p. 85.

as, viewed from the human point of view, it is also eminently the rejection of the human condition.⁴

If suicide is a gesture of despair, so also is euthanasia. The victim requesting death has despaired of life. The doctor who accedes to the request despairs of the ongoing power of the medical profession and of the role of palliative care when confronted with the challenge of grave illness and suffering. Heartrending examples are put forward to further the case for euthanasia. As has often been said, the best response to these is not rational argument but expert care and heartfelt compassion for the poor people engulfed by despair and pain. The real challenge is to ease the pain and proffer the hand of love and compassion to the person in the depths of despair.

Preserving Life and the Limits to This Obligation

We now take up the second arm of the moral duty to respect all human life, namely, the obligation to preserve human life and the extent to which this binds us. Does life always and in all circumstances have to be prolonged?



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Human life, though not the most important of human goods, is obviously the most fundamental one, for without life other human goods cannot be realised. As the Christian tradition has always taught, life is of inestimable value. However, life is not an absolute good nor is it of ultimate value. As we accept without question, life may be sacrificed for the sake of other more important values, like freedom and love, or the good of one's neighbour, which transcend it. The value and benefit of biological life is relative to these higher values. In the light of this the tradition holds that the moral obligation to preserve life is therefore a limited one, in the sense that we are bound to use ordinary means to preserve and prolong life but not extraordinary means.

Against the background of the terrible pain and mutilation attendant upon surgical procedures of the time, the question of the lengths one might be obliged to go in this regard began to be discussed by Spanish moral theologians in the 16th century. One of them, the Dominican Bañez, was the first to employ the terms 'ordinary' and 'extraordinary' means of treatment, his argument being that a person is obliged to preserve his/her life but not to have to use *extraordinary* means to do this. Thus one is obliged to use nourishment, clothing and medicine common to everybody, even at the cost of some common pain and suffering, but not measures which would cause 'extraordinary' or excruciating pain or which entailed expenses disproportionate to that person's state of life.

In the changed situation resulting from the enormous development of medical science and techniques in modern times, these moral principles have been greatly expanded and refined by moral theologians. It is much more difficult today to define and distinguish ordinary and extraordinary means, but the distinction remains relevant, provided it is realised that there is no absolute norm for determining what is to be judged ordinary and extraordinary. The following principles of interpretation are now generally accepted.

1. The distinction between ordinary (or proportionate, as some prefer) and extraordinary (disproportionate) means of treatment is to be understood, not in relation to an abstract classification of

⁴ W. Daniel SJ from an unpublished paper, 'A Few Thoughts on Euthanasia' (Selected Papers of the Annual Conference of the Catholic Moral Theology Association on Australasia (1986-1992).

procedures and technologies or ‘what is usually done’, but as regards what is appropriate (and therefore morally obligatory) for a particular person or, on the contrary, inappropriate (and therefore morally optional). No absolute norm exists to decide this distinction. The only acceptable way is to base the moral judgment on the circumstances obtaining in the situation.

2. Throughout a lengthy tradition moral theologians have taught that principal among the circumstances to be considered are the foreseeable benefit and burden to the person who is seriously ill. In the Catholic tradition life-sustaining measures are adjudged as extraordinary when they fail to offer a reasonable hope of benefit or impose excessive burdens. The well-known moral theologian, the late Fr. Gerald Kelly, defined ordinary treatments (in the moral sense⁵) as ‘all medicines, treatments, and operations, which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain, or other inconvenience’⁶. If either of these conditions is lacking, the means of prolonging life are extraordinary.

Accordingly extraordinary treatments are ‘all medicines, treatments and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit’.⁷ For example, having to travel overseas to obtain treatment unavailable in Australia could for many Australians be an extraordinary means of preserving life because of the expense and the difficulty of travel involved. But Government subsidies or private contributions might radically change the situation. It is worth remarking also that what is considered ordinary treatment in wealthy countries might well be extraordinary in some developing countries.

Both Catholic and non-Catholic ethicists quote the statement of Pope Pius XII in his Discourse of 24th November, 1957, where he refers to the burdensomeness of the treatment itself without considering the degree of benefit the patient might hope to realise from the treatment. Having stressed the right and duty we all have in the case of serious illness to take the necessary treatment for the preservation of life and health, the Pope goes on:

Normally one is held to use only ordinary means – according to circumstances of persons, places, times and culture – that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most and would render the attainment of the higher, more important goals too difficult. Life, health, all temporal activities are in fact subordinated to spiritual ends.⁸

In his 1995 encyclical letter *Evangelium Vitae* (Gospel of Life), Pope John Paul II explicitly took into account the hope of benefit to the patient:

Certainly there is a moral obligation to care for oneself and to allow oneself to be cared for, but this duty must take account of concrete circumstances. It needs to be determined whether the means of treatment available are objectively proportionate to the prospects of improvement (n. 65)

This is spelled out in more detail in the Vatican II *Declaration on Euthanasia* of August 1980:

It will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources (n. 10).

⁵ From the medical point of view, procedures or medications might be considered extraordinary if they were fanciful, bizarre, experimental, unorthodox or unrecognised. ‘Ordinary’ tends to be equated with ‘standard,’ ‘extraordinary’ with ‘unusual’ means.

⁶ *Medico-Moral Problems* (Clonmore and Reynolds: London, 1960), p. 129.

⁷ *Medico-Moral Problems*, p. 129.

⁸ ‘The Prolongation of Life’, an address to an international Congress of Anaesthesiologists, *The Pope Speaks* 4 (Spring, 1958), 393- 398.

A practical illustration of such a judgment is suggested by Sissela Bok: ‘Take the case of the person dying of cancer, in great pain, close to death, who develops pneumonia. Certainly antibiotics are now the standard arsenal of medicine; yet many would consider it cruel and extraordinary to use them to prolong such a patient’s care’.⁹

In general, then, at least two circumstantial considerations should inform the moral decision regarding life-sustaining treatment: benefit and burden to the person concerned. Accordingly life-sustaining measures are not morally obligatory if they are either unduly burdensome in terms of pain, stress or expense in comparison with the likely benefits or in fact useless.

3. In the Catholic moral tradition the overall burden of an intervention may also need to be considered in the wider context of the effect upon the immediate family and those responsible for care, as well as on the community. Following Pope Pius XII, the *Declaration on Euthanasia* allows for the burden on the family or the community to be included in judging whether a treatment is extraordinary or disproportionate.¹⁰ Seeing a loved one or a patient for whom one is caring reduced to such a state and being constantly reminded of one’s helplessness to bring about any real improvement is indeed, as Pope John Paul II affirmed a few years ago, ‘a heavy human, psychological and financial burden’.¹¹

This moral judgment should be made, not simply by comparing burdens with the benefits, but by doing so in the broad context of the ill person’s total life project. As Pope Pius XII pointed out in the passage already cited, ‘Life, health, all temporal activities are in fact subordinated to spiritual ends’. In other words, not only burdens and benefits but ultimately the kind of life that is being prolonged by the treatment must be considered. In a 1981 statement the Vatican Pontifical Council, *Cor Unum*, said quite plainly:

Among all the criteria for decision, particular importance must be given to the quality of the life to be saved or kept living by therapy... The fundamental point is that the decision should be made according to rational arguments that have taken well into account the many and varied aspects of the situation, including what effect will be had on the family.¹²

By the term ‘quality of life’ is not meant here a judgment about the value of either biological or personal life in regard to social utility (for in the Christian view all human physical and personal life is of equal value and may not be directly destroyed). In the present context quality-of-life judgments are understood as the balance between the present state of the person and the ability to pursue one’s life goals and values, be they material, moral or spiritual.

Hence such judgments help to specify in the concrete the actual meaning of the terms ‘burdens’, ‘benefits’ and ‘best interest’ of a patient, as well as the limits of medical interventions in the situation. If medical intervention can improve the quality of the relation between the patient’s condition and his/her pursuit of life’s goals, it can be considered a benefit to the patient and to be in the patient’s best interests and so be a positive argument in favour of continuing that treatment.



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⁹ ‘Death and Dying: Ethical Views’, *Encyclopaedia of Bioethics I*, p. 271.

¹⁰ Vatican II, *Declaration on Euthanasia*, n. 16.

¹¹ *March Address* to the International Congress in Rome on Life-Sustaining Treatments and Vegetative State, 20th March, 2004. See *Origins*, April 8th, 2004, p.737- 752.

¹² ‘Questions of Ethics regarding the fatally Ill and the Dying’ (Pontifical Council *Cor Unum*: Vatican City, 1981), p. 8.

If on the other hand, because of the patient's condition, that treatment, which may not be in itself burdensome and may prolong life, cannot offer any reasonable hope of pursuing life's purposes at all or only with deep frustration, such medical intervention or treatment can be considered unduly burdensome, not in the patient's best interests, and so may justify refusal of further medical treatment. However, as moral theologian, Richard McCormick, stressed, these decisions are value judgments, not mathematical equations, and the evaluations can often be complex and difficult.¹³

The ultimate decision should rest as far as possible with the patient. If this is not possible, then the decision should be made by the next of kin, because the family is best placed to know what is in the patient's best interests. But in either case the doctor or the medical team should be consulted in the decision-making process.

The distinction between euthanasia/assisted suicide and allowing someone to die

Is allowing a person to die the same as killing that person? The distinction is an important one in the euthanasia debate and needs to be defended.

Killing means taking a life either by direct intervention to terminate life or by failing to prevent death when we can and should, witness for example the neglect practised on unwanted handicapped infants, whose lives could easily be saved if their parents wanted them. Letting someone die, however, can mean withholding or withdrawing life-sustaining treatment that has become useless or proportionately burdensome with the result that death ensues. The question to be answered is whether allowing death to result in this situation is the same as killing that person, as for example in euthanasia or assisted suicide. The traditional Catholic position holds firmly that at least in some situations this is not so and that therefore in such cases there is an important moral difference between killing and letting die. Others just as strongly disagree.

Some ethicists maintain that there is no moral difference of any significance between killing and allowing to die. In the view of these ethicists, the end result is the same in both cases and it doesn't matter which way one goes about it. The distinction is irrelevant from a moral standpoint. In Australia Peter Singer and Helga Kuhse¹⁴ are well known supporters of this view.

Other ethicists in the Protestant tradition hold a middle position, for example, Robert Veatch, James Childress and the late Paul Ramsey.¹⁵ For them the distinction remains significant and is valid for the most part. Life is sacred and therefore taking human life is presumptively morally evil, but in rare situations where further treatment is no longer serving any useful purpose love, justice and mercy may dictate ending a life that has become humanly unendurable.

As has already been shown, in the Catholic tradition direct killing of the innocent is never morally justified, no matter what the circumstances, whereas the decision not to prolong life is, at least in some circumstances, the morally proper way to care for the dying. To refuse treatment which is futile or disproportionately burdensome (in short, extraordinary) is the morally appropriate foregoing of treatment. It is neither euthanasia nor assisted suicide (see Pope John Paul II, *Evangelium Vitae*, n. 65).

The underlying reason for making this distinction lies in the *intention*, which in both the teaching of St. Thomas Aquinas and in Common Law determines the morality of human action. The intention of the doctor giving an injection or a lethal drug to end the life of a terminally ill person is clearly the death of that person. Is this intention to kill necessarily the same in the case where life-sustaining treatment is withheld or withdrawn?

Take, for instance, the case of the person dying of cancer, in great pain, close to death, who develops pneumonia. Even though antibiotics are today standard treatment for pneumonia, the decision is made not to

¹³ Richard McCormick SJ, *Health and Medicine in the Catholic Tradition: Tradition in Transition* (Crossroads: New York, 1984), p. 146.

¹⁴ See Helga Kuhse, 'Voluntary euthanasia and the doctor', *Free Inquiry* 89 (Winter 1988), p. 17-19.

¹⁵ See Richard M. Gula SS, *Euthanasia' in Christian Ethics: An Introduction*, ed Bernard Hoose, (Cassell: London, 1998), p.277-289.

administer antibiotics but simply to relieve symptoms. Death from pneumonia will probably result. What of the intention here? Is it different from the doctor's who gives a lethal drug?

The patient who requests help in the form of medication or information, whether to cause death by his own hand or to get the doctor to do it for him, has a suicidal wish. He/she *deliberately seeks* death as an end or a means, and in so doing rejects life. The patient, however, who *welcomes* death as a deliverance from pain and hopelessness or the increasing burdens of old age but who does nothing positive to bring death about, cannot be said to have a suicidal frame of mind.¹⁶

Such a person, perhaps dying of cancer and now developing pneumonia, will no doubt be glad about being able to choose either to treat or not treat this probably fatal illness. To refuse to treat the pneumonia with antibiotics will be reasonable or not (and so morally good or bad) according to the quality of life that he or she can look forward to. An unreasonable refusal will be of its nature suicidal and equivalent to voluntary euthanasia, because it shows a lack of appropriate care for life and a rejection of life. A reasonable refusal, that is, a choice that is measured according to the principles outlined above, is a morally appropriate foregoing of treatment, a measured response to the obligation we have to preserve life.¹⁷ The intention in cases of this nature will be the foregoing of measures that in this situation are futile, disproportionate and so not called for, that is, not morally obligatory. The intention might be said to be to restore the situation to reasonableness.

The Catholic Church abides by the distinction between killing and allowing to die. If there were no difference between killing and letting die, then every decision to forego or resile from useless or disproportionately burdensome treatment could be considered direct killing. And if that were so, then we would further grease the already slippery slope towards a general policy of euthanasia. The supporters of the distinction in all circumstances oppose any move to euthanasia. Those who allow for exceptions in very rare cases maintain that this does not necessarily lead to the support of a general practice of euthanasia and assisted suicide. For them the exception proves the rule.

¹⁶ It is a common experience to come across people, especially religious people, who desire death to be with God and to be free of pain yet do nothing to cause death. The family also may see the death of a dear one, as is often said, as a merciful release, desire it to happen, and welcome its advent.

¹⁷ See Paul Ramsey, *The Patient as Person* (New Haven: Yale U.P., 1970), p.126- 130.