

Yamauchi Lecture, March 15, 1998

**The Christian Art of Dying:
A Response to the Assisted-Suicide Movement**

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In the United States today, there is a widely acknowledged crisis in end-of-life care. Recent surveys by the American Medical Association and two Gallup polls suggest that nine out of ten people are worried about end-of-life care. Dr. Ira Byock, the president of the American Academy of Hospice and Palliative Medicine and a national leader in trying to change the way we die, has offered this analysis:

Underpinning the crisis in end-of-life care are factors that lie deeper than deficiencies in medical education, misguided health care policies, and financing strategies. I believe that the root cause underlying the mistreatment and needless misery of the dying is that America, as a culture, has no positive vision and no sense of direction with regard to life's end. Without a position on the compass pointing the way, the health care professions and society's approach to care for the dying has been confused, inconsistent, and frequently ill-considered. Often, despite the best of intentions, efforts to improve care have only made matters worse.¹

In the 1990's, an efficient, quick, and low-cost solution to this crisis has rapidly gained public sympathy: physician-assisted suicide. The dubious icon of the movement to legalize physician-assisted suicide is Jack Kevorkian, the unlicensed Michigan pathologist, who proclaims: "the right not to suffer." Kevorkian's antics and arrogance notwithstanding, many thoughtful people pose the question: Why should a competent terminally-ill adult who is experiencing intolerable pain not be able to receive help in committing suicide if he or she so chooses?

Last June the U.S. Supreme Court unanimously ruled that there is no constitutional right to assisted suicide. However the Court's decision did not thereby forbid its legalization by the individual states. Chief Justice William Renquist wrote:

"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."

The Court made its position doubly clear when it rejected an appeal against Oregon's 1994 "Death with Dignity" act. Last November, the Oregon voters resoundingly reaffirmed this

measure that permits doctors to prescribe a lethal dosage to competent, terminally ill persons judged to have 6 months or less to live, subject to certain minimal conditions. Though PAS has been the subject of debate or practice in several other nations, most notably Holland, Oregon is at the present time the only legal jurisdiction in the world to grant it the status of legality.

As a Catholic theologian, I would like to address this momentous moral and legal dispute that is too often clouded by sloganeering and euphemisms. My presentation has four parts: I will begin by sketching the cultural context of the crisis in end-of-life care and then trace the emergence of physician-assisted suicide [=PAS] as a plausible “health service” option. Secondly, I will reflect on the logic associated with the advocacy of PAS. Thirdly, I will offer reasons for opposing the legalization of PAS. Finally, I will offer some reflections and suggestions for a renewed Christian Art of Dying.

At the outset, I want to highlight one particular conviction that informs my presentation: it seems to me that our culture is in the throes of a deep spiritual crisis concerning the meaning and purpose of suffering and that this crisis is rooted in the refusal to accept our vulnerability and our mortality. How can the Christian

vision of living and dying help us respond to our society's quandary over how to die?

Part I

The circumstances that mark dying and death – what might be called our cultural “style” of dying – have dramatically changed during the course of the last century. Death has moved out of homes and into institutions. In an era of less sophisticated medical technology, most Americans died at home in the comfort of familiar surroundings, with their loved ones around them; today, by contrast, about 80% die in hospitals or nursing homes. Many of us could share stories of beautiful deaths as well as distressing stories of needless confusion and pain.

Cultural historian Philippe Ariès has documented a fundamental shift in western culture from the experience of dying and death as a social and public fact to the prevalent experience of “invisible death,” from what Ariès terms “tame” death to “untamed” death.² Dying and death have become medicalized and privatized. There has been a corresponding tendency to suppress the experience of grief. Ernest Becker succinctly called it “*The Denial of Death.*”³

While excelling in acute care, modern medicine has one-sidedly stressed a curative approach to illness, tending to view death as failure. The medical ethicist Daniel Callahan has described “an unwillingness to let nature take its course,” that often leads to an impersonal and unwittingly cruel “death in a technologic cocoon.”⁴ The line between living and dying has become harder and harder to find. Death is viewed “as a kind of accident, a contingent event that greater prevention, proven technology, and further research could do away with.”⁵ This situation has spawned an understandable dread of a protracted and impersonal dying process. There is fear of suffering and pain, fear and outrage at the indignities associated with the final stages of terminal disease, fear of abandonment, fear of mountainous medical costs, and deep fear of losing personal control over one’s life and death. Fear of the grim reaper has been replaced by fear of the gradual reaper.

In the early 1970’s the “death with dignity” movement took shape. There was a 3-part agenda: first, the promotion of advance directive legislation to allow the patient greater power of self-determination; secondly, the instituting of hospice programs dedicated to palliative care instead of aggressive medical

treatment; and thirdly, efforts to sensitize doctors and medical personnel to treat the patient as a person and not just a disease, and especially to accept the reality of death.⁶ The slogan the “right to die” was championed in a series of “termination of treatment” cases in which the Courts affirmed the right to refuse unwanted invasive and burdensome treatments. At the same time the concept of “advance care planning” was devised to allow people to indicate how they want to be treated should serious illness or injury leave them incapacitated. This concept includes documents known as advance directives – including the power of attorney for health care and “living wills” – and DNR protocols that are now legally recognized almost everywhere. Overall, the legal reasoning pertaining to end-of-life treatment has “reinforced a shift in emphasis in medical ethics from a dominant paternalism in which the physician judged what is in the best interests of the patients towards autonomy which maintains the patients’ right to choose the course they prefer.”⁷

The history of the modern mercy killing movement is another story though its use of phrases like the “right to die” and “death with dignity” tends to confuse its agenda with the distinctive moral and legal issues apropos of withholding or

withdrawing burdensome treatment. At this point, I need to define some terms: “Euthanasia” refers to direct measures, such as lethal injection, by one person to terminate another person’s life for the purpose of ending suffering. Euthanasia may be voluntary or involuntary: voluntary when a competent person explicitly consents to his death by the action of another; involuntary when no consent is given. Sometimes the withdrawal of life support that results in death is termed “passive” euthanasia, but there is a clear moral distinction to be made between killing and letting die. “Assisted suicide” occurs when someone else provides the means by which an individual ends his life. For example, a physician may prescribe medication knowing that the individual intends to use it to commit suicide. Other health care professionals such as pharmacists and nurses could also be involved. In theory, the person who wants to die self-administers the lethal dosage.

In 1938, the Euthanasia Society of America was founded. It drafted a proposal to legalize “the termination of human life by painless means for the purpose of avoiding unnecessary suffering.” News of the Nazi euthanasia program put a damper on the growth of America’s euthanasia movement in the decades

after the war. In 1967, the Euthanasia Society started a tax-exempt Euthanasia Education Fund; in 1975 it underwent a face lift by changing its name to the Society for the Right to Die.

The organization most identified with the drive to legalize mercy killing in the form of PAS is the Hemlock Society, founded in 1980 by Derek Humphry. Humphry was a British journalist who has dedicated his energies to promoting the right to suicide. He wrote the 1991 bestseller *Final Exit* – a “do it yourself” suicide manual. In a bit of “linguistic laundering” that is not uncommon among mercy killing proponents, he euphemistically refers to suicide as “self-deliverance.” Humphry was once asked in an interview why the suicide rights movement had picked up momentum. He responded that the legalization of abortion was the turning point. Indeed, it is a striking fact that judicial decisions favorable to assisted suicide have cited Roe v. Wade and Planned Parenthood v. Casey in support of their rulings. This latter decision affirmed a constitutionally protected “liberty” interest in procuring an abortion the logic of which has been extended not surprisingly to the legalization of assisted suicide:

These matters, involving the most intimate and personal choices a person may make in a lifetime,

choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life.⁸

In the early 1990's, the Hemlock society was unsuccessful in getting mercy killing referenda approved in the states of Washington and California. Oregon's measure was shrewdly designed to allay people's anxieties about euthanasia so it omitted any provision for death by lethal injection – an option that had scared people off in the earlier referenda. After the successful 1994 vote, Derek Humphry admitted that about 25% of assisted suicides fail and “that the new Oregon way to die will only work if in every instance a doctor is standing by to administer the coup de grâce if necessary.” The realization that assisted suicide could not be cleanly distinguished from euthanasia prompted the Oregon AMA to take a strong stand against the 1997 measure. However, Oregonians were not to be deterred from reaffirming their original vote. Exit polls indicated that a media campaign entitled “Don't Let Them Shove Their Religion down your Throats” – blatantly nativist and anti-Catholic in its message – had achieved its effect. Referring to the approval of Oregon's

“Death with Dignity” act, Humphry remarked that the euphemisms had won.

Part II

In my second part, I propose to criticize three convictions that characterize the advocacy of assisted suicide. These convictions are implied in the ambiguous slogans “the right to choose,” the “right not to suffer,” and “the right to die.” These catch phrases instinctively strike a sympathetic chord by invoking the “rights talk” which has come to dominate contemporary public discourse. Implicit in these slogans are three assumptions: first, that the individual’s autonomy is absolute, to the exclusion of other equally important values; second, that suffering is a purely negative experience to be avoided by any means; and third, that there is no significant ethical distinction between killing and letting die.

The commitment to unconditional autonomy is the conviction that the individual’s self-determination is sovereign, severed from the realities of truth and responsibility. Furthermore, it is assumed that the experience of unfettered choice is the common psychological reality. Now the value of legitimate autonomy, grounded in the fundamental worth of the

person, is a supreme achievement of Western culture under the influence of the Greek philosophical and Judeo-Christian traditions. The human person, created in God's image, has an incomparable dignity that gives rise to rights and responsibilities. The safeguarding of these rights [the right to life, the right to equal protection under the law, the right to worship God, etc.] and the promotion of corresponding responsibilities are the hallmark of a just society.

However, as Mary Ann Glendon, Learned Hand Professor of Law at Harvard University, has contended in her book *Rights Talk*, a hyper-rights rhetoric manifesting a radical individualism has taken hold in our society, crowding out other fundamental values touching the essential sociality of human personhood and its corresponding responsibilities. American rights rhetoric renders "extraordinary homage to independence and self-sufficiency, based on an image of the rights-bearer as a self-determining, unencumbered, individual, a being connected to others only by choice."⁹ The result is that "our rights-laden public discourse easily accommodates the economic, the immediate, and the personal dimensions of a problem, while it regularly neglects the moral, the long-term, and the social implications."¹⁰

The “right to choose” rhetoric reinforces the concept of the human being as an isolated, sovereign individual. Such discourse implicitly pays homage to radical autonomy and self-sufficiency while downgrading healthy forms of interdependence. The ideal of self-sufficiency, a radical version of individual autonomy, has become normative. Dependency is implicitly viewed as something to be avoided in oneself and disdained in others. Glendon remarks: “By exalting autonomy to the degree we do, we systematically slight the very young, the severely ill or disabled, the frail elderly, as well as those who care for them – and impair their own ability to be free and independent in so doing.”¹¹

Radical individual autonomy has become embedded in American law in the notion of privacy that imagines a sphere enclosing an isolated individual. Glendon writes: “No aspect of American rights discourse more tellingly illustrates the isolated character of the rights-bearer than our protean right of privacy.” This notion is the logical development of an understanding of the individual found in the works of English philosophers Hobbes and Locke, and whose classic formulation is found in the work of utilitarian philosopher John Stuart Mill. It has evolved into the right to privacy that served as the basis for Roe v. Wade. It also

anchors the suicide rights movement. Glendon sums up: “The right to privacy, the quintessential right of individual autonomy and isolation, seemed indeed to be, as [Justice Louis] Brandeis had claimed, ‘the most comprehensive of rights.’”¹²

Now this notion of the isolated, self-sufficient individual endowed with the right to privacy (and, I might add, in the American scenario, packing a six-shooter) is a philosophical fiction. There is the fallacious implication that the isolated individual possesses a freedom that has no inherent connection to an order of truth that transcends the self. Human beings are not sovereign, isolated monads. In the words of the poet John Donne: “No man is an island, entire of itself..” Human beings are embedded in a social context, they are part of a social web. How urgently we need to retrieve in our rights discourse a sense of the person situated within, and constituted by, her relationships with others. The principle of autonomy simply can’t function as the defining note of human dignity without falsifying the complex texture of human life. We are born dependent and remain so for several years; many of us will die in a dependent condition; so many of life’s richest experiences like “falling in love” cannot be adequately accounted for by the ideal of individual and

autonomous control. It is my impression that when the proponents of PAS and euthanasia speak of death with “dignity,” they equate dignity with being “in control.” This view of human life when converted into social policy threatens everyone who falls short of this fictitious ideal.

The movement to legalize assisted suicide plays on the pernicious separation between private and public morality which corrodes our society. Physician-assisted suicide is presented as a private affair between two consenting adults. Proponents thus artificially isolate the act of assisted suicide from the social context in which the physician and the patient operate. But the taking of life is never simply a private, individual affair. In a *New Yorker* essay, Andrew Solomon – a proponent of PAS – offered this revealing reflection following his mother’s death by assisted suicide:

“To assist in a suicide is to lose a fragile virginity; and the experience is the more enormous because it compromises an innocence of which you have never thought to take note. ...[S]uicide is the saddest thing in the world. Insofar as you assist in it, it is still a kind of murder, and murder is not easy to live with. It will out, and not always in savory ways. I have not come across anything about euthanasia by anyone who took part in it that was not as some profound level an

apology: the act of writing or speaking about your involvement is, inevitably, a plea for absolution. ...Euthanasia is a toxic subject: if you think about it too much, it will begin quietly to poison you.”¹³

Derek Humphry told Solomon that “all true believers in euthanasia believe in the right to suicide in general.”

The social ramifications PAS are just beginning to manifest themselves in Oregon. For example, the pharmacists and the nurses are grappling with their role. Pharmacists are demanding to know when they are being asked to fill prescriptions that will be used to commit suicide so they can refuse to participate if they conscientiously object. A second example is that the Oregon state health insurance has made PAS a priority health care “treatment” for the poor under the label of “comfort care” which the taxpayers will have to fund. The Oregon Health Division published a study that shows that Oregonians who are poor or in poor health are much more likely to consider suicide. In 1994, the state’s suicide rate was 42% higher than the national rate.

Thus the controversy over PAS crystallizes two fundamentally different notions of human personhood. On the one hand, are those like philosopher and legal scholar Ronald

Dworkin who argue for the primacy of autonomy. On the other hand, are those who are opposed to its legalization because of their concern for “common good” which includes a protective stance towards the vulnerable groups in society. They are concerned about how the legalization of PAS would affect the way people think “about physical and mental decline, about suffering, about their responsibilities to themselves and others.” They wonder how the establishment of these practices would “shape the obligations that adult children feel toward their failing parents, or how parents in need of care feel toward their children.” “How would the self-understanding of the severely disabled be changed, or their relations with family and society?”¹⁴

A second conviction driving the logic of PAS legalization is embedded in the catch phrase: “the right not to have to suffer.” There is an important distinction to be made between “pain” and “suffering.” Pain typically refers to the bodily sensation of hurt or strong discomfort. Pain results from physical symptoms which usually have an objective basis though, to be sure, people’s pain tolerance varies. The undertreatment of pain is a widespread failure of current medical practice which Hospice among others is seeking to remedy. With the tremendous advances in pain

control, every patient should be assured of adequate pain relief. However sheer physical pain seems not to be the primary reason why people express a desire to suicide. There is a high correlation between the expression of this desire and the experience of depression. Contrary to what many believe, the vast majority of individuals who are terminally ill or who face severe pain or disability are not suicidal. When the terminally ill receive appropriate treatment for depression, they usually abandon their wish to commit suicide. Perhaps the real issue is not pain, but our attitude to suffering.

In contrast to pain, “suffering” refers to a more deeply personal experience that may or may not be concomitant with physical pain. To use French Catholic philosopher Gabriel Marcel’s distinction: suffering is a mystery and not merely a problem. As a mystery, the experience of suffering eludes our capacity to fathom and objectify. It has physical, psychological, social, and spiritual aspects that defy cut and dried analysis. Ultimately, the suffering in each of our lives is an intensely personal experience the depths of which we have trouble articulating or fully understanding. Eric Cassell puts it succinctly:

“Suffering is a consequence of personhood – bodies do not suffer, persons do.”

Suffering is woven into the very fabric of our human life just as much as our social bondedness or our shared longing for happiness. A life without suffering is simply inconceivable this side of the veil that separates us from the next life. The experience of vulnerability is an inescapable aspect of our finitude. Our society has found any sort of suffering increasingly difficult to bear. There is a stigma attached to suffering and to those who suffer. It imperils our ideal of self-mastery and control, our pretense to self-sufficiency. All too often, the suffering person feels compelled to bear his or her anguish alone. At best we take a therapeutic approach to our suffering, viewing it as a medical problem and not recognizing its spiritual dimensions. It seems that in contemporary society where therapeutic and legal categories have tended to crowd out moral categories, suffering has come to be identified as the unquestionably absolute evil – a sort of secular substitute for the reality of sin.

The third conviction held by PAS proponents is that there is no ethically significant distinction between killing and letting die. For example, they see no qualitative difference between pulling

the plug on a ventilator that results in death and prescribing lethal drugs. The failure to distinguish between introducing an outside agent that causes death and the withdrawal or withholding of treatment that poses a disproportionate burden can lead to absurd consequences. For example, as Dr. George Annas has argued, one would have to conclude that when a physician stops attempted cardiopulmonary resuscitation on a patient in cardiac arrest, what kills the patient is not the arrest but rather the physician who intentionally stops compressing the heart.¹⁵ Reasoning that denies an ethically significant distinction between killing and letting die confuses causality and culpability. “When a patient refuses life-sustaining medical treatment, he dies from the underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication.”¹⁶

Part III: Why oppose PAS?

The Christian conscience recoils before the idea of self-killing. A distraught Hamlet soliloquizes: “Oh, that this too too solid flesh would melt, Thaw, and resolve itself into a dew! Or that the Everlasting had not fixed His canon ^âgainst self-slaughter!”¹⁷ The Church has always taught that the intentional

taking of one's own life is as morally objectionable as murder. The Bible teaches that God alone has power over life and death: "It is I who bring both death and life."¹⁸ God has made human beings stewards, not absolute masters, of their life's destiny. In its deepest reality, suicide represents a rejection of God's absolute sovereignty over life and death. As St. Paul wrote in his letter to the Romans: "None of us lives for oneself, and no one dies for oneself. For if we live, we live for the Lord, and if we die, we die for the Lord; so then, whether we live or die, we are the Lord's."¹⁹ Joining the phrase "physician-assisted" to "suicide" does not convert an objectively wrong action into a morally acceptable one. The very term "physician-assisted suicide" muffles the uneasiness of conscience before the act of self-killing by invoking the approbation of the healing profession: as if to say, if one commits suicide with the physician's approval, indeed with her help, it must be "okay." However, for a physician or anyone else to help another commit suicide is never morally permissible. St. Augustine wrote: "It is never licit to kill another: even if he should wish it, indeed if he request it because, hanging between life and death, he begs for help in freeing the soul struggling against the

bonds of the body and longing to be released; nor is it licit even when a sick person is no longer able to live.”²⁰

But in our pluralist society, not everyone adheres to the Christian teaching on mercy killing. Are there effective arguments for opposing the legalization of PAS that can appeal to any reasonable person? It seems to me that there are two compelling lines of reasoning:

This “slippery slope” argument asserts that once it is legalized, there will be no effective brake to its progressive expansion. Proponents of PAS argue that legal stipulations and restrictions can effectively limit the suicide option to competent terminally ill adults with 6 months or less to live who freely request it. Proponents of PAS like Dr. Timothy Quill are optimistic that PAS can be so limited. But such legal restrictions are specious; rather than constructing a firewall to contain PAS, they set-up a cardboard screen which the expansive logic of mercy killing would quickly burn through. The requirement of having to be terminally ill with 6 months to live is both completely arbitrary and difficult to ascertain. If someone who has only 6 months to live can get assistance to commit suicide, why not someone with an incurable and intolerable condition who may have years to live

with their suffering? And why should the option be restricted to the so-called competent terminally ill? “Termination of treatment” cases have already recognized the right of incompetent patients to have their death “hastened.”

Jack Kevorkian has given candid and chilling indications of the inexorable logic of “suicide rights.” In an address to the National Press Club, he stated that terminal cancer patients with only 6 months to live comprise but 10% of the people who need assisted-suicide. He envisions quadriplegics, M.S. sufferers, and those with severe arthritis as potential clients. His one hundred acknowledged assisted suicides certainly indicate his willingness to put this into practice.

There would be strong “economic” incentives to make mercy killing an attractive “treatment” option. PAS would be a lethal weapon in the managed care revolution. Doctors and hospitals may find that they make more money by providing less care. A recent study has suggested that withholding high-tech life support will not significantly lower the overall expense of caring for the terminally ill. However, a prescribed fatal overdose could well become the most powerful cost-control tool available to managed care. With “market medicine,” loyalty is being

demanded not to patients and their families but to managers, insurers, and investors.²¹

The aging of the baby boomer generation will put an additional strain on health care resources. In the real world of managed care, doctors won't have time to become "familiar with all the circumstances" of a patient's situation. "And this doesn't take into account inequalities within the health care system caused by racism, sexism, ageism or that 41 million Americans do not have health insurance."²² What does it mean to talk about an "autonomous" choice when one is saddled with poverty? A recent report entitled "The Millennium Breach" – released on the anniversary of the Kerner Commission report – concludes that the economic and racial divide in the U.S. is getting wider. "The rich are getting richer, the poor are getting poorer, and minorities are suffering disproportionately." It is understandable that the vulnerable: the poor, the minorities, and the disabled are not enthusiastic about PAS.

The Dutch experience is a loud wakeup call to anyone who thinks assisted suicide ought legally to be a matter of choice. In the Netherlands, mercy killing began as a voluntary practice with consenting adults back in the 1960's. Though technically illegal, it

is tolerated by the authorities if certain protocols are followed. However, voluntary assisted suicide and euthanasia have steadily widened to include involuntary euthanasia and assisted suicide of those with mental suffering. A Dutch government study reported that instances of involuntary euthanasia were outpacing those of voluntary euthanasia and assisted suicide.²³ The situation is so frightening that the Dutch Patients' Association, a disability rights group, distributed a wallet-sized card that is a sort of "right to life" passport on which is written: "no treatment is to be administered with the intention to terminate life." The long term consequences of elevating PAS to the status of a norm for society is that terminally ill or disabled individuals will have to defend their choice to live. The legalization of PAS will inevitably create a climate in which the "right to die" could morph into a duty to die. Several years ago, the New York State Task Force on Life and the Law – whose membership was not universally opposed to suicide *per se* – unanimously concluded that a change of public policy would be profoundly dangerous for many individuals who are ill and vulnerable. The risks would be most severe for the elderly, the poor, the socially disadvantaged, or those without access to good medical care.²⁴

A second reason to oppose the legalization of PAS is the corrupting impact that would have on the doctor's role. For centuries most physicians upheld the Hippocratic Oath whereby they promised to "give no deadly medicine to anyone if asked, nor suggest any such counsel." And this code of conduct prevailed before the development of effective anesthetics! To authorize physicians to play a role in the killing of their patients is fundamentally inconsistent with the nature of the healing profession. PAS turns healers into death-dealers, charged with the role of judging someone's quality and quantity of life. The only guide will be their own very fallible judgment in which some like Kevorkian place too much confidence.

Many physicians, it is said, have a personality type that prompts them to intervene boldly. This is sometimes termed the "medicine man's burden syndrome." The data on Dutch mercy killing indicate that physicians go ahead and act on their own. They often do not follow the protocols established by the government. Their trust in their own judgment and calling tends to augment as they get used to their new, legally sanctioned role as death's gatekeeper. Thus the role of physician, a position of

immense prestige and authority, which participates in the “divine” art of healing, too easily lends itself to perversion.

It is naive to think that physicians would play an unbiased role in assisted suicide. The influence physicians hold in society as well as the control they have over information supplied to patients gives them great power. A doctor who makes a decision to assist a suicide is making not a medical but a moral decision. The very act of providing a prescription for a lethal dose of medication sends a message to the patient that the doctor thinks that the patient is better off dead.

In our society, “stranger” medicine is increasingly the norm as doctor-patient relationships become more depersonalized and contractual. Fewer doctors are adept at responding to the needs of the whole person, and many doctors are particularly maladept at interacting with dying patients. Only five of 121 surveyed medical schools require a course devoted exclusively to death and dying. And in contrast with the older generation of doctors, those most recently out of medical school seem more favorably disposed to PAS. It presents a way of “managing” death. To give this power to physicians will only further undermine the trust that is essential to the doctor-patient relationship. In reiterating its

opposition to physician-assisted suicide and euthanasia, the American Medical Association concisely summarizes this second argument: “Physician-assisted suicide is fundamentally inconsistent with the physician’s professional role.”

Part IV: “Dying Well”: the Christian Art of Dying

“Dying is the most general human event, something we all have to do. But do we do it well?”²⁵ What does it mean to “die well”? How would each of us imagine a “good death” for ourselves? How much pain and suffering should you and I be willing to bear and for what reason? What are our fears and anxieties when we think about our own dying and death? What meaning can we find in our experience of dying and death? What spiritual resources does the Christian tradition offer for a renewed *Ars Moriendi*, the Christian art of dying well?

The *Ars Moriendi* was a type of devotional book that was very popular in the late Middle Ages and early modern period. These manuals offered spiritual advice on how to “die well.” The *Ars Moriendi* of the Jesuit theologian Robert Bellarmine contains meditations on the sacraments, final judgment, heaven, and hell.²⁶ Not surprisingly it contained no guidelines about how to make the difficult treatment decisions faced by today’s seriously ill – though

Bellarmino does get practical when he advises the preparation of a will. In that era, the Jesuits of Rome started “Bona Mors” confraternities – that is, “Good Death” associations – to offer people communal and spiritual support to face dying and death. Overall, the *Ars Moriendi* handbooks and the Bona Mors confraternities remind us that dying and death are not just medical problems, but spiritual challenges in which religious faith and its sacramental rituals can strengthen us to cope with the inevitable diminishment and suffering brought on by aging and the dying process. How might that emphasis be retrieved today in the new circumstances of dying?

Our attitudes to dying and death take shape long before we are lie on our death bed. Christian life – which entails an ongoing dying to self – is in itself a preparation to face dying and death. The ideal is not “self-mastery” but surrender to a larger Mystery that embraces us. Karl Rahner has written:

In the light of this constant presence of death in the whole course of life Christian wisdom has always been aware of a *memento mori*. [”remember you must die”]. If and insofar as dying and death amount not only to a purely passively endured happening at the end of life, but also to an active deed of man, and if this act, as we said, cannot be located

simply at the moment of the advent of death in the medical sense, then for the Christian, coming death cannot be something which does not concern him “for the time being,” something that he might now suppress as much as possible. Within life he has to live with death. This happens primarily and fundamentally through all those accomplishments of freedom in which a person accepts with resignation the finiteness of his milieu and environment and of himself in hope of the incomprehensible and thus abandons the attempt to regard as absolute anything that can be experienced in itself...²⁷

I think what Rahner is getting at is the constant challenge of accepting one’s vulnerability, one’s finitude, one’s mortality. These are realities that we instinctively shrink from. We are tempted to cling to our biological immortality projects. But it is in accepting the truth of our vulnerability that we prepare ourselves for a “good death.” Henri Nouwen writes:

We, too, must move from action to “passion,” from being in control to being dependent, from taking initiatives to having to wait, from living to dying...Believing that our lives come to fulfillment in dependence requires a tremendous leap of faith. Everything that we see or feel and everything that our society suggests to us through the values and ideas it holds up to us point in the opposite direction. Success counts, not fruitfulness – and certainly not fruitfulness that comes

through passivity. But passion is God's way, shown to us through the cross of Jesus. It's the way we try to avoid at all costs, but it is the way to salvation. This explains why it is so important to care for the dying. To care for the dying is to help the dying make that hard move from action to passion, from success to fruitfulness, from wondering how much they can still accomplish to making their very lives a gift for others. Caring for the dying means helping the dying discover that, in their increasing weakness, God's strength becomes visible.²⁸

What does this mean in the practical order? There is a need to develop what Professor James Gaffney of the Loyola Religious Studies Department terms "death education." Hospice has shown how to retrieve an approach to dying that is attentive to the spiritual and emotional needs of patients and their loved ones, that views dying and death not as "failure," but as the final stage of growth. Its mission has been to do something about the total pain and suffering – physical, psychological, social and spiritual – that dying patients undergo.²⁹ Its prioritizes "palliative" medicine, that is, comfort care that effectively manages pain. Some pain medications may hasten a patient's death, but these are morally acceptable so long as their intention is to alleviate pain and severe discomfort and not to cause death.

This past fall, Hospice enabled one of my uncles to die at home with his family. He had been diagnosed with Lou Gehrig's disease and later with cancer. He chose not to aggressively treat the cancer, opting for a few months of quality living. Hospice gave effective comfort and support to him and his family. Hospice has now nearly 3,000 programs across the country; the percentage of the dying who are served by Hospice continues to grow each year. Hospice shows the way to a renewed Christian "art of dying" that steers a middle course between a "medical vitalism" which does everything to needlessly prolong the dying process and a "peremptory termination" of life by mercy killing in whatever form.

Another component of death education is the advance directive. One form is the "living will" by which a person indicates what treatments they desire to forego if they are incapacitated and irreversibly moribund. They should begin with a clear statement of reverence for life. Advance directives work best when one discusses with a trusted friend or family member one's general wishes for end-of-life care. For example, my mother and aunt have discussed with me their desire to forego certain burdensome treatments if they are irreversibly moribund. They

have named me their health proxy to make decisions for them if they are incapacitated.

How can the spiritual dimension of dying and death be more effectively addressed? The retreat programs at the New Orleans Cenacle offered to people with cancer and their caregivers offer a model. Could not those afflicted with progressive and/or life-threatening diseases benefit from special retreats and days of recollection? These retreats might offer reflections and guided sharings on facing the burden of illness and the prospect of diminishment, dying and death. There would be the opportunity to share fears, anxieties, and hopes. These realities are not easy to face and share; the experience of illness can be so isolating. Those diagnosed with a life-threatening disease could make these days of prayer and reflection made with a trusted friend or caregiver. Advance directives could be explained and discussed with a Christian lawyer or doctor; Hospice personnel could explain their approach. There would be the opportunity to reflect on the possibilities of growth in the last stage of life; the participants would have the opportunity to share their own feelings about facing illness, diminishment, and the prospect of death. There would be an opportunity to face together the challenges of

accepting one's vulnerability and mortality in the light of Christian faith. Those carrying the cross of serious illness would have the opportunity to reflect on their condition in the light of the paschal mystery: the passion, death and resurrection of Jesus Christ. Christian faith spurs us to find the meaning of our own story in the light of the paschal mystery of Christ. In the light of the cross of Christ, the unavoidable sufferings of life can be turned into a source of spiritual fruitfulness. The Christian doctrine of the communion of saints reminds us of the solidarity among the sick and the dying with the entire Body of Christ. Pope John Paul II has declared February 11, the feast of our Lady of Lourdes, as the annual World Day of the Sick to honor those who "undergo the Calvary of suffering" and remind those who provide care and compassion that "love for the suffering is the sign and measure of the degree of civilization and progress of a people."

A traditional corporal work of mercy is to visit the sick. No one should have to face their dying and death in isolation. There is a need for diocesan programs to train people in the basics of pastoral care to the sick and dying. "To care for others as they become weaker and closer to death is to allow them to fulfill their deepest vocation, that of becoming ever-more fully what they

already are: daughters and sons of God. It is to help them to claim, especially in their dying hours, their divine childhood and to let the Spirit of God cry out from their hearts, 'Abba, Father.' To care for the dying is to keep saying, "You are the beloved daughter of God, you are the beloved son of God."³⁰ A good death is a death in solidarity with others. To prepare ourselves for a good death means deepening this sense of solidarity.

A year and a half ago, Joseph Cardinal Bernardin died from cancer. With medical treatment, he had been able to enjoy a remission from his disease for 15 months. Throughout his struggle with cancer, he spent time reaching out to fellow cancer sufferers to offer them support. In his last months he reflected: "As you enter the dying process, that process prepares you for death as you slow down. ...So when I talk about being at peace, I'm talking not only about peace at the level of faith, but also humanly speaking. Before too long, I'm going to go, and I think that I will be ready for it."³¹

I conclude with the words of Henri Nouwen who died this past year:

Befriending our death is a lifelong spiritual task but a task that, in all its different nuances, deeply affects our relationships with our fellow human beings. Every step we take toward deeper self-understanding brings us closer to those with whom we share our lives. As we learn, over time, to live the truth that death does not have a sting, we find within ourselves the gift to guide others to discover the same truth. We do not first do one of these things and later the other. *Befriending our own death and helping others to befriend theirs are inseparable. In the realm of the Spirit of God, living and caring are one.*³²

End Notes

¹Ira Byock, M.D., *Dying Well* (New York: G.P. Putnam's Sons, 1997), 244.

²See Philippe Ariès, *The Hour of Our Death*, translated by Helen Weaver (New York: Vintage Books, 1981).

³(New York: Free Press, 1973).

⁴Daniel Callahan, "Frustrated Mastery: The Cultural Context of Death in America" *Western Journal of Medicine* 163 (1995), 227. Cited in *A Profile of Death in America*, Committee on Care at the End of Life, Marilyn J. Field and Christine K. Cassel, eds. (Wash., D.C.: National Academy Press, 1997; accessible at web site:

<http://www.nap.edu/readingroom/books/approaching>

⁵ *Ibid.*, 227.

⁶Daniel Callahan, *The Troubled Dream of Life: In Search of Peaceful Death* (New York: Simon & Schuster, 1993), 37-8.

⁷James Childress, *Who Should Decide?: Paternalism in Health Care* (New York: Oxford Univ. Press, 1982), cited in *A Profile of Death in America*.

⁸ Planned Parenthood v. Casey, 851, 112 S.Ct. at 2807.

⁹ Mary Ann Glendon, *Rights Talk: The Impoverishment of Political Discourse* (New York: Free Press, 1991), 48.

¹⁰ *Ibid.*, 171.

¹¹ *Ibid.*, 74.

¹² *Ibid.*, 59-60.

¹³ Andrew Solomon, "A Death of One's Own," *New Yorker* (5/22/1995), 68.

¹⁴ See Peter Steinfels, "Beliefs," *New York Times*, 8 Feb. 1997.

¹⁵ See Richard A. McCormick, "Vive la Diff_rence! Killing and Allowing to Die," *America* 177 (Dec. 6, 1997), 7-8.

¹⁶ *Ibid.*, 9.

¹⁷ Act 1, sc.ii, ll.129-132.

¹⁸ Deuteronomy 32:39.

¹⁹ Romans 14: 7-8.

- ²⁰ Letter 204, 5; cited in Pope John Paul II's encyclical *The Gospel of Life*, no. 66; see also *Catechism of the Catholic Church*, nos. 2276-2283.
- ²¹ John F. Kavanaugh, S.J., "Capitalism's Cost to Care" *America* 178 (March 14, 1998), 37.
- ²² Wesley J. Smith, "Letter to the Editor," *New York Times*, 26 Dec. 1996.
- ²³ See *Medische Beslissingen Rond Het Levenseinde* (May, 1991). This study is commonly termed the "Rommelink Report."
- ²⁴ New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (New York, 1994), ix.
- ²⁵ Henri Nouwen, *Our Greatest Gift: A Meditation on Dying and Caring* (San Francisco: HarperCollins, 1994), xiv.
- ²⁶ Robert Bellarmine, *Spiritual Writings* trans. and edited by John Patrick Donnelly, S.J., and Roland J. Teske, S.J. (Mahwah: Paulist, 1989), 321-386.
- ²⁷ Karl Rahner, S.J., *The Practice of Faith*, ed. Karl Lehmann and Albert Raffelt (New York: Crossroad, 1986), 293-4.

²⁸ Nouwen, *Our Greatest Gift*, 92 and 93-4.

²⁹ See "Hospice: Dying Well," *The Oregonian* 9 Sept. 1997.

³⁰ *Ibid.*, 58.

³¹ Joseph Cardinal Bernardin, *Gift of Peace* (Chicago: Loyola University Press, 1997), 115.

³² Henri Nouwen, *Our Greatest Gift*, 51.

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