

Going Gracefully

*How the Christian Gospel invites us
to trust God in the midst of suffering
instead of settling for assisted suicide*

by Rev. Michael W. Salemink



“Help me.”

“It hurts.”

“Please make it stop!”

Helen was dying of bladder cancer. She lay twisted in the hospital bedsheets, writhing in pain and wasting away. Her sunken eyes pleaded wide at me—or past me, actually. She recognized me as a person but probably not as her pastor. Through cracked lips she mumbled about somebody trying to kill her. I had ministered to plenty of terminal parishioners before but never witnessed anyone this miserable. Her husband and children had already spent several sleepless nights beside her. For now, they’d gone home to change clothes, nibble lunch, and maybe catch their breath a moment. I stepped forward and smoothed her thin white hair, then rested a hand on her forehead while wrapping my fingers around hers. After several minutes assuring her of the Lord’s presence, reciting His promises, and reminding her of His blessings, I shared Helen’s message with the nurses’ station—asking if they could look into anything for easing her agony.

Assisted Suicide: The Semantics

Assisted suicide happens when someone helps a person take his or her own life. This includes providing information, instruction, and means to an individual seeking to die so that he or she may bring about that death. **Physician-assisted suicide** involves a doctor prescribing a lethal dose of medication for this purpose. Assisted suicide attempts to avoid the process of **natural death** where vital body systems shut down due to an ailment or fail because of advanced age. Declining an improbable or experimental treatment does not constitute assisted suicide. Neither does withholding a treatment that might prolong survival but will produce greater suffering. Withdrawing machines that operate the organs artificially also does not qualify as assisted suicide. Allowing a natural death does not imply any obligation to extend one’s physical existence by every available measure.

In an assisted suicide, the patient takes the fatal action. When anyone else initiates the final act that causes death, assisted suicide becomes euthanasia—and only this distinguishes one from the other. **Euthanasia** means intentionally ending the life of a dependent human being for his or her alleged benefit. Death because of inaction, like not providing necessary and ordinary care or nutrition and hydration, is defined as **passive euthanasia**. On the other hand, **active euthanasia** results from performing the act that induces death. **Voluntary euthanasia** takes place at the patient’s request and with the patient’s consent. (**VSED**, which stands for “voluntarily stopping eating and drinking,” does not amount to assisted suicide or euthanasia but rather death from starvation or suicide by dehydration.) For **non-voluntary euthanasia**, the patient makes no present request and gives no current consent to die because he or she is incompetent or uncommunicative. **Involuntary euthanasia** essentially resembles outright homicide in that it occurs without a person’s expressed will.

These practices violate the law almost everywhere. Assisted suicide and euthanasia remain crimes in nearly all countries of the world and in most of the United States. Human civilizations have long recognized the danger of mingling the ability to heal with the power to kill. For this

reason, assisted suicide and euthanasia especially present ethical problems for doctors. From ancient times the medical profession has refused to participate in promoting or prompting death. Many centuries of new physicians have sworn to uphold the specific ethical standards outlined in the **Hippocratic Oath**, one of the oldest binding documents in history. It explicitly forbids assisted suicide and euthanasia by declaring, “Nor shall any man’s entreaty prevail upon me to administer poison to anyone; neither will I counsel any man to do so.” While this vow no longer holds legal force, the philosophy and spirit of the Hippocratic tradition continue to govern the good-faith relationship between physician and patient.

Assisted suicide activists argue that patients retain ultimate **autonomy**. This right to self-determination, personal liberty in pursuit of happiness, and the freedom to decide life’s meaning include control over the circumstances of one’s own death. It necessarily checks and balances against a doctor’s knowledge, privilege, and influence infringing upon the patient’s independence and dignity. For example, a health care provider may deny a particular treatment due to **medical futility**, finding it does not offer enough benefits to the patient to outweigh its threats. Organizations like Compassion and Choices campaign for cultural and legal acceptance of assisted suicide by phrasing it as “**medical aid in dying**,” “**death with dignity**,” “**end-of-life options**,” and “**right to die**.”

Advocates for natural death conclude these euphemisms obscure real risks and costs. They express concerns about assisted suicide encouraging suffering people to kill themselves. In fact, Compassion and Choices began in 1980 as the Hemlock Society (named after the poisonous plant the ancient philosopher Socrates famously ingested to end his life). Its founder, Derek Humphry, wrote a book called *Final Exit*, which outlines the most “efficient” methods for committing suicide. Instead, natural death defenders suggest, civilized societies have a responsibility to support those who are hurting. **Palliative care**, which manages pain and other symptoms alongside or apart from other efforts to cure, can address not only bodily needs but also a patient’s emotional and spiritual well-being. **Hospice** programs care for terminally ill patients with pain relief, nourishment and hygiene, companionship and comfort—either at home or in a dedicated medical facility.

Existing laws do enable individuals to dictate end-of-life health care preferences. **Advance directive** documents indicate directions for treatment wishes should the patient become unable to communicate. A **DNR**, or “do not resuscitate” order, stipulates a very specific advance directive. A doctor writes a DNR as a legal order, usually reflecting the patient’s desire to refrain from CPR or advanced cardiac life support (ACLS) if the heart or breathing stops. More broadly, a **living will** records a person’s wishes about undergoing or foregoing a range of particular medical treatments. However, living wills do not legally bind in all situations and jurisdictions, and many hospitals permit physicians to exercise professional judgment regarding DNRs. A **durable power of attorney for health care** provides the most comprehensive kind of advance directive by designating somebody else to make health care decisions in the event the patient is incapacitated.

Assisted Suicide: The Statistics

Oregon

All fifty U. S. states prohibited assisted suicide until 1994. Since then, four states have passed legislation permitting physician-assisted suicide, while euthanasia remains illegal nationwide. Oregon's unprecedented 1994 "Death with Dignity Act" (DWDA) authorizes an adult resident of the state to ask a doctor for deadly medication. Two individuals, one unrelated to the patient, are to serve as witnesses certifying the written request. The patient must also repeat the request orally in the physician's presence. This attending physician must determine that the patient has an incurable condition that will cause death within six months. The physician must then declare the patient is acting rationally and without compulsion. A consulting physician has to confirm the diagnosis and the mental assessment. If either doctor thinks the patient suffers from a psychological disorder that impairs judgment, the regulation requires that the doctor refer the patient for counseling and refuse to dispense the deadly medication until the concerns are resolved.

Oregon's 2015 annual assisted suicide report indicates a 26% increase in deaths over 2014. The previous year also saw a 44% swell, totaling 81% more in just two years. Only 14 of the 132 people who died by assisted suicide in 2015 had their attending physician present at ingestion. In 103 of the cases, no health care provider at all witnessed the death (allowing for coercion), and for 105 patients, officials do not know whether complications occurred. Physicians prescribed assisted suicide drugs to 218 people, and the state documents 43 still living. The report cannot account for what happened with the other 43, or 20%, of the prescriptions. One person died 517 days—more than 1½ years—after obtaining the lethal dose. Doctors had a median treatment relationship length of nine weeks with their patients. Five patients received referrals for psychiatric evaluation, and over 17 years a mere 5.5% of assisted-suicide candidates underwent such assessments. The majority of 2015 patients (62.5%) depend on publicly funded health insurance (up from a past average of 38.3%). Oregon's Health Authority approves payment for assisted suicide but not suicide prevention for adults.

Washington

Washington, Oregon's northerly neighbor, next opened its doors to assisted suicide. Its 2008 "Initiative 1000" mimics the Oregon DWDA almost verbatim. The most recent records reveal a 275% increase in assisted suicide prescriptions over only six years. No health care provider monitored 32% of ingestions, and in 16% of cases no one knows who was present with the patient at the time of death. Physicians had been caring for 43% of the patients less than six months and 80% of patients for less than one year. The doctors recommended psychiatric review for only six patients. The report offers no information about the circumstances of 27 individuals' deaths.

After Washington and Oregon sanctioned physician-assisted suicide, they experienced a 6.3% increase in the total number of (non-assisted) suicides. Suicides among the elderly rose by 14.5%, and the suicide rate of persons aged 34-65 spiked nearly 50% between 1999 and 2010 in Oregon (compared to 28% nationally). Furthermore, Oregon faced 10% more allegations and investigations of elder abuse in 2014 than in previous years.

Other States

Vermont's "Patient Choice and Control at End of Life Act" legalized assisted suicide in 2013. It requires the attending physician to consult the patient's primary care doctor. It forbids any "interested person" (relative or heir) from serving as either of the two witnesses. However, it obligates no oversight reporting at all, and in three years only two physicians have submitted assisted suicide records. Otherwise it substantially duplicates Oregon's statute. California's 2015 "End of Life Option Act" (effective June 2016) also reproduces all the permissions and restrictions of the Oregon edict. In fact, since 1994, 35 states and the District of Columbia have introduced 175 physician-assisted suicide bills, modeling most of them after Oregon's DWDA. Except for Vermont, all have failed. (Oregon and Washington passed by general referendum, and California relied on other legislative maneuvering.) Montana's Supreme Court ruled a physician may claim patient consent as a legal defense if charged with assisted suicide, but none have tested the decision.

The Netherlands

The Netherlands made euthanasia and physician-assisted suicide legal in 2002. Doctors widely practiced them prior and without prosecution, but the 2002 act standardized procedures and limitations. Patients qualify even without a terminal diagnosis if they consider their situation unbearable with no prospect of improvement. Anyone over age twelve may request, but he or she must do so voluntarily, repeatedly, and without impaired judgment or influence from others. Authorities have agreed not to take action against pediatric euthanizers as long as they follow the conditions of the doctor-developed "Groningen Protocol" (certain prognosis, parental consent, hopeless and intolerable suffering, and medical consultation). The physician must be present to administer or witness and has to report every case to a review committee.

Deaths from euthanasia and assisted suicide have multiplied every year in the Netherlands. The most recent year's figures registered 5,306 assisted deaths in 2014, up from 1,923 in 2006. In 2013, 650 infants euthanized made up 13.5% of the 4,829 patients who died under the law. Physician-assisted suicide and euthanasia account for one of every 28 deaths in the country. Psychiatric reasons led to 41 of the 2014 deaths. Doctors have helped patients with multiple sclerosis, depression, autism, and blindness take their own lives. The deaths of disabled children, comatose patients, and persons with dementia have been caused without their consent. Furthermore, one 2010 study estimates that physicians do not report 23% of all such deaths.

Belgium

Belgium also agreed to euthanasia in 2002 and physician-assisted suicide in 2006. The Euthanasia Act specifies that an eligible adult has a "futile medical condition of constant and unbearable physical or mental suffering that cannot be alleviated." Only permanent residents who have a long-term history with their physician may apply. Two doctors must approve, and a commission examines each case to verify voluntary and recurrent requesting. These deaths escalated 860% from 2003 (235) to 2015 (2,021). Euthanasia and assisted suicide resulted in 5.1% of all deaths, or 1 of every 20 in 2013. Applying this rate to 61,621 people who died in Flanders, Belgium that year and subtracting the 1,454 confirmed assisted deaths from that region

yields as many as 1,688 undocumented (and without scrutiny) cases – well over half. The nation also expanded its law to allow euthanizing of minors suffering from incurable diseases who demonstrate rational decision-making.

The *New England Journal of Medicine* published a survey of Belgian practices in 2015. This research found that physicians admitted hastening 1.7% of all deaths without explicit request. A 2015 *British Medical Journal* study analyzed 100 consecutive requests for euthanasia at a Belgian psychiatric outpatient clinic between 2007 and 2011. It revealed that the average patient was aged 47, 81 were unemployed, and 58 were depressed. Personality disorders afflicted 50 patients, 12 suffered from autism, 11 faced anxiety disorders, 10 struggled with eating disorders, and 13 were experiencing PTSD. Clinic physicians recommended lethal injection of 48 patients—nearly half—for psychiatric reasons. They referred only 38 people for further testing, and even approved 17 of these for euthanasia. Non-terminal psychological distress led to similar deaths for 67 people in Belgium during 2013. A paper in the *Journal of Bioethical Inquiry* observed that a palliative care team visited only 40% of euthanized patients in 2012-2013, and only 9% consulted a psychiatrist.

Other Nations

Switzerland permits physician-assisted suicide even for non-citizens. Courts have interpreted the Swiss Criminal Code of 1942 in favor of it since the 1980s. While local law does not allow active euthanasia, the country hosts several clinics that “suicide tourists” visit with the intention of ending their lives. A 2007 *European Psychiatry* journal survey showed that some 20% of family members or close friends present at an assisted suicide there met the criteria for full or subthreshold post-traumatic stress disorder (PTSD). Prevalence of depression in the sample likewise exceeded that of the general population. Luxembourg’s legislators in 2009 also granted physicians permission to practice assisted suicide. And the Supreme Court of Canada issued a 2015 decision invalidating the law’s express injunction against assisted suicide. The Court then instructed the federal government to formulate provisions for it within twelve months (which it has since extended by another six months). During that time, details emerged of some Québec doctors neglecting life-saving remedies after assisted suicides, although those interventions would have had no ill after-effects. This compelled the province’s College of Physicians to issue an ethics bulletin emphasizing their obligation to treat under such circumstances.

Motivation

Annual DWDA reports in Oregon record stated reasons for seeking assisted suicide. In 2015, 96.2% of patients listed “decreasing ability to participate in activities that made life enjoyable” as a primary end-of-life concern. “Loss of autonomy” proved decisive for 92.4% of patients, and “loss of dignity” bothered 75.4%. “Becoming a burden on family, friends, and caregivers” troubled 48.1% of persons requesting physician-assisted suicide. Only 35.7% worried about “losing control of bodily functions,” and just 28.7% feared “inadequate pain control.” These responses reflected previous years’ results as well. Washington’s yearly statements relate similar opinions. Loss of enjoyable activities upset patients in 94% of cases, loss of autonomy in 89%, and loss of dignity in 79%. Becoming a burden weighed on 59%, but bodily functions plagued 51% and pain control wearied 41%.

The National Institutes of Health led an investigation of Netherland's euthanasia cases in 2015. These scientists announced their findings in the *Journal of the American Medical Association* (JAMA) as discussed in the following paragraphs.

Psychiatry

In 66 instances of assisted death for psychiatric conditions, 52% had previously attempted (non-assisted) suicide. Physicians noted social isolation or loneliness for 56% of patients and diagnosed depression as the primary psychiatric issue for 55%. The vast majority of patients (80%) disclosed previous psychiatric hospitalizations, and 56% had refused some treatment – half due to “no motivation.” Twenty-seven percent of the time, the doctor performing the procedure had never met the patient before. Consulting physicians disagreed about 24% of patients' eligibility, and those concerns went unresolved for most of them.

Another (JAMA) article explores the first-year operations of a Netherlands end-of-life clinic. In that time, physicians carried out assisted deaths for 11 persons (7%) who were “tired of living.” This means that the person has no specific illness at all. Cognitive decline, such as dementia, qualified 21 more (13%) to die. An incompetent woman died there by euthanasia, even after her residential care facility fought it. A healthy woman suffering from persistent ringing in the ears underwent assisted suicide there as well. One woman lamented she had a life without love and, therefore, no right to exist. Another pursued her death despite feeling healthy and happy simply because she and her recently deceased husband had promised one would not live without the other.

Opposition

Many medical and disability organizations support natural death rather than assisted suicide.

American Academy of Hospice and Palliative Medicine	College of American Pathologists
American Academy of Medical Ethics	Concerned Women for America
American Academy of Neurology	Disability Rights Center
American Academy of Orthopaedic Surgeons	Disability Rights Education and Defense Fund
American Academy of Pain Management	Hospice Nurses Association
American Academy of Pain Medicine	Justice for All
American Academy of Physical Medicine	National Association for Hospice and Palliative Care
American Association of Clinical Endocrinologists	National Council on Disability
American Association of Critical-Care Nurses	National Council on Independent Living
American Association of People with Disabilities	National Spinal Cord Injury Association
American College of Pediatricians	Not Dead Yet
American Disabled for Attendant Programs Today	Oncology Nurses Society
American Medical Association	Patients' Rights Council
American Neurological Association	United Spinal Association
American Nursing Association	Society of Medical Consultants to the Armed Forces
American Osteopathic Association	World Association of Persons with Disabilities
American Psychiatric Association	World Health Organization
American Society of Abdominal Surgeons	World Institute on Disability
American Society of Anesthesiologists	World Medical Association
American Society of Clinical Pathologists	
Association of Programs for Rural Independent Living	
Autistic Self-Advocacy Network	

Associations who have publicly advocated this position include:

A January 2015 Marist poll surveyed over 2,000 adults about assisted suicide. The majority (61%) do not favor a doctor prescribing or administering a lethal dose. Similar proportions of the public worry that it will prompt the depressed toward taking their own lives (64%), put elderly at risk in nursing homes (65%), and lead to fewer available life-saving options (67%). Most Americans also worry about trusting a doctor who practices assisted suicide (57%), fear a wrong diagnosis (59%) or a physician misjudging a patient's state of mind (55%), and see assisted suicide becoming a cost-saving measure for health care decisions (55%). Only 7% would definitely request assisted suicide, while 51% definitely would not. Moreover, Gallup's researchers discovered that perceptions about assisted suicide depend on its description. Support decreased from 70% to 51% when "help end a patient's life" changed to helping "commit suicide."

Assisted Suicide: The Solutions

Autonomy

Why It's Bad: "My body, my death, my choice." The main argument assisted suicide enthusiasts make involves autonomy. They claim that imposing anyone else's priorities and desires, politics and beliefs, or obliging somebody to endure something unwanted encroaches on a person's independence and diminishes freedom. Expressing myself and defining the meaning of my own life encompasses deciding the timing and manner of my dying. However, to avoid the inherent abuses and reduce the risks that come with causing death, *assisted* suicide requires the cooperation of doctors and nurses, hospitals and pharmacists, coroners and insurance companies, lawmakers and prosecutors, family and caregivers. Assisted suicide also conflicts with and corrupts the sacred trust patients place in their physicians, allowing them to exercise significant influence and power over their lives for their healing. Assisted suicide particularly threatens already vulnerable populations, such as those with a disability or depression. It creates a cultural expectation that the suffering would be "better off dead" (especially as a source for organ transplants) and should "put themselves out of our misery" rather than unduly burdening society. It discriminates which suicidal persons receive compassionate interventions while urging others toward death.

In fact, assisted suicide introduces additional possibilities for pressure and coercion both by relatives and providers, however subtle and manipulative. Physicians themselves frequently face compulsion to defy their own consciences because the patient's right becomes the doctor's responsibility. Furthermore, Oregon's example and the European models have proven how in practice, assisted suicide has inevitably expanded beyond its original limits, from terminal illness to chronic illness, from physical pain to psychological distress, and from voluntary to nonvoluntary and even involuntary euthanasia. Finally, uninhibited autonomy endangers everyone, the reason for which civilizations establish any laws at all.

What Is Better: Interdependence. Autonomy may appear attractive, but it also leads to loneliness. "There is a way that seems right to a man, but its end is the way to death" (Proverbs 14:12). The Gospel of Jesus Christ promises a better way. It presents Almighty Maker as every single sufferer's Heavenly Father who wills life above all and through all and who reserves

for Himself both the privilege of providing life and the responsibility for deciding death. “See now that I, even I, am he, and there is no god beside me; I kill and I make alive” (Deuteronomy 32:39a). Every human breath and heartbeat testifies to this singular will: “[T]he Lord God formed the man of dust from the ground and breathed into his nostrils the breath of life, and the man became a living creature” (Genesis 2:7). The gift of life always arrives in His time and on His terms, and it also only ever resides or retreats according to the same greater wisdom of His good will, even when humankind seems to exercise some influence. “But God said to him, ‘Fool! This night your soul is required of you’” (Luke 12:20a).

He has incarnated this control in the compassion of Jesus Christ. The Creator has embodied and enacted His competence in the servanthood of the world’s crucified and resurrected Savior. His coming confirms that God always intends to work life and give it in abundance and unto eternity. “I came that they may have life and have it abundantly” (John 10:10b). This holds true—especially so, perhaps—amid afflictions as well. “[T]hus says the Lord, he who created you ... ‘Fear not, for I have redeemed you; I have called you by name, you are mine. When you pass through the waters, I will be with you...when you walk through fire you shall not be burned’” (Isaiah 43:1-2). “[E]ven to your old age I am he, and to gray hairs I will carry you. I have made, and I will bear” (Isaiah 46:4). Abandoning this faith, not the body’s failure, represents the supreme threat to human well-being. “[D]o not fear those who kill the body but cannot kill the soul. Rather fear him who can destroy both soul and body in hell. Are not two sparrows sold for a penny? And not one of them will fall to the ground apart from your Father. But even the hairs of your head are all numbered” (Matthew 10:28-30). “[T]he world has hated them because they are not of the world, just as I am not of the world. I do not ask that you take them out of the world, but that you keep them from the evil one” (John 17:14-15).

Even autonomy’s wrestling tension yields to this relieving affirmation and trust. Minds and mouths may fear to confess it, but hearts and spirits already sense that power over life and death—and consequent accountability to it—does indeed lie outside of human hands. “[W]hen the king of Israel read the letter, he tore his clothes and said, ‘Am I God, to kill and to make alive ... ?’” (2 Kings 5:7). “No man has power to retain the spirit, or power over the day of death” (Ecclesiastes 8:8a). Yet death, while bigger than we, does not hold ultimate control. It also is itself tamed as a tool of God to serve the purpose of divine love and heavenly life for humankind’s good. “What then shall we say to these things? If God is for us, who can be against us? He who did not spare his own Son but gave him up for us all, how will he not also with him graciously give us all things?” (Romans 8:31-32). “No, in all these things we are more than conquerors through him who loved us. For I am sure that neither death nor life...nor things present nor things to come ...nor anything else in all creation, will be able to separate us from the love of God in Christ Jesus our Lord” (Romans 8:37-39).

Human nature entails an elegant dependence also upon each other. Far from weakness and quite the opposite of failure, the deep degree of this interdependence—particularly when it is altruistic—delightfully elevates humankind above the animal kingdom. Consciously complementary community constitutes the very image of God. “Then God said, ‘Let us make man in our image, after our likeness’ ... So God created man in his own image, in the image of God he created him; male and female he created them. And God blessed them. And God said to

them, ‘Be fruitful and multiply and fill the earth and subdue it and have dominion ...’” (Genesis 1:26-28). Relationships such as marriage and parenting bud into a beautiful bouquet of burden-bearing bonds that reflect the Father-Son-and-Holy-Spirit’s three-persons-as-one-God dynamic.

Christian Scripture and tradition recognize this not only as Trinity but as love. The Trinitarian Being furnishes the foundation and fountain of all reality and life, culminating in the incorporation of individuals into the mystical body of Christ. Each self exists for sharing and not just expressing, and every other exists for receiving and not using only. “For none of us lives to himself, and none of us dies to himself” (Romans 14:7). “[W]e, though many, are one body in Christ, and individually members one of another” (Romans 12:5). We have the privilege of responsibility for each other and the honor of expecting from one another, making the humanity in which we all participate greater than the simple sum of its parts. “If one member suffers, all suffer together; if one member is honored, all rejoice together” (1 Corinthians 12:26). “Bear one another’s burdens, and so fulfill the law of Christ” (Galatians 6:2). “[He] comforts us in all our affliction, so that we may be able to comfort those who are in any affliction, with the comfort which we ourselves are comforted by God” (2 Corinthians 1:4).

Vulnerability clearly reveals the value of dependence. “Open your mouth for the mute, for the rights of all who are destitute ... defend the rights of the poor and needy” (Proverbs 31:8-9). “If I say to the wicked, ‘You shall surely die,’ and you give no warning ... in order to save his life, that wicked person shall die for his iniquity, but his blood I will require at your hand” (Ezekiel 3:18). Desire for suicide—assisted or otherwise—suggests somebody is feeling disconnected. Instead of confirming and completing the exclusion in death, only embracing with company, empathy, and care addresses and eases such suffering. “But a Samaritan, as he journeyed, came to where he was [beaten, abandoned, and half dead], and when he saw him, he had compassion. He went to him and bound up his wounds...and brought him to an inn and took care of him... You go, and do likewise” (Luke 10:33-34, 37b). “[Elijah] asked that he might die ... [And the Lord said to him], ‘... Yet I will leave seven thousand in Israel, all the knees that have not bowed to Baal, and every mouth that has not kissed him’” (1 Kings 19:4, 18). Even when accompanied suffering does not extend an individual’s life, it enriches every connected life and our common life together.

Pain

Why It’s Bad: Sometimes death offers the only deliverance from agony. Those who endorse assisted suicide assert that early death is preferable to prolonging pain. When a terminal diagnosis anticipates impending death anyway, and the pain remains unrelenting, putting off death proves both futile and cruel. Only selfishness would force a patient who wants it over with to endure apparent torture just to appease a survivor’s desire to have him or her around a little longer or to satisfy someone else’s religious principles. Better a merciful euthanasia than a miserable existence.

But assisted suicide actually aims to kill the person instead of only killing the pain. It does not address resolution of the suffering’s root causes—the noble goal of responsible medicine—and ignores resulting complications altogether. Data demonstrate that doctors do not prescribe assisted suicide exclusively for (otherwise) terminal situations, and patients do not always pursue

it because of a physical ailment. Neither does the administration of assisted suicide in every case proceed as planned. It employs the same chemicals whose frequent complications have caused some United States courts (and the pharmaceutical manufacturers themselves) to suspend their use in government executions as cruel and unusual punishment.

In fact, assisted suicide does not lift any misery at all. It just shifts it onto the survivors and leaves them with the complex tangle of questions, accusations, grief, and guilt. Assisted suicide seems most to comfort not the victim nor the survivors but the surrounding culture. It takes the edge off the awkwardness of helplessly witnessing suffering and meets the natural, human need to do something for (to?) the neighbor. In this way, assisted suicide removes a key reason for caregivers to continue seeking further means of relieving patients' pain, as well as reducing society's responsibility to discover new physical and psychological pain management strategies.

What Is Better: Purpose. Even assisted suicide cannot eliminate pain. Suffering persists as a given of the human condition. We often willingly withstand almost constant discomfort in some measure, as long as we understand what greater good it accomplishes. The Gospel of Jesus Christ reveals a meaning to suffering and gives pain purpose. It imparts to us the presence and power of God's Son to accompany us as Savior, especially in our suffering. He does not simply sprinkle magic dust, snap His almighty fingers, say the secret word, wave His supernatural hand, and make pain instantly disappear. Rather, as God Himself, Jesus steps into and among our hurting to abide it beside us, rescuing us while redeeming also our sorrow, so that we may behold, believe in, and be held by His compassion.

Jesus empathizes with what we undergo because of His own experience of it. "Jesus wept" (John 11:35). "He took our illnesses and bore our diseases" (Matthew 8:17). "And about the ninth hour Jesus cried out with a loud voice, saying, 'Eli, Eli, lema sabachthani?', that is, 'My God, my God, why have you forsaken me?'" (Matthew 27:46). "For we do not have a high priest who is unable to sympathize with our weaknesses, but one who in every respect has been tempted as we are, yet without sin. Let us then with confidence draw near to the throne of grace, that we may receive mercy and find grace to help in time of need" (Hebrews 4:15-16). He remains well aware of our limits and weaknesses, perhaps more so than we ourselves. Since His hands, feet, forehead, and side still have the scars of his crucifixion, no one ever suffers alone. "The Lord is near to the brokenhearted and saves the crushed in spirit" (Psalm 34:18). "As a father shows compassion to his children, so the Lord shows compassion to those who fear him. For he knows our frame; he remembers that we are dust" (Psalm 103:13-14).

Not only is Jesus suffering with us, but God also suffers in us and indeed suffers it for us. "[A] thorn was given me in the flesh, a messenger of Satan to harass me ... Three times I pleaded with the Lord about this, that it should leave me. But he said to me, 'My grace is sufficient for you, for my power is made perfect in weakness'" (2 Corinthians 12:7-9). "[F]or it is God who works in you, both to will and to work for his good pleasure" (Philippians 2:13). In every case He supplies precisely the necessities, whether we perceive it or not. "No temptation has overtaken you that is not common to man. God is faithful, and he will not let you be tempted beyond your ability, but with the temptation he will also provide the way of escape, that you may be able to endure it" (1 Corinthians 10:13). "Come to me, all who labor and are heavy laden, and I will give you

rest ... For I am gentle and lowly in heart, and you will find rest for your souls. For my yoke is easy, and my burden is light” (Matthew 11:28-30). This, of course, includes medical means like palliative care, pain management, and even sedation if necessary.

As God’s instrument, suffering often achieves outcomes that more than compensate for its costs. “I consider that the sufferings of this present time are not worth comparing with the glory that is to be revealed ... And we know that for those who love God all things work together for good” (Romans 8:18, 28). “[W]e rejoice in our sufferings, knowing that suffering produces endurance, and endurance produces character, and character produces hope, and hope does not put us to shame, because God’s love has been poured into our hearts” (Romans 5:3-5). Since Jesus atoned and reconciled, suffering never serves its own ends as punishment from a vengeful God or cosmic karma’s payback. “[H]is disciples asked him, ‘Rabbi, who sinned, this man or his parents, that he was born blind?’ Jesus answered, ‘It was not that this man sinned, or his parents, but that the works of God might be displayed in him’” (John 9:2-3).

Suffering can become sacrifice to benefit another by the voluntary giving of self. “[W]hich I shall choose I cannot tell. I am hard pressed between the two. My desire is to depart and be with Christ, for that is far better. But to remain in the flesh is more necessary on your account. Convinced of this, I know that I will remain ... for your progress and joy” (Philippians 1:22-25). “[B]y the mercies of God ... present your bodies as a living sacrifice ... Do not be conformed to this world, but be transformed by the renewal of your mind” (Romans 12:1-2). Sharing unpleasant ordeals unites lives together in otherwise impossible ways. “If we are afflicted, it is for your comfort and salvation; and if we are comforted, it is for your comfort, which you experience when you patiently endure the same sufferings that we suffer” (2 Corinthians 1:6). “[W]e have this treasure in jars of clay, to show that the surpassing power belongs to God and not to us ... For we who live are always being given over to death for Jesus’ sake, so that the life of Jesus also may be manifested in our mortal flesh. So death is at work in us, but life in you” (2 Corinthians 4:7, 11-12).

Persevering together through pain testifies to things even greater than comfort. “So we do not lose heart. Though our outer self is wasting away, our inner self is being renewed day by day. For this light momentary affliction is preparing for us an eternal weight of glory beyond all comparison” (2 Corinthians 4:16-17). “[D]o you not know that your body is a temple of the Holy Spirit within you, whom you have from God? You are not your own, for you were bought with a price. So glorify God in your body” (1 Corinthians 6:19-20). “Blessed are the poor in spirit, for theirs is the kingdom of heaven. Blessed are those who mourn, for they shall be comforted” (Matthew 5:3-4). Paradoxically, suffering signals goodness in the worst circumstances, something worth suffering for.

Quality of Life

Why It’s Bad: “Quality of life” tries to calculate the value of continuing versus terminating life. It attempts to compare the net weight of a patient’s pains against his or her pleasures. The balance between the two forms the basis for finding rational justifications and making empirical decisions in emotionally and ethically weighty situations. A quality-of-life approach accepts that patients need not universally and unquestioningly prioritize sheer quantity of minutes alive.

It intentionally avoids imposing ideological assumptions, such as the expectation that a patient always perceives life worth living. Measuring quality of life emphasizes instead that modern medicine has mastered death as just another instrument available for attaining one's sense of well-being. It claims to equip patients and physicians with a more honest and fair method of evaluating their health care options.

Such estimations, however, are subjective, adjustable, and inconclusive. They rest on intensely personal experiences and on the effectiveness of communicating these perceptions. They represent frequently momentary and temporary states of mind. Assisted suicide, on the other hand, features an incongruent finality. Minds change and feelings fluctuate, but death can never be undone. Quality of life also undermines the equality that sanctity of human life establishes. It supposes only some lives worth living (and some not!) and leads to discrimination against elderly, disabled, or depressed persons.

Even physicians admit themselves capable of mistaken diagnoses and inaccurate prognoses. A permanent decision like assisted suicide ought to require an absolute certainty, which medical professionals cannot currently provide. Numerous studies indicate that people with disabilities state a higher quality of life for themselves than their doctors appraise for them. Overall, the quality-of-life discussion encourages quantifying intangibles, even computing the value of one person or life over another. Intentionally or otherwise, connecting assisted suicide and quality of life incentivizes the rationing of health care as a cost-control tactic. It dangerously favors certain people or lives as more secure investments of allegedly limited resources.

What Is Better: Sanctity of Life. Quality-of-life thinking can only diminish the value of people. It applies inherently relative scales and grades and implies some lives have more value than others. The Gospel of Jesus Christ gives a firmer footing and surer support for every life's worth. The gracious actions of God, not the abilities—or inabilities—of anyone else, endow each human life with absolute and unconditional sanctity at every stage and in every state. Regardless of either intrinsic capacities or external critiques, all human beings own divine-above-all approval by virtue of God's intimate involvement in their creation. “Did you not pour me out like milk and curdle me like cheese? You clothed me with skin and flesh, and knit me together with bones and sinews” (Job 10:10-11). “My frame was not hidden from you, when I was being made in secret, intricately woven in the depths ... Your eyes saw my unformed substance; in your book were written, every one of them, the days that were formed for me, when as yet there was none of them” (Psalm 139:15-16).

He conferred further honor upon us all by incarnating Himself in humanity from womb to tomb. Jesus sanctified all humankind genetically descended from Adam and Eve and granted this privilege to no other creature. This He did both by His own human life from conception to expiration and by His ministering attention to those whose bodies were compromised. “And the Word became flesh and dwelt among us, and we have seen his glory, glory as of the only Son from the Father, full of grace and truth” (John 1:14). “Christ Jesus ... though he was in the form of God, did not count equality with God a thing to be grasped, but emptied himself ... being born in the likeness of men. And being found in human form, he humbled himself by becoming obedient to the point of death, even death on a cross” (Philippians 2:5-8). “Since therefore the

children share in flesh and blood, he himself likewise partook of the same things ... surely it is not angels that he helps, but he helps the offspring of Abraham” (Hebrews 2:14, 16).

He completes His acceptance of humankind by arranging an ongoing communion. He establishes our acceptableness as everlasting. He consecrates not spirits, hearts, or minds only but human bodies and bodily life as well, evidenced by extending to everyone His own flesh’s resurrection from the dead. “If the Spirit of him who raised Jesus from the dead dwells in you, he who raised Christ Jesus from the dead will also give life to your mortal bodies” (Romans 8:11). “For as many of you as were baptized into Christ have put on Christ” (Galatians 3:27). “I have been crucified with Christ. It is no longer I who live, but Christ who lives in me” (Galatians 2:20a). “Let the word of Christ dwell in you richly” (Colossians 3:16a). “The cup of blessing that we bless, is it not a participation in the blood of Christ? The bread that we break, is it not a participation in the body of Christ?” (1 Corinthians 10:16). This total devotion to human life motivates Him to proclaim, “For I have no pleasure in the death of anyone, declares the Lord God; so turn, and live” (Ezekiel 18:32).

Human abilities and emotions display life’s worth instead of determining it. Nor does the absence or eroding of any passions or capacities undermine anybody’s essential importance. “[A]ll have sinned and fall short of the glory of God, and are justified by his grace as a gift, through the redemption that is in Christ Jesus ... For we hold that one is justified by faith apart from works” (Romans 3:23-24, 28). “But you are a chosen race ... a people for his own possession, that you may proclaim the excellencies of him who called you out of darkness into his marvelous light” (1 Peter 2:9). “For by grace you have been saved through faith. And this is not your own doing; it is the gift of God, not a result of works ... we are his workmanship, created in Christ Jesus for good works, which God prepared beforehand” (Ephesians 2:8-10).

Even our most basic efforts and accomplishments function chiefly for others’ benefit. “In this is love, not that we have loved God but that he loved us and sent his Son ... if God so loved us, we also ought to love one another ... We love because he first loved us” (1 John 4:10-11, 19). “[L]et your light shine before others, so that they may see your good works and give glory to your Father who is in heaven” (Matthew 5:16). “[I]n your hearts honor Christ the Lord as holy, always being prepared to make a defense to anyone who asks you for a reason for the hope that is in you; yet do it with gentleness and respect” (1 Peter 3:15). Simply existing, even apart from any obvious outward operation, serves not only to vindicate one’s own value but also to validate everyone else around. “A healthy tree cannot bear bad fruit, nor can a diseased tree bear good fruit” (Matthew 7:18). “I am the vine; you are the branches. Whoever abides in me and I in him, he it is that bears much fruit, for apart from me you can do nothing” (John 15:5). “And I am sure of this, that he who began a good work in you will bring it to completion at the day of Jesus Christ” (Philippians 1:6).

Death with Dignity

Why It’s Bad: Proponents of assisted suicide contend it preserves the patient’s dignity. Deteriorating into an infantile, animal, or vegetable-like state (sometimes even medically categorized as a “persistent vegetative state”) robs a person of the respectability everybody deserves. Assisted suicide spares the dying this vulnerable and embarrassing process. It lets

them depart with pride intact and leave a legacy with their last hours that inspires unadulterated appreciation rather than pity.

Nevertheless, death does not and cannot deprive a person of dignity. Dignity depends on the character and composition of a person and not on circumstances or needs. Insinuating that impairments or appearances negate any person's innate dignity dangerously discriminates against and outright offends the common dignity of all. If dying dishonors any deaths, it dishonors them all by definition, since it fundamentally takes away not just dignity but humanity. The description of dignity presupposed by the "death with dignity" push actually classifies assisted suicide itself as undignified because it requires the assistance of others to exert complete control over one's own functions and life unto its ending.

Assisted suicide does not grant a death with dignity at all. It consists not simply of dying but of killing because it intentionally causes or hastens death. It also steals dignity from participants and survivors. Premature death by assisted suicide denies them dignities such as self-sacrifice, courage, closure, a clear conscience, moments, and memories. Adding organ harvesting to assisted suicide further cheapens human dignity. This arrangement prefers the worth of spare parts to donate and transplant to the value of the person's continued company.

What Is Better: Life with Grace. In the end, no death affords dignity to any life that does not already possess it. A person gives dignity to his or her situation, not vice versa. The Gospel of Jesus Christ irrevocably lends God's own dignity to devalued lives. Jesus regularly reached, touched, and received them not only as acquaintances, neighbors, and associates but as sisters, sons, brothers, and daughters. "[H]e spat on the ground and made mud with the saliva. Then he anointed the man's eyes with the mud and said ... 'Go, wash...' So he went and washed and came back seeing" (John 9:6-7). "[T]here was a woman who had had a discharge of blood for twelve years ... She came up behind him and touched the fringe of his garment, and immediately her discharge of blood ceased ... And he said to her, 'Daughter, your faith has made you well; go in peace'" (Luke 8:43-44, 48). "[T]here came a man full of leprosy ... And Jesus stretched out his hand and touched him, saying, 'I will; be clean.' And immediately the leprosy left him" (Luke 5:12-13).

For centuries Christians have changed the world by mirroring His mercy. Their compassion has improved the perception and treatment of people with impairments even in non-Christian cultures. Followers of Jesus acknowledge that no life goes undamaged spiritually, if not physically, and God's love justifies and dignifies them all. "[A] woman of the city, who was a sinner ... brought an alabaster flask of ointment, and standing behind him at his feet, weeping, she began to wet his feet with her tears and wiped them with the hair of her head ... And he said to her, 'Your sins are forgiven ... go in peace'" (Luke 7:37-38, 48-50). "But while he was still a long way off, his father saw him and felt compassion, and ran and embraced him and kissed him. And the son said to him, 'Father, I have sinned against heaven and before you. I am no longer worthy to be called your son.' But the father said to his servants, 'Bring quickly the best robe, and put it on him, and put a ring on his hand, and shoes on his feet. And bring the fattened calf and kill it, and let us eat and celebrate. For this my son was dead, and is alive again'" (Luke 15:20-24).

The Christian message deems such lives worth having and worth saving even without being healed. “[I]f your hand or your foot causes you to sin, cut it off and throw it away. It is better for you to enter life crippled or lame than with two hands or two feet to be thrown into the eternal fire ... See that you do not despise one of these little ones. For I tell you that in heaven their angels always see the face of my Father” (Matthew 18:8, 10). “[W]hen you give a feast, invite the poor, the crippled, the lame, the blind, and you will be blessed, because they cannot repay you. For you will be repaid at the resurrection of the just” (Luke 14:13-14). “Jesus said to him ... ‘Truly, truly, I say to you, when you were young, you used to dress yourself and walk wherever you wanted, but when you are old, you will stretch out your hands, and another will dress you and carry you where you do not want to go.’ (This he said to show by what kind of death he was to glorify God.)” (John 21:17b-19).

In fact, Christian faith raises a person above death’s apparent indignities. Because of the uplifting witness given in them, Christianity echoes God in commending deaths the culture calls undignified and makes assisted suicide difficult to justify. “Then Job arose and tore his robe and shaved his head and fell on the ground and worshiped. And he said, ‘Naked I came from my mother’s womb, and naked shall I return. The Lord gave, and the Lord has taken away; blessed be the name of the Lord’ ... Then his wife said to him, ‘Do you still hold fast your integrity? Curse God and die.’ But he said to her, ‘You speak as one of the foolish women would speak. Shall we receive good from God, and shall we not receive evil?’ In all this Job did not sin with his lips” (Job 1:20-21; 2:9-10). “And when they came to a place called Golgotha (which means Place of a Skull), they offered him wine to drink, mixed with gall, but when he tasted it, he would not drink it. And when they had crucified him, they divided his garments among them by casting lots” (Matthew 27:33-35).

Faith equips sufferers with a greater dignity that waits upon the Lord’s will and others’ well-being. “[I]t had been revealed to him by the Holy Spirit that he would not see death before he had seen the Lord’s Christ. And he came in the Spirit to the temple, and when the parents brought in the child Jesus...he took him up in his arms and blessed God and said, ‘Lord, now you are letting your servant depart in peace, according to your word; for my eyes have seen your salvation’” (Luke 2:26-30). “[A]s they were stoning Stephen, he called out, ‘Lord Jesus, receive my spirit.’ And falling to his knees he cried out with a loud voice, ‘Lord, do not hold this sin against them’” (Acts 7:59-60). “[H]e withdrew from them about a stone’s throw, and knelt down and prayed, saying, ‘Father, if you are willing, remove this cup from me. Nevertheless, not my will, but yours, be done.’ And there appeared to him an angel from heaven, strengthening him” (Luke 22:41-43).

Assisted Suicide: Famous Stories

United States Supreme Court

The United States Supreme Court considered laws prohibiting assisted suicide in 1997. In both *Washington v. Glucksberg* and *Vacco v. Quill*, the Court delivered unanimous 9-0 verdicts that the U. S. Constitution does not guarantee any right to assisted suicide nor to a broader “right to die.” Individual states may legally prohibit assisted suicide. This decision does not parallel Supreme Court rulings regarding abortion, which have mandated allowing abortion in all states. However,

the Court decided in *Gonzales v. Oregon* (2006) that the United States Attorney General could not prosecute, under the federal Controlled Substances Act, any physicians prescribing fatal medications according to Oregon law.

Jack Kevorkian & Philip Nitschke

Jack Kevorkian received certification to practice medicine in Michigan. From the 1950s to the 1980s, he not only advocated euthanasia but also favored vivisection, proposed harvesting organs from executed inmates, and experimented with transfusing blood from deceased into live patients. He claimed to have assisted more than 130 suicides in the 1990s, even after the state revoked his medical license in 1991. Kevorkian developed multiple devices for poisoning or suffocating his patients, many of whom had no terminal illness. His cavalier activism earned him celebrity status with American media, and a national television network broadcast a 1998 recording of him euthanizing a client and taunting authorities. Despite four previous failed trials, Michigan officials charged him with second-degree murder and delivery of a controlled substance. The jury found him guilty and sentenced him to 10-25 years in prison, of which he served about eight before parole. Kevorkian then resumed his publicity campaign for euthanasia (and even ran unsuccessfully for Congress). He died in 2011 at age 83 from liver cancer, reportedly caused by hepatitis he contracted during his controversial research.

Philip Nitschke studied physics, and later medicine, in Australia. He has admitted assisting four people to commit suicide and advising others. He also claims to be the first physician in the world to administer a “legal, lethal, voluntary injection,” under a short-lived Australian legislation. He founded Exit International, a worldwide organization encouraging euthanasia, in 1997. Australian media outlets have eagerly documented his actions and arguments. Nitschke and Exit have created and marketed asphyxiating apparatuses (“undetectable in autopsies”) and believe in making a “peaceful pill” (deadly chemical) available to every adult. After his national medical board suspended him as “a serious risk to public health and safety,” Nitschke publicly burned his certificate to practice.

Terri Schiavo

Terri Schiavo suffered brain damage during cardiac arrest in 1990. After being comatose for two months, doctors diagnosed her as in “a persistent vegetative state” (now “unresponsive wakefulness syndrome”). Two further years of therapy appeared unproductive in rehabilitating her consciousness. Her husband then requested a DNR upon her developing a urinary tract infection. He also won a \$2 million malpractice suit against her obstetrician, who had overlooked the bulimia that may have led to her heart failure. The husband became romantically involved with another woman but remained married to Terri. He stood to receive the malpractice judgment funds upon Terri’s death, but the money would pass to her parents in the event of divorce. In 1998, he petitioned the court to order removal of Terri’s feeding tube, since her physicians foresaw no recovery for her. Terri’s parents opposed this action, and trials and appeals ensued for years to determine Terri’s wishes and prognosis. High-profile legal proceedings involved the state legislature, governor, and Supreme Court, as well as the U. S. Congress and president. Courts granted the petition, and Terri died in 2005 after two weeks of starvation and dehydration.

Chris Dunn

Chris Dunn entered a hospital in late 2015 due to a mass on his pancreas. Within about six weeks he was depending upon life-sustaining care for survival. His attending physician concluded it was medically futile to continue treatment measures, despite Chris' and his family's objections. The hospital's ethics committee confirmed the doctor's decision, which Texas state law permitted. While Chris' family worked to transfer him to a different facility before the ten-day "grace period" ended, hospital officials sought medical guardianship. News stations carried video of Chris, conscious and alert, pleading for his life, and a judge instructed care to continue until the court resolved the dispute. Before legal proceedings settled, Chris died, just two days prior to Christmas.

Baby Doe & Simon Crosier

Baby Doe died in infancy in 1982. He was born with Down syndrome and esophageal complications that prevented proper nutrition and hydration. Surgery could have corrected the defect, but his parents declined the procedure, denying him food and water as well. The Surgeon General of the United States argued that the child's intellectual disability influenced the decision. This case, and another like it, led to laws that invalidated assessments of a child's quality of life as a reason for withholding medical care.

Doctors diagnosed Simon Crosier with Trisomy 18 three days after birth in 2010. They declared him "incompatible with life" because of his cardiac handicaps. (Heart defects afflict 90% of babies with Trisomy 18, and 95% are miscarried or aborted; only 1 in 6000 survive to birth.) After Simon died in his third month, his parents learned that a physician had issued a DNR order without their consent and that NICU staff intentionally underfed him. Many hospitals permit this neglect, and a 2016 *BioEdge* article counted 77% of neonatologists who think it ethically permissible to write a "unilateral" (without parental consultation) DNR. Lawmakers in Simon's home state of Missouri, as well as neighboring Kansas, have introduced bills called "Simon's Law" to recover parents' rights.

Marc & Eddy Verbessem

Twin brothers Marc & Eddy Verbessem lived together their entire adult lives. Except for deafness, they enjoyed exceptional health and employment as cobblers at age 45. When their local doctor in Belgium predicted their genetic glaucoma would eventually render them blind, they sought a hospital to end their lives by euthanasia. Their family pleaded to dissuade them, and for two years the men found no provider willing to approve and arrange their death. However, the brothers, because they feared not seeing each other and losing independence in an institution, prevailed in 2013, despite suffering no terminal illness or physical pain.

Barbara Wagner & Randy Stroup

At age 64, Barbara Wagner's lung cancer returned. Her Oregon doctor prescribed a life-extending chemotherapy, but the state's Medicaid refused coverage. Randy Stroup, 53, encountered a similar situation with a medicine to decelerate his prostate cancer and alleviate its pain. Administrators notified both in 2008 that Oregon would pay for less costly assisted suicide drugs, even though neither person had asked for them.

Karen Ann Quinlan

Karen Ann Quinlan overdosed on drugs and alcohol while dieting in 1975. The 21 year old lost consciousness and stopped breathing, but emergency personnel saved her life. Hospitalized and unresponsive, she required artificial nutrition and respiration. Tests detected minimal brain-wave activity, and she sometimes violently thrashed about. Her parents requested disconnecting her from the ventilation machine so that she could die. Doctors and a court-appointed guardian disagreed, but the New Jersey Supreme Court permitted it. Karen continued to breathe unaided for nine more years until succumbing to pneumonia, although she never recovered from her coma.

Brittany Maynard, Maggie Karner, Kara Tippetts

Brittany Maynard's assisted suicide gained great exposure in 2014. She developed incurable brain cancer, known as glioblastoma, at 29 years old. With her husband of two years, she relocated from California to Oregon to pursue assisted suicide. Compassion and Choices drew national attention to her plight, and media such as *People* magazine and CNN featured stories sympathetic to her perspective. Maggie Karner, Director of Life and Health Ministries for the Lutheran Church-Missouri Synod, had the same brain cancer. The 52-year-old mother of three publicly appealed to Brittany to reconsider and opposed assisted suicide in media appearances of her own. Kara Tippetts, dying from breast cancer at age 38, also wrote an open letter (which the *New York Times* noted) to convince Brittany to continue living. Both Maggie and Kara celebrated the blessings of extending time, deepening relationships, and new opportunities with loved ones. Brittany carried out her assisted suicide in November, having outlived her doctor's six-month prognosis. Kara died naturally the following March, and Maggie survived until her cancer claimed her in September.

Martin Pistorius

Martin Pistorius began losing motor control around age twelve in 1987. He became comatose for the next three years. His South African doctors could not determine the cause of his symptoms and presumed he would not ever reawaken or survive much longer. As he turned sixteen, Martin started regaining consciousness but still could not move or communicate. By nineteen he had complete awareness and was making slight movements, but his caregivers did not take notice. Physicians call this condition "locked-in syndrome," where paralysis prevents an alert patient from communicating with others. One therapist eventually began observing Martin responding to specific statements and questions. When he was nearly 25 years old, specialists evaluated him and confirmed his intact intellectual faculties. He has regained limited function of his head and arms, and Martin married in 2008. With help from speech software and a co-author, he wrote his autobiography, *Ghost Boy*, in 2011.

Jahi McMath

Severe blood loss resulted from Jahi McMath's minor surgery in 2013. California doctors identified no independent breathing, no blood flow to the brain, and no neurological activity. They declared the thirteen-year-old girl legally dead and intended to discontinue life support. Her family filed suit contesting it, and a series of rulings agreed with the hospital but mandated mechanical ventilation to continue while appeals proceeded. Although the county coroner issued an incomplete death certificate, pending autopsy to discern cause of death, officials released Jahi

to her mother's custody. Care continues, including a feeding tube, at a hospital and apartment in New Jersey. In late 2014, the McMaths' lawyer announced that recent medical tests indicated blood flow and electrical impulses in Jahi's brain. He also showed videos of her moving on command, and doctors remarked that her organs have not atrophied as expected.

Valentina Maureira

"I urgently request to speak to the president because I'm tired of living with this illness." Valentina Maureira, a teenager from Chile, lived with cystic fibrosis. Her older brother died at six years old from the same disease. She posted a video on the internet in 2015 asking the nation's leader for "approval so I can get a shot that will make me sleep forever." The president responded that the country has never made euthanasia legal. Public compassion for Valentina swelled, including a visit from the president and other children with CF. Meeting another patient who survived past age twenty also gave her hope, and she soon said her mind had changed. Valentina passed away naturally two months later.

Theo Boer

For many years, Theo Boer supported policies that allowed euthanasia in the Netherlands. The Dutch professor of health care ethics also served an appointment to one of five regional review committees that examined cases for legal compliance. In this role he saw firsthand the abuse of euthanasia and expansion beyond its original intentions. Frequent recent advancements in palliative care also impressed Dr. Boer. These realizations led him to reverse his position and to contest assisted deaths.

Mark & Cori Salchert

Cori Salchert works as perinatal hospice nurse in Wisconsin. She watched families sometimes abandon their terminally ill infants. The mother of eight would cradle the sick little ones so that "no one had to die alone." So she and her husband Mark started fostering these dying children in their own home, even adopting one into their family. Though these infants have extraordinary medical needs and often live only months or weeks, the Salcherts form rewarding relationships and make meaningful memories with the beloved babies.

Assisted Suicide: A Few Suggestions

Doctors, lawmakers, hospitals, and insurers certainly can take actions to avoid assisted suicides. The rest of us, however, have greater opportunities—and the greater responsibilities. As Christian citizens and caring neighbors, and in all our vocations and relationships, we can ensure and pursue compassionate alternatives when we or others around us are suffering. Indeed, it starts with us. We can **deliberate how we would face** our own potential end-of-life or impairment situations, particularly those most likely given our health history. We can investigate relevant regulations in our states, as well as coverage policies of our insurance plans. We can **get educated about treatment** and management strategies available for cure and care from our medical providers (both physicians and facilities) and support organizations (such as hospice agencies or elderly and disability advocates). Then we can **formulate our preferences and plans** regarding life-extending measures and comfort needs.

We can **communicate** about these matters. We can keep **our pastors** cognizant of assisted suicide risks in our culture and community. We can seek their counsel when we prepare or as we experience disease and dying. We can make them aware of others suffering among us and ask for their aid. We can **update our doctors and loved ones** about our convictions and expectations in the event of tragedy or entering life's twilight. We can also **collaborate with our attorneys** in drafting specific and Christian advance directives. Perhaps most importantly, we can **celebrate** our lives and everyone else's. We can identify and enjoy the blessings our Heavenly Father bestows unique to each circumstance, even those appearing unpleasant, less productive, or without dignity.

We can **insulate our loved ones** against assisted suicide temptations. We can lead **our children** to realize and appreciate the distinctions between the culture's perspectives and Gospel promises. Public events and personal episodes can provide occasions for discussion. We can walk with **our parents and elder relatives** during their ailments and later years. We can ask about their symptoms and emotions, and we can talk them through all of the above as well. We can visit them frequently, listen attentively and empathetically, and assist them physically. We can grieve and rejoice with them, encourage and reassure them, and assert on their behalf.

We can **motivate our congregations and communities** to respect and protect compromised lives. We can **accommodate** our functions and facilities so that all ages and abilities may participate. We can **affirm** the worth of their indispensable company and their irreplaceable contributions. We can **connect** ourselves and our societies to them consciously and constantly. We can **engage** in public discussion and decision-making. We can submit letters to the editor in newspapers and contact legislators and elected representatives. We can **vote** in favor of leaders and laws that protect and empower even the weakest human beings. We can **take advantage of informal and chance interactions**, both face-to-face and in internet forums, to raise and sustain reverence for all our neighbors. We can also urge our pastors and churches to offer **life-minded sermons and Bible studies**, and then we can attend them and invite others as well.

Lutherans For Life wants to partner with you in living and sharing this Gospel. Not only can we equip you to speak and work for life, we will serve and support you as you do it. Lutherans For Life strives to equip Lutherans to be Gospel-motivated voices for Life—not merely a message or a cause but a Person, and not simply an institution or a movement but relationships. Together we can accomplish this nationwide mission. Resources such as *LifeDate* (quarterly journal of research and reflection), Life on the Web (twice-weekly digest of online reports and stories), Life Sunday materials (sermons, services, Bible studies, bulletin inserts, children's messages), and a large library of articles and booklets at www.lutheransforlife.org will prepare you to advocate God's gift of life. Networks like Life Teams and Life Chapters (over 200 across the country), Y4Life (student ministry), in-person presentations, and on-site workshops will position you to take action with thousands of others and reach millions more with the life-saving love of Jesus. Because funding comes completely from donations, Lutherans For Life makes almost all of this available for free.

We do not have to settle for assisted suicide. The Christian Gospel accompanies anyone suffering with the presence of Jesus, the power of God, and the compassion of caregivers and loving others. It invites us to go gracefully and insist on accepting nothing less for ourselves or anybody else.



Lutherans For Life

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