End-of-life: the traditional Christian view

H Tristram Engelhardt Jr, Ana Smith Iltis

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This is the fifth Viewpoint in a series about end-of-life issues for different religions.

Rice University, Department of Philosophy MS-14, 6100 Main St, Houston, TX 77005-1892, USA (Prof H T Engelhardt MD); **and Center for Health Care Ethics, St Louis University, St Louis, MO, USA** (A S Iltis PhD)

Correspondence to:
Prof H Tristram Engelhardt Jr
htengelh@rice.edu

The Christian pursuit of eternal life through repentance has implications for how health care technology should be used at the end of life. Although there is no obligation always to postpone death, there could be a duty to use high-technology medicine to gain a last opportunity for repentance. Health, health care, and long life are put into perspective by Christianity's transcendent goals. The Christian pursuit of holiness through humble submission to God excludes intentionally bringing about death through either omission or commission. At the same time, it prohibits using medicine in an all-consuming pursuit of health and postponement of death; the attempt to save life at all costs is thus forbidden. Christianity also accepts the appropriateness of analgesia and sedation to avoid terminal suffering and despair if this does not, by obtunding consciousness, take away a final opportunity for repentance. The logic of these commitments can be fully understood only within Christianity's all-encompassing way of living and dying aimed at holiness. This otherworldly focus can create tensions with many secular moral views as well as with individuals who identify themselves as Christians but who possess non-traditional moral theological beliefs. Such tensions exist as well both between and within Christian groups.

Spirituality and the ambiguity of the term Christian

Traditional Christian concerns regarding end-of-life decisions run counter to the assumptions of a secular culture. They involve an otherworldly appreciation of health: eternal salvation. We use the term traditional Christians to identify those who hold commitments regarding end-of-life decision-making grounded in the Christianity of the first millennium and still shared, at least officially, by most Christians. Concerns about life after death radically inform the choices one makes. This difference in focus can cause misunderstandings and conflicts at the bedside. A person who knows there is eternal life will approach end-of-life decisions quite differently from one who regards this present life as all there is. For Christians, the moral issues about withholding or withdrawing treatment or provision of terminal sedation can be fully considered only within the spiritual goal of eternal salvation. Specifically, traditional Christian moral prohibitions such as those against suicide and euthanasia should not be interpreted as independent moral constraints, but as flowing from an all-encompassing way of living and dying aimed at union with God.

Understanding Christian interests in decisions at the end of life is complicated by the dominance of Christian culture, which has framed much of the law and public policy governing end-of-life decisions in many countries. This influence is exemplified by the US Supreme Court's upholding a prohibition of physician-assisted suicide because of a traditional prohibition in Anglo-American law, which was grounded in Christian moral understandings.[1,2] The Christian understanding is also burdened by natural-law attempts to make Christian prohibitions plausible to non-believers. Christianity is so much a part of western culture and its global influence that separating Christianity's secularised cultural influence from its actual spiritual commitments is difficult. Such influences are often confused with traditional Christian understandings. This study of end-of-life decisions places Christian rules and prohibitions within the larger context of Christian spirituality.

An adequate account of Christian end-of-life decisions is also complicated by the ambiguity of the term Christian, which encompasses a cluster of religious groups sharing at best family resemblances. Those who call themselves Christians range from Unitarians, Seventh-Day Adventists, and Mormons, to Lutherans, Anglicans, Roman Catholics, and Orthodox Christians. These groups differ both in foundational theology and in matters of bioethics bearing on end-of-life decisions. If a moral and religious community is characterised by shared premises, moral and religious rules of evidence, or the ability to resolve moral controversies by appeal to a particular source of authority, then Christians are separated into different such communities. They have different understandings of the content and character of moral theological knowledge and of how to resolve controversies regarding appropriate end-of-life decisions. In tending to the spiritual needs of patients, physicians must recognise that there is no single Christian religion, but a cluster of such religions with different accounts of how to live and die properly. The contemporary convention of speaking of Christian denominations rather than religions can in many circumstances be misleading (eg, by obscuring the differences between Unitarians and Roman Catholics). The differences between traditional Christian and post-traditional understandings of Christianity can be substantial (eg, the first rejecting physician-assisted suicide and the second accepting it).

We should also acknowledge that many Christian communities are in disarray about particular areas of moral theology. A failure to attend to the differences between and within particular Christian communities can impose approaches to end-of-life decisions that patients would in fact repudiate. The ambiguity of a proper Christian approach to end-of-life decisions can be displayed on five axes along which differences in moral

understandings are arrayed. These axes provide particular points of difference, which are important for appreciation of the commitments of a patient.

Traditional versus developmental or post-traditional

Christians range from groups committed to maintaining unaltered their moral theological commitments to those embracing various notions of theological development or innovation. On the one hand, Orthodox Christians understand their moral theology as unchanging,[3] and on the other, Roman Catholics and many Protestants embrace accounts of doctrinal innovation. This article gives special focus to the Christian moral theology and canons of the first thousand years after Christ, out of which Roman Catholic and the various Protestant approaches developed. It would be impossible to address adequately the multiplicity of views held by different Christian groups regarding end-of-life care because they are so varied. Therefore, our focus is on the Christian beliefs out of which the various Christian groups have emerged.

Liturgical or ceremonial versus non-liturgical or non-ceremonial

Truth for Christians is ultimately a Who, not a what, so prayer and worship constitute a personal relationship with that Truth. Liturgically oriented Christian communities generally regard last rites as integral to that relationship. End-of-life decisions will often involve particular ministers as well as sufficient time and an appropriate place for those rites. The sacramental concerns of Christians can generate special challenges. Physicians will need to attend carefully to the different perceptions of Christian groups as to who may perform last rites for whom and under what circumstances. Many Protestant chaplains will consider it benevolent to provide the Eucharist and final prayers for all Christians in extremis, while Orthodox Christians will consider it a spiritual violation to receive communion or last rites from any priest not in union with their own bishop, therefore adamantly refusing last rites from Protestant ministers or Roman Catholic priests, even though the latter often consider it appropriate to give last rites to Orthodox Christians.

Metaphysical versus cultural understandings of Christianity

Christians range from those who recognise Christianity as disclosing the truth about eternal salvation to those who regard Christianity in merely cultural terms. For the latter, Christianity is a worldview or narrative within which to find comfort and peace. These Christians will be more likely to make various accommodations to prevailing secular approaches to end-of-life decisions. For the former, Christian moral commitments regarding appropriate end-of-life decisions are of eternal and non-negotiable significance tied to a very particular view of salvation.

Observant versus non-observant

People are complex and inconsistent. Many who affirm particular moral and religious beliefs nevertheless act without a consistent commitment. As a result, end-of-life decisions often involve various levels of cognitive dissonance. This dissonance can lead patients to change their views about appropriate treatment and sacramental needs as they approach death.

Religiously and morally coherent versus incoherent

People often marry and make close bonds with those with whom they share few, if any, common religious and moral commitments. Members of the same family, even when nominally sharing the same religion, can be alienated from the religious commitments endorsed by the patient. In this context, Christian sacramental concerns can raise special problems. As a consequence, physicians are usually well advised to establish with the patient in advance who will be likely to help ensure that the patient's religious commitments will be properly honoured. Advance directives allow patients to appoint proxy decision-makers and provide instructions that can help avoid familial conflict and ensure that the religious wishes of patients are adequately understood and fulfilled. Traditional Christians should regard such advance directives as important aids in their preparation for death. Contact with a patient's spiritual father, adviser, pastor, or at least with a chaplain of the same faith, can be crucial.[4]

End-of-life decisions

Beyond death with dignity: aiming at repentance

Western Christians once prayed, "a subitanea et improvisa morte, libera nos, Domine" (from a sudden and unprovided death, deliver us, O Lord).[5] Unlike many who hope to die painlessly in their sleep without warning, traditional Christians recognise that no death could be worse. Knowledge of one's impending death offers a final chance to become reconciled with those whom one has harmed and to ask God's forgiveness. For these reasons, the traditional Christian emphasis has not been on death with dignity, but on death with repentance. The exemplar death for Christians is that of Christ on the cross, not a dignified but a humble death. As a result, the Christian preparation for death can take on a rigorously ascetic character of self-examination, repentance, and a final crucified submission to the will of God. Nevertheless, Christians have for centuries prayed to be spared terminal suffering (eg, the liturgies of St Basil and St John Chrysostom include the petition, "A Christian ending to our life, painless, blameless, peaceful, and a good defense before the fearful judgment seat of Christ"),[6] while accepting unavoidable suffering as an opportunity for spiritual growth through humble submission.

The focus on repentant preparation makes the opportunity to reflect self-consciously on one's death

essential. For liturgical Christian groups, this includes a chance to confess formally, to receive Communion and final anointing. Where such an opportunity has not been available, there is a strong religious justification for employing high-technology medicine to maintain consciousness, postpone death, and even prolong the process of dying to gain time for repentance and final preparation. This concern for final repentance will also affect the choice of the amount of sedation at the end of life. On the other hand, those who have already repentantly prepared for death may recognise no need for aggressive interventions to postpone death. For them, aggressive, high-technology medical interventions at the end of life could constitute an unjustified spiritual burden and distraction. Physicians who do not share these views might regard such Christians as asking for either too much or too little medical intervention. For post-traditional Christians, such concerns may seem out of place.

The relative importance of health care

Christianity traditionally affirms the importance of health care. St Basil the Great (AD 329–79) argued that medicine is a gift from God: "Each of the arts is God's gift to us, remedying the deficiencies of nature . . . the medical art was given to us to relieve the sick, in some degree at least."[7] The importance of health care is radically put into perspective because the primary commitment is to salvation (Matt 16: 24–26). Since early Christianity, it has been understood that health care should be used only up to the point where the pursuit of health and the postponement of death become all-consuming. St Basil, having medicine in mind, condemns "whatever requires an undue amount of thought or trouble or involves a large expenditure of effort and causes our whole life to revolve, as it were, around solicitude for the flesh".[7]

From similar concerns to avoid harm due to the inordinate use of medicine, in the 16th century Roman Catholicism developed a very influential distinction between ordinary versus extraordinary, proportionate versus disproportionate, and obligatory versus non-obligatory health care, which is not simply to be equated with the notion of usual versus unusual treatment.[8] The obligation to use medicine is defeated either by the inordinate economic, social, psychological, and moral costs associated with treatment, or by the unlikelihood of achieving health. Traditionally, one is obliged to accept treatment only if there is hope of recovery or restoration of health and the treatment does not involve undue—ie, spiritually distracting—burdens.[9] The Christian Medical and Dental Association Ethics Statement includes the claim that if "medical treatment only prolongs pain and suffering and postpones the moment of death . . . it may then be appropriate for a patient with decision-making capacity to refuse medical interventions."[10] This appreciation of the relative importance of physical health compared with eternal salvation acknowledges that the attempt to save life at all costs can entail serious, if not ultimate, spiritual and moral costs to the patient, the patient's family, and the patient's carers. To help traditional Christian patients and their families understand the moral significance of end-of-life decisions, physicians will often need to translate decisions into these terms.

Intending and causing death

Traditional Christianity regards suicide as self-murder, and therefore physician-assisted suicide and euthanasia as forms of assisted self-murder or direct murder. Consent of the patient does not defeat the evil, although it is recognised that those who are insane can take their lives without true consent and culpability. An early Christian reflection on Christian burial for those who committed suicide when no longer in possession of their faculties is given in canon 14 of Pope Timothy of Alexandria (fl AD370).[11] Since the focus of a good Christian life following the exemplary death of Christ is on humble submission to God's will, it is understood that one may not take active steps to end life;[12] hence the traditional Christian condemnation of both passive euthanasia (ie, stopping or withholding of treatment intentionally to bring about death) and active euthanasia (ie, acting intentionally to bring about an early death). Still, the concern to avoid the moral and spiritual distortions due to all-encompassing medical interventions can require limiting medical treatment even if this unintentionally leads to an earlier death. Christianity has also accepted the use of both pain medication and sedatives; St Basil the Great noted with approbation "with mandrake doctors give us sleep; with opium they lull violent pain".[13] Christian physicians have thus employed adequate pain control and sedation to ensure that patients do not despair in the face of uncontrolled terminal suffering.

The difference between intended and foreseen outcomes was sharpened through the Roman Catholic doctrine of double effect. This distinction, which widely influenced western law and western Christian moral reflection, builds on the ordinary circumstance that one often intends only one of an action's probable effects. Thus, a surgeon foresees that making an incision will cause pain, although intending only the therapeutic goals. Noxious side-effects are regarded as unintended, albeit foreseeable, effects. This analysis clarifies why one may engage in both actions and omissions that may lead to a patient's premature death, as long as (1) the action or omission does not independently involve the violation of a moral obligation (eg, a head of state in a time of crisis may be obliged to assume greater burdens to maintain life than an ordinary citizen), (2) death is not directly intended, (3) the patient's death itself is not the means to the goal (eg, pain relief or the cessation of a disproportionate therapeutic burden), and (4) there is

sufficient reason for risking an earlier death (eg, giving sedation to protect a patient against despair from terminal suffering, or withdrawal of all-encompassing medical interventions because they are spiritually and morally distracting).

End-of-life decisions provoke controversies. Within the great variety of Protestant theologies, opinions range widely, and often less attention is paid in cases of passive euthanasia to the concern never directly to intend death, than among Orthodox Christians and Roman Catholics. The absence of unanimity between Protestants about euthanasia is increasing.[14–20] Some Protestant groups have clearly opposed all euthanasia and assisted suicide.[21,22] Others are opposed to active euthanasia but accept passive euthanasia.[23,24] Yet other Protestant groups accept euthanasia and assisted suicide as personal choices to be made by individuals.[25] Furthermore, some Protestants and Roman Catholics even express openness in specific circumstances to physician-assisted suicide and euthanasia.[26] Much controversy also exists about the appropriateness of withdrawing artificial hydration and nutrition at the end of life and for people in a persistent vegetative state.[23,24,27–30] At stake is whether such treatment is limited to avoid the spiritual harms that St Basil the Great noted as being associated with becoming immersed in all-consuming medical interventions, or whether the choice to withhold or withdraw artificial nutrition and hydration is undertaken with the intention to cause death. Prohibitions against intentionally bringing about death through omission or commission must be understood in light of the Christian commitment to turning away from self to wholehearted love of God and others. The obligation recognised by traditional Christians never intentionally to cause death will need special attention by physicians in approaching end-of-life decisions.

Salvation and moral rules

Christianity is aimed at curing the soul from pride and self-love to achieve eternal salvation through Christ's death and resurrection. This goal puts the importance of physical health and medical care into perspective, but also prohibits actions and omissions intentionally done to cause death. Christianity's focus on intention in these matters might seem precious to outsiders, because it can only be fully understood within a way of life directed by a very particular understanding of the pursuit of holiness, which gives content and purpose to Christianity's moral rules. Because of this transcendent focus, traditional Christian end-of-life decisions will often engage concerns alien to secular medical decision-making and cause conflicts with the moral expectations of secular physicians.[31]

As a consequence, physicians treating Christians should develop an understanding of their own commitments and of how the special spiritual needs of their patients could cause conflicts with the physician's values during treatment. They should develop an adequate understanding of patients' Christian values, so as to appreciate that a patient's desire to extend life to make peace with God is not futile care and that respecting a patient's decision to terminate treatment that has become a spiritually burdensome pursuit of earthly life can be appropriate. As a consequence, it can be appropriate for patients with the same medical condition and the same prognosis to use technology differently because of their different spiritual needs. Finally, caregivers will need to recognise that, although patients may decline or withdraw spiritually burdensome treatment as well as request appropriate pain control, traditional Christians may not directly intend death. Physicians who anticipate conflicts between their own commitments and the requests of their patients (or their patients' families) should discuss with a chaplain or minister of the patient's religion the nature of the conflict, and should discuss with the patient or family about transferral of care to a physician who will not experience such conflicts.

Traditional Christian physicians and nurses may find themselves in moral conflict when asked to engage in treatment that involves an all-encompassing pursuit of earthly life. Since traditional Christian physicians and nurses may not participate in the intentional causation of a patient's death through physician-assisted suicide or euthanasia, they will need to take steps so as not to be involved by engaging in such procedures or recommending who might provide them. We will all need to acknowledge that our culture is rent by profound religious and moral disagreements.

Conflict of interest statement

We declare that we have no conflict of interest.

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