INTERSECT Special Insert: Physician Assisted Suicide: A Christian perspective from the Massachusetts Council of Churches

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Adopted unanimously by the Board of Directors of the Massachusetts Council of Churches on November 30, 2000

"For now we see in a mirror, dimly, but then we will see face to face (1 Cor. 13:12 NRSV)."

Introduction

Christians "look for the resurrection of the dead, and the life of the world to come." (Nicene-Constantinopolitan Creed) At the same time, "we have this treasure in earthen vessels, to show that the transcendent power belongs to God and not to us (2 Cor. 4:7 RSV)." Mortality is our human lot. In some cultures, the fact of death is familiar because the experience is woven into the customs of the whole, often tightly knit, community. In contemporary American society, however, we have gone to great lengths to push this hard fact of life out of our consciousness.

We cannot avoid our mortality, however, and recent public policy debates about "physician assisted suicide" once again have raised the subject.[1] The Board of Directors of the Massachusetts Council of Churches (MCC) has spent much time discussing the ethical issues involved in legislation about physician assisted suicide. We have done so because this controversial public policy issue raises basic questions of the meaning of morality, of faith, of belief, and of value—topics about which Christians and Christian churches should have something to say since death and resurrection are a central part of the Christian story.

During our discussion, the MCC Board has considered two questions: 1) what, if anything, can this ecumenically diverse and inclusive body say together about this potentially divisive subject? And 2) if we disagree, can we reach a deeper understanding of why, and share that understanding with others in ways that will help ecumenical and public discussions?

Fifteen Protestant denominations are members of the Massachusetts Council of Churches. They are represented officially on the Board of Directors. As a way of living into fuller ecumenical relationships, Roman Catholic ecumenical officers from three dioceses in the Commonwealth (the Archdiocese of Boston, the Diocese of Fall River and the Diocese of Worcester), from the Greek Orthodox Diocese of Boston, and a representative from the Armenian Apostolic Church also are seated on the MCC Board of Directors. We also are indebted to the MCC Ethics Advisory Board, an appointed body of individuals with academic expertise in the field of Christian social ethics, for preparatory papers which informed our dialogue. This ecumenical mix has given a challenging richness to our discussions.

We celebrate these ecumenical encounters. As is the case in all such ecumenical deliberations, we have been mindful of the aim of discerning together what the God we know through Jesus Christ would have us say and do together in this situation. We have learned from each other. We discovered more areas of agreement than we had expected. We share the fruit of these conversations with churches and with the public to reflect the way that honest, open, respectful dialogue can increase mutual understanding and enhance the common good.

Some legislative background

Proposed legislation that would decriminalize physician assisted suicide (PAS) was introduced in the Massachusetts state legislature beginning in 1997.[2] Although the bill thus far has not received approval from the Committee on Health Care, it undoubtedly will be reconsidered regularly.

Voters in the state of Oregon had approved such a law (the "Death with Dignity Act") through referendum in 1994. When challenged in federal appeals court in 1997, the law was allowed to stand. Thus far, Oregon is the only state in the U.S.A. where PAS has been declared legal under certain, circumscribed conditions.

Around the same time, the United States Supreme Court ruled that the federal Constitution does not protect the right of competent, terminally ill patients to seek the assistance of physicians in terminating their life. Thus, as of now this issue will be decided through state legislative and judicial processes. An international meeting of the "right to die" movement was held in Boston in September 2000. Countering efforts also have been initiated. For example, a "Pain Relief Promotion Act" that would prevent federally regulated drugs from being used for PAS recently has been proposed in the United States Senate. So the subject will continue to receive greater visibility both locally and nationally.

A clarification of terms

Conversations about this topic can be complex and confusing. Definitions have a way of blurring. Language becomes slippery. When we use examples out of our life experiences to talk about this issue, we often speak of situations that, in fact, are different from the situations covered by PAS. We offer this as a cautionary note for others who explore this subject.

- *What it is.* Proposed legislation authorizing physician assisted suicide would enable an adult who has been certified terminally ill by attending and consulting physicians to request that the attending physician prescribe medication that will end his/her life. The physician does not directly administer the medication.
- *What it is not.* PAS is not euthanasia, also called "mercy killing," in which an outside attendant participates directly in taking the life of a patient. It is not the same as a decision to remove someone from life support systems (sometimes colloquially referred to as "pulling the plug.") For example, PAS does not relate to decisions about ending life support for persons in a permanent vegetative state (now legally permitted and morally accepted under certain conditions by most Christian ethicists). PAS also is distinct from the right of patients to refuse treatment—a right persons now have, and a right that can be exercised on our behalf by a "health care proxy" if we have taken the necessary steps to designate one.
- Some who oppose this measure refer to it as "physician assisted *suicide*," while some who support the measure tend to call it "physician assisted *dying.*" Although the latter phrase is ambiguous, the difference in terminology reflects two distinct perspectives about the morality of the act.

Personal and societal issues driving the debate

A wide range of personal and societal factors have stimulated PAS initiatives. These factors highlight serious challenges faced by a variety of institutions—families, churches and other religious bodies, the system of health care financing and delivery, medical training, and an adversarial legal process.

- People who are terminally ill may seek relief from unbearable pain and suffering, or the fear of it. They may be clinically depressed. They may feel alone, isolated, and without the understanding and support of family, friends, and/or caregivers. They may want control over the manner and time of the final factor of life that ultimately is beyond their control—death.
- When people are placed in unfamiliar institutional settings, tended by strangers, surrounded by intrusive machines, and robbed of their dignity and control, this clinicalization of end of life experience exacerbates fears of isolation.
- The terminally ill and/or their families may be concerned about the high cost of prolonged medical care, in which they fear becoming financially destitute or "a burden on the family."

- In our litigious society, physicians may be reluctant to take all legally possible and ethically appropriate measures to help the patient in the dying process because they fear malpractice lawsuits.
- Until recently, minimal medical training was given about pain management and palliative (i.e. comfort) care. Furthermore, physicians whose education has been focussed on health and healing sometimes find it difficult to make the transition to palliative care.

A Christian understanding of humanity

An ancient Psalmist wondered, "O Lord, what are human beings that you regard them, or mortals that you think of them? (Psalm 144:3 NRSV) These are not only the abstract musings of poets and philosophers. They also reflect basic human impulses experienced by most people from time to time. When pastors, priests, and parish visitors, counselors and caregivers talk with the sick, the dying, and the bereaved, the questions become pressing. "What is the meaning of life? What has been the significance of my *life? How can I apprehend the meaning of physical and mental suffering? Of* my *suffering, or that of my loved one? Is it possible to have a 'good death'?"*

Christians have turned to Biblical texts and the interpretive teachings rooted in them to comprehend the mystery of human beings, their relationship to the whole creation, and to their divine Creator. The story of Creation in Genesis reads, "Then God said, 'Let us make humankind in our image, according to our likeness (Gen. 1:26a NRSV);" Christians understand humanity in relation to the divine. We believe human beings are created by *God, and bear the* image *of God, even though blurred by human frailty. We understand the nature of this image most fully through Jesus Christ. Through the process of living, with its struggle, its sin, and its creative potential, we are called to become more Christ-like, to reflect this image ever more fully. Even in our brokenness, we trust that this image may be obscured but it never can be obliterated. We trust in the grace of God to draw us to God's self, in this world and the next. "The Lord is merciful and gracious, slow to anger and abounding in steadfast love (Ps.103:8)." The ultimate end of life on earth, from the perspective of Christian faith and hope, is to participate in eternal life with the Risen Christ. "For now we see in a mirror, dimly, but then we will see face to face. Now I know only in part; then I will know fully, even as I have been fully known (1 Cor. 13:12 NRSV)."*

Thus, Christians believe each human being has transcendent and infinite value from God's perspective. Human dignity is inherent because it is bestowed by God, and extends beyond any merit or state of the person at a particular stage or state of life. This is what gives ultimate meaning to our life and to our death. This provides the lens through which we examine all moral issues in order to make those "hard choices" that sometimes arise at the end of life—hard choices that may be made more complex and confusing by modern medical technology.

The nature of suffering and death

Christians view suffering and death through the lens of a tradition that is two millennia old, but we now engage the mystery of suffering in some new ways. Many in modern life assume that we can eliminate all human suffering. Medicine's ability to prolong life raises new questions about the correct use and potential abuse of new technologies.

From a Christian perspective, life is a mystery and a gift; death is a paradox. It sometimes appears to be a defeat. This is especially true of the unexpected death of the young, the death of the just, and the long life of the unjust. Death is "the last ultimate enemy to be destroyed" (1 Cor. 15:26).

Like death, suffering also poses a paradox. On the one hand, Christians do not enjoy suffering, any more than Christ did. It is difficult to sustain. We pray for relief from suffering, for ourselves and for others. In fact, Christians should work to eliminate suffering, especially suffering that is a result of sin; for example, sins related to poverty, oppression, racism, or abuse.

On the other hand, Christians acknowledge the place of suffering in our discipleship. We are disciples of the "head of our faith" who "in place of the joy that was set before him, suffered the Cross" (Heb. 12:2) We know that God suffers with *us and* for *us. Thus it is not only possible, but also desirable, to have a "good death." In such circumstances, the dying person gives thanks for the gift of life and its blessings, seeks forgiveness and reconciliation when amends need to be made, and places him/herself in the care of God.*

Christians believe that death leads to full life with God. It is a prelude to new life. The redemptive death of Christ becomes the paradigm of acceptance with the promise of a new beginning. We must learn to die to self in order to be fully alive. On the road to Emmaus, the risen Christ asks, "Was it not necessary that the Messiah should suffer these things and then enter into his glory?" (Luke 24:26) Here we find an invitation to appreciate each moment of life as God-given gift.

Our prayer, then, is for the grace to live life to the full, to enjoy the gift. In the good times and in the bad we journey in faith. We know from Christian teaching and experience that suffering often has a redemptive, saving quality. When suffering does enter our lives we find meaning rather than absurdity precisely because we are disciples, striving to follow the example of Christ "and him crucified" in making it a redemptive force for all.

Some things we learned from this process of dialogue about PAS

The process of discussing this difficult issue was a positive learning experience for the members of the MCC Board of Directors. Here are some things we have learned which we want to share:

- Many of us have not had much experience comfortably discussing values-laden issues when perspectives may differ. Because of this, we found it necessary to take time to talk about PAS, gradually moving more deeply into the heart of the matter.[3]
- Experiences and emotions on this matter are strong. Discussion about this issue often starts at an intensely personal level. Despite the cultural denial of death, many individuals have a story to tell about an experience of death and dying—of a family member, a friend or neighbor, a co-worker, a parishioner… and all of us face the prospect of our own mortality. These experiences (sometimes confusing, conflicted, and painful) often are the entry points into the discussion about the merits of PAS as a matter of public policy. In dialogue about PAS, participants need to honor what may be tender and painful places.
- The process used for ethical decision-making affects where we end up. As several members of the MCC Ethics Advisory Board observed, "Our traditions differ sharply at the basic level of moral theory and method, on how we address intention, situation or context, and consequences and alternatives…" How our churches understand their nature and purpose, and how they exercise authority, also differ, impacting what they say and how they say it.
- The relationship between individual and communal rights and responsibilities is a source of tension in American society, with many emphasizing individual right at the expense of communal responsibilities. Those on the MCC Board of Directors would agree with the MCC Ethics Advisory Board: "All of us face the question of moral agency. None of us argues for a list of absolute and unqualified individual rights as an abstract claim. Our individual claims must be tempered by a sense of responsibility and accountability to and within some community (family, church, friends, and hopefully universal). But we do not surrender the fundamental presumption that, in order to exercise moral responsibility for our acts, there must be a basic claim to choice by the agent…"
- Ambiguity often accompanies end of life decisions. It exists because of the particularities of each case, and reflects the challenges of end of life decisions and the limits to human knowledge. Thus, the moment for decision-making about care at the end of life is not always clear or easily regulated. This ambiguity could be reduced, though probably not eliminated, if in both medical training and in the health care environment, physicians and other health care givers were encouraged and helped to provide honest information about what is happening, as best they can discern it, and about the range of choices open to patients and their families. At the same time, we recognize and resist the desire for neat formulae, which create the illusion of clarity in situations that often defy such clearness.
- Patients and families sometimes have difficulty in receiving information about end of life issues. These difficulties might be eased if families had explored the subject in a non-crisis situation. Vehicles now exist whereby the wishes of persons concerning health care decisions can be honored by family and health care professionals. In Massachusetts, persons are encouraged to designate a durable power of attorney for health care (a health care proxy).

- Seeking the guidance of a pastor, priest, or minister can help the patient and family respect the life the person has lived, and lead them to prepare for death in a way that preserves certain fundamental values and goals. Pastoral caregivers can help reflect on the sacredness of life, the potentially redemptive quality of suffering, the nature of human limitations, and the possibility of deepening relationships with God, family, friends and community—all in obedience to the commands of Christ. The patient needs to preserve to the fullest extent possible a conscious and personal relationship with the divine, the holy, with other people. Family and friends can offer, through their spiritual friends and guides, a presence and prayer as the patient—their loved one—surrenders life into the hands of God.
- We also acknowledge the context in which many Americans live today—geographically mobile, separated from family and community, with little time to create new connections, and growing numbers of single person households. This situation places added responsibility on other communities of care such as pastors, parish visitors, and congregations, for providing support as an antidote to loneliness, for helping terminally ill persons and their families, as they may need to address unresolved issues, and for addressing spiritual needs. We recognize the ways in which these communities of care have not always fulfilled these responsibilities adequately, and in fact may be overwhelmed by them.
- We honor the role of so many caregivers, such as nurses and other health care workers, who often are present, caring companions on this final journey.
- Additional medical research and training needs to focus on optimum palliative, i.e. comfort care. Furthermore, the hospice movement, which enables compassionate residential or home care for the dying, and ancillary services, deserve maximum private and public support.
- We are concerned about the impact of the rising cost of health care delivery on end of life decisions. It would be socially irresponsible if the lack of affordable health care prompted people to consider the alternative of physician assisted suicide, fearing that they were an economic burden or that they were no longer "useful" and "productive." Thus, we support accessible, affordable, quality health care for all, and are concerned that countervailing economic pressures could narrow appropriate options for terminally ill patients.

Statement of agreement

The members of the Massachusetts Council of Churches share a common concern on this vital issue. After careful reflection and prayer, members of the MCC Board of Directors seriously doubt, and some reject categorically, that physician assisted suicide is an ethically responsible option.

The dialogue must continue. We are committed to work together to articulate a position about end of life issues for women and men of faith today. This position is based on our faith in the Author of Life and the role of Jesus Christ and his Spirit in our lives.

Physician assisted suicide is not the answer. A right and good answer is found in the creation of measures that will effectively diminish suffering, so that the terminally ill patient can live and die with a maximum of consciousness and a minimum of pain.

There is a time to live and a time to die. Once the body has entered the terminal state, then reasonable and faithful treatment will consist of pain management and the provision of comfort. This allows the peaceful separation of soul and body. Medical heroics all too often represent a kind of bio-idolatry, a vitalism that seeks to preserve mere biological existence, in spite of the patient's wishes or the cost to society. Unqualified respect for the patient as a bearer of the divine image is paramount. This means that in the final analysis the decision must have as its final aim, the surrender of the person into the loving and merciful hands of God with unwavering conviction that God, and God alone, should determine the limits of life and death.

We are able to articulate some areas for committed action together:

- We support efforts to highlight the value of human life as a God-given gift.
- We believe it is irresponsible and lacking in stewardship to prolong the dying process, once clearly begun, through technological wizardry (traditionally called "extraordinary means").
- We support the importance and availability of pastoral care for the dying, their families and loved ones;
- We support accessible, affordable, quality health care for all, and we are concerned that countervailing economic pressures could narrow appropriate options for terminally ill patients.
- We support all efforts to improve palliative care, including additional medical research to focus on optimum palliative care.
- We support the hospice movement, which enables compassionate residential or home care for the dying, and we urge maximum private and public funding for hospice care.

We have learned from each other through the process of dialogue leading to this statement. We have deepened our understanding of the issues. We invite all Christians and their churches to engage in similar ecumenical reflection. With gratitude to God for giving us life, we are committed to cherishing the gift.

Appendix: Some church statements about PAS

Members of the Board of Directors of the Massachusetts Council of Churches come to the ecumenical table with multiple perspectives: as individuals, as representatives of member churches (denominations) or ecumenical bodies, and as members together of this ecumenical partnership called the Massachusetts Council of Churches. When we began to explore this issue, we conducted a brief survey of official church positions on PAS. Several churches oppose PAS. They have spoken with a clear voice. A group within one religious body suppports PAS. Other churches have not yet considered this issue. We encourage them to do so at appropriate authoritative levels, benefiting from ecumenical dialogue whenever possible.

The Roman Catholic position is reflected in the 1995 encyclical "The Gospel of Life," which states "To concur with the intention of another person to commit suicide and to help in carrying it out through so called 'assisted suicide' means to cooperate in, and at times to be the actual perpetrator of, an injustice which can never be excused, even if it is requested." (n. 65)

In testimony before the Sub-committee on Health and the Environment of the Committee on Commerce of the House of Representatives, Greek Orthodox ethicist Rev. Fr. Stanley Harakas articulated a Greek Orthodox perspective as follows: "From the perspective that suicide is by definition self-murder, assisted suicide becomes a contradiction in terms. To assist another to kill him or herself is no longer self-murder but a form of murder. It should therefore be kept illegal, as is any other form of murder."

On August 7, 1998, the Lambeth Conference of the Anglican communion said that euthanasia "is neither compatible with the Christian faith nor should be permitted in civil legislation." Lambeth continued, "withholding, withdrawing, declining or terminating excessive medical treatment and intervention…may be consonant with Christian faith in allowing a person to die with dignity." The 73rd General Convention of the Episcopal Church in July 2000 said that "…[T]he Episcopal Church should continue to oppose physician-assisted suicide near the end-of-life because suicide is never just a private, self-regarding act. It is an act that affects those with whom we are in relation within the community, denying them the sense of meaning and purpose to be derived from caring for us as we die. Moreover, it threatens to erode our trust in physicians, who are pledged to an ethic of healing. Finally, it denies our relationship of love and trust in God and sets us up as gods in the place of God."

A representative of the Massachusetts Divisional Headquarters of The Salvation Army testified against PAS legislation in 1997, saying "The Salvation Army today is not speaking in opposition to the sensible withdrawal of life-support systems made in careful consultation between medical staff and relatives. We are not in favor of artificially or officiously prolonging life. Instead, I represent the Army today to make clear our deep and principled aversion to the legalization of pro-active measures deliberately taken with the primary and direct intention of killing a terminally ill person and purposely aimed at accelerating the moment of death."

The Evangelical Lutheran Church in America Church Council adopted a

statement in 1992 which said "We oppose the legalization of physician-assisted death, which would allow the private killing of one person by another. Public control and regulation of such actions would be extremely difficult, if not impossible. The potential for abuse, especially of people who are most vulnerable, would be substantially increased."

United Methodist Social Principles, adopted in 1992, provided guidelines rather than directives: (I.D.) "The direct, intentional termination of human life, either by oneself or by another, generally has been treated in the history of Christian thought as contradictory in such stewardship because it is a claim to absolute dominion over human life…When a person's suffering is unbearable and irreversible or when the burdens of living outweigh the benefits for a person suffering from a terminal or fatal illness, the cessation of life may be considered a relative good.

"Christian theological and ethical reflection shows that the obligations to use life-sustaining treatments cease when the physical, emotional, financial, or social burdens exceed the benefits for the dying patient and the care givers."

(II.D.) "Among the issues of stewardship to be considered in such a decision [suicide] are: (a) God's sacred gift of life and the characteristics or boundaries of meaningful life; (b) the rights and responsibilities of the person in relationship to the community; (c) the exercise and

limits of human freedom; and (d) the burdens and benefits for both the person and the community."

A resolution passed at the 27th General Assembly of the Unitarian Universalist Association (1988) supported the general spirit of PAS, under the title, "The right to die with dignity." UUA resolutions such as this express the position of the General Assembly at the time of passage and do not bind member churches who are expected to follow their own consciences in these matters.

We recognize that the particular understanding of the church, of authority in church life, and of the relationship between individual conscience and church guidance varies considerably among Christian churches. Perspectives of conscientious Christians may differ from the positions articulated above.

Notes

[1] The Massachusetts Council of Churches was a lead supporter of "living will" legislation, and was instrumental in passage of a law recognizing a durable power of attorney for health care.

[2] See "A Model State Act To Authorize and Regulate Physician-Assisted Suicide, " by Charles H. Baron, et al, in the *Harvard Journal on Legislation*, vol. 33: 1996, pp 1-34.

[3] For some help with such dialogues, see *Constructive Conflict in Ecumenical Contexts: A document for dialogue; Guidelines for good practice*, prepared by a Working Group of the Massachusetts Council of Churches, 14 Beacon Street, Room 416, Boston, Mass. 02108, and available at the Council's web site: www.masscouncilofchurches.org.