The theologic ethics of euthanasia

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As Easter approached, the contrast of the two pronouncements kept going through my mind:

I injected the morphine intravenously...within seconds her breathing slowed to a normal rate. Her eyes closed and her features softened. She seemed restful at last. The older woman stroked the hair of the now-sleeping patient. I waited for the inevitable next effect of depressing the respiratory drive...the breathing slowed...became irregular, then ceased. It's over, Debbie.(1)

The strife is o'er, the battle done, the victory o'er death is won. The song of triumph has begun. Hallelujah(2)!

Debbie’s was one of those epochal cases that seem to engage our whole society in an issue that troubles everyone to the very core of his being. Current practices in Holland and political initiatives in the United States suggest an urgency to debate on euthanasia with implications spanning personal, professional, and legal concerns. How shall we personally meet a good death? How shall physicians act in the face of terminal illness and imminent death? What policy, if any, shall our society promulgate?

A Transcendant Ethic

The questions of deliberate death and euthanasia present issues that move our reflection beyond the customary modes of ethical analysis. We are no longer faced with the gruesome stipulates of an "ecological ethic" of weeding out the old and the weak. Here also we move beyond the philosophic ethic that speaks of a "right to die," a professional ethic that affirms a "duty to preserve life," and the legal ethic that prescribes acts of medical murder, even if the victim is a pleading patient and the perpetrator a compassionate physician. At times such as this, what is called for is an ethic transcending both reason and convention, an ethic rooted in patient plight and the ultimate ground of being. For here we touch the mysteries of life and death, and face the human impulses of risk, guilt, and sacrifice. In these moments, and "borderline situations," other parameters of ethics do not fit.

Yet the radical and "different" ethic required is also traditional, in that its elements are imbedded in particular cultures. The dominant moral ethos in America is Christian, commingled with Judaism and secular humanism. Our religiomoral ethos is anchored in beliefs of radical ethical freedom, the sacred origin and destiny of the human soul, persistent sin, and the drama of suffering, death, and transfiguration as a decisional paradigm for difficult choices. It is grounded in belief in the sacredness of the human being in vitality and in frailty, and in the ultimacy of grace and forgiveness. These convictions should profoundly influence our perspectives on euthanasia.

When a situation or moral decision is viewed theologically in this manner, three new ethical perspectives are disclosed. First, when God is acknowledged as the giver, sustainer, and receiver of life, we see and evaluate that life with awe and wonder: responses of quick dispatch or highly principled withdrawal are no longer possible. We also view death as transparent and nonfinal. Though death is feared because life is celebrated, this fear is transformed by belief in the reality of life hereafter. Finally, we are prompted to give "intensive" care and companionship to the dying.

What implications does this system of theological ethics hold for the issue of euthanasia?

Types of Euthanasia

Let us begin with the most easily justifiable class of cases, passive euthanasia, in which death occurs in the course of treating a terminally ill person by forgoing potentially life-prolonging measures. It is not considered obligatory to initiate CPR, antimicrobial therapy, mechanical ventilation, or artificial nutrition and hydration when it is futile or only marginally helpful. Patients are not obliged to accept surgery, organ transplantation, or mechanical organs when hearts or kidneys fail. We are learning when to partake in
technology's feast and when to decline—what Ivan Illich calls a "technofast." As free, responsible, and immortal creatures, we will often find passive euthanasia acceptable.

A second class of actions can be designated "double effect euthanasia." Theologically and morally it is acceptable for a patient to choose palliative treatments that may result in death and for a physician to administer potentially lethal analgesia in the relief of pain. And many ethicists argue that the administrator of a lethal dosage is not culpable if his primary intent is to relieve suffering, though the ensuing death may be foreseeable, so long as the patient and family consent.

We might understand Debbie's case best from this perspective. Debbie suffered from ovarian cancer; she was given morphine to relieve her suffering, but it also happened to hasten her death.

This type of double-edged intention and bivalent action is certainly the most difficult to assess morally. The unfortunate side-effect was grievous, but not unethical. In the narrative, the doctor's stated intent seemed to be to provide relief and rest, fully aware that the merciful analgesia might end the patient's life. We can also infer that the stated intent to kill was not serious, but rather a melodramatic or anguished afterthought. Morphine is not normally a drug used for suicide or homicide. Often it does not depress respiratory function and since pain increases respiration the relief given by morphine usually diminishes a respiratory crisis. Moreover, twenty milligrams of morphine for a terminal cancer patient in intense pain is, in the words of one expert on oncologic analgesia, "a piddly dose." In cancer clinics today patients are given 140, 400, even in exceptional cases 700 mg per hour of morphine. The resident could not possibly know in advance that this dosage would cause certain death. I would infer from both the choice and dosage of medication that this was a case of double-effect euthanasia, even if the expressed premeditation and volition were ambiguous. This doctor entertained, I believe, both the hope of rest and relief and the probability of death.

Our moral heritage condones mercy in the face of suffering, courage in the face of uncertainty, and forgiveness in the face of tragic extremes; my colleagues in the Roman Catholic tradition, for example, counsel that compassion dictates that one offer relief to someone in Debbie's situation. It would be unconscionable to condemn a patient to greater anguish because of guilt-ridden hesitancy to risk death. Our moral tradition demands that we act courageously, even though our actions might result in double-effect euthanasia.

Exceptional Case Euthanasia

A third and controversial type of action, active euthanasia, must be proscribed in principle, but the tradition of medicine, religious tradition, and contemporary precedent may permit it in exceptional cases. This permission has always existed alongside the dominant ethic of prolonging and sustaining life. Paul Carrick, a scholar of ancient medical ethics, contends that the physician "possessed what might be described as a discretionary professional right to assist in abortion or voluntary euthanasia."(3)

The position of "exceptional case" euthanasia is grounded in classical clinical wisdom. In this tradition the physician was discouraged from invading the atrium of death therapeutically or technologically. Attempts to cure were now to yield to attempts to comfort. In the Hippocratic treatise The Art, the techneiastrate is defined as follows: In general terms, it is (1) to do away with the sufferings of the sick, (2) to lessen the violence of their diseases, and (3) to refuse to treat those who are overmastered by their diseases, realizing that in such cases medicine is powerless.(4)

This reflects the fundamental religious and ethical genius of classical ethics: In the atrium of death, one's life is given over to the transcending spirit who gave it. The god known by the Pythagorean mystics at the vortex of temporal perfection, at the junction of the finite and the infinite, was the lord of death. In both a natural and a transcendent perspective it is a graceful virtue to accept death.

In Hebraic and Christian medicine, art becomes ministry and service. In Judaism the gosos, or imminently dying one, is treated with reverence and respect. Christianity, which historically extolled and endorsed the moral and spiritual excellence of the sect of Hippocrates, exhibited the same awe and reverence for the dying individual. However, Greek contempt for the material body was transformed into esteem and stewardship, and the centrality of the crucified one in faith created a new positive meaning to excruciating suffering.

It is remarkable that, with these prolongest impulses, the tradition contended that death could be greeted boldly and triumphanty, and that no one should impede another in his appointed hour. In the Christian perspective the recognition of impending death initiated the ars mordiendi. The art of dying now included the individual's preparations for and orchestration of the dying process, and signalled the withdrawal to only modest medical activity. In the English Prayerbook one prays to be delivered from a swift and unexpected death, where one is denied the grace of such preparation and orchestration.

Beginning in the middle decades of this century we transformed death into an act of human deliberation and technological manipulation. How has this come about? First of all, modern diseases have displaced earlier diseases; newer chronic conditions have replaced acute illness. By significantly checking infections with vaccines and antibiotics we have opened the door of morbidity, which like the door of mortality seems to be a constant in human history. Now it has been opened to chronic diseases like Alzheimers, osteoporosis, arthritis, and cancer.

Today a vivid set of cases involving patients who are not dying but are suffering from the final stages of Lou Gehrig's disease, cystic fibrosis, cerebral palsy, or other irreversible and fatal afflictions have been set before us in newspapers, courts, and television dramas. Some of these patients eventually ask their physicians to disconnect life-supports and ease them into death with barbiturates and muscle relaxants.(5) In my view such cases are compelling and justify active euthanasia.

The most moving evidence I have witnessed for this direction in my twenty-five years as a consultant in medical ethics is the testimony of ethical and humane physicians who out of love would give a lethal dose to their wife, parent, or other loved one if his or her dying was marked by suffering and agony. I find it strange and hypocritical that the imperative of compassion would allow an
action with loved ones but not with patients. This may say that we have lost empathy, sympathy, and the covenant of care with those who have entrusted their lives to us because they believe we embody those very qualities.

Physician Participation

The life-and-death nature of a scenario like Debbie's is in a sense a contrivance of our own making. Chemotherapy radically altered her entire physiology and biochemistry. Her pain thresholds and equilibrium were modified by the disease and by analgesia, and her nutritional state maintained completely by artificial means. She is dying in a hospital. The entire situation is one of technological and institutional contrivance. Now, in the words of the Czech playwright Capek, we must become accountable for "what we have wrought." It would be a moral cop-out to act boldly and put a Swann-Ganz catheter in her neck and a mechanical respirator tube down her throat to save her life, and then plead incompetence and reluctant conscience to remove them when it becomes clear she cannot recover.

In Debbie's case more faithful care would have been slow and deliberate, across several hours. The physician should have drained the effusion in her chest, titrated morphine every two minutes until her pain was relieved, and then made considerate decisions with her about the need for resuscitation and other expected events. All this should have been done with the fully informed consent of the primary physician, health team, chaplain, ethics committee, and loved ones. This more customary protocol should have been followed not to draw out her suffering--an absolute ethical prohibition--but rather to attend her need in the most humane and sensitive manner possible.

If this line of argument is valid, it follows that the physician should superintend and participate in his patient's dying. The patient and physician should come to "will one will" together in receiving death. This new engagement with the patient, involving informing, consenting, and to use Paul Ramsey's felicitous phrase, "co-adventuring," is incurred by the changes in the patient's readiness for death, brought about by the preceding series of interventions.

Death is different in our time. Some will succumb to sudden coronary death, others to stroke or myocardial infarction. Some will contract pneumonia and die swiftly. Others will commit suicide. Yet a large number of people will move toward chronic patterns of demise. Patients with cancer, arthritis, Alzheimers, AIDS, emphysema, and other afflictions will now have the occasion to deliberate and decide the time and manner of their own deaths. This opportunity will give patients, physicians, and pastors new possibilities for courage, responsibility, and sympathetic cooperation.

We must, at this point acknowledge and respond to a formidable conviction that presents a different conclusion. As he confronted his own terminal illness and impending death, Paul Ramsey wrote an essay entitled, "Should Physicians Hasten the Death Angel When She Pauses in her Flight?", in which he argued that the medical-ethical and biblical traditions, the normative centers of our moral system, absolutely condemn "the intention to cause death."(6) In his inimitable way he criticized both the active euthanasic modes of "strychnine, gun, and morphine" and the passive modes of withdrawing nutrition and hydration. For Ramsey the will is decisive; paraphrasing papal teaching, he concluded that "any act or omission that by design and in reality brings on death is wrong morally."

While I wholeheartedly agree with the general tenor of Ramsey's view, I suggest that he has not fully understood how we have already "designed" the death-defying and death-prolonging situation. We have created the conditions for suspension of mortality so that it becomes morally incumbent upon us willfully to offer at some point a fissure of release in our own barricade. Having barred the door to death, are we not then obliged at some point to open it?

Resisting death is indeed noble; we must do it. But we must finally yield. As Teilhard said:

We must struggle against death with all our force, for it is our fundamental duty as living creatures. But when by virtue of a state of things, death takes us, we must experience that paroxysm of faith in life that causes us to abandon ourselves to death as to a falling into a greater life.(7)

We must beware of allowing a case like Debbie's to create a general medical precedent. But neither should our fearful antipathy toward what happened to her make us inhumanely force individuals to outlive themselves. Just as physicians must not be accomplices to the modern euthanasic ritual we euphemistically call cost cutting, they must never open themselves to the currently widespread criticism that they cruelly prolong patients' dying. Our irresistible technology, joined to an insatiable need to help and an incoherent fear of death, could do this to us. Alternatively a new courage, grace, and reciprocity may mark our future, if we choose.


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