THANKS TO JOE BAROODY for this timely article and also for inviting the pastoral care community into a dialogue around the issue of PAS. My response to his article picks up this challenge and hopefully continues the dialogue.

When I think of physician assisted suicide, I am saddened. There are persons whose suffering is great, whose options seem limited, whose caregivers have competing commitments, and for whom death is a release and relief. I envision a responsive and loving God with compassion for those persons who have come to the choice of physician-assisted suicide (PAS). I believe that as chaplains and practical theologians we must explore vigilantly ways to relieve suffering, to expand options for those facing such affliction at end of life, to support caregivers, and to provide comforting services to the terminally ill. We must honor the feelings of those among us who come to the end of life where death holds more hope than life.

PAS is one answer to the ever-present question about how to address the concerns of persons facing death in the context of a culture of increasing medical technology that expands life-sustaining treatments without relieving suffering and providing cure. The hypothesis of Baroody’s article is that the theological premise that death is the enemy is implicit in the AMA’s “Code of Medical Ethics” and that this premise is connected to an Augustinian interpretation of death as the consequence of sin, suffering, and evil.

Role of physicians and clergy/chaplains

The American Medical Association statement on PAS is comprehensive and directive. Physicians are...

I N “ADAM, EVE, AND THE AMA,” Joe Baroody seeks to engage the American Medical Association as a proxy for American medicine in a dialogue about physician-assisted suicide (PAS). This effort is ambitious, even courageous, and deserves serious consideration. Baroody has advanced a bold, cross-disciplinary vision in an effort to enhance our response to suffering and dying patients. He has marshaled impressive scholarly resources on behalf of his understanding of the AMA’s opposition to PAS and his view that PAS deserves support from the medical and spiritual care communities.

Baroody creatively draws connections between Hippocratic medicine and the Christian tradition. In the end, his historical-theological argument about the AMA’s basis for opposing PAS is not fully persuasive. Nevertheless, he makes telling points about moralistic responses to suffering and religiously grounded attitudes that inform those responses. He reopens the debate about PAS from a fresh vantage point and presses chaplains and physicians (and whoever else is listening) to reconsider how to address suffering and dying.

I will comment first on Baroody’s claims for a direct connection between the AMA’s position on assisted suicide and specific theological emphases in the Christian tradition. Then I will consider the experience of suffering as a context for PAS and conclude with reflections about PAS and its significance for chaplains and physicians.

A direct link?

Baroody proposes not just a loose cultural connection but a “direct link” between the AMA’s policy on...
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given a clear message. There is no such commonly held practice for spiritual care providers. So, what is the role of spiritual care providers whether they are institutional chaplains, community chaplains and clergy, or lay caregivers? In the absence of an organizational rubric, it seems even more important to determine how chaplains view and interact with patients facing the decisions related to end of life care.

I am reminded of various stories I have read about PAS and of patients with whom I have interacted whose prayer is to die. Persons facing decisions related to life-ending diagnoses function in a complex system where economics, culture, social and religious values as well as familial and intimate relationships form a web from which a decision such as PAS emerges.

So perhaps the dialogue to which Baroody invites us as readers, begins with our own reflection and follows empathically toward the complex web of the patient and her/his faith struggle.

**Patient autonomy and informed consent**

The hallmarks of decision making at the end of life are patient autonomy and informed consent. Are the wishes of the patient being honored? Has the medical team provided an appropriate level of transparency to enable the patient to make decisions? Is the patient capable of making decisions?

In his book, *Life’s Worth: The Case Against Physician Assisted Suicide*, Arthur Dyck describes the case in which Dr. Timothy E. Quill helped a patient, “Diane” to die following her wishes. Quill hoped to legalize PAS to increase acceptance of the wishes of suffering patients, to identify circumstances that make suicide a rational act, and to supercede the alleviation of suffering by eliminating it altogether.¹

James L. Werth, Jr, editor of *Contemporary Perspectives on Rational Suicide*, writes that “most of the discussion about physician aid-in-dying has failed to address the more fundamental issues of whether or not people can make a rational decision to die (regardless of whether the decision involves taking their own lives or asking for the assistance of another).”²

There are new contributions to the theoretical material pertinent to PAS including “rational” suicide and “demoralization syndrome.” Rational suicide has been linked to “5 to 30 percent of suicides in older people … not associated with psychiatric disorder.”³ Harwood et al. described a finding which challenges this disturbing statistic. They note that “problems related to severe physical dependence or life-threatening illness account for only a minority of suicides in older people without psychiatric disorder … suggesting that the decisions to die in this group were less likely to have been influenced by psychiatric or personality factors.”⁴ In a *Washington Post* article of March 2004, Margaret P. Battin is quoted as characterizing PAS as “an idea for the coming century…. Rational suicide represents one of the fullest forms of expression of one’s autonomy. It is the right of people to shape the ends of their lives.”⁵ Werth describes three criteria for rational suicide:

1. Decision maker has a hopeless condition including low quality of life and psychological as well as physical pain.

2. Decision maker is free of coercion.

3. Decision maker is engaged in sound decision making.⁶

Demoralization syndrome complements rational suicide theory. It is a “loss of confidence, pessimism, exaggeration of the ‘terrible’ state of any predicament, hopelessness, and worthlessness [that] all influence the perspective of choice at a point in time, only to be viewed differently when the mental state changes.”⁷

In an article entitled, “The Contribution of Demoralization to End-of-life Decision Making,” David W. Kissane asks, “Should a plea to hasten dying be viewed as a rational request for merciful assistance, or is it symptomatic of a suicidal mind disordered through illness and warranting a therapeutic response?”⁸

According to Kissane, there are two characteristics of demoralization:

1. Persistent failure to cope with internally or externally induced stresses that the person and those close to him expect him to handle.

2. Anxiety and depression; need for hope.⁹

Demoralization is associated with being “elderly, disabled, disfigured, dependent, socially isolated, alienated, concerned about being a burden, fearing loss of dignity or control, desiring death or becoming actively suicidal.”¹⁰ Kissane maintains that a decision about suicide requires more than a psychiatric assessment about
depression; it should include an assessment of the level of demoralization of the patient. One could argue that the list from Kissane is the docket for a hospital chaplain on any given day. Further, it could be argued that the chaplain has a multitude of experiences and resources to bring to the discussion.

That being the case, the struggle to find ways to assess patients who request PAS is ongoing and needs the input of professional chaplaincy. Psychiatric diagnoses of depression or “demoralization” are both attempts to assess the decision-making capacity of the patient. Even proponents of PAS like Werth require assessment of a factor such as “sound decision making.” All these attempts at assessment of the patient’s capacity to make a PAS decision underscore the struggle with whether PAS can be a rational choice which honors patient autonomy.

Response to suffering in context

How do we respond to suffering? How does society care for those who are suffering? The PAS debate is firmly embedded in a value system which esteem life. How then does one understand cutting short that which is so cherished?

One response is clearly articulated and subsequently refuted by Baroody. Still, there are abortions, debates over when life begins, capital punishment, and violent war scenarios that include belief that death is compatible with some life values such as the right to die for preservation of freedom. If we look to these arguments about the value of life there may be some helpful paradigms. However, the dialogue in those arenas also underlines the complexity of the question of PAS.

Alternatives for PAS

I continue to wonder if those persons who contemplate PAS are, in fact, seeking relief from suffering, further choices in terms of palliation, relationship healing, or more resources for their ongoing care. They are rational people who do not want to live with the ongoing pain or humiliation, subject loved ones to more than it seems they can bear economically or emotionally, or whose care has been neglected. Werth points out that part of what could be considered “internal coercion (toward PAS) are factors like ageism or ableism beliefs.”

The conceptual framework known as “ethics of care” holds a paradigm that could be helpful in this regard. This framework requires the caregiver to be caring—to bring a personal attitude of care to the relationship as well as to provide caring acts. Nel Noddings calls this “natural sentiment … [a] natural disposition of being human.”

Diann Uustal further explains that an “attribute of caring is its status as a precondition for caring behaviors.” To provide care means that this care comes from a personal investment and relationship, not as a rote behavior or intervention.

Ethics of care asks what is most caring, given the larger systems involved, the person, the relationships/alternatives, and, finally, the goals for the disease and for life itself. Ethics of care focuses on “goals of care” and asks what is important and, given the circumstances, what will we deem a successful outcome?

Ethics of care is not situational, but rather is person specific and engages in a dialogue and process that focus on the individual. While ethical frameworks such as autonomy, beneficence, justice, and non-maleficence are important, there is an exponential quality to the integration of all the principles with an understanding of care for another human being. Uustal quotes Howard Brody: “The patient ideally has a right to a relationship that assures that s/he will be treated with respect and that medical knowledge will be used to further his/her life plans and values.”

Practical aspects

As chaplains and practical theologians we need to participate in the PAS debate. We need to provide a relationally-centered approach that has integrity for us as care providers as well as a reasoned approach to those persons contemplating PAS. In this regard, Kissane’s parameter for care calls for caregivers to provide support which promotes hope, addresses spiritual concerns, and treats comorbid depression with appropriate medication.

I would advocate for an integrated approach to PAS that includes the following:

• Reflection for the chaplain.

• Organizational (systemic) dialogue and response.

• Cultural and religious sensitivity to persons contemplating PAS.

Existing resources, including caregiving services, palliative care, pain management, caregiver support, and discernment services also need further development.

Reflection for the chaplain

It seems important for every chaplain to engage in a variation on a personal or group exercise...
where the following questions are addressed and discussed:

- Would you ever consider PAS for yourself? For a loved one?
- Whom would you involve in the discernment process?
- Would you include the Divine in the discernment process? How?
- Whom would you trust as part of the discernment process? Physician? Chaplain?

In my clinical pastoral education resident education groups, I have done such an exercise where the group members imagine being placed in the shocking situation of being at the end of life. The group is given a set of identified choices that must be made and the resources to help make them. PAS is one resource. The exercise persists by asking that each person continue to make decisions but with each decision, a resource is lost. Many students keep the PAS in their deck of choices almost as a safeguard if all other resources fail. While this is anecdotal and the sample of students is small, the view that PAS could be a “right” choice provides for a rich discussion. I believe the goal of dialogue to be the crucial intent of Baroody’s article.

Organizational dialogue and response

Pastoral care organizations need to step up and assert their professional voices about important social and ethical issues of our time. Where is our pastoral care proclamation about PAS? While rudimentary steps are being taken to coalesce some pastoral care voices so that there is a constituency of substantive proportions, the silence is deafening on many important issues. PAS is one of these.

Cultural and religious sensitivity

The choice of PAS must be made within a cultural and religious understanding of the value system of the patient and family. Chaplains are educated and practice in this framework on a daily basis. The keys to pastoral competence and sensitivity are knowledge and presence.

Presence involves coming alongside in suffering and the giving and sharing of oneself and one’s skills. Presence means being there wholeheartedly and embraces a genuine willingness to be involved and available to the individual who is vulnerable and has needs. Presence encompasses attentive and active listening—which is different than hearing.

Listening involves hearing the things that are said as well as paying attention to what is not spoken, but communicated nonetheless. This kind of listening is done not only with the ear, but also with the heart.16

Research supports outcomes for a ministry of presence that includes gaining courage, feeling more grounded, more able to think clearly, as well as ability to cope and a decreased sense of vulnerability. Feelings of isolation, alienation and suffering diminish.17 All of these outcomes seem more than relevant to a decision making process that could involve PAS.

PAS as a last resort

Dyck writes that “human suffering is what launches any consideration of assisted suicide.”18 He notes that there are many options to PAS, such as comfort-only care. I imagine a medical community in which science continues to push the edges of technological understanding of illness and cure. I imagine a community of caregivers who respect and are willing to work toward individual goals of care for each person who falls ill. In that context of exquisite science and humanity, each person would be in conversation and discernment about what is needed for cure, and when cure is no longer possible, for healing of the mind, spirit, and relationships.

Baroody brings before us a theological justification for PAS. In my ideal medical community, PAS would be a last resort—one not often chosen and certainly not preferred.

References

2 James L. Werth Jr., Contemporary Perspectives on Rational Suicide (Philadelphia: Brunner/Mazel, 1999), 2.
4 Ibid., 365.
McCurdy . . .

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PAS and “the message of the Adam and Eve story,” particularly as interpreted by Augustine. Tracing the history of the church’s relationship with—and cooption of—Hippocratic medicine, Baroody concludes that the AMA’s current view of death and assisted suicide is substantially informed by a particular Christian vision of death and suffering. In this vision, death is the enemy, both suffering and death are consequences of sin, and endurance of suffering plays a key role in the drama of redemption. Hence, the AMA opposes PAS because of a theologically grounded moralism regarding both death and suffering.

I cannot comment knowledgeably on Baroody’s broad historical claims about the relationship between the medieval church and Hippocratic medicine. Surely, however, the force of any such historical influence has waned. For centuries, professional medicine and the church have essentially gone their separate ways. Despite some interchange (for example, through organizations of “Christian” physicians), the likelihood that a deeply internalized Augustinian reading of Adam and Eve has directly shaped the AMA’s response to PAS seems remote. Augustinian ideas have undoubtedly influenced Western culture, but they are more likely one thread among others that contribute to modern medicine’s understanding of death and suffering.

The text of the AMA policy itself—actually an opinion issued by the AMA’s Council on Ethical and Judicial Affairs (CEJA)—does not provide evidence for a direct Augustinian connection. Baroody hinges much of his analysis on an assertion that the CEJA opinion condemns as “tragic” any patient’s desire for assisted death. He construes tragic in light of the AMA’s presumed Augustinian theology: patients, in their dire straits, may be tempted to turn away from the redemptive/healing potential of living with their suffering all the way to the end. According to Baroody, it is for the AMA not only a moral failing—“cowardly” and “a betrayal”—to reject this “healing” opportunity; it is also “tragic” because it amounts to making “friends with the enemy,” namely, death. Physicians should never join in such an enterprise.

I cannot tell just what CEJA intended by calling a patient’s desire for death in such circumstances tragic. The text of the opinion provides no real clues in this regard. Baroody, however, takes tragic to mean something akin to morally reprehensible. He cites several well-known physicians who appear to insinuate that the patient choosing PAS is indeed forsaking a moral responsibility. Baroody’s interpretation of the CEJA opinion seems to rest on the words of these physicians, whom he depicts as representative spokespersons for medicine and/or the AMA. Read on its own terms, however, CEJA’s statement does not appear to be a moral condemnation of the mere desire for PAS.

And what of death as the enemy? The CEJA opinion does not use the term, but for Baroody “Augustine’s voice comes through loud and clear” in the opinion’s rejection of assisted death: death must never be embraced, particularly as “a palliative method of pain control.” However, in the Augustinian view as Baroody describes it, death itself

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8 Ibid.
9 Ibid., 24.
10 Ibid.
11 Werth, “Rational suicide.”
13 Ibid.
14 Ibid., 147.
16 Kilner, Cutting-Edge Bioethics, 152.
17 Ibid., 153.
18 Dyck, Life’s Worth, 8.
The real question may be, in what sense does modern medicine see death as the enemy? For most of its history, Hippocratic medicine's ability to cure disease and to forestall death was limited at best. Its stricture against directly causing death defined a moral boundary without implying a significant ability to preserve life. Only recently has medicine found remarkable success in this regard. Was death itself really the enemy for medicine through all its centuries of relative ineffectiveness? If anything, suffering should have been the enemy of choice for a medicine most adept at palliation.¹

Has death become such an enemy only now, as medicine relishes its newfound powers and death is a defeat that should not happen? Such a view, reflecting the “messianic belief” in medicine to which Baroody himself refers, is quite different from Paul's or Augustine's notion of death as an enemy. Here the physician is a healer who extends life, resists death, and certainly will not cause the very death he or she has striven to overcome. I suspect that something like this latter sense of death-as-enemy is operative in the CEJA opinion, more than an Augustinian understanding of death and dying. After all, neither Paul nor Augustine would have believed that any merely human intervention could defeat this enemy, which could be overcome only through Christ's death.

The experience of suffering
According to Baroody, the experience of pain and suffering has changed in the contemporary era, and American medicine has not kept pace, either in attitude or in practice. In the new “epidemiology of dying,” chronic illness may impose “years” of suffering. There comes a point when any purification or “cultivation of virtue” through suffering runs its course.² This new reality of suffering is coupled with an old one: medicine's control of pain is often inadequate. American medicine compounds the problem by classifying unrelieved sufferers who have the temerity to request PAS as mentally ill, psychologically fragile, or “spiritually immature.”

Baroody has identified a crucial set of issues that should be considered in any discussion of assisted death. He correctly points out that medicine's general inability to address psychological and spiritual pain is part of the problem. Indeed, this lack, which is totally unrecognized in the CEJA opinion, may be a factor in requests for PAS or calls to legalize it. Further, the implied expectations of the eminent physicians he quotes, to the effect that worthy patients will have the temerity to request PAS as mentally ill, psychologically fragile, or “spiritually immature,” may view legalized PAS as unacceptable public policy, at least in part because it would enable and encourage patients to circumvent the moral or spiritual requirements of dying well. Further, what happens in the clinical realm has an impact in the policy arena. A belief that suffering should be borne with courage or lead to growth may be in fear of “hastening” death...
with “too much” pain medication, reluctance to sedate patients to control pain, or inordinate fear of “addicting” patients at the end of life. Such tendencies, in the aggregate, contribute to public perceptions that in fact pain will not be adequately controlled, and they ultimately fuel public support for legalized PAS.

Baroody challenges the “absolute certainty, even arrogance” of the medical attitudes toward suffering that he cites. He calls for greater openness to new understandings of dying and suffering in light of the new epidemiology of dying. Surely prolonged dying increases the likelihood of useless suffering, and its increased incidence may constitute one more argument for PAS. It is not clear to me, however, that Baroody’s appeal needs to rely so heavily on the growing incidence of “delayed degenerative diseases.”

It appears, for example, that the illness of Diane, Dr. Quill’s patient, did not reflect this new paradigm. Her leukemia was not necessarily a late-onser disease and, without curative therapy (which she did not seek), death was likely within “days, weeks, or at most a few months.” Although Baroody treats her case as an instance of the new epidemiology, the question of pointless suffering emerged early in the disease course and had more to do with the patient’s experience and perspective on suffering than a clinical expectation of a slow and prolonged decline.

As chaplains have long known, it is not the objective chronology of suffering, measured in quantitative terms, but the subjective experience of suffering that determines its meaning for the person affected. The lesson that American medicine, and ultimately all of us, may (still) need to learn from suffering, however brief or prolonged, is essentially Kübler-Ross’s lesson from dying patients: let the patient be your teacher. It may be most appropriate to be more “reticent,” to take time to listen to patients in their struggles, and to cultivate capacities for empathy. Perhaps there could even be opportunities for physicians and chaplains to engage jointly in such an endeavor. In doing so, we might together discover that there actually is, for some patients or for many, “a medical fate worse than death.” Then we would at least be closer to possessing the right kind of information to formulate intelligent and compassionate public policy about PAS.

Should PAS be practiced and “legal?”

Although Baroody briefly discusses the ethical issues surrounding PAS in his commentary on the CEJA opinion, his main focus lies elsewhere, and the ethical analysis is limited. In his conclusion, for example, he does not indicate why it is important to establish clinical and spiritual criteria that must be met before PAS can be provided to a patient. Having rejected the AMA’s grounds for opposing PAS, he leaves open the question of why there should be any restrictions on such a practice. Might his introduction of spiritually oriented criteria inadvertently cast chaplains or pastoral counselors as the “faith police” in such cases?

Baroody’s consideration of apoptosis does include some ethical analysis grounded in this concept. Despite a protestation to the contrary, however, his theological-ethical claims seem to hinge on comparing the suicide of a cell to the suicide of a human being. Apoptosis may inspire fresh thinking about who we human beings are in relation to our biology, but comparing the “intentionality” of biological processes with the intentionality of moral agents is a dubious proposition. The positive organismic purpose served by a cell’s programmed self-extinction is simply not the same as the kind of good that might emerge from a person’s choice of PAS. While suicide may indeed be “a courageous act of faith” in some instances, I cannot see how apoptosis provides a basis for such a judgment.

To its discredit, as Baroody observes, the CEJA opinion on PAS fails to acknowledge the undeniable shortcomings that have long plagued medicine’s management of physical pain. Many hold that patients’ pain can usually—but not always—be relieved with available means, and then contend that PAS must be available for his small group of patients. Baroody might have considered terminal sedation as an alternative to PAS in such cases.

Terminal sedation can ensure the relief of pain by rendering the patient unconscious until death occurs. It remains an under-used option, at least in part because unconsciousness unto death is not an acceptable alternative for many patients and/or families, and perhaps for some physicians as well. Further, some question whether this practice is ethically acceptable under the principle of double effect. The alternate term “palliative sedation” has been proposed by those who contend that it more accurately conveys the intent of the treatment.

On the public policy questions, I am inclined to agree with those who hold that the best way to address
PAS is “not … by prohibitions but by showing that there are better alternatives.” Then the burden of proof passes to all those—including physicians and chaplains—who are engaged in any aspect of the palliative care enterprise. Rather like current calls for pay-for-performance in healthcare, this approach would invite both the public and suffering patients to require evidence that current methods of pain management and palliative care genuinely are effective. In the process, the law would cease to be an instrument by which a particular religious or cultural (medical) attitude toward suicide is imposed on sufferers who may not share that attitude.

Stanley Hauerwas observes that “it is one thing for us to make our own suffering part of our life in service to God; it is quite another to make another’s suffering part of his or her service to God.” (However, it should be noted that Hauerwas is not addressing the subject of assisted suicide, let alone supporting the practice or its legalization.)

Perhaps in good ethicist fashion, I also am reluctant to embrace my inclination. Baroody discounts the AMA’s appeal to slippery slope arguments, largely because available data from Oregon and the Netherlands admit of conflicting interpretations. However, I believe there are legitimate worries that the reality of patients’ actual situations—and constitutional law—would eventually require the extension of legalized aid-in-dying to encompass some instances of active euthanasia. In addition, I share a fear that legalizing PAS may jeopardize the consensus that currently supports a legal distinction between killing and allowing to die. Those, for example, who believe society is already too permissive in allowing artificial nutrition and hydration to be withheld or withdrawn, might seize the opportunity to equate such forgoings with a newly legalized practice of PAS—or even suggest that “starvation” of decisionally incapacitated patients by removing a feeding tube is actually worse than assisting in voluntarily requested suicide.

My other, perhaps idiosyncratic, fear about legalizing PAS stems from an experience I had years ago as a chaplain. A colleague and I were interviewing another chaplain, I believe as part of a certification process of the time, and somehow the subject of assisted death came up. The chaplain disclosed past involvement in helping some patients take their lives. What struck me at the time, and made an indelible impression, was the evident attraction that this engagement with death had for the chaplain, who seemed, in a sense, to be intoxicated by death. This realization gave me a profoundly uneasy feeling. Part of my public policy hesitation about PAS is also a professional hesitation, not only for professional medicine but for other professions, including chaplaincy. If PAS becomes a legally-sanctioned practice, I have no doubt that some—albeit a very few—will fall in love with the process and with death itself or perhaps with the power over life that PAS offers. Chaplains and physicians both have a professional stake in anticipating and avoiding such an outcome if, as is likely, the legalization of PAS becomes more widespread.

References
6 Merry, “Evil, sin and suffering,” 82.
10 Stanley Hauerwas, Naming the Silences: God, Medicine, and the Problem of Suffering (Grand Rapids, MI: Eerdmans Publishing Company, 1990), 86.
11 Kelly, Contemporary Catholic Health Care, 201-02.
12 Ibid., 203.