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The "Death With Dignity" Debate:

WHY WE CARE

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Prologue:

The remarkable advances in medical technology and the life sciences, particularly in the last quarter-century, have posed a critical range of ethical and social dilemmas. The gap between the widespread recognition of the issues and a reasonable and informed response on the part of the Christian community is enormous, surpassed in magnitude and ethical urgency only by the gravity of the consequences of the "biological revolution" for individual human lives, their dignity and their future. Bioethics, still an infant discipline, encompasses a broad range of critical issues in medicine, biology, and allied disciplines. Abortion, human experimentation, genetic engineering, organ transplantation, behavioral control, and death and dying are the most frequently identified problem areas.

Ethical scrutiny of the great potential for good and evil in the rapidly expanding horizons of the biomedical sciences does not arise from idle curiosity or from a detached bemusement. Unless the Christian witness of a carefully considered ethical response is brought to bear upon the technology of medicine and its use there is danger that we will have to cope, as the Reverend Charles Carroll has warned, with "medicine without an ethic; the law without a norm; and the religious community without a theology of life and death, man and nature."¹ In this ethical vacuum, where even to make no morally informed decision has consequences, the final victim will be man himself. In the face of an overriding utilitarian ethic, the individual person, with an "alien dignity" given by God, will be overwhelmed by the consequences of "the coming control of life," symbolically identified as the "Second Genesis" by the noted science writer, Albert Rosenfeld.²

From "womb to tomb," as the cliché aptly puts it, the full range of human experience is affected by the new powers to control life and death, raising the spectre of men "playing God," in the sense of making God-like decisions, who have forgotten how to "play man." When, as in the Supreme Court pronouncement of January 22, 1973 (*Roe v. Wade*), a particular point of view on a vital life-concerns issue is sanctioned and formalized as public policy, the forum of concern is widened beyond the private decisions of individuals in the doctor-patient relationship. Abortion legislation, pro or con, was and is not a sectarian issue, but one of the broadest public morality. Christian citizens cannot rest content with assuring themselves that their personal choices are in keeping with the Will of God; they must work out a responsible *social* ethic that conforms,

as in our own case, both to the Biblical witness and the Lutheran understanding of the Christian's dual citizenship.

Like the abortion debate, the current controversy concerning euthanasia leaves few Americans, Christian or non-Christian, unmoved or unaffected. There can be no doubt; it is a life-concerns issue that involves fundamental theological principles. The core of the problem is suggested by the query: Can a man, or others for him, exercise any control over the manner and time of his death? Behind this concern are even more fundamental questions about the very nature of man, the meaning of our *humanum*, and the freedom and responsibilities of man before God. A myriad of specific problems, some of definition, some of ethical analysis, some of practice, and some of appropriate Christian response, are subsumed within the "death with dignity" slogan. I do not propose to offer a solution to each one of them, but simply to sort out the most pertinent questions, especially those to which a clear and unequivocal Christian reply can now be given, and isolate those areas which will need additional consideration.³

I. THE CONTEXT OF THE "DEATH AND DYING" DEBATE

Since ancient times it has been assumed that a man is dead when he stops breathing and his heart stops beating, criteria which are still traditional to forensic medicine.⁴ Technology's new possibilities, the availability of cardiac resuscitation, electric shock, transfusions, infusions, transplants, respirators, defibrillators and similar marvelously ingenious machines, have created chaos with the once commonplace definition of the moment of death as the cessation of heartbeat and respiration. Heartbeat and breathing, through the aid of supplemental machinery, can be artificially maintained in a person whose brain is crushed or even deteriorated to the point of liquefaction.⁵

In its battle against untimely death, due to infectious diseases, for example, medicine has made significant and very praiseworthy contributions to the public's physical well-being. Under the present conditions nearly two-thirds of the population reach the age of seventy. As a result many people fear the isolation and suffering which accompany chronic deterioration more than they do death from some quick, acute illness.⁶ The progress of technology has put into the physicians' hands the ability to intervene in the course of a patient's illness to such an extent that questions are raised as to whether medical wizardry is not in fact prolonging the dying process rather than prolonging life.

More dramatically, the question can be asked: When are we dealing with a living patient and when are we dealing with an unburied corpse whose bodily processes (traditionally thought of as "vital signs") are being artificially maintained? "Putting it in religious language," writes the ethicist Daniel C. Maguire, "can the Will of God regarding a person's death be manifested only through disease or the collapse of sick and wounded organs, or could it also be discovered through the sensitive appreciations and reasonings of moral man?"⁷

II. DEFINING DEATH

Agreeing upon and updating criteria to ascertain the cessation of life is not, of course, the same as defining death itself. To determine *when death has occurred* is not the same as defining death, which has various meanings at various levels of thought. The theological understanding of death as the separation of the soul from the body is not the same as biological death, namely the cessation of the simple life processes of the various organs and tissues of the body. Science cannot give us a litmus test for determining when death, in the theological sense, has taken place. But our notion of death, be it theological or not, does have bearing upon the medical criteria we fasten upon for telling us when death has occurred. And it certainly has serious implications for both pastoral and medical care, for again the watershed question in a particular case is, as Paul Ramsey writes, whether or not we have "a life still among us who lays claim to the immunities, respect, and protection which in ethics and/or law are accorded men to a fellow man."⁸

The pronouncement that biological death has taken place is a medical question. Updating the clinical procedures for ascertaining biological death raises no new moral concerns, unless the motivation for pronouncing the clinical fact of death lies in interests outside of those of the patient. The urgency of obtaining a transplant for someone else, for example, should not color the marking of the borderline between life and death of the patient in the first instance.⁹ Under most circumstances the clinically observed cessation of spontaneous cardiac activity and spontaneous respiratory activity will be adequate indications that death has occurred, but in the borderline situations the addition of what has come to be called "brain death" is a necessary criteria. In those cases in which there is permanent brain damage and, consequently, an irreversible coma, and where the traditional signs of death are obscured by the intervention of resuscitation machinery, the addition of the criteria of "brain death," verified by a flat or isoelectric electroencephalogram is, as the "Report of the *Ad Hoc* Committee of the Harvard Medical School to Examine the Definition of Brain Death" states, "of great confirmatory value."¹⁰ Once the patient is determined to have suffered "brain death," death is to be declared and *then* the respirator turned off. Two states, Kansas and Maryland, have modified statute law to include "brain death."¹¹

In addition to the refinement of the methods for determining that death has occurred, attention has been given to the traditional notion of the "moment of death." Even the "moment of death" was, of course, a span of time in which, at various degrees, biological death encompassed the whole organism (clinical death, psychological death, organ death, cellular death). But now the concern seems to be to move away from an understanding of "death" as a clearly defined event and toward one that views death as a *process*, in which, as Robert Morrison has written, "the life of the dying patient becomes steadily less complicated and rich, and, as a result, less worth living or preserving." As the pain and suffering mount, along with escalating

costs and decreasing benefits to the patient and to society, the process of death is said to be hastening onward. As the process continues, since life and death are part of a continuum, some decision must be made, Morrison argues, about the "quality of life" of the patient, some decision as to whether or not it is worth prolonging.¹²

While we can, in the restricted sense, agree that death is a process, we must still affirm that the symbol of the "moment of death" has important moral content. "The trouble with Morrison's position," contends Leon Kass, is that "he does not distinguish the question of when a man is dead from the question of when life is not worth prolonging."¹³ The utilitarian ethicist, weighing the "quality of life" of the patient over against the needs of society, may indeed ask the question: "Is it better that this man live or die?" But the Christian ethicist cannot. For him moral consideration is shaped only in response to the question, "Is this patient dying or is he dead?" The problem for Christian ethics, which holds that life is a gift of God and under his dominion alone, is not measuring the "quality of life" of any individual. It is, instead, trying to determine when to refrain from impeding a patient's dying, by, for example withdrawing artificial means of life support, or when to cease struggling against death by recognizing that one is in the presence of "arrested death" or death itself.

III. EUTHANASIA AS "MERCY MURDER"

The utilitarian frame of mind would have us believe that there is no ethical difference between hastening the process of dying and not artificially prolonging dying. In distinction to the "sanctity of life" ethic, the "quality of life" ethic sees no moral difference between active or positive euthanasia and passive or negative euthanasia. Since both have the same consequence, namely the death of the patient, administered death and allowing a patient to die by, for example, withdrawing or withholding *extraordinary* means, are held to be the same. "A decision *not* to keep a patient alive is as morally deliberate," writes Joseph Fletcher, "as a decision to *end* a life."¹⁴ Framed in this fashion, the moral distinction between acts of omission and acts of commission, even when the consequences may be the same, is blurred. To let death have the victory that it has already won, at the biological level, is substantially different from death by commission. *Permitting* an evil effect to take place (death by omission) is ethically distinguishable from *willing* an evil effect (death by commission). We shall return to this distinction again in a discussion of the moral necessity of using "ordinary" means and "extraordinary" means.

Confusion regarding active and passive euthanasia is widely prevalent in the "death with dignity" literature. The word "euthanasia" (*eu*, well, good, pleasant; *thanatos*, death) has become a catch-all and seems to bear as much freight as an individual author wishes to load it with. Advocates of the "easy, painless death," such as the Euthanasia Educational Council, protest that they are only interested in legalizing passive euthanasia, "to be allowed to die and not be kept alive by artificial means or 'heroic measures,'" as the Council's *A Living Will* states.¹⁵ Yet the American public is already being psycho-

logically prepared for "Killing with Kindness" for lives supposedly devoid of value, such as that of a child with birth defects or the suffering, but not dying, sick and aged.¹⁶ In 1973 the Gallop Poll asked the public: "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it?" Nationally, fifty-three per cent gave an affirmative answer; yet in 1950 only thirty-six per cent did.¹⁷

Perhaps it might be useful, given the current confusion, to restrict "euthanasia" to the active application of a death-accelerating measure, to active or positive means, voluntarily or involuntarily administered, to shorten life. In this restricted sense, the use of the popular term "mercy killing," instead of euthanasia, may alleviate some of the semantic confusion.

Mercy killing, the direct ending of the life of a person, with or without his or her sanction, who has an "incurable" physical or mental disease or is hopelessly retarded or is suffering from intractable pain, should be universally condemned by the Christian community. Professionals in the health sciences, while they need not sustain life under all circumstances, may not take life. Both the Commandment—"Thou shalt not kill"—which might better be translated "Thou shalt not murder" and the traditional oath of Hippocrates ("... I will give no deadly medicine to anyone if asked, nor suggest any such counsel...") prescribe against administered death. Euthanasia as "mercy-killing" when voluntarily submitted to is tantamount to suicide, even though the motives and circumstances might vary and the cooperation of an outside party is needed. Both suicide and murder are infringements upon the dominion over life and death which is God's alone. As Dietrich Bonhoeffer stated in his *Ethics*:

If there is even the slightest responsible possibility of allowing others to remain alive, then the destruction of their lives are never of equal value in the making of this decision; the sparing of life has an incomparably higher claim than killing can have. Life may invoke all possible reasons in its cause; but only one single reason can be valid reason for killing. To fail to bear this in mind is to undo the work of the Creator and Preserver of life Himself.¹⁸

All willful acts of terminating human life, even though done without malice, to relieve pain or suffering or for any other "humanitarian" motive, can be characterized as "mercy murder." "The innocent . . . slay thou not" (Ex. 23:7), must remain an inviolable principle of Christian ethics.

IV. ON THE USE OF "ORDINARY" AND "EXTRAORDINARY" MEANS

Centuries before the advent of the sophisticated medical technology now at the physician's disposal, Christian ethicists distinguished between "ordinary" and "extraordinary" means of sustaining life. The assumption was that a failure to employ "ordinary" means of preserving life was the ethical equivalent of "mercy murder," but

that doctors and others attending a dying patient could, as Paul Ramsey has stated, refuse "to 'war without retreat and without quarter' against almighty God for the last shred of sentient life, world value, or physiological existence in the dying man."¹⁹ Likewise, a patient might elect not to undergo "extraordinary" means without fear of an adverse moral judgment. The American Medical Association's House of Delegates has recently recommended: "The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family."²⁰

Much, of course, hinges upon the definitions of "ordinary," and, therefore, mandatory means, and of "extraordinary," and, consequently elective means. A fundamental difficulty, which has only been made more complex by the advancement of medical technology in our own day, arises from the differing perspectives of moralists and physicians. Physicians tend to define ordinary means as those which are "standard, recognized, orthodox, or established medicines or procedures of that time-period, at that level of medical practice, and within the limits of availability." In contrast, moralists include "not only normal food, drink, and rest but also—in terms of hospital practice—all medicines, treatments and operations, which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain, or other inconvenience." Extraordinary means, on the other hand, involve, from the physicians point of view, "a mendicament or procedure that might be fanciful, bizarre, experimental, incompletely established, unorthodox, or not recognized." From the moralist's point of view, however, *extraordinary means* are "all medicines, treatments, and operations which cannot be obtained or used without excessive expense, pain, or other inconvenience for the patient or for others, or which if used, would not offer a reasonable hope of benefit to the patient."²¹

Several observations are obviously in order. First, the definitions by themselves do not offer infallible guides to practice; decisions will still have to be made on a case by case basis, with all of the risk of error that this circumstance may involve. Secondly, it seems that the physicians focus for distinguishing between "ordinary" and "extraordinary" means is on the *remedy* itself, while that of the moralist is on the *patient*. Both involve certain relativities. As medical procedures are perfected, what was once an extraordinary means, such as amputation of a limb or a kidney transplant from a compatible donor, may become, from the physician's point of view, an "ordinary" one. From that of a moralist, an ordinary means may become extraordinary as the patient's condition changes, as a "reasonable hope of benefit" becomes less certain. "The first relativity," writes Paul Ramsey, "is to the disease and to what is ordinarily done to remedy it. The second relativity is to the condition of the man who has the disease."²²

Considerable moral weight was given to the ethical correctness of not employing extraordinary means in the November 1957 address of Pope Pius XII to a congress of anesthesiologists. With the example of a patient with a cerebral lesion, plunged into unconsciousness and with no hope of recovery, in mind, the papal allocution states that

the apparatus for artificial respiration is an "extraordinary" means and with the consent of the family can be withdrawn. "Even when it causes the arrest of circulation, the interruption of attempts at resuscitation is never more than an indirect cause of the cessation of life," the statement argued, "and one must apply in this case the principle of double effect and of '*voluntarium in causa*.'"²³ The employment of the "double effect" mode of ethical reasoning as a justification for the dispensability of "extraordinary" means of resuscitation is questionable. In this specific case, Pope Pius XII argued that "if it appears that the attempt at resuscitation constitutes in reality such a burden for the family that one cannot in all conscience impose it upon them, they can lawfully insist that the doctor should discontinue these attempts, and the doctor can lawfully comply."²⁴ Is not this a case of doing evil that good may come? Making the burden on the family the main justification for withdrawing "extraordinary" means does not seem warranted.

Strictly speaking, the "double effect" frame of reference best fits conflict situations in which one is faced with a lesser-evil-greater-evil continuum. Therapeutic abortion to save the life of the mother has traditionally been viewed as a "double effect" situation. Likewise when a physician administers a pain-killing drug to a patient to relieve suffering, but it also hastens the dying process, the "double effect" principle is employed. Because the death of the patient, if it is brought about by the drug, is not the direct or primary intention of the doctor in this instance, the action might be called "indirect euthanasia." Nevertheless, it has traditionally been permitted under the "double effect" principle.²⁵

In medical ethics we are often confronted with problem situations, moral conundrums, if you will, in which "Do God's will and you will be right," while sound theoretical advice, falls short of the practical situation. "When you know that your conduct will have two consequences; one in itself good and one in itself evil," writes Glanville Williams, "you are compelled as a moral agent to choose between acting and not acting by making a judgment of value, that is to say by deciding whether the good is more to be desired than the evil is to be avoided."²⁶ Even though we may agree, on the "lesser evil-greater good" principle that it may regrettably be right to do something bad (because there seem to be no better alternatives), the bad does not automatically become good because it is the right thing to do under the *particular* circumstances. Our actions, even though they serve a good end, are still tinged with evil, and that is why Christians are daily driven to the CROSS.

V. ON (ONLY) CARING FOR THE DYING

The death of a patient is a defeat for the medical professions. It is evidence that all of their attempts to cure, no matter how well-managed, thorough, and heroic, have failed. Medical vitalism, the view that biological life must be sustained at any cost, attempts to hold death at bay as long as possible by seeking to cure the disease or illness from which the patient is dying. "When I worked as a nurse," a professor of hospital administration has stated, "our goal was to keep

the patient alive by any means until the next shift came on duty. Never have the patient die on your shift."²⁷ Medicine cannot distinguish between the "good death" and the "bad death." Death is the natural enemy of the healing arts.

When we view the patient as a whole person, and not just a residual of diseases which, one by one, must be conquered, the question is raised as to whether or not the time comes when we are justified in ceasing to attempt a cure and begin only to care. Is it ever proper for a patient to request that his or her doctors refrain from attempting to cure, either by not initiating a medical treatment or stopping it if it has been started? The patient may wish to be allowed to die unvexed by outside interference, to voluntarily surrender to the dying process and spend his or her remaining time with family, friends, and spiritual advisors in preparation for death. As James Nelson has written, "caring is a broader model that should inform all curing."²⁸

Certainly the individual physician and patient have no moral responsibility to use "extraordinary" means once it is determined that they would be useless, that is, when they are no longer remedies. "When, in the opinion of attending physicians," as the New York Academy of Medicine has affirmed, "measures to prolong life which have no realistic hope of effecting significant improvement will cause further pain and suffering to the patient and family, we support conservative, passive medical care in place of heroic measures in the management of a patient afflicted with a terminal illness."²⁹ Nor must useless "ordinary" or customary means, except for food, drink, and standard hospital care, be employed. A determination of whether or not a particular case is "hopeless" and, therefore, one in which all means to *cure* have become useless, is, of course, a most perplexing one, fraught with great risk of error. The term "hopelessly ill," as Richard McCormick points out, is ambiguous, for it is often used to refer both to those patients who are "irretrievably in the dying process" and to those "that can be saved, but in a wretched, painful, or deformed condition."³⁰ It seems apparent that the suffering-dying are "hopeless" in a sense that the latter are not. And, as Dr. Laurance Foy warns: "We must never forget that on occasion patients, their families, and their physicians will conclude that a disease has reached the hopeless stage and death is imminent—and be wrong."³¹

Only a physician can, with the best judgment humanly possible, determine the onset of biological death in a given case. Once an affirmative decision to this effect has been made, treatments of the disease or chronic illness are no longer remedies with a reasonable hope of benefit for the patient. The focus then shifts from curing to (only) caring for the "suffering-dying" patient. If the patient is to die, he should be allowed to die in comfort and dignity.

It is not unusual today that when a man dies his mind is fogged with drugs, he is alone, surrounded and sustained only by the hum of machines. "If the sting of death is sin," writes Paul Ramsey, "then the sting of dying is solitude."³² Many dying people, according to Elizabeth Kubler Ross, fear desertion, being deprived of the chance to share life's waning moments, more than they do death itself.³³

There are few death-bed scenes in the Biblical record, but one that strongly contrasts with the manner of dying in solitude is that of Jacob, of whom we read: "When Jacob finished charging his sons, he drew up his feet into the bed, and breathed his last, and was gathered to his people" (Gen. 49:33). Here was a finely finished death. It strongly suggests that we ought not push the dying from the circle that especially owes them love and care and that there is no excuse for denying them human presence and pastoral care, now threatened by the intervention of technical wizardry, as their appointed time comes to an end.

VI. "THE GOOD DYING" VS. "THE GOOD DEATH"

There is a curious notion running through much of the "death with dignity" literature that death is in itself a good, a boon to be sought when the suffering becomes too intense or an illness judged incurable. "Death is man's greatest blessing," states one doctor, "when it cancels a life wracked with suffering and stripped of its meaning."³⁴ Death is viewed as a merciful *coup de grace*, to be welcomed and perhaps even sought, when the suffering becomes unbearable or is judged to be meaningless. Mary McDermott Shidler, quoting Robinson Jeffers, writes: "A creature progressively thirsty for life will be for death too."³⁵ Death is said to be "a fact of life," indeed, one of the most popular surveys on updating life and death, by David Hendin, a journalist, is entitled *Death As a Fact of Life*.

From the materialistic and mechanistic point of view, death is "natural," in the sense that it is but the last way-station of human experience, a necessary ebb in the rhythm of life. And so, in a Socratic manner, men can drink "the cup of hemlock" assured that death is a friend. In contrast to Socrates, who shed no tears as death approached, Jesus' sweat was like great drops of blood as he contemplated the cup of suffering which included his death. Like many slogans, "death with dignity," when understood as the right to a fast, clean, and painless death-as-a-friend end to life, betrays some questionable presuppositions.

Nothing in Biblical theology suggests otherwise than that biological death is an enemy; "the fate of the sons of men and the fate of beasts is the same; as one dies so dies the other" (Ecclesiastes 12:7). The "good death," viewed from the Christian perspective, is a contradiction in terms. Death is not "natural," a necessary and beneficial aspect of the ordering of nature, but it is a curse, "the last enemy" (I Cor. 15:26). Apart from the new life in Christ, death turns only its bitter visage toward the beholder. Death and separation from God go together, for death is the result of sin (Gen. 3:14-19), and, as the Lutheran Confessions (Formula of Concord, Epitome I, 4; Solid Declaration I, 2, 46f; Smalcald Articles, Part III, Art. I, 11) make clear, radically affects both body and soul. "Death ought not to be," writes Helmut Thielicke. "But insofar as it nevertheless is, it constitutes only the symptom of a much deeper unnaturalness, namely that we have torn ourselves loose from God, that we are no longer in the Father's house (Luke 15:11 ff.), and that we have thus

alienated ourselves from our intrinsic nature of being God's children."³⁶

To all those who would, like Walter Sackett, Jr., physician and legislator in Florida, propose that "Death, like birth, is glorious—let it come easy,"³⁷ the Biblical witness asserts the indignity of death. "The dying have at least this advantage," writes Paul Ramsey, "that in these projects for dehumanizing death by naturalizing it, the dying finally cannot succeed, and death makes its threatening visage known to them before ever there are any societal or evolutionary replacement values of the everlasting arms or Abraham's bosom to rest on."³⁸ This is not to imply that the suffering-dying ought to be abandoned to a state in which the fragile fabric of their personhood is torn upon the rocks of loneliness, pain, and heroic attempts to "officially keep alive." It is to say that while there can be nobility and dignity in dying, death is in itself the *finis*, the final assault upon life.

Concern for the suffering-dying obligates those who are charged with their care to spare no effort or expense in making them as comfortable and capable of maintaining their sense of self-worth as is possible. In some cases, this may mean honoring their request *not* to prolong artificially the dying process by the intervention of supportive devices deemed "extraordinary," or by ceasing to do so. Upon ceasing to rescue the perishing, in the sense of *curing*, and moving to (only) *caring* for the dying, the Christian may speak of the "will of God" in the sense of God's permissive will, or his "will of good pleasure," to which our response is one of acceptance and entrustment of the dying to the mercy of God. But having concluded, in a particular case, that death, and not recovery, is God's will, we can never go on to conclude that it is part of God's "prescribed will" that we are to take steps to end the patient's life.³⁹

Even though ordinary means of care are every patient's due, not all suffering can be eliminated. The victim of bone cancer, for example, may be beyond the relief of even the most sophisticated anodynes. In such instances, pastoral care of the suffering-dying seeks to sort out the meaningful from the meaningless aspects of pain. Lutherans would surely take exception to the conservative Roman Catholic view, as expressed by Edwin F. Healy, S.J., in his *Medical Ethics*, that pain and suffering are of value "in storing up merit and in shortening one's purgatory."⁴⁰ Suffering is never redemptive in the sense that it can be man's last act of positive obedience in co-operation with the suffering of Jesus. But Lutheran Christians can assert that even suffering, while not willed for its own sake, nor to be allowed to be left unchecked, is not outside the purposeful will of God. As the Apostle Paul writes, "suffering produces endurance, and endurance produces character, and character produces hope, and hope does not disappoint us, because God's love has been poured into our hearts through the Holy Spirit which has been given to us" (Romans 5:3-5).

Postscript:

Justice William O. Douglas reports that his father, when facing death, commented: "If I die, it will be glory; if I live, it will be

grace."¹¹ In capsule form, this captures the Christian perspective on life and death. The Christian view of death, which cannot be understood apart from the death of Adam and the death and resurrection of Christ, is, as Jaroslav Pelikan states, "not intended to supplement the clinical information about death. . . . It is intended to give men faith to live in courage and to die in dignity, knowing very little about the undiscovered country, except that, by the grace of his cross, Our Lord Jesus Christ has changed the shape of death."¹²

The updating of criteria for determining when death has occurred, the Gordian knot of ethical problems in the use of new medical devices, and the current thanatology boom, which has attracted widespread public curiosity, may have reshaped the manner of dying in our day, but not death itself, nor the Christian proclamation of victory over death in Jesus Christ. To be sure, the Church, if it is to minister effectively to people, must be aware of and responsibly deal with the moral dilemmas posed by medicine and the life-sciences today. Estrangement between the healing professions and theology has, in part, precipitated the potential crisis of having to live (and die) with medicine-without-an ethic. But the Church, and this will, in the end, be her greatest contribution, must ever hold before men the good news of that first Easter morning. Death is the Conquered Enemy.

FOOTNOTES

1. Charles Carroll, "Medicine Without an Ethic," *The Journal of the Louisiana State Medical Society*, Vol. 214, No. 9 (September 1972), p. 313.
2. Albert Rosenfeld, *The Second Genesis: The Coming Control of Life* (New York: Arena Books, 1972). Rosenfeld coins a word for the anticipation of biomedicine's future impact upon society—biosocioprolepsis. His principle concerns are the refabrication of the individual, the exploration of prenativity, and the peril and promise in control of the brain and behavior.
3. The legal ramifications of updating life and death are of immense significance, but, for the moment, beyond the scope of this paper. In brief, however, medicine has been running ahead of the law. The existing legal framework is simply not equipped to resolve the many ethical dilemmas raised by the application of the new medicine to specific cases. For an overview of "the laggardly state of the law," see Daniel C. Maquire, *Death by Choice* (Garden City, New York: Doubleday & Company, Inc., 1974), Chapter II, pp. 22-54. See also, George Fletcher, "Prolonging Life," *Washington Law Review*, Vol. 42 (1967), pp. 999-1016; and, Roger B. Dworkin, "Death in Context," *Indiana Law Journal*, Vol. 48 (Summer), pp. 623-39.
4. *Black's Law Dictionary* (1951) describes death as "the cessation of life; the ceasing to exist; defined by physicians as a total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereupon, such as respiration, pulsation, etc." Quoted by David Hendin, *Death As a Fact of Life* (New York: Warner Books, Inc., 1973), p. 36.
5. Hendin, *Death As a Fact of Life*, pp. 21-42, *passim*.
6. Robert S. Morison, "Dying," *Scientific American*, Vol. 229, No. 3 (September 1973), p. 55.
7. Maquire, *Death by Choice*, p. 9.
8. Paul Ramsey, *The Patient As Person: Explorations in Medical Ethics* (New Haven and London: Yale University Press, 1970), p. 53. I freely acknowledge my debt to Prof. Ramsey for the broader outlines of my thinking on the problems addressed in this paper. Harrington

- Spear Paine Professor of Religion at Princeton University, Ramsey is perhaps the most influential Protestant writer in contemporary ethics.
9. Hans Jonas, *Philosophical Essay: From Ancient Creed to Technological Man* (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1974), pp. 132-40. Jonas is properly concerned that physicians, in the interest of obtaining organs for transplantation, might decree that the body is in the domain of things on a rationale other than that of the patient as a "whole organism."
 10. The *Ad Hoc* Committee listed the criteria of brain death—clearly irreversible coma—as unreceptivity and unresponsivity to externally applied stimuli and inner need, no spontaneous muscular movements or spontaneous breathing, no elicitable reflexes, and a flat electroencephalogram. All tests must be repeated at least twenty-four hours later with no change. The effects of low temperature and certain barbiturates, the report noted, might affect the validity of the data. "A Definition of Irreversible Coma," Report of the *Ad Hoc* Committee of the Harvard Medical School to Examine the Definition of Brain Death, *The Journal of The American Medical Association*, Vol. 205, No. 6 (August 5, 1968), pp. 337-340.
 11. Maguire, *Death by Choice*, p. 50. For a negative critique of the Kansas Act, see Ian McCall Kennedy, LL.B., "The Kansas Statute on Death—An Appraisal," *The New England Journal of Medicine*, Vol. 285, No. 17 (Oct. 21, 1971), pp. 946-50.
 12. Robert S. Morison, "Death—Process or Event?," *Science*, Vol. 173 (August 20, 1971), p. 696.
 13. Leon R. Kass, "Death as an Event: A Commentary on Robert Morison," *Science*, Vol. 173 (August 20, 1971), p. 699.
 14. Joseph Fletcher, "The Patient's Right to Die," in *Euthanasia and the Right to Death: The Case for Voluntary Euthanasia*, edited by A. B. Downing (New York: Humanities Press, 1971), p. 68. Fletcher has consistently set his personalistic ethics against what he calls the "vitalist fallacy," namely, the identification of "the will of God" with the workings of blind, brute nature. See his pioneering *Morals and Medicine* (Princeton, N.J.: Princeton University Press, 1954). For a concise summary of his typology of elective death in at least four forms of euthanasia, see his "Elective Death," in *Ethical Issues in Medicine: The Role of the Physician in Today's Society*, edited by E. Fuller Torrey (Boston: Little, Brown and Company, 1968), pp. 141-57.
 15. Although *A Living Will* is not legally binding, it is being widely distributed. The inadequacies of *A Living Will*, from the Roman Catholic perspective, are pointed out by Kevin A. O'Rourke, O.P., "Christian Affirmation of Life," *Hospital Progress* (July 1974). Recently the Catholic Hospital Association has introduced a variant on the living will, entitled "Christian Affirmation of Life." Should we have a Lutheran "living will"?
 16. For a collection of statements in this direction, see *The Mercy Killers*, by Paul Marx, produced by Right to Life, Verdes Estes, California, copyright by Infomat, 1974. I do not specifically address the question of the "defective newborn" in this paper, yet the same dilemmas are present in the pediatric nursery, where doctors must find a way between the two extremes of *always* using heroic measures and resorting to "mercy murder."
 17. "Approval of 'Mercy Killing' Rises," *American Medical News* (August 13, 1973).
 18. Dietrich Bonhoeffer, *Ethics*, edited by Eberhard Bethge (New York: The Macmillan Company, 1955), pp. 160-61. Under the "single reason" rubric, Bonhoeffer would place "killing" in war and capital punishment.
 19. Ramsey, *Patient As Person*, p. 119.
 20. "Some Welcome Guidelines on Death and Dying," *American Medical News* (January 7, 1974).
 21. Clarence Blomquist, "Moral and Medical Distinctions between 'Ordinary' and 'Extraordinary' Means," *Appendix 4 to Decisions About Life and Death: A Problem in Modern Medicine*, published for the Church of England Assembly Board for Social Responsibilities by the Church In-

- formation Service (Oxford Church Army Press, 1965), pp. 56-57. The brief study by the Anglicans is an excellent model for other church bodies.
22. Ramsey, *Patient As Person*, p. 120. Two circumstances might, in traditional medical ethics, make an "extraordinary" means "ordinary" and, therefore, morally obligatory, in a given case: (1) if the patient was not spiritually prepared for death, and (2) as in the case of a statesman or military leader in time of war, the common good could be served by the patient's continued existence. See Charles J. McFadden, O. S. A., *Medical Ethics*, Fifth edition, with a foreword by Fulton J. Sheen (Philadelphia: F. A. Davis, 1961), pp. 231-32.
 23. "The Prolongation of Life," *The Pope Speaks*, Vol. 4 (1958), p. 397.
 24. *Ibid.*, p. 396.
 25. Ramsey, *Patient As Person*, pp. 129, 149-50. The dilemma is not resolved by the Hippocratic Oath, which enjoins physicians both to preserve life and prevent pain.
 26. Glanville Williams, *The Sanctity of Life and the Criminal Law* (London: Faber and Faber, 1958), p. 322.
 27. Quoted by James B. Nelson, *Human Medicine: Ethical Perspectives on New Medical Issues* (Minneapolis, Minn.: Augsburg Publishing House, 1973), p. 130. Pilot studies on those who choose medicine as a career have led several psychiatrists to suggest that medical professionals view their craft as a means to control and govern their own fears of death (thanatophobia), fears that are stronger than those of both the physically sick and healthy normal groups. Cited in Hendin, *Death As a Fact of Life*, p. 115. See also Richard Trubo, *An Act of Mercy; Euthanasia Today* (Los Angeles: Nash Publishing Corporation, 1973), pp. 64-66.
 28. Nelson, *Human Medicine*, p. 28.
 29. "Statement on Measures Employed to Prolong Life in Terminal Illness," *Bulletin of the New York Academy of Medicine*, Second Series, Vol. 49, No. 4 (April 1973), p. 351.
 30. Richard A. McCormick, "To Save or Let Die," *America* (July 13, 1974), p. 7.
 31. Quoted in "Dying with Dignity," *Focus on Public Affairs*, Vol. 6, No. 15 (September 1, 1972), p. 1.
 32. Ramsey, *Patient As Person*, p. 134.
 33. Elizabeth Kubler-Ross, *On Death and Dying* (New York: Macmillan Publishing Co., Inc., 1969), p. 268.
 34. Dr. Roland Stevens of the University of Rochester Medical School, quoted by Trubo, *An Act of Mercy*, p. 87.
 35. Mary McDermott Shidler, "Coup de Grace," *The Christian Century* (December 7, 1966), p. 1502.
 36. Helmut Thielicke, *Death and Life*, translated by Edward H. Schroeder (Philadelphia: Fortress Press, 1970), p. 113.
 37. Quoted by Hendin, *Death As a Fact of Life*, p. 80.
 38. Paul Ramsey, "The Indignity of 'Death with Dignity,'" *Hastings Center Studies*, Vol. 2, No. 2 (May, 1974), p. 53.
 39. Church of England study pamphlet, *Decisions About Life and Death*, pp. 26-27.
 40. Edwin F. Healy, S. J., *Medical Ethics* (Chicago: Loyola University Press, 1956), p. 268.
 41. Quoted in Jacques Choron, *Death and Western Thought* (New York: The Macmillan Company, Inc., 1963), p. 87.
 42. Jaroslav Pelikan, *The Shape of Death: Life, Death, and Immortality in the Early Fathers* (New York: Abingdon Press, 1961), pp. 122-23.