
END-OF-LIFE CARE AND PREPARATION FOR DEATH IN A POST-CHRISTIAN AGE

Mark J. Cherry*

The Dr. Patricia A. Hayes Professor in Applied Ethics and Professor of Philosophy, St. Edward's University, Department of Philosophy, 3001 S. Congress Avenue, Box 844, Austin, Texas, 78704

(Received 15 June 2012)

Abstract

Richard Rorty, Gianni Vattimo, and H. Tristram Engelhardt, Jr. are correct in their assessment of our contemporary culture; namely, that a rupture has occurred separating the contemporary dominant secular culture's understanding of morality from that of Kant's Enlightenment. It is not just that the contemporary culture is moving towards affirming rights to physician-assisted suicide and voluntary active euthanasia, but, more significantly, the new morality and Bioethics that are emerging accepts physician-assisted suicide and euthanasia because they have demoralized choices in these matters to issues of death-style decision making. Killing with consent and assistance in self-killing have been demoralized in their significance, thus deflating as well the significance of end-of-life care, which is the primary focus of palliative care. Palliative care is regarded in merely immanent terms as a cost-effective approach to treating the morbidity of patients in the last months of their lives, rather than to regard such care as a support in the preparation through repentance for death. Rorty and Vattimo in different ways recognize that the contemporary culture prohibits such transcendent concerns. Engelhardt recognizes that Rorty and Vattimo are right in their diagnosis, but that this state of affairs constitutes the cardinal danger from the now dominant secular culture: there has been an all-encompassing, immanent displacement of transcendent concerns.

Keywords: Christian bioethics, end-of-life care, palliative care, euthanasia, secularism

1. Christianity and secularism: contrasting Bioethics

Traditional Christian bioethics frames the proper use of Medicine within the authentic experience of a fully Christian life. Contemporary secular bioethics, in contrast, functions as an academic, moral, social and political endeavour seeking fully to secularize medical practice. Where Christianity brings a content-full appreciation of the demands of God to communicate the why and wherefore of existence, appropriately to evaluate and guide technological, social, and moral choice, secular bioethics emphasizes healthcare welfare entitlements and individual liberty conceptualized as personal autonomy, to the detriment and marginalization of traditional forms of moral and spiritual

* E-mail: markc@stedwards.edu

authority. The established secular bioethics seeks ever further to secularize society, medicine, and permissible moral judgment. Traditional Christian bioethics is thus set against and acts as a religious counterpoint to the dominant secular bioethical establishment, and its general understanding that moral debates be conducted in terms of claims and reasons that are fundamentally secular.

This paper critically explores key aspects of the increasing gulf between traditional Christian bioethics and the moral reflections that dominate contemporary secular bioethics. Orthodox Christianity appreciates, for example, the profound sinfulness of abortion and infanticide, of physician-assisted suicide and euthanasia; knowing that proper preparation for death is a central aspect of a Christian life. The established secular bioethics, in contrast, accents entitlements to medical choices that are judged integral to the realization of important life projects, such as the ready availability of abortion, infanticide, and physician-assisted suicide. Unlike secular bioethics, Christianity recognizes suicide and assisted suicide as self-murder and assisting in self-murder. It is not just that the contemporary culture is moving towards affirming rights to physician-assisted suicide and voluntary active euthanasia, but, more significantly, the new morality and bioethics that are emerging accept physician-assisted suicide and euthanasia because they have demoralized choices in these matters to issues of death-style decision making. As this paper argues, end-of-life care, in particular palliative care, is regarded in merely immanent terms as a cost-effective approach to treating the morbidity of patients in the last months of their lives, rather than to regard such care as a support in the preparation through proper repentance for death.

2. Palliative care after God and after Metaphysics: the immanentization of morality

To borrow an observation from Jürgen Habermas, as a field of inquiry secular bioethics begins all moral analysis from the perspective of methodological atheism; that is, with the foundational assumption that there is no God. In his recent reflections, Jürgen Habermas has contrasted a theistic methodological postulate with an atheistic methodological postulate in his critical explorations of Science, morality and politics. His analysis concerns which foundational assumption – theism or atheism – should guide moral discussion, accounts of the reasonable and the rational, public deliberation, institutional guidelines, and social policy decision making. Habermas rightly notes that such starkly contrasting underlying postulates create deep divisions in the moral analyzes that guide judgment about the appropriate contours of social debate and the proper objectives of public policy [1, 2].

As a result, in its rejection of Christianity, contemporary biomedical ethics places persons, rather than God, in authority to define the right, the good, and the virtuous. Thereby severed from any transcendent account of moral truth, human flourishing is not to be found in submitting to God or living within the

richly textured life of Traditional Christianity; instead, cardinal moral value is assigned to individual liberty conceptualized as autonomous self-determination. As H. Tristram Engelhardt, Jr. argues: “These changes also reflect an independent shift in accent towards individual authority. This shift brought into question the role of the family in determining what should be told to a family member receiving medical care. At stake was a widespread change in who was accepted in the dominant culture as an authority for health care decisions. The authority of physicians, the clergy, the family, and traditional authority figures was displaced by the authority of autonomous, rights-bearing individuals. The result was the disestablishment of those who had traditionally been in authority for giving advice and direction with regard to health care, namely, respected physicians, priests, rabbis, and ministers” [3]. Having marginalized traditional religious concerns, personal autonomy has been highlighted as integral to human good and human flourishing, with individuals choosing life values, private perceptions of virtue, and moral content for themselves. Even killing with consent and assistance in self-killing have been demoralized in their significance to a personal choice regarding death-style, thus deflating as well the significance of end-of-life care, which is the primary focus of palliative care.

For example, the modern hospice movement, and its accompanying palliative care, is regarded merely in immanent terms as a cost-effective approach to treating the morbidity of patients in the last months of life. Physician Cicely Saunders founded the first modern hospice, St. Christopher’s Hospice, in a suburb near London, to address the symptoms of distress and pain that frequently accompany the dying process. The National Hospice and Palliative Care Organization defines palliative care as “Treatment that enhances comfort and improves the quality of an individual’s life during the last phase of life. No specific therapy is excluded from consideration. The test of palliative care lies in the agreement between the individual, physician(s), primary caregiver, and the hospice team that the expected outcome is relief from distressing symptoms, the easing of pain, and/or enhancing the quality of life.” [National Hospice and Palliative Care Organization. *An explanation of Palliative Care*, online at <http://www.nhpco.org/i4a/pages/index.cfm?pageid=4646>] Rather than appreciating dying as raising profound religious concerns, the dying process is reduced to mere physical symptoms and the potential for personal psychological disquiet. The psychological distress of dying is, for example, often summarized through a five step process: denial, anger, bargaining, depression, and acceptance [4, 5].

Insofar as religious concerns are taken into consideration, they are deflated into forms of psychological distress. For example, while the World Health Organization suggests that spiritual interests be integrated into palliative care, it reduces spirituality to a special genre of psychological wellness. “Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical,

psychosocial and spiritual” [WHO definitive of palliative care, online at www.who.int/cancer/palliative/definition/en/]. As *Last Acts*, a palliative care organization, summarizes:

Palliative care looks after the medical, emotional, social and spiritual needs of the dying person. It...

- offers ways for you to be comfortable and ease pain and other physical discomfort;
- helps you and your family make needed changes if the illness gets worse;
- makes sure you are not alone;
- understands there may be difficulties, fears and painful feelings;
- gives you the chance to say and do what matters most to you;
- helps you look back on your life and make peace, even giving you a chance to grow [*Means to a Better End: A Report on Dying in America Today*, Last Acts, 2002, online at <http://www.rwjf.org/files/publications/other/meansbetterend.pdf>].

Here the goal is ‘psychologically therapeutic’ but not Christian; one is to make peace with one’s past actions rather than to repent of them; to manipulate one’s sense of well-being, rather than to seek forgiveness for one’s sins. As Philip Rieff puts the point: “By this time men may have gone too far, beyond the old deception of good and evil, to specialize at last, wittingly, in techniques that are to be called ... ‘therapeutic,’ with nothing at stake beyond a manipulatable sense of well-being” [6]. Secular bioethics seeks a rational death, free of physical or psychological discomfort, so as to preserve individual autonomous choice and personal dignity. Such a concern with personal autonomy and ‘death with dignity’ underlies the secular endorsement of physician-assisted suicide [7, 8]. In a culture of permissiveness and self-satisfaction, immanent concerns predominate.

As a result, the palliative care movement is now conceived, even by many purported Christians, in thoroughly immanent terms. At best, many Christians forward palliative care as an alternative to physician-assisted suicide and euthanasia, arguing that good palliative care can sufficiently ameliorate the morbidities at the end of life so as to undermine temptations to engage in physician-assisted suicide and euthanasia. In doing so, the meaning of palliative care is placed fully within the horizon of the finite and immanent. The immanentization of palliative care, however, separates medical treatment from the governing goal that Christians have traditionally recognized as core to end-of-life care: the work of final repentance.

Christians know that death should be approached with humility and repentance, with prayer and confession, so as to be able to stand at Christ’s dread judgment uncondemned. Orthodox Christians do not ask God for a ‘death with dignity’; but instead: “That we may complete the remaining time of our life in peace and repentance, let us ask of the Lord” [9]. A petition that is read as part of a litany in Vespers, Matins, and Divine Liturgy states: “A Christian ending to our life, painless, blameless, peaceful; and a good defence before the dread judgment Seat of Christ, let us ask of the Lord” [9]. In Western Europe of the

fifteenth century, the *ars moriendi* movement provided detailed advice, including specialized books, on achieving a proper death. Such volumes admonished the dying to avoid sinful temptations (e.g., lack of faith, despair, impatience, spiritual pride and avarice), encouraged the family and other caregivers to remind the dying of the redemptive power of Christ's love, and provided a list of prayers to be said for the dying [10, 11]. As Allen Verhey describes, in the past: "The rituals were simple enough. After acknowledging the imminence of death with a certain ambivalence, expressive at once of regret and resignation, the dying person said good-by to his family and friends, forgiving them and asking forgiveness, blessing them and instructing them, and commending them to God's care and protection. Having said his farewells, the dying person would pray, confessing his sins and commending his soul to God" [12]. In contrast, the modern secular world seeks a painless and psychologically comfortable death through palliative medicine, often in one's sleep and without warning, perhaps with good financial planning, but surely without the labour of repentance and spiritual preparation. The challenge, though, as Traditional Christians realize is that dying well, like living well, takes thought and effort.

3. Palliative care in a secular idiom

The proposal to regard palliative care as properly focused on assisting patients in their preparation for final judgment constitutes a major affront to the now dominant secular culture. It is a challenge in threatening to re-moralize end-of-life decisions and to insert transcendent concerns in a secular culture that is in principle opposed to such an ingression of ultimate meaning. The dominant bioethical and political ideologies of the contemporary Western world have come to be not merely secular, but often passionately atheistic. Throughout Western Europe and North America, for example, there is a growing movement to undermine the salience of religious discourse, to undue its influence in the public forum, and to erase religion from the public space. Attempts to frame all of medicine within a completely secular morality, relegating religious belief and practice to the realm of private personal choice, have become ever more prominent. In law and public policy there has been a profound rupture from Traditional Christianity.

For secular activists, the social goal is fully to sever the dominant, contemporary culture from the Christianity that had framed the West for more than one and a half millennia. Consider, for example, the passionate rejection of secularists even to permit in the preamble of the European Union's 2003 proposed Constitution a factual mention of the 'Christian roots of Europe'. The European parliament even reportedly rejected any mention of Europe's 'Judaeo-Christian roots' [13]. Consider also the United Kingdom legal case of Caroline Petrie, a Christian nurse, who was suspended for offering to pray with a patient [14]. Such secularism – its ethics and bioethics as well as its political ideological commitments – strives to be essentially different from Christian culture. It is a secular movement with a laicist zealotry maneuvering to relegate

Christianity in particular, and other religions in general, but especially traditional monotheistic religions, to the distant and superstitious past. It is committed to utilizing political and social institutions, as well as fully secular non-religious moral constructs, to reshape culture, society, and bioethics, rejecting both God and the transcendent [15, 16]. The secularization of palliative care is integral to a secular recasting of medicine, which among other things eliminates conscience clauses. One is to live in a fully secular practice of Medicine.

For example, legal limits are urged on the ability of physicians and nurses to refuse to participate in such services as abortion and physician-assisted suicide on religious grounds. Julie D. Cantor argues that it is unprofessional for physicians conscientiously to refuse to participate in abortion services. "Conscientious objection ... is worrisome when professionals who freely choose their field parse care and withhold information that patients need. ... Conscience is a burden that belongs to the individual professional; patients should not have to shoulder it." [17]. Similarly, Bernard Dickens asserts that conscientious objection is unethical because it treats patients as a means to achieve personal spiritual ends [18, 19]. The moral concerns of physicians not to be involved in what they know to be murder is cast as less important than the liberty interests of women, who might wish to terminate a pregnancy. Appeals to conscience, it is asserted, should have no bearing on medical options offered to patients; all options, including abortion, it is claimed, should be presented, so that women can autonomously choose for themselves. The purported liberty rights of patients to at will abortion services, it is urged, ought to trump the forbearance rights of physicians not to be used in ways to which they deeply morally object. What is lost here, however, is any adequate acknowledgement of the ways in which physicians are being reduced to mere technical functionaries, who serve the autonomous ends of their patients [20].

Within palliative care, secularization means that all reference to the transcendent must be eliminated and spirituality reduced to a form of psychological wellness. Authentic Christianity undermines such secular goals. Christians know that properly practiced and lived, religion is spiritual therapy sought through repentance (*metanoia*, a changing of the heart towards God); secular morality appreciates religion as, at best, a psychologically comforting practice for those so weak as to need such consolation. Consequently, a Christian palliative care physician categorically condemning physician-assisted suicide and/or euthanasia becomes a prohibited intrusion of authentic religion into the now secular discourse of a secular profession.

4. A Christian ethics of palliative care: a needed reaction against the threat of secularization

If Christians take it to be sufficient for palliative care to ameliorate the morbidities at the end of life because this will serve as a protection against the widespread use of physician-assisted suicide and euthanasia, the result will be the further displacement of Medicine within a thoroughgoing secular discourse.

It will no longer be appropriate for physicians to ask dying patients, “Have you prepared with repentance for death?” “Do you need to see a priest so that you can confess your sins?” All such discourse has been rendered non-professional because the profession of medicine is now fully secular due to the secular culture. Christians need to reclaim the recognition of the obligation of physicians and other healthcare professionals to tend not only to physical and psychological, but also truly spiritual needs as integral to palliative care. These spiritual needs must not be reduced to the immanentized discourse of spirituality, which allows one to hint at a transcendent reality but never to take it seriously.

Christian bioethics must resist the immanent reduction of palliative care to concerns that can be articulated without reference to final judgment and to God. Properly framed medical decision making requires recognizing that all persons are in a relationship with God. This core relationship exists regardless of whether particular individuals choose to recognize this fact of the matter. As John Romanides notes, everyone is destined to see the glory of God; the question is whether they are properly prepared so as to experience it as an exceedingly sweet light or are they destined to experience it as a devouring fire: “... everyone throughout the world will finish their earthly course in the same way, regardless of whether they are Orthodox, Buddhist, Hindu, agnostic, atheist, or anything else. Everyone on earth is destined to see the glory of God. ... And since all people will see God’s glory, they will all meet the same end. Truly, all will see the glory of God, but not in the same way – for some, the glory of God will be an exceedingly sweet Light that never sets; for others, the same glory of God will be like a “devouring fire” that will consume them. We expect this vision of God’s glory to occur as a real event. This vision of God – of His Glory and His Light – is something that will take place whether we want it to happen or not. But the experience of that Light will be different for both groups.” [21].

Where secular bioethics finds itself obsessed with self-gratification, personally defined accounts of human flourishing, appropriate life-styles and death-styles, Christians are concerned to learn how best to orient themselves, their families and children towards God. Consequently, the professional commitments of palliative care physicians and nurses must be recognized as posing serious questions to patients about what help they need in repenting for their sins and reconciling themselves with God before death.

5. Conclusion

Without God, morality is no more than what humans make of it; its content and theoretical construction are contingent and socio-historically conditioned. Without God, and His uniquely objective understanding of reality, moral truth, human flourishing, and even the deep moral intuitions of bioethicists are no more than particular human creations. As Gianni Vattimo expresses the nature of our postmodern predicament, cut off from God and His

uniquely True perspective on reality: “In a beautiful passage from *The Twilight of the Idols*, Nietzsche tells us how the real world has become a dream. It was the Platonic world of ideas that gave us the idea of the real world in the first place. Later, the real world was construed as the promised world after death (at least for the righteous). Still later, in the mind of Descartes, the thought of the real world was evidence of clear and distinct ideas (but only in mind). With positivism the real world became the world of experimental verified truths and then a product of the experimental scientist . . . At this point, the so-called real world has become a story that we tell each other.” [22]. Max Horkheimer (1895–1973) summarized a similar conclusion: “To seek to salvage an unconditional meaning without God is a futile undertaking” [1, citing 23, p. 95]; and “With God dies eternal truth” [1, citing 23, p. 99]. Without God to secure objective being and objective knowledge of reality, the world is no more than the various narratives we tell each other – each narrative potentially embodying very different socio-historically conditioned interpretations of reality. Richard Rorty (1931-2007) recognized this state of affairs when he acknowledged that “there is no way to step outside the various vocabularies we have employed and find a metavocabulary which somehow takes account of *all possible* vocabularies, all possible ways of judging and feeling. A historicist and nominalist culture of the sort I envisage would settle instead for narratives which connect the present with the past, on the one hand, and with utopian futures, on the other” [24]. Absent God, there exists no standpoint outside of particular cultural socio-historically conditioned perspectives from which to communicate any deeper perspective of reality or of the bioethics that such a perspective on reality would secure. Without appeal to God, and His unique perspective on reality, morality and bioethics are trapped in immanence.

Consequently, Christian bioethics and secular bioethics have become two quite different, often contradictory, practices and, as illustrated, the gulf between the traditionally Christian and the devoutly secular continues to widen. The plight of palliative care in our contemporary culture is the plight of any institution in this culture: the surrounding secular culture demands that palliative care be understood in fully secular and immanent terms. Christian physicians and nurses, the culture to the contrary notwithstanding, have the obligation to resist the secular deflation of end-of-life care and the demoralization of end-of-life decision-making. If the secular culture has its way, it will reduce palliative care to a fully immanent undertaking. All of this will occur while wrapping this secular profession in the mantle of virtue; namely, as a profession that cares for the dying, ameliorates their suffering, and is tolerant of the beliefs of all its patients. However, just as physicians owe their patients warnings about the dangers of smoking, palliative care physicians and nurses owe their patients warnings about the eternal dangers of dying unrepentant. No matter how attentive to the physical and psychological needs of patients palliative care might be, if it fails to support the true spiritual needs of repentance, it will be a perverting and distorting undertaking.

References

- [1] J. Habermas. *Religion and Rationality: Essays on Reason, God, and Modernity*, E. Mendieta (ed.), The MIT Press, Cambridge, 2002, pag.
- [2] J. Habermas, *Between Naturalism and Religion*, English translation by C. Cronin, Polity, Cambridge, 2008, pag.
- [3] H.T. Engelhardt, Jr., *Introduction: Bioethics as a global phenomenon*, in *Regional Perspectives in Bioethics*, J.F. Peppin, and M.J. Cherry (eds.), Swets & Zeitlinger, Lisse, 2003, xviii.
- [4] E. Kübler-Ross, *On Death and Dying*, Routledge, New York, 1969, pag.
- [5] E. Kübler-Ross, *On Grief and Grieving: Finding the Meaning of Grief through the Five Stages of Loss*, Simon & Schuster Ltd, New York, 2005, pag.
- [6] P. Rieff, *The Triumph of the Therapeutic: Uses of Faith after Freud*, Chicago: University of Chicago Press, Chicago, 1987, 13.
- [7] G.K. Kimsma and E. Van Leeuwen, HEC Forum, **19** (2007) 365-373.
- [8] S. Reiter-Theil, M. Mertz, and B. Meyer-Zehnder, HEC Forum, **19** (2007) 341-364.
- [9] ***, *Service Book of the Holy Eastern Orthodox Catholic and Apostolic Church According to the use of the Antiochian Orthodox Christian Archdiocese of North America*, 10th edn., Antiochian Orthodox Christian Archdiocese of North American, Engelwood, 1997, 108.
- [10] M.C. O'Connor, *The Art of Dying Well: The Development of the Ars Moriendi*, Columbia University Press, New York, 1942.
- [11] D.W. Atkinson (ed.), *Crafte and knowledge for to dye well*, in *The English ars moriendi*, vol. 5, Peter Lang, New York, 1992, 1-20.
- [12] A. Verhey, *The Christian Art of Dying: Learning from Jesus*, Eerdmans, Grand Rapids, 2011, 11.
- [13] I. Black, The Guardian, **May 24** (2004), online at <http://www.guardian.co.uk/world/2004/may/25/eu.religion>.
- [14] C. Gammell, The Telegraph, **February 07** (2009), online at www.telegraph.co.uk/news/religion/4537452/Nurse-Caroline-Petrie-I-will-continue-praying-for-patients.html.
- [15] H.T. Engelhardt, Jr., *Politeia*, **26(91)** (2010) 59-79.
- [16] H.T. Engelhardt, Jr., *Notizie di Politeia*, **26(97)** (2010) 59-79.
- [17] J.D. Cantor, *New Engl. J. Med.*, **360(15)** (2009) 1484-1485.
- [18] R.J. Cook and B.M. Dickens, *Int. J. Gynecol. Obstet.*, **106(2)** (2009) 106-109.
- [19] B.M. Dickens, *Medicine and Law*, **28(2)** (2009) 337-347.
- [20] T.M. Pope, *Journal of Clinical Ethics*, **21(2)** (2010) 163-176.
- [21] J.S. Romanides, *Patristic Theology*, Uncut Mountain Press, Thessaloniki, 2008, 47.
- [22] G. Vattimo, *Toward a nonreligious Christianity*, in *After the Death of God*, J.W. Robbins (ed.), Columbia University Press, New York, 2007, 39.
- [23] M. Horkheimer, *Gespräch mit Helmut Gumnior*, *Gesammelte Schriften*, Frankfurt, 1985-1991.
- [24] R. Rorty, *Contingency, Irony, and Solidarity*, Cambridge University Press, New York, 1989, xvi.