If we want to help those who struggle in anticipation of prolonged dying, as well as those who care for them with compassion, we need a new corporal work of mercy.

The Catholic Art of Dying

By JAMES F. BRESNAHAN

The corporal works of mercy, a treasured expression of our Catholic Christian spirituality, include “to visit the sick” and “to bury the dead.” For us today, the power of contemporary high-technology medical care has complicated the practice of these works of mercy. Our cure-oriented, science-based medical interventions all too often prolong dying.

To cite only two examples, the irreversibly unconscious dying person (in what is called the “permanent vegetative state”) and the severely demented Alzheimer sufferer in the final stages can have their dying prolonged by use of ventilator and/or tube feedings and antibiotics—though these interventions cannot reverse the dying process itself. If we want to help those who struggle in anticipation of such prolonged dying, as well as those who care for them with compassion, we need a new corporal work of mercy that combines the older two: “To visit and support those whose dying is prolonged, and to help those who care for them.”

I am convinced that we are called to practice this new corporal work of mercy primarily as an expression of Christian compassion for suffering persons, but also as a critically important means of confronting a social crisis menacing our Christian care of the dying. This crisis is currently expressed in the successful advocacy of what is euphemistically termed “physician assisted death.” Despite earlier defeats in the states of Washington and California, last year in Oregon voters, in a referendum, approved of medical help to cut short suffering by inflicting death when this is requested by a dying person. The constitutionality of this law is presently under challenge in a Federal court. But similar ballot initiatives are being advanced in several other states on the West Coast and in New England.

The ethical acceptability of this alleged right, as well as legal recognition of it, are vigorously debated in current medical ethics literature. In these debates our traditional Catholic theological rejection of deliberately inflicted death is often looked at askance, and the affirmative dimensions of our moral theology of care of the dying are neglected or misunderstood. We need to understand better how to respond practically in a way that will help the dying and, at the same time, ward off this danger to our Catholic tradition of caring well for them.

The Paradox: Fear of Dying and Demand for Inflicted Death.

As people shaped by our late 20th-century American culture, we prefer to think of our scientifically based medicine as inevitably beneficial. But this cultural optimism contributes to what Richard A. McCormick, S.J., has called “medical vitalism”—a willingness of some to make death the only enemy, so as to justify “doing everything” medically to ward off death, even if this needlessly afflicts a dying patient. As medical people have acquired
more experience with this danger, they have begun to accept measures to prevent medically prolonged dying. Wide agreement now exists on the moral appropriateness of rejecting medical interventions that merely lengthen the process of dying. To forestall this, physicians order “Do Not Attempt Resuscitation” and patients prepare “advance directives” (power of attorney for health care and “living wills”).

Though not universally accepted, these measures fit in with a growing emphasis in contemporary medical ethics on patient autonomy. This affirms that the dying patient should have a decisive role in determining when proposed life-prolonging medical treatments have become excessively burdensome. But this emphasis on patient autonomy has also brought to the fore another defect of science-based medical culture—our near obsession with finding a medical “quick fix” for all problems. So our people have come to fear both dying and the unrelieved suffering that prolonged dying can produce. Some patients demand to be provided with painful life-prolonging treatment even when caregivers believe this will be futile; other patients demand that they be given the means to inflict death if they become convinced that they need this to end their suffering.

Paradoxically, the high-technology culture that led people at first to expect that medical treatments can always further postpone death now appears to support both these classes of patients.

Catholic Moral Theology, Moral Sensibility and Spirituality.

Our Catholic medical ethics urges a counter-cultural response to fears of both too little and too much medical intervention in the dying process. I call this “Catholic medical pacifism.”

To begin with, our moral theology presses us always to make a judgment: Does the benefit of a proposed medical intervention really outweigh the harm it will inevitably concurrently produce? Medicine is a human activity like any other and should therefore not be judged to be only and always beneficial. Given technologically powerful means of rescuing a patient from death, we are taught to avoid inflicting useless suffering, but at the same time we are taught not to end life deliberately.

This moral heritage prepares us to choose an alternative kind of treatment—which is not the same as no medical treatment at all—when death is at hand. Palliative medical care aims to relieve suffering. Fortunately, we find this morally appropriate care of the dying practiced today in the hospice movement. Seeking neither to prolong nor to shorten dying, hospice care is skilled both in pain control and in personal response to suffering. Hospice nurtures a search both by patient and family to find meaning in dying as the final stage of living.

To make morally good judgments about when to use palliative medicine in the care of the dying, we need sci-

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Scientific medical information and a rationally developed moral theology. But we also need, through our spirituality, to foster a Catholic art of dying. This grounds a distinctive Catholic moral sensibility—an affective attitude toward dying. This Catholic moral sensibility frees us to use our Catholic moral theory appropriately when we come face to face with dying, either our own or a neighbor’s.

To develop our Catholic art of dying, we start by acquiring a “sober Christian realism” (the phrase is Karl Rahner’s). We ponder our limits and seek to learn to accept and deal with them. We come to terms with living within limits, the limits imposed by mortality and by the two-edged sword of high-technology medical intervention. Then we are comfortable, affectionately, in making both those decisions that refuse excessively burdensome medical treatment, so as to allow death to arrive, and also those that employ adequate pain-relieving medicine to treat the suffering, even if that will, as a “second effect,” somewhat accelerate dying. But, being affectionately comfortable with these ways of caring for the dying, we find that our moral sensibility has made us profoundly uncomfortable with current proposals to inflict death deliberately, should a dying person claim to need this.

Our Catholic moral sensibility is not, as sometimes alleged, grounded in a perversive belief that unrelieved suffering is inevitably redemptive. Rather, this moral sensibility derives from our spirituality, which teaches that we are called to live in the likeness of Jesus. We are called not only to live lives of love in his likeness but also, finally, to enter in our own way into Christ’s dying.

On the one hand, we learn from the Scriptures that the dying of Christ expresses his loving surrender of self to human death, trusting that he will be cared for in this suffering by God. On the other hand, in the drama of Mount Olivet and Calvary, Christ’s dying also exemplifies a struggle to deal with the human suffering of others by compassionate interaction with all who are involved. Jesus expresses compassion toward those who inflict death on him, toward those who are crucified with him and especially toward his followers, both those who stand by the cross and those who flee in fear and despair.

So Catholic spirituality recognizes in this drama a twofold invitation. We are to deal with suffering as an inevitable part of human living and dying, but also as something that should always evoke a compassionate response offering relief of suffering in every way possible.

A moral sensibility shaped by Catholic spirituality makes us comfortable both with accepting the arrival of death and also with doing everything possible to relieve suffering in our fellow wayfarers who have come to the time of their dying.

Our moral dispositions to follow Jesus into his dying, however, make us medical pacifists. We find deeply repugnant the proposal to kill actively as a means to interrupt the suffering of a dying person. For Jesus neither kills those who treat him unjustly nor does he kill himself.

Our Response to the Fear of Medically Prolonged Dying.

I am convinced that many Oregon voters feared abusive use of modern medical techniques to prolong dying. In the face of increasingly bureaucratized and depersonalized medical care, they saw the option of physician aid with inflicted death as a kind of preemptive self-defense measure to protect them from having their dying unduly prolonged. We must understand this fear if we would offer a better way to deal with it.

The suffering involved in dying is always more than just the experience of physical pain. Anticipation of loss and of an unknown beyond this loss engenders a crisis in which grief and love, guilt and longing also play their part. Besides fear of neglected pain, there is fear of abandonment by those one needs most. Our faith gives us a hope that we can sometimes share with the dying. Practically, we can always respond to these fears by the hospice way of meeting this crisis of approaching death. By compassionate companionship and effective pain relief we enable communication, a precious solace for both the dying and the living they will leave behind.

When we foster such hospice practice, we shape a powerful corrective to the fear that the suffering of medically prolonged dying can only be dealt with by suicide. Thus our practice of this new corporal work of mercy can respond to the fear that motivated some of the voters in Oregon. But we need to foster prayerfully the art of dying, our personal spiritual preparation for our own dying, in order to support this affirmative response to fear.

Our Response to Claims of Conscience.

I believe that some Oregon voters supported physician-assisted suicide less from fear than from a conscientiously held moral ideal, one very different from our own. Indeed, their moral ideal directly contradicts our Catholic spiritu-
ality. To this we find it much more difficult to respond. In our pluralistic first world culture, we claim the right to act according to our deepest, most sincerely held conscientious convictions. The First Amendment provides for freedom of religion not only with respect to the expression of belief in words but also with respect to actions demanded by our belief—at least when those actions are not harmful to others and to their expressions of belief. Thus if we want respect for our own deeply held beliefs as Catholics, we need to respect the sincerely held beliefs of others.

Though it may seem strange to us Catholic believers, some advocates of the inflicted-death option (such as members of the Hemlock Society) share with us a claim to be allowed to die with moral integrity. But their belief in the “inflicted-death option” resonates with an ideal of dying that historically resembles that of such ancient Roman stoic philosophers as Marcus Aurelius and Seneca. These thinkers believed it morally virtuous to exercise preemptive control of the uncertainties and complications of one’s dying. They urged that when one sinks into the weakness and suffering that come with approaching death, one is morally called to commit suicide. Some contemporary proponents of the inflicted-death option express a similar altruistic concern to avoid leaving a mess for others.

We who oppose making physician aid in inflicting death a legally accepted medical treatment have good rea-

**Quid Pro Quo**

Just after my wife’s miscarriage (her second in four months), I was sitting in an empty classroom exchanging notes with my friend, a budding Joyce scholar with steelrimmed glasses, when, lapsed Irish Catholic that he was, he surprised me by asking what I thought now of God’s ways towards man. It was spring,

such spring as came to the flintbacked Chenango Valley thirty years ago, the full force of Siberia behind each blast of wind. Once more my poor wife was in the local four-room hospital, recovering. The sun was going down, the room’s pinewood panels all but swallowing the gelid light, when, suddenly, I surprised not only myself but my colleague

by raising my middle finger up to heaven, quid pro quo, the hardly grand defiant gesture a variant on Vannucci’s figs, shocking not only my friend but in truth the gesture’s perpetrator too. I was 24, and, in spite of having pored over the Confessions & that Catholic tractate called the Summa, was sure

I’d seen enough of God’s erstwhile ways towards man.

That summer, under a pulsing midnight sky shimmering with Van Gogh stars, in a rustic, cedar-scented cabin off Lake George, having lied to the gentrified owner of the boys’ camp

that indeed I knew wilderness & lakes and could, if need be, lead a whole fleet of canoes down the turbulent whitewater passages of the Fulton Chain

(I who had last been in a rowboat with my parents at the age of six), my wife and I made love, trying not to disturb whoever’s headboard & waterglass lay just beyond the paper-thin partition at our feet. In the broad black Adirondack stillness, as we lay there on our sagging mattress, my wife & I gazed out through the broken roof into a sky that seemed somehow to look back down on us, and in that place, that holy place, she must have conceived again, for nine months later in a New York hospital she brought forth a son, a little buddha-bellied rumpelstiltskin rumpelstiltskin runt of a man who burned to face the sun, the fact of his being there both terrifying & lifting me at once, this son,

this gift, whom I still look upon with joy & awe. Worst, best, just last year, this same son, grown to manhood now, knelt before a marble altar to vow everything he had to the same God I had had my own erstwhile dealings with. How does one bargain with a God like this, who, quid pro quo, ups the ante each time He answers one sign with another?

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son to doubt that such a death can really produce the benefits claimed for it. And we anticipate grave harm from such a practice to our own conscientious practice of good care of the dying. How can inflicted death be limited in practice to its conscientiously convinced proponents? Our way of compassionate care of the dying will be undermined if legalized inflicted death becomes not just a desperate measure for rare cases of extreme suffering but a widely recommended, “optional” practice throughout health care. Then both subtle and overt coercion will threaten the most vulnerable of the dying.

Catholics have reason to doubt that the procedural constraints now claimed to be sufficient to prevent abuse of the inflicted death option will really protect the exercise of our religious freedom to care well for the dying in our own way. In the Netherlands we see substantial evidence that permission for inflicted death has evolved into something like a “standard treatment.” In the present disarray of U.S. health care, such use of inflicted death would offer a cheaper and quicker response to dying than hospice care. And since the passage of the Oregon initiative, sharp conflict has developed within hospice programs there about whether to accommodate or to exclude from their care those who demand to receive help with legally permitted suicide. Such conflict threatens to impair, perhaps even eliminate hospice care as an accepted medical alternative within which we Catholics can practice our religiously inspired way of caring for the dying.

Affirmative Response to the Challenge to Care Well for the Dying.

How shall we resist these dangers we perceive from what threatens to become, practically speaking, legal establishment of the contemporary stoic ideal of inflicted death? We ought not permit our religious freedom to be destroyed. But neither ought we threaten simply to suppress the conscientious convictions of these proponents of inflicted death. I believe that we will probably have to concede to those who believe conscientiously in inflicted death some special sector of care where they can practice their beliefs. But I believe that we should insist that this be outside what is presently standard medical practice and caregiving. We are morally justified in insisting on more legal constraints against the abuses we fear than some proponents of inflicted death appear to find convenient, and more than have, in fact, been included in the Oregon law.

This struggle indicates that we will experience a growing chasm separating health care institutions that consent to engage in physician-inflicted dying and those, like our own, that exclude the practice. Inflicted death will become a more divisive issue than abortion. Our most effective response will be to put into vigorous practice our new corporal work of mercy. Humanly compassionate, faithful practice of our art of dying can attract people of good will to want to join us in caring well for the dying.

Catholic health care institutions will be essential in this effort. To offer splendid witness to the practical human value of our spirituality of compassion has always been a basic goal of these institutions. I believe there are ways for them to help us refine our Catholic way of caring well for the dying in the future. Here are a few suggestions.

First, Catholic institutions must be proud to become known as “good places to die” and must do what is necessary to be such. By fostering hospice, they can provide a context for “sober realism” about dying. This should include helping people discern the theological and spiritual inappropriateness of trying to claim that because God may miraculously intervene, one is morally justified in demanding use of futile cure-oriented treatments rather than good palliative medical care of the dying.

Second, our Catholic readiness to accept our dying with Christ should give our institutions courage to sponsor systematic clinical medical “outcome” studies of so-called life-prolonging treatments in order to establish their limits. Such outcome studies should not be thought unwelcome bearers of bad news. They are needed to enable caregivers to provide to dying patients and their families ever more realistic prognosis of benefit, or lack of it. Such studies, pioneered in the area of intensive care medicine by the APACHE scoring system for seriousness of illness to predict outcome, will appropriately demythologize our high-technology medical practice, reduce demands for futile treatment and encourage hospice care.

If we embrace these and other affirmative responses to the needs of the dying, our Catholic "medical pacifism" rejecting the inflicted death option will appear less unreasonable and less hostile to those who advocate formally legalizing that option. Our spiritually renewed art of dying and our practice of a new corporal work of mercy can exercise an inspiring influence on the health care culture of our time.