Suicide: Secular Perspectives

Suicide has been unacceptable in most western societies for centuries. The social upheaval of the 1960s in the United States has resulted in an increased emphasis on individual rights and an accompanying de-emphasis on responsibilities. This focus on individualism has also caused many secularists (and some Christians) to re-think the issue of suicide. Many see it as the ultimate expression of personal autonomy, therefore socially acceptable and even honorable in some circumstances.

Increasing societal acceptance of people’s right to exert control over their own death has led to the publication of numerous articles and books, some supporting the idea and others offering instruction on successful suicide measures. In addition, several organizations have been formed with the express purpose of disseminating this philosophy and literature, as well as with the intention of encouraging individuals to assist their loved ones in this "self-deliverance."

The act of suicide is most often an act of desperation, a presumed solution for an insoluble situation. The reasons behind and the motivation for self-destruction are usually complex, often the end result of depression or other mental illness. It sometimes appears to be the "only answer" for people who feel hopeless because they do not know God or have rejected God’s love. Sadly, it sometimes also occurs in the godly person who feels unable to cope with the burdens of life.

Suicide: Theological Perspectives

Christians have long subscribed to the idea that "we are not our own" but are stewards of a life given to us by the Creator God, a life made in His image (Genesis 1:27). This concept underlies
in a longstanding Judeo-Christian belief that suicide is wrong. While there is no clear scriptural prohibition against self-destruction, many interpret the commandment against killing (Exodus 20:13) as applying to the self as well as to others.

In the early church when persecution was common, there was some uncertainty about the dividing line between suicide (taking one's life) and martyrdom (laying down one's life). Some of the teachings of the early church fathers may have been initiated to help clarify this dilemma. Augustine and Aquinas are primarily responsible for the formulation of the current Christian position against suicide.

Problems with suicide include the attitudes it implies toward oneself, the community, and God. First, it manifests an unwillingness to bear, in love, with the weaknesses of the person for whom one has a unique and special responsibility: oneself. Second, it also has the effect of discouraging others in their own struggles. Even a suicide committed out of a motivation to relieve caregivers from suffering cuts a tie that binds all of us together and supports us all in our task of living. Third, suicide is a statement that there is no hope for an acceptable future, that such a future is not within God's ability and will. It constitutes an attempt on the part of people to determine the end of their lives, as if they know fully the goal for which God has sustained them to this point. However, it is God's prerogative to determine when there is no purpose for a life to continue. To assume ultimate responsibility for one's life is to reject God, no matter when in the course of life one elects to do so.

The Bible does indeed record various examples of suicide that it neither commends nor condemns explicitly. Since the Bible communicates its message through both the failures and triumphs of people, this silence says nothing about the moral legitimacy of suicide. A broader analysis of other relevant biblical concepts is necessary to determine the moral status of suicide.

Christian motivation has undergirded a significant portion of the modern hospice movement in Europe and North America. Many Christians (and others) believe it is insufficient to say to people who are dying, "You should not take your own life." Instead people should offer to help them and their families with their physical, psychological, and spiritual needs during this exceedingly difficult time.

**Assisted Suicide and Euthanasia: Secular Perspectives**

Discussions of assisted suicide and euthanasia often become confused unless terms are clearly defined. While various conflicting definitions, unfortunately, are employed today, the following are as clear and useful as any. Assisted suicide occurs when a physician or someone else helps a person take his or her own life by giving advice, writing a prescription for lethal medication, or assisting the individual with some device which allows the person to take his or her own life. The physician or another lends expertise; the person does the act.

Voluntary euthanasia occurs when someone, out of compassion, does an action with the intention of ending the life of a suffering patient at his or her request. Non-voluntary euthanasia is a similar compassionate act, but in circumstances where the patient is unable to make a voluntary request (e.g. an unconscious, retarded or demented adult; an infant or child).
Involuntary euthanasia is a compassionate act to end the life of a patient who is perceived to be suffering and could make a voluntary request, but has not done so.

The distinction between active euthanasia and passive euthanasia is not helpful, and is often confusing. It is clearer to limit the term euthanasia to situations in which one person acts to cause the death of another (which is what many people mean by active euthanasia). According to this understanding, acts of discontinuing treatment with the realization that patients will die of their disease do not constitute euthanasia. Thus, using the term passive euthanasia to describe such acts is a misnomer. When discontinuation is done with the intention of ending the life of someone who is not already unavoidably in a dying process, it is morally objectionable for many of the same reasons that euthanasia is objectionable. But in the long run, it is probably clearest to criticize such premature discontinuation on the basis of the reasons themselves, rather than calling such discontinuation euthanasia. In some situations, discontinuation or withholding of treatment may be appropriate from Christian and secular perspectives alike: for example, when it is medically evident that death will occur soon with or without treatment, and treatment will add to the suffering of the dying process.

Societal changes in recent decades have led to a focus and emphasis on an individual's right to self-determination. While this includes some increased acceptance of suicide as a rational option for an individual who feels that life has become too burdensome, the act of suicide is still viewed by others as a tragic and lonely experience. This is especially true when the means of self destruction involves violence (e.g. guns and other self-inflicted wounds, hanging, jumping from heights, etc.). Thus there has been a move to depersonalize suicide by involving others (assisted suicide) and to sanitize it by making it a medical procedure (physician-assisted suicide and euthanasia).

Proponents of the legalization of euthanasia and/or assisted suicide offer several reasons why society should allow physicians to be involved in these acts: some people have no loved one who can help them; some people are unwilling or unable to help their loved ones commit suicide; physicians know the prognosis so are better able to assess the appropriateness of a request; physicians have access to and know how to use lethal drugs; medical expertise can prevent “botched up” suicide attempts; physicians know how to obey standards; and, physicians can be more objective because they are not emotionally involved.

Euthanasia has been openly practiced by physicians in The Netherlands since the 1980s, and in recent years the Dutch courts have agreed not to prosecute such cases under certain specified conditions. The best estimates are that about 3% of all deaths in that country are induced by physicians. There is public debate about extending the availability of euthanasia to children and incompetent adults, and there is a professional inclination to change the system to physician-assisted suicide rather than physicians directly killing patients.
Other euthanasia-related legal initiatives are also appearing. The Northern Territory of Australia legalized physician-assisted suicide and physician-administered euthanasia in 1995. Attempts in several U.S. states to pass legislation allowing physician-assisted suicide and/or euthanasia failed by narrow margins in the late 1980s and early 1990s. In 1994, the state of Oregon passed a voter initiative to allow physician-assisted suicide with restrictions, although legal challenges blocked its immediate implementation.

Support for physician-assisted suicide has been increasingly gaining momentum, as is illustrated by the following legal decisions. The decision in Compassion in Dying v. Roe (U.S. Ninth Circuit Court of Appeals) upheld a federal trial court’s ruling that Washington’s ban on physician-assisted suicide was in violation of the constitutionally endorsed liberty interests of those who are terminally ill. Further, the Second Circuit Court of Appeals has ruled that physicians may prescribe drugs which would enable competent but terminally ill patients who are in the last stages of their illness to end their lives. The suit maintained that the Fourteenth Amendment grants individuals the liberty of choosing a dignified death. Because such a liberty is honored when physicians remove breathing or feeding tubes from patients, prescribing medication to patients so that they may hasten their death must also be allowed in keeping with the Fourteenth Amendment’s "equal protection" guarantee. This ruling overturned that of the district court, which denied three terminally ill patients the right to end their lives via the self-administration of medication prescribed by their physicians.

In addition, Dr. Jack Kevorkian has now been acquitted by juries three times in cases where he has admittedly assisted people to commit suicide. Kevorkian was tried under the now expired Michigan ban on assisted suicide, which holds that such an act is not to be permitted unless the expressed purpose is not death, but the relief of pain. It was the imprecise language of this ban which allowed for Dr. Kevorkian’s acquittal.

Physician-assisted suicide and euthanasia were explicitly proscribed in the Hippocratic Oath. Although this was a minority opinion when introduced 2500 years ago, the Hippocratic outlook gradually became the dominant influence for practitioners of modern medicine. Practitioners have adopted the role of healer, with the goals of healing when possible and relief of suffering. While there have doubtless been individual physicians over the centuries who have occasionally helped their patients to die, this activity has clearly remained outside the boundaries of acceptable medical treatment.

There is professional concern that acceptance of physician involvement in either direct killing or indirectly induced death would seriously undermine the trust that is a necessary component of the physician-patient relationship. If euthanasia becomes accepted, a physician might be tempted to end a patient’s life without a request, either out of compassion or out of self-interest (e.g. when the care of a patient becomes too difficult or burdensome). In addition, there is concern that the impetus to continue work on the significant gains made in good palliative care in the past 20 years may be weakened.

Assisted Suicide and Euthanasia: Theological Perspectives
What is fundamentally wrong with euthanasia from a biblical perspective is that it involves the killing of innocent human beings, who are necessarily made in the image of God (Genesis 9:6). Physician-assisted suicide is wrong for similar reasons, in that people kill human beings (themselves) with the assistance of others who thereby become accessories to killing. Patient autonomy (or better: freedom) must be understood within the limits of God's sovereignty and does not include the right to dispose of that which is not one's own ("you are not your own"--1 Corinthians 6:19).

Christians are indeed called upon to be compassionate and to relieve suffering, but not at any expense. If happiness were what life is all about, then suffering would be the ultimate evil to be avoided at all costs. The cross would represent the epitome of what is to be avoided. Its crushing load on Jesus' back and the nails driven through his hands and feet graphically display the burden of the fallenness of the world that Jesus had to bear, in fact, chose to bear. Yet, those who follow Jesus are not called to avoid such suffering but to suffer this fallenness with him, to take up crosses of their own.

The basic question, then, is whether God or suffering is going to set the agenda of one's life--and death. Christian physicians and their patients will not find God's way by trying to avoid all suffering at any cost. They will find it by remaining true to God's biblically-revealed character and will, especially in the midst of suffering. The ultimate test of what is setting the agenda of our lives may well be how we deal with suffering in the face of death.

Such was the case for Jesus in the garden of Gethsemane. He was "overwhelmed with sorrow to the point of death" (14:34) and zealously prayed to be spared from the suffering that he knew would only get worse. Yet he affirmed that his primary commitment was to the larger purposes of God, whatever suffering they might entail. The absence of suffering is, generally speaking, something good--which is why Jesus prayed for it. But it is not the highest good--which is why he was willing to endure substantial suffering.

Yielding to the call of "compassion" to kill or assist in the killing of a patient is misguided for another reason as well. It is all too easy to underestimate the fallenness (self-centeredness) of human nature, particularly when the people in view seem to have the needs of others at heart. The statements of so-called "mercy-killers" in the past have often been telling in this regard. "I killed her because I could not bear to see her suffer" may well mean what it says--that first and foremost the action reflects the killer's need to be free from his or her own discomfort. Barriers to killing patients or assisting them to kill themselves not only protect society in general and patients in particular but also protect physicians and surrogate decision-makers from their own weaknesses, from subtly self-centered decisions that may well haunt them for the rest of their lives.

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