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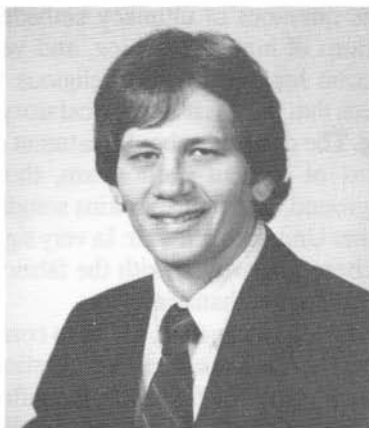
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Religion and the Moral Meaning of Euthanasia

by

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We have reached a stage in our society's ongoing debate over ethically controversial end-of-life decisions where such matters have been put up for public vote. A Washington State initiative to legally permit physician-assisted suicide and voluntary active euthanasia was defeated in November 1991 by 53% to 47%, but supporters, heartened by the fact that the initiative received over 701,000 votes, have announced plans to place similar proposals before citizens in California (1992) and Oregon (1994). The expectations for ultimate success rely heavily on a perception that such "right to die" or "death with dignity" initiatives reflect a strong populist sentiment. In the forums of public discussion, the voices that have come to the fore are those of terminally ill patients, and their families who have become their principal caregivers, and these stories resonate with many other persons who have come to see the Karen Ann Quinlans, Nancy Cruzans, and Janet Adkins of the past 15 years as visible symbols of what it means to die in a culture obsessed with the technological conquest of death.

The common parameters of the public debate are already familiar to us from other contexts: the right of expanded choice is pitted against claims about the sanctity of human life, thereby making the political polarization of the discussion seem unavoidable. Nevertheless, it seems morally myopic to reduce the question

of legalized physician-assisted suicide or voluntary euthanasia only to an issue of the boundaries of public or state intervention in a private choice. The public policy issue is merely the most visible dimension of a dialogue that in fact engages embedded questions of the deepest substantive significance and of ultimate meaning: the nature of our lives, and our selves, the meaning of dependency, the place of pain and suffering in life, the reality of finitude and death.

Such issues are not really problems to be "solved" by legislative fiat or a voter referendum, but neither should they be bracketed out in debates over the legalization of euthanasia. Indeed, only by attending to such questions can we explain the nature of the fundamental differences of positions that emerge. In short, raising these questions of ultimacy will render the debate over legalized euthanasia more intelligible and, equally important, more honest.

The questions of ultimacy embedded in the euthanasia debate are common questions of human meaning, and yet historically their most visible context of reflection has been within religious traditions. It is not coincidental, I would suggest, that there is a theological story to be about each of the symbols of modern dying. The decisions about treatment of Karen Ann Quinlan were shaped by the context of Roman Catholicism, those about Nancy Cruzan by a Methodist background, and Janet Adkins sought out Dr. Jack Kevorkian after consulting with her Unitarian minister. In very significant ways, religious themes and symbols have been interwoven with the fabric of public discussion about the right to die and legalized euthanasia.

In the following, then, I wish to consider the religious dimensions of euthanasia as they bear on five embedded questions of ultimacy and meaning — control and empowerment, the finite self, the gifted nature of life, suffering and compassion, and the good death. Such themes indicate that in our care of the dying, there are preferable alternatives to affirm the humanity of the dying and to relieve their pain and suffering (the two principal arguments supporting legalized euthanasia), short of resorting to taking their lives. In so doing, I hope to illustrate that the issue of legalized euthanasia provides an illuminating way to examine the relevance of religious themes to moral and civic discourse in the public square.

Religious Diversity

It is often intimated that the moral fault-lines over euthanasia reflect a secular versus religious fissure. However, there is no monolithic religious position on euthanasia (morally or legally), and indeed the diversity of religious positions is rather striking. This diversity, which reflects instead the pluralism of American religiosity in general, is manifest at several different levels of discussion.

The level of theological discussion displays a range of views, from a general *prohibition* of euthanasia, to a *permission* in exceptional cases or circumstances, to a permission as a matter of public policy, to even an *obligatory* response in cases of extreme suffering.¹ Sometimes these differences reflect a general identification with a particular tradition of religious ethics, but not always. While the Roman Catholic Church, for example, has been vigorously opposed to assisted suicide and legalized active euthanasia, some theologians, such as Lisa Cahill and Daniel

Maguire, are willing to permit euthanasia within very limited or exceptional cases, typically, a competent terminally ill patient who voluntarily requests euthanasia and for whom there is no viable alternative to relieve extreme pain and suffering.² Protestant theologians such as Gilbert Meilaender and Allen Verhey, meanwhile, argue for a conservative, prohibitory approach to euthanasia,³ despite the historical Protestant emphasis on freedom of personal choice.

A similar range of positions is evident in the resolutions regarding end-of-life decisions adopted by "authoritative" ecclesiastical institutions. While it is the case that the majority of denominational resolutions in the U.S. have affirmed opposition to euthanasia, there are some, such as that approved in July 1991 by the United Church of Christ, that see the morality of euthanasia resting in an "individual decision" (current study documents in the United Methodist Church and the Presbyterian Church also seem to move in this direction), while others, such as in the Unitarian Universalist Assembly, are committed to seek changes in laws to allow for assisted suicide and active euthanasia.⁴

The moral and policy weight that such resolutions carry is also open to question. There is, in many instances, an evident disparity in positions articulated by an institutionalized ecclesiastical body and those advanced by the lay members of the tradition. One can no more infer what the position of any particular Roman Catholic, or Episcopalian, Baptist, Methodist, Congregationalist, etc., on euthanasia will be from a denominational resolution than one can the views of any given professional caregiver from the official "opinions" of the American Medical Association or the American Nursing Association.

Moreover, many resolutions speak primarily to an audience of the religious community, and only secondarily, if at all, to the public policy question. To be sure, resolutions that characterize euthanasia as "homicide" or "murder" have fairly direct implications for legal sanctions. However, even the most vehement denominational opposition to legalized euthanasia often will distinguish between the *act* of euthanasia and the *agent* that requests euthanasia. While the act may be forbidden, the patient may well be excused from moral and religious responsibility, due to the underlying circumstances of pain and suffering. Moreover, recommendations that an attitude of "compassion" or "forgiveness" be adopted towards the patient, rather than "punishment," also may have policy implications, as such language suggests a softening of a legalistic judgment in favor of considering extenuating circumstances. Of course, such modification of moral and legal judgment would not necessarily apply to a professional, such as a Dr. Kevorkian, who engages in a *practice* of assisting in suicide.

Finally, diverse religiosity is also expressed in the private piety of individual patients faced with end-of-life decisions. The biblical admonition that there is "a time to die" provides a sense of comfort for many terminally ill patients, who frequently acknowledge their impending death by expressing, in effect, that their destiny is "in God's hands." Some patients, however, take a more active role, as displayed by Marjorie Wantz, a Michigan woman with a painful pelvic disease who asked Dr. Kevorkian to assist in her suicide: "If God won't come to me, I'm going to find God."⁵ The voices of the ill, which have played such a powerful public role in the debate over legalized euthanasia, are not, then, absent

religious conviction.

Each of the manifestations of religious diversity suggest that it is misleading to portray growing public interest in assisted suicide and active euthanasia as a sign of a "godless" society that has lost its faith bearings. The problem is not so much loss of faith in a secular society, but rather the context of modern dying. We are rightfully concerned with where death occurs (typically in institutions experienced as alien and impersonal); at what age (our life expectancy has increased in this century from 47 to 74, but in its wake has come greater sickness and morbidity); the causative disease (chronic diseases — the cancers, heart problems, strokes, dementia — that extend the duration of the dying process); the degree of pain that accompanies this protracted process; and, finally, the orientation of professional caregivers towards curing rather than caring, meaning that patients may experience as part of their dying the tyranny and terror of technology.

This modern context of dying has occasioned a theological re-thinking of traditional religious views and norms regarding the sanctity and the dignity of human life, and helps in part to explain the kinds of diversity present in religious discourse about euthanasia. In the midst of such diversity, nevertheless, one can identify some fairly common themes and unifying issues that reveal a dimension of ultimacy embedded in the euthanasia debate.

Control and Empowerment

The public debate over euthanasia continuously makes reference to ideologies of control and power. The greatest threat to the dignity and self-identity of terminally ill patients, it is argued, is the experience of "loss of control," an indignity that is especially assaulting because of the private and intimate nature of one's dying. Patients fear losing control to technologies, to professionals, to the state, and in some instances, to their families. (Caregivers themselves may well feel "controlled" by the requests of patients, or their families, or the law and lurking malpractice concerns, or more and more, economics and the cost of care). The recourse is frequently a strong moral affirmation of the responsibility to respect patient self-determination regarding end-of-life decisions, coupled with a quest for legal "empowerment" through relevant advance directives. In a very fundamental respect, the demand for "dignity" in dying is connected with having control over and being able to manage one's dying.

The assertion of control and empowerment reveals some very paradoxical features at the heart of practices of care for the dying. The experience of loss of control has come just as the dominant traditions in medicine, the law, and ethics have converged to form a consensus that patients ought to have control over their dying. This is the point, after all, of all the legislation and case law regarding advance directives since *Quinlan*, culminating in the "Patient Self-Determination Act" that went into effect in December 1991, and requires all health care facilities receiving federal funds to inform patients about advance directive upon admission. There thus appears to be a profound disparity between what patients are experiencing in the course of their dying and what they are supposed to be experiencing.

Yet, at the same time, the very experience of illness and more fundamentally the process of aging that inevitably culminates in death reveals that we are subject to some kind of ultimate powers *beyond* our control. We perhaps aspire, through our technology and knowledge, to a mastery of nature and the *immortality of the gods*, but we continually receive reminders of our limited and finite nature. We may therefore experience these ultimate powers as arbitrary, as abusive, as cruel—because we are deprived not only of what we have but also what we wish to be—or as creative, nurturing, and preserving, but we cannot in any event help but acknowledge that any “control” we assert over our dying is limited and qualified with respect to these ultimate powers.

The religious dimensions of this sense of control by an ultimate Other are displayed in the bedside expressions of “being in God’s hands,” or “letting God’s will be done”; or, it may be stated in more formal theological affirmations regarding the “sovereignty” of the creator of human life over our death and destiny as well. This appeal to “God’s hands,” “will,” or “sovereignty” reflects not so much the closure of the question at stake, but rather its *context*. Patients, caregivers, and families still have choices to make, lest this dimension of ultimacy become a guise for fatalism. That is, it still is an intelligible question to ask whether patient choice for death *expresses or contradicts* the basic sense of powers that are beyond our control and ultimately sovereign.

Another way to frame this dimension is to ask whether patients who are “empowered” with choices regarding end-of-life decisions also have accountability for the content of that choice. Does a right to choose imply that all choices regarding the bringing about of death are morally equal? While setting standards for responsible choice seems an alien idea in a pluralistic culture, a core theme in religious discourse about taking human life is accountability, to self and conscience, to others, such as family or professional religious caregivers in medicine, and to an ultimate Other. In evaluating proposals for legalized euthanasia, we might follow the suggestions of some ethicists who see in the Just War tradition formal moral criteria that have broad applicability to situations where the taking of human life is contemplated.⁶ The case for legalized euthanasia, I submit, may meet many of these criteria, but almost certainly fail the test of last resort.

The Finite Self

It is sometimes maintained that the fact of illness compromises personal autonomy, that the experience of pain and suffering disables not only the body but also the self’s capacities for informed decision making. Such a perception has historically been important to justifications of medical paternalism. As well, it surfaces in theological claims that a deliberate choice for death through suicide is rationally compromised if not entirely irrational. Yet, the paradigm case for voluntary euthanasia presents a patient who is fully autonomous and possesses sufficient decision-making capacity, notwithstanding a condition of terminal illness. It is evident then that an ethic of euthanasia presupposes a conception of the nature of the self in the face of illness and death that is somewhat contrary to conventional wisdom in medical and theological traditions. Since such an ethic

places so much stress on patient self-determination, this conception of “self” bears some scrutiny.

There is little reason to dispute that some deliberate choices for death are carefully considered and continuously expressed. Some just as surely are not, but are occasioned by depression, reversals of fortune, etc. An important safeguard is to ensure that a patient’s first words are not his or her last words: The demand for death, if it is an authentic expression of the desires of the self, would be reiterated over time. Such a view is implicit in our allowance for revocations of advance directives. We know the self over time can change its mind, and respecting such changes in this context is especially pertinent, since failure to heed a changed treatment preference may lead to an irrevocable mistake.

We can also ask whether a patient’s consistently expressed request to die may well signify a form of isolation experienced by the dying person. The exemplary patient of an ethic of euthanasia is a paradigm of individualism. We do not, however, live our lives shorn of social relationships, and it is this social dimension of the self that seems neglected by the stress on personal autonomy. The autonomous self requesting assisted suicide or euthanasia is affirming independence, when the character of our lives is marked by mutual dependency.

Thus, it is imperative to ask whether the care of the dying person has somehow disrupted or severed the relational bonds and connectedness for the person. This is not to suggest that, all things considered, the wishes of a competent patient ought always be trumped by the interests of others. It is to contend, however, that many discussions of euthanasia do not consider all things. Hospitals are wonderful places for curative medicine, but they are not at all conducive to a humanizing experience of dying.

The institutionalization of dying in our culture can be a profoundly alienating and isolating experience for the terminally ill. There are, however, other venues for care that can be more supportive of experienced social patterns of life, including hospice and home care. Our culture needs to be much more supportive of these venues, lest we drive the terminally ill to euthanasia out of a sense that they have been abandoned. The dying patient may be beyond the realm of technological cure, but our attitudes and practices must ensure that they are always within the realm of human care, that their pain and suffering is an occasion for compassionate bonding rather than social severing and isolation.

A third aspect of the moral self pertinent to the euthanasia debate is often expressed in both theological and popular discourse in the metaphor of “playing God.” A principal thrust of this slogan is to suggest that deliberate choices for death are an arrogant usurpation of authority regarding the manner and time of one’s dying. It is to encroach on the dominion of the powers beyond our control that we experience as sovereign and ultimate.

Doing ethics by slogan inevitably risks distortion of the issue, and the problem with this particular metaphor is that it appears to deprive persons of the capacity for responsible moral agency with respect to *all* end-of-life decisions. On one hand, the appeal to playing God seems to push in the direction of *fatalism*, viewing even the occurrence of illness and disease as manifestations of the inscrutable divine will. A provocative literary example of this attitude is to be found in Albert

Camus's *The Plague*, in which the priest Paneloux accepts his lethal affliction as God's will and refuses to allow the physician, Dr. Rieux, to administer a potential inoculating serum.⁷ Thus, providing technological interventions that alter the natural course of the disease process might be rejected as a form of playing God.

Alternatively, the concern about playing God may be expressed in *vitalism*, an attitude that requires all medical technologies, as gifts of divine grace, to be used to prolong life and forestall death. In this view, a decision not to provide such treatments is a pretentious usurpation of dominion over life and death by human authority. Such an attitude was displayed in the recent Minnesota case of Helga Wanglie, a persistently comatose, 87-year old woman whose husband refused to allow her physicians to disconnect the respirator because of his wife's convictions that "Only He who gave life has the right to take life."⁸

The problem with both fatalism and vitalism is that human beings are not conceived as moral agents with decisionmaking capacity and responsibility. However, the theological concern expressed in the playing God metaphor is best seen as the presupposition within which we are called to exercise responsible agency. While human beings do not have ultimate control over life and death, we are accountable as *stewards* over our own lives and for the lives of others.

It is, moreover, in the actions contemplated in responsible stewardship that the playing God theme can be a useful reminder of the constraints on our decisions. The point is not that we should not make choices about medical treatment at life's end, but rather that we should recognize such choices are made in the context of our finitude and fallibility.

These inherent limitations of human nature are particularly germane to public policy about legalized euthanasia. We have limited *predictive* capabilities about the outcomes of actions and policies that we initiate, which demands caution in evaluating claims either that a social practice of euthanasia will be relatively "clean," or that it will culminate in an ethos not dissimilar to that of Nazism. Similarly, however many safeguards built into a social practice to regulate and manage such a practice, we seldom are able to *control* the courses of action we initiate. The Dutch experience with de facto toleration of euthanasia is especially revealing of this point. The first governmental study of the scope of the practice indicated that, despite a decade-long effort to establish professional guidelines under which physicians would not be subject to prosecution for performing voluntary euthanasia, 44% of patient deaths did not meet the strict criteria for the practice.⁹

The context for our personal and social choices, then, is that of finitude displayed in limited knowledge and limited control, rather than supporting pretensions of omniscience and omnipotence. It is also constituted by our *fallibility* and propensity for making mistakes, the magnitude of which is enormously heightened in a practice of euthanasia, because any mistake is irrevocable. Recent proposals for legalized euthanasia, as in Washington State, stipulate that the option of euthanasia would be made available only to patients diagnosed with a terminal illness, but medical professionals are the first to acknowledge that such diagnoses are not infallible and that the duration of terminality cannot be specified by imposing a rather arbitrary time frame, such as six months.

The pitfalls of presuming that all our technology has brought us certainty with respect to the end of mortality are tragically highlighted in the story of Wanda Bauer, a 69-year-old Colorado woman. In July 1991, Ms. Bauer was informed by her physicians that she had terminal liver and pancreatic cancer. Returning home from a hospital stay, she asked her son to retrieve a .22 caliber pistol, which she then used to take her life. An autopsy revealed that Ms. Bauer was in fact suffering from a serious liver infection, both treatable and non-cancerous.¹⁰

One could validly contend that the Bauer narrative is an aberration, and that a legalized practice of euthanasia could incorporate procedural safeguards (independent review panels, for example) to reduce diagnostic and prognostic mistakes to the minimum humanly possible. Yet, the need for such procedures concedes, in effect, the larger claim at issue here respecting human finitude and fallibility. Indeed, the permissive or restricted nature of the procedures proposed or constructed to compensate for human limitations will themselves reflect certain understandings of human nature.

The Giftedness of Life

Perspectives on euthanasia also reflect conceptions of the character of our lives. We may, on one hand, make claims of "ownership" over our lives and consider our bodies "personal property," notions which fit readily within a paradigm of self-determination. Yet, we also know that we are radically dependent on others for our very existence and for the basic conditions — air, food, clothing — of continued existence.

This sense of ultimate dependency often assumes a more religious characterization of life as a "gift," as something of intrinsic value that we receive from others, and not merely instrumental value with which we can do whatever we please. Indeed, historically much theological objection to suicide focused on how such acts expressed repudiation of the divine gift of life, and therefore comprised a wrong, constituted as much by the sin of *ingratitude* as by a sense of unjustifiable killing.

At first glance, "gifts" seem to have a fundamental dimension of freedom to them. We receive them not because of desert or work we have done (otherwise the gift becomes a "wage"), but by the generosity of the giver. Moreover, gifts frequently are made in the absence of expectations of remuneration to the giver, expectations that transform the gift into an inducement.

The paradox of gifts, however, is that we also feel, sometimes very powerfully, that they *create* bonds of community with others,¹¹ and in that respect are not free. We feel, for example, that certain attitudes towards the giver are appropriate, such as gratitude and thankfulness, while others, disrespect, indifference, or ingratitude, are not.

In addition, gifts seem to create a kind of moral imbalance between persons. It's not merely that we seem to feel the recipient should hold a certain attitude towards the giver, but the recipient typically feels some kind of inner imperative of reciprocation. That doesn't entail (at least necessarily) a tit-for-tat exchange, which in all likelihood would diminish the moral significance of the original gift and

transform the relationship into a form of trade and barter. However, the recipient commonly engages in some practices of response to the gift, such as the expression of gratefulness, which can affirm a deep bond between giver and recipient. The recipient may also indicate a desire to "make it up" to the giver at some future date, implying again that some type of reciprocity can rectify the moral imbalance created by the original gift.

Part of the nature of gifts is that they come with "no strings attached," and so once given, the recipient is in a practical respect free to use, transfer, or dispose of the gift as his or her own. Yet, this practical freedom may not correspond to a deeper existential reality, especially present with gifts of great value, of an experienced responsibility to use the gift in a manner intended by the giver. Indifference to the gift may itself be a form of ingratitude, and exchanging an unwanted gift (a tie for Christmas, for example) for something we really wanted may involve us in an embarrassing explanation, if not deception, should someone inquire how we liked the particular gift.

Thus, our common parlance suggests dimensions in which gifts are, paradoxically, both free and binding. The same features, I suggest, are embedded in our discourse about life as a "gift." The sense of gratitude to parents, and within a religious community to the ultimate Giver of Life, seems a basic, natural human inclination. This gift, in an ultimate sense cannot be reciprocated, but we may seek other modes of expressing gratitude, for example, caring for our parents as they age and become increasingly dependent on others.

Whether we can use our lives in a manner consistent with the intentions of the givers is a more complex question, yet also one of particular relevance to the ethics of euthanasia. We would first need to know what the intentions in giving us life were,¹² and our parents may not have had any, or have such general intentions that several ways of life could satisfy them. Very specific intentions — "You will be an attorney," etc. — can so limit the recipient's freedom that one's life will not be experienced as a gift. Similarly, while theological communities affirm the fundamental goodness of God's intention in creation, it may be unclear what this implies for the specific actions of a particular individual.

As with many gifts we receive, our bodies age and deteriorate, and become less instrumentally useful to ourselves and to others. That does not necessarily mean either that the intrinsic value of the gift has been eroded or lost, or that a choice for death while in the terminal stage of illness expresses ingratitude. Indeed, in such contexts, patients and caregivers may talk about "giving up" the fight against death, which presents two quite distinct meanings. It might suggest a despondent resignation to one's demise, that all reasonable resorts to prolong life have (or will prove) futile. However, "giving up" can also express a sense of responsibility to return one's life and self into the hands of its ultimate Giver. On this latter construction, it would be vital to preserve the relational value of "giving" rather than "taking" life, such as through assisted suicide or euthanasia.

Suffering and Compassion

In addition to the argument from patient self-determination, a common

justification for euthanasia appeals to the pain and suffering experienced by the terminally ill, an appeal that converges with the strong emphasis in the moral tradition of medicine to relieve the pain and suffering of patients. This imperative seems especially appealing in a culture oriented to instantaneous technological gratification, and from which we demand immediate relief from the vicissitudes of life. In such an ethos, pain and suffering come to be looked upon as evils, perhaps of an absolute kind.

A set of assumptions about suffering are embedded in this argument that need to be challenged both culturally and theologically. A first is its too easy identification of "pain" with "suffering." What suffering seems to amount to is but an extreme on the continuum of pain; suffering is simply unbearable or uncontrollable, or perhaps unnecessary, pain. Surely, however, if biomedical researchers only apply themselves more diligently, we can develop therapies that will bring suffering under our mastery as well.

Yet, we know full well from our own experience that we can feel pain but not suffer, and we can experience suffering without being in pain.¹³ Though illness and disease, and especially terminal illness, can surely be an occasion for suffering, suffering is ultimately something more than a bio-physiological phenomenon; in suffering, the integrity and identity of the self is threatened or called into question.

Such a conception of suffering tends to place it beyond the biomedical model, however, as something that is not susceptible to curing or fixing by one or another of the technological remedies at the disposal of caregivers. Suffering is in this respect medically and technologically incorrigible; yet, it is precisely because we can't medically manage suffering that its obstinate presence becomes an occasion to affirm the rights of the terminally ill to euthanasia. We seek to solve the problem of suffering by taking the life of the sufferer.

Such an attitude suggests that the modern medical enterprise simply cannot accommodate suffering. It appears as an unmitigated, unredeemed evil that ranks along with death as the mortal enemies modern medicine seeks to conquer. Indeed, as the increasing public sentiment for euthanasia reveals, in some instances death is the lesser and preferable evil.

This cannot fail to have its effects on the moral identity of medicine. Paradoxically, even though the virtue of compassion is often cited as a motivation for euthanasia, the failure of medicine to account for suffering renders the entire notion of compassion morally vacuous. For compassion means to suffer *with* or *share* in the sufferings of the other. Yet, such a virtue would have no moral point or meaning when the elimination of suffering and/or the sufferer becomes a central purpose of the medical ethos.

The problem here is that modern medicine, and our technologically obsessed culture more generally, has simply lost sight of a central religious dimension to suffering, namely, the tradition of *meaningful* suffering. That does not mean that suffering is to be praised as a good, or that it is to be sought after. Dr. Rieux in *The Plague* is surely correct to contend that it is preferable to relieve suffering than to portray its excellence.¹⁴ The point of this religious dimension, rather, is that even in the midst of such an evil, purpose and meaning can be found and ascribed. We cannot, then, simply consider suffering as always an unqualified evil whose

presence is a symbol of our failure and whose mastery is our objective.

Historically, religious thought has pointed to three principal purposes for human suffering: A punitive purpose due to sinfulness; a pedagogical purpose to expand the character of the self; and a redemptive purpose to purify the soul. The former purpose should not be a consideration in the case of the terminally ill, as all will one day experience such a condition. However, the latter two dimensions of suffering can be significant for both patients and caregivers. The ordeal of suffering may bring knowledge and a cleansing to patients while providing an occasion for compassionate stewardship by others.¹⁵

The tradition of meaningful suffering could not be more at odds with a medical ethos that seeks to eradicate all suffering. The late theologian Paul Ramsey, at a conference on chronic illness, speculated that the purpose of modern medicine was to *relieve* the human condition of the human condition, with "human condition" referring to the pain and suffering we experience as our common mortal lot. It is worth asking, whether in the ideological drive to eliminate suffering or, if that fails, eliminating the sufferer through euthanasia, we are not dehumanizing both professional caregivers and patients.

The Good Death

It is well-known that the classical meaning of the term "euthanasia" refers to an "easy," "painless," or "happy" death.¹⁶ In our century, however, such language has become very problematic, because of the association of euthanasia with the involuntary killing by the medical profession under the racist and eugenicist ideology of Nazism. Thus, the recent Washington State initiative sought to circumvent the terminological problem by proposing statutory language of "aid-in-dying" rather than "assisted suicide" or "euthanasia" to describe the envisioned actions of physicians.

It is nonetheless not hard to see that a conception of a good death is bound up in the debate over euthanasia, as displayed by the popular slogan of "death *with dignity*." In our pursuit of technological mastery, however, we often seem to have foreclosed the possibility of euthanasia in the classical sense without resort to some lethal action. Indeed, as philosopher Margaret Pabst Battin has suggested, the technological imperative behind modern medicine suggests our quest is not so much for the good death as for "the least worst death."¹⁷

In the voices of terminally ill patients and their relatives, three principal features seem to constitute the modern vision of the good or dignified death — a desire to die *painlessly, quickly, and in one's sleep*. That is perhaps not surprising, given that the public images of modern dying present to us persons who may be experiencing great pain, for a protracted period of time, during the latter stages of dementia. Thus, to avoid the "worst" death we may well seek alternatives such as assisted suicide or euthanasia to ensure a comparatively better death.

Yet, such features perhaps are a comment not so much about death as about dying, about a process rather than an event. While the fear of death may well be still deeply embedded in our personal and collective psyches, it is possible to contend that our fear of dying, of a painful, protracted, technologically-managed

process that precedes death, has become the pre-eminent fear. Such fear likewise plays into support for euthanasia, which appears as an alternative to avoid a bad dying as well as a worst death.

Some, perhaps much, of that fear is uneducated and can be overcome with more public discussion of dying and death. Persons who feel that diagnosis of a terminal condition means being trapped by technology and abandonment to strangers need to be informed about alternative measures of empowerment, such as advance directives, and alternative venues of care, such as hospice. Perhaps much of this education can occur through the instrumentality of the Patient Self-Determination Act; for several reasons, however, a hospital is not the ideal forum for such discussions, and more sustained efforts will be needed to counter the prevalent taboo about death.

In such forums, be they private, institutional, or publicly-situated, religious images of dying and death will be unavoidable reference points and can nourish a rich discourse, and it will be important to trace out the implications of such images and how they connect with sentiments regarding euthanasia. The religious and medical notion of death as "enemy," for example, sustains the relentless quest for technological conquest and mastery of death, and one consequence of that quest is increased popular support for euthanasia.

Similarly, for many people in our culture, especially the young, death is perceived as "the stranger" or as "the intruder." This is attributable in large measure to our cultural practices of institutionalizing dying and death in hospitals or nursing homes, which isolate the dying person from our midst. Few more potent symbols could be conveyed about how dying means alienation and abandonment in our culture, sentiments that also can provide fertile soil for support of euthanasia.

An image of death as blessing or deliverer or even friend, by contrast, would support a different set of attitudes and practices in our care of the dying. We would perhaps be more sparing in our use of technology, and perhaps erode the stigma and taboo of death that is reinforced by our isolation of the dying through an accepting rather than adversarial relation to death.

My general point here is that our practices of caring for the dying are connected with certain images of death embedded deep within our cultural ethos. These images are formative of understandings of a good death in our society, and, for better or worse, whether euthanasia is a means of achieving that kind of death. The retrieval of these images for public discussion is a necessary part of our quest for moral meaning and integrity in modern society.

The Relevance of Religion

The relevance of religion to public discussions over the ethics or the legalization of euthanasia is often disputed. It is claimed that in a pluralistic society, any meaningful public discourse about such matters must proceed from common and shared premises, whereas religious traditions provide moral frameworks of use only within the private realm of a particular community. This public irrelevance is magnified when we focus particularly on issues of public policy, given that laws in

our constitutional configuration must have a non-religious, secular rationale.

While valid in certain respects, such claims often suffer from a severe case of moral myopia. This historical influence of ideas drawn from the formative religious traditions of our culture is undeniable, and along with other moral traditions, continue to shape that common ground we are so anxious to find for public discourse. In a democratic society, religious communities themselves constitute various "publics," constituencies that need to be taken into account in policymaking. In such a society, religious communities and their members have not only a right but a responsibility of *citizenship* to participate in such discussions, though as "citizens," participants from religious communities are no less required to seek a moral vocabulary that is accessible by fellow citizens (at least, if they want to entertain ideas of persuading others to a different position).

Finally, in focusing above on certain "ultimate" questions embedded in the debate over euthanasia, I have intended to suggest the presence of a deeply religious core to the debate. The questions of control and empowerment, the finite nature of the self, the dependency and gifted nature of human life, the place of pain and suffering, and the moral and existential significance of death are common, human questions, but also ones that historically have been vital to the moral dialogue of religious communities. While in a pluralistic society, we may not agree with the answers such traditions present on the issue of legalized euthanasia, the ultimate questions they raise are unavoidable for believer and nonbeliever alike.

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