EUTHANASIA

In these pastoral reflections the Catholic Bishops of Ohio explain their perspective on the current debate about the legalization of euthanasia and assisted suicide. Writing both to the Catholic community and to all others concerned for the dignity of the human person, the bishops contend that legalizing euthanasia and assisted suicide violates the dignity of persons—especially those most vulnerable—and undermines public trust in the medical profession. The bishops assert that compassion for people in pain and suffering is better expressed by appropriate pain management, intelligent use of stated ethical principles regarding life-sustaining medical treatment and use of advance directives relating to health care decisions.

There is a difference, the bishops argue, between *stewardship* and dominion relative to the gift of life. *Stewardship* involves responsible care for human life; dominion, the attitude undergirding movements toward euthanasia and assisted suicide, presumes ultimate power over human life. Creativity, humility and compassion are qualities essential for proper *stewardship.*

HOPES AND FEARS: PASTORAL REFLECTIONS ON DEATH

The Ohio Catholic Conference of Bishops, 1993

I. INTRODUCTION

Many in society consider the option of assisted suicide and/or euthanasia to be morally appropriate choices in the face of death. Evidence of that opinion abounds, from a bestselling book of home formulas for suicide, to proposals for the legalization of physician assisted suicide, to often moving accounts of, and arguments for, assisted suicide in the secular media.

Many people harbor fears about death, fears that we believe are driving the movement toward euthanasia and assisted suicide. There is the fear of dying in pain or dying alone. There is the fear of burdening others as one dies or exhausting one's life savings. There is the fear of dying after months or years suspended between life and death, or dying in an over-technologized and impersonal way.

We acknowledge these fears, and we share in them. We also share the call to compassion in the face of pain, suffering, and death. But we believe that to legalize euthanasia and/or assisted suicide is not consistent with a Catholic perspective on dying, nor is it in the best interests of humankind.

A policy that would allow physician assisted suicide—even if motivated by laudatory compassion and driven by understandable fears—will undermine reverence for life, respect for the dignity of the human person and trust in the medical profession. Concern for the dignity of each person—especially the most

vulnerable members of society—is the foundation of our opposition to the legalization of euthanasia and/or assisted suicide.

We offer these pastoral reflections not only to help form the consciences of Catholic people, but to contribute to conversations regarding public policy on these issues. Drawing on Catholic faith and moral teaching, and attentive to the fears fueling the movement towards euthanasia and assisted suicide, we hope our reflections prove helpful to all concerned for the dignity of the human person.

Legalizing euthanasia or assisted suicide will diminish rather than enhance the dignity of the person. We believe there are better ways to extend care and compassion to those facing death, ways that offer solace to those in pain and foster personal support and presence in the midst of suffering. Our reflections, therefore, are directed not only toward what we are called to oppose, but to what we are committed to promote: care and compassion in the face of pain and suffering, intelligent use of ethical principles including advance directives for health care decisions regarding medical treatment, and *"stewardship."*

II. PAIN AND SUFFERING, CARE AND COMPASSION

In the dialogue between Moses and God in the book of Exodus, Moses asked God, "Who am I that I should go to Pharaoh and lead the Israelites out of Egypt?" God answered, "I will be with you." (Exodus 3: 11-12; see also Isaiah 7:14; Matthew 1: 21-23). We believe that in Jesus Christ, God has become one with us, embracing even our fears and pains. The conviction of God's presence sustains us to face life's pain and difficulty with hope and confidence that no pain or sorrow—not even death—is the final word. God's presence in the life of Jesus did not prevent pain or death; God's power and presence saw Jesus transformed and raised to a glorious life (1 Corinthians 15: 51-57; Acts 2: 22-24).

We are convinced that God's presence and compassion in suffering and in death are meant to be the model for our relationships with one another.

In the face of the pain and suffering sometimes associated with illness and death, we are called to be with one another in caring compassion—"to suffer with," as the word "compassion" signifies. Caring and compassionate presence with one who is suffering is reassuring and transforming to both parties.

Our experience convinces us that what we have just stated is not simply poetic religious sentiment or wishful thinking, but reality. Although Christians are called to a compassionate presence that has the power to foster acceptance and hope, compassionate presence is also a call to humankind itself. Compassion brings out the best in all of us.

This call to compassion has important implications for dealing with two related realities: pain and interdependence.

PAIN

While attempts to prevent pain and alleviate suffering are important, it is unrealistic to think that all pain and suffering can be eliminated from the human condition. We acknowledge, however, that pain management can assist patients in dealing with pain and suffering. Courage and hope are called for in the face of pain and suffering, and, as demonstrated so powerfully in the life and death of Jesus, these qualities also call forth the best in humanity.

INTERDEPENDENCE

Compassion recognizes the interdependence of human beings. We need one another, not only for what we can give in love to each other, but to mediate God's loving presence (Matthew 25: 31-40). This view may be counter-cultural. Radical independence of the person has been elevated to the absolute. Freedom and control are revered values, and fear of "losing control" as one moves toward death is a genuine concern. We agree that a patient should be the center of medical-moral decision making. But we do not agree with a radical form of patient independence that claims complete control over life and death. We are mutually dependent upon one another, and in our compassion and care for one another, the compassion and love of God for all of us are made evident.

III. CATHOLIC TEACHING ON THE USE AND NON-USE OF MEDICAL TREATMENT

Closely allied to fear of loss of control in the face of terminal illness is fear that one's death will be prolonged needlessly through inappropriate use of medical technology.

Such fear is understandable, but it does not warrant euthanasia or assisted suicide. An intelligent application of medical moral principles—principles deeply embedded in Catholic tradition but shared by many others—is the better response.

Catholic moral tradition on human life issues begins with the conviction that life is a gift of God and reflects God's creativity and love. Animated by God's presence, the gift of life is holy, not only to be respected but reverenced (Genesis 1: 27). We are called to be *stewards* of human life—our own and one another's. We have a serious moral obligation to take reasonable steps to care for our life and health. But we need not take all measures at all times and at all costs to prolong life. Such an attitude does not promote what is best spiritually or physically for individual patients, nor is it realistic in regard to society's limited health care resources. Moreover, for those of us who believe in a resurrection-destiny, clinging desperately to physical life "at all costs" is out of keeping with our hope for future glory. Death is part of life, a natural and inevitable consequence of life, but death is not the end. We are called to union with God (Philippians 3: 20-21).

ORDINARY AND EXTRAORDINARY MEANS FOR PRESERVING LIFE

Stewardship for life does not charge us to take all measures at all times to preserve human life. We are obliged to use ordinary means to preserve human life, but need not use extraordinary means. In 1950, moral theologian Gerald Kelly offered these definitions:

Ordinary means of preserving life are all medicines, treatments, and operations which offer a reasonable hope of benefit and which can be used without excessive expense, pain, or other inconvenience.

Extraordinary means 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 (Theological Studies, V. XXII, 1950, 550).

There are, then, two criteria for determining whether a proposed intervention is an ordinary or extraordinary means of treatment: 1) Does it offer a reasonable hope of benefit?; 2) Can it be used without excessive expense, pain or other inconvenience? What is called for is a prudent, practical moral judgment about the relative benefits and burdens of a given treatment for a particular patient, at a particular time and place.

PROPORTIONALITY OF BENEFITS AND BURDENS

In recent years the meaning of the ordinary/extraordinary distinction has become blurred. “Ordinary” has often become associated, if not equated, with “standard medical practice,” giving rise to extended lists of “ordinary” medical treatments. The contextual, patient-specific nature of the term has been lost.

Without changing the substance of the distinction, the 1980 “Declaration on Euthanasia” of the Vatican Congregation for the Doctrine of the Faith (CDF) offered the following update:

In the past, moralists replied that one is never obliged to use “extraordinary” means. This reply, which as a principle still holds good, is perhaps less clear today, by reason of the imprecision of the term and the rapid progress made in the treatment of sickness. Thus some people prefer to speak of “proportionate” and “disproportionate” means. In any case, 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 while taking into account the state of the sick person and his or her physical and moral resources (St. Paul Editions, 11).

The burden/benefit criteria are now more usually related to the principle of proportionality: Are the hoped-for benefits of a treatment in proportion to the

burdens that will be involved? The criteria are substantive enough to provide valid moral guidance, but open-ended enough to allow for flexible application to diverse medical-moral situations.

KILLING VS. ALLOWING TO DIE

Built into traditional Catholic teaching is a conviction that there is a substantive moral difference between foregoing treatment (thereby allowing one to die naturally from an underlying pathology), and an action which “of itself or by intention causes death, in order that suffering may in this way be eliminated” (CDF, “Vatican Declaration on Euthanasia”, Section II, May 1980).

There are many who are not convinced of the validity of this distinction. For some, the difference seems a matter of semantics: the patient dies in either case. Discussions will continue, and we encourage Catholic scholars to take an active role in the dialogue. We however, remain convinced that the distinction is valid. In the first case (foregoing treatment) death is permitted, allowed to occur. One is not obliged to prevent death if the means required would be morally disproportionate. In the second case (euthanasia, assisted suicide—such as through lethal injection) the **immediate and direct cause of death** is introduced by the person himself or herself or his or her agent. Such an action is objectively wrong because it assumes ultimate control and dominion over life, rather than stewardship of human life.

PAIN MANAGEMENT

Recognizing that the fear of dying in pain is significant, we advocate pain management that is effective and, as needed, aggressive. Pain medication that moves a patient to unconsciousness is regrettable, and less drastic measures are preferable.

Nevertheless, such pain management is ethically justified when necessary, even though such pain management may occasionally and unintentionally shorten the life of the patient. In these instances death is not intended or directly sought, but comes more quickly as a side effect of what is intended, namely the alleviation of pain. Further, the cause of death, ethically speaking, is not the medical intervention, but the underlying pathology. In our view, this analysis is based on a distinction that is essential to maintain.

We recognize that pain management has not been well developed or applied in health care practices. The medical-technological model of care and fears regarding the use of pain relief modalities, have not always enabled the health care community to respond well to the relief of pain and suffering. We must direct ourselves to a better understanding and practice of pain management in all of its aspects—physical, emotional, spiritual and social.

PATIENT'S PREFERENCES AND ADVANCE DIRECTIVES

In the midst of any discussion about medical-moral decisions, it is important to comment on who should be making the decisions. The "Declaration on Euthanasia" states:

Account will have to be taken of the reasonable wishes of the patient and the patient's family, as also of the advice of the doctors who are specially competent in the matter (Section IV-12).

In line with this teaching, we believe that the patient should be at **the center** of the decision making process, surrounded by family and significant loved ones, as well as the patient's health care team.

Catholic tradition acknowledges that the moral assessment of a proposed treatment may reasonably and responsibly include financial expenses as a relevant factor. We are aware of the possible abuse of such a criterion through judgments that are aimed at solving public or private health care costs by eliminating certain patient groups whose lives are considered to be no longer "worthy" of care. Nevertheless, the costs of medical treatment can and should be part of the assessment of burden. When patients, families and health care professionals face decisions regarding medical treatment, the burdens and benefits **to the patient** should remain **the center** of the conversation, but the ultimate decision may involve wider considerations. The social nature of each person and individual personal choices have familial and social implications.

This emphasis on the "benefit/burden assessment" relative to the patient and the patient's wishes and preferences should not be taken to mean that patient autonomy is absolute. Patients do not have a right, for example, to demand medically futile treatment, nor can they demand that others take direct steps to bring about their death through euthanasia or assisted suicide. Moreover, the moral convictions of physicians and other members of health care teams should be respected: they should not be expected to take part in medical interventions against the dictates of their consciences.

When a patient is no longer able to take an active role in the decision making process, an advance directive for health care can be a legitimate and helpful way to bring the patient's values and preferences into the decision making. Ohio's legally recognized instruments—the Living Will and the Durable Power of Attorney for Health Care—can serve this purpose, and for this reason we do not oppose their use.

These documents, however, do not provide easy answers for difficult end-of-life decisions. In fact, such instruments are only as good as the quality of conversation and communication—with family, loved ones, physicians, etc.—that precede and lead to their completion.

IV. STEWARDSHIP

We wish to elaborate further on the notion of stewardship. Stewardship presupposes three qualities that have spiritual and moral implications: **creativity, humility** and **compassion.**

CREATIVITY

God is the author of human life. "The Lord God has formed the man out of the clay of the ground and blew into his nostrils the breath of life, and he became a living being" (Genesis 2: 7). We believe that in some mysterious and marvelous way the Creator continues to fashion each of us and to breathe life into us. As a result we are inspirited with God's life and holiness. This is the basis not only for our reverence and respect for life, but also for stewardship of life.

To be stewards means to care for, to foster and nourish the gift of life—our own and that of others—so that our lives might flourish abundantly. Because we have been fashioned in the image of the Creator, we are, in a sense, "co-creators." And so it is appropriate that our stewardship for life be marked by all the ingenuity and **creativity** we can muster.

HUMILITY

If creativity marks stewardship for life, so too does **humility.** Humility, the acceptance of the way things are and our role in them, is seen as a basis for viewing the distinction between "stewardship" and "dominion." Stewardship entails the acceptance—indeed the embrace—of the Creator's gift of life and calls on human intelligence and creativity to cultivate and care for that gift. Dominion likewise musters human intelligence and resourcefulness in the management of life, but, disconnected from a view of life as a gift of the Creator, it claims control over life in a radical and ultimate way.

We see stewardship expressed in energetic and creative attempts to cure illness, to alleviate pain and ease suffering. We see stewardship in a patient's desire to be self-determining in regard to the use of medical treatments, even to the point of foregoing treatment at life's end when it becomes futile or excessively burdensome.

There is also a certain humility about stewardship. First, unlike what is expressed in dominion, stewardship entails a humble acceptance of the human condition: pain cannot always be eliminated any more than suffering can always be avoided. Second, unlike dominion, stewardship does not claim absolute control over life and death, but accepts limitations to the desire for self-determination, limitations inherent in being "only" co-creators, and not the author of life itself.

Creativity and humility ground our opposition to suicide, assisted suicide and euthanasia. Some of the current proposals for assisted suicide appear to be

cautious and the criteria narrowly drawn. For example, a competent adult patient moving towards the end stages of a terminal illness makes a persistent request for assisted suicide from his/her attending physician when alternate treatments and/or palliative efforts have failed (Quill et. al., NEJM, V. 327, No. 19, Nov. 5, 1992; 1381-1382). We do not support assisted suicide even in instances such as these because we view it as an attempt to absolutize patient self-determination or autonomy, a gesture that expresses dominion, not stewardship.

An even more serious concern is that assisted suicide today may well turn into full-blown euthanasia tomorrow. We are doubtful that the practice of physician assisted suicide, regulated by carefully constructed "clinical criteria," would in fact remain carefully controlled. It is not hard to imagine subsequent proposals to legalize active euthanasia, "mercy killing," for the very old who have become severely mentally impaired. With the well-established projections relating to a dramatic increase in numbers of older persons over the next several decades, questions are already being raised regarding the extent to which this population should have access to specialized medical procedures and life sustaining medical treatments. Implications for those who are not only old but also severely mentally impaired are obvious. It is imperative that creative and humble stewardship for life be extended to those most vulnerable.

COMPASSION

Another quality inherent in the stewardship for life is compassion. We are called to be people of compassion. We try to eliminate pain and ease suffering, but, even more so, we must accompany one another in and through pain and suffering. We are our sister's and brother's keepers (Genesis 4: 9). We are called to be with one another in pain and to support one another in suffering (Luke: 10: 29-37). We hold up the hopeful conviction that in and through such compassionate care for one another, in and through such compassionate stewardship for life, the compassion of God is revealed.

V. CONCLUSION: A CALL TO ACTION

In this pastoral reflection, we call Catholics and others to renew their commitment to develop a "stewardship spirituality." We recognize that individuals cannot develop this spirituality in isolation from the larger spiritual community in which they live. In this light, we encourage our Catholic parishes, educational institutions, hospitals, nursing homes and other social and health care ministries to assist individuals and families to experience the creativity, humility and compassion we discussed in this reflection.

We propose some concrete and practical suggestions for action by our faith community in order to help families deal with a death, and to be in solidarity with these persons and families who face pain and suffering. Certainly, this list is not exhaustive, but it is a place to begin.

PASTORAL MINISTRY

We encourage parish leaders and ministers to develop programs in their parishes to educate parishioners on the issues of death and dying. Parishioners should be afforded the opportunity to understand the Church's teachings on death and dying and the Church's perspectives on end of life decision-making, living wills and durable powers of attorney for health care.

We encourage parishioners to celebrate the Sacrament of the Anointing of the Sick in a public fashion so that issues of health and dying can be reflected upon a liturgical-communal setting.

CATHOLIC SOCIAL AND HEALTH MINISTRIES

We urge Catholic social service institutions and Catholic health care facilities (acute and long-term) to provide assistance to parishes in developing programs for families and individuals to understand advance directives and medical decision-making. This can be accomplished through educational events, materials or support groups.

We encourage Catholic health care professionals to become more involved in Church ministries, such as parish nursing programs, in order to assist parish ministers in their role of creating a "stewardship spirituality" and helping families and individuals deal with issues of health and dying.

ADVOCACY

We encourage Respect Life committees and offices to educate the community on the Church's teaching on these matters, and to become active voices in their area for the respect of life—the sacred gift from God.

We encourage social action committees of parishes and dioceses to promote legislation in Ohio and at the federal level which would oppose the legalization of assisted suicide and euthanasia.

These suggestions are not exhaustive of all the many activities and programs that can be offered in Catholic parishes, hospitals, nursing homes, social service institutions, and homes. Our hope in this call to action is to enable parish communities to become more involved in being "Emmanuel"—"God with us"—to all families, especially those faced with decisions surrounding death.