Euthanasia and Assisted Suicide: Elements of Church Teaching

BY REV. JAMES J. McCARTNEY, OSA, PhD

The popularity of Derek Humphry's book *Final Exit*,[1] which explains how to assist in someone's suicide, indicates the need to review, from a number of perspectives, issues related to euthanasia. In the December issue of *Health Progress*, Stephen G. Post analyzed changing American attitudes toward the idea of a "good death" (see "American Culture and Euthanasia," pp. 32-37). In this column I briefly review elements of current Roman Catholic ethical analyses of assisted suicide and mercy killing, focusing mainly on official Church teaching while touching on revisionist perspectives where appropriate.

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Basic Positions

Although the Catholic Church hopes and prays that all people will experience a "good death" (the Greek meaning of "euthanasia") and does not see biological life as an absolute value that must be maintained at all costs, nevertheless it rejects assisted suicide and mercy killing because it considers these actions intrinsically opposed to the reverence for personal life that Christians are called on to manifest and express. Church teaching, in agreement with the teaching of Orthodox Judaism, interprets the Book of Genesis as holding that God is the source and author of life, that life is God's precious gift to us, that we are stewards, not masters, of our lives, and that therefore the direct intention of taking innocent life, either by active or passive means, is always objectively wrong. According to the Church, in performing euthanasia we make a decision (to end life) that is solely God's to make. This is the primary basis for the Church's absolute opposition to assisted suicide and mercy killing, no matter how compassionate and caring the motives.

Revisionist moral theologians within the Roman Catholic tradition and some non-Catholic Christian ethicists would approach these issues differently.[2] Although they hold that biological life is an extremely important value, they would argue that life is not so much a gift of God as a manifestation of divinely originated loving activity in the world, an activity that should be supported and preserved by others manifesting their creative love, unless doing so causes such evil (suffering and death) that loving activity would be better manifested by other means. Revisionist thinkers such as Lawrence J. Nelson[3] would consider assisted suicide and euthanasia acceptable only in situations in which serious harm would occur if the person were not killed or assisted in suicide *and* no other way exists to avert the evil. In this approach, the model of God as loving and creative ground of being is much more operative than the model of God as all-knowing lawgiver and judge.

Sometimes, opposition to assisted suicide and mercy killing is grounded on the "slippery slope" or "wedge" principle. According to this argument, once society grants healthcare professionals the right to kill a patient who requests death, it will be impossible to prevent them from performing euthanasia on anyone whose life they consider "not worth living." A major weakness of this argument is that the law can clearly distinguish between voluntary and involuntary assisted suicide and mercy killing.

Much more persuasive is the utilitarian philosophical argument that, whatever we may think of assisted suicide or mercy killing, healthcare professionals should be prohibited from these activities. According to this argument, allowing physicians or nurses to participate in assisted suicide or mercy killing would erode public trust in these important professions because it would encourage the perception that healthcare professionals simply do whatever patients want, even when these requests conflict with traditional canons of professional ethics. People who hold this position would argue that a breakdown of trust in healthcare professionals would be detrimental to society as a whole.

Reasonable Exceptions

Although official Church teaching strongly opposes assisted suicide and mercy killing, it does

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munity service organization. For example, when an explicit charity policy is in place—one that everyone from the chief executive officer to the billing clerk understands—the hospital is more charitable. It treats poor people who cannot pay in a much kinder and more caring way than does a hospital with less clear charity policies.

Fourth, we learned that many important programs are not necessarily costly. For example, health promotion and screening programs may be low cost but provide terribly important benefits to all populations in our communities.

Finally, we learned that in spite of fiscal constraints, we can protect important community services and services to the poor, and even enhance them, by including them in strategic plans and budgets. Members of our communities, especially the poor, the uninsured, and other special populations, need us as much now as at any time in our history, and we can serve them if we plan to meet their needs.

Reinforcing the Tradition

I believe that we can and must address pressing healthcare needs in our communities. If we maintain and reinforce this tradition of community service and response to the poor, the results will be rewarding:

- Through CHA's *Social Accountability Budget* and other planning processes, we can sustain and increase our commitment to providing community benefits in response to needs.
- We will be seen as part of the solution to the current healthcare crisis, allowing us to take a leadership role in the design of policy solutions.
- We will maintain our tax-exempt status and the public trust exemption represents.
- We will relieve some of the human distress inherent in a healthcare system that denies service to people in need.
- We will preserve the tradition, started years ago by those who established our fine institutions, by galvanizing community resources to respond to community needs. □

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not hold that all means must be employed to prolong and preserve biological life. Assisted suicide and mercy killing are prohibited by a negative command (Thou shalt not kill), which binds absolutely. The command to prolong and preserve biological life, on the other hand, is a type of affirmative command that always allows for reasonable exceptions (similar to the command to participate at mass on Sundays). Thus the Catholic Church teaches that people are only obliged to use *reasonable* means to prolong and preserve life and health, but not every means available in this age of high-technology medicine.

Specifically, papal teachings[4] and other official Church documents[5] make it clear that medical interventions may be refused or removed when the person (or if the person is incompetent, the family or authorized surrogate) considers them unusual, burdensome, or futile. A treatment is unusual when the person believes that it does not fit well in the context of his or her life right now. For example, a Third World missionary who gets seriously ill might legitimately choose not to return home for more advanced medical care, even though this decision might seriously shorten life or impair health. Burdensome treatment is any that causes disproportionate pain, suffering, psychological duress, economic hardship, or other dislocation. A treatment is considered futile when it will not restore well-being within a reasonable amount of time.

Persons may refuse or remove these kinds of interventions because they are extraordinary or disproportionate, even if natural death occurs more quickly as a result of this decision. Thus the Catholic tradition does not insist on the prolongation of dying, but does teach that the compassion and care we render to dying persons should not include the willingness to assist in the direct ending of their lives. Revisionist theologians generally accept this line of reasoning, although they would, as mentioned earlier, accept assisted suicide and mercy killing in some limited situations.

Need for Perspective

Whatever their own position, those who wish to contribute to the debate on euthanasia should be familiar with changing attitudes on the issue, as well as the principles on which persons base their views. Persons familiar with Church teaching on euthanasia will have a valuable perspective on an issue that often creates tension between the dictates of compassion and a fundamental commitment to the sanctity of life. □

For a more detailed analysis of euthanasia, see Principled and Virtuous Care of the Dying: A Catholic Response to Euthanasia, *by Rev. Richard M. Gula, SS—available for $3 from the Catholic Health Association of the United States, 4455 Woodson Road, St. Louis, MO 63134-3797, or call 314-427-2500, ext. 258.*

NOTES

1. Derek Humphry, *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide*, National Hemlock Society, Eugene, OR, 1991.
2. See Daniel C. Maguire, *Death by Choice*, Doubleday, Garden City, NJ, 1984, especially pp. 118-122; Joseph Fletcher, "Ethics and Euthanasia," in Robert H. Williams, ed., *To Live and to Die: When, Why and How*, Springer-Verlag, New York City, 1973.
3. Lawrence J. Nelson, "Ethics of Intentionally Killing the Innocent," paper presented at Controversies in the Care of Dying Patients, sponsored by the University of Florida, Orlando, February 16, 1991.
4. Pope Pius XII, "The Prolongation of Life," *The Pope Speaks*, vol. 4, 1958, pp. 393-398.
5. Congregation for the Doctrine of the Faith, *Jura et Bona* (Document on Euthanasia), *The Pope Speaks*, vol. 26, 1980, pp. 289-296.