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The Church and the Public Discussion Of Assisted Suicide

A Pastoral Statement on How We Can Keep Company With the Dying

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Bp. Gregory of Belleville, IL, issued this pastoral statement in October 1996.

In his recent encyclical letter, "The Gospel of Life," Pope John Paul II challenges us to develop a culture of life in which the incomparable value of every person is protected and affirmed. As we celebrate Right to Life Month, all of us sadly know that such a culture is not yet a reality. In addition to the ancient scourges of poverty, hunger, and war, new crimes against life have emerged that, in some ways, are more urgent because they are falsely or erroneously justified in the name of freedom and seek authorization by the state.

In this month dedicated to life, I want to present the teaching of the Church in regard to the issue of physician-assisted suicide that we hear and read about with increasing frequency in the media. Not only has there been a sharp increase in the publicity surrounding national and local incidents of active physician-assisted suicide, but existing laws against assisted suicide have been challenged in many states.

The emerging debate surrounding physician-assisted suicide forces all the members of society to pause and clarifies the shared assumptions about life and death that our laws are meant to protect. The Church has a rightful place in this public discussion because the issues surrounding death are not only medical and legal, but they are religious and moral as well.

The Light of Faith

As Christians, our faith shapes our attitude toward sickness and death in three important ways. First, we believe that human life is good. Human life is a gift from God to be cherished and respected because every human being is created in the image and likeness of God (Gn 1:26). Our Church teaches that we are stewards of life and in heeding God's command, "Thou shall not kill" (Ex 20:13), we recognize that we cannot dispose of life as we please.

Second, we believe that the Son of God became man to reconcile us with the Father and to be our model of holiness (Mt 11:29). His sacrifice of himself is the model of the new law, "Love one another as I have loved you" (Jn 15:12). By living among us, Jesus has created a new communion or solidarity among us (1 Cor 12:26-27), making everyone a neighbor worthy of our charity and care (Lk 10:25-36).

Third, we believe that we are redeemed by Christ and called to share eternal life with him. The Christian vision of death is expressed in the funeral liturgy when we pray: "Lord, for your faithful people life is changed, not ended. When the body of our earthly dwelling lies in death we gain an everlasting dwelling place in heaven" (Preface for Christian Death I).

As Christians, we face death with the confidence of our faith in him who has conquered death by his resurrection (Rom 6:3-9; Phil 3:10-11). Christians live in the world knowing that although the advantages that science and technology provide enrich our lives immensely in so many different ways, they will never exempt us from our personal encounter with the mystery of death. Christ has overcome death. He has rendered death's dividend barren. Still, each one of us must follow the Lord in his triumphant passage to life. Our faith does not dispense us from this encounter with the vanquished foe that we call death.

Teaching of the Church

These convictions guide the Church's teaching and practice with regard to euthanasia and physician-assisted suicide. In the recently revised catechism of the Catholic Church, the Church condemns absolutely "an act or omission which, of itself or by intention, causes death in order to

eliminate suffering" (no. 2277). The meaning of this statement can be made clear by two examples. Active euthanasia occurs when a doctor or medical staff person administers a lethal dose of medication with the intention of killing the patient. Assisted suicide occurs when a doctor or medical staff prescribes the lethal amount of medication and leaves the choice between a natural or an accelerated death to the patient. In both active euthanasia and assisted suicide, death is induced before its time.

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Facing Our Own Deaths

The discussions that are going on in our society about physician-assisted suicide represent, in part, our anticipation and fear of the circumstances of our own deaths. What we may fear first of all is being given too much technology and dying not at peace but in a wild frenzy of efforts to give us a little more time to live. Second, we may fear that, despite all the marvelous successes of medicine and technology, they will not be able to help us recover our health but merely entrap us in the dying process longer than we can endure.

To help guide the decisions that we may face about medical treatments for ourselves or for others and to give us some control in the dying process, the Church draws a distinction between *ordinary* and *extraordinary* means of preserving life. When we use these terms, we often focus on the level of sophistication of the technologies that are at our disposal to maintain human life. Unfortunately, trying to categorize treatments this way reduces the distinction to the difference between *customary* and *unusual* treatment.

To avoid this misunderstanding, the Church has recently used the terms of *proportionate* and *disproportionate* means of treatment. This more appropriate terminology aims to show that the use of technology is at the service of the total well-being of the person. Treatments cannot be evaluated without reference to the patient receiving them.

As stewards of life, we are obligated to use only proportionate means of treatment to maintain life; they are those means that offer a reasonable hope of benefit and do not involve an excessive burden. We are not obligated to use disproportionate means to maintain life; they are those means that do not offer us a reasonable hope of benefit or impose on us an excessive burden. To forgo disproportionate means of treatment is not the same as suicide or euthanasia; rather, it signals the acceptance of the inevitability of death as part of human life.

With these distinctions, the Church helps guide us in making a prudential treatment decision. In assessing the burdens and benefits of the medical options that are available to us, we should inquire whether the treatment offers any hope for recovery, whether the procedure may be painful or dangerous, or whether the treatment will impose on us or on others considerable hardships, as when it may be excessively expensive.

Help in Dying

Finally, we fear that when a person decides to forgo disproportionate means of treatment and remove the barriers to death, he or she will face death in the most dramatic way—alone. Facing death can be a time of isolation, anguish, and despair; it can also be a time of extraordinary spiritual growth and fulfillment. Each of us will long for the saving touch of Christ through the sacraments. The Church offers us in our infirmity the comforting grace of the anointing of the sick and the Eucharist as the sacrament of passing over from death to life, from this world to the father (Jn 13:1).

Each of us, too, will long for the warmth of a human touch in the form of being accompanied through the final mystery of life. None of us wants to die deserted and isolated from human love. When faced with death, a person should be given an opportunity to say good-bye to family and friends. As fearful as it might be, we should be willing to take the risk to selflessly walk with those who experience in their illness the limitations and fragility of the human condition. We must keep company with the dying in order to

affirm their dignity in every phase of life. No amount of medical intervention can replace the compassion and love that the person needs and deserves in the hour of death.

This deep love for the sick and dying has given rise to a long and outstanding history of charity. All of us in the Church of Belleville can be particularly grateful to the many women religious, doctors, medical staffs, and pastoral care ministers who, through their leadership in the healthcare ministry in our diocese, present an eloquent example of Christ's compassion toward the sick.

> Our opposition to assisted suicide must be backed up with compassionate action.

Managing Pain Effectively

The contemporary discussion in which we are involved also goes to the heart of the purpose of the medical profession. Physicians and other caregivers have the obligation to maintain life and to relieve pain. These two duties, however, may come into conflict in the dying process.

Proponents of physician-assisted suicide at times argue that their initiatives are the only way to protect the dying from severe and intractable pain. It is true, too, that public opinion polls reveal that many people who favor assisted suicide do so because they do not want to endure a physically painful death. Quite understandably, people want to make the last steps in life without pain. It is important to point out that the effective treatment of pain guarantees that no one will suffer a painful death. Healthcare providers must make every effort to ensure that the available medications to eliminate or control pain are provided to a patient.

From a moral perspective, a physician may responsibly administer medications to control or alleviate pain even when doing so may hasten death. The physician's intention is not to kill the patient but to relieve pain effectively with the medicines available.

Much of the debate in this matter fails to distinguish between pain and suffering. The distinction is far more than academic for a person of faith. Pain most frequently refers to the physical experience of discomfort. Suffering is more profound than the endurance of physical pain and may well be present even in the absence of pain. Suffering can also be an expression of one's faith and love. Suffering endured out of love is redemptive. Our suffering, from apostolic times, has also been a way that each one of us identifies with and shares in the salvific work of Christ himself (Col 1:24; 1 Pt 4:13).

Conclusion

As a people of faith, we have an important role in the public discussion about physician-assisted suicide. In this public conversation our position must not only be stated clearly and confidently, but our opposition to assisted suicide must be backed up with compassionate action. Our opposition to physician-assisted suicide is not to hinder freedom but to protect the right to die with human and Christian dignity. Between the two extremes of active euthanasia or assisted suicide and the use of every possible means to prolong life at all costs, the Church offers a third alternative of action that can help to guide the public discussion.

The Church recognizes a person's right to refuse disproportionate medical treatment. What we must safeguard in our society is that a person's informed treatment decisions are respected.

The Church also recognizes the need for the proper management of pain. In this regard, we must ensure in the clinical setting that a person need not seek death in order to escape pain.

And finally, the Church recognizes the importance of the interpersonal aspects of human suffering and death. As members of the Church, we offer to the sick and dying our service of charity as a resplendent sign that "God has visited his people" (Lk 7:16). It will be our compassion toward the sick and dying that will ultimately make our teaching on assisted suicide effective and credible enough to shape and guide the public agenda.

In the midst of the final looming controversy over his own fate, Jesus uttered the words of faith that continue to inspire and to guide the Church's teaching in this mystery of the death of a Christian: "This is why the Father loves me, because I lay down my life in order to take it up again" (Jn 10:17). □