Euthanasia

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Euthanasia is a word that keeps popping up in the media quite frequently. In recent months the notoriety given to the Karen Quinlan case led to a rash of references to euthanasia. It is understandable then that the program committee of our conference should ask for a discussion of this topic.

The term itself is generic. It covers two species: active euthanasia and passive euthanasia. Active euthanasia refers to terminating the life of those who are victims of illness in which there is no prognosis of recovery. Passive euthanasia refers to stopping medication or mechanical stimulants when there is no prognosis of recovery. Since our evaluation of these two types of euthanasia may differ, we shall consider them successively, first active euthanasia and then passive euthanasia.

I.

The argument in favor of active euthanasia runs something like this: Here is someone who is in the last stages of cancer. Medical experience says that there is no prospect of recovery, that it is only a matter of time until the destruction of vital organs will bring about death. Meanwhile the patient is suffering intense pain. Even though the dosage of sedatives has been constantly increased, they no longer are strong enough to deaden pain. Why not be humane and give the patient a lethal dose of morphine, for example, to allow him quietly to sleep away? The same line of reasoning is applied in the case of someone whose physical and mental condition has deteriorated to such an extent that he has become what is commonly called a vegetable. Again, would it not be humane to terminate the life of this person for his own good and the good of his family? One advocate of active euthanasia presents a touching description of a hydrocephalous child whose condition deteriorated from year to year without any prognosis of improvement and asks why in the name of humanity such an existence should not be terminated. The next step is to plead for the right of someone who knows that he has a terminal illness to avoid the agony of the last stages of his malady by terminating his own life. It wasn't too long ago that the media reported the case of a retired clergyman whose wife had terminal cancer. They entered into a suicide pact, ran a hose from the exhaust pipe of their car into the car in a closed garage. There were those who applauded what they called the wisdom and courage of this couple.

Since the arguments in favor of active euthanasia have a strong sentimental appeal but under existing laws the physician who would dare to practice it is liable to criminal prosecution and malpractice suits, there is agitation in many areas to legalize active euthanasia under well-defined conditions. No doubt we shall be hearing more about the matter in the future.

How are we to evaluate active euthanasia? Is it murder since it involves the deliberate use of means which are intended to end a human life? In our ethical evaluations we are conditioned to look not only at the act, but also at the motive behind the act. The motive behind murder is hate. The Word of God teaches us that even if hate in the heart does not lead to the act of murder, the Fifth Commandment has been broken. "Whosoever hateth his brother is a murderer"' (Jn 3:15). But not every termination of human life is motivated by hate. The cities of refuge were established by the Lord in the territory of the Israelites for those who ended a human life accidentally, not in hate. "Then Moses severed three cities on this side Jordan toward the sun rising; that the slayer might flee thither, which should kill his neighbor unawares, and hated him not in times past; and that fleeing unto one of these cities he might live" (Dt 4:41-42). Now the arguments in favor of active euthanasia are always based upon the premise that the motive for

the practice is not ill will toward the patient but rather humane considerations, pity, yes, love. Do these motives make designating active euthanasia as murder inappropriate? Well, the word "love" is often used quite loosely. There is, however, an objective criterion for determining whether what we call love is really love. "By this we know that we love the children of God, when we love God, and keep his commandments" (1 Jn 5:2). If a commandment of God is being obeyed, what is being done is an act of love whether it looks like an act of love or not. Conversely, if a commandment of God is being violated, what is being done is not an act of love no matter how loving the act seems to be. So we cannot say that we are acting out of love when we disobey the Fifth Commandment.

An argument a fortiori plays in. We do not hesitate to shoot a horse which has broken a leg or to have the humane society put away a dog which has grown so old that it is helpless and in constant misery. If we show so much humane consideration for an animal, should we show less for a human being? But that brings us to the fact that man is not just another type of animal. He is a distinct creation. The Lord reveals that the fact that he himself has made this distinction ought to lead us to take a different attitude toward the ending of human life from that toward the ending of animal life. In Genesis 9:3 we hear him saying: "Every moving thing that liveth shall be meat for you." But he is quick to add: "At the hand of every man's brother will I require the life of man. Whoso sheddeth man's blood, by man shall his blood be shed: for in the image of God made he man" (Ge 9:5-6). So for the child of God the argument a fortiori will not hold. We may not equate what is done to animals to what may be done to human beings.

I don't suppose that we dare to prove too much with the argument: "If you say A, you will also have to say B." Still the Lord himself operates with the axiom as one that is universally valid, an axiom that Paul thus states in 1 Corinthians 5:6: "Know ye not that a little leaven leaveneth the whole lump?" If we approve or legalize the ending of life under certain sharply defined conditions, will the next step not be to broaden the conditions and justify the termination of the life of the mental and physical defectives who are not able to lead what is called a useful existence, of the aged, and of the chronic criminals? The heathen in the apostolic age had gone that far and so in modern times had Hitler's Germany.

What are we to do if we reach a condition in which there is no prognosis of recovery but only the prospect of increasing pain and deterioration? What are we to do if one of our dear ones reaches such a state? There is nothing wrong with a Christian's desiring to die. But his emphasis is not so much on what he will be leaving as on what he will be entering. So Paul desired to depart because then he would be with Christ, and that, he says, "is far better" (Php 1:23). But with him, as is also the case with other believers, there was a willingness to leave the determination as to the time of death to the Lord. The sovereignty of our God includes his sole right to determine when death is to come. "My times are in thy hand" (Ps 31:15). "Thou turnest man to destruction; and sayest, Return, ye children of men" (Ps 90:3). So whether it is we ourselves or one of our dear ones who must bear the burden to which we have been referring, we shall patiently wait until the Lord's good time has come to remove the burden by calling us or them home. In the meantime we shall be sustained by the words of comfort: "We know that all things work together for good to them that love God, to them who are the called according to his purpose" (Ro 8:28).

When we speak of this kind of patient submission, this does not imply that we frown upon using whatever means are at the disposal of the medical profession to relieve the pain of the sufferer and to make him as comfortable as possible until the end comes. There is a calculated risk involved in determining the size of the dose of pain reliever that is to be given to the patient. The amount necessary to relieve intense and continuing pain has to be constantly increased both because the pain accelerates and because the body adjusts to the pain reliever so

that what once was adequate no longer is sufficient. We may have heard the comment that a patient has received a dose large enough to kill a horse, but neither does the patient die nor is his pain completely relieved. But it can be that the dose needed to relieve pain at this stage could prove to be lethal. Since the intention is not to shorten life but to relieve pain. I believe that even good Lutherans can agree with a statement attributed to Pope Pius XII: "The removal of pain and consciousness by means of drugs when medical reasons suggest it, is permitted by religion and morality to both doctor and patient; even if the use of drugs will shorten life" (quoted in *Euthanasia*, a pamphlet published by the Euthanasia Educational Council under date of November, 1973).

So much for active euthanasia. We shall now proceed to discuss passive euthanasia.

II

Perhaps a repetition of the definition of passive euthanasia that was given at the beginning of this presentation is in order: Passive euthanasia refers to stopping medication or mechanical stimulants when there is no prognosis of recovery. The credo of the Euthanasia Educational council is slightly more detailed, "We believe supporting measures should not be used to prolong dying in cases of terminal illness with intractable pain or irreversible brain damage. Medication should be given to the dying in sufficient quantity to eliminate pain even if tending to shorten life" (ibid.).

Perhaps most of us have had this kind of experience: An older member of our congregation has terminal cancer. We minister to him and see the progressive deterioration of physical and mental functions that has taken place between visits. Then we receive a call informing us that our patient is dying. When we enter his room we see a beehive of activity around his bed. Adrenaline is being administered to stimulate heart action. His blood pressure is being taken almost constantly. A proliferation of tubes is attached to various parts of his body. In his eyes there is a vacant stare. Did we find ourselves wondering: "Why all this fuss? It has been evident for some time that his time was running out. Why not let him die in peace?"

One answer that has been suggested in the material that I perused while preparing this presentation is that doctors are conditioned to thinking terms of preserving life. Every seriously ill patient is a challenge to their skill. Every recovery under their care is a victory and, by the same token, every death of a patient is a defeat. Since it is hard to admit defeat, every possible heroic measure is employed to stave off defeat even when the prognosis is that there are no prospects of recovery.

Another factor may enter in some cases. Someone has observed that it is appropriately called the practice of medicine. There are few absolutes. There is constant experimentation with new drugs and new procedures. What more challenging time could there be for trying out something new than when the patient is moribund? If it works, even only to the extent of keeping him alive for a few more hours or days, it may be very valuable in the treatment of other than terminal cases. If it doesn't work—well, the patient was dying anyhow. We might call such thinking brutal and inhumane, but others might consider it justified experimentation.

Be that as it may, an adverse reaction to the heroic measures that are still resorted to when terminally ill patients are dying is mounting. The slogan used is: Death with dignity. The option which is offered by those who rally around the slogan is to let the terminally ill patient die at home, receiving as much care and medication as are needed to make him comfortable. I don't wish to imply that that does not ever happen now. It does, but not too frequently.

One of the devices which has been promoted to insure death with dignity is what is known as the "Living Will." Since it may not be familiar to all of you and is comparatively brief, I'll read it to you.

To my family, my physician, my clergyman, my lawyer— If the time comes when I can no longer take part in decisions for my own future, let this statement stand as the testament of my wishes: If there is no reasonable expectation of my recovery from physical or mental disability, 1, _____, request that I be allowed to die and not be kept alive by artificial means or heroic measures. Death is as much a reality as birth, growth, maturity, and old age it is the one certainty. I do not fear death as much as I fear the indignity of deterioration, dependence and hopeless pain. I ask that medication be mercifully administered to me for terminal suffering even if it hastens the moment of death. This request is made after careful consideration. Although this document is not legally binding, you who care for me will, I hope, feel morally bound to follow its mandate. I recognize that it places a heavy burden of responsibility upon you, and it is with the intention of sharing that responsibility and of mitigating any feelings of guilt that this statement is made. (Published by the Euthanasia Educational Council.)

What shall we say then about passive euthanasia? It is not a matter of terminating life. The impression was given that almost immediately after the plug would be pulled in the case of Karen Quinlan she would die. The plug has been pulled long since, but the patient is still alive. Occasionally one hears of cases which seemed hopeless and where there was still survival and recovery, perhaps even without medical assistance. Death will not come until the Lord's hour has struck!

Lest we sound too critical of heroic measures, we know that they are often used not only in the case of the terminally ill but also in the case of accident victims or of diseases which involve a crisis and full recovery if the crisis is passed. The difference lies in the prognosis. In the case of the terminally ill there is no prospect of recovery even if the heroic measures should prove to be effective for a time. In the other case the prognosis is that if the patient comes out of shock or survives the first impact of the accident or disease, he may have many years of useful living before him. For such there is no plea to let them die with dignity. Rather, the urging is to do what can be done to help them recover.

What is involved in situations in which some advocate passive euthanasia? The question has rightly been asked: Is it really a case of keeping the patient alive or is it not rather a case of keeping him from dying? If it is the latter, we are very close to a situation where man undertakes to play God.

I realize that my evaluation of euthanasia may be simplistic. Legislation legitimizing passive euthanasia may be abused, witness how the Living Will sneaks in mental disability with physical disability. We would be much better off if this question could be kept out of the legislative chambers and certainly out of the media and left with the judgment of the physician. I know that families do appreciate it when in cases of terminal illness the physician tells them that he will do all in his power to keep the patient comfortable, but will use no heroic measures to prolong his life.

As for me, I don't want my life to be terminated by men. That puts me squarely against active euthanasia. On the other hand, I do not want men to interfere when the Lord has shown that the time has come for me to die. To that extent I'll have to be counted as being in favor of passive euthanasia.