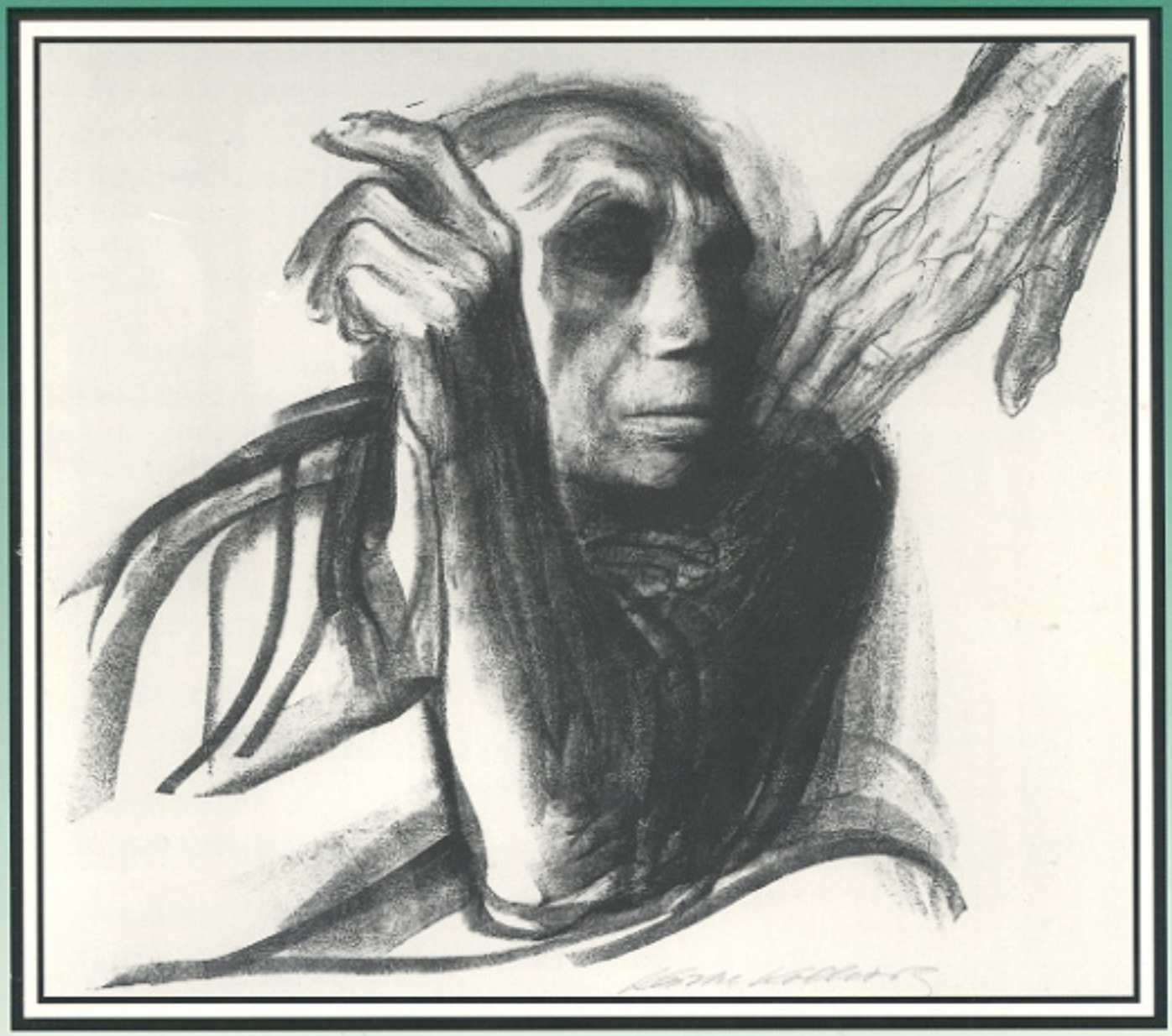
In Life and in Death We Belong to God

Euthanasia, Assisted Suicide, and End-of-Life Issues



A Study Guide

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In Life and in Death We Belong to God: Euthanasia, Assisted Suicide, and End-of-Life Issues

A Study Guide

Christian Faith and Life Area, Congregational Ministries Division,
Presbyterian Church (U.S.A.)

INTRODUCTION

Why has the denomination prepared this study guide?

The 202nd General Assembly (1990) of the Presbyterian Church (U.S.A.) directed the Theology and Worship Ministry Unit (now called the Offices of Theology and Worship) to prepare a study document examining the theological issues that emerge from a consideration of the public debate of euthanasia and assisted suicide. While previous General Assemblies have touched on the topic of euthanasia (see Appendix 3), it has not up to now been the subject of a full-scale denominational study.

As part of its effort, the Office of Theology encouraged a number of congregations and other grassroots groups throughout the denomination to engage in study of these issues, and to appraise preliminary study materials.

On the basis of what it learned from participants in these groups, as well as from a group of professors in one of our denomination's theological schools, the Office of Theology supervised the preparation of this second and final study guide, working with a task force of thirteen persons, many of whom had participated in the grassroots studies.

What does the study guide include?

Each of the twelve sessions includes:

- Goals
- A list of resources
- Suggested Scripture readings
- Critical issues (a summary statement of basic theological issues)
- Questions of group discussion
- Suggested prayers
- Suggestions for group process

Study participants may wish to prepare for each session by reading the goals, the suggested Scripture, and the critical issues. The other resources that are listed can also be read in advance or can be used as material for further reflection at the end of the study.

While it is possible to structure discussion around the "Questions for Group Discussion," the task force and the Office of Theology believe that the study will have greater value if it takes place in communities characterized by prayer and mutual accountability. The "Suggestions for Group Process" indicate ways to give significant attention to the community's common life. Note that each session includes more suggestions than a study group will probably use. Participants are encouraged to modify sessions to meet the needs of their particular groups.

It is possible to condense the study into fewer sessions. The Office of Theology, however, encourages groups to use as many sessions as possible. (A possible eight-session study would utilize Sessions 1 through 4 and Sessions 9 through 12.) Personal, self-directed study of each session is also possible.

The appendices include a glossary of terms, a brief bibliography, and portions of prior denominational statements that

touch on euthanasia. In addition, a sermon and a response are included as a model for the kind of discussion that can take place in congregations.

At the end of the study, participants are asked to return a response form (pp. 57-59) to the Office of Theology. Your comments will help the Office of Theology determine whether to take additional steps to address issues relating to euthanasia, assisted suicide, and end-of-life decisions. A summary of responses will be shared with the General Assembly and General Assembly Council.

Who can lead a group?

Any minister or member who has a lively interest in helping others explore and understand euthanasia, assisted suicide, and end-of-life issues can help lead the study. In some cases, it may be possible to form a leadership team of pastors, physicians, nurses, and attorneys from within a congregation.

What assumptions shape the study guide?

The study does not promote a particular church policy or legislative agenda relating to euthanasia or assisted suicide. It does encourage participants to consider a wide spectrum of views and experiences.

Persons will come away from this study having wrestled with the gravity of these issues for themselves. They will encounter the Christian moral tradition, address questions of faith, and listen to the wisdom of others who have engaged in similar reflection.

As the task force explored issues relating to euthanasia and assisted suicide, it concluded that they point to broader issues of suffering and dying. The study's overall goal, therefore, is to help Christians consider what is at stake for the faith when people face end-of-life issues, including euthanasia and assisted suicide. Basic to the study are questions of Christians' response to those who suffer and die.

While the study suggests no neat resolution of the issues, it will encourage participants to wrestle with ambiguities, to respect one another's perspectives, and to model ways of effectively considering controversial topics. The authors hope that, when the study concludes, participants not only will have learned new information but will have also grown in faith.

This growth in faith may embody a certain tension. On the one hand, the study encourages open conversation. As a community of moral discourse and action, we can learn as a church that controversy need not tear us apart. If a group meets in a spirit of respect and understanding, it can find its common life stronger in the end, despite people's differences.

On the other hand, the study identifies Scripture, confessions, and personal resources that can help participants make decisions, identify boundaries, clarify their own positions, become aware of different cultural perspectives, and know what God requires both of them and of the church as a whole.

Session 6, "The Experience of Sufferers: A Personal Encounter," will require special preparation. This session asks class participants to engage in conversation with persons who have

faced end-of-life decisions, with persons who have actually considered the option of euthanasia or assisted suicide, and with health care professionals. Study leaders will need to be in extended conversation with physicians, nurses, chaplains, hospice workers, and others in order to arrange this session.

An important supplemental resource is the book *Choosing Death: Active Euthanasia, Religion, and the Public Debate*, edited by Ron P. Hamel and published in 1991 by Trinity Press International. This book provides a summary of past and contemporary Christian thought relating to euthanasia, assisted suicide, and end-of-life issues. Copies of *Choosing Death* may be ordered from the publisher (Trinity Press International, 3725 Chestnut Street, Philadelphia, PA 19104). The study, however, is not of the book itself but of the theological issues that emerge from a consideration of euthanasia, assisted suicide, and end-of-life decisions.

Since reflection on Scripture will be an important part of the study, participants should bring a Bible to each session. It will also be helpful for each member of the group to have a copy of the study guide.

Members of the Task Force

Task force members included: Richard Allman, Villanova, PA; Eugene Bay, Bryn Mawr, PA; Margaret Cheesbrough, Prescott, AZ; Brian Childs, Decatur, GA; John Dalles, Pittsburgh, PA; Bruce Humphrey, Prescott, AZ; Peggy Lindamood, Paradise Valley, AZ; Michael Krech, Memphis, TN; Linda Peeno, Louisville, KY; Dell Richards, Iowa City, IA; Blake Richter, Iowa City, IA; and Polly Schrimper, Memphis, TN.

Joan McIver Gibson, Albuquerque, NM, and Herbert Hendin, New York City, NY, offered the task force special assistance.

John Burgess and Dick Junkin provided staff support from the Offices of Theology and Worship in the Christian Faith and Life Area.

SESSION 1

Moral Discourse in the Christian Community

Goals

In this session, participants will (1) get acquainted with one another; (2) get oriented to the study as a whole, including what they will do, why they will do it, and how they will do it; and (3) be invited to commit themselves to making the study a success.

Suggested Resources

"The Church: A Community of Moral Discourse," James M. Gustafson, in *The Church as Moral Decision Maker* (Pilgrim Press, 1970)

A Brief Statement of Faith

Glossary of Terms (Appendix 1)

Suggested Scripture:

Ecclesiastes 3:1-22
Romans 8:28-39
Romans 12:3-5

Critical Issues

When Christians gather to reflect on euthanasia, assisted suicide, and end-of-life issues, our principal goal in neither to engage one another in debate not to satisfy intellectual curiosity. Debate and satisfaction of curiosity are good and have their place, but Christians gather for another purpose. When Christians approach euthanasia, assisted suicide, and end-of-life issues, we seek to learn more about ourselves, about our world, and about God. We seek to grow in our capacity to live with faith and joy, to come nearer both to God and to one another, and to draw on our theological and moral tradition in order to relate it to new challenges and situations.

As Reformed Christians, we believe that God generally speaks better through all of us, as we engage each other, than through the view of any one of us individually. The church is and should be a community of moral discourse and action. A community of moral discourse and action is one in which people acknowledge their need for each other's wisdom and experience as they try to resolve basic questions of right and wrong. When the church is such a community, it allows people to speak freely, to raise big questions, and to grapple with the fundamental issues of human existence.

As we begin this study, it is appropriate for us to think together about the character of the church. In baptism, we die and rise with Christ (*Romans 6:1-4*). We become a covenant people committed to realizing God's purposes. Though we often fall short of these purposes, we cannot forsake them without forsaking ourselves. As the *Brief Statement of Faith* proclaims, "In life and in death we belong to God." It is this identity as God's people that make us a community of moral discourse and action, and that makes discussion in the Christian community distinctive.

Life in community with God and with one another contrasts with much of contemporary society and its commitment to autonomy. (For a definition of "autonomy," see the Glossary of Terms, Appendix 1.)

Throughout the study, we will be asking ourselves how our being

Christians and members of a community of moral discourse and action shapes our understanding of these issues and our response to them.

This study is both deeply personal and deeply corporate. It is personal because it is we ourselves who are to be transformed and renewed in the depths of our beings. The life of each of us is on the line. But we are also on the line together. We are not a gathering of isolated individuals, but of brothers and sisters who learn from one another and who are accountable to one another. Rightly undertaken, therefore, our study involves mutual commitments and a common discipline.

Questions for Group Discussion

1. Why are we interested in studying euthanasia, assisted suicide, and end-of-life issues? What is there about our own lives that makes the issues important to us? How would we like to be different as a result of this study?

2. What will it mean for us to approach these difficult moral issues as persons who in life and death belong to God? What is (or should be) different about our doing this study together than if it were being done by a group of persons without a common faith in Jesus Christ?

3. What do we owe one another as we undertake this study? How might we become a community of moral discourse? What commitments might we make to one another that would help all of us benefit from the study to the greatest possible extent?

Suggestions for Group Process

1. Read *Ecclesiastes 3:1-22*. Invite participants to join in praying together: **Opening Prayer:** O God of every moment, we read your Word, and so we believe that there is a time, a season, for every purpose under heaven. And yet, when we face the tough issues of intractable pain or overwhelming suffering, and when we know that we have technology to prolong our dying, what does it mean to say, "a time to be born and a time to die"? These words sound so fitting, but then out circumstances blur their meaning. When this happens, O God, how can we know whether it is a time to weep, or a time to mourn? Speak to us, we pray, so that all we say and do together may be synchronized to your timing. In Jesus Christ our Lord. Amen.

2. Invite participants to mention their names and to take a few moments to say why it is that, at this particular moment of their lives, they choose to invest their time and energy in this particular study.

3. Draw out stories from participants based upon their own experiences with family members or friends in the last stages of life. Then, in pairs or threesomes, ask participants to reflect on what obstacles may exist for them personally or for the entire group in discussing this topic. Invite them to share some

of their concerns with the whole class.

4. Discuss with participants the goals for the study and the way you are going to try to achieve them. As you do so, you might wish to make such points as the following:
    a. You will be intentional in looking at euthanasia, assisted suicide, and end-of-life issues not as just anyone might but as people who find their identity in Jesus Christ.
    b. You will therefore be approaching these issues as people who live in a certain way: who pray together, who share their lives with others, who take the concerns of the world seriously and try to understand what is happening in it, who listen carefully to Scripture, and who seek to know God's will for the community and to act upon it.
    c. When this study is over, the most important thing will be not what has been learned about euthanasia, assisted suicide, and end-of-life issues, but whether the participants have grown in faith and in their capacity to live their lives faithfully.
    d. While the content of each of the sessions of the study will be related to euthanasia, assisted suicide, and end-of-life issues, these issues will be framed in such a way as to draw attention to issues of a more general nature, including our identity in Christ, the relationship of faith and culture, and the way Christians make decisions.
    e. We are approaching this study opportunity open to one another's diverse views, opinions, beliefs, and cultural traditions.

5. Invite participants to read together *Romans 12:3-5* and to discuss the commitments they are prepared to make both to themselves and to one another as members of one body of Christ in order to help make the study a success. (Such commitments might include that of being present at each session, carrying out any assignments, praying for the class as a whole and for one another in particular, responding honestly and openly as issues come up in the class sessions, and keeping a journal of thought, feelings, and reflections.)

6. Before concluding, tell participants that in the next session they will be discussing the new challenges and responsibilities presented by advances in medical technology.

7. Conclude by reading *Romans 8:28-39* and inviting participants to pray together:
    Closing Prayer: O God, our source and sovereign, you chart

all of our journeys and every moment of life is in your keeping. We praise you for you never-failing love in Jesus Christ, and we rejoice that you care for us without limit. You hold us close through all circumstances, whether mountaintops of joy or valleys of sorrow. O God, when we walk those valleys, may we remember that we were not born for death but for life. Be with us and with all who cry out, "O Lord, save my life." When the winnowing wind sweeps over us, may we learn to bend and yet not break. And though we are turned about, help out faith remain an ever-fixed mark. In Jesus Christ our Lord. Amen.

SESSION 2

It's a New Day—Or Night

Goals

In this session, participants will (1) list the concerns that make our era a new day (or night) in relation to euthanasia, assisted suicide, and end-of-life issues; (2) explore the social context of these issues; and (3) reflect on what it means to deal with these issues as Christians.

Suggested Resources

Heidelberg Catechism, question 1

A Brief Statement of Faith

Glossary of Terms (Appendix 1)

Suggested Scripture:

Genesis 11:1-9
Psalm 14
1 Corinthians 13:8-13

Supplemental Scripture:

Genesis 1-3
Romans 3:10-18
1 John 1

Critical Issues

The Gospels tell us again and again of Jesus' concern to heal people with physical, emotional, and mental afflictions. Jesus was deeply concerned for the wholeness and well-being of people. As Christians, we too seek the wholeness and well-being of others. We are committed to healing the brokenness of the world and to helping people with illness and disease.

Yet issues of wholeness and healing are complex. We can celebrate the good that medical science offers: More people are able to get well, and people generally live longer. We can affirm a health care system that values and protects our autonomy: We should have a right to receive and refuse treatment. Yet out technology had advanced so rapidly that we are experiencing a new day (or night) in our medical capabilities. Difficult, troubling issues confront us. We have reason to fear that the good we intend with our medicine can become distorted. At what cost do we prolong our dying after many good years of living? At what cost do we prevent those with multiple birth defects from dying, even if their future "quality of life" appears minimal?

These questions imply a number of larger issues. One set of issues concerns our faith in technology. While the best intent of the medical community is to heal, we know that we live in a world of sinful human nature. Are we tempted to make technology our god, seeking to prolong human life at any cost?

A second set of issues concerns the complexities of medical economics. What forces provide for, or prevent access to, health care? How do we provide for just allocation of resources for healing? How do we deal with realities of resource rationing both in our own country and in a world context (where, for example, the cost of one heart transplant may be equivalent to the cost of vaccinating thousands of children in the third world)?

Third, we face issues relating to the nature of suffering, especially suffering at the end of life. What constitutes "quality of life"? How do we care for

the least of our brothers and sisters? What does it mean to be a child of God, dependent both upon God and upon others?

Fourth, there is the danger that the cost of medical treatment will undermine our commitment to compassion. What will happen if a right to euthanasia converges with a situation of economic constraint? How do we guard against the possibility that people will choose death or be pressured to choose death in order to save money?

Questions of euthanasia and assisted suicide cannot be separated from larger issues surrounding suffering and dying. Twentieth-century medical and technological advances have created a new kind of crevice between life and death. In this crevice, we find those whose dying is a lingering twilight, those in a permanently unconscious state, as well as newly-born children with such severe problems that their very existence seems more a biological mischance than a genuine life. Our laws and our ethics have not yet managed to bridge this crevice.

These questions challenge our theology too. How might our Reformed faith address the needs of these living-dead, or dead-living? How might it respond to those who wish to choose death, even if they are still relatively healthy? What does it mean to be a member of Christ's body? Are there limits to our freedom to choose for ourselves?

Christians are called to address these issues from a faith perspective, utilizing the traditional resources of faith: engaging in personal and corporate prayer; reading and appealing to Scripture as the basis for what we believe and do; drawing on the best wisdom of our tradition; engaging in ministries of compassion; acting as faithful stewards of God's creation; seeking justice and living in obedience to God's Word.

The question narrowly defined appears to be whether it is ever morally acceptable and consistent with Christian practice for people to kill themselves or to seek assistance in ending their lives when death is imminent or suffering is intractable.

Yet it is not entirely clear that this question is the most important one for us to ask. As this and the remaining sessions of this study unfold, many other end-of-life issues will emerge, including questions of withdrawal of treatment, alleviation of pain (even at the risk of death), and quality of care. As participants work together, they will consider the possibility that issues of euthanasia and assisted suicide raise a more fundamental question: How do we shape a kind of medicine that concentrates not only upon curing but also upon caring, and where medical personnel and patients are more fully partners in healing and decision-making?

Questions for Group Discussion

1. What in your experience helps explain why euthanasia, assisted suicide, and end-of-life issues have become topics of such great concern over the past century?

2. What current medical technology have you experienced that reassures you? What do you find frightening about it?

3. Which concerns in particular do Christians bring to a discussion of euthanasia, assisted suicide, and end-of-life issues?

Suggestions for Group Process

1. Read aloud *1 Corinthians 13:8-13* and the first question and answer of the *Heidelberg Catechism*. Invite participants to join in praying together:

Opening prayer: O God of all, our fortress and fountain, we celebrate the wonders of life and the goodness of health and the authority of your healing power. We thank you, as well, that you have given us a measure of your own wisdom and a knowledge of how to work for the healing of others. Yet, we admit that our thankfulness sometimes oversteps appreciation and moves to an infatuation with medical technology. Our trust twists away from you to lesser purposes. For this, we are sorry. Be with us as we seek to understand how medicine can be an instrument of your everlasting care as will as a source of bodily cure. Through Jesus Christ our Lord. Amen.

2. As what, if anything, the participants have seen or heard since the last session (newspapers, television, radio, art, etc.) that has reminded them of the concerns of this study.

3. Refer participants to the "Glossary of Terms" (Appendix 1), and ask them to become familiar with it.

4. Invite participants to discuss any personal experiences that help account for why euthanasia, assisted suicide, and end-of-life issues are more of a concern today than a century ago. You may wish to ask them to consider ways they have experienced (a) the ability of modern medicine to keep people alive beyond what was possible in past generations, (b) the impact of suffering on quality of life, and (c) the unevenness in medical about how they experience the technology of modern medicine: What seems reassuring about it? What seems frightening about it?

5. Invite the participants in small groups to consider one or both of the following case studies:

Case A

Alec is a Christian, a 35-year-old man who has a history of heart problems. He wears a pacemaker. He has also been diagnosed with metastatic lung cancer. He has no blood relatives. A close friend has agreed to be the decision maker for him, but Alec has not yet signed a durable power of attorney statement. His illness has brought him to the hospital, where he learns that chemotherapy will provide him, at best, about six more months to live. As he talks with his physician, Dr. Pratt, in the hospital, Alec says that he is tired of fighting his disease, that he does not want to go on with the chemotherapy, and that he no longer wishes to receive morphine for his pain. He is not afraid of addiction; he wants the course of his disease to proceed naturally. Alec also says that he wishes Dr. Pratt to "zap" his pacemaker, to scramble its signal, so he will die. Alec reasons with his

doctor that since he gave permission to insert the pacemaker, he also has the right to request that it be deprogrammed. Dr. Pratt, troubled by the role Alec is asking him to play, consults the hospital's ethics department. Among the concerns Dr. Pratt wishes to discuss are whether deactivating Alec's pacemaker will be considered a lethal action.

Case B

Della is a lifelong Presbyterian and 63-year-old widow. Until her recent hospitalization three weeks ago, she had lived alone in a first floor apartment and enjoyed her independent living. She was admitted to the hospital for difficulty in breathing caused by her pain medication, which gave her relief from the pain of poor circulation in her legs and arms. Della is also a diabetic and has heart problems. Because of her circulatory problems, the doctors are recommending multiple amputations of her fingers and feet. They do not expect her to be able to live alone and predict that she will need constant attention. Her daughter and son-in-law want her to have the operation, though they live in another part of the country and cannot take her into their small home. Della refuses to have the operation. She says, "I have lived a good life. Why should we spend what I have on a nursing home? My daughter, son-in-law, and grandchild would be better off with my insurance money now, rather than go into debt to pay some nursing home to watch me die. If my heart doesn't stop soon, why can't my doctor help me with the pain medication? That would be the most loving thing either one of could do."

Following the discussion in small groups, invite a member of each group to describe in plenary the issues raised by the case they discussed, asking the group as a whole: "Is it morally acceptable and consistent with Christian practice for persons to seek assistance in ending their lives?"

6. Move into a general discussion. Invite people to discuss the way Christians should think about these issues. Remind participants of the affirmation in *A Brief Statement of Faith* that "In life and in death we belong to God." Ask them how this affirmation might affect the way they think about these issues. (You may wish to use the supplemental Scripture readings to help move the discussion forward.)

7. Before ending this session, tell participants that in the next session they will be discussing issues of control, autonomy, and stewardship of our bodies and invite them to prepare by reading chapter 3 of the book *Choosing Death*.

8. Conclude by reading *Psalm 14* and inviting the participants to pray together:
   Closing prayer: O Righteous One of Israel, we acknowledge that we are your children. In life and in death we belong to you and are linked to one another by your love. Help us be more

aware of how dependent we are upon you and how interdependent we are with the rest of your children, who comprise our global family. Give us a greater measure of mutual concern, and restore to us a reciprocal joy in our service to one another. As we join in a shared quest for each other's well-being, may we ever hold in common a reliance upon your grace. Through Jesus Christ our Lord. Amen.

SESSION 3

Whose Life Is It, Anyhow?

Goals

In this session, participants will be invited (1) to discuss why our lives are not ours alone; (2) to explore issues of personal autonomy and life in community; and (3) to determine, from a Christian perspective, whether or not there is such a thing as a right to die.

Suggested Resources

Choosing Death, chapter 3

Westminster Shorter Catechism, question 1

Suggested Scripture:

Genesis 1:26-31
Philippians 2:1-18

Supplemental Scripture:

Genesis 23:4
Exodus 20:13
Deuteronomy 26:5
Judges 21:25
Isaiah 40:8
Matthew 25:31-46
Romans 14:7-9
1 Corinthians 6:20
Ephesians 5:29
Philippians 1:21

Critical Issues

We often live as though life were our own to do with as we please. We are tempted to act as if our lives go on forever and are completely under our control. When we experience constraints on what we wish to do, we protest. We claim a right to choose what is best for ourselves.

Yet none of us can escape nagging anxieties about the end of life. Our desire to be in control of our destiny merely underscores our fear that we really are not in control, that powers and forces greater than ourselves will finally dictate both the way we live now and the way we will eventually die.

We may attempt to ignore these anxieties or even to repress them. We may try to keep ourselves busy with the lives that we wish to make for ourselves. But again and again we experience limits to our efforts. For all our talk about individual rights, we know that we also need others. We long for friendship and community. We long for comfort in the midst of our own brokenness and in the midst of a broken world. We long for ultimate assurance that we make a difference and that we are not entirely alone.

As Christians, we understand life as a gift that we hold in trust from God, our Creator. Even when we succumb to anxious strategies either of trying to control what we cannot or of refusing to do what we can (trusting God and each other), we hear another voice among us, the words of Scripture and of Christians of other times and places, reminding us that we belong to God and that our chief purpose is "to glorify God and enjoy him forever" (*Westminster Shorter Catechism*, question 1).

When we understand that we hold our lives in trust from God, we become all the more aware that life is fragile, precious, and passes so very quickly, that we are therefore called upon to be

good stewards of life, both our own and others'. We also become thankful. We come to mark our lives with daily gestures of gratitude, trusting that God will care for us through life and death, even when we are unable to make sense of them for ourselves anymore.

Yet living by this trust is not easy. As Christians make decisions in the face of suffering and death, we find that the good that we seek for ourselves does not necessarily correspond to the good that God seeks for us.

In broad terms, "personal autonomy" is the major concern here. If our life is God's gift in trust to us, and if death is the end of our earthly life, how do we, as members of the Christian community of moral discourse and action, face death? If God cares for us, must we accept even intractable suffering and a process of prolonged dying? Does God ever ask us to end our life? How do we know, and what do we do when God appears to be absent, giving us no clear answer? What are the limits to our decision-making? If we decide to leave some things in the hands of God, how do we know whether we are trusting God or simply evading the responsibility that God gives us to make decisions?

Personal autonomy also raises the question of accountability to the Christian community. As Christians, we believe that we belong to each other. We are members of the one body of Jesus Christ. What does this community owe each of us individually as we face our deaths, and what do we owe it? Is there any meaningful way in which Christians can guide each other through the valley of the shadow of death (*Psalm 23*)? How far can the Christian community go in asking us to test our decisions against its larger wisdom? Can we ever become such a burden to the community that it has the obligation to let go of us for the common good?

Christian moral tradition has generally been reluctant to allow for the possibility of euthanasia or assisted suicide. It has, however, often justified the decision to withhold or withdraw treatment, even if death results more quickly. The key question has been whether or not medical interventions are able to reverse the dying process.

One finds a similar tension in relation to pain. The Christian tradition has often allowed for the possibility that alleviating pain through drugs may induce death. The key question has been one's intent in administering them.

As we noted in Session 2, we live in a new day. Medical technology puts Christians in a new situation. Because we wish to respond faithfully to the choices that come at life's end, we must examine the wisdom of the past and determine how it speaks to our circumstances today.

Questions for Group Discussion

1. Is life really a gift? Why or why not?

2. How do we as Christians respond to those who assert that we are free to do whatever we please with our lives?

3. Can faithful stewardship of the life that we hold in trust from God ever mean the decision to give it back to God? Why or why not?

4. Is there a right to die or a right to be dead?

5. Is there a difference between putting down a pet and human euthanasia?

6. How might a Christian reconcile the tension between personal autonomy and life in community? To whom am I accountable? Are there limits to our freedom to choose for ourselves?

7. What do we believe about the biblical mandate of dominion over creation? Does it mean to exercise this responsibility over all of life, including those created in the image of God? What responsibility do we have to the senile and comatose?

Suggestions for Group Process

1. Read *Genesis 1:26-31* aloud. Invite participants to join in praying together:
   Opening prayer: O God, our mercy and our might, you give life, and your purpose gives life its meaning. Yet, we avoid your purpose, and instead we carve our names for ourselves. In the carving, we forget you, we forget others. How long, O Lord, until we learn the long-term effects of instant gratification? Our concern is self-worth; yet, what will become of us when, no longer able to work, we ask, "Am I only valuable as long as I am productive?" May we at last return to you and discover life's meaning in you and in your charge to us to care for portions of your creation, and to seek to sustain the very lives of our brothers and our sisters. In Jesus Christ our Lord. Amen.

2. Ask what, if anything, participants have seen or heard since the last session (newspapers, television, radio, art, etc.) that has reminded them of the concerns of this class.

3. In plenary, invite participants to discuss the following quotation from *Choosing Death*: "It's my life do to with as I please, to live out in accordance with my beliefs, values, personality and style" (p. 30). Do we agree? Is this life ours alone? Why or why not?

   or

   In plenary, invite participants to discuss whether there is a difference between the merciful act of putting down a cherished pet and human euthanasia. Is human life an absolute good? Is death an absolute evil? Do we have "mastery" or "dominion" over life? Is there a right to die, a right to be dead?

4. In pairs or threesomes, read *Genesis 1*. Ask participants to reflect upon what it means to be given dominion over God's creation. Ask each group to write a summary statement and to share it with the whole group.

5. Ask participants to discuss the following: To what extent is the

desire to die with dignity a denial of what it means to be created by God? To what extent is the desire to have doctors employ "heroic measures" to save us a denial of what it means to be created by God?

6. Ask members of the group to read aloud *1 Corinthians 6:20*. (You may wish to include some or all of the other supplemental Scripture passages: *Genesis 23:4*, *Exodus 20:13*, *Deuteronomy 26:5*, *Judges 21:25*, *Isaiah 40:8*, *Matthew 25:31-46*, *Romans 14:7-9*, *Ephesians 5:29*, *Philippians 1:21*.) Then, consider how a Christian might resolve the tension between personal autonomy and accountability to God and to the Christian community when considering euthanasia, assisted suicide, and end-of-life issues.

7. Tell participants that in the next session they will be discussing the meaning of "good death" and "bad death." Ask then to read the preface and chapter 2 of *Choosing Death*.

8. Conclude by reading aloud *Philippians 2:1-18* and inviting the participants to pray together:
Closing prayer: O God, our Shepherd and Savior, who in your son Jesus chose to serve rather than to be served and who came to redeem the lost, grant that we may follow you. Guide us in Christ's way, so that we too will put ourselves in the place of the least of our sisters and brothers. There, may we look beyond our own self-interest to the larger scope of human need. In so doing, may we ever know that our ties to one another and our ties to you are not limited by time or circumstance, for in life and in death we belong to you. Through Jesus Christ our Lord. Amen.

SESSION 4

Good Death, Bad Death

Goals

In this session, participants will (1) share with one another what they regard as a "good death" or "bad death"; and (2) reflect on their fears and hopes when they think about dying.

Suggested Resources

Choosing Death, preface and chapter 2

Suggested Scripture:

Deuteronomy 34:1-8
1 Samuel 31:1-6
Job 14:1-4
Luke 2:25-35
John 10:14-18
John 14:25-27
Acts 7:54-60

Supplemental resources:

Phaedo, Plato (The death of Socrates)

The Death of Ivan Ilych, Leo Nikolaevich Tolstoy

How We Die, Sherwin Nuland (chapter on accidents, suicide, and euthanasia)

"Because I Could Not Stop For Death," poem by Emily Dickinson

We Live Too Short and Die Too Long, Walter M. Bortz (chapter on "The Last Passage")

Critical Issues

Our dying is the final, most impenetrable mystery of our lives. Many of us have a tendency to deny its reality, to think about it as little as possible, to live as if death did not, in fact, await us at the bend of the road we are traveling.

When we do manage to contemplate our own mortality, it is natural to imagine the circumstances of our dying and to hope for certain things and to fear others. Having witnessed or heard about others' deaths, we begin to project ourselves forward to our own bend in the road and say, "May it happen like this," or "May it not happen to me like that."

In contemplating our anxieties about our own death, we come face to face with the issue of our limits and finitude as creatures of this earth. Our hopes and fears with respect to our dying reveal a great deal about the values we hold with respect to our living. They are, therefore, immensely valuable material for theological reflection. They are a profound test case, helping us understand with greater clarity what we actually believe about the meaning of life, about God's providence, about human freedom, and about out salvation in Jesus Christ. Needless to say, the reverse can also be true: To clarify our beliefs about life's meaning and God's providence and human freedom and salvation can also be an opportunity to reshape our hopes and fears about our dying.

Questions for Group Discussion

1. How do we define for ourselves "good death" and "bad death"? What is it that we hope for and what is it that we fear with respect to our dying?

2. In what sense is what we hope for (e.g., absence of pain) and what we fear (e.g., loss of control) also that which we hope

for and fear with respect to our living?

3. Does the fact that Jesus Christ claims our lives make it harder or easier for us to die? Is it easier, since we trust that we will inherit eternal life? Is it harder, since God may yet have a reason for us to be alive?

Suggestions for Group Process

1. Read *Job 141-4* together. Invite the group to join in praying together:
   Opening prayer: O God of each of life's passages, we confess that our first reflex is to avoid thoughts of death—especially our own death or that of people we love. Yet, we know that death is part of our human life, and even when we are in the presence of death, you are our very present help. Help us, then, to understand what it means to trust in you. Grant us a calm with a depth of assurance, knowing that neither death nor life, nor things present nor things to come, nor heights nor depths nor anything else can separate us from your love, a love more continuous than the starts. In Jesus Christ our Lord. Amen.

2. Ask what, if anything, participants have seen or heard since the last session that has reminded them of the concerns of this class.

3. If it seems helpful, participants may recall and renew the commitments they made at the first session.

4. Explain to participants that they will spend ten minutes in silence. During the silence, each person should think about "good death" and "bad death," preparing to describe, in about five minutes each (or however much time will be available

5. After the few minutes of silence, invite all the group members to share their thoughts.

6. After all have spoken, spend some time talking about what participants have said. What do they hope for with respect to their deaths? What do they fear the most? Do any of these hopes or fears also relate to what they hope for or fear about their living?

7. Invite participants to consider any differences in perspective that may result from cultural differences among them.

8. In plenary, ask the participants to discuss the following: Does the fact that Jesus Christ claims our lives make it harder or easier for us to think about our own death? Why is it easier? Why is it harder?

9. In plenary, ask participants how being a person of faith might affect what one hopes for or fears with respect to death.

or

Have participants look up *Deuteronomy 34:1-8*, *1 Samuel 31:1-*

6, *Luke 2:25-35*, *John 10:14-18*, *Acts 7:54-60*. In each of these passages, is death "good" or "bad"? Why?

or

If your group is reading *Choosing Death*, you may wish to invite participants to share any particular questions or observations related to the assigned reading in chapter 2. Note any questions for which they hope to receive answers during the remainder of this study. How does the reading connect with the issue of the participants' hopes and fears in respect to their deaths?

10. Before concluding, tell participants that in the next session they will be discussing the suffering of Jesus.

11. Read *John 14:25-27* together. Remind participants to be in prayer for all who are taking part.

As you close in prayer, suggest that people bear in mind the fears and hopes that have been expressed during this session.

Invite the group to join in praying together:

Closing prayer: O God, you are the very soul of concern, and while the world is uncertain, you alone are ever sure. All of life moves to the fullness of your timing, and in life and death we belong to you. We pray for ourselves and all persons that we may not die alone, without our friends or family, nor in a senseless way. Yet, grant that whenever the time comes to die, you will tenderly gather us as pebbles in your holy stream, refresh us with your living water, and keep us in perfect peace, all sorrows ended, all loss restored. In Jesus Christ. Amen.

SESSION 5

Scriptural Perspectives on Suffering and Death

Goals

In this session, participants will (1) listen to different biblical understandings of the meaning of pain, suffering, and death; (2) relate these different understandings to their own life experience; and (3) talk about what it means to be a part of a community that has resolved to listen carefully to Scripture in the fullness of its witness.

Suggested Resources

Choosing Death, chapter 4

Suggested Scripture:

Deuteronomy 30:15-20
Job 42:2-3
Psalm 20:6
Psalm 22:1-21
Psalm 44
Ecclesiastes 3:2-8
Isaiah 53:1-6, 10-12
Amos 8:1-8
Mark 8:31
Mark 15:33-34
John 9:2-3
Romans 5:3-8
Romans 8:18-22
2 Corinthians 4:7-12
Philippians 2:4-11
Colossians 1:24
Hebrews 2:10, 14-18
2 Timothy 1:8, 12

Critical Thinking

Christians listen to Scripture. Scripture helps us unlock the mysteries of human existence. While it is important to know the historical context of particular scriptural passages, our primary concern is to listen to Scripture as God's Word for us today.

One approach to Scripture would be to line up all the passages that seem to speak for or against euthanasia. On the one hand, the Bible affirms life and prohibits murder. On the other hand, the Bible records several stories of suicide without appearing to condemn it.

Yet this approach may be too narrow. For euthanasia, assisted suicide, and end-of-life issues raise basic concerns about our understanding of pain, suffering, and death. Here Scripture has a great deal to say.

When we inquire of Scripture with respect to the meaning of pain, suffering, and death, we discover several strands of thought, a variety of insights and emphases. In some of these strands, pain, suffering, and death are the result of human sin. They represent divine punishment. In other strands, there is no clear reason for pain, suffering, and death. They defy explanation; we are left with the mystery of God's ways, perhaps even a fear of divine neglect. Elsewhere, Scripture sees suffering as having redemptive possibilities; it may deepen our faith. God may even ask us to suffer on behalf of others. Yet Scripture also recognizes that some forms of pain, suffering, and death are the consequence of human oppression and human evil. God asks us to resist the sources and causes of such pain, suffering, and death. Finally, Scripture recognizes that pain, suffering, and death are part of the human condition; they reflect our finitude.

Listening to the whole of Scripture is no easy matter when we have to sort out these different strands and apply them to the complex circumstances that surround euthanasia, assisted suicide, and end-of-life issues. As Christians, we believe, nonetheless, that it is in the whole of Scripture that God meets and speaks to us. Our challenge is to take all of Scripture seriously and to find a way to live within its tensions.

Some may ask, "What do I do with a book filled with tensions, even seeming contradictions?" Perhaps our task is not to deny the various strands, but to view them as pieces of a whole fabric of understanding about suffering. Because human suffering has many facets, it is not surprising that Scripture speaks to it in different ways.

Questions for Group Discussion

1. What points of view do we find in the Bible, with respect to the meaning of pain, suffering, and death? How should the Christian community respond to suffering or death that is perceived in one way or another?

2. How do we understand the fact that Scripture appears to offer different points of view, different strands of thought? Is this fact troubling to us or comforting?

3. What does it mean to take the whole of Scripture seriously? How do we live within the tensions created by the existence of different strands of thought? How do we take seriously the variety of witness about pain, suffering, and death?

Suggestions for Group Process

1. Read *Romans 5:3-4* together. Invite the group to join in prayer together:
   Opening prayer: O God, speak to our hearts and minds. Tell us of your authenticity that is beyond our human understanding. Help us hear you and by your insight know that the voices of human suffering defy any particular time or nation. They are our sisters and brothers who cry out; their experience of suffering is universal to our mortal life. O Present Help, be with us, and with them, with all whose cross seems too great to bear. Help us to place all burdens upon you and to know, even in the midst of turmoil, the peace that you alone can give. In Jesus Christ our Lord. Amen.

2. Invite participants to share anything relating to the issues in this study that has come to their attention since the last session.

3. Divide participants into small groups. Distribute the follow Old Testament texts: (a) *Deuteronomy 30:15-20*; (b) *Psalm 22:1-21*; (c) *Isaiah 53:1-6*; (d) *Amos 8:1-8*; (e) *Ecclesiastes 3:2-8*. (Or use some of the other suggested Scripture passages.) Note that each of these passages has a different understanding of suffering. Ask each group to read it assigned text or text, to talk about what might be inferred from each about the meaning of suffering, and to call to mind a personal experience of suffering that the text suggests.

4. In plenary, have someone from each small group report, sharing what text was read, what perspective on the meaning of suffering they heard in it, and what personal experience of suffering (if any) the text suggested. After each small group has reported, invite people from other small groups to suggest other ways each text might be heard. Finally, invite participants to discuss how the community of faith should relate to anyone who might be experiencing the kind of suffering described in each text. (The way the community responds to those who suffer oppression will be different from the way it responds to those who suffer because of disease.)

5. Ask participants to listen to the following texts from the New Testament: (a) *Mark 15:33-34*; (b) *2 Corinthians 4:7-12*; (c) *Hebrews 2:10, 14-18*; and (d) *Philippians 2:4-11*. (Or use some of the other suggested Scripture passages.) Again ask them to identify the meaning or significance of suffering in each passage.

6. Part of our Christian identity is that we take all of Scripture seriously. Is it possible to do so even if there appear to be voices and viewpoints that are in tension with one another?

7. Before concluding, tell participants that in the next session they will be visiting with persons who have either considered euthanasia or assisted death for themselves, or have been close to persons who have considered such an option. Explain that the purpose of the session will be to clarify the issues from the perspective both of health care providers and of sufferers.

8. Read *Isaiah 53:2-12* together. Invite the group to join in prayer together:
   Closing prayer: O merciful God, you have given us your Word and shown us in Jesus our Savior that when we suffer, you suffer alongside us, that our pain is your pain, our despair is your despair. Hear our cry for comfort in time of distress! Come quickly, O God, and meet our every need, extending your brokenness as our source of wholeness, your torment as our source of relief. In all times and places, may we remember that in you we live and move and have our being, and may we hold fast to the truth that in life and in death we belong to you. Through Jesus our Lord. Amen.

SESSION 6

The Experience of Sufferers: A Personal Encounter

Goals

In this session, participants will (1) listen to the stories of persons, including persons of faith, who have contemplated euthanasia or assisted suicide themselves, or who have known or worked professionally with persons who have contemplated one or the other, or who have grappled with other end-of-life decisions; (2) become aware of some of the factors that lead people to consider the option of euthanasia or assisted suicide; and (3) hear how health care workers and patients think about pain, suffering, and death and about the possibility of effectively relieving pain and suffering.

Suggested Resources

Suggested Scripture:

Psalm 42:11
1 Peter 3:12-14

Critical Issues

It is possible to discuss pain, suffering, and death as theoretical issues. They are, however, anything but theoretical. Together they constitute a major portion of human experience.

One way to convince ourselves of the issues under discussion is to deliberately put ourselves in contact with persons who are struggling with them. Such contact provides us an opportunity to increase our awareness of the complexity of the issues and to test the reality of whatever ideas we have about them.

Listening to the experience of sufferers may help us face complex issues that we would often rather avoid. To come face-to-face with the pain, suffering, and death of others may also be the "means of grace" that allows us to face our own pain, suffering, and death.

Special Instructions for Preparing This Session

In preparing for this session, participants are asked to discuss among themselves whom they might invite to speak our of their own life experience as it relates to these issues. While groups may feel some hesitancy about inviting such people, especially from within the congregation, forming such a panel can also be an opportunity to bring members to a deeper appreciation of each other's struggles and perspectives.

Guest speakers could include legal and medical professionals, family members of persons who are sick, parents of children with terminal illnesses, chronically ill persons, and/or persons on dialysis. In virtually every congregation, there will be persons who have faced end-of-life decisions for themselves or with others.

Also, most congregations will access to agencies that care for persons with terminal illness (cancer, AIDS) as well as agencies that advocate a particular position on euthanasia and assisted suicide, such as the Hemlock Society or the American Suicide Foundation.

Participants may need to consider other options if no one in the local community is available to serve as a guest speaker. Persons in the group might be invited to focus on their own personal experiences

where end-of-life decisions had to be made and the question of euthanasia or assisted suicide came up or could have come up. Whether the guest speakers are from within or beyond the local congregation, be sure that there are people present to facilitate the discussion and to support the persons who share information. If it is helpful, consider adding another session or two to the study in order to have several meetings with guest speakers.

Another option is to utilize videos. The National Bioethics Resource Center has a good library of such videos.

Suggestions for Group Process

1. Read *Psalm 42:11*. Invite the participants to join in praying together:
   Opening prayer: O God of storm and stillness, we offer you our thanks and praise, for you are with us in all times and through all circumstances. We ask your blessing upon all who are in pain this day, and for whom the future holds little hope for recovery from illness. We pray that you might surround them with your tender mercies and bless them in ways beyond our earthly art or science. We pray as well for all who work with those who are facing death, or who help to meet the needs of those whose daily realities include terrible anguish of body, mind, or spirit. Help us to minister unto them and to see how they minister to us, as together we seek wisdom. In Jesus Christ our Lord. Amen.

2. Introduce the guests and participants to each other. Explain to the guests that participants are involved in a study of euthanasia, assisted suicide, and end-of-life issues and that they are trying to learn how to think about these issues as people of Christian faith. Explain that as a part of the study it will help participants to hear the personal stories of some who have contemplated euthanasia or assisted suicide, or who have actually been involved with ending life in one way or another, whether by euthanasia, assisted suicide, or other end-of-life decisions, such as withdrawal or withholding of treatment.

3. Then invite the guests to share their stories. Afterward, participants in the study are likely to have questions, and the guests may well have questions that they would like to put to the participants. Encourage participants in the study to write down any new insights.

4. Before concluding, remind participants to read chapter 5 of *Choosing Death* for next time.

5. Conclude by thanking the guests for their help. Then read *1 Peter 3:12-14* and invite guests and participants to join in praying together:
   Closing prayer: O God, our word and our source of wisdom, we thank you for the witness of those who share their stories with us. Because they have opened their life journeys to us, we can begin to sense the wide range of feelings present when we

consider suffering and pain.
Help us, by hearing them, to
discern ways in which we and
your church can more faithfully
serve you by serving them,
remembering that in life and in
death we belong to you.
Through the action of the Holy
Spirit and in the love of Jesus
Christ. Amen.

SESSION 7

The Experience of Sufferers: What We Learn

Goals

In this session, participants will (1) think together about insights that they have gained from the guests' personal struggles with euthanasia, assisted suicide, and end-of-life decisions; (2) examine which of their insights and experiences helped us better understand these issues and which raised new questions; (3) discuss ways in which our Christian faith might help any who are dealing personally with euthanasia, assisted suicide, and end-of-life decisions; and (4) discuss the difference between pain and suffering.

Suggested Resources

Insights offered by guests in Session 6

Choosing Death, chapter 5

Suggested Scripture:

Judges 16:23-31
2 Samuel 18:9-33
Job 1 & 2:1-10
Psalm 139
Matthew 27:5
Luke 19:41-42
John 1:1-5
John 9:11-12
2 Corinthians 12:7-10
(also see the passages listed for Session 5)

Supplemental resources:

Medical Nemesis, Ivan Illich
The Nature of Suffering, Eric Cassell

Critical Issues

The guest speakers from the previous session may have made us aware in new ways of the complexities of the debate relating to euthanasia, assisted suicide, and end-of-life issues. Particular guests may have given us insight into legal, moral, or medical dimensions of these issues. Others may have shared either explicitly or implicitly their own struggle to resolve their questions about euthanasia and assisted suicide.

As we listened to any guests who described their suffering, we may have learned that it is difficult to determine just what constitutes pain. While patients' descriptions of pain may be so vivid and intense that we feel overwhelmed, medical science has no adequate way to measure or gauge pain. Within the medical community, people debate whether or not there exists pain too severe for medicine to alleviate without inducing death.

Another consideration may be the difference between pain and suffering. Some mistakenly think that if we diminish the pain, the suffering too will decrease. But pain and suffering are not identical. Even when one's pain is under control, one's suffering, one's sense of being burdened, can continue.

Yet another consideration may be the array of emotions expressed by people who contemplate assisted suicide and euthanasia regret, remorse, sorrow, guilt, embarrassment, pain, loneliness, estrangement, abandonment. Persons of faith may be called upon to help sufferers recognize and address these emotions.

Finally, those who suffer have an effect on those around them. When one contemplates or indeed chooses euthanasia or assisted suicide, family members, close friends, concerned neighbors, and the community in general experience many feelings—including anger and anguish. Again, the community of faith may be able to help people deal with these feelings.

Questions for Group Discussion

1. What aspects of the guests' information and experience added to our understanding of euthanasia, assisted suicide, and end-of-life issues?

2. What aspects of the guests' information and experience challenged us to think in new ways about euthanasia, assisted suicide, and end-of-life issues? What, if anything, disturbed us?

3. What might our Christian faith say to these particular guests, who shared what it means for them to have contemplated the questions surrounding euthanasia, assisted suicide, and end-of-life decisions?

4. What are the differences between pain and suffering?

Suggestions for Group Process

1. Read *Psalm 139* together. Invite the participants to join in praying together:
   Opening prayer: O God, our root and vine, we pray for all whose lives are intertwined with those who are facing death. Be with them all: those who stand beside loved ones in the valley of the shadows; those who wait upon others in a ministry of presence and prayer; those who carry in their hearts bitter memories, painful regrets, harsh remorse, or the anguish of broken relationships. Comfort the lonely, be with all who are left behind, and by your presence, ease their melancholy. In Jesus Christ our Lord. Amen.

2. Ask what, if anything, participants have seen or heard since the last session that has reminded them of the concerns of this class.

3. Ask participants in pairs or threesomes to discuss which of the comments made by the guests in Session 6 were helpful to their understanding of euthanasia, assisted suicide, and end-of-life issues. Similarly, invite participants to discuss which of the comments made by the guests raised questions or concerns.

   or

   In pairs or threesomes, ask participants to list on newsprint or a chalkboard the feelings expressed by the guests in Session 6 (e.g., anger, anguish, pain, remorse, embarrassment, guilt, regret, fear of abandonment). How might we respond to each of these feelings?

4. Ask persons in the class to keep in mind the comments of the guest speakers while reading aloud several of the passages of

Scripture that appeared in Session 5: (a) *Deuteronomy 30:15-20*; (b) *Psalm 22:1-21*; (c) *Isaiah 53:1-6*; (d) *Amos 8:1-8*; (e) *Ecclesiastes 3:2-8*; (f) *Mark 15:33-34*; (g) *2 Corinthians 4:7-12*; (h) *Hebrews 2:10, 14-18*; and (i) *Philippians 2:4-11*. (Or use some of the other suggested Scripture passages.) Ask participants to consider, in a period of silence, which of the texts help them better understand what is happening in the lives of the guests and which do not.

5. Following the period of silence, invite participants to share the results of their personal reflections. Which of the texts help make sense of suffering and which do not? Why or why not?

6. Ask participants to reflect upon the experiences of the guest speakers with regard to pain and suffering. Encourage them to identify the difference between pain and suffering.

7. Tell participants that in the next session they will be discussing the meaning of suffering. Ask them to read chapter 4 in *Choosing Death*.

8. Conclude by reading *John 1:1-5* and inviting the participants to pray together:
   Closing prayer: O God, whose life all life conferred, if we but knew how, our aim would be to soothe the bodily pain of those whose lives are broken, and to grant a solace to those whose minds are assailed by anguish. We would, as well, seek to lift the spirits of all who are downhearted. In your great mercy, help us to help others in their distress. We pray your blessing for all whose misery is beyond our ability to grant relief, or whose sorrow is beyond our gift of consolation. In their woe, O God, be their ever-present comfort. Surround them with the assurance that in all circumstances, in life and in death, they belong to you. In Jesus Christ. Amen.

SESSION 8
Christ's Suffering

Goals

In this session, participants will (1) consider a portion of the witness of Scripture that speaks of the suffering and death of Jesus Christ; (2) think about what it means to be a people who find their identity in Christ and are enjoyed to "have the same mind" as he had; and (3) as persons who find their identity in Christ, relate their thinking about euthanasia, assisted suicide, and end-of-life issues.

Suggested Resources

Suggested Scripture:

Job 42:2-3
Psalm 20:6
Psalm 22:1-21
Psalm 44
Deuteronomy 30:15-20
Ecclesiastes 3:2-8
Isaiah 53:1-6, 10-12
Amos 8:1-8
Mark 8:31-9:1, 9:30-32, 10:32-34
Mark 15:21-41
John 9:2-3
Romans 5:3-8
Romans 8:18-22
2 Corinthians 4:7-12
Philippians 2:1-11
Colossians 1:24
2 Timothy 1:8, 12
Hebrews 2:10, 14-18

Critical Issues

Christians acknowledge that their identity and the very meaning and purpose of their lives is found in Jesus Christ. To know ourselves in Christ, however, we must first listen carefully to Scripture's witness to him.

At the very heart of the biblical witness to Jesus is a story that includes pain, suffering, and death. Jesus is the one who relieved the suffering of many with whom he came into contact, and he is the one who called back to life a friend who had died. But he is also the one who, when his own time had come, entrusted himself into God's hands and endured suffering and death for the sake of the life of the world.

For people of faith, Christ's witness stands as a profound challenge to our culture's assumptions that the "good death" is easy and painless, while the "bad death" is hard and painful. If ever a death was "good", it was that of Jesus, for it is to that death that we owe our life in God. But, if ever a death was "bad," in terms of suffering and pain, it was also that of Jesus.

What a challenge Scripture gives us, therefore, when it enjoins us to "have the same mind" Christ had, or when it tells us that we are to take up our cross and follow him. On the one hand, Jesus' suffering and death do not necessarily give us any clear guidance for our decisions in the face of suffering and death. Jesus died at the hands of sinners; most of us will die of disease or perhaps in a tragic accident. Jesus understood God to require him to suffer on behalf of a sinful world; our suffering may appear to have no intrinsic value. For us to have the same mind as Christ is for us to focus first of all on his ministry, not to equate our suffering and dying with his.

On the other hand, we may find meaning in our own experience of pain, suffering, and death as we contemplate Jesus' crucifixion. The one who has gone before us has plumbed the depths of human experience. We are not alone as we face the mystery of our own end.

This tension challenges us to exercise great care in relating Christ's suffering to our own. Rather than being a source of comfort, Christ's suffering may actually remind us that we too often seek to escape the kind of suffering that Jesus endured. Yet Christ's suffering also testifies to God's compelling power in human life. In contemplating the mystery of Christ's suffering, we may become aware in a new way of God's power to sustain us and to call us to new life even in the midst of our suffering and dying.

Perhaps of equally great consequences for our understanding of suffering and death is Jesus' resurrection. By virtue of our baptism, we share in that resurrection. We trust that our lives belong to God. Sin and death do not have the last word; they cannot ultimately rob our lives of meaning. How, then, do we live as a resurrection people as we face suffering and death? How does our confidence in sharing in "life everlasting" free us to take responsibility for whatever decisions present themselves to us in our final days and hours?

Here too are dangers. We easily trivialize the resurrection, seeking to avoid the reality of suffering and death. We may try to forget that suffering and dying also bring moments of despair. Jesus' own words from the cross remind us that he himself felt forsaken in his suffering and dying.

Both the cross and the resurrection teach us not only of God's presence, but also of the experience of God's absence. A life of faith does not save us from moments of doubt and protest. We can believe even now, however, that Christ has claimed us as his own, regardless of the struggles and questions that we face in moments of intense suffering and in our final hours.

Questions for Group Discussion

1. In what sense can it be said that the most important thing about the life of Jesus Christ was his death?

2. What do we learn about pain, suffering, and death from Jesus' life and ministry? From his death?

3. How does the scriptural witness about the life and death of Jesus challenge or affirm our own notions about "good death" and "bad death"?

4. With respect to our own deaths, what might it mean to follow Jesus, to have the same mind he had? What would it *not* mean?

5. In what respect was Christ's suffering unique and not applicable to our own?

Suggestions for Group Process

1. Read *Mark 15:33-39* together. Invite the group to join in prayer together:
   Opening prayer: O God of mystery and meaning, we cannot

sufficiently understand your limitless love. You care for us to such an extent that you accepted undeserved ridicule, and an unthinkable death on our behalf. Yet, we know all we need to know, that you did it, and that you did it for us. We can do no more and no less than thank you, love you in return, and pledge ourselves to you. We know that a part of human life is suffering. And while we would recoil from needless, irrational suffering, help us not to shrink when you call us to bear crosses for the sake and in the name of Jesus Christ our Lord. Amen.

2. Ask what, if anything, participants have seen or heard since the last session that has reminded them of concerns of this class.

3. Write on the chalkboard or newsprint the following Old Testament texts: (a) *Job 42:2-3* (in which Job resigns himself to the undeniable, yet baffling wisdom of God); (b) *Psalm 44* (which assails God violently for neglecting the people); (c) *Psalm 20:6* (which suggests suffering is divine education by which the people will return to God); and (d) *Isaiah 53:10-12* (which affirms that God suffers in solidarity with humanity). (Alternatively, participants could revisit the Old Testament texts listed in Session 5). Suggest that participants read each text in silence, imagining themselves to be Jewish followers of Jesus who are trying to make sense of his suffering and death in the days following his crucifixion. Ask them to decide which texts help them understand what happened to Jesus and which do not.

4. Following the period of silence, invite participants to share the results of their personal reflections. Which texts help them make sense of Jesus' suffering and death, and which do not? Why does each help or not help?

5. Ask participants to listen to these New Testament texts: (a) *Mark 8:31-9:1* (in which Jesus explains that he must suffer and die—also see *9:30-32* and *10:32-34*); (b) *John 9:2-3* (in which Jesus sees suffering not as a consequence of sin, but as an opportunity for God to work); (c) *Romans 5:3-8* (in which Paul says that suffering can teach Christians endurance); (d) *Romans 8:18-22* (in which Paul sees suffering as relatively unimportant in the full context of God's plans and purposes); (e) *2 Corinthians 4:7-12* and/or *Colossians 1:24* and/or *2 Timothy 1:8, 12* (which speak of the suffering that the church must be prepared to endure). (Alternatively, participants could revisit the New Testament texts listed in Session 5). After each text has been read, invite conversation. Which passages help participants understand the suffering and dying that they may someday face?

or

Read the story of Jesus' death in *Mark 15:21-41*. Talk together about what you have heard. Was it a "good death" or a "bad death"? On what grounds would one call it either?

6. Invite participants to talk with one another about what they have heard during this session and about what they think and feel about what they have heard. Is it important to listen to Scripture in this way? Do we really want to be persons who have in ourselves "the same mind that was in Christ Jesus?" If we do wish to be such persons, what can we do to help make it happen?

7. Ask the participants to discuss the following:

    a. Did Jesus choose to end his life? If you believe that he did, do you see parallels to people considering euthanasia or assisted suicide? Why or why not?

    b. How was Christ's suffering unique and not comparable to our own?

8. Tell participants that in the next session they will be discussing the possibility of knowing when one's time has come.

9. Read *Philippians 2:1-11* together. Invite participants to join in prayer together and to remember all those Christians throughout the world who are also praying to be conformed to the mind of Christ. If they wish, participants may voice brief prayers, then close by praying together:
   Closing prayer: O God, our counselor and comfort, our lives are lived in the light of your presence. In life and in death we belong to you. Yet, to each there comes a time when life and death collide, with a dimming of the light and a drawing-down of the blinds. While our every instinct tells us to rage against the dying of the light, we know that in Jesus our Lord is light and life eternal. Help us cherish this tender grace you give us, hear the sound of your still voice, and trust your love which never fails. In Jesus Christ our Lord. Amen.

SESSION 9

On the Possibility of Knowing That One's Time Has Come

Goals

In this session, participants will (1) discuss the possibility of knowing that "one's time has come"; (2) discuss how one might determine whether his or her time, or the time of another, had come; and (3) discuss how the suffering and death of Jesus Christ help us reflect on the question of knowing one's time.

Suggested Resources

Suggested Scripture:

Exodus 13:21-22
1 Kings 19:9-13
Mark 8:31-33, 9:30-32, 10:32-34
Luke 9:51

Supplemental Scripture:

1 Kings 21
Job 38:4, 42:2-3
Ecclesiastes 3
Isaiah 55:8
Luke 2:25-35
John 2:4
John 12:27-33
John 13:1
John 14:16
Acts 13:1-3
Acts 15
Romans 8:26
Galatians 4:4

Critical Issues

Some persons at some point in their lives decide that their "time has come." They conclude that they have lived enough, have accomplished enough, have loved enough. They are ready, perhaps even eager, to die. Death for such persons becomes a friend. By the same token, it is not uncommon for such persons to discover later that they were mistaken. The mystery is that many times we do not know and cannot predict when death may be near. (Indeed, a third of all deaths are sudden and without forewarning.)

The theological issues are complex. For instance, *what* is it that one "knows" if that one's time has come? Does one know that God is ready for a given life to end, or does one know only that God is permitting one to exercise her or his freedom to allow death to come?

Second, *how* does one come to know such a thing? Is it a private determination that requires no confirmation from the community of faith? What is there to ensure that the decision is not simply a reaction out of fatigue or depression in the aftermath of much pain and suffering?

And third, is it really possible that death, the "last enemy" (see 1 Corinthians 15:26) can finally be regarded by a person of faith as a friend? How should a Christian view death? And what about those whose families include those of other faiths, or of no faith?

Jesus himself seemed to know that his time had come. Yet his death for the life of the world, after persecution and at the hands of sinners, is a calling few of us experience. What may we learn from Jesus' experience and what should we not learn, we who one day may wish to know whether our time or the time of another has come?

Questions for Group Discussion

1. Is it possible for us to know that our time has come? That the time for another has come? How would we know?

2. How might we faithfully test our sense that our time or the time of another has come?

3. What do we learn about our suffering and dying from Jesus' way of approaching his suffering and dying?

Suggestions for Group Process

1. Read *Exodus 13:21-22* together. Invite the group to join in prayer together:

   Opening prayer: O God of cloud and fire, God of all wisdom and knowledge, all certainty rests upon your truth and all flawless insight comes from you. It is you discernment that we seek so that we may comprehend the circumstances of our lives. We are so grateful that by grasping your truth we may begin to perceive what is right, and that by following your counsel, we may start to understand what we are to do. We ask your perfect guidance in all of life, and especially when we seek to identify the end of life. Help us watch the signs so that we may recognize your voice calling us home. And when our time comes, may we ever remember that in life and in death we belong to you. Through Jesus Christ. Amen.

2. Invite participants to share anything relating to the themes of the class that they have heard, seen or thought since the last session.

3. Tell the group that in this session we will be thinking about whether or not it is possible to "know that one's time has come," and if so, how one can know such a thing. Invite participants to spend a few moments in silence reflecting on a time when they knew that their lives were reaching some important turning point. How did they know? In retrospect, how confident are they that their knowing was accurate? Ask them to reflect upon a time when they did not now that they were reaching some important turning point. After a few moments of silence, invite a few persons to share their stories if they wish.

4. Invite participants to share stories about persons they have known who thought their time had come. What led those persons to believe that their time had come? Was it in some way tied to a medical disclosure? Have any of the participants thought that their own time had come? Is it possible to will one's self to die? How might we faithfully test our sense that our time or the time of another has come? You may wish to include some or all of the supplemental Scripture passages to augment this discussion.

5. Read the following texts: *Mark 8:31-33*; *9:30-32*; *10:32-34*; *Luke 9:51*. Did Jesus know that his time had come? How did he know? How did he act on his knowledge, or not act? Would his example help us to know

whether our own time or the time of another had come? Why, or why not?

6. Tell participants that in the next session they will be discussing issues of caring for the suffering and dying.

7. Read *1 Kings 19:9-13* together. Invite the group to join in a prayer together:

Closing prayer: O God, who speaks through fire, wind, and earthquake, help us ever to listen for your still, small voice! When our life circumstances become extreme and it seems that we alone are left to cope with illness, degeneration, and pain, bring to us, we pray, your timely message of direction and pertinence. Even as you hear every earnestly whispered prayer, help us, as we call to you, to know your timing for our lives and to trust you, even when it is time for us to die. For in you we live and move and have our being, and ever and always we are yours, O God. Through Jesus Christ our Lord. Amen.

SESSION 10

Responses of Caring

Goals

In this session, participants will (1) discuss ways in which the church can be a community of caring and compassionate action as people confront euthanasia, assisted suicide, and end-of-life issues; (2) identify obstacles that keep the church from being this kind of community; (3) discuss ways in which we can share the love and grace of Jesus Christ with persons in crisis; and (4) seek ways to pray for each other.

Suggested Resources

Descent Into Hell, Charles Williams (chapter on "The Doctrine of Substituted Love")

Suggested Scripture:

Psalm 23
1 Corinthians 13:4-7
Galatians 6:2
1 John 4:7-8

Supplemental Scripture:

Genesis 1
Ruth 1:16-17
Matthew 7:12
Luke 6:31, Isaiah 53:4
Romans 12:17
Romans 14:7-9
James 2:8-26

Supplemental Resources:

The Death of Ivan Ilych, Leo Nikolaevich Tolstoy

"Whose Participation and Whose Humanity? Medicine's Challenge to Theological Anthropology," Brian Childs, in *The Treasure of Earthen Vessels: Exploration in Theological Anthropology*, ed. Brian H. Childs and David W. Waanders

Hope Springs from Mended Places: Images of Grace in the Shadows of Life, Diane M. Komp

Critical Issues

In the face of pain, suffering, and death, doctors seek cures that will restore us to health. This concern for healing has deep roots in the Christian tradition. The Christian community has often been at the forefront of establishing and supporting hospitals and clinics and of training people to enter medical professions.

At the same time, the church has understood itself to be concerned with more than curing. As a company of the faithful, we also seek to become a community of caring, a community of compassion. Caring includes measures to cure disease and illness but goes beyond them.

When we care for each other, we seek to be present to each other. Even when we cannot cure another, we can stand by him or her. Our very physical presence may bring comfort. A loving touch may be as powerful as words. Or we may find ourselves simply listening, encouraging those in distress to tell us the best and the worst of all they are experiencing. Even when others can no longer recognize our care, our standing by them in the presence of death may offer us privileged moments of remembering and experiencing God's mysterious grace.

Yet such caring is not easy. Those who are suffering and dying may resist it. Despair, on the one hand, and a desire for control and autonomy, on the other, especially in those moments when one feels least in control, can wrap a band of isolation around a person. In such a situation, Christians are challenged not to impose their presence on others, but also not to abandon them.

Caring is also difficult because the Christian community itself is imperfect. We find ourselves with busy schedules. Individual caregivers may reach points of exhaustion. They may find themselves torn between the needs of the one who is suffering or dying and the needs of his or her family or friends who feel unable to deal with the situation. In other cases, communities may find their resources of money and energy depleted. Moreover, there is concern about intruding into other people's lives. And those who are suffering and dying may make us feel uncomfortable, even anxious, if we find ourselves thinking about our own dying.

It is also important that we examine our own motivations if offering care. We may be tempted to believe that we can do more than we really can. In priding ourselves on our commitment to care for others, we may fail to recognize that there is a time to let go.

Yet the Christians discipline of caring is all the more important in a world in which many fear that their suffering and dying will put them at the mercy of machines and experts. The very cry for euthanasia and assistance in dying may reflect people's fear of abandonment and of becoming a mere object of futile efforts to "cure" them in their last days and hours.

Public interest in a "right to die" may also reflect a fear of death, a sense of powerlessness and depression in the face of death. As Christians, we acknowledge that any of us may one day utter, like Jesus, "My God, my God, why have you forsaken me?" Yet we believe that even in the darkest moments of despair, such a cry also conveys an enduring hope that God will hear. We wish, therefore, to be present to others and to comfort them.

Such caring continues even when medical treatment reaches its limits and is only futile. Such caring may include honest words that the time has come to withhold or even withdraw treatment that can no longer restore life. Such caring may require the Christian community to take initiative in developing and supporting new models of car, such as hospice. Such caring also challenges the Christian community to find ways to support and assist medical professionals to deepen their own capacity to integrate caring and curing.

Within the Christian community itself, prayer will have a special place as Christians minister to those who are suffering and dying. Through prayer, the Christian community seeks wholeness and healing for those in need. Christians cannot promise that prayer will cure people. They pray not because it guarantees a better "success rate," but because it opens the possibility of our recognizing God's Spirit moving among us, caring for us in life and in death, as people who belong to God.

Questions for Group Discussion

1. How might the church be a community of caring and compassion for all those who face end-of-life issues, including decisions relating to euthanasia and assisted suicide?

2. What obstacles prevent the church of Jesus Christ from being this kind of community?

3. How might Christians better share the love and grace of Jesus Christ with persons in crisis?

4. How might Christians better pray with persons facing life-and-death decisions and predicaments? For what might one pray? Why?

Suggestions for Group Process

1. Read *1 Corinthians 13:4-7* and invite the group to join in prayer together:

   Opening prayer: O compassionate and caring God, you alone grant healing, and all you touch receives comfort. Thank you for listening to our concerns with infinite patience and love. We would satisfy the needs of others as Jesus did, waiting with those who wait, weeping with those who weep, in a personal encounter, with a calm and peace to go beyond words or understanding. Help us press forward into all places in an attitude of prayer, so that in diminishing isolation and increasing community, we may represent you and your church. Fashion us as agents of your peace. We ask in Jesus' name. Amen.

2. Ask participants to share anything relating to the issues in this study that has come to their attention since the last session.

3. Read *Psalm 23* aloud together.

then

In small groups, invite participants to discuss ways in which the church can be a community of caring and compassion for those who are confronting end-of-life issues and may even be considering euthanasia or assisted suicide. Have participants list these ways on chart paper and share them with the entire group. Help participants become aware of any resources that may be unfamiliar to them, such as hospice care.

or

In plenary, have participants identify particular individuals in their congregation who are presently facing these kinds of decisions. Ask participants what the congregation might be doing to minister to these people. Try to be specific and concrete about your strategies for caring for them.

4. In plenary, consider which obstacles keep the church from being a community of care.

5. Ask members of the group to read aloud from the supplemental Scripture passages.

or

Read together excerpts from the chapter entitled "The Doctrine of Substituted Love" in British novelist Charles Williams' book, *Descent Into Hell* and *Galatians 6:2*.

then

Ask the group to think of ways we might try to express the love and grace of Jesus Christ toward persons in crisis (such as being present, using touch, listening, becoming aware of others' emotions, speaking a word of love, praying).

6. Share a time when prayer has made a difference in your life or in the life of someone you know. As a group, discuss ways in which prayer opens us to God's presence.

7. Tell participants that in the next session they will be discussing ways in which Christians and the church might respond to public policy relating to euthanasia, assisted suicide, and end-of-life issues. Ask them to read *Choosing Death*, chapter 6.

8. Read *1 John 4:7-8* together. Invite participants to conclude in prayer together:

Closing prayer: O God of encounters, who meets us in all phases of life and who challenges us to live the adventure of the unfolding of time, may we seek for others the wholeness we would like for ourselves. Gather us from wherever we have wandered; confront us with our responsibilities to our neighbors, our sisters and brothers, all who are your children. Greet us with an assuring word that overcomes our every fear. Answer us in our thundering doubts; satisfy us in our unquenchable fearsome place. May we be thankful, now and always, that in life and in death we belong to you, O God. In Jesus Christ our Lord. Amen.

SESSION 11

Public Policy: Striving for a Better World

Goals

In this session, participants will (1) discuss the role of Christians in effecting change in society; (2) consider ways in which this study might influence their outlook on public policy relating to euthanasia, assisted suicide, and end-of-life issues; and (3) seek to identify projected action for the future.

Suggested Resources

Choosing Death, chapter 6

The Confession of 1967

Suggested Scripture:

Isaiah 65:17-25
Amos 5:24
Matthew 25:31-46
Acts 3:1-10, 4:13-14
1 John 5:19
Revelation 21:1-4

Critical Issues

The General Assembly overture that called for this study of euthanasia and assisted suicide noted that the Presbyterian Church (U.S.A.) could "no longer remain aloof from this important debate" if it were to "be responsible to the mission and ministry of Jesus Christ." Since the Assembly's action, several states have considered ballot initiatives to legalize euthanasia and/or assisted suicide under certain circumstances. It seems clear that these issues will remain on the legislative agenda in the days ahead.

As Christians, we profess Jesus not only as our Savior but also as our Lord. This Lord claims us not only for salvation but also for service. From the ago of John Calvin onward, we Presbyterians have stressed our calling to order society in ways that reflect God's will. As we confront issues of euthanasia and assisted suicide, we again find ourselves called to help shape public policy.

Yet those questions of euthanasia and assisted suicide are complex. In calling for the study of euthanasia and assisted suicide, the General Assembly explicitly directed the Office of Theology and Worship to prepare study materials, not a denominational position paper. Moreover, the task force that met to prepare these materials found its own thinking evolving to include broader issues of care for the terminally ill.

The church will have to decide whether to support, reject, reframe, or ignore particular proposals for public policy and legislation relating to euthanasia and assisted suicide. But these are not the only public policy questions and are not necessarily the most important public policy questions. While the public debate of euthanasia and assisted suicide is sometimes posed in terms of "right" language, something more may be going on. The public interest in euthanasia and assisted suicide may, in fact, reflect people's fear that they will be abandoned in their times of suffering and dying and become objects of an impersonal medical establishment.

Both as a community of caring (see Session 10) and in its commitment to just public policies and legislation, the Christian community can speak to this

fear. First, the Christian community can support public policies that inform patients of their right to refuse treatment. The Christian moral tradition allows for the possibility of withholding or withdrawing treatment when it can no longer restore life. People should not have to fear that others will unnecessarily prolong their dying.

Second, the Christian community can work to guarantee health care to all people. In a society without universal health care, the legalization of euthanasia and assisted suicide could implicitly pressure the most vulnerable to choose death rather than to burden society with the expenses for their treatment. People should not have to fear that their lives are worth less than others'. Nor should they choose death out of a temporary depression that may be treatable and reversible—a major issue of concern, since some studies suggest that the overwhelming majority of people seeking euthanasia or assisted suicide are in fact suffering from treatable forms of depression.

Third, the Christian community can support public establishment of hospice and similar programs that help relieve people of the fear of dying alone and out of control. Similarly, the Christian community can support public policies that encourage research into pain management and that educate health care professionals in pain management, so that no patient has to choose death out of fear of intractable pain.

Fourth, the Christian community can support the establishment of public commissions and panels that provide for our nation's best minds to discuss end-of-life issues and to consider strategies that we do not yet have or have not yet adequately implemented. Questions of euthanasia and assisted suicide belong to this larger context.

Fifth, the Christian community can help engage society in consideration of the larger implications of legalizing euthanasia and assisted suicide. It is important to note that hard cases do not necessarily make for good law. Some who support the possibility of euthanasia and assisted suicide under certain circumstances, nonetheless argue against legalization. The Christian community will be concerned about ways in which laws shape public morality and about legalization of euthanasia and assisted suicide if it further devalues life in a society in which violence is rampant and not all members of society feel valued.

Christ calls us to risk involving ourselves in the world. The question is how we can be most faithful God and to each other as these debates continue. Perhaps we still need time for consensus to emerge both in the church and in society on issues of such complexity. Perhaps it is right to continue our study of these issues, seeking to be thoughtful and prayerful, until such consensus emerges.

Questions for Group Discussion

1. Do Christians have an obligation to help shape public policy? Why or why not?

2. Which public policy questions does the euthanasia/assisted suicide debate raise?

3. Should Presbyterians now develop a position paper on euthanasia and assisted suicide,

seeking to influence legislation one way or another? Why or why not?

Suggestions for Group Process

1. Read *Isaiah 65:17-25* together. Invite the group to join in prayer together:

   Opening prayer: O Perfect One of Israel, we live in an imperfect world. We are an imperfect people, an indistinct reflection of your flawless design. So too, our hospitals and medical abilities, wonderful as they may be, nonetheless comprise an imperfect system of healing efforts, all too underdeveloped and all too inaccessible. You are unlimited power and purpose; may we be your representatives as we work to transform public policy, until the long awaited day when all of your children may receive without restriction the full measure of healing you intend for them. In Jesus Christ our Lord. Amen.

2. Invite participants to share anything that has come to their attention since the last session.

3. Distribute Part III ("The Fulfillment of Reconciliation") from *The Confession of 1967*, emphasizing the following:

   God's redeeming work in Jesus Christ embraces the whole of man's life; social and cultural, economic and political, scientific and technological, individual and corporate…With an urgency born of this hope the church applies itself to present tasks and strives for a better world. It does not identify limited progress with the kingdom of God on earth, nor does it despair in the face of disappointment and defeat.

   Then, invite discussion with respect to the role of the church as a community of moral discourse and action by posing this question: Do Christians have a responsibility to shape the life of the greater society? Why or why not?

4. Divide the participants into five small groups. Assign each group one of the five positions on public policy in chapter 6 of *Choosing Death* (Margaret Murphey, Robert Moss, Don C. Shaw, Albert R. Johnson, Albert W. Alschuler). Invite each group to develop a plan for action in the area of public policy based on its assigned viewpoint. In plenary, request each small group to report their action plans. Note similarities and discrepancies and highlight areas of agreement.

   or

   Read Isaiah *65:17-25* again (or one of the other suggested Scripture passages). Before reading, ask participants to listen to the text with ears sensitive to the issues that they have been discussing over the last weeks. Then, invite conversation about what the participants heard in the reading that suggests how the church could strive for a better world where pain, suffering, and

the threat of death will lose their dehumanizing power.

5. Inquire if any participants believe that the group as a whole should undertake initiatives in the area of public policy. If so, ask if any participants would like to work on the development of these initiatives.

6. Remind participants that the next session will be the final session and that they will be discussing how any of their perspectives have changed over the course of the study.

7. Conclude by reading *Revelation 21:1-4* and inviting the participants to pray together:

Closing prayer: O Word of Life, you have called us to speak to one another your good news. Yet, in so many corners of our communities, the news is not good. Make us bold to speak your truth, so we may say to the medical community your word of justice for all. May we speak to our dehumanizing social structures your will for equities in service and dignity. May we speak to the favoritism still present in our judicial system your spirit of impartiality that transcends the letter of narrow laws. Until that day, O God, may we not rest our voices in the cry for truth! This we ask in Jesus' name. Amen.

SESSION 12
Conclusion

Goals

In this session, participants will (1) review the study as a whole; (2) share with one another ways in which they have grown in faith; and (3) identify what they have learned about dealing openly with a complex and controversial issue.

Suggested Resources

"A Commitment to Caring" (see Appendix 4)

Suggested Scripture:

Ecclesiastes 3:1-22
Romans 14:7-9

Critical Issues

See the statement under "Critical Issues" for Session 1.

Questions for Group Discussion

1. Was the study a success? Why or why not? What were the high points of the study and why? What sessions were the most difficult or disturbing and why?

2. What key questions have emerged? (Responses might include such issues as autonomy and accountability; the relationship between the Creator and the created; suffering, both redemptive and meaningless; access to health care.

3. How have we been changed? How are we different at the end of this study? Do we know more? Is our faith stronger? Are we living our faith in new ways? Has this study prompted (or could it prompt) new or further outreach toward meeting the needs of persons facing end-of-life decisions? Has our study been (or could it become) the occasion for other initiatives on our part (educational, public policy, etc.)?

4. What did participants learn about how a group of Christians can deal openly with a complex and controversial issue? How has this study impacted us? In what ways has this study been helpful in providing material for our denomination in developing public policy?

5. How did you feel about the topic of euthanasia/assisted suicide when this study began? How do you feel about it now? Do you think that euthanasia or assisted suicide can be a faithful decision? Why or why not? How does your understanding of what we owe God and each other affect your response?

6. If you do see euthanasia/assisted suicide as an option, under what conditions and with which safeguards? If you do not see it as an option, what are the alternatives?

7. Should the church take a stand on the legalization of euthanasia and assisted suicide? Why or why not? If we close the discussion, are we better off or not as a

society and a church? Who are the winners and the losers if euthanasia and assisted suicide are legalized?

Suggestions for Group Process

1. Read *Romans 14:7-9* together. Invite the group to join in prayer together:

   Opening prayer: O God, assist us in sharing what we have learned, so we may pass it on the others who face these issues. Make us alert to the many ways in which we can work to change inequities in out health community. Give us minds of faith and hearts of compassion to provide comfort for all who suffer and experience pain. Even as you are working out your purposes, O God, make us persons of open minds and willing hearts, so we do not shy from difficult issues, not resist the transforming wind of your Holy Spirit. Even as you prompt us, may we respond by joining in the pursuit of righteousness for all people, and by entering into the enterprise of fulfilling your plan for all creation. Through Jesus Christ our Lord. Amen.

2. Invite participants to tell about anything new they have heard, seen, or thought since the last session in relation to the themes under discussion in this study.

3. Share with participants the statement under "Critical Issues" in Session 1 of this study guide.

   or

   Explain to participants the possibility of participating in a Commitment to Caring as one response to this study. Read aloud the Commitment to Caring statement (Appendix 4).

   then

   Invite discussion on the study as a whole in light of the "Critical Issues" or the Commitment to Caring. How, if at all, have the faith and life of the participants been affected by this study? What, if anything, might they wish to do in response?

4. Invite participants to respond to any and all of the "Questions for Group Discussion" listed for Session 12.

5. Invite participants to fill out the response form on pp. 57-59. Please return forms to the Office of Theology. Your comments will help the Office Theology determine whether to take additional steps to address issues relating to euthanasia, assisted suicide, and end-of-life decisions. A summary of responses will be shared with the General Assembly and General Assembly Council.

6. Read *Ecclesiastes 3:1-22* together. Invite the group to join in prayer together:

   Closing prayer: O matchless God, we have gathered trusting one another and trusting you as we seek to understand end-of-life issues, including concerns surrounding euthanasia and

assisted suicide. The questions are so many! Like pieces of an unformed quilt, they have at times confounded us. Yet, we have looked at the many hues of the affected lives and the many shapes of the arguments pro and con and in between. In the looking, we have tried to see the pattern of your hand amid the crazy-work. We have searched, as well, for a way in which to put together the pieces in a design favorable to others and pleasing to you. We know that, in this study, our work has only begun. Still and awed, we pray it would form a motif for the future, for ourselves, and for our church, until we realize the full potential of our calling, remembering that in life and in death, we belong to you, O God. In Jesus Christ our Lord. Amen.

APPENDIX 1

Glossary of Terms

With acknowledgement to Tom L. Beauchamp, J. Fletcher, Robert George, Richard M. Gula, Steven Miles, Edmund D. Pellegrino, and Lawrence Schneiderman.

Assisted Suicide: See *suicide*. Assisting in suicide entails one's being a necessary and relevant condition of death, but not a sufficient condition. Assisting in suicide requires affirmative, assertive, proximate, direct conduct such as furnishing a gun, poison knife, or other instrumentality or usable means by which another could physically and immediately inflict some death-producing injury upon himself or herself. Such situations are far different than the mere presence of a doctor during the exercise of a patient's constitutional rights to refuse treatment.

Autonomy: Rule of the self. To be author of one's life plan.

Euthanasia—Mercy Killing: Death is intended by at least one other person who is either the cause of death or a casually relevant condition of the death. The person who is to die is either acutely suffering or irreversibly comatose (or soon will be), and this alone is the primary reason for intending the person's death.

Futility: Inability to achieve goals of an action, no matter how often repeated; an expectation of success that is either predictable or empirically so unlikely that its exact probability is incalculable; interventions that are physiologically implausible or are statistically improbable, unproven, or of no value to the patient as a person.

Involuntary Euthanasia: See *euthanasia*. Carried out without the patient's consent when it could have been obtained. Also includes euthanasia performed against the patient's wishes.

Nonvoluntary Euthanasia: See *euthanasia*. Performed when consent cannot be obtained, as in the case of comatose, profoundly demented, or retarded persons.

Passive Euthanasia: Thought by most scholars not to be a useful concept. Withdrawing or withholding treatment that the patient does not want because the relief afforded by it would not outweigh the burden resulting from it. Confuses euthanasia with the well-established and acceptable practice of withholding or withdrawing useless treatment.

Suicide: Acts or omissions that intentionally bring about one's death.

Voluntary Euthanasia: See *euthanasia*. Done with the patient's consent. An active or direct means to end the life of a dying person who requests another to terminate his or her life in the name of mercy.

APPENDIX 2

A Sermon and a Response

I.
THE CHRISTIAN FAITH AND EUTHANASIA

A sermon from the pulpit of
THE BRYN MAWR PRESBYTERIAN CHURCH
Bryn Mawr, Pennsylvania
November 7, 1993
By
Dr. Eugene C. Bay

Readings: *Genesis 1:26-31*
Romans 14:1-12

Text: So then, each of us will be accountable to God (*Romans 14:12*).

Earlier this fall, I said that any congregation that is serious about Christian nurture has to be ready and willing to explore the complex and often ambiguous issues with which people are confronted today. I am devoting this morning's sermon time to one such matter. It involves decisions that some within this congregation have already had to make. Many more will likely be involved with such questions in the future.

Let me say, at the outset, that this sermon is not intended as any kind of final word. My purpose is not to *stop* conversation, but to get it *started*. Whether or not you agree with me doesn't matter. That you think about these issues from a Christian perspective does.

I should also say that my topic is more inclusive than the sermon title might suggest. The word "euthanasia" is a combination of two Greek words meaning "a good death." These days, the word refers to the taking of the life of a terminally ill or dying person for reasons of compassion—either by *doing* something to cause death, called "*active* euthanasia," or by *not* doing something that might prolong life, called "*passive* euthanasia."

The topic, as I conceive it, has many dimensions: physician assisted dying—of which Dr. Kevorkian is the most prominent, if also one of the least ethical, examples; the freedom to refuse medical treatment, or to stop treatment once it has begun; the responsibilities of physicians, nurses, hospitals, and nursing homes; the involvement of family members; the role of the courts; and the question of how, as a society, we should allocate health care resources. In other words, I have in mind the broad range of issues concerning what is sometimes called "the right to die."

So far, I have been talking about these matters in an abstract and impersonal way. But these issues come to our attention because they involve real people. It's time to meet a few of them.

Dr. and Mrs. Henry Pitt VanDusen, for example. Some of you may recall hearing, some twenty years ago, about their double suicide. Dr. VanDusen was a Presbyterian minister and a former president of Union Theological Seminary in New York. At the time of their suicide, he and his wife were both elderly, both physically enfeebled, and both intellectually alert. They left a letter saying that their infirmities had

become intolerable, and that their decision to end their lives was an expression of Christian stewardship, thoughtfully and prayerfully made… What do you think? Is it possible for such a decision to be called "Christian"?

Another, "for instance." Diane was diagnosed as having acute leukemia. After exploring her options with her physician and her family, she not only decided to refuse treatment, but asked her doctor if he would help her end her life when *she* determined the time had come to give it up. After many discussions with Diane and much soul-searching, the physician gave Diane a prescription for barbiturates, exacting from her a promise to consult him before taking enough of them to commit suicide. Months later, the two of them met for what was to be the final time. Of that encounter, the physician writes: "…It was clear that (Diane) knew what she was doing, that she was sad and frightened to be leaving, but that she would be even more terrified to stay and suffer…" Two days later her husband called to say that Diane had died.[1] …What do you think? Should Diane's doctor be condemned or commended?

Charles Lukey was a pastor. He died a few years ago of a rare disease that, as one man describes it, involves "a galloping degeneration of the nerve cells." When the crisis came, Lukey wrote a letter to his friends. "What," he asked, "does the Christian do when he stands over the abyss of his own death and the doctors have told him that the disease is ravaging his brain and that his whole personality may be warped, twisted, changed?" Then, does the Christian have any right to self-destruction, especially when he knows that the changed personality may bring out some horrible beast within himself? Answering his own questions, Lukey said: "…it comes to me that, ultimately and finally, the Christian has always to view life as a gift from God, and see that every precious drop of life was not earned but was a grace, lovingly bestowed on him by his Creator, and it is not his to pick up and smash.

"And so," Lukey went on, "I find the position of suicide untenable, not because I lack the courage to blow out my brains, but rather because of my deep abiding faith in the Creator who put the brains there in the first place. And now the result is that I lie here blind in my bed and trust in the loving, sustaining power of the great Creator who knew and loved me before I was fashioned in my mother's womb. But I do not think it is wrong to pray for an early release from this diseased and ravaged carcass."[2]

This is a courageous and profound state of faith! …What do you think? Could someone else have made a different choice and been equally faithful in doing so? Or did Lukey make the only possible *Christian* decision?

A final example. Elizabeth is twenty-eight and suffering from severe cerebral palsy. She is a quadriplegic and wholly unable to care for herself. She also suffers from degenerative arthritis and is in continuous pain. She wants to die. The guess is that by force-feeding her, Elizabeth could live another fifteen or twenty years. Right-to-life advocates believe she has a duty to live. Elizabeth has gone to court to secure permission to forego medical treatment or life support through mechanical means.[3] What do

you think? Does Elizabeth have the right to say when her life no longer has quality or meaning? Or, is she obligated to wait until her body revolts against the medical technologies that are keeping her alive?

Time was when questions such as these had neither to be asked nor answered. Life and death decisions were made *for* us, not *by* us. The tragedy was that many people died before their time, prematurely.

Today, the situation is different. Some children and young people will die before their time, as some in this congregation know only too well. But now there are many older people who feel that they have lived *beyond* their time. Medical technology is able to prolong life and cure disease, but it can also keep "alive" those who are severely brain damaged, or the comatose, or those, like Elizabeth, who no longer want to live.

The result is that, today, what people fear, sometimes, is not the approach of death, but its postponement—they fear that their dying will be prolonged beyond what is reasonable, or that their lives will be extended when their dignity and purpose have long since disappeared. It's because of this new situation that we are facing the issued of euthanasia and the related questions I mentioned earlier.

The question is how, given this new situation, we can make wise, compassionate, faithful moral choices. As Christians, what should we keep in mind as we encounter these new and difficult dilemmas? As I have thought about it, here are some things I have come to see as important.

First, we need to remember the biblical warning about human frailty and human sinfulness. We are limited in wisdom. We are imperfect people, with mixed motives and hidden agendas. So, as regards these life and death decisions, caution is called for, not recklessness. Ethicists are right to worry about "the slippery slope"—a way of saying that once we start down a certain path, something like gravity will pull us further along. Applied to euthanasia, the worry is that once we allow physicians, or others, to end the lives of people like Diane or Elizabeth, it won't stop there, and before long we will be intervening to end the lives of the senile, say, or of handicapped newborns, or the lives of those whose care is judged to be too expensive.

This cautionary note is important, but for me, at least, it doesn't end the discussion, or relieve us from the responsibility and burden of deciding in individual instances. So what other guidance is there?

There is, of course, the biblical admonition to "choose life," along with the commandment *not* to kill. But, at the time when Moses urged his people to "choose life," the definition of life was simple: if you were breathing only because he or she is hooked up to a machine? Again, is the command not to kill absolute? What about killing in self-defense? What about war? What about capital punishment? In these cases, many Christians make exceptions to the rule. Is euthanasia another possible exception? These biblical injunctions are important, but they don't end the

discussion either, they don't relieve us from the burden of decision-making.

So where are we? With regard to these life and death dilemmas, where we are, and where we will always be, I think is somewhere between two poles of a theological kind: one we might call "finitude" and the other, "freedom."

At the one end, near the pole labeled "finitude," the emphasis is on acceptance, on playing the hand that life deals you, not complaining about the quality of the cards, but playing them to the best of your ability—in other words, accepting whatever comes, be it good or bad, joyful or sad, and seeking in and through your acceptance to honor God. Of the people we met earlier, Charles Lukey heroically represents this response.

At the other end of the spectrum, near the pole labeled "freedom," the emphasis is on taking responsibility. The passage read earlier, from Genesis, seems to encourage this response. For there it is said that human beings are created in God's image and are given "dominion." When, in other words, we take responsibility for our lives, we are not usurping a divine prerogative, but only assuming our God-given power and responsibility. The VanDusens are representatives of this response.

Somewhere along this spectrum, between finitude and freedom, between acceptance and responsibility, Christians will take their place as they are confronted by these life and death decisions. Rarely will we confront a clear moral choice. Most of the time the choice will be ambiguous. And my contention is that there may well be more than one acceptable decision from a Christian perspective. As a Christian community we should, of course, support a Charles Lukey when he chooses to live out his life, come what may. But should we not also respond compassionately to a Diane or an Elizabeth, not condemning, but valuing a different kind of courage and faithfulness?

Which is where the lesson read earlier, from Romans, comes into the picture. The issue Paul was dealing with seems trivial when compared with the questions we are thinking about. But his warning against making one's own decisions normative for everybody else, applies nonetheless. Each of us, says Paul, is accountable to God. But even though we all are equally serious about our accountability, we may not all arrive at the same decision. And Paul pleads with us to refrain from easy judgments about the difficult decisions others make.

One final thought: I am persuaded that this new situation in which we find ourselves should cause us to re-examine our understandings of both life and death.

Those who oppose "the right to die," for example, are often heard to speak of the "sacredness" of life. Life is a precious gift, to be received with gratitude and treated with utmost respect. But, while life is precious, for people of faith it is not the only thing of value in this world. Something more important can cause us to put our lives on the line. It is clear teaching of the New Testament that something more important caused Jesus to put his obedience to his heavenly Father. "No one takes my life from me," Jesus said.

"but I lay it down of my own accord." The question is, may people like the VanDusens, or Diane, or Elizabeth also lay down their lives if and when they decide that their lives have become unbearably painful and without meaning? My own answer is yes, that *can* be a faithful decision. And as a pastor, I have supported people in making such a decision.

We also need to think anew about death—about how to define or recognize it. A hospital chaplain by the name of Gerald Oosterveen, writes: "It is time for the Christian community to see death in a broader context than mere biological or brain death…A human being is more than the total of his or her functions, more than heartbeat and breathing and brain flow combined. Life is relationships with God and human beings." He goes on: "As the evidence mounts that a loved one will never again have a meaningful relationship with another human being on earth, is that person not dead? …Have we, as committed Christians, the right to bring to the bedside every possible machine, drug or procedure that cannot change the ultimate outcome but only prolongs the dying process? If," Oosterveen concludes, "we truly believe that 'this world is not our home, that we are only passing through,' how can we justify delaying the going-home of a dying person? Do we," he asks, "love our loved ones enough to let go? And do we trust God enough to let our loved ones enter into God's presence?"[4] I would add: As Christians, should not our perspective on these matters be different from those who hold onto life because they have nothing else to hold onto?

We are faced today with choices our grandparents did not have to make. It's obvious that I cannot offer you a few easy solutions on how to deal with these questions, something to laminate in plastic and carry in your wallet. As regards those two poles I talked about earlier, I myself gravitate—not without fear and trembling—to the responsibility side. But you will have to determine your own position. What I want to do, above all, this morning, is remind you that you are not alone as you make these life-and-death decisions. Whether you are deciding for yourself or another, whether you are patient or physician, family member or friend, attorney or pastor, God is with you in your struggle. Be confident of that. Do the best you can. And know that God's grace and mercy surround you.

II.
MEMORANDUM

DATE: June 20, 1994
TO: Gene Bay
FROM: Rich Allman
SUBJECT: THE CHRISTIAN FAITH AND EUTHANASIA

Thank you for your willingness thoughtfully and courageously to address a vexing issue which engages our concern as professionals and as Christians. I am pleased to accept your invitation to use what you have said as a beginning of dialogue. Areas of common ground exist; areas of confusion should be clarified; areas of irreconcilable difference summon our need for mutual respect. You are familiar with my position, often stated—you might say overstated!

I believe euthanasia to be bad medicine, misapplied compassion, and

socially destructive. My views, if not very original are deeply felt, hopefully coherent, and open to what I know will be your spirited rebuttal.

Regarding euthanasia, no matter how merciful the intent, the result is still the deliberate killing our patients distorts and perverts the purpose of medicine, which is to facilitate healing. Notice I didn't say curing, which is often, and ultimately always impossible, but rather I said healing. The good of healing can and must be achieved by means other than killing patients. We cannot heal and improve our patients' lives by ending those lives. We can improve their lives as Stanley Hauerwas writes by embodying fidelity in our commitment to be partners in a caring community and by being present to those we cannot cure.[5] In a single act of mercy, or desperation, or exasperation, or annoyance, or faulty judgment, to deliberately end the life of a patient is a wrong turn on the road to human dignity. It deprives dying persons of the opportunity for the proper relational and spiritual closure that will occur for those whose symptoms are controlled and whose care givers are the presence Hauerwas demands. At a time when medicine stands accused of a technocratic, impersonal approach to patients, sanctioned killing is a wrong way back to improved doctor-patient communications. Even if one generation—my generation—of physicians would carry out euthanasia with awe, respect, fear and trembling, the routine would soon become rote and mechanistic and simply another treatment choice. It would undermine and abort the genuine progress we have made in patient self-determination and high touch, as opposed to high tech end-of-life care. The prohibition of medical killing has been a genuine impetus to developments in palliative care. We should take further steps in improving our patients' dying rather than taking the wrong step and simply kill them.

What ought we to think of a society that conspires to work out way to kill patients before it has provided a decent minimum of health care for 37 million of its citizens? A related question is: Will euthanasia become a tool for resource allocation? In any inevitable multitiered health care system, will those with more robust levels of coverage get comprehensive medical care? Will those with more limited coverage more frequently be economically compelled to opt for euthanasia? A further societal concern is: When in human history has moral progress occurred when the circumstances for sanctioned killing have been expanded? I know from conversations that you share some of these concerns.

After hearing, reading, and rereading your sermon, I was disturbed by how much I agreed with much of what you said. I even feared that my mind might be changed! Paraphrasing, but hopefully staying true to your thoughts, I share your rejection of the idolatry of biological life. Physical conditions that are gravely burdensome do exist, certainly in the opinion of those who suffer such torments. Life without the possibility of any human interaction is no life at all. The preservations of such life violate the standards of good medicine, evoked as early as Hippocrates, who admonished doctors to recognize when patients were overmastered by disease. I am persuaded that such pointless and

meddlesome therapy violates sound theological practice as well.

Those faithful people in your sermon who chose to end their lives all had moving narratives. Most suicides are in the context of depression and thus are not truly autonomous or rational, but some are. Statistically, fewer than 2 percent of suicides are for the kinds of situations you have so movingly described. Rather than to condemn or commend, I prefer to wonder if the choice taken was the only way to face what was happening in their lives. I am uncomfortable with endorsing suicide when the statistical odds are so overwhelming that the act is neither autonomous nor rational, although admitting it may occasionally be. Similarly, I am fearful of a retreat from medicine's, society's, and hopefully the church's commitment to the prevention of suicide. Yale Psychiatrist Patricia Wesley has properly wondered how Diane would have responded had Dr. Quill as an act of human nurturing said "no…but" to her request for barbiturates and, instead of referring her to the Hemlock Society, had referred her to a cancer support group and suicide prevention society.[6]

Where I come down in the face of progressive disability and decline is to support, comfort, be a presence, and try to render healing that is neither biological cure nor medicalized assault with unwanted burdensome interventions that provide no benefits to the patient as a person. Good care requires attentiveness to medical needs and symptom control, even if that symptom control runs the risk, acceptable I believe, of shortening life by suppression of respiration. Vigorous pastoral care and the interactive and nurturing techniques we can learn from you and your colleagues are vital adjuncts to the care of the dying. You can do something that as a physician I cannot do, that is, to help the sick and dying understand the meaning of their suffering and of the presence of God and God's servants in the face of inevitable demise. You can also serve as valued intermediaries in helping the dying, their loved ones, and their care givers to establish treatment goals that meet their needs and life plan at penultimate moments. Ventilators, intravenous lines, dialysis machines, and feeding tubes are poor substitutes for the humanity God wants us to provide. Intensively kind, supportive end-of-life care ought not to be confused with intensive care and mechanical life support. The morally, as opposed to technically, heroic care I refer to must be medically and technologically restrained, unencumbered by the idea that if something can be done, it must be done.

In your sermon, you set out to think about euthanasia, but what you accomplished was to present in a Christian context a catalogue of alternatives to euthanasia, some of which, like assisted suicide trouble me, others of which such as honoring patient wishes for withholding of treatment or withdrawal of burdensome and futile treatment, as a physician, I demand. In our own faith tradition, Bonhoeffer writes that where death is only one of several plausible choices, it is the choice that always must be rejected.[7]

This from a man who paid with his life for the conviction—correct, I believe—that the only way out of the moral sewer that was Nazi Germany was

by the assassination of Hitler. The kind of intervention and nonintervention you describe and directly or inferentially endorse provides a rich menu of alternatives to that which would take us as health professionals and Christians onto a pernicious path of medicalized killing of persons.

You framed end-of-life decision-making on a continuum between the extremes of finitude and freedom. I prefer to think of two separate continua. One has as its polar extremes finitude and infinitude. The other continuum has as its polar extremes enslavement and at the opposite end hubris and license. The midpoint of this continuum is freedom. Where medicine gets into trouble is when we deny the finitude of biologic life and of our resources to preserve that life, however burdensome or poor its quality. If we as physicians deny the finitude of human existence, we will acknowledge no limits to what we can do and no limits to how much of society's resources are to be used in such an elusive quest. At the end of this misbegotten journey, human death and decline still await. Human finitude, if I might quote a prior sermon of yours that still resonates, demonstrates to us who is God, and who is not. I perceive that the opposite of finitude is God, who though incomprehensible except in the person of Jesus, is the only infiniteness I can imagine. The other continuum is one more grounded in values. Enslavement to pointless technology and hubristic notions of control by acts such as euthanasia and other acts that assume medicine can control everything are the polar extremes. Patient choices about treatment options, within proper moral boundaries, coincide with the virtuous midpoint of that continuum at a place called freedom. Such freedom excludes the impulse to euthanasia, which would be the Janis Joplin freedom—just another word for nothing left to lose. Finding the moral locus of freedom is better than asking an old and honorable (though admittedly flawed) profession to take on a role it has historically rejected. This would grant to physicians a responsibility society heretofore has only given to soldiers, police, and executioners, that of killing persons. What would we call mistakes? Malpractice? Homicide?

Gene, your ministry is a constant blessing and gift in the lives of my fellow congregants, my family, and myself. One of the reasons why this is so is because of the seriousness with which take your ordination vows. As a physician, on the day I graduated from medical school, I too swore an oath to all that I hold holy to live my life in a certain way. Whether one swears the oath of Hippocrates, or of Maimonides, or of the World Health Organization, a constant element of those oaths is that we will not, even if asked, kill our patients. This moral precept has stood our profession in good stead for two and a half millennia. I hope the church will always hold my colleagues and me to fidelity to the oath. Within the confines of that prohibition has developed a rich matrix of palliative, comfort care; pain control; and end-of-life care. If an urgency exists in our society, it is to make that care available to all—"to the least of these"—rather than to add a new and grotesque dimension such as killing by physicians or physician-assisted suicide. If a place for such activity exists, it is neither historically, uniquely, nor properly medical. Anyone with access to a knife, a gun, a poison, a rope,

a club, or a live electrical wire could do the deed.

As a moral profession, medicine at its best responds to prophetic voices, both within and beyond the institutional religious community. Sometimes those voices arise within our professional community. Leon Kass raises such a voice. He writes:

> People who are for autonomy and dignity should try to reverse this dehumanization of the last stages of life, instead of giving dehumanization its final triumph by welcoming the desperate goodbye-to-all that is contained in one final plea for poison…
>
> …Should doctors cave in, should doctors become technical dispensers of death, they will not only be abandoning their posts, their patients, and their duty to care; they will set the worse sort of example for the community at large—teaching technicism and so-called humaneness where encouragement and humanity are both required and sorely lacking. On the other hand, should physicians hold fast…should doctors learn that finitude is no disgrace and that human wholeness can be cared for to the very end, medicine may serve not only the good of its patients but also, by example, the failing moral health of modern times."[8]

As a Christian physician, I can only try to hold to such high standards. End-of-life care still has its purpose—enrichment of whatever limited and compromised life remains. The British AIDS hospice physician, Robert George, in his "quest…for dignity, hope, freedom, and healing for our patients as they pass through death," [9] quotes a more familiar prophetic voice, Isaiah:

> The Spirit of the Sovereign Lord is on me, because the Lord has anointed me to preach good news to the poor. He has sent me to bind up the broken hearted, to proclaim freedom for the captives and release from darkness for the prisoners, to proclaim the year of the Lord's favor and the day of vengeance of our God, to comfort all who mourn, and provide for those who grieve in Zion—to bestow on them a crown of beauty instead of ashes, the oil of gladness instead of mourning, and a garment of praise instead of a spirit of despair. They will be called oaks of righteousness, a planting of the Lord for the display of his splendor. (Isaiah 61:1-3, NIV)

This is how I believe good doctors, good patients, and a good society achieve their freedom in the face of finitude. To take up your summons, it's the best I can do. And thanks for the assurance that God's grace and mercy surround me as a person and as a physician.

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[1] Timothy E. Quill. M.D., "Death and Dignity"—A Case of Individualized Decision Making," *The New England Journal of Medicine*, (March 7, 1991): 691-694.
[2] James W. Crawford, *Worthy to Raise Issues* (Cleveland: Pilgrim Press, 1991), p. 41.
[3] Howard Moody, "Life Sentence," *Christianity and Crisis* (October 12, 1987).
[4] Gerald Oosterveen, "Decisions at Life's End," *Presbyterian Survey* (November, 1993): 19.
[5] S. Hauerwas and R. Bondi, "Memory, Community, and Reasons for Living: Reflection on Suicide and Euthanasia," in S. Hauerwas, *Truthfulness and Tragedy* (Notre Dame, IN: University of Notre Dame Press, 1977).
[6] P. Wesley, "Dying Safely," *Issues in Law and Medicine* 8 (1993): 467-85.
[7] D. Bonhoeffer, *Ethics*, trans. N. H. Smith (New York: MacMillan, 1995), pp. 160-6.
[8] L. R. Kass, "Neither for Love Nor Money: Why Doctors Must Not Kill," *Public Interest* 94 (Winter 1989): 25-46.
[9] R. George, "Euthanasia: The AIDS Dimension," in *Death Without Dignity*, ed. N. Cameron (Rutherford House, 1990), pp. 176-195.

APPENDIX 3

Prior Denominational Statements on Euthanasia

I.
EXCERPTS FROM "THE NATURE AND VALUE OF HUMAN LIFE"

A Paper Adopted by the 121st General Assembly (1981) of the Presbyterian Church in the United States and Commended to the Church for Study

pp. 16-19

Euthanasia. The topic of euthanasia is complicated by the fact that one term is often applied to quite different kinds of circumstances. Therefore it is important at the outset to make a fundamental distinction between taking life (sometimes referred to as "active euthanasia") and allowing to die (sometimes referred to as "passive euthanasia"). Our consideration of each of these matters will be carried out in terms of the framework utilized in the discussion of abortions.

(i.) *Taking Life*. "Active euthanasia" is a question that arises in situations of medical extremity where it is thought that an individual is beyond the reach of medical care. Some have at least posed the question of whether the most humane treatment might be to terminate life. However, the dominant value of respect for human life and its accompanying obligations to do no harm and to protect from harm establish a clear prejudice against such direct taking of life. The only relevant question for us is whether there is a conceivable conflict between these obligations. Once again it is also necessary to formulate a judgment about which obligation is more expressive of respect for life if conflict is seen to exist.

Perhaps cases of intense and unrelievable pain furnish the most difficult examples. Because human beings are finite creatures, we know that there are definite limits to the amount of pain that anyone can bear without having the relational quality of their life completely consumed by the relentless battle with pain. It is not terribly difficult to imagine some such circumstance where we would be inclined to perceive the obligations to do no harm and to protect from harm as being in direct conflict. The harms also would appear to be proportionate to one another since uninterrupted, intense pain can probably destroy the ability to enjoy relationships as fully as can physical death. Thus the judgment called for at this point in the process would be the designation of which obligation is more consistent with respect for life in this situation. It might be argued that contradiction of its meaning and purpose and causes such palpable harm to the person in question, that greater respect is shown for life by giving priority to the obligation to protect from harm.

Happily extreme situations of such intense and unrelievable pain are less and less likely in the context of modern medical services, especially with the availability of pain relieving drugs. Therefore, the conflict of obligations just described can often be reduced through drug therapy. While human life might be less than ideal under such treatment, it does not present us with a direct conflict between the obligations of doing

no harm and protecting from harm. Nonetheless, there may be circumstances which have no access to such medical treatment and which would continue to pose a situation of conflict. Moreover, there may be other circumstances than sheer pain which could present us with a conflict of obligations. Thus it is useful to illustrate the procedure of determining whether a conflict exists and which obligation best satisfies the concern for respect for life. It reminds us as well that certain tragic choices do confront us at the boundaries, for which we do well to have a clear procedure to guide our consideration.

If and when we are confronted by such boundary choices, caution and consultation are important ingredients of our deliberations. From our earlier considerations on the moral character of human life, we recall our proclivity to let our self-interest cloud our judgments on important matters. From our analysis of the finite character of human life we also recall limitations on our knowledge and the importance of being aware of all relevant knowledge. Thus we should not encourage hasty decision-making, nor should we abandon patients, families, and doctors to make such monumental decisions with the collaboration of other experts. Here too there is a need for relatively disinterested helpers in the decision-making process, so that judgments satisfying the moral claims described in this study might be reached.

"Active euthanasia" is extremely difficult to defend morally. There are, however, extreme circumstances in which we may have to at least raise the question of a fundamental conflict of obligations. There is an analogy between such cases of "active euthanasia" and abortions, questions that are based on the circumstances of the fetus. There is an accompanying prejudice against the taking of life in both cases, since the conflict between doing no harm and protecting from harm has reference to one and the same individual. The ambiguity of this situation serves to reinforce what has already been said about cautious and consultative decision-making.

(ii.) *Allowing to Die*. "Passive euthanasia" presents a somewhat different picture from "active euthanasia." Whereas the latter assumes that death cannot be expected to follow from the person's medical condition, the former assumes that death is predictable. The question is basically whether medical interventions should be made or continued, or whether the person should be allowed to die as a result of the medical condition.

The moral question posed here is not whether two obligations are in conflict. It is rather the question of what constitutes the fulfillment of the obligation to protect from harm. In allowing to die, one is not active but passive. It follows that the activity of doing harm cannot be attributed to the passive procedure of not intervening. Thus we are not confronted with a conflict between obligations to do no harm and to protect from harm. Rather, we are confronted with the question of what our obligation to protect from harm means in such circumstances.

In one sense, every medical intervention represents a decision not to allow a person to die. Therefore, it would appear that normally we assume that the obligation to protect from harm

means that we do not allow people to die if we can do something about it. Yet a further distinction is relevant just at this point. When we speak of not allowing a person to die, we usually mean that we are prolonging their life. However, there is a difference between prolonging life and prolonging dying. If the effect of a given intervention is not to prolong life, but to prolong dying, then we cannot claim that we have protected human life from harm by the intervention. Our earlier discussion of the finite character of human life makes plain that death is not always to be understood as a harm. Where ding is judged imminent and inevitable, death is not a harm from which we can conceivably be protected. Hence, there can be no obligation to protect from this event.

Thus the fundamental judgment that has to be made in the matter of "passive euthanasia" is whether the person in question is dying or not. This is not the same thing as asking whether a patient is terminal. A person with a certain form of cancer may clearly be terminal, but this does not necessarily mean that the individual is confronted by impending death. The dying condition obtains when it becomes apparent that no available medical treatment will reduce the disability or improve the capabilities of a terminal patient facing impending death. The effect of medical treatment in this case cannot be to prolong life, but at most to prolong dying by marginally forestalling impending death. The determination of the condition of dying is fundamentally a medical judgment that will need to be rendered by qualified medical personnel. Once the judgment is made, the situation can be analyzed in terms of our obligation to protect from harm.

In such a situation the obligation to protect human life from harm does not require us to treat the condition that is leading to death. On the other hand, it does require us to accompany and care for persons in every relevant way. Certainly it obliges us not to abandon persons, leaving them to die alone. Instead, protection from harm means that we will remain with them, offering company and support as they confront the inevitable implication of their own finitude. Additionally, medical treatment designed to relieve pain and make persons more comfortable would continue to be very much in order. Entailed in this commitment to accompany dying patients is a readiness to undertake medical treatment that will prolong dying if requested by patients, assuming their competence. Perhaps most often in the situation of dying, the person will be unable to make judgments or requests of this sort. Here, where doctors and guardians are necessarily entrusted with the decision, no moral obligation to treat the dying patient exists. However, if a patient is able to and does make a request for so-called "heroic" medical measures, even against the best medical judgment, it would be a failure of readiness to support and accompany to refuse such a request.

Obviously this response assumes that the requested treatment does not portend a more harmful result for the patient than already experienced; nor does responsiveness to such a request preclude careful review with the patient of the medical judgment and even the theological implications to enable the patient to better grasp the rationale for not prolonging dying. Nevertheless, the medical judgments involved are human

and therefore fallible. With due explanation and discussion, it would not be appropriate to refuse request for treatment from the patient.

It should go without saying that should the medical indications suggest that the person is not in a condition of dying, then the obligation to protect includes the obligation to treat medically to the maximum extent possible. Such a severe, even terminal, but non-dying medical condition does not change the normal implication of out obligation to protect from harm. Here not to intervene medically constitutes a clear violation of the obligation to protect.

Just as "active euthanasia" requires a process of moral reasoning that is deliberately cautious and collaborative, so "passive euthanasia" requires the same ingredient. While we are not concerned in "passive euthanasia" with a conflict between the obligations to do no harm and to protect, very difficult judgments, especially of a medical nature, need to be made. It is especially important that people deeply involved in the situation are helped to ask and answer the question of whether the condition is one of dying, then those involved medically and familially must be assisted in determining how they can continue to care for and accompany the person as death is confronted.

(iii.) *Acknowledging Death*. While not technically part of our consideration of euthanasia, the matter of determining when death occurs is an important related issue. There are circumstances in which taking life or allowing to die can be confused with acknowledging death, as when the use of a respirator for a comatose patient is discontinued. The act could constitute taking life, allowing to die, or acknowledging death—depending upon the condition of the patient. If it were either of the first two possibilities, it would be subject to analysis in terms already provided. Here we need to indicate what is involved if the third possibility, acknowledging death obtains.

To determine when death occurs is a subtle admixture of medical and philosophical or theological judgment. On the basis of our earlier discussion of the relational character of human life, our theological judgment is that death occurs where the capacity for such relationships is irretrievably lost. The related medical judgment is that such capacity is lost when cerebral function is lost. Traditionally, the most readily evident signs of lost cerebral function have been lost heart and lung function. Modern medical technology complicates the picture, however, since heart and lung function can sometimes be supported by the use of a respirator. In such a situation, the question is whether any determination can be made about cerebral function. Through the use of electroencephalogram and possibly other tests of responsiveness and reflexes, judgments about whether cerebral function is present or not can be made. If judged to have been irretrievably lost, the individual is properly determined to be dead.

There are important considerations for certain difficult cases. It is important to insist that removal of life support systems is such a circumstance is neither taking life, not allowing to die. It is acknowledging death. Thus it constitutes no failure of the obligations

to do no harm or to protect from harm, to take such action.

(iv.) *Summary and Conclusions*. What goes under the label "euthanasia" can be usefully distinguished as "active euthanasia" and "passive euthanasia." The former, which is the act of taking life directly, can only be raised as a moral possibility in situations where we experience a conflict between out two-fold obligation not to harm another and to protect that person as well. To justify such action morally requires the demonstration that the conflict is real, cannot be reduced, and that the action of protecting for harm is more consistent with respect for life. Each of these conditions is extremely difficult to fulfill. In any event, the inherent ambiguity of such a decision requires that it be [made] thoughtfully and prayerfully, in collaboration with knowledgeable persons not emotionally captured by the situation.

"Passive euthanasia" or "allowing to die" is indistinguishable from "active euthanasia" if the person is not in a condition of dying. If, however, the patient is determined by appropriate medical indications to be dying, the matter becomes one of a right understanding of the obligation to protect from harm. Protecting persons from harm involves caring for them and accompanying them, but not medical interventions which can only prolong dying. Decision-making requires expert medical consultation as well as other consultation that enables affected parties to distinguish meaningfully between prolonging dying and prolonging life. Of special importance is continuing to care for and support the person who is allowed to die. It is also important to acknowledge the fact of death whenever cerebral function, which makes possible human relationships, is irretrievably lost, distinguishing it from both taking life and allowing to die.

II.
EXCERPTS FROM "THE COVENANT OF LIFE AND THE CARING COMMUNITY"
The 195th General Assembly (1983)
Received the Report and Adopted the Policy Statements and Recommendations
pp. 20-24, 29-30.

Chapter 5: Decision-Making at the End-of-Life

> Do not seek death. Death will find you. But seek the road which makes death fulfillment. (Dag Hammarskjold)
>
> Never harm (primum non nocere), cure sometimes, comfort always! (Medical Maxim)

The primary focus in decisions about life or death should be the individual's wishes and needs, but decisions of this magnitude ought also to occur within the context of community. Since individuals differ in their understanding and acceptance of death, their decisions regarding care at the end of life will also differ. Those views must be considered. In Christian perceptions the believing community is the body of Chris, so we must be concerned with the whole body and also with the individual members. As a body sensitive to corporate as well as personal needs and desires, the Christian community should provide a model to guide others in society. But this is no easy task since individuals differ, as is illustrated by the following case studies.

> Fourteen-year-old Tim Clark said good-by Wednesday night to his friends

during a prayer meeting at Abbots Creek Baptist Church. Weary of three and a half years of dialysis treatments and three unsuccessful transplant attempts, Tim finally chose to die having received a sign from God to "come home" to live. Mrs. Clark said Tim had discussed going off dialysis for more than a month. "On Tuesday night after reading his Bible and saying his prayer, I heard him say, 'God, if you want me to come home and live with you, give me a sign.' A little later, I heard him get up and he came down the stairs. He was aglow. He showed me his arm. It was bleeding where the dialysis needles had been nine hours before. He interpreted this as a sign that God wanted him to come home."[1]

When Jane Gahagan, a young woman from Evanston, Illinois, read the story, she was not moved. Having struggled with dialysis treatments for 8 years, "…I thought of all those who are struggling to hang on, who five everything they've got to be alive." Gahagan wrote an open Christmas letter to her fellow dialysis patients. "Life really begins when we know we might lose it. Suddenly, all the little things become important again, as they were when we were children. The sun on the lake, the flow of the seasons, the sting of wintry air on our faces, the sound of leaves falling…Most of us know that time in the middle of the night when we are very much alone. That hour of truth, the one in which we have no voice but our own echo…Still, that moment becomes a triumph. There is always rising an instinct toward another day and the desire to make it count. And that is life, burgeoning in the midst of death, defiantly saying, 'I will not give in.'"[2]

The vignettes above briefly describe two inspiring and courageous perspectives on chronic illness and ways of accepting death: two theologies of death and eternal life. These two stories frame the single human experience that most invites, indeed mandates, that biomedical and theological reflection be joined: that of dying and death. Our attention now turns to biomedical developments that affect the end of life and then to theological and ethical analysis of those developments.

A. The Biomedical Assault on Death

Life expectancy has changed dramatically in the last forty years due to the discovery and use of vaccinations and antibiotics, in addition to improvements in sanitation. In the typical deathbed scene of the nineteenth century, the physician looked on helplessly as infection carried the person away. At the present time infections remain a frequent cause of death, especially in the developing countries; but in Western culture, other factors such as renal failure, toxemia, or cardiopulmonary collapse are more likely to be its cause.

A major changeover. The past fifty years have brought a major change in the place where death occurs. Today this event takes place more often in institutions, namely, in hospitals and medical centers. In 1937, 37 percent of Americans died in hospitals; in 1958, the percentage had increased to 73 percent. Today over 80 percent of deaths occur away from home in hospitals or other institutions. This statistic underlies two primary characteristics of death in the modern world: (1) Death most often occurs in the presence of powerful technology. (2) Death most often occurs at a time, place, and manner outside of one's control.

Most people die in centers where advanced technologies capable of prolonging life, and thus the dying

process, are available and often used. In a clinical consultation at a university teaching hospital, the question was raised whether emergency dialysis should be used for a patient who was refusing therapy. "Of course," the dialysis team claimed, "that's what we're here for." When the services are available and highly trained teams are on hand to initiate these efforts, it is virtually assumed they will be used. This is also true for resuscitation efforts and a wide range of emergency measures. The modern hospital is well equipped with a number of specialty teams who are always on call to do all they can to stave off inevitable death.

As a result, many persons now die in institutions under intensive care, at a much older age, surrounded by an impressive battery of devices and machines. Under these circumstances, dying takes much longer and costs far more. Our technology may be capable of rescuing an individual from death but may not be able to save the person from existence in a vegetative state with high social costs. Severely ill or injured persons are often stabilized in conditions of permanent impairment, which raises questions about the long-range efficacy of these technological efforts.

Modern technology has forced us to reexamine the question, "When does death occur?" This questioning has been made more urgent by economic and organ transplant considerations. The older definitions of death: "when a physician declares death," or "when heart and lung function cease," have in recent years yielded to the criterion of cessation of brain function as the decisive factor in determining death. The Harvard ad hoc committee's definition of irreversible coma (or some modification thereof) has been widely accepted as the best objective standard by which to determine death and has been adopted into legislative statutes and hospital policies.[3]

The great Puritan physician, Sir Thomas Browne, summarized the plight of modern society seeking both to assault death via biomedical skill and yet to retain the grace of acceptance, even victory, in the face of the inevitable.

> With what shifts and pains we come into the world, we remember not; but 'tis commonly found no easy matter to get out of it. Many have studied to exasperate the ways of Death, but fewer hours have been spent to soften that necessity.[4]

Many people today fear that they will lose control over their lives when they approach death; that things will be done to them that they would not want; and that they will not be given a choice to accept or refuse contemplated therapies. This fear has given rise to two movements in public policy that have import for our consideration of death and dying, particularly as the church contemplates its own policy and its counsel to the secular society on these issues. Some persons have signed a "living will." This is a document that attempts to clarify a person's wishes about time, manner, and condition of his or her own death and what he or she insists not be done.[5] It is limited in its usefulness because of its lack of specificity. Various religious bodies have formulated versions of a living will. The Roman Catholic affirmation of life and Sissela Bok's "Personal Directions for Care at the End of Life"[6] are more specific and thus are helpful examples. Both are included in the

appendix along with text examples from the Euthanasia Educational Council (name now changed to Concern For Dying).

The "living will" movement is both tragic and encouraging. It is tragic in that it is necessary. Individuals and families should, under optimal conditions, have discussed these issues fully and made their wishes clear to physician, family, and designated agents before the final days of life. In an earlier time, when one's pastor, physician, lawyer, and mortician were personal friends, these convictions could be voiced and arrangements made, so that formal documents were unnecessary. Now, one may die in unfamiliar surroundings in the presence of strangers where one's wishes are not known. People are therefore beginning to take initiatives so that guidance is given to loved ones in the event that he or she lapses into coma or in some other way is unable to control medical decisions through personal consent. Thus, proxy judgments can be made according to the patient's desires. This, of course, confronts the proxy with new responsibility and burden as a maker of moral decisions.

An increasing number of states have enacted in law "natural death acts." This type of legislation seeks to give legal authority to a person's wishes and at the same time protects health professionals and institutions from litigation arising out of an accusation that they failed to do all that could be done to prolong life. An interesting philosophical and theological concept underlies these laws. They suggest that there are "natural" and "unnatural" ways to die and that ethical and legal sanctions should apply to safeguard persons from unnatural deaths and assure that their rights to "natural deaths" are sustained.

The experience of death has not changed dramatically since the dawn of human history. It is terrifying because it is either the end of everything, or it leads to the unknown. In theological language it portends salvation or damnation. To a large measure death remains out of human control. As Sissela Bok, the Harvard philosopher, has argued, it is not the fear of being dead that brings dread to modern people; it is the fear of dying, fear of long and hard suffering and pain, fear of losing contact with loved one, and fear of "physical debilitation, senility…the loss of freedom and the loss of knowing what's going on."[7]

How does theology reflect on these developments in the experience of death and what ethical wisdom does that theology present?

B. The Christian Theology of Life, Death, Eternal Life

We seek good deaths, natural deaths, explainable deaths in the same way that the ancients did. In his study of primitive cultures, Frazer shows that all people stand in awe of death, seek to avoid it, and propose all manner of rationalizations and escapes from it.[8] Death was sometimes likened to a dream in which a person enters another world. Reverence for the dead is evident at the prehistoric burial sites in Africa, the Near East, and Europe. This reverence in part arose from the belief that the dead still had contact with and could influence for good or ill the lives of the living.

Whether death is seen as natural (a part of life) or unnatural (provoked by evil spirits) by primitive persons is disputed by the anthropologists. It is likely that people from earliest times saw death as it is seen today—with a mixture of emotions. On the one hand, it is natural, a part of life and inevitable. On the other hand, it is unnatural and an intrusion, an evil to be explained, a problem to be solved. The early Christians were divided over the question whether death was part of the original creation. Would our progenitors have died even if they had not disobeyed God? Or is immortality the primal natural state? In some cultures infanticide and senilicide are practiced in order to hasten facilitate natural destruction. In other cultures childhood and old age are revered and protected from assault. The seeds of the modern impulses of both accepting and fighting death seem to have existed since the beginning.[9]

The Hebrews in biblical times began to reflect on death in a new way. Taking these primitive precedents, they found several explanations of the meaning of death. On the one hand, death was natural. Death was the normal end of life. When a human life, like a fruit, is full grown, it is harvested (Job 5:25). "Full of years," one is gathered to one's people (Genesis 15:15). We are like the grass that flourishes, then dies, our days are a fragile breath that will soon be over (Psalm 39). In another understanding, life continues through the offspring into the next generation. Thus, to die without children was to be completely dead. Also there is the question of the fullness of one's life. Jepthah's daughter wept about her unfulfilled maidenhood (Cf. Judges 11). The prophetic tradition found a primal transgression as the root cause of human death. Thus even at this early intuitional stage, death was separation from the source of life.

In the first tradition, death is merely the cessation of life. Vital power (*nephesh*) is exhausted from the body when breath leaves, and the body lapses into corruption and impurity (Numbers 9:6). In the complementary tradition, death is a force controlled by God. Premature death was seen as a punishment allowed by God but delivered by a hostile power. This strain in Hebrew thought became the basis of Paul's doctrine that death is the "sting" which is the just wage of sin (Romans 6:23).

Superseding both of these notions, in which death is seen either as natural or as evil, is the confidence that God contends against death with humanity. God snatches believers from the hand of death (Psalm 18:6, 116:3). God accompanies persons in the valley of death and allays their fears, sustaining them forever (Psalm 23). God holds power over death. For those who have turned against God, death is the instrument of isolation and condemnation. For God's own, death is an instrument of deliverance and salvation. Thus the meaning of death, like the meaning of life, is determined by the covenant relationship.

The essential Christian teaching that bears on death is centered in the death and resurrection of Christ. In Christ's crucifixion, God has decisively conquered the powers and dominions of this world, especially the power of death (Acts 2:24, I Cor. 15:45-46, Rev. 6:8). The "last enemy," whose fate is sealed in Christ's atoning death, is death itself. In

its fellowship with the living Christ, the Christian community has already been transported in anticipation to the other side of death. New life in Christ, which is resurrection, can look back at death from beyond (Colossians 3:2, cf. Col. 2). The Gospel of John uses eternal life as both experience and promise for Christians (Cf. John 5-6).

To set the stage for an ethical response to the biomedical issues of dying and death, it is necessary to review briefly the evolution of Christian thought about death and resurrection. Early Christians believed, as did the Jews of the first century A.D., that a universal bodily resurrection of the dead was forthcoming in the messianic age. This belief informed their understanding of the destiny of Jesus, then dead, now vital to their faith. This resurrection belief was further intensified by the experience with Jesus. The earliest Christian burial customs and tests, and the abandon with which first and second century disciples went to their deaths, exemplify in behavior their faith in bodily resurrection. It is clear that the apostolic community knew that Jesus, alive and powerful, was with them. They expected his imminent return, which would mark the final victory over the grave. Thus, there was watchful waiting and a call to be faithful unto death.

In the first and second centuries a great struggle ensued over the manner and meaning of Christ's death and resurrection. Generally, Hellenistic Christians, especially Gnostics, emphasized a spiritual resurrection and the derivative doctrine of the immortality of the soul, while Jewish Christians ordinarily held a more apocalyptic belief in the resurrection of the body. These two ideas framed the theology of human death in early Christian history and were crucial as individual persons and the community came to terms with physical death. Oscar Cullmann writes:

> Only he or she who apprehends with the first Christian the horror of death, who takes death seriously as death, can comprehend the Easter exultation of the primitive Christian community. …Belief in the immortality of the soul is not belief in a revolutionary event. Immortality, in fact, is only a negative assertion; the soul does not die, but simply lives on. Resurrection is a positive assertion: The whole person, who has really died, is recalled to life by a new act of creation by God. Something has happened—a miracle of creation! For something has also happened previously, something fearful: Life formed by God has been destroyed.[10]

The biomedical implications of the theology of death and eternal life reflected in contemporary theologians are several: (1) We fight with God against the power of death; (2) we hope for a time in history when disease and untimely death will be overcome; (3) we accept death as a part of life experience; (4) we do not live under the dominion of death but live toward the promise of life; (5) we trust the details to God; and (6) in life and death we are with God.

C. The Ethics of Life and Death

Reformed theological ethics lift up several points about death that are moral issues of life and living.

(1) The direction of biblical ethics is against taking the life of another, even for benevolent reasons. Persons should not be deemed worthless, too old, too

weak, unproductive, sociopathic, or a burden, thereby justifying some act of positive "mercy killing," or the more fashionable slow killing by neglect. When persons fall into deep sickness, pain, suffering, unconsciousness; when they life helpless under deep sedation or at the brink of danger in intensive care, they must know that they will not be abandoned.

While the direction of biblical ethics is against taking the life of another, it in no way claims that it is necessary to prolong the life—or the dying process—of a person who is gravely ill with little or no hope for cure or remission. Persons who are terminally ill must be able to trust that their dying will no be prolonged by unrequested technological interventions. As theologian Paul Ramsey has stated, "We need…to discover the moral limits properly surrounding offers to save life. We need to recover the meaning of only caring for the dying, and the justification—indeed the obligation—of intervening against many a medical intervention that is possible today."[11] The existence of specific medical technology does not require that it be used.

Admittedly, it is often difficult to know or to acknowledge when a person is dying. It is equally difficult to stop aggressive, curative types of treatments and therapies or to say that ordinary types of therapy have become extraordinary. Sometimes the person will know that he or she is dying, will try to communicate that knowledge to family and caregivers who prefer not to hear and keep busy trying to cure, rather than sitting quietly by, showing care and concern. Ramsey admonishes readers to be aware of "the duty only to care for the dying, simply to comfort and company with them, to be present to them."[12]

(2) Most discussions of ethics in health care address the issue of autonomy (i.e., a person's right to make—or at least participate in—decisions related to his or her own body), primarily when discussing death and dying. The popular clichés related to this issues are: "the right to die," "death with dignity," and the "right to refuse treatment." Although cases (Quinlan, Fox, Saikewicz) that have been prominent in the mass media and that have focused on these extraordinary issues are more dramatic than commonplace, they still necessitate a moral response. In a pluralistic society where people have different beliefs about life and death, basic Christian respect for persons demands that a person's decisions about death be honored in most instances.

The choice of whether or not to undergo further treatment, whether or not to consent to experimental therapy, or to donate tissue should be a personal decision. Since the atmosphere of critical care medicine is highly charged with values such as medical authority, vested interest, and patient submission, care should be taken by the physician to converse freely and candidly with the patient. The patient ought to know the options, the pros and cons of each option, the thoughts of the attending clinicians, and then be encouraged to make his or her own decision. This view holds that it is unkind or unreasonable to invite the patient into the debate over options (and that the physician knows best), and so the physician proceeds to make proxy decisions for the patient. The second unfortunate course sets the

options and scenarios before the patient like a computer. It gives the probabilities and statistics and then says, "There you are, now decided!" Both of these approaches shrink from the pain and reward of cooperative judgment. The best course is one that involves coming to a thoughtful medical judgment, sharing this with the patient, reviewing the alternative courses, and inviting the patient's response. The tragedy of patient refusal—or thoughtless acceptance—of procedures and the increased possibility of legal action often arise from failures to respect the patient's humanity and enter into responsible dialogue with him or her.

Another variation on paternalistic decision-making involves the externally imposed judgment about a patient's quality of life. If a patient's quality of life is deemed unsuitable or intolerable by members of the health care team, treatment may be terminated—or not initiated—and the patient allowed to die. This judgment about a person's quality of life made by someone other than the patient is far different from an individual's making such a decision about his or her own life quality. While members of the health care professions are called upon to make quality-of-life decisions at many levels—and it is unrealistic to deny that such decisions are not necessary—a word of caution is in order to those who make such decisions and to all who may be patients at some point in time. We must take great care not to denigrate the worth or life of others and impose a judgment of poor quality that might provide justification for stopping treatment or avoiding the patient.

For the time being, given the complexity of the modern medical center, the anonymity of doctor-patient relationships, the tendency to do things to and for other people, and conflicting interests, it is best to safeguard autonomy in medical decision-making by whatever means. Patient review boards, hospital ethics committees, institutional review boards for research protocol, patient advocates, and a patient bill of rights all serve the function of safeguarding personal freedom. None of these can take the place, however, of honest, fair, and compassionate human relations and communication.

(3) The real, almost inevitable danger of reducing human lives to statistics or mechanical processes must be acknowledged. The influences of economic factors, often unspoken, loom large. The efforts to place economic values on patients' lives or determine how many treatments an individual deserves, while reprehensible, nonetheless occur. If medical care must be rationed (e.g., no dialysis after 60 years of age), policies should be made following public deliberation so that those affected will have had a chance to participate.

Impulses to quantify or stage the experiences of moving toward death or beyond death should be stifled. The thought of nurses or others with handbooks trying to assess whether the patient is in the "denial" or "acceptance" stage of dying is frightening. To reduce a person to a stage, a disease ("the ulcer in Room 210"), or a statistic is to wish that person dead. The awesome mystery and unpredictability of life and living, to say nothing of an enduring respect for

persons, should be sustained in I-Thou rather than I-It relations.

(4) There is the danger and temptation to idolize bodily life by making retention of physical life the only good and primary goal. Jesus touches this subject when he says that "Whoever would save his life shall lose it." Too much effort to defend one's own life, to bury it in a safe place like the one-talent man, to refuse to give life away, or to fail to use it up goes against the grain of Christian calling. It is indeed idolatrous to try to keep a person's body alive no matter how to empty that life may be. Human beings are transcendent creatures. Real life comes from beyond bodily function. Jesus asks: "Is not life more than food, and body more than clothing?" (Matthew 6:25b). Often hospitals and medical personnel are simply engaged in a contest to preserve "life," with little concern for quality or expectation. Sometimes they win the battle, but the patient loses. Clinging to life rather than reaching out to life compounds the tragedy.

(5) The affirmation about eternal life that is woven into the Gospel according to John should be emphasized. Eternal life is here and now. According to the apostle Paul, the light of promise shines in the present moment. Eternal life, not death, is the ultimate reality. That assurance keeps Christians from living all of life being afraid of death. For Christians the adventure is never toward an end but toward new beginnings. Elizabeth Kubler-Ross has written that death is the final stage of growth; it would be more appropriate to affirm that death is another stage of becoming. For Christians, death can be understood as the next chapter in the surprising story of life.

(6) Decision-making is never sure; deciders are seldom secure. Persons are ambivalent about whether to approach death with dread or hope, whether to resist or to accept. Possibly this ambivalence comes from the built-in will to live and the corresponding will to die. Whatever its origin, ambivalence is woven into the fabric of being itself, and decisions of life and death are met with a kind of frustrating ambiguity. Since life-death decisions can rarely be made with certainty, even when all the evidence is in, decisions must be made with humility and with a posture of seeking God's forgiveness and acceptance.

(7) Finally, the church is in the world to be an example, not to impose values or beliefs. By its life and its attitude toward life, it can and should bear witness to the faith. The church in this area, as in many others, must be the community of care, protection, and nurture. In this way, the church can be a model in a pluralistic society for how these decisions ought to be made while preserving and enhancing human dignity and worth.

Decision-Making at the End-of-Life

1. Many members of the Presbyterian Church (U.S.A.) will face health care decisions toward the end-of-life that they could not have anticipated, and many of those decisions will require judgments that relate to values held

by the patient. Therefore, the 195th General Assembly (1983) calls upon its members to:

a. Select their physicians with regard not only to the skillfulness of the medical care that they can provide but also for their values regarding human life and community, whenever such a choice is available.

b. Take time to reflect on their own values and discuss these with family members, close friends, and their clergy.

c. Speak with their physicians about their concerns regarding care and become educated about their conditions in order to permit informed decision-making.

d. Provide instructions (and designate two agents to carry out instructions) with regard to extraordinary therapies and treatments to prolong life.

2. The church should be a place where individual and families can make plans about death, manner of death, living wills, etc. Therefore, the 195th General Assembly (1983) calls upon the church to:

a. Request the Program Agency to make available information and study tools for use by congregations regarding options available at the end-of-life and means of informing health care professionals of these wishes.

b. Hold seminars utilizing the aforementioned materials and qualified resource persons whenever possible.

c. Advocate that human need and benevolence replace the opportunism and exploitation that so often surround the death experience presently.

3. Harmony and integration should be sought between intensive care, curative hospitals, and hospices so that end-of-life care can be free from jurisdictional conflict and that therapeutic and palliative care are available to all.

Appendix A

Directions for My Care

I, _____, want to participate in my own medical care as long as I am able. But I recognize that an accident or illness may someday make me unable to do so. Should this come to be the case, this document is intended to direct those who make choices on my behalf. I have prepared it while still legally competent and of sound mind. If these instructions create a conflict with the desires of my relatives, or with hospital policies or with the principles of those providing my care, I ask that my instructions prevail, unless they are contrary to existing law or would expose medical personnel or the hospital to a substantial risk of legal liability.

I wish to live a full and long life, but not at all costs. If my death is near and cannot be avoided, and if I have lost the ability to interact with others and have no reasonable chance of regaining this

ability, or if my suffering is intense and irreversible, I do not want to have my life prolonged. I would then ask not to be subjected to surgery or resuscitation. Nor would I then wish to have life support from mechanical ventilators, intensive care services, or other life prolonging procedures, including the administration of antibiotics and blood products. I would wish, rather, to have care that gives comfort and support, which facilitates my interaction with others to the extent that this is possible, and which brings peace.

In order to carry out these instructions and to interpret them, I authorize _____, to accept, plan and refuse treatment on my behalf in cooperation with attending physicians and health personnel. This person knows how I value the experience of living, and how I would weigh incompetence, suffering, and dying. Should it be impossible to reach this person, I authorize _____ to make such choices for me. I have discussed my desires concerning terminal care with them, and I trust their judgment on my behalf.

In addition, I have discussed with them the following specific instructions regarding my care:

(Please continue on back.)

Date _____

Signed _____

Witnessed by _____ and _____

(Source: Sissela Bok, "Personal Directions for Care at the End-of-Life," *New England Journal of Medicine* 295 (August 12, 1976), 367-369.)

Appendix B

Christian Affirmation of Life[1]

To my family, friends, physician, lawyer, and clergyman:

I believe that each individual person is created by God our Father in love and that God retains a loving relationship to each person throughout human life and eternity.

I believe that Jesus Christ, lived, suffered, and died for me and that his suffering, death, and resurrection prefigure and make possible the death-resurrection process which I now anticipate.

I believe that each person's worth and dignity derives from the relationship of love in Christ that God has for each individual person and not from one's usefulness or effectiveness in society.

I believe that God our Father has entrusted to me a shared dominion with him over my earthly existence so that I am bound to use ordinary means to preserve my life but I am free to refuse extraordinary means to prolong my life.

I believe that through death life is not taken away but merely changed, and though I may experience fear, suffering, and sorrow, by the grace of the Holy Spirit, I hope to accept death as a free human act which enables me to surrender this life and to be united with God for eternity.

Because of my belief:

I request that I be informed as death approaches so that I may continue to prepare for the full encounter of Christ through the help of the Sacraments and the consolation and prayers of my family and friends.

I request that, if possible, I be consulted concerning the medical procedures that might be used to prolong my life as death approaches. If I can no longer take part in decisions concerning my own future, and there is no reasonable expectation of my recovery from physical and mental disability, I request that no extraordinary means be used to prolong my life.

I request, though I wish to join my suffering to the suffering of Jesus so I may be united fully with him in the act of death-resurrection, that my pain, if unbearable, be alleviated. However, no means should be used with the intention of shortening my life.

I request, because I am a sinner and in need of reconciliation and because my faith, hope, and love may not overcome all fear and doubt, that my family, friends and the whole Christian community join me in prayer and mortification as I prepare for the great personal act of dying.

Finally, I request that after my death, my family, my friends, and the whole Christian community pray for me and rejoice with me because of the mercy and love of the Trinity, with whom I hope to be united for all eternity.

Signed _____

Date _____

Appendix C

A Living Will

To My Family, My Physician, My Lawyer, My Clergyman: To Any Medical Faculty In Whose Care I Happen To Be; To Any Individual Who May Become Responsible For My Health, Welfare, Or Affairs:

Death is as much a reality as birth, growth, maturity, and old age—it is the one certainty of life. If the time comes when I _____ can no longer take part in decisions for my own future, let this statement stand as an expression of my wishes, while I am still of sound mind.

If the situation should arise in which there is no reasonable expectation of my recovery from physical or mental disability, I request that I be allowed to die and not be kept alive by artificial means or "heroic measures." I do not fear death itself as much as the indignities of deterioration, dependency, and hopeless pain. I, therefore, ask that medication be mercifully administered to me to alleviate suffering even though this may hasten the moment of death.

This request is made after careful consideration. I hope you who care for me will feel morally bound to follow its mandate. I recognize that this appears to place a heavy responsibility upon you, but it is with the intention of relieving you of such responsibility and of placing it upon myself in accordance with my strong convictions, that this statement is made.

Signed _____

Date _____

Witness _____

Witness _____

Copies of this request have been given to

_____

_____

_____

_____

Appendix D

Form or Declaration under the Voluntary Euthanasia Act 1969

Declaration made _____

[and re-executed _____]

by _____

of _____

I DECLARE that I subscribe to the code set out under the following articles:

A. If I should at any time suffer from a serious physical illness or impairment reasonably thought in my case to be incurable and expected to cause me severe distress or render me incapable of rational existence, I request the administration of euthanasia at a time or in circumstances to be indicated or specified by me or, if it is apparent that I have become incapable of giving directions, at the discretion of the physician in charge of my case.

B. In the event of my suffering from any of the conditions specified above, I request that no active steps should be taken, and in particular that no resuscitatory techniques be used, to prolong my life or restore me to consciousness.

C. This declaration is to remain in force unless I revoke it, which I may do at any time, and any request I may make concerning action to be taken or withheld in connection with this declaration will be made without further formalities.

I WISH it to be understood that I have confidence in the good faith of my relatives and physicians, and fear degeneration and indignity far more that I fear premature death. I ask and authorize the physician in charge of my case to bear these statements in mind when considering what my wishes would be in any uncertain situation.
SIGNED _____
[SIGNED ON RE-EXECUTION]

WE TESTIFY that the above-named declarant [2][signed][2][was unable to write but assented to] this declaration in our presence, and appeared to appreciate its significance. We do not know of any pressure being brought on him to make a declaration, and we believe it is made by his own wish. Insofar as we are aware, we are entitled to attest this declaration and do not stand to benefit by the death of the declarant.

Signed by _____ of _____

Signed by _____ of _____

[Signed by _____ of _____ on re-execution]

[Signed by _____ of _____ on re-execution]

ENDNOTES:

Chapter 5: Decision-making at the End-of-Life

[1] "Boy Needs 'Signs,' Makes Choice to Die," *Chicago Tribune*, Thursday, June 22, 1982, p. 1.
[2] "Her Choice: Don't Give in to Death," *Chicago Tribune*, Friday, July 30, p. 4., Sec. 1.
[3] "A Definition of Irreversible Coma," *Journal of the American Medical Association*, 205, No. 6, August 5, 1968, pp. 85-88.
[4] Sir Thomas Browne, *Christian Morals*, Part II, Sec. XII, Works IV, ed. S. Wilkon, London: William Pickering, 1835, p. 170.
[5] See versions of "Living Wills" in Kenneth Vaux, *Will to Live/will to Die*, Minneapolis: Augsburg Press, 1978; Marvin Kohl, ed. *Beneficent Euthanasia*, Buffalo, NY: Prometheus Books, 1975; "Death," *Encyclopedia of Bioethics*, New York: Macmillan Free Press, Vol. 1, 1978, p. 221.
[6] Sissela Bok, "Personal Directions for Care at the End-of-Life," *New England Journal of Medicine*, 295:7, August 12, 1976, pp. 367-369.
[7] Sissela Bok in "Death and Dying," *Hard Choices*, produced by KCTS/9, Seattle, Washington, p. 4.
[8] James George Frazer, *The Belief in Immortality and the Worship of the Dead*, 3 Vols., London: MacMillan, 1913-1922.
[9] "Death: An Anthropological Perspective," *The Encyclopedia of Bioethics*, op. cit. pp. 225ff.
[10] Oscar Cullman, "Immortality of the Soul or Resurrection of the Dead?," in *Immortality and Resurrection*, ed. Krister Stendalh, New York: MacMillan, 1965, pp. 26-27.
[11] Paul Ramsey, *The Patient as Person*, New Haven and London: Yale University Press, 1970, p. 118.
[12] Ibid., p. 125.

APPENDIX 4

A Commitment to Caring

God's compassion toward humanity is shown in Scripture, in the history of the church, and most specifically in the person and message of Christ Jesus. Although people seek to live for themselves alone, God continually acts to set people free from selfishness, calling them into a community of faithful discipleship, and directing them toward particular ministries of caring.

Responding to God's compassion and guided by the Holy Spirit, the church seeks to become an intentional community of caring to represent more fully the living Christ in faith and practice. For this reason, the session of _____ Church now commits itself to a covenant of caring. In fulfilling this commitment, we will engage in ministries of caring through:

WORSHIP—providing worship that conveys the reality of God's compassion to our congregation.

PRAYER AND BIBLE STUDY—encouraging members of our congregation to accept God's compassion in their own lives and, by daily prayer and openness to Scripture, to seek God's compassion for today's world.

EDUCATION FOR CHILDREN, YOUTH, AND ADULTS—giving members of the congregation means to help them grow as caring persons in their homes, their church, and their community.

SERVICE—holding before the congregation an urgency to work for compassion in the public arena: to confront apathy, insolation, and the marginalization of children, the poor, the hungry, the stranger, the homeless, the chronically and terminally ill, the prisoner, and others in need of care, knowing that even as we serve them, we serve the Lord Jesus. (Matthew 25:31ff.)

RECONCILIATION—demonstrating in our individual and corporate lives a love that is genuine, an abhorrence of evil, a zeal for service, a joyful hopefulness, patience in adversity, a constancy in prayer, a generosity toward others, and hospitality for all, so that the many may become one. (Romans 12:9ff.)

ADVOCACY—standing with and for those who cannot speak for themselves, as advocates of compassion in their lives, to be a prophetic witness for removing economic, social, and structural obstacles to care in society, including care at the end-of-life.

RESPONSIBILITY—involving the congregation in one or more acts of caring, such as: member-to-member care-giving (e.g., Stephen Ministry); support for in-home health care (e.g., hospice); establishing parish nurse program; organizing a bereavement committee; housing and/or supporting a health clinic; caring for, supporting, nurturing, and empowering professional and volunteer care-givers.

The session will lead and support the congregation in this caring response to God's compassion for us.

Moderator of Session, _____

Date _____

Clerk of Session, _____

Date _____

---

1. What is the Commitment to Caring?

The Commitment to Caring is a way for the session to state the intention that the church shall engage in a ministry focused upon caring.

2. What value does making a Commitment to Caring hold for our congregation?

a. It may help a church grow in its vision and understanding of compassion, until caring is an inherent part of the church's life.

b. It offers members a pattern for planning providing care in the congregation. The Commitment to Caring implies that caring can be a component of much of the church's ministry, including worship, prayer, Bible study, education, and service, and acts of reconciliation, advocacy, and responsibility.

c. It gives direction to the church leaders as they plan for the future.

d. It serves as a witness to others, both members of the church and the larger community, that an essential component of being Christian is to care for others.

e. It offers a series of guidelines for assessing the church's caring efforts.

f. It can become a vehicle for networking the ministries of care of different churches.

g. It can offer a congregation new energy and initiative.

3. Does a congregation have to do something in all seven areas of the Commitment to Caring at one time?

No. Most congregations will seek to target several areas initially. They may also find that they are already engaged in caring efforts in a number of these areas. It is hoped that *eventually* a congregation will choose to be involved in all seven areas. By adopting the Commitment to Caring, a congregation states its intent to become involved in all seven areas at a pace consistent with its own resources and abilities.

4. What prompted the Commitment to Caring?

Since 1990, at the direction of General Assembly, the Offices of Theology and Worship have been engaged in producing a study guide for pastors and churches about end-of-life issues, including euthanasia and assisted suicide. As the task force met over the course of a year to plan this study document, it came to believe that these issues are part of a much larger concern, that is, that our churches become intentional communities of caring. In order to highlight this need, the Commitment to Caring was created.

5. Caring has always been an important aspect of the life of our church. Why should our congregation make such a commitment now?

Even though the church may assume it is caring community, a Commitment to Caring moves the congregation beyond assumptions to actions. By taking the steps to adopt and then highlight the Commitment to Caring, a congregation makes specific and intentional what may have been unspecified and haphazard in its approach to compassionate ministry in the name of Christ.

6. May we rewrite the Commitment to Caring to make it more appropriate to our church's vision of caring?

Certainly. It is expected and likely that many congregation will use the Commitment to Caring as is, but it is also offered as a guideline for churches to consider and to tailor to suit their own circumstances and needs.

7. Why should the session be the body to agree to the "Commitment to Caring"?

Because according to our Presbyterian form of government the session is the primary body of leadership in a congregation. Elders who have been chosen, elected, ordained, and installed to direct the church have the proper authority to implement a new initiative such as is described in the Commitment to Caring.

8. How might a session decide to adopt the Commitment to Caring?

It could be presented by the clerk, moderator, or any session committee for a first reading and further study. Then, it would probably be discussed at the following meeting of session. Members of session might be asked to note areas of the Commitment to Caring in which the congregation is already engaged.

9. Is there help available to our congregation as we inaugurate our Commitment to Caring?

Yes. The study guide on euthanasia, assisted suicide, and end-of-life issues addresses many of the themes of the Commitment to Caring. For other, helpful resources, see the bibliography (Appendix 5).

APPENDIX 5

Selected Bibliography

These are resources in addition to ones previously listed. *Choosing Death* also has an excellent bibliography.

"Are Your Affairs in Order? A Planning Guide and Resource Book" (available from Bryn Mawr Presbyterian Church, Bryn Mawr, PA, 19010).

A helpful, practical guide to putting one's affairs into order (including financial, medical, and funeral planning), so that one's wishes for oneself and for others can best be respected when death comes.

Joseph E. Beltran, *The Living Will (and Other Life and Death Medical Choices)* (Thomas Nelson Publishers, 1994)/

A helpful, practical guide for individuals wishing to make responsible medical choices for themselves. Medical, legal, and theological issues are considered.

Dan W. Brock, "Voluntary Active Euthanasia," *The Hastings Center Report* (March-April 1992): 10-22.

A thoughtful assessment of arguments for and against euthanasia. While the author argues for the possibility of euthanasia and assisted suicide, he demonstrates the complexity of the issue.

Baruch Brody, ed., *Suicide and Euthanasia: Historical and Contemporary Themes* (Kluwer Academic Publishers, 1989).

An important set of essays, providing an overview of historical and contemporary perspectives on the topic.

Howard Brody, "Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide," *New England Journal of Medicine* (November 5, 1992): 1380-1388.

A significant article in the discussion of assisted suicide.

Daniel Callahan, *The Troubled Dream of Life: Living with Mortality* (Simon and Schuster, 1993).

An important investigation of what constitutes a life fully-lived. While the author opposes euthanasia, he raises provocative questions about how far we should go in sustaining life in the face of death.

Daniel Callahan, Gilbert Meilander, Christine Whitbeck, William Smith, M. Therese Lysaught, William May, and Eric Cassell, "The Sanctity of Life Seduced: A Symposium on Medical Ethics," *First Things* (April 1994): 13-27.

A fine discussion centering on death and dying, euthanasia, religion, and public policy. Virtually all points of view are expressed.

Courtney S. Campbell, "Religious Ethics and Active Euthanasia in a Pluralistic Society," *Kennedy Institute of Ethics Journal* (September 1992): 253-277.

A survey of various religious and denominational perspectives on euthanasia, with particular attention to themes of sovereignty, stewardship, and the self.

Eric J. Cassell, "Recognizing Suffering," *The Hastings Center Report* (May-June 1991): 24-31.

An important essay on the nature of suffering, and on how we become aware of another's suffering and more sensitive to it. Also, see his book *The Nature of Suffering* (Oxford, 1991).

Ezekiel J. Emanuel, "Euthanasia: Historical, Ethical and Empiric Perspectives," *Archives of Internal Medicine* (September 12, 1994): 1890-1901.

A clear historical and ethical approach to the issue, written for the nonspecialist. It is a valuable general introduction.

Stanley Hauerwas, *Naming the Silences: God, Medicine, and the Problem of Suffering* (Eerdmans, 1990).

A provocative set of reflections on the distinctive character of the Christian community, including its ability in faith to protest suffering.

Herbert Hendin and Gerald Klerman, "Physician Assisted Suicide: The Dangers of Legalization," *American Journal of Psychiatry* (January 1993): 143-145.

A psychiatric perspective. The authors argue that the majority of persons requesting euthanasia or assistance in dying are suffering from treatable forms of depression.

Leon R. Kass, "Is There a Right to Die?," *The Hastings Center Report* (January-February 1993): 34-43.

An argument that there is no firm philosophical or legal argument for a "right to die." To speak of rights in the very troubling matter of medically managed death is ill suited both to sound personal decision-making and to sensible public policy.

Gilbert Meilander, "I Want to Burden My Loved Ones," *First Things* (October 1991): 12-14.

A provocative essay on Christian responsibility in the face of suffering and dying. The author argues for the importance of our bearing each other's burdens. Also, see relevant chapters in the author's book *The Limits of Love: Some Theological Explorations* (Pennsylvania State University Press, 1987).

J.P. Moreland and David M. Ciocchi, *Christian Perspectives on Being Human* (Baker Book House, 1993).

Readily accessible to a lay audience. The author expresses a fairly traditional evangelical point of view. See especially Chapter 8, "Views of Human Nature at the Edge of Life."

Timothy E. Quill, "Death and Dignity: A Case of Individualized Decision Making," *New England Journal of Medicine* (March 7, 1991): 691-694.

An important and controversial essay. Quill relates a personal experience and argues for the right of physicians to assist patients in dying.

Response Form for Study on Euthanasia, Assisted Suicide, and End-of-Life Decisions

Your comments will help the Office of Theology determine whether to take additional steps to address issues relating to euthanasia, assisted suicide, and end-of-life decisions. A summary of responses will be shared with the General Assembly and General Assembly Council.

Please type or print, and return to the address at the end of the form. Many thanks for your participation and response.

PART I.

1. Name of Congregation (or if not congregationally based, a description of your study group): _____

   _____

2. Location: _____

3. Number of Study Sessions: _____

4. Approximate Time Per Study Session: _____

5. Average Number of Participants Per Session: _____

6. Name, Address, and Phone Number of a Contact Person: _____

   _____

   _____

PART II.

7. What were the high points of the study, and why? _____

   _____

   _____

_____

8. What key questions or concerns emerged? _____

_____

_____

_____

9. Did you use the background book, *Choosing Death: Active Euthanasia, Religion, and the Public Debate* (ed. Ron Hamel)? (Circle one) Yes No

10. How did you feel about the subject of euthanasia/assisted suicide at the beginning of the study? (Choose one.)

    a. I could contemplate it for myself and could support the legalization of euthanasia/assisted suicide, with certain safeguards.

    b. I could not contemplate it for myself but could support the legalization of euthanasia/assisted suicide, with certain safeguards.

    c. I believed that euthanasia/assisted suicide is wrong under all or almost all circumstances but should be legalized, with certain safeguards.

    d. I believed that euthanasia/assisted suicide is wrong under all almost all circumstances and should not be legalized.

    e. I had not given the subject much thought, or I had no opinion.

11. How do you feel about the subject of euthanasia/assisted suicide now, at the end of the study? (Choose one.)

    a. I can contemplate it for myself and can support the legalization of euthanasia/assisted suicide, with certain safeguards.

    b. I cannot contemplate it for myself but can support the legalization of euthanasia/assisted suicide, with certain safeguards.

c. I believe that euthanasia/assisted suicide is wrong under all or almost all circumstances but should be legalized, with certain safeguards.

d. I believe that euthanasia/assisted suicide is wrong under all or almost all circumstances and should not be legalized.

e. I have no opinion.

12. Should the General Assembly of the Presbyterian Church (U.S.A.) take a stand on the legalization of euthanasia/assisted suicide?

a. Yes, for this reason: _____

_____

_____

b. No, for this reason: _____

_____

_____

c. I don't know, here's why: _____

_____

_____

13. If you answered "Yes" to Question 12, please answer the following:

What stand should the General Assembly take? _____

_____

_____

14. In your opinion, how important is it that the church does each of the following, in response to the public discussion of euthanasia/assisted suicide? (Answer each of the following.)

	very important	important	somewhat important	not very important	don't know/ no opinion
a. promote hospice care, both by offering financial support to hospice programs and by making people more aware of hospice services					
b. work to ensure that all people have access to sufficient health care					
c. work to ensure that doctors receive better training in pain management					
d. work to ensure that the church reaches out to people who experience isolation or fear as they face suffering and/or dying					
e. help to resolve—one way or the other—the issue of whether or not euthanasia/assisted suicide should be legalized					

PART IV.

Any other comments that you would like to direct to the Office of Theology and Worship:

_____

_____

_____

_____

PART V.

Results will be tabulated and shared with the General Assembly and the General Assembly Council. If you wish to receive a copy of the results, please check here (___) and provide your name and address if different from the contact person listed in Part I:

(Please print.)

Name: _____

Address: _____

_____

Please send response form to: Charles Wiley, Office of Theology and Worship, Presbyterian Church (U.S.A.), 100 Witherspoon St., Louisville, KY 40202, phone: 502-569-5734.