

Preparing the Community At Large For A Good Death

The Church's Role in Understanding End-of-life Issues and Providing Compassionate Alternative Care For the Sick and Dying

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There is a time for everything...a time to be born and a time to die.... (Ecclesiastes 3:1,2)

Over the past fifty years, attitudes concerning medical care have dramatically shifted from a paternalistic approach (i.e., doctor knows best) to an autonomous or self-chosen scheme that allows individuals more freedom in making their own personal health care choices and decisions. This growing respect for autonomy is gaining greater acceptance by the general population, especially in end-of-life issues. Many people in the United States and other western nations believe medical treatment for the terminally ill and those suffering from painful diseases can actually prolong an individual's misery, as well as generating undue financial burdens. As American society begins to ponder and consider the benefits of life-ending medical solutions, such as euthanasia and doctor-assisted suicide, will the acceptance of these practices create an atmosphere where the dying are truly treated with dignity, or will it produce an uncompassionate nation that views the elderly, terminally ill and handicapped in only selfish terms?

It is very important that the ethics of care and cure do not go to the extreme of trying to preserve life at all costs, or in other words, making life into a god; or conversely, allowing unethical practices to pressure individuals into thinking it is their duty to die. The Book of Ecclesiastes clearly states that there is a time to live and a time to die, but each individual, made in the image of God, should not be placed in any medical situation that intentionally puts him or her in harm's way.

As earth's human inhabitants began the 21st Century with an official world population of six billion people, many perspectives from various scientific, legal, political and social authorities continued clashing to control the way societies function. Technological advances are pushing many vocations, especially the medical profession, into a growing number of ethical dilemmas that require wise discernment and gracious application. More than ever, the Christian viewpoint on end-of-life issues needs to be vigorously exercised, not only in religious circles, but also in the secular marketplace of ideas. Regrettably, much public policy discussion of bioethics does not consider the religious point of view as valid.

To be sure, religious reflection on complex issues has at times not been helpful, but public policy is formulated today in a way that appears to be biased against any contribution of religious perspectives and fails to appreciate the productive contribution these various perspectives can make (Rae and Cox, p. 52, 1999).

It is against this bias that Christians are tempted to give up or compromise the biblical approach in order to win approval from secular critics.

No "watered-down" compromise is really necessary, but a Christian strategy to better relate to the public in bioethical matters is warranted. This new strategy needs to first promote Christian theology and principles into terms the secular world can initially understand, and then without apology provide biblical arguments to complex bioethical issues. There is an old gospel hymn that

states, “they will know we are Christians by our love.” This simple but profound song reveals a blessed truth that the Lord has used effectively in the past, and He desires the Body of Christ to continue this expression of love in both word and deed, so that the fallen world will see Christ in each believer.

End-of-life issues are not just concerns for doctors, terminally ill patients and bioethicists. They are everyone’s concern, especially that of Christians. Many individuals and groups throughout the world have developed “final” solutions to approach or remedy the “sting of death” in ways contrary to biblical truths. Unfortunately, numerous doctors, nurses, lawyers, politicians, educators and scientists have a distorted concept of “love” when dealing with end-of-life issues. In fact, many of these professionals no longer believe in any “absolutes” that guide their ethical decision-making process. A disturbing number of doctors now look at the Hippocratic Oath as outdated, and are willing to assist in the voluntary and involuntary killing of their patients.

To counter this “culture of death,” it is imperative that an effective Christian worldview be put into practice. This can be done by first educating church congregations on end-of-life issues, then interacting with the community at large with solid arguments against euthanasia and doctor-assisted suicide, providing compassionate alternatives to people facing end-of-life issues. If the Christian perspective on bioethics remains static or segregated from the culture, the future outlook for the aging “baby boomer” generation is not promising. The foundation for America to embrace euthanasia and doctor-assisted suicide is beginning to take root. Dr. Richard Swenson, M.D. describes it this way:

There will be more and more people living longer and longer with more and more chronic diseases taking more and more medications (that are even more expensive), using more and more technology, with higher and higher expectations in a context of more and more lawyers. These trend pressures are all increasing, and the convergences are exponential. Do the math (Bioethics in the New Millennium Conference, July 20, 2000).

Even though Americans are living longer, their general overall health is not very good. For instance, as people grow older, medical expenses increase, which suggests a decline in health.

It is estimated that per-capita hospital spending of the sixty-five-and over group is more than 250% higher than that of the under-sixty-fives, and the eighty-five-or-over group is 77% higher again. All of these factors contribute to a climate in which many are calling for legislation to legalize and regulate various forms of euthanasia (Feinberg and Feinberg, p. 100, 1993).

In the early 1900’s there were some organizations in America that promoted euthanasia even though public opinion and U.S. law reflected opposition to the practice. In more recent years a greater tolerance of euthanasia and doctor-assisted suicide has been the trend. “For example, in 1973 a Gallup Poll asked if in cases of incurable disease, doctors should be allowed to end a patient’s life by some painless means if the patient and his family request it. Of those responding, 53% said yes” (Feinberg and Feinberg, p. 102, 1993).

Proponents of using various forms of euthanasia or doctor-assisted suicide claim that their efforts are focused primarily on helping the terminally ill patient end life in a dignified manner. Similar reasoning was used in the early 1970’s when supporters of reproductive rights said they were only interested in providing legal, safe and limited abortions for Americans. After 38 years of unrestricted abortion in the United States, the number of deaths and methods of destroying our

future generations are mind numbing: over 50 million babies killed, and procedures that unmercifully tear off limbs or suck the brains out of helpless children.

It does not take much insight to see that our nation is on a “slippery slope” of moral decline as it continues to execute approximately 3300 “young ones” each day in the name of choice. Will Americans also succumb to the temptations of voluntary and involuntary euthanasia and doctor assisted suicide? The following examples should give an adequate snapshot into the direction America is heading concerning end-of-life issues, as well as provide the incentive for promoting effective, humane, Christian alternatives to better prepare the community to support those who are sick and dying:

I do not recommend the plastic bag alone (as prisoners who are suicidal are sometimes obliged to do). It is thus necessary to have taken a fair amount of sleeping pills to eliminate that slight discomfort... So, the plastic bag should be loose, but not huge since that will take longer. The pills should be fast-acting sleep inducers... Should you use a clear plastic bag or an opaque one? That’s a matter of taste. Loving the world as I do, I’ll opt for a clear one if I have to (Humphry, pp. 97-98, 1991).

The quote above was taken from *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying* by Derek Humphry, founder of the Hemlock Society and the Euthanasia Research and Guidance Organization. Mr. Humphry wrote *Final Exit* in 1991 to supposedly help people end their lives when in unbearable, incurable suffering. The book found many interested subscribers and remained on the New York Times bestsellers list for 18 weeks, and continues to sell additional copies every month in North America.

In November, 1994, the voters of Oregon passed an initiative measure (Measure 16) which allowed terminally ill patients to request a prescription of lethal drugs from a doctor enabling them to commit suicide. The passage of this measure placed Oregon as the first jurisdiction in the world to legalize doctor-assisted suicide. In 1997 Measure 16 was back on the November ballot under a new measure (Measure 51) for reconsideration and repeal, but it lost, allowing assisted-suicide to be permanently established in Oregon. The Oregon Department of Human Resources 1999 Annual Report said that 43 individuals had died from doctor-assisted suicide since the defeat of Measure 51.

In 1999 Princeton appointed Professor Peter Singer to its faculty as the deCamp Professor in the University Center for Human Values. Peter Unger, a distinguished New York University philosophy professor, recently wrote a letter to the *Wall Street Journal* stating, “...this world-renowned Australian may well be the most prominent professor his country has ever produced; by many measures, he’s the most influential ethicist alive.” Singer, who is a founder of the animal-rights movement, believes infanticide is an ethical act. “He believes that medically defenseless people should be killed if it will enhance the happiness of family and society... Singer is now so mainstream that he even wrote the essay on ethics for the *Encyclopedia Britannica*” (Smith, p. 1, 1998).

Dutch courts during the latter portion of the 20th Century have agreed not to allow the prosecution of euthanasia cases, as long as certain conditions were met. This tolerance toward euthanasia has not only produced a substantial number of voluntary deaths, but has opened the door to a disturbing number of involuntary deaths. Earlier Dutch proposals contained a number of provisions including conditions involving children. For example, Provision 5 states:

Children between the ages of 12 and 16 must have their parents' consent in order for a request for euthanasia to be granted. However, in cases deemed "exceptional,"—e.g., those marked by serious and incurable disease or intolerable and unrelenting suffering—a physician may grant a request for euthanasia even without parental consent (Jochemsen, p. 1, 1999).

The Netherlands has gone from tolerating euthanasia to legalizing the practice under very specific cases by creating the "Termination of Life on Request and Assisted Suicide (Review Procedures) Act," which took effect on April 1, 2002.

Many believe the United States will follow the Dutch example concerning end-of-life issues in the not-too-distant future. Oregon has already set the framework for allowing physician-assisted suicide to move into other states across the nation. The state of Washington has passed a similar law with strong movements to legalize doctor-assisted suicide in Montana, Connecticut and Massachusetts. Active "right to die" advocates in judicial law, education, government and the media are challenging the mindset against euthanasia by influencing the general populace to accept their agenda. Their arguments foster two ideas: respect for autonomy (i.e., it's my life, so let me decide how to end it) and compassion (i.e., not allowing prolonged intense suffering).

Derek Humphry believes the right to die movement has gained a great deal of momentum over the last four decades, especially since the U.S. Supreme Court legalized abortion in 1973. When the highest court decided it was perfectly legal to terminate a pregnancy and kill the unborn baby (established on the basis of one's right to privacy), an openness to euthanasia began to germinate and steadily gain acceptance.

Once the privacy principle was legally established in the *Roe* case so as to allow the taking of human life, it became increasingly difficult, if not impossible, to brake the descent. A momentum has been established in which the former presumption in favor of human life has given way to many forms of rationalization and excuses for the taking of human life (Stewart et al, p. 27, 1998).

Is there a strategy or decision-making process that can be followed, to empower Christians to rightly handle the troubling aspects that surround end-of-life issues? Can a truly Christian perspective on the care and treatment of the sick and dying be properly recognized within a culture that is dominated by a secular bioethics philosophy? Are there alternative methods of medical care and practice that the Christian Church can embrace, providing loving, compassionate physical and spiritual support to the terminally ill? These and other questions need to be answered by the Body of Christ in ways that will hopefully change the face of health care in the United States. However, before addressing these questions, it is important to define and understand euthanasia and doctor-assisted suicide.

Euthanasia is derived from two classical Greek words, *eu* meaning "good" and *thanatos*, meaning "death." In other words, euthanasia literally means "good death." In general, euthanasia refers to the process by which people's deaths are manufactured or intentionally terminated by themselves (i.e., suicide) or others (i.e., assisted suicide or mercy killing). Euthanasia is usually associated with individuals wanting to end their lives because of terminal illness or unbearable suffering. Terms and definitions surrounding euthanasia can sometimes be confusing and deceptive. The most common terms are: voluntary, involuntary, nonvoluntary, active, passive, direct and indirect euthanasia. These seven terms, along with the concept of assisted suicide need to be understood thoroughly to reasonably discuss the subject.

If a person requests death or grants permission to be put to death, the resulting type of euthanasia is termed *voluntary*. This form of mercy killing is often considered equivalent to suicide. For euthanasia to be *involuntary* someone is put to death without requesting it or granting permission. What is termed *nonvoluntary* euthanasia occurs when somebody is killed by an individual who cannot obtain the patient's wishes, or chooses not to attain them.

Active and *passive* euthanasia are terms that focus on what kind of action takes place to end a life. *Active* euthanasia refers to initiating some deliberate action to cause someone's death; *passive* euthanasia is the removing of treatment already begun, or withholding medical care designed to prolong life.

The distinction is often equated with the ideas of commission (active) and omission (passive), and some see it as the difference between killing (active) and letting someone die (passive). Giving a lethal dose of drugs to someone diagnosed with AIDS is *active* euthanasia. Removal of Clarence Herbert's feeding tube is an example of *passive* euthanasia (Feinberg and Feinberg, p. 105, 1993).

The terms *direct* and *indirect* euthanasia signify the role played by the person who dies. *Direct* euthanasia refers to situations in which the person alone carries out the decision to die, while *indirect* refers to instances that involve somebody else carrying out the decision. *Direct* and *indirect* are not to be confused with *voluntary* and *involuntary*, because the latter terms refer to whether the individual requests or permits the deed, but does not take part in the actual act of killing himself.

In assisted suicide, especially doctor-assisted suicide, the whole concept of medical professionals as healers comes into question.

Assisted suicide is suicide that occurs when someone either provides the means by which a person ends his or her own life or otherwise enables the suicide to occur. Physician-assisted suicide is when the physician provides the assistance... "Physician-assisted suicide turns the healers into death-dealers, charged with the role of judging someone's quality and quantity of life. The only guide will be their own very fallible judgment" (Stewart et al, p. 22, 1998).

The various forms of euthanasia mentioned above are becoming increasingly prevalent in the western world today, especially in places like the Netherlands. On September 10, 1991, the Dutch Committee to Investigate the Medical Practice released a two volume report – popularly referred to as the Rimmelin Report. This report (formally entitled "Medical Decisions About End-of-Life. I. Report of the Committee to Study the Medical Practice Concerning Euthanasia. II. The Study for the Committee on Medical Practice Concerning Euthanasia") revealed what many feared, that despite long-standing, court-approved euthanasia guidelines developed to protect patients, Dutch doctors were actively killing many patients without their consent. According to the Rimmelin Report, in 1990:

* 10,615 lives, upon their request, were terminated by doctors. Breakdown of this total is as follows: direct killing of patients (2,300 cases), deliberate overdoses of pain medication (3,159 cases), intentional withholding or withdrawing of life-sustaining treatment (4,756 cases) and provision for doctor-assisted suicide (400 cases).

* 14,691 lives, without their expressed consent, were terminated by doctors. Breakdown of this total is as follows: direct killing of patients (1000 cases), deliberate overdoses of pain medication (4,941 cases) and intentional withholding or withdrawing of life-sustaining treatment (8,750 cases).

Even though the Dutch government set up supposedly safe guidelines for controlling the practice of physician assisted suicide and voluntary euthanasia, abuse by the medical community became very obvious. Certain definitions involving critical terms have been broadly interpreted by medical and legal professions, causing concern for patient care in Dutch hospitals. For example, the interpretation of the “unbearable pain” requirement reflected in the Hague Court of Appeals 1986 decision states that the pain guideline was not limited to physical pain. Though right-to-die advocates focus on their concern for the terminally ill and those suffering from extreme physical pain, their hidden agenda is to create a society that will allow individuals to die whenever they feel like dying.

The practice of euthanasia has moved from the terminally ill to the chronically ill, from those with physical illness to those patients with psychological distress, and from voluntary euthanasia to involuntary euthanasia. It seems possible that our future concern may not be merely sliding down the slippery slope of euthanasia but falling off its precipice (Stewart et al, p. 53, 1998).

As mentioned earlier, despite the evidence showing Dutch doctors actively killing patients without their consent, the Netherlands parliament still enacted a law in 2002 that legalizes and regulates euthanasia in accordance with due care.

The need for Christians to permeate society with a Godly perspective on death and dying, as well as creating compassionate solutions in caring for the dying, must be recognized, supported and practiced by the greater body of believers, if the culture of death is going to be effectively kept in abeyance or defeated. Biblical truth must be the basis of ethical thinking and decision-making concerning end-of-life issues. Once believers understand their stance on the many unsettling problems emerging from these issues, they need to be discerning in presenting a Christian perspective to other cultures and religious backgrounds.

Theological views must be communicated in a way that is persuasive to this public policy sector without excessive reliance on a worldview that it does not accept. This is not to say that appeals to Scripture and theology are not important, but since many public policy makers do not accept the Christian view of the world and thus do not frame the issues in this way, it is important not only to help them see the issues from within a Christian framework but also to make sense of a Christian perspective on the issue without dependence solely on Scripture and theology (Rae and Cox, pp 282-283, 1999).

To help develop sound Christian approaches and decision-making processes in bioethical issues, understanding the secular approach to bioethics is essential.

The field of bioethics is a relatively new discipline that blossomed in the mid-1960s, initially allowing religious perspectives to be voiced in relation to the growing number of issues and dilemmas confronting the medical profession. However, the tolerance for religious viewpoints was quickly marginalized when a wave of enthusiasm for human reason and individual autonomy took over the American mindset. This so-called “enlightenment” basically rejected theological and

religious contributions toward answering tough moral questions raised within the medical profession.

In fact, this marginalization of theological and religious perspectives had been accomplished by 1989, when the primary question at the Hastings Center symposium on “Religion and Bioethics” was, “What significance, if any, does [religion] hold for the ways we now do bioethics?” (Rae and Cox, p. 55, 1999)

The “enlightenment” movement created a secular philosophy of bioethics that celebrates individual autonomy over religious as well as political authority.

This ‘secular’ approach is characterized by several factors. First, for the most part it perceives ethical theories as primarily reduced to deontological [fixed moral order - certain things are right and wrong] and utilitarian [morally right if it produces the most utility] theories of ethics. Second, it develops principles and rules from the application of these two theories to the various scenarios faced by the medical community. Third, it usually, then, identifies four major biomedical principles: (1) autonomy [self chosen plan]; (2) non-maleficence [do no harm to others]; (3) beneficence [to help others]; and (4) justice [equals must be treated equally] (Rae and Cox, p. 55, 1999).

Many of the current secular bioethicists believe they can apply general ethical principles to medical situations because their model makes the assumption that medicine is value-neutral or valueless, that is, there are no real inborn moral relationships within medicine. The pattern by which secular moralists apply human reason to the four main principles listed above is a moving target. Secular bioethicists constantly adjust their worldview, believing there are always exceptions to the rules, duties, and principles that form their particular ethical theory. This avoidance of consistent “absolutes” in ethical approaches to complex moral issues leaves the secular viewpoint lacking insight and finality to the many problems facing the world today.

Once Western society separated itself from a religious perspective, it looked to a universal rationality to fill the gap left by the extraction of a common religious vision. However, the hopes of modernity have been slaughtered at the altar of confusion and diversity. Instead of reason providing one moral vision, it provided many outlooks (Rae and Cox, pp. 62-63, 1999).

It is for such a time as this that Christians are called to be faithful to Jesus’ command to be “salt and light.” There is a place for Christian bioethics in a secular culture. Christians can have a greater influence in public policy discussions of bioethics by boldly presenting ethically sound approaches to end-of-life issues, while providing Godly alternatives that truly care for the sick and dying. These two types of responses are key steps in effectively challenging secular approaches in bioethics.

Many bioethical issues and end-of-life technologies are not overtly addressed in the Bible. However, the Word of God offers something very special: a way of thinking that can be applied to the important questions of life. It is this type of thinking, fueled with biblical knowledge and Holy Spirit insight that can help Christians answer questions such as when to forego treatment for dying patients. Dr. John Kilner, Director, The Center for Bioethics and Human Dignity, sees three characteristics that consistently mark a biblical way of thinking. His idea of God-centered, reality-

bounded and love-impelled ethics introduces effective approaches with which Christians can address tough bioethical problems in both religious and secular environments.

For example, when facing the decision to forego medical treatment for someone who is dying, Dr. Kilner advises Christians to walk the issue through a biblical “ethical filter.” This situation suggests certain questions: “Is the patient willing?” and “Is death intended?” need to be answered in a way that is best for the dying person. A God-centered view sees men and women not merely as products of random chance in time, but in terms of their relationship with God. God-centered ethics cares more about who people are instead of who are people. This focus on people made in His image dismisses the worldly idea of excluding the unworthy or the unlovely (see Colossians 3:10-11), and refocuses the human community to live holy and God-honoring lives.

The Bible is an incredible source that reveals many aspects of reality that have tremendous ethical significance. For instance, the sanctity of human life is planted firmly in a biblical viewpoint of reality. However, if Christians are not careful, the sanctity of human life can be put on a pedestal, taking the place of God and becoming an idol.

Just as neglecting the sanctity of human life can lead to premature ending of it, idolizing life can lead to useless attempts to prolong life when life is unavoidably at an end...The best way to avoid either pitfall is to understand life’s particular place in the purposes of God in creation (Kilner, Miller and Pellegrino, pp. 74-75, 1996).

Individual freedom in God’s creation is another aspect of reality that allows people to live God’s way (e.g., love of God and neighbor) or not, while worldly freedom or autonomy keeps a person in bondage to whatever the self wants.

The third aspect or love-impelled ethic of a biblical way of thinking centers on what the apostle Paul calls “the most excellent way” (1 Corinthians 12:31). This ethic requires individuals to “look not only to your own interests, but also to the interests of others” (Philippians 2:4). “Yes, the patient is willing to forego treatment” or “No, death is not intended” could be appropriate responses from a God-centered, reality bounded approach, but discerning if the treatment will do more harm than good falls under the love-impelled ethic. Sensitivity to others in timing the foregoing of treatment is critical. There may be a circumstance in which the patient needs to resolve relational issues, so continuing the treatment actually provides a greater benefit that outweighs the burdens.

But in many other situations, with the benefit of the best available medical counsel, patients can recognize that their death is at hand. They ethically forgo treatment in such situations not because they intend death—life to a significant degree cannot continue even with treatment – but because treatment will only add suffering to dying (Kilner, Miller and Pellegrino, p. 80, 1996).

As Christians develop ways of thinking shaped by Scripture to address the many ethical problems facing our world, a second response is required to stem the pressures to overtreat, undertreat or terminate the sick and dying. Innovative approaches in hospice, long-term care, parish nursing and home health care are creating opportunities for the Christian Church to lead in compassionate alternative care. For many people the idea of opening their homes for a stranger’s health care needs or volunteering their time, money and other resources to assist in long-term care for family, friends or relatives is absolutely foreign. Many Christians who are not medical professionals don’t see themselves as healers or care givers. This way of thinking needs to end. To put it bluntly, Christians need to seek God’s direction in reaching out to the sick and dying (see

Matthew 25: 31-40). The Christian community needs to return to the “love” mandate that commands believers to care for others. The combination of what the Body of Christ proclaims and what believers do with those proclamations will either show the world they are Christians by their lust or by their love.

Two fundamental concerns that people suffering from a terminal illness fear the most are living in unbearable pain and dying alone. Hospice care combines a team concept of doctor, nurse and volunteers who shepherd patients through the physical, social, psychological and spiritual dimensions of pain. This whole-person-care approach provides the needed social and spiritual support to the patient and family through the last days or months of terminal illness. Hospice physicians and nurses see themselves as “enablers” who provide options to their patients, and are committed to relieving symptoms. These enablers create an atmosphere of love and trust that can ease the anguish of dying. The hospice doctor and nurse see themselves coming alongside their patients and accompanying them through the death process. The volunteers, whether or not they have medical credentials, have opportunity to reassure patients of their worthiness through social and spiritual interaction with them, as well as communicating any patient fears or concerns to the other hospice team members.

Volunteers often assist in what is known as ‘biography therapy’ – the creation of a scrapbook, tape recording, a collection of letters, etc. – that allows the patient to see death in a context of life and not as an isolated experience. Patients may more readily share fears and questions with their volunteer than with the medical staff (Kilner, Miller and Pellegrino, p. 187, 1996).

Besides short-term hospice care, Christians need to champion improved alternatives in long-term health care, and help devise low-cost living options for the seriously disabled. Some may say that hospice and long-term care should be the responsibility of the government and established medical community. The problem with that line of reasoning is the fact that many of our politicians and professional guilds no longer value human life. Medical resources will become more and more stressed as the “baby boomer” generation ages. Few or no alternatives to the present health care system evolve, the pressures placed upon the secular world of medicine will naturally drift toward accepting euthanasia and doctor-assisted suicide. The current national health care plan passed by Congress in 2010 includes questionable provisions that deal with possible ration care that will affect everyone, especially the elderly and the terminally ill.

Though the church has abdicated its role and responsibility in health care, it can return to its roots and minister to persons in need. “If Christians are going to take a stand, then the church should ‘put its money where its mouth is’. A recognition that barriers exist does not render institutional development untenable” (Kilner, Miller and Pellegrino, p. 203, 1996). Developing in-home transitional and independent living support and respite care are compassionate alternatives that could change health care trends in the United States. In the case of respite care, church communities could set up a network in which Christians open their homes for temporary care of the sick and dying, providing individuals who have been caring for seriously ill or dying family members a short hiatus from their caregiving. Permanent respite care homes or institutions could be developed by churches. It might be wise to integrate these alternatives with a group residential or transitional living homes. Opportunities for Christians to show God’s love and mercy in matters of health care are boundless. The phrase ‘death with dignity’ has a hollow sound when it is tied to euthanasia and doctor-assisted suicide. If the Body of Christ embraces its calling to provide compassionate alternatives in end-of-life issues, the sick and dying will experience truly “good

death,” “...that is, to die as we have lived, with interpersonal relationships, spirituality, and a sense of self intact” (Kilner, Miller and Pellegrino, pp. 183-184, 1996).

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