A Christian Ending to Our Life

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Introduction

The American public has recently demonstrated considerable interest in issues surrounding death and the dying process. This fascination and concern regarding death has been highlighted on the one hand by such phenomena as Dr. Jack Kevorkian's advocacy of physician-assisted suicide and euthanasia and the unprecedented recent legalization of physician-assisted suicide in the State of Oregon, and, on the other hand, by the rapid growth of the hospice movement in this country. The Orthodox Church has much to say in her theological understanding of death that would speak directly to the American public's anxieties regarding these issues. Translating the Orthodox theology of death into a practical response to the current approaches in this country to care of the dying is a critical need.

As Orthodox Christian physicians who are actively involved in the care of the dying, our intent in this manuscript is to present a critique of the current approaches in America to care of the dying. In this critique we will first review demographic aspects of the problem, second, discuss the process of adjustment and life after a terminal diagnosis has been made, third, examine the major approaches to end of life issues as they relate to medical practice and public policy, and fourth, suggest an Orthodox Christian response.

Death and Dying in America

The major conclusion of a recent survey of 1,200 adults completed just prior to the June 1997 Supreme Court decision on physician-

assisted suicide was that "... the American people want to reclaim and reassert the spiritual dimension in dying."[1] This resurgent interest in spirituality and the dying process is in tension with certain economic realities. One third of health care expenditures occur during the last year of life, with half of these occurring in the last two months of life.[2] When confronted with the possibility of death, to whom do people look for comfort? The majority seek comfort from family (81%) and friends (61%). Only a minority would seek comfort from clergy (36%), their physician (30%) or nurse (21%).[3]

The five greatest concerns that the American public has concerning death are: 1) the possibility of being in a persistent vegetative state (73%); 2) not having the opportunity to say good-bye (73%); 3) the possibility of experiencing severe physical pain (67%); 4) uncertainty about how family and loved ones will be cared for in their absence (65%); and 5) the inconvenience and stress their death may cause for loved ones (64%).[4]

As might be expected in our secular society, spiritual concerns are less common, but include the following: 1) not receiving forgiveness from God (56%); 2) not being reconciled with others (56%); 3) at the time of death being removed or cut off from God or a higher power (51%); 4) not receiving forgiveness for something you did (49%); 5) not being able to receive a blessing from a family member or member of the clergy (39%); and 6) anxieties about one's condition after death (39%).[5]

The data reviewed above suggest a number of observations about American attitudes and expectations regarding death. In keeping with the emphasis on individual autonomy in our culture, Americans have a great deal of anxiety about maintaining control

1 The George H Gallup International Institute, *Spiritual Beliefs and the Dying Process*, p 1, A Report of a National Survey Conducted for the Nathan Cummings Foundation and Fetzer Institute, October 1997

2 *Ibid*, p 3

3 *Ibid*, p 7

4 *Ibid*, p 8

5 *Ibid*, pp 34, 35

over the dying process, as evidenced by the largest (73%) majority expressing concern over potentially being in a persistent vegetative state and also being unable to say good-bye.[6] Spiritual concerns are primarily related to forgiveness and reconciliation. Ironically for those involved in pastoral or other direct care of the dying, most people look to family and friends rather than to them for comfort and 'spiritual' support. All of this is against a backdrop of ever-increasing economic pressures to reduce the cost of health care (so much of which is incurred just prior to death).

How can we as Orthodox caregivers impart to our patients, and especially those who are dying, that sense of peace and security regarding death expressed with such confidence by St Anthony the Great?

> ...As we rise daily, let us suppose that we shall not survive till evening, and again, as we prepare for sleep, let us consider that we shall not awaken. By its very nature our life is uncertain, and is meted out daily by Providence. If we think this way, and in this way live—daily—we will not sin ...[7]

Living with Terminal Illness

Even for many Christians, being given a diagnosis of a terminal illness can provoke a crisis. In our secular American culture which is typified by its denial of death, such a diagnosis is usually attended by a host of reactions. In addition to the initial shock and denial, early reactions to the diagnosis of a terminal illness often include anger (why me?) and feelings of guilt (particularly where the disease may have resulted from self-injurious behaviors). These initial reactions may be followed by depression, which is frequently accompanied by suicidal thoughts. Of course, the suicidal thoughts can further exacerbate a sense of guilt in Christians. The whole experience is characterized by uncertainty which almost paradoxically may give way to relief (particularly when the diagnosis

6 *Ibid.*, p. 8.

7 Athanasius, *The Life of Antony and the Letter to Marcellinus*, The Classics of Western Spirituality (New York: Paulist Press, 1980), p. 45.

has been preceded by a long search for answers regarding troubling symptoms).

At its core, the crisis associated with a diagnosis of terminal illness is centered in the human unwillingness to confront and anticipate the reality of death on a personal level. Only in the tradition and prayers of the Church has this been addressed so directly, "Lord, spare me from an unexpected death!"[8]

A stigma accompanies terminal illness which may include a feeling of being "unclean," as if death were "catching"! In many ways, the terminally ill are the lepers of modern society. They experience a real sense of abandonment, both physical and emotional. This progressive isolation and abandonment is described with moving detail in Tolstoy's short work, *The Death of Ivan Ilych*,

> ... in the third month of Ivan Ilych's illness, his wife, his daughter, his son, his acquaintances, the doctors, the servants, and above all, he himself, were aware that the whole interest he had for other people was whether he would soon vacate his place, and at last release the living from the discomfort caused by his presence...[9]

The stigma of terminal illness in some instances actually leads to discrimination against the dying individual. This has been especially true for those suffering from acquired immunodeficiency syndrome (AIDS). Other major elements contributing to the stigma of the dying include loss of self-esteem, loss of personal dignity and particularly loss of control over one's life. There is often a desperate need to stay in control; and, as we shall see later, despair over this apparent loss of control can be a powerful motivating factor for those terminally ill who seek to end their lives with the aid of a physician.

To *live* with a terminal illness requires re-establishment of an equilibrium—making the choice to "go on living" and not to "give

8 John Breck, *The Sacred Gift of Life Orthodox Christianity and Bioethics* (Crestwood, NY. SVS Press, 1998), p. 225.

9 Leo Tolstoy, *The Death of Ivan Ilych and Other Stories* (New York: Signet Classics, 1960,) pp. 134, 135.

up." Accomplishing this difficult and painful task requires letting go of anger, breaking through denial, restoring self-esteem, and, most importantly, learning to live with uncertainty. The Christian has the advantage in this process of knowing that we humans were never 'in control' and that trust in God makes it possible for us to accept anything, even death. Our hope resides in this acceptance. "... Christ redeems from death those who have accepted death."[10]

There are many opportunities for personal growth and maturation when facing one's mortality in a terminal illness. One can learn, even when 'it's too late,' from the consequences of negative and destructive behaviors to appreciate the value of the life remaining. This can lead to conscious changes in lifestyle and in the Christian context to repentance. In their suffering, the terminally ill have an imperative to finally seek real meaning in their lives and especially in their experience of suffering. "Suffering... can transform life and become, as an icon experienced, a window opening on heaven."[11] Finally, being confronted with a terminal illness presents the dying with the opportunity (which hopefully will not be squandered) to really say good-bye, to truly be reconciled with friends and enemies alike. "Reconciliation is the most crucial thing for the dying irrespective of whether or not the person is religious or secular... Even as their bodies are disintegrating they are becoming whole."[12]

Terminal illness not only generates tremendous anguish and suffering for the dying patient, but can also produce some very negative feelings in the caregiver. Because death, like so many other medical challenges facing the caregiver, is viewed in this culture as yet another problem to be solved, failure to cure becomes a personal failure for the physician. Sometimes, unfortunately, the feelings of shame, failure, and impotence are displaced onto the pa-

10 Matthew the Poor, *The Communion of Love* (Crestwood, NY: SVS Press, 1989), p. 119.

11 Stanley Samuel Harakas, *Health and Medicine in the Eastern Orthodox Tradition* (New York: Crossroad, 1990), p. 55.

12 Sharon Burns quoted by Vigen Guroian in *Life's Living Toward Dying* (Grand Rapids, MI: William B. Eerdman's Publishing Company, 1996), p. 87.

tient, who may even 'apologize' for being a treatment failure. At some level, making and sharing the diagnosis of a terminal illness with the patient forces caregivers also to face their own mortality. This experience often elicits fear, a strong sense of one's own vulnerability, and a breakdown of the caregiver's own denial about death. This can lead to a number of very negative behaviors including: avoidance of the patient, emotional distancing, poor communication (even lying to the patient), and referral elsewhere to rid oneself of the emotional burden, all of which can only add to the patient's suffering and sense of isolation. This response to the dying, of course, is not limited to physicians and other health care providers, but may also be a problem for clergy who bear a responsibility to minister to the dying as well.

If caregivers have been able to face their own mortality while also recognizing their own limitations, they may in the Christian context be able to integrate the hope of the resurrection with their care for the dying. Most importantly, they can remain available, showing real empathy to the patient while at the same time being professional about the relationship. Because they realize and can accept their own limitations, they are not afraid to seek the help of consultants where appropriate. The value of developing a relationship based on trust cannot be underestimated. A relationship with the patient based on trust and a willingness on the part of the caregiver to talk about death will prepare the way for fruitful discussions with the caregiver and/or clergy when the patient is ready.

To summarize, some of the critical interventions which should be initiated at the time of diagnosis of a terminal illness include: 1) maximizing access to medical care (especially care directed at relief of symptoms); 2) assessing for severe depressive symptoms (including thoughts of suicide); 3) determining the level of support available to the patient (including spiritual support) and providing referrals if needed; 4) always remaining available to the patient and family; and 5) remaining honest and open, sharing information with the dying patient as they are ready. Hopefully, with appropriate and timely support the dying patient can engage in a real and

productive reflection on their end. "In everything you do, remember your end, and you will never sin."[13] And, again... "No one who has acquired the remembrance of death will ever be able to sin."[14]

Current Approaches to End of Life Issues

The tension which exists between the renewed interest of the American public in spirituality and the dying process and the harsh realities of health care economics is also mirrored by the preeminence achieved by scientific-curative medicine in the last 150 years over simple provision of care and comfort to the sick and dying. Although the disease-oriented curative approach to medicine has in this century yielded breathtaking results in many areas, it has not altered the inevitability of death and may even have added to the suffering of the dying. In the last century, the Russian author Turgenev perceptively described the beginnings of this trend toward focusing on diagnosis and cure, sometimes to the exclusion of relief of suffering, in his description of a medical consultation in his moving short story, *Living Relic*. In the story the protagonist is a beautiful young peasant woman, Lukeria, who is reduced to a spastic form of paralysis with extreme physical wasting and weakness following a tragic, freak accident. Although she is prepared to accept her condition as her "cross," a well-meaning individual insists on providing the best in hospital treatment. She responds by describing her experience with the medical profession:

> Once a doctor came here and wanted to have a look at me. I said to him, begging him: "Don't disturb me for Christ's sake!" What good was it! He started turning me this way and that, straightening and bending my legs and arms and telling me: "I'm doing this for learning, that's why. I'm one who serves, a scientist! And don't you try to stop me, because they've pinned a medal on me for my contributions to science and it's for you, you dolts, that I'm working so hard." He

13 *Sirach (Ecclesiasticus)* 7:36.

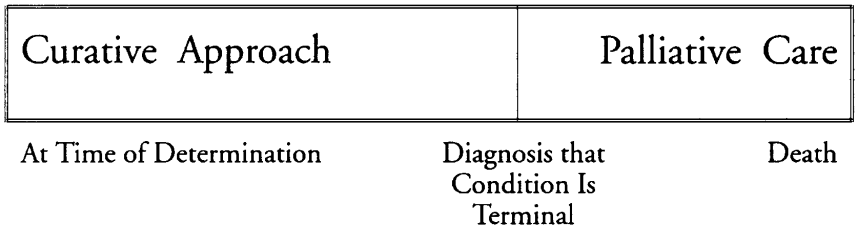
14 Hesychius the Horebite, as quoted by St John Climacus in *The Ladder of Divine Ascent*, The Classics of Western Spirituality (Mahwah, NJ: Paulist Press, 1982), p. 134.

> pulled me about and pulled me about, named what was wrong with me—and a fine name it was!—and with that he left.[15]

This same enthusiasm for diagnosing and treating the disease rather than the patient has led to the current crisis in our culture regarding care for the dying. A recent study which has reviewed many of the issues underlying the debate over physician-assisted suicide has drawn the significant conclusion that, "Access to and delivery of pain treatment and other palliative measures are seriously deficient in the present health care systems in the United States."[16]

In the "Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments" (SUPPORT), a multicenter prospective study examining patient-physician communication regarding aggressive interventions to prevent death in the context of serious illness, it was noted by family members that "... half of the patients who were able to communicate in their last few days spent most of the time in moderate or severe pain."[17]

Figure 1



15 Ivan Turgenev, "Living Relic" in *Sketches from a Hunter's Album* (Harmondsworth, Middlesex, England: Penguin Books, 1972), p. 218.

16 Timothy E. Quill, M.D.; Diane E. Meier, M.D.; Susan D. Block, M.D.; and Andrew Billings, M.D., "The Debate over Physician-Assisted Suicide: Empirical Data and Convergent Views, *Annals of Internal Medicine* 128:552–58, 1998.

17 The SUPPORT principal investigators, "A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)," *Journal of the American Medical Association* (JAMA) 274:1591–98, 1995.

Figure 1 graphically depicts the ongoing dichotomy which exists in modern health care.[18] At the time of diagnosis, great energy and resources are expended to effect a "cure." Little attention is often paid to the patient's primary concerns (symptoms) unless they coincide with the curative treatment goals. If indeed the condition is curable, the therapeutic disconnect is often tolerated with minimal complaint or lasting frustration on the part of the patient. However, in the event that the aggressive therapy fails (e.g., metastatic cancer), the sudden shift to a new set of caregivers for relief of symptoms and overall palliation in the context of a now "hopeless" diagnosis hits the patient and family like a bolt of lightning. The ability of the new team to actually help palliate the patient's condition is severely compromised and much of their effort is expended dealing with a considerable amount of anger from the patient and family displaced from the original "curative" team. In this approach, the referral for palliative care typically occurs very late in the course of the illness, leaving little time for addressing the many serious issues described above which the terminally ill need to confront.

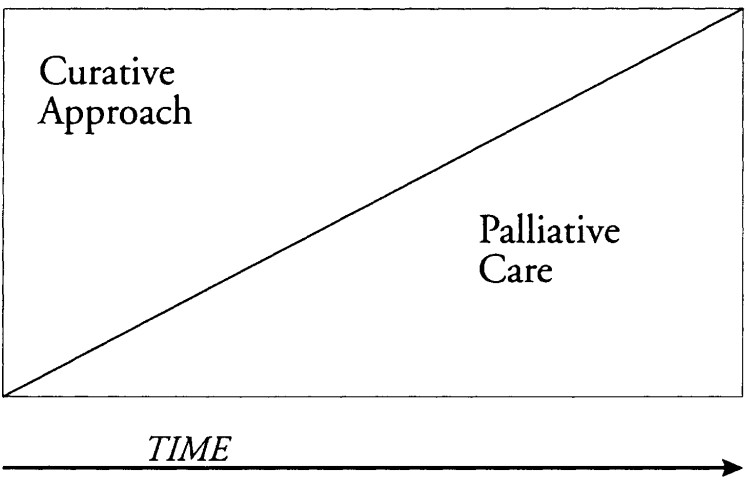
An alternative approach, depicted in figure 2, incorporates palliative care in the management of any serious life-threatening illness at the outset of treatment.[19] In those situations where the prospect for cure diminishes with time, the steady and incremental increase in caring for the patient's symptoms and total needs from the outset of the treatment allows for a gradual and seamless movement toward palliation as the primary goal of treatment at the end of a fatal illness.

The World Health Organization has defined hospice or palliative care as: "The active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems, is paramount. The goal of palliative care is achievement of the best quality

18 Adapted from *Cancer Pain Relief and Palliative Care: Report of a WHO Expert Committee* (Geneva, Switzerland: World Health Organization, 1990), p. 16.

19 *Ibid.*

Figure 2: Continuum of illness and its R_x



of life for patients and their families..."[20] This concern for addressing *all* the needs of patients at the end of life has even been mandated in this country by the major healthcare accrediting body, the Joint Commission on Accreditation of Health Care Organizations (JCAHO). In addition to aggressively and effectively managing pain and other symptoms of the dying patient, the intent of the JCAHO standard relating to end of life care also focuses specifically on the need to address the social, emotional, psychological, spiritual and cultural concerns of the patient and family while demonstrating respect for their values, philosophy, and religion.[21]

Some of the major physical symptoms of the dying include: pain, shortness of breath, loss of appetite, nausea and vomiting, generalized fatigue, and confusion (delirium). Attempts to address the psychological and spiritual concerns of the dying without at the same time addressing basic physical needs will be doomed to failure.

20 *Ibid.*, p. 11.

21 JCAHO Standard RI.1.2.7, *The hospital addresses care at the end of life*, p. RI-13, Joint Commission on the Accreditation of Healthcare Organizations Manual, November, 1998.

Any group concerned with service to the dying should be talking about smoothing sheets, rubbing bottoms, relieving constipation, and sitting up at night. Counseling a dying person who is lying in a wet bed is ineffective. Such concerns loom large in the lives of critically-ill patients and must be of importance to the physician if the physician is to treat the whole person.[22] Also, "...no man can be rendered pain free whilst he still wrestles with his faith. No man can come to terms with his God when every waking moment is taken up with pain or vomiting."[23]

These observations regarding care for the dying are thoroughly consistent with the Orthodox Christian teaching concerning the unity of the body and soul as opposed to the Neoplatonic dualism so prevalent in Western thought. As St John Climacus says of his own body:

> ...How can I hate him when my nature disposes me to love him? How can I break away from him when I am bound to him forever? How can I escape from him when he is going to rise with me?...[24]

Unfortunately, even with the best of efforts, "...palliative care can relieve most but not all terminal suffering."[25] In a culture which does not recognize any value or potential good associated with human suffering, this 'deficiency' of palliative care has opened the door for those who advocate physician-assisted suicide and euthanasia as an appropriate means of eliminating the suffering of the dying. Their argument flows naturally from the concept of individual patient autonomy or rights, so much a part of the American

22 Sylvia A. Lack, MD, as quoted by Porter Storey, MD in, *Primer of Palliative Care* (Gainesville, FL: American Academy of Hospice and Palliative Medicine, 1996), p. 19.

23 Derek Doyle, Geoffrey Hanks, and Neil MacDonald, Introduction in *Oxford Textbook of Palliative Medicine*, second edition (New York, NY: Oxford University Press, 1998), p. 6.

24 St John Climacus, *The Ladder of Divine Ascent*, The Classics of Western Spirituality (Mahwah, NJ: Paulist Press, 1982) , p. 185.

25 Timothy E. Quill, MD; Diane E. Meier, MD; Susan D. Block, MD; and Andrew Billings, MD, "The Debate over Physician-Assisted Suicide: Empirical Data and Convergent Views," *Annals of Internal Medicine* 128:552–58, 1998.

obsession with individual rights defined in the Declaration of Independence and the Constitution.

Not only does this approach run counter to the Orthodox Christian understanding of the sacredness of life as well as the very real possibility for believers to participate in the suffering of Christ through acceptance of their own suffering, but it also contradicts more than two thousand years of tradition within western medicine. Asking physicians to kill their patients directly contradicts the role of the physician in the Hippocratic and Judeo-Christian tradition as an advocate for life.

> ... I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them. *I will not give poison to anyone though asked to do so, nor will I suggest such a plan.* Similarly I will not give a pessary to a woman to cause abortion. But in purity and in holiness I will guard my life and my art ...[26]

Regardless of the motivation of the more vocal advocates for physician-assisted suicide, the important practical issue is to understand why patients might request such assistance.

> Requests may be a sign of unrecognized and potentially ameliorable suffering (such as pain; depression; or a psychosocial, family, or spiritual crisis) and should initiate a comprehensive evaluation and strenuous effort to relieve distress and make continued living desirable.[27]

It is important to clarify the terms used in this debate. In physician-assisted suicide, the physician provides the means, but the patient is the direct cause of his/her death. In active euthanasia, the physician serves as the direct cause of the patient's death with (voluntary) or without (involuntary) his/her consent. Although the less direct role of the physician in physician-assisted suicide has

26 From the Hippocratic Oath as quoted by Nigel M. de S. Cameron in *The New Medicine Life and Death after Hippocrates* (Wheaton, IL: Crossway Books, 1992), p. 25.

27 Timothy E. Quill, MD; Diane E. Meier, MD; Susan D. Block, MD; and Andrew Billings, MD, "The Debate over Physician-Assisted Suicide: Empirical Data and Convergent Views," *Annals of Internal Medicine* 128:552–58, 1998.

been emphasized successfully in the campaign to legalize physician-assisted suicide in Oregon, Dixon[28] argues persuasively that the moral issues surrounding active euthanasia and physician-assisted suicide are essentially the same. Both approaches implicate a physician in the death of a patient, and by way of analogy, he indicates, there is no fundamental difference in culpability between the person who plans a bank robbery and the actual person who carries away the stolen money.[29] The one difference of any significance may be the more clear-cut demonstration of the desire to die by the patient willing to commit suicide.[30] One of the fallacies of the Oregon Death with Dignity Act (Oregon's physician-assisted suicide law) which underscores Dixon's analysis of the moral differences between active euthanasia and physician-assisted suicide is the great emphasis placed on maintaining a private patient-physician relationship in the process. Woolfrey[31] identifies the dilemma which pharmacists in Oregon must face when asked to fill prescriptions for medications which may be used for lethal purposes. Issues of patient confidentiality come into direct conflict with the moral concerns of individual pharmacists and potentially other providers as a result of this law.

So-called "passive" euthanasia is fundamentally different from active euthanasia. Withdrawal of aggressive therapy (i.e., "letting nature take its course") in the face of terminal illness is not the moral equivalent of 'mercy' killing (active euthanasia), contrary to the arguments of Rachels.[32] The key issue again involves the role of the physician and other providers. Acceptance of the inevitable and withdrawal of therapy which only prolongs the dying process are a far cry from *planning* and *causing* directly or indirectly the death of

28 Nicholas Dixon, "On the Difference between Physician-Assisted Suicide and Active Euthanasia," *Hastings Center Report* 28(5):25–29, 1998.

29 *Ibid.*

30 *Ibid.*

31 Joan Woolfrey, "What Happens Now? Oregon and Physician-Assisted Suicide," *Hastings Center Report* 28(3):9–17, 1998.

32 James Rachels, "Active and Passive Euthanasia," *New England Journal of Medicine* 292(2):78–80, 1975.

a patient. Even treatments directed at alleviating the distress of dying patients which secondarily may accelerate the dying process when truly intended for relief of symptoms in a *dying* patient are not the equivalent of active euthanasia. However, once the caregiver can be consulted specifically to aid in causing the death of the patient, the whole physician-patient relationship is altered completely. The omnipresent force of economic pressures can now synergize with the loss of provider advocacy for life and accelerate the process of the "slippery slope" to full active voluntary and eventual involuntary euthanasia in the name of 'sound' fiscal management of health care costs. Indeed, there is already evidence that managed care organizations in Oregon will fully cover the cost for lethal prescriptions for physician-assisted suicide, but are drastically limiting spending for hospice care.[33] In the June 1997 unanimous decision by the Supreme Court ruling that there is no constitutional right to physician-assisted suicide, Chief Justice William Rehnquist affirmed this concern by stating that if there were a constitutional right, "many might resort to it to spare their families the substantial financial burden of end-of-life health care costs."[34]

There are two extensions of "passive" euthanasia which should be discussed briefly. Terminal sedation refers to medically-induced sedation to the point of unconsciousness for relief of pain and other symptoms which may hasten death. Termination of hydration and nutrition refers to the cessation of fluid intake and feeding. The important point to consider with respect to both of these options is the condition of the patient. If the patient is truly near death (e.g., advanced cancer), one or both of these options might be very helpful in easing the dying process. It is very natural for the dying to voluntarily diminish or to cease oral intake of fluid and food prior to death. The gradual dehydration can act together with pain medications to blunt the dying patient's perception of pain. Terminal sedation, if carried to the point of rendering the patient unconscious,

33 Mark O'Keefe, "Assisted Suicide: Bitter Ends in Oregon?," *Hospitals & Health Networks*, May 20, 1998, p. 62

34 Quoted in *Ibid*

may conflict, however, with the goals of hospice to enhance a patient's ability to interact meaningfully with loved ones. Inasmuch as it may also prevent necessary spiritual preparation prior to death, terminal sedation may not be acceptable from an Orthodox Christian perspective. Interestingly, providing artificial feeding by means of tube feedings or intravenous methods has never been shown to prolong life and, in fact, under some circumstances may actually be associated with serious complications.[35]

It is important to note that requests for physician-assisted death (suicide and active euthanasia) in the Netherlands, where these practices are tolerated, are not primarily because of unrelieved pain. Unrelieved pain was the only reason in 5% of cases and was only a contributing factor in 40% of requests. The majority of requests were due to very different issues: intolerance of physical disintegration, dependence, being a burden, extreme fatigue, and *lack of meaning* (author's emphasis).[36] These observations have also been confirmed in the first year's experience with legalized physician-assisted suicide in Oregon.[37] In this case-control study only one patient receiving a prescription for lethal medications expressed concern about uncontrolled pain.[38] The primary concerns leading to a request for lethal medications were related to loss of autonomy and control of bodily functions.[39] The Gallup survey completed just prior to the June 1997 Supreme Court decision on physician-assisted suicide provides some helpful insights into the American public's attitudes toward this issue and why an initiative (Proposal B) in Michigan similar to the Oregon law was defeated in

35 Porter Storey, M.D., *Primer of Palliative Care* (Gainesville, FL: American Academy of Hospice and Palliative Medicine, 1996), p. 22

36 Timothy E. Quill, MD; Diane E. Meier, MD; Susan D. Block, MD; and Andrew Billings, MD, "The Debate over Physician-Assisted Suicide: Empirical Data and Convergent Views," *Annals of Internal Medicine* 128:552–58, 1998.

37 Arthur Chin, MD, Katrina Hedberg, MD, MPH, Grant K. Higginson, MD, MPH, and David W. Fleming, MD, "Legalized Physician-Assisted Suicide in Oregon—The First Year's Experience," *New England Journal of Medicine* 340:577–83, 1999.

38 *Ibid.*

39 *Ibid.*

November 1998.[40] Attitudes in the American public regarding physician-assisted suicide are essentially split into thirds: 33% support making it legal under a wide variety of circumstances; 32% support making it legal in a few cases but oppose it in most circumstances; and 31% oppose making it legal for any reason.[41] Clearly the fate of both the Oregon and Michigan initiatives depended on the perception of each initiative by the middle third. The lack of a clear position articulated by the hospice organizations of Oregon combined with a late attempt to reverse the initial close vote supporting the measure by the aggressive lobbying of religious organizations is perceived to have contributed to the ultimate passage of the Oregon law.[42]

Lest there be any confusion about history repeating itself and the "slippery slope," one need only compare the remarkably similar language of the early Nazi initiatives in this area to our own recent experience:

> ... it shall be made possible for physicians to end the tortures of incurable patients, upon request, in the interests of true humanity ...incurability would be determined not only by the attending physician, but also by two official doctors who would carefully trace the history of the case and personally examine the patient ...[43]

versus Michigan's Proposal B

> ... The proposal would: 1) Allow a Michigan resident and certain out-of-state relatives of Michigan residents confirmed by 1 psychiatrist to be mentally competent and 2 physicians to be terminally ill with 6 months or less to live to obtain a lethal dose of medication to end his/her life ...[44]

40 The George H. Gallup International Institute, *Spiritual Beliefs and the Dying Process*, A Report of a National Survey Conducted for the Nathan Cummings Foundation and Fetzer Institute, October 1997, p. 11.

41 *Ibid.*, p. 11.

42 Joan Woolfrey, "What Happens Now? Oregon and Physician-Assisted Suicide," *Hastings Center Report* 28(3):9-17, 1998.

43 The Associated Press, "Nazis Plan to Kill Incurables to End Pain; German Religious Groups Oppose Move," *New York Times*, October 8, 1933.

44 Full Text of Michigan's Proposal B is as follows: *Initiated Legislation to Legalize the*

Perhaps the fundamental question underlying this issue is best stated by quoting a political brochure prepared by Merian's Friends, a group advocating for Michigan's Proposal B in the fall of 1998: *"Let dying people die their way! Whose life is it, anyway?"*

If we are created in the image of God and our life is in Christ, the answer to this question will be very different from that enshrined in our individualistic American culture. Rather, with St Paul let us say, "...Christ will be magnified in my body, whether by life or by death. For to me, to live *is* Christ, and to die is gain."[45]

"...What Shall We Do Then?"[46]

Orthodox Christianity has always sought to embrace that which was fundamentally good within a culture while at the same time seeking to transform the bad. Aspects of the care currently available for the dying in America, especially as represented by the hospice movement, are in keeping with the Orthodox emphasis on preparation for a "good" death. Achieving the best quality of life remaining by aggressive symptoms management and other interventions, as far as they go, is consistent with Christ's statement: "... I have come that they may have life, and that they may have it more abundantly."[47]

Although only 28% of the American public have prepared one,[48] an advanced directive may be of real value for the dying.

Prescription of a Lethal Dose of Medication of Terminally Ill, Competent, Informed Adults in Order to Commit Suicide The proposal would (1) Allow a Michigan resident, or certain out-of-state relatives of Michigan residents, confirmed by 1 psychiatrist to be mentally competent, and 2 physicians, to be terminally ill with 6 months or less to live, to obtain a lethal dose of medication to end his/her life (2) Allow physicians, after following required protocols, to prescribe a lethal dose of medication to enable a terminally ill adult to end his/her life (3) Establish a gubernatorially appointed, publicly-funded oversight committee, exempt from Open Meetings Act and whose records, including confidential medical records, and minutes are exempt from Freedom of Information Act (4) Create penalties for violating law

45 Phil 1 20, 21

46 Lk 3 10

47 Jn 10 10

48 The George H Gallup International Institute, *Spiritual Beliefs and the Dying Process*, A Report of a National Survey Conducted for the Nathan Cummings Founda-

Advanced directives typically take the form of a living will and/or a durable power of attorney for health care. A Living Will is a statement of an individual's treatment preferences for end-of-life care or in a life-threatening illness in which he/she may no longer be able to communicate. A durable power of attorney for health care is a formal assignment to an individual (usually a spouse) of the responsibility of conveying the patient's wishes to the health care team in the event the patient can no longer communicate these wishes. Clearly, the advanced directive can be used to direct aggressive (resuscitate under any circumstances) or non-aggressive (do not resuscitate under the following circumstances) treatment at the end of life. The value of preparing an advanced directive may be twofold. In addition to helping to avoid ambiguities in patient-physician communication, perhaps its major value may be in the process of thought ("remembrance of death") and discussion it may stimulate in the individual patient with his/her family. Unfortunately, the potential benefit of advanced directives to clarifying patient wishes to providers has not been borne out by a recent prospective study from the University of North Carolina.[49] When patients were interviewed specifically to determine their wishes regarding aggressive measures to sustain life and then followed for six months, there was no significant association between their willingness to receive aggressive therapy and whether they actually received the therapy when they were critically ill.[50] This study underscores the ongoing problems in communication which exist between patient and provider in the setting of critical, life-threatening illness. It may also be a reflection of the relatively small number of advanced directives actually prepared in America,[51] em-

tion and Fetzer Institute, October 1997, p. 47.

49 Marion Davis, MD, Elizabeth Mutran, PhD, Joanne M. Garrett, PhD, Sally C. Stearns, PhD, Rebecca T. Slifkin, PhD, Laura Hanson, MD, Jude F. Williams, MPH, and Larry R. Churchill, PhD, "A prospective study of the impact of patient preferences on life-sustaining treatment and hospital cost," *Critical Care Medicine* 24:1811-1817, 1996.

50 *Ibid.*

51 The George H. Gallup International Institute, *Spiritual Beliefs and the Dying Pro-*

phasizing again our culture's (including the medical culture's) denial of death. Nonetheless, preparation of an advanced directive may still be of real value depending on the dialogue between patient, family, and caregivers that follows its completion. An excellent interdisciplinary effort has been made to create a template for an Orthodox Christian advanced directive.[52] It contains a very helpful, succinct discussion of the issues surrounding death with many quotes from the Church Fathers.

Although Orthodoxy clearly has never sanctioned suicide or killing in the form of active euthanasia, the answer regarding "passive" euthanasia is not so clear. With "passive" euthanasia the critical question appears to be: Is death *inevitable* and *imminent*? Certainly within the Church's tradition, there has been no virtue associated with needless prolongation of the dying process. "...Yea, Master, Lord our God, hearken unto me a sinner and thine unworthy servant in this hour, and loose thy servant, N., from this intolerable sickness and the bitter impotency which holdeth him, and give him rest where the souls of the righteous dwell..."[53]

In the end, dying is a spiritual task. "...But even what you do according to the flesh is spiritual, for you do all things in Jesus Christ."[54] Thus, ministering to even the most mundane physical needs of the dying can be a participation in and sharing of their spiritual task and a preparation for our own. "...There is no meeting more meaningful than that which takes place in the sharing of suffering, unless it be in the sharing of death itself when we touch immortality."[55]

cess, A Report of a National Survey Conducted for the Nathan Cummings Foundation and Fetzer Institute, October 1997, p. 47.

52 *A Living Will and a Christian Death* (St John of Kronstadt Press Book Service, Rt. 1, Box 205, Liberty, TN 37095, Inquiries to M. L. Sill, Rt. 2, Box 2343, Wayne, WV, 25570).

53 "Prayer for one who has suffered long" from *Prayers for the Dying—An Abridged Euchologion*, ed. by David F. Abramtsov (Thompson Ridge, NY: St German's Chapel Press, 1971).

54 Matthew the Poor, *The Communion of Love* (Crestwood, NY: SVS Press, 1989), p. 123

55 Ignatius of Antioch, *Letter to the Ephesians* 8:2.

How can Orthodoxy find its voice to speak out to our American culture regarding a real understanding and approach to death? It cannot be only in having the fullest theological understanding of death and dying. It must be a visible, tangible response to our culture which "incarnates" this fullness of theological understanding. After all, Christ said, "Come and *see*."[56] If we try to transform our culture using only some of the spiritual weapons given to us by Tradition, for example with prayer and fasting but neglecting acts of mercy (almsgiving), we risk suffering from the same dualism of our materialistic Western culture. The only difference will be our extreme "spirituality" as opposed to our culture's extreme materialism. A disembodied spirituality cannot be a living, healing, and redemptive spirituality.

> A brother asked a certain old man, saying, "There be two brothers, and one of them is quiet in his cell, and prolongs his fast for six days, and lays much travail on himself: but the other tends the sick. Whose work is more acceptable to God?" And the old man answered, "If that brother who carries his fast for six days were to hang himself up by the nostrils, he could not equal the other, who does service to the sick."[57]

Fr John Breck has recently suggested that caring for the dying may be an important ministry for Orthodox Christians.

> A new form of philanthropic organization, even a new expression of Christian vocation, seems required today, if the Church is to provide a genuine alternative to physician-assisted suicide. True "aid-in-dying" could be furnished by specially trained Christian lay persons or medical professionals ... Orthodox hospice programs ... should be ranked as high priorities among the many pastoral tasks the church is called to assume ...[58]

56 Jn 1:39.

57 From the *Sayings of the Fathers in The Desert Fathers*, translated by Helen Waddell (Ann Arbor, MI: University of Michigan Press, 1957), p. 124.

58 John Breck, *The Sacred Gift of Life: Orthodox Christianity and Bioethics* (Crestwood, NY: SVS Press, 1998), p. 239.

As a direct extension of Fr Breck's proposal, of the three tiers of hospice care in America: 1) hospital-based, 2) free-standing residential facilities, and 3) home-based hospice services—free-standing residential hospice facilities are in short supply.[59] This is a specific need to which Orthodox Christians could respond, creating a wedding of the best in palliative medicine with Orthodox pastoral care in a uniquely Orthodox setting to serve those poorest members of our society who will never be able to afford home-based hospice services (especially since many of them are homeless!). If properly endowed, the vision for care could include following in the footsteps of the unmercenary saints of the Church who did not charge for their services. Is there an historical precedent for this in Orthodox Christian experience? Timothy Miller in his study of the development of hospitals in the Byzantine Empire[60] has identified the founding of hospitals (*xenones*) as perhaps the most dramatic example of a wide-ranging Christian *philanthropia* which also included the founding of orphanages, old age homes, and even bathing facilities. His review of the *Typikon* of the twelfth-century Pantokrator *Xenon* outlines in detail the structure, function, and governance of this hospital which was attached to the Pantokrator monastery in Constantinople. Critical features of the *xenon* included chapels which inpatients could attend four times a week to receive the Eucharist and the Sacrament of Confession.[61] Although the purpose of the *xenones* was to provide "state of the art" curative therapy, spiritual and pastoral care were fully integrated with the rest of the treatment regimen, not awkward additions as is so often seen today. It is this integration which could be brought to the care of the dying in an Orthodox hospice. One might ask, how can a non-Orthodox person benefit from an environment permeated with Orthodox worship? As fairly recent converts to the Orthodox

59 Timothy E. Quill, MD; Diane E. Meier, MD; Susan D. Block, MD; and Andrew Billings, MD, "The Debate over Physician-Assisted Suicide: Empirical Data and Convergent Views," *Annals of Internal Medicine* 128:552–58,1998.

60 Timothy S. Miller, *The Birth of the Hospital in the Byzantine Empire* (Baltimore, MD: John Hopkins University Press, 1985).

61 *Ibid.*, p. 19.

faith, we can personally attest to the grace and mercy one can experience in the presence of Orthodox worship without full understanding. For that matter, who among us Orthodox fully understands, and yet we receive!

One of the most compelling ways Christians have been able to live out their faith in the world is the way in which they respond to the needs of the sick and suffering. Eusebius, in his *Ecclesiastical History*, quotes Bishop Dionysios of Alexandria describing the Christian response to a plague in Alexandria in the mid-third century.[62] The Christians, who had not yet recovered from a violent persecution, without hesitation began taking care of the sick, *'therapeuontes en Christo'* (healing in Christ), while the pagans fled the city. Already, at this early point in Christian history, there is a model for the Orthodox hospice—*therapeuontes en Christo*—healing in Christ. Even as they are dying, they are being healed in the deepest sense of the word. Perhaps it's not an accident that the primary meaning of the other Greek word used so frequently in the context of Christ's healing miracles, *sozo*, relates specifically to salvation.

> A Christian ending to our life: painless, blameless, and peaceful; and a good defense before the dread judgment seat of Christ, let us ask of the Lord.[63]

62 Eusebius, *Ecclesiastical History*, Bk. 2, Loeb Classical Library (Cambridge, MA: Harvard University Press, 1994), pp. 185–87.

63 Prayer from *The Divine Liturgy according to St. John Chrysostom* (South Canaan, PA: St Tikhon's Seminary Press, second edition, 1977), p. 72.

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