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Psychospiritual Care of the Dying Patient: The Impact of Being a Christian

by

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Why do you fear your last day? It contributes no more to your day than each of the others."¹

American society wishes that the religiously devout would treat their religion as a sort of hobby, so that religious principles could be overlooked when they are in conflict with the prevailing secular world-view. It is easy to be moral when treating a sore throat: matters become troublesome when one's theology squares off with a patient request for euthanasia. This is when the primary care physician is challenged to a higher moral code. Some would argue that the refusal of an immoral request is a violation of a patient's autonomy. However, for the Christian physician this is not an issue of legal rights. The Christian is called to discern and then enact the will of God.²

Awareness of the value system within which physicians work is vital, as "Values are inevitable and a pervasive part of psychotherapy"³ and medicine as a whole. The health system has two broad classes of secular values which may conflict with theistic systems of belief. In general, secularization may be defined as a separation of central institutions or values (i.e. medicine and health) from the influence of religious thought and practice⁴. Specifically, clinical pragmatism defines its values in terms of the dominant social system. Humanistic idealism

stresses self-actualization, independence, autonomy, truth, honesty and happiness. Both of these systems of belief ignore spiritual factors that influence human behavior. They exclude the largest sub-group in our patient population, i.e., the patients who believe in God and try to adjust their lives and their world-view to what they believe to be His Will. The theistic system of belief implies an absolute and universalistic structure of ethics based on God's Law. It is in sharp contrast to the clinical-humanistic approach that sees humans as supreme and always calls for situational ethics³.

Many psychiatrists believe as Freud did, that religiosity is a kind of neurosis⁵. However religion was considered so important to our founding fathers that the Constitution was amended to protect its free exercise. In the recent political past, the anti-war movements and the civil rights movement unapologetically used religious principles as important arguments for their causes⁶. Now, religion is out of fashion in the scientific and political community and, therefore, it is not considered an important aspect of the psyche of our patients. It can not even be acknowledged in discussions of bioethics⁴. The biopsychosocial model must be extended to the biopsychosocial-spiritual model in patients where religion is important. A resurgence in religious faith by the terminally ill patient must be recognized. In a recent study of 104 patients, it was found that hospitalized terminally ill patients indicated a greater spirituality than either the non-terminally ill hospitalized group or the healthy group⁷. The primary care physician can treat dying patients more effectively when the patient's world-view is accommodated and integrated into the therapeutic approach.

Involving any aspect of religion in patient care may be looked upon negatively by colleagues; especially when the faith of the physician or patient effects the therapeutic approach. Physicians who take their religion seriously may be viewed as slightly off-balance. Going to church on Sundays is fine, just don't bring religion into the practice of medicine. Physician first, believer second. This is the secular view, the dogma of the media. Since religion in the United States is seen as 'private', it cannot be a part of medical treatment. Thus in medicine, as in politics, one's religion is considered 'suspect'. For the Christian physician, religious faith is at the forefront when caring for the dying person. The story of the Good Samaritan exemplifies the moral code of self-sacrifice, care and compassion that is to be shown to patients. The negative connotation of 'playing God' is a reminder of our finitude and fallibility⁴. For the faithful, humans are merely stewards of the lives given to them by God. A Christian can not "consider himself to be the arbiter of death, just as and because he does not consider himself the arbiter of anyone's life"⁹. The attitude of physicians to the mortally ill is the most challenging test of their justice, charity, nobility of mind, and professionalism⁹.

Treatment of the Mortally Ill Requires the Physician to Develop His Own Attitude About Death

Death is an unspoken subject today as was sex in the last century. Mitford¹⁰ illustrates this by the funeral industry whose goal is to disguise death. The dead

are dressed and make-up applied until they look "better than they did in life." Folks "pass on" or "go to Jesus." Gorer¹¹ states in his essay "Pornography of Death"

Our grandparents said that babies were found under cabbage leaves or were brought by the stork. Our children will probably say that those who 'have passed away' are changed into sleeping flowers or sleeping somewhere in a lovely garden.

To deal with the dying, a physician must be convinced of the inevitability of his own death, though it is feared because it brings an end to a cherished existence. Aging is the constant bearer of death. Because aging is a fact of this earthly existence, the ultimate destruction of the physical body is foreseen. As bodies change, faces line, and hair grays, the living are reminded that they are constantly dying. Elizabeth Kubler-Ross¹² explains that death is always distasteful to man, so he does not admit to death of natural causes. One dies by being killed. Thus, death is a frightening event that calls for retribution and punishment. But, "a denial of death at any level is a denial of one's basic nature and begets an increasingly pervasive restriction of awareness and experience".¹³

Physicians also experience death anxiety and are members of our death denying society. Physicians who are able to realistically accept the fact of their own death are in a better position to accept the death of others and to help them accept their own mortality. Since the definition of a terminal illness is one in which the disease state is beyond recovery and the patient is beyond the usefulness of curative medicine, some physicians may feel a sense of failure and defeat because of their inability to save their dying patient. Unfortunately, many primary care physicians feel that if they can not cure their patients, they can no longer effectively treat them¹⁴. To deal with the impending demise, the physician lessens his emotional investment in the dying patient. The patient may be abandoned emotionally or become merely the 'lung patient on 5-West'. Or, the physician may go to the other extreme of denying the terminal nature of the patient and become overly zealous in his effort to 'cure' his patient¹⁵.

Because death is 'unspeakable' and because it is not treatable in the conventional medical sense, training of physicians in the care of the dying is lacking. This leads to misinformation and misperceptions of the needs of the dying. Dr. Weisman has outlined several common fallacies about dying patients¹⁶. Briefly, these are:

1. No one wants to die unless they are suicidal or psychotic.
2. As man gets closer to death his fear of death becomes more intense.
3. Preparation for death is impossible.
4. Dying people don't ask many questions because they do not want to know their future.
5. Patients who are not candidates for further treatment should be treated for pain and left alone to die in peace.
6. Doctors have no further obligation after death.

The physician may avoid dealing with death so totally that the dying patient may not even be informed of his prognosis. The physician may convince himself that appraising the patient of the terminal nature of his illness would make the patient

more depressed. And, after all, if he suspects he will die and wants to know, he will ask. The duty to be truthful demands discernment, respect and charity and should be accomplished by the physician (not the medical student or nurse). The physician must be prepared for the range of patient reactions and allow sufficient uninterrupted time to answer all the patient's questions. The goal must not simply be to present an overview of the clinical situation; the goal must be a meaningful human-to-human communication.

The Meaning of Death

Death for the non-Christian has many descriptions. It may be described as "non-being" (Kierkegaard), of "fragility of being" (Jaspers) and the "impossibility of further possibility" (Heidegger)¹⁷. One may believe that death results in annihilation or reabsorption onto the Ultimate Spiritual Reality. Lucretius wrote: "We can feel assured that, in death, there is nothing to be afraid of. If one is non-existent, one is immune from misery. When once immortal death has relieved us of mortal life, it is as good as if we had never been born . . ." ¹⁸

For the Christian, death has meaning beyond 'ceasing to exist'. Christ contained all men in His death upon the cross [2 Co 5:14]. Hence death can be seen as an effective reality for each man and yet also as a part of Christ's death. Dying with Christ is a dying to death itself. For the Christian, belief in Christ is freedom from death. For "he who believes in me will live, even though he dies; and whoever lives and believes in me will never die" [Jn 11:25-26]. What happens after earthly death depends on one's choice when offered salvation through Christ. For the Christian, it is eternal life, for others it is the horror of a 'second death'. As does suffering, death has meaning through Christ. When Christians die in grace, their "physical death is a participation in the death of the Lord, so that they can also share in his Resurrection". As Paul wrote: "For to me, to live is Christ and to die is gain" [Phil 1:21]. True wisdom accepts death as divine decree [Si 41:4]; this underlies the lowliness of a mere human when faced with an immortal God; "for dust you are and to dust you will return." [Gn 3:19]

Death for the Christian as well as the non-Christian can be viewed as a positive event. Socrates displayed much composure in his approach to death by a happy "Let's have a drink". For both belief systems, death marks the end of earthly existence. For the Christian, it is the time when the soul separates from the body and goes to God to be joined with a new, spiritual body. Christians have a faith that promises resurrection and a new life, an ultimate victory in Christ.

The Meaning of Suffering

The concept of suffering is important because medicine has the moral commitment to care for the ill and to relieve suffering¹⁹. But "our society has made a fetish of comfort. All pain, whatever its function, its roots or consequences, must be avoided . . . [but] society also tells us that pain is somehow ennobling and that, if we put an end to it, we are undoing God's work"²⁰. Thus, the societal view of suffering is confused.

Hinduism teaches that the cause of suffering is our desires; the Greeks said it came from our lack of self-knowledge; and, existentialism claims certain suffering is simply absurd or just a part of existence²¹. But the mainstream of American society is Judeo-Christian and hence looks for meaning and answers in that context. "Human beings have a deep need to have their lives make sense, to transcend the dynamics of individualism and selfishness that predominates in a competitive market society and to find a way to place their lives in a context of meaning and purpose"²². A patient might ask: does God have a purpose for this suffering? Is there a reason for everything? Can suffering be educational? Can it cure us of our faults and make us better people? Rabbi Joseph B. Soloveitchik answers, "Suffering comes to the ignoble man to purge his thoughts of pride and superficiality, to expand his horizons. In summary, the purpose of suffering is to repair that which is faulty in a man's personality."²² Boeyink suggests that we "ordinarily mean suffering as an anguish which we experience, not only as a pressure to change, but as a threat to our composure, our integrity, and the fulfillment of our intentions"²³. Some claim that suffering ought to be accepted because it makes us better people. Unfortunately, in reality this does not seem to always be the case. Too much suffering can make people cynical, depressed and miserable. It may not be apparent that God limits suffering to what we can handle. Sometimes we are destroyed by our suffering. Iris Murdoch wrote in her novels that suffering is seldom ennobling, because it takes an extraordinary person to survive either great suffering or great sadness.¹⁹ Paul Claudel states: "Happy is he who suffers and who knows why."¹⁹ Is it preferable to suffer for a reason than for no reason at all?

Christian patients can find meaning for their suffering through their faith. Suffering has an intercessory and redemptive value: if "we share in his sufferings . . . we may also share in his glory." [Rom 8:17] Through suffering, the Christian takes part in Christ's suffering on the cross. The opportunity for application of one's suffering for the good of others is understood through the benefit Christians gain by Christ's passion. God has allowed suffering to occur and has provided the grace for personal growth through suffering. St. Paul recognized the value of suffering: "knowing that suffering produces endurance, and endurance produces character, and character produces hope" [Rom 5:3-4] and, "for Christ's sake, I delight in weaknesses, in insults, in hardships, in persecutions, in difficulties. For when I am weak, I am strong [2 Cor 12:10]. But, he also wrote of the need for God's grace and comfort:

Praise be to the God and Father of our Lord Jesus Christ, the Father of compassion, and the God of all comfort, who comforts us in our troubles, so that we can comfort in any trouble with the comfort we ourselves have received from God. For just as the sufferings of Christ flow over into our lives, so also through Christ our comfort overflows. [2 Cor 1:3-5].

Effects of Suffering

1. Suffering can lead to bodily loathing

One way the dying can cope with physical suffering is to attempt to divorce the

concept of "Spirit" or "personhood" from their material forms, i.e., their bodies. They may be inclined to see their bodies as boxes, containment systems for who they really are (their souls), their bodies being inconvenient vehicles for moving them about. The body is like a car that must be fueled, watered, cleaned, but, unfortunately, breaks down and needs repair. This view has been called *angelism* by the French philosopher Jaques Maritan. He described it more eloquently as the view that we are pure spirit and that our corruptible bodies are what keep us from soaring unimpeded to God²⁴. The Gnostic-Cartesian model advocates that the true person is trapped in subpersonal matter; the body is the prison of the person. Because I think, I am, and not vice versa²⁵. Gilbert Ryle, a contemporary British philosopher, calls the soul "the ghost in the machine"²⁴. No matter how hard we search, what advanced technology is used, that which comprises the soul is yet to be elucidated — hence, the "ghost" that operates our bodies. Some modern researchers believe that the "bio" portion of the bio-psycho-social model determines who we are. The "soul", or "self-theory" is explained by the complex of millions of neurons within our brains. The soul itself seems ageless. Some people say that they do not feel any older than their thirties. The aging soma (or body) seems to exist in contrast to the ageless psyche. The Greek word soma comes from the word for tomb, *sema*. This reflects the view of the body as the tomb of the soul²⁶.

"One of the problems of suffering is that it alienates us from ourselves — this thing that is happening to me is not me . . ." It is exactly the ability to make suffering a part of us that is crucial if one is to be an integral self¹⁹. The Judeo-Christian model declares that the integral person is a soul-body composite²⁵. Jesus was God made flesh. He suffered, died and was buried. Jesus was incarnated as both body and soul. At His resurrection, Christ rose from the dead as he appeared in life — body and soul. The teaching of the Resurrection tells us that we will live as integral beings, not as free floating spirits, although the nature of our substance is not yet clear.

2. Suffering can lead to depression

Depression in terminally ill patients usually stems from a sense of real or fantasized past loss, and anxiety is brought on by fear of future loss. Patients expect to lose their independence, bodily function, their family and friends, in essence everything that they love¹⁵. Also, patients feel bad because (1) people believe that the world should make sense and hence there must be a cause for every effect and a reason for everything that happens and (2) people then believe that we are the cause of what happens, especially the bad things²². Many patients get angry with God or Fate. However, anger can be directed inward and be manifested as depression¹⁵. Maladaptive behaviors and depression may be exacerbated by an insensitive delivery of the news regarding the terminal nature of a patient's illness by the primary care physician.

The diagnosis of depression may be delayed because the vegetative signs—loss of appetite, sleep and energy and a sense of hopelessness — may be attributed to the illness in a terminally ill person. Thus the additional problem of depression is left unaddressed by insensitive physicians. Once the depression is recognized, the

most important (and time-consuming) treat is for the physician to be continually caring, supportive, and physically present at the bedside as often as needed. The dying person should never feel abandoned. A recurrent theme in the literature concerning death is the fear of dying alone [26,27].

Because there is an inverse relationship between depression and religious coping²⁸, spiritual guidance can be helpful to the Christian patient. Encouraging Christian patients to pray for the strength to deal with their suffering instead of blaming God for their misfortune can be beneficial. To avoid crossing perceived role boundaries, or possibly damaging the physician-patient relationship, the physician should be clear when he moves from the role of "medical healer" to "ordinary Christian"²⁹. When asked, the physician may gain a type of informed consent by saying, "I would be happy to talk to you about spiritual issues. I myself find these to be important, but this would be as a person and not your physician"³⁰. Relating to the patient on this personal level may be more helpful than automatically dismissing patient concerns to the clergy whenever spiritual issues are involved.

If the physician-patient relationship does not allow for interactive spiritual care, Christian physicians can pray for their patients. Medication can supplement (not replace) supportive care.

3. Suffering can lead to feelings of guilt and shame.

Some patients may blame themselves for their illness. They may feel guilty for past morally or socially unacceptable behavior (promiscuity, alcoholism, drug addiction, etc.) and hence conclude that their impending death is a punishment for their transgressions. Tillich³² states that guilt may stem from the failure against oneself, the failure to live the life one was given. Rank wrote "... we feel guilty on account of the unused life, the un-lived life in us"³³. Guilt (I feel bad for what I did) can be internalized to shame (I am bad)³⁴.

Self-castigation can be "treated" by self-forgiveness. Forgiveness can be defined as "the overcoming of negative thoughts, feelings, and behavior not by some form of denying the offense or the right to be hurt/angry, but by viewing the offender at least with acceptance (if not compassion) so that the forgiver can be healed"³⁵. To forgive one's self as the offender, requires an ego-split, so that the ego can examine itself. This is difficult because guilt and shame are affectively charged. Forgiveness requires that one re-experience the pain of his mistake and examine it with expanded awareness, including his motives and personal circumstances³⁶.

For the non-Christian, the motivation for forgiveness is self-healing. For the Christian, it is an emulation of Christ and a mechanism of salvation³⁵. For most patients, guilt may also be decreased by completion of duties; taking care of wills, and reconciliation of differences. Christian patients can be encouraged to pray. The Christian physician can assist in the process of forgiveness by sharing personal experiences with forgiveness.

The patient may also feel guilty over the financial aspect of his care. Paul warns "one [should] consider what he will leave to his children" (II Corinthians 12:14) The physician can address this concern by limiting hospital expenditures where

possible and by suggesting hospice care at home. Hospice care provides for the terminally ill the freedom to decide the circumstances of their death. The goal is to help the patient be fully alive while dying. All hospice patients know that they will receive support and care from the medical staff and hopefully their families and that they will not be abandoned. They are reassured that they will be kept pain-free³⁷.

Relief From Suffering:

A Christian approach for determining if a patient request is moral

Unusual patient requests may arise when the patient requires more than supportive, palliative care. Because each patient represents a unique complex of circumstances with which the physician must deal, it is advantageous, especially to the young physician, to review his or her own moral standards with respect to death and dying. Personal reflection, reading, and discussion with colleagues without the pressure of actual care of a dying patient are preferable to "winging it", where decisions made in haste or in ignorance may be made and regretted later. When faced with a dilemma over the morality of a patient request, one can examine the moral object, the intent and the circumstances of the action to be decided upon. Each aspect of the decision must be moral for the action to be moral. The double effect criterion is helpful when breaking down a decision into its component parts and examining the ramifications. The double effect principle states five ethical criteria that enable a person to act in good conscience^{38,39}.

With respect to the Object of the act:

- (1) the proposed action must not be intrinsically contradictory to one's fundamental commitment to God and neighbor (the act is in itself good or at least morally indifferent)

With respect to the Intention of the act:

- (2) the intention of the agent must be to realize good effects alone and so far as possible to avoid harmful effects

With respect to the due measure of the Circumstances of the effects and the act itself:

- (3) the foreseen beneficial effects must be equal to or greater than the foreseen harmful effects (due proportion)
- (4) the good effect must not be achieved by means of the bad effect, or as a direct consequence of it
- (5) the good effect can only be achieved concomitant with, but not by means of, the bad effect.

Especially for the Christian physician, it is important to step back and review decisions involving critical care and not to be led astray by secular ethics that are not moral. "Before the mystery of death we are powerless: human certainties waiver. But it is precisely in the face of such a checkmate that Christian faith . . . becomes a fount of serenity and peace . . . What is meaningless takes on meaning and worth"⁴⁰.

1. A patient refuses treatment

A terminally ill patient may refuse a suggested treatment. A general Christian guideline is that a treatment is only obligatory when its benefits outweigh its burdens⁴¹. The patient is free to refuse treatment that would only prolong an inevitable death so long as the object of the refusal is to avoid suffering and not to hasten death. Extraordinary treatment is only morally obligatory if the patient is not reconciled with God or if other lives depend on the patient⁴².

For example, a patient in the terminal stage of AIDS, with a CD4 count of zero, develops pneumonia. Can this patient refuse to go into the hospital for x-rays, cultures and intravenous antibiotic treatment? Many would consider hospitalization to be standard treatment. But an ordinary treatment can be defined as one that is beneficial, useful and not unreasonably burdensome to the patient⁴². In this case, the patient feels that hospitalization would be too burdensome. He wishes to live his last days at home surrounded by his family and friends. His goal is not to die now, but to avoid the burden of a hospitalization and treatment that would only prolong his dying. He is willing to take oral medications at home as long as he is able.

The intent of this patient is to avoid hospitalization and the endless tests, loss of privacy, fatigue, and change in surroundings that it entails. He does not wish to hasten his death. The circumstances are that he is mortally ill. Treatment of his pneumonia would only prolong his dying. He is ready to die, having reconciled with family and God. The moral object is the refusal of a treatment option that requires hospitalization, pain, fatigue, discomfort and loss of privacy. In this case, the patient is free to refuse treatment that would prolong an inevitable death, since the object of his refusal is to avoid suffering and not to hasten death. One duty of the primary care physician is to avoid "therapeutic tyranny." The burden to the patient as an individual must always be weighed against the possible benefit.**

2. The patient asks for an increase in pain medication

The goal of appropriate pain management is to keep the patient relatively pain free, balancing the need to reduce suffering with the desire to retain as high and effective level of functioning as is possible. If a patient is forced to beg for relief from pain or is constantly in fear of not getting adequate pain relief, his experience of pain is compounded by his loss of autonomy. Effective pain management is necessary to allow the patient to prepare for death with hope and peace⁴³ and to allow for resolution of residual conflicts. It also frees the patient to fulfill moral, family and religious obligations⁹.

The physician should be aggressive with pain medication, recalling for example that analgesic doses for terminally ill cancer patients can be astounding. The literature suggests that physicians today continue to use insufficient pain medication. Older physicians may be afraid of the DEA. Other physicians may have misguided fears about drug addiction. Still others may see pain as a side effect of the disease state, thus, not deserving much attention. Problems may also arise when pain medication is ordered on an as needed basis. This sets up a

potential antagonistic relationship between nurse and patient that can lead to poor pain control. The patient may be viewed as a "cry baby" which can antagonize the physician because the patient is constantly demanding drugs. Physicians taking care of dying patients need to fully understand the analgesic armamentarium. If necessary for adequate pain relief, or if requested by the patient, the physician is free to heavily sedate the patient (which may decrease respiratory rate) so long as the intent is to relieve suffering in the circumstance of unmanageable pain and not hasten death.

Pain is a complex human response that is effected by the physical lesion (nociception), the cortical response and the state of mind of the patient. Distraction, auto-hypnosis and faith effect the perception of pain in ways not fully understood. Physicians tend to focus on the biological process and limit pain management to medication. Supportive care of the psycho-spiritual needs of the patient can be helpful. Sit with the patient and ask him to describe his pain and what it means to him. The primary care physician can empathize and "walk" with the suffering person. As appropriate, spiritual strength can be encouraged.

3. Can death be a moral treatment for suffering?

While it is true that death releases the patient instantly from all further temporal suffering, "in the name of eliminating suffering, must we eliminate the sufferer?"¹⁹ The principles of the Hippocratic Oath specify to first do no harm and, second to be of benefit to the patient. When the patient is suffering and dying, these two principles appear to be at odds. Death may seem to be the only solution to ease the patient's suffering. Does this mean death may be considered a last resort treatment for the suffering, terminal patient? Is this doing harm? Or is this a benefit?

The secularists ask, is it moral or ethical to deny people the right of choosing how they die as they were allowed to choose how to live?²⁷ After all, "To have given Patrick Henry life without liberty would have been a betrayal. Similarly, to insist that an individual continue to live without certain implementation of the conditions under which he chooses to live may be a violation of his rights, if not his privacy."²⁰ Others might argue that a person who is legally competent to consent to medical treatment is also then legally competent to decide to commit suicide. Most physicians would agree that modern bioethics is a trinity of moral concepts: beneficence, justice and autonomy⁴. Legally, autonomy is seen as the overriding moral principle. Then, is not depriving a patient of his right to terminate his life a violation of a patient's autonomy and an abridgement of freedom?

Derek Humphry⁴⁷, founder of the Hemlock Society and ERGO (Euthanaisa Research and Guidance Organization), argues that dying people should be allowed to "self-deliver" with or without a physician's assistance if they feel that they can no longer go on living. He also argues that laws should be enacted to allow for physician-assistance suicide and active euthanasia. Good medicine, says Humphry includes "helping some patients die when all options have been exhausted." He feels that a physician's primary work is to alleviate suffering, and if death is the only option left, it should be the final "treatment." The seeming

growing popularity of suicide as a patient's right is exemplified by Humphry's popular book *The Final Exit* which is a suicide manual explaining how to "self-deliver" by various methods including cyanide, electrocution, hanging, drowning, shooting and car exhaust as well as fatal dosages of various medications.

Euthanasia is advertised to the public as an "act of mercy" when in fact it is an act of an individual and societal self-pity. When a patient makes a unilateral decision to commit suicide, the opportunity for personal growth and family healing is lost. The "rational suicide" can be considered as the most selfish act of individualism. It is the premise of a humanistic value system of "me first". My life is mine and I have no responsibility to God or to anyone else. The precept of autonomy presupposes an excessively narrow view of moral life, one in which the relationship of the individual with the community is seen as less important⁴. But in defense of the dying patient, their judgment is often clouded by their pain, discomfort, and loss of hope. It is the suffering part of their personality that decides for the whole person that "it is a good day to die." In a sense, suicide can be viewed as an external agency that convinces its victim to make a choice based on despair. Suicide is the negation of one's ego-ideal, and leads to a death that is the antithesis of the circumstances and conditions for a "good death"⁴⁸. Depression can overshadow a patient request for death or it may reflect the uncovering of long hidden personality traits. For instance, the compulsive personality who requires precise routine and organization and now has lost his sense of control³¹.

Euthanasia activists frequently equate disability with terminal illness as conditions in which euthanasia should be legalized. The living will disseminated by the Society For the Right to Die states:

I direct that life-sustaining procedures should be withheld or withdrawn if I have an illness, disease or injury, or experience extreme mental deterioration, such that there is no reasonable expectation of recovering or regaining a meaningful quality of life.

This living will does not even contain the word "terminal", hence any chronic condition is presented as an appropriate time for "mercy killing"⁴⁹. Note, that in several of the suicides in which Dr. Kevorkian assisted, the patients were not terminal, only disabled. It might seem plausible that the voluntary and competent patient could be allowed active euthanasia. But his technologic solution merely abolishes the "dying", it does not overcome death. And if active euthanasia is the means to a "good death" for the competent patient, shouldn't the less fortunate also be afforded this solution? If the misery of death can be abolished, the privilege of a swift and painless death must be given to all, the suffering, the retarded, the demented, all⁵⁰.

Physicians, as a whole, should contemplate whether the public outcry for aid in dying is a reflection of the medical profession's poor care of the terminally ill. Are physicians woefully ignorant about how to be compassionate and caring to the dying? Are patients forced to choose between assisted suicide and therapeutic tyranny?⁵¹ The elderly often believe that death itself is preferable over the process of dying³¹.

For the Christian physician or patient, euthanasia, suicide, or self-deliverance are not options. "The avoidance of suffering may never be a criterion by which death may be sought"⁴⁴. There is no question of "the Right to Die." The sixth commandment clearly states. "Thou shall not kill." In particular "nothing and no one can authorize the killing of an innocent human being . . . Moreover, no one can request this homicidal act for themselves or for another for whom they are responsible, nor can they consent to it explicitly or implicitly"⁵². The inherent value of human life invalidates ever killing an innocent person even when dressed-up to be an "act of mercy"⁴¹. When a patient requests death, it is a challenge to the physician to determine why the patient wishes to die. Suicidal people feel hopeless, alone and if Christian, alienated from God. They convince themselves that the only way out of an unbearable situation is through suicide. To kill a patient that is confronting an overwhelming sense of worthlessness is to confirm what they believe to be true. True mercy gives hope.

I eagerly expect and hope that I will in no way be ashamed but will have sufficient courage so that now as always Christ will be exalted in my body, whether by life or death. For to me, to live is Christ and to die is gain. If I am to go on living in the body, it will mean fruitful labor for me. Yet, what shall I choose? I do not know! I am torn between the two: I desire to depart and be with Christ, which is better by far, but it is more necessary for you that I remain in the body. [PH 1:20-24].

In both Jewish and Catholic thought, God has given us stewardship (not ownership) over our physical bodies and our temporal lives. To act with disregard toward ourselves, either our lives or our bodies, is a violation of this sacred trust⁴ "Thou shalt not kill" is the plain instruction given to Christians by God. Secular moralists, who wish Christians would keep their pesky religious morals to themselves, are trying to convince physicians that a lethal injection to the dying is no different than withdrawing medical treatment. But allowing a mortally ill patient to die when prolonging their life would involve grave burden is morally and ethically distinct from murder. Even if legislation is passed to allow physician assisted suicide, Martin Luther King reminds us that a "just law is a man-made code that squares with the moral law or the law of God"⁵³.

Conclusion

Death is not necessarily premature or terrifying when the circumstances of death allow for acceptance and true dignity. Many dying patients are able to accept death with equanimity. Because half of the American population over 65 attend church on Sunday mornings²⁸, 90% believe in God and 80% pray regularly⁵⁴, it is reasonable for primary care physicians to consider spirituality as an important medical tool. Historically, religion and medicine have been the "twin guardians" of healing²⁸. If the mortally ill patient has a faith and answers that give him hope and comfort, it should be encouraged. If the patient asks about the faith of the physician, the physician should feel free to share his testimony as a human being (not as omniscient physician) and follower of Christ. It is in the decisive hour of a person's life that the physician can be called to witness his own

faith and hope in God. This is the best way to humanize death⁹. This is not proselytizing, but a sharing of God's grace between two fellow human beings. Many Christian physicians feel they have been called to care for the sick, but our secular society tries to tell them that they must divorce their medical practice from their faith. This is to divorce the body from the soul. It cannot be done. For "Charity sees in the dying person, as in no other, the face of the suffering and dying Christ calling out for love . . . [it] is a privileged expression of love of God in one's neighbor."⁹

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