



Social Statements

THE LUTHERAN CHURCH IN AMERICA

DEATH AND DYING

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Today it is commonplace to speak of the triumphs of modern medicine—achievements such as open heart surgery and organ transplants, dialysis machines that substitute for the kidneys, pacemakers that regulate the beating of the heart, and vaccines that have made once-dreaded diseases almost forgotten words. Each of these discoveries has saved countless lives and relieved much suffering. None of this, however, has changed the fact that death still occurs. The new technologies do not always cure but sometimes only prolong the dying process, at times with great suffering. The irony of modern medicine is that with the new technologies that vastly expand the range of what it is possible to do has also come the anguish of deciding when it is appropriate to use these capabilities.

Nowhere are these ethical dilemmas more pressing than with respect to death and dying. A terminal cancer patient who is experiencing great pain suffers cardiac arrest; should the patient be resuscitated? A newborn infant with massive and multiple birth defects is unlikely to survive without surgical intervention; is such intervention appropriate? A family member with a life-threatening illness refuses to undergo treatment; should treatment be administered in violation of his or her expressed wishes? In these and countless similar situations, we confront not only the grief and anguish always associated with death and dying, but also new and difficult moral decisions that call for prayerful reflection and the support of a caring community.

THEOLOGICAL PERSPECTIVES ON DEATH AND DYING

Perspectives on death and dying within the Christian tradition, both in its biblical origins and in its subsequent development, reflect several contrasting and complementary themes:

Death as Natural. Death is frequently viewed as a natural part of the life cycle. Like all other creatures, human beings have a limited life span. "The years of our life," the psalmist observed, "are threescore and ten, or even by reason of strength fourscore" (Psalm 90:10). The fact that our span of life is limited serves to remind us that we are finite. We are created by God; we are not God. Both living and dying are part of the dynamic processes of the created order, which biblical faith affirms as being good. The story of Abraham's death reflects this view: "Abraham breathed his last and died in a good old age, an old man and full of years, and was gathered to his people" (Genesis 25:8).

Death as Tragic. Death may also be experienced as an unwelcome event that involves a tragic dimension. Sometimes this is because death seems untimely, as in

the case of the death of a child, a youth, or an adult in the prime of life. Or its unwelcomeness may be due simply to the desire to continue living rather than depart life, a desire that in its own way gives eloquent testimony to the goodness of the life that God has created. Sometimes the reluctance to die arises from dread of the suffering which may accompany the dying process. Thus it is in keeping with a wide range of human experience that the psalmist prays for deliverance from mortal illness: "Turn, O Lord, save my life; deliver me for the sake of thy steadfast love" (Psalm 6:4).

Death as Friend. When dying involves prolonged suffering, death can be experienced as a deliverance, and in this sense as a friend. This does not imply that one should deliberately end life to avoid suffering, for the Christian witness is that meaning and hope are possible even in deepest adversity. It does imply that death, when it brings relief from suffering, can be understood and accepted as merciful.

Death as Enemy. Even though death must be viewed as part of the created order and can sometimes be a friend, the sinfulness of the human condition makes death an enemy. As the apostle Paul puts it, "The sting of death is sin" (I Corinthians 15:56). The alienation and estrangement that are pervasive in our lives make us unready to face death, an anxiety that may be heightened by fear of what lies beyond the grave.

Victory over Death. The New Testament message of Christ's victory over death speaks directly to this alienation and anxiety. Through Baptism, the believer is buried with him "into death, so that as Christ was raised from the dead by the glory of the Father, we too might walk in newness of life" (Romans 6:4). The new life of faith enables the Christian to face death with courage and with the assurance of forgiveness. The promise of the resurrection of the body and eternal life provides comfort and reassurance that death is not the end.

Whether death is viewed as natural or as tragic, as a friend or as an enemy, all who experience death-and-dying situations can be certain of God's love. Thus the apostle Paul asserts, "For I am sure that neither death, nor life, nor angels, nor principalities, nor things present, nor things to come, nor powers, nor height, nor depth, nor anything else in all creation, will be able to separate us from the love of God in Christ Jesus our Lord" (Romans 8:38-39).

ETHICAL DECISION-MAKING

Careful and prayerful reflection in the immediacy of the situation is an essential ingredient in a responsible decision-making process. At the same time, Scripture, tradition, and the shared wisdom of Christian people provide important resources for making these decisions.

While the exact nature of death-and-dying situations can never be anticipated fully, it is possible to identify interpretive principles that are useful in shaping our response. These include the following:

1. Life is a gift of God, to be received with thanksgiving.
2. The integrity of the life processes which God has created should be respected; both birth and death are part of these life processes.
3. Both living and dying should occur within a caring community.
4. A Christian perspective mandates respect for each person; such respect includes giving due recognition to each person's carefully considered preferences regarding treatment decisions.

5. Truthfulness and faithfulness in our relations with others are essential to the texture of human life.
6. Hope and meaning in life are possible even in times of suffering and adversity—a truth powerfully proclaimed in the resurrection faith of the church.

The decision-making process involves not only the question of what principles should be used in responding to death-and-dying situations but also the questions of who should make such decisions. If the person is capable of actively participating in the decision-making process, respect for that person mandates that he or she be recognized as the prime decision-maker. At the same time, to relegate such decisions solely to the individual facing death is to deprive that person of love and care. Therefore, it is appropriate that the physician, family members, close friends, the pastor, and other members of the health care team play a supportive role.

If the person in question is not capable of active participation, the situation is somewhat more complex. In some cases, the person's clearly stated preferences, made before he or she lost the capacity to participate, are on record; respect for that person requires that these preferences be given recognition. In other cases, no preferences are on record because the person never gave expression to his or her preferences while still able to do so, and is now too weakened to respond. If the situation involves a child under the age of majority, who is therefore legally incompetent, or a person who is mentally impaired and hence unable to participate fully in the decision-making process, a shared decision-making process is preferable. Collective wisdom is likely to result in better decisions, and no one should be left to bear alone the full burden of deciding. Participants in this decision-making process may include family members, the physician and other health care professionals, the pastor, and others close to the person. If it is not possible for those immediately involved to reach a consensus, a hospital ethics committee, if one exists, can be an important resource. Appeal to the courts should be avoided unless so doing is the only way to protect individual rights or to resolve the controversy.

WITHDRAWING AND WITHHOLDING TREATMENT

Among the most difficult decisions which confront family members and others in death-and-dying situations are those that involve withdrawing or withholding medical treatment. Opinions differ as to whether there is a significant ethical difference between withdrawing a treatment (e.g., a respirator) that has already been initiated, and simply deciding not to administer it in the first place. Both, essentially, are decisions not to treat.

The situations in which these treatment decisions arise vary widely. At least three different types of situations can be identified, each of which demands a different response:

A. The Irreversibly Dying Person

The first type of situation involves persons whose disease is progressive and for whom no effective therapy is available. As the final stages of the dying process occur, there comes a time to recognize the reality of what is happening by refraining from attempts to resuscitate the person and by discontinuing the use of artificial life support systems. To try desperately to maintain the vital signs of an irreversibly dying person for whom death is imminent is inconsistent with a Christian ethic that mandates respect for dying, as well as for living.

This does not, however, in any way preclude supportive care intended to maintain comfort and otherwise respond to the needs of the dying person. Indeed, quite the opposite is the case; when no cure is available, the responsibility to extend loving care not only continues but assumes even greater importance. This includes not only controlling physical pain, but also responding to the fear, guilt, and anger, the sense of isolation, the blocked communications, and the family stress that are often experienced by the dying.

B. Burdensome Treatments

In some cases there are forms of therapy which offer prospects for sustaining life but which themselves involve considerable discomfort, thereby necessitating a choice between quantity of life and quality of life for the patient. Examples of this type of situation include persons with widespread malignancy who are experiencing extensive side effects from chemotherapy and terminally ill children whose lives can be sustained for a greater period of time if they are hospitalized, but who will be separated from their familiar home environment. In such cases, the issue is whether it is preferable to have a greater number of days that are overshadowed by the rigors of therapy or a lesser number of days that are more peaceful, i.e., whether quantity of life or quality of life should be accorded priority.

Factors to be considered in making these decisions include the following:

1. The probability that a particular form of medical treatment will help sustain the life of the patient
2. The length of time that the life of the patient is likely to be sustained
3. The anticipated risks and side effects of the treatment
4. Other forms of treatment available, if any, and their relative advantages and disadvantages
5. The patient's adjustment to hospitalization or to the treatment
6. The extent to which the treatment will interfere with the person's most cherished activities
7. Available support systems at home or in alternative institutional settings

Second opinions and consultations are often useful in clarifying and assessing these factors.

C. Chronically Ill Individuals

The foregoing should not be taken to imply that chronically ill persons should be allowed to die because their lives are judged to be not worth living or because they are viewed as burdensome or useless to society. Whether the person in question is a newborn infant with serious birth defects or an aged person whose capacities have begun to wane, the Christian response in such cases must be a strong presumption in favor of treatment. Exceptions might arise in cases of extreme and overwhelming suffering from which death would be a merciful release, or in cases in which the patient has irretrievably lost consciousness.

Just as abandoning the chronically ill to die is inconsistent with Christian conscience, so also is abandoning the family members who, along with the patient, must bear the psychological, social, and economic costs of chronic illness. Responding to these needs involves the stewardship of time (e.g., offering to share in the responsibility of caring for a chronically ill person) as well as seeking to make adequate financial resources and supportive services available, whether by public or private means.

Finally, to assert that all lives are worth saving does not eliminate the necessity of establishing priorities when available medical resources are inadequate to treat all who are in need. In these tragic situations, it is inevitable that the priorities that are established, regardless of what they might be, will result in reduced levels of treatment for some, perhaps even to the point that death occurs earlier than would be the case if adequate resources were available.

REFUSING TREATMENT

If the patient has the prime decision-making role, the question then becomes one of refusing treatment for oneself, rather than withdrawing or withholding treatment from another. Since our responsibilities for stewardship of our own lives do not differ significantly from our responsibilities for the lives of others, the general guidelines outlined above are pertinent here also. Thus, for example, one may in good conscience refuse burdensome treatments in some situations.

A further question, however, also arises: Should persons be allowed to refuse treatment in situations in which such refusal is not supported by these guidelines? Or should they be treated in violation of their wishes? Here the principle of respect for individual self-determination comes into play. To treat a patient in violation of his or her deeply held, carefully considered, and clearly expressed preferences is to do violence to that person just as surely as would physically assaulting that person or deliberately destroying his or her property. This is as true in the case of an incompetent patient who has made his or her preferences known while still competent as it is in the case of a competent patient who can actively participate in the decision-making process.

At the same time, it must be emphasized that pain and other factors often distort the decision-making process, resulting in expressions of preference that may not represent a person's true wishes. In such cases, it may be appropriate to administer treatment (by authority of court order, if necessary) if so doing would sustain the life of the patient.

In all cases—including those situations in which a person's considered judgments are unmistakably clear—there is a continuing responsibility to care for and to extend the warmth of human community to that individual. A decision to allow refusal of medical treatment must never become an excuse for abandoning that person.

USE OF PAIN-KILLING DRUGS

In certain instances, some drugs administered in order to control pain experienced by terminally ill patients also have the effect of hastening the dying process, thus securing a better quality of life at the expense of quantity of life. As with burdensome forms of therapy, it is appropriate to ask whether there are alternative courses of action that do not pose this conflict—i.e., whether there are available means of controlling pain that would not hasten death. If there are not, the choice between quality and quantity of life cannot be avoided. In cases of great suffering, administering pain-killing drugs is justifiable even if this hastens the dying process. At the same time, adjustments in administering such drugs should be made so as not to deprive the patient of consciousness prematurely. In all cases, recognition should be given to patient preferences, when they are known.

ACTIVE EUTHANASIA

Deliberately administering a lethal drug in order to kill the patient, or otherwise taking steps to cause death, is quite a different matter. This is frequently called "active euthanasia" or "mercy killing" (as contrasted with the cases discussed above, which involve withholding or withdrawing medical treatment, thereby allowing death to occur from a disease or injury).

Some might maintain that active euthanasia can represent an appropriate course of action if motivated by the desire to end suffering: Christian stewardship of life, however, mandates treasuring and preserving the life which God has given, be it our own life or the life of some other person. This view is supported by the affirmation that meaning and hope are possible in all of life's situations, even those involving great suffering. To depart from this view by performing active euthanasia, thereby deliberately destroying life created in the image of God, is contrary to Christian conscience.

Whatever the circumstances, it must be remembered that the Christian commitment to caring community mandates reaching out to those in distress and sharing hope and meaning in life which might elicit a renewed commitment to living.

CARING FOR THE LIVING AND FOR THE DYING

Health care includes not only attempting to cure disease and repair injury, but also caring for and relating to the patient as a person. As noted above, in the case of a terminally ill person for whom no cure is available, the responsibility to care not only continues, but assumes even greater importance, so that life may be lived to the fullest until death occurs.

Moreover, the responsibility to care includes extending care to the family and to all those who are involved in such situations. Hospice programs (which provide a wide range of supportive services for patients and their families) and other supportive care programs represent useful and constructive ways of assisting the patient and family members in relating to the human dimensions of death and dying and subsequent bereavement. Such support for family members is needed in cases of sudden death, as well as prolonged terminal illness.

Health care professionals as well as family members have a responsibility to be truthful in relations with patients. Information must be shared so that the person can understand the disease and the options for treatment. Being informed of terminal illness is also essential so that one can prepare for death.

In death-and-dying situations, the Church's ministry of Word and Sacrament through its members and ordained ministers is of great significance. Remembrance of Baptism renews the Christian's sense of unity with Christ and the Church, and the Sacrament of Holy Communion serves as a reassurance of Christ's living presence and offers hope for the life to come. Simply to be with those for whom death is approaching—to pray with and for them, to listen and to respond, to comfort and to console—is also an essential ministry.

A commitment to caring community must also give recognition to the humanity of health care professionals, who are frequently asked to bear tremendous burdens. They, too, have a need for grief therapy sessions and other supportive programs, which in turn will enable them to minister more effectively and compassionately to patients and their families and friends.

A particular responsibility of each individual is making treatment preferences known, after careful consideration, so as to facilitate the decision-making process and relieve the burden on others. Living wills (signed and witnessed statements completed while a person is still in sound mind indicating treatment preferences) represent one way of doing this. Other areas of broader responsibility for patients and family members include considering the possibility of organ donation as a means of sharing life with others, authorizing an autopsy, and the donation of the body for scientific purposes.

FORGIVENESS AND THANKSGIVING

There is much that we do not know. We do not know when a debilitating disease may strike, what course that disease might take, and when death will occur. And there is much that we do not understand. Sometimes the death of a child or the large measure of suffering that may accompany the dying process seems to make no sense at all. Our finitude not only involves the fact that our life spans are limited; it is also reflected in the limitations of what we know and can understand.

Moreover, in responding to the dilemmas that are thrust upon us in death-and-dying situations, we sometimes make the wrong decision, or at least are uncertain as to whether we have made the right one. And we are often woefully inadequate in extending compassion and understanding to our fellow human beings. Even in the best of circumstances, our sins and shortcomings are manifold.

But this we know: God is merciful and forgiving. Thus, by grace, we can both experience forgiveness and forgive others, as God forgives us.

We also know that God may be closest to us in times of adversity, for then the pretensions that alienate us and the diversions which preoccupy us are stripped away. It is then that we learn to rejoice again in the marvelous gift of life, and the privilege of sharing this life with family and friends and all those we have known and loved. Thus even at the moment of death we can proclaim with the psalmist:

O give thanks to the Lord, for he is good;
for his steadfast love endures for ever! (Psalm 107:1)

IMPLEMENTING RESOLUTION

The Lutheran Church in America recommends to its congregations and their members, synods, agencies, and institutions, the following as appropriate ways of implementing the principles set forth in the statement "Death and Dying."

I. Congregations

- A. Provide an educational program that includes sessions on death and dying, so as to encourage members to reflect about these issues within a Christian context.
- B. Sponsor training sessions to help members learn how to minister to the chronically ill and to those in death-and-dying situations, and to members of their families.
- C. Encourage the development of mutual support groups within the congregation.
- D. Join with other congregations and community groups to establish and maintain supportive care programs, including hospice care.

II. Churchwide Agencies, Synods

- A. Prepare study material on death and dying to be used in educational programs.
- B. Provide continuing educational opportunities and supportive services for clergy and laity to help them relate effectively to death and dying.
- C. Encourage the development of hospice programs and other supportive care programs designed to respond to the human dimensions of death and dying.
- D. Advocate with federal, provincial/state and local governments legislation and administrative regulations that advance the best interests of persons with respect to dying and death.
- E. Advocate and support public and private measures designed to relieve the economic burden of terminal illness and to promote the just distribution of medical resources.

III. Church-Related Health Care Institutions and Social Service Agencies

- A. Review and discuss institutional policies in terms of the guidelines outlined in the social statement.
- B. Introduce and maintain programs designed to help health care professionals deal with death and dying.
- C. Introduce and maintain programs designed to help patients and members of their families relate to death and dying.

IV. Educational Institutions (Seminaries and Church-Related Colleges)

- A. Design college courses and programs on issues related to death and dying.
- B. Provide seminary courses and programs to train future pastors and lay professionals for their ministry to the dying and to members of their families.
- C. Cooperate with the synods in offering continuing education for clergy and laity in this area of concern.

V. Individuals

- A. Prayerfully examine the ethical questions related to death and dying and make treatment preferences known to family members and to others as appropriate (e.g., by completing a living will).
- B. Share time and other resources with those whose lives are affected by chronic illness or by death and dying.
- C. Consider the possibility of organ donation as a means of sharing life with others.