

## Euthanasia and Religion

*What are the attitudes of traditional religions toward euthanasia? Gerald Larue conducted a poll in 1984 to find out. He shares his findings with us.*

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### Gerald A. Larue

In 1984, I conducted a survey to ascertain the attitudes of different religions toward euthanasia.<sup>1</sup> My primary tool was a two-page questionnaire that posed questions pertaining to both passive and active euthanasia, defined these terms with reference to specific cases, and sought to discover the anticipated effects that participation in euthanasia might have on funeral rituals and on one's karma or on one's role in an afterlife.

As one might suspect, the responses were varied. In some religions, both passive and active euthanasia are forbidden. In Nichiren Buddhism, for example, to hasten death or to shorten the period of suffering could affect the karma of both the sufferer and the one who gave assistance. George Williams, general director of Nichiren Shoshu Soka Gakkai of America, provided an "unofficial" viewpoint based upon "many concepts of Nichiren Shoshu Buddhism":

It is taught in Buddhism that a human life does not end by physical death but

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continues to exist throughout eternity, and that its karma, both good and bad, is carried with it into the future. From this, it follows that one's suffering does not end by physical death but that it vanishes only when one changes that karma for the better. Thus Buddhism provides the means to change one's bad karma. . . .

Of course I agree that it is unbearable to see a loved one in extreme pain. In such a condition, that person feels he has no reason to live, so he wants to be allowed to die. The people close to him will think that they should allow his wish to be granted out of their own sense of compassion. But isn't this too materialistic a view of life? Moreover, the truth of life reveals that death is not the final solution to the problem of suffering. The people who cannot bear to see their loved one suffer from pain will be able to stop their own suffering by allowing the person to die, but the karma of suffering still exists within that person's life. The only possible solution is to infuse that person with the life-force to change his own karma for the better.

Philip Kaplan, who edited *The Wheel of Death* (New York, 1971) records the tale told by Sri Ramana Maharshi concerning Sri Bhagavan (Maharshi), who was offered a palliative to relieve lung congestion; he refused it. He asked to be sat upright. "They knew already that every movement, every

touch, was painful, but he told them not to worry about that. He sat with one of the attendants supporting his head. A doctor began to give him oxygen, but with a wave of his hand he motioned him away" (p. 61). He died peacefully shortly afterward.

Kaplan also called attention to the ten precepts of Buddhism, two which read:

I resolve not to kill but to cherish life.

I resolve not to cause others to use liquors or drugs which confuse or weaken the mind, nor to do so myself, but to keep my mind clear.

Kaplan wrote, "No matter where you are in your last hours, insofar as you can control your circumstances do not allow your mind to be weakened by drugs or other treatments which numb or impair the clarity of your consciousness. If your pain becomes too intense, let your doctor or attendant ease it with drugs which do not render you unconscious. Your state of mind at the time you draw your last breath is crucial, for upon this hinges your following rebirth" (pp. 80 f.).

Most Christian groups do not oppose passive euthanasia. They sanction the abandonment of life-support systems that function only as "heroic measures" on the part of the healing profession and that do not really benefit the patient either by relieving pain or by curing the disease but, on the contrary, simply prolong the life and the suffering of a patient who would otherwise die. In such cases, some respondents wrote that it became a matter of letting God (or nature) take over.

Almost all religious groups opposed active euthanasia, sometimes on the basis of the commandment "Thou shalt not kill." The exceptions are Humanists and members of the Ethical Culture Societies. Indeed, some of the respondents acknowledged having participated in active euthanasia. The humanist position is given in Humanist Manifesto II: "To enhance freedom and dignity the individual must experience a full range of civil liberties in all societies. This . . . includes a recognition of an individual's right to die with dignity, euthanasia, and the right to suicide."

In 1974, "A Plea for Beneficent Euthanasia," signed by leading humanists, appealed to "an enlightened public opinion to transcend traditional taboos and to move in the direction of a compassionate view toward needless suffering in dying. . . . On the basis of a compassionate approach to life and death, it seems to us at times difficult to distinguish between passive and active approaches. The acceptance of both forms

of euthanasia seems to us implied by a fitting respect for the right to live and die with dignity."<sup>2</sup>

Some groups would alter burial rituals for those involved in active euthanasia, but most would not. Professor Stanley S. Haraka, who teaches Orthodox Christian Ethics at Holy Cross Greek Orthodox School of Theology, in Brookline, Massachusetts, suggests that burial patterns might be affected: "If the act of 'active' euthanasia were understood clearly as an act of suicide, the Church cannot by Canon Law bury the individual unless it is shown through competent medical certification that the person was mentally ill in doing the act. The chance is that the person who had announced previously the intention to commit 'active' euthanasia would not be buried from the church."

It is important to recognize that behind each position lies a belief system that in traditional religions is based on a mythology, a sacred story, a religious fiction, and that this belief system conditions responses. The fundamental belief is that in some special way the divine has penetrated the realm of the secular, or that the deity has broken into the sphere of human life, to reveal acceptable life patterns and legal regulations governing life and death. Each religion has its own hero figure, whether it be Buddha, Moses, Jesus, Muhammad, Mary Baker Eddy, Joseph Smith, Madam Blavatsky, or Emanuel Swedenborg. Out of the *mythos* or sacred story emerge rules and laws to control and direct the lives and the living of true believers. The guiding principles are believed to have been supernaturally revealed and to represent the divine will for humans. This concept is not new. It goes back at least to the twenty-first century B.C.E., when King Ur Nammu proclaimed laws for the Sumerian city of Ur and claimed that these were in accord with the revealed will of Utu, the sun god, and to the nineteenth century B.C.E., when King Lipit Ishtar said his laws emanated from Enlil the wind god. Still later, Hammurabi enunciated laws provided by Shamash, the Babylonian sun-god. The same pattern occurs in the Jewish scriptures, with Moses receiving laws from the Hebrew deity Yahweh. Jesus becomes the revealer for the Christians, Muhammad for the Muslims, and Joseph Smith for the Mormons. Each scriptural collection of laws makes the claim of divine approval. Each is supposed to represent the final, authentic will of the deity.

Deviation from revealed truth is heresy; and heresy, during varying periods of history, including modern times, has been punished by social rejection, excommunica-

tion, expulsion from the religious community, and even death. Therefore, when an organization as extensive and as powerful as the Roman Catholic church issues a "Declaration on Euthanasia," although some points may be debated in theological seminaries and in philosophy classes, most believing Catholics go along with its teaching without questioning. Where there is deviation, as there is now by Catholics who are opposed to the church's rulings on birth control and abortion, those who break the rules can be deprived of the rituals of the church until they mend their ways (which, in the case of birth control, can conveniently be delayed until menopause). While individuals are in violation of the church's teachings, they cannot help but feel guilt and fear—guilt for acting against divine rules and fear that by some unforeseen accident they might die outside a state of grace and be condemned to hell.

So powerful is the grip of such religions on their followers that there is little encouragement to engage in free thought. The ancient Deuteronomic formula "Hear and obey" is operative, and one need only read the curses in Deuteronomy 28, or in the Revelation to John, to become aware of the threat of divine punishment for disobedience.

When suffering comes to believers during a terminal illness, it can be explained as an opportunity to come into touch with the sufferings of Christ, or perhaps it will be argued that there is some spiritual merit in suffering. For example, the Roman Catholic church's "Declaration on Euthanasia," issued in May 1980 by the Sacred Congregation for the Doctrine of Faith, declares:

According to Christian teaching, however, suffering, especially suffering during the last moments of life, has a special place in God's saving plan; it is in fact a sharing in Christ's Passion and a union with the redeeming sacrifice which he offered in obedience to the Father's will. Therefore one must not be surprised if some Christians prefer to moderate their use of pain-killers, in order to accept voluntarily at least a part of their sufferings and thus associate themselves in a conscious way with the sufferings of Christ crucified. [Cf. Matt. 27:34.]

The scriptural reference is to Jesus tasting a mixture of gall and wine prior to being crucified and refusing to drink it. Gall is a bitter, toxic herb (Hebrew: *Rosh*; Greek: *chole*) that is said to have a vile taste; so it could have been on the basis of taste alone that Jesus rejected the mixture, rather than its having been a turning away from a narcotic palliative or because of some misguided impulse

to be heroic or a masochistic desire to heighten his martyrdom. The document does not make clear the relationship between the mystical redemptive suffering associated with Jesus' death in Christian theology and the pain experienced by those in the terminal stage of cancer or some other affliction.

Although many religious groups see no merit in suffering and encourage the use of pain-relieving drugs, there are some who utilize theology as a spiritual palliative for those in pain. One fundamentalist minister told me that, when his wife was undergoing a long and painful pregnancy, he "comforted her" by reminding her that Jesus had suffered even greater pain for her sins. He said that he would use this same message at the bedside of a terminally ill parishioner in intractable pain.

It has become clear through the reading of the responses to the questionnaire, from perusing documents provided by respondents, and from consulting articles in religious journals, that in most instances the issue of euthanasia is confronted from a theological or academic stance rather than from direct contact with pain and suffering. It is all too easy to formulate a position on the basis of the Torah, the Talmudic *halakha*, and what the rabbis have said. It is too simple to look to the traditions set by the church fathers and, from this wisdom of the past, to draw guidelines for the present. Some liberal Protestant churches, while continuing to look to the Bible for spiritual guidance, confront the issue of euthanasia for the terminally ill in intractable pain from a humane or person-oriented posture rather than simply trying to find what the Bible may or may not have recorded.

One wonders what the theologians and theoreticians might say if someone they loved was writhing in pain, gasping for breath, crying out for release from a life that has become a living hell of torment that drugs and medical knowledge are not able to relieve. Theology and theological discussion are fine in the classroom and from the pulpit; they have no relevance and no place at the bedside of the suffering terminally ill patient. I was moved by some information that reflected the anguish engendered in believers when someone they loved was dying in pain. I could hear the pain in the voice of one Science of Mind clergyman with whom I talked on the telephone when he made reference to someone close to him who was in such a predicament. Yet he did not return the questionnaire, perhaps because he might compromise his theological position.

The survey has made clear that those of us who press for fair and just legislation

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# New Problems in Medical Ethics

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## Vern L. Bullough

to make active euthanasia possible for the terminally ill have a long way to go. Most religious organizations support passive euthanasia. There is no battle here except how to bring about the removal of a life-support system once it has been activated. Many respondents referred to the "Living Will" as an instrument of instruction to guide the medical profession, the legal profession, the clergy, and the family concerning the wishes of the person who is dying. Perhaps, with the active support of the clergy, such documents will assume real significance in the near future, because at present they are in many cases, if not in most, politely ignored.

Perhaps at some future time the sacred scriptures of the various religious groups, and the sayings and the teachings of the fathers of the different faiths, will be reexamined and reinterpreted so that sanction may be found for the support of active euthanasia. Such a pattern of continuing reinterpretation is evident in many religious groups. For example, on Friday, June 9, 1978, Spencer W. Kimball, president of the Church of Jesus Christ of the Latter Day Saints, and two counselors announced that the Mormon Church would no longer bar blacks from the Mormon priesthood. The rejection of blacks was based on the passages found in sacred Mormon documents: the Book of Moses and the Book of Abraham. The change was attributed to a new revelation. Kimball, after many hours of prayer in the Upper Room of the Mormon Temple in Salt Lake City, received the new interpretation. Similarly, changes have come in other religious groups. Out of the continuing reexamination and reinterpretation of sacred scripture, some churches and synagogues have ordained women and homosexuals. Indeed, certain groups appear to be engaged in feminizing the patriarchal deity of the Bible! Thus the time may come too when a scriptural basis for acceptance of active euthanasia may be discovered. For the present, on the basis of my limited research, it is only possible to say: (1) There is growing support in some Jewish, Roman Catholic, and Eastern Orthodox churches and in most Protestant groups for passive euthanasia. (2) There is almost unanimous opposition to active euthanasia.

### Notes

1. The full report of this survey appears in *Euthanasia and Religion*, published this year by The Hemlock Society, P.O.B. 66218, Los Angeles, CA 90066.

2. Published in *Benevolent Euthanasia*, ed. by Marvin Kohl (Buffalo, N.Y.: Prometheus, 1975). •

The death of Karen Ann Quinlan after ten years in a coma, the birth of septuplets in California, the mounting concern over substance abuse, from alcohol to drugs to cigarettes, and the establishment of DRGs (Diagnostic Related Groupings) are seemingly unrelated topics. They comprise a new problem in medical ethics—one brought about because cost is a factor. The result is a new kind of ethical determinant that will, consciously or unconsciously, play a role in decision making.

While money has always been a factor in determining the kind of health care one received, with the richest usually receiving the best, the issue now extends far beyond individual wealth. In the United States, as the government, through Medicare, Medicaid, Veteran's Administration, and other programs, becomes more and more a factor in health care, the health and habits and actions of other people affect each individual's tax bill.

Though Quinlan's family early withdrew her respiratory support, she was still kept alive by intravenous feeding and through a nursing plan that called for regular turning, bathing, and massage, all of which cost money, taxpayers' money. To maintain her life in a coma for ten years, even with minimum nursing care, cost hundreds of thousands, if not millions, of dollars.

The California woman who took fertility pills to become pregnant—and then proceeded with the pregnancy when it became known that seven fetuses were involved and that the chances of survival of a majority of them, let alone all of them, were astronomical—made a decision that ultimately cost taxpayers millions of dollars. Even delivery preparations cost well into six figures. Though the couple may still financially benefit by selling their story, as may some of the various participating specialists, their financial remuneration will be much less than it would have been had all seven of the babies survived. Still, the couple and

the specialists involved can enter the *Guinness Book of Records* for their contribution to the most expensive birthing event in history—at least so far. Scores and scores of specialists were and, at this writing, still are involved.

A high proportion of patients in the country's various veteran's hospitals are there not because of war-related injuries but because they are alcoholics, have drug problems, or suffer from diseases brought on by a lifetime of smoking. The escalating costs come as the alcoholic begins to deteriorate physically and the treatment of various health problems begins, usually at the expense of the taxpayer. The same is true of substance abusers in general.

The list could go on, but a sign of the changing times is the Diagnostic Related Groupings, which have been implemented by the U.S. government. DRGs, for the uninitiated, are prepayment guarantees for specific diagnoses. If the patient leaves the hospital sooner than the established norms would predict, the hospital makes money. If recovery is slower, and the patient stays in the hospital longer, it loses money. Not all diagnoses are covered, but the potential for making a fast dollar is hard to ignore. The immediate result has been an emptying of hospital beds. Many patients would be better off with longer hospital stays, while others thrive with the new policy. Unfortunately, as with the move of two decades ago to discharge vast numbers of mental-hospital patients, the cost-cutting cuts both ways. Just as in the mental-health field, however, it can be predicted that it will take some time for the pendulum to swing back to a more moderate stance. In the meantime, home-health-care industries are a growth stock, since for most patients it is cheaper to be treated in their homes than in hospitals. Home care, however, causes a great deal of family disruption and personal tragedy. Anyone who is aware of the growing number of home-bound patients cared for by loved ones knows of the growing exhaustion of the spouse or the children (or in some cases the parents) as the medical establishment sits on its hands or observes from the sidelines.

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