Ask the Doctors

Church Education Plan for End-of-Life Decision-Making

Leaders' Notes

The biblical analysis and practical advice offered in the leaders' notes have been road-tested, both in the hospital and in the classroom. The author is not a licensed attorney and legal observations should not be construed as legal advice. Concerning legal matters, users are encouraged to seek the advice of qualified legal counsel. The author is also not trained in medicine. His qualifications are only as a philosopher and teacher with experience and training as a hospital ethics consultant.

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Suggestions for Using These Leaders' Notes

I. This material assumes that at least one medical professional is willing to serve as an expert source of insight on medical matters. Ideally, two medical professionals would be willing to work together.
   A. Any physician would be able to serve effectively in this role, since physician training requires "rotations" through all the areas of practice, including intensive care and emergency services.
   B. Most experienced nurse practitioners would also be able to give authoritative answers, as would registered nurses who have cared for people near the end of life, including in hospice care.
   C. Physician's assistants with experience in the hospital setting would also be equipped to give helpful answers.
   D. Two or more physicians can work well together even when they do not agree on some issues. They are trained to work as colleagues and to handle disagreements productively.
   E. Having a physician and a nondoctor (nurse or physician's assistant) answer questions together can lead to some rough moments unless they have worked together before in another context. In general, physicians are not trained to listen to nonphysicians, and nurses are trained to give way to a doctor's judgment. This training even affects how Christian physicians and nurses relate to one another on health matters.

II. The focus of the sessions should be on the medical experts' answers to the questions given with the case studies and questions posed by the session participants (audience). It would help for the leader to be familiar with the notes below, but it is not crucial.

III. The Leaders' Guide for Session 1 includes extensive case notes to help in preparing for the first session. Extensive case notes are not provided for Sessions 2, 3, and 4 because it is best if the medical professionals take on the task of filling in the medical picture. Attorneys attending the sessions are *much* more likely to clarify legal matters, and elders or members of the pastoral staff can help the participants become comfortable with the ways that the sponsoring church talks about and handles cases like these.

IV. Note: *If the physicians, attorneys, or pastoral caregivers object to any of the answers proposed by this Leaders' Guide, it is best not to defend the answers in the guide unless the leader agrees with them. The goal is for all the participants to grow more confident in dealing with these cases. Local voices are much more valuable than the answers in this guide*.

V. The leader will need to make some decisions ahead of time about how the session will unfold. Some options:
   A. Announce the *issue* for the session (for the first session, it is "Must We 'Do Everything'?")

B. Read the first passage (John 10:1–18) or have someone in the gathering read it.
C. Optional: Say a few words about what light the passage sheds on the *issue*, possibly drawing from the observations offered under Biblical Reflection #1.
D. Pray (or ask someone else to pray), asking for the Spirit to draw the group together and lead the participants into the truth.
E. Read (or ask someone else to read) the first case study aloud.
F. Ask the doctors the questions one at a time; *or* ask the doctors to answer the question that seems most important; *or* ask the doctors to talk about what stands out to them about the case.

VI. What to do when things get tense:
A. Talking about anyone's death is difficult. Talking about the prospect of one's own death is even more difficult. Having doctors and nurses present to answer questions makes it unlikely that participants will be bored or wondering when the session will end.
B. Because the participants will be engaged with the issue, they will be more likely to be alarmed when someone else offers an opinion that disagrees with their own.
C. Concerning end-of-life issues, it is likely that the medical experts will say things to surprise (and maybe shock) some discussion participants.
D. Pray ahead of time that you will quickly see a way to de-escalate any tensions that arise, and that all participants will be supernaturally eager to *listen* rather than just to dig in their heels and be heard.
E. One way to cool things down is to say to the person who is shocked or disappointed, "I think I see what you are saying. May I try to put it into my own words?" Your restatement of the question or concern can remove the tone of distrust (or worse), focus on the central question, and express a willingness to discover that the matter is complex. And it will certainly be complex.

VII. Near the halfway mark in the time allotted for the session, determine whether it would be best to leave Case Study #2 for participants to think through on their own. If the discussion of Case Study #1 is lively, it may be best to let it run, leaving time to discuss the principles proposed at the end of this session.

VIII. Plan ahead how the session will end. If one of the medical experts is willing to close in prayer, that may be the best way to cap the conversation. (This allows the medical expert to get the last word, which is probably right, since he or she volunteered to help out.) Even in the midst of a tense discussion, you can always end things neatly by saying, "Oh, my; we are out of time. Dr. X, will you close our time with a word of prayer?" (Alerting the expert ahead of time that you might end this way would be nice, of course.)

IX. Many of the principles and recommendations discussed in this guide are explained in more detail—and with more attention to what the Bible says—in Bill Davis's *Departing in Peace* (Phillipsburg, NJ: P&R Publishing, 2017). Prof. Davis is also eager to answer questions sent by e-mail to bill.davis@covenant.edu.

FIRST SESSION

Must We "Do Everything"?

BIBLICAL REFLECTION #1: JOHN 10:1–18—THE TRUE SHEPHERD LAYS DOWN HIS LIFE

After healing the man blind from birth, Jesus dealt with the Pharisees who had expelled the man from the synagogue (John 9:34ff.). Jesus drew a contrast between the Pharisees (faithless thieves) and himself, the true Shepherd. He gave powerful reasons for trusting him to care for his sheep: He enters by the gate, and the sheep hear his voice and follow him. Most importantly of all, when he sees the wolf coming, the true Shepherd does not run away. He lays down his life for his sheep.

The picture Jesus drew of a shepherd willing to lay down his life for his sheep would have been easy for his listeners to imagine. They knew what shepherds did; they knew the threat that wolves posed. But his listeners may have marveled at the idea of a shepherd willing to die to save the lives of his sheep. Jesus wasn't talking about ordinary, literal sheep here. His sheep are people, and we can imagine someone loving people enough to die for them. As Jesus said later in John's Gospel, "Greater love has no one than this, that someone lay down his life for his friends" (John 15:13).

What is striking here is Jesus' teaching that his ultimate aim was not living as long a physical life as he could. Saving his sheep was more important than keeping his body alive as long as possible. As Jesus made clear, his life was not taken from him against his will: "No one takes [my life] from me, but I lay it down of my own accord. I have authority to lay it down, and I have authority to take it up again" (John 10:18). Jesus could have lived longer. He could have crushed his opposition by force or simply made them unable to recognize him. Because our redemption was more important, he chose a shorter physical life over a longer one in order to achieve something even more important than a longer life: our redemption.

Accomplishing our redemption is an outstanding spiritual good, and since it has already been done, we could never choose that end over living longer. But because Jesus chose our redemption over a longer life, we can know that extending physical life is not the ultimate goal. We can be as pro-life as Jesus and still believe that it is possible for some things to be more important than living as long as possible. A biblical concern for the sanctity of life can be consistent with passing up an opportunity to live longer. We may choose to pursue spiritual goods even when it may mean living a shorter life.

CASE #1

Mary is a 69-year-old believer who "beat" breast cancer ten years ago but has recently been diagnosed with stage 4 pancreatic cancer. Mary's oncologist is Dr. Smith,

who says that Mary's prognosis is not good. Although Mary was in good health before her first bout with cancer, she is now too weak to do much more than watch TV and have short visits from friends. Because of her experience with breast cancer, she knows firsthand what chemotherapy would involve for her: prolonged nausea, greatly diminished ability to concentrate, and incontinence that would make it embarrassing to entertain guests.

Dr. Smith is aware of an experimental trial of a treatment that might extend Mary's life by as much as nine months, but its side effects are likely to be even more intense than those that Mary experienced with her previous cancer treatment. Without this treatment, Mary is (humanly speaking) likely to die within two months.

CASE NOTES

I. *Medical background information:*
   A. Stage 4 pancreatic cancer is a condition that is very likely to be fatal. The five-year survival rate for people in this condition is under 10 percent.
   B. Mary's weakened state diminishes the likelihood that any treatment will be as effective for her as it would be for someone in good health. Her weakness also means that the side effects of any treatment are likely to be more severe than they would be in an average case.
   C. The scenario does not indicate the projected likelihood that the experimental therapy will make any difference at all. The medical professionals in your discussion can fill in what is likely in a case such as this. If no one is willing to offer an estimate, Mary is probably only about 30 percent likely to receive any benefit, and she is 80 percent likely to experience side effects that are as unpleasant as those attending her previous chemotherapy.
   D. Dr. Smith is aware of the experimental-trial option, but is not urging Mary to participate in it.

II. *Legal background information:*
   A. The law permits Mary to participate in the trial or decline to participate.
   B. If Mary were to participate in the trial, those conducting it (the doctors and other researchers) would be legally obligated to obtain Mary's *informed consent*. Her doctor's explanation of the experimental drug's likely side effects would be only the beginning of that process. The researchers would need to make sure that Mary understood the risks and benefits involved in her participation, that she was not clinically depressed or otherwise confused, and that she was making the decision voluntarily (not being coerced or deceived).

III. *Pastoral background information:*
   A. Mary's children are grown and live within a couple of hours' drive. Each of them has expressed a willingness to "cram" nine months of visits into two months if asked. None of them are hoping that Mary will die sooner rather than later.
   B. Mary's husband died four years ago from cancer. He had participated in an

experimental-drug trial, but did not see any clear improvements from it. Mary remembers that he was frustrated with many aspects of his involvement with the trial.

C. Mary is not afraid to die, and she is not looking for a way to hasten her own death.

FOR DISCUSSION

I. Is Mary biblically required to participate in this experimental trial?
   A. Saying that Mary *is* biblically *required* to participate in the experimental therapy is the same as saying that Mary would be *sinning* if she decided not to do so. The biblical grounds for thinking that it was sinful would center on thinking that the Bible calls us always and everywhere, no matter what, to extend life.
   B. If the experimental trial cost Mary absolutely nothing (in pain, isolation, spiritual deprivation, or money), then it would be at least reckless (and maybe sinful) for her to turn it down.
   C. But of course, no medical care is absolutely free.
   D. Because there are costs involved, Mary is facing an opportunity to lose physical comfort, time with family, and other goods in order to gain a few months of life.

II. Is Mary (sinfully or recklessly) "giving up on life" if she declines this treatment?
   A. It is not sinful for Mary to avoid the pain and suffering involved in the experimental treatment.
   B. If Mary were to neglect painless and effective treatment that would be likely to restore her to health, she would be wrongly forsaking God's provision for her. But the proposed treatment involves physical and spiritual burdens and is likely to be ineffective.
   C. We are not required to see all treatment possibilities as God's will for us.

III. What facts might be altered in this case to change the answer about whether participation is biblically required?
   A. If the experimental treatment did not have significantly burdensome side effects *and* if it was not a financial burden for Mary to use it, then it would be wrong for Mary not to try it.
   B. If Mary did not think the likely side effects would be a great burden, then no matter what her loved ones thought of the side effects, the balance of burdens and benefits would favor attempting the treatment.
   C. If Mary wanted to live long enough to see the birth of a grandchild or enjoy some other event scheduled to occur within the time that the treatment would probably "buy" her, then even with serious side effects she could judge that the benefits outweighed the burdens.

IV. What would Christian physicians and nurses want Mary and her family to think about in order to make this choice faithfully?
   A. Mary and her loved ones should pay close attention to what medical personnel are saying about her current condition and the likely changes in her condition both with and without the treatment.

BIBLICAL REFLECTION #2: ACTS 6:8–7:2; 7:51–60—THE STONING OF STEPHEN

When Stephen was hauled in front of the religious leaders, he must have known that they were eager for him to make a big mistake. Alarmed at the rapid growth of the group who preached and healed in the name of Jesus (Acts 4–5), the religious leaders were ready to make an example of someone. Asked to answer the false accusations made against him (6:13–7:1), Stephen chose to show that he knew the Law and the Prophets (7:2–50), to exalt Christ as the Lord of all, and to call the leaders to repentance (7:51–56). It was the most infuriating answer he could have given to teachers of the law, and they were plugging their ears as he finished. With barely a pause, they took him out and stoned him until he died.

Stephen died in defending the lordship of Christ. Like Jesus, he chose to live a shorter life in order to realize a spiritual good. Extending his earthly life as long as possible was not his ultimate goal. Stephen could have lived longer simply by keeping his answers brief and avoiding controversy. If his number-one priority had been living as long as possible, he would have kept quiet. Instead, he testified. He is commended for testifying of Christ even though it meant death, so we can know that the Bible does not teach that our number-one priority is living as long as we can.

Stephen chose a shorter physical life over a longer physical life *in order to achieve an even greater good than physical existence*. All martyrs who could have avoided their fate have made the same choice, and it is a pro-life choice: they are choosing one kind of life over another kind. Stephen did not choose death. He chose a life of honoring Christ even though it meant that others would kill him. In this, Stephen is following Christ's example. Christ laid down his life for his sheep; Stephen laid down his life for Christ's honor.

People nearing the end of life in failing health are not facing martyrdom. But because our chief end is to glorify God and enjoy him, living as long as possible is *not* our ultimate aim. When medical treatment needed to maximize length of life would keep us from glorifying and enjoying God, it may be time to stop the treatment. It may mean choosing a shorter life over a longer one in order to achieve more important spiritual goods.

When the Lord offered to grant Solomon one request (in 1 Kings 3), Solomon asked for wisdom to rule God's people. God granted his request, and God went on to say that Solomon had asked for the most important thing. He could have asked for long life or victory over his enemies, but he asked for wisdom. And because Solomon had asked for what was best, God would give him these other, lesser things as well. From this we can see that wisdom is more important in God's eyes than long physical life. So while physical life is a great good, it is not the ultimate good. It is sometimes biblically permissible to choose other goods *over* long physical life.

CASE #2

Bob is an 86-year-old believer who has suffered more than one heart attack and is now in the hospital with an erratic heart rhythm, limited kidney and liver function, and difficulty breathing. His breathing is being supported by a machine that helps him to breathe (BiPap). Much of the time, Bob is confused and anxious, but he is still lucid enough to make

decisions about his own care. Just yesterday, he had a clear and productive discussion with the intensivist about his prognosis.

The intensivist said that it is (humanly speaking) unlikely that medicine can cure Bob's various problems. By staying in the hospital on the breathing machine, Bob might live for months, although the amount of medical machinery involved would probably increase. If Bob were to leave the hospital, he could be kept comfortable at home, but the breathing assistance would be less efficient, and he would die sooner than if he stayed in the hospital.

CASE NOTES

I. *Medical background information:*
   A. The breathing assistance that Bob is using is designed for use in the hospital. Its purpose is to allow other problems to be treated in an effort to restore a person to health. It was not designed to be a long-term replacement for routine breathing.
   B. If difficulty in breathing were Bob's only problem, and if the doctors believed that his breathing would be restored by staying in the hospital, then no one would be asking Bob about discontinuing the breathing support.
   C. Bob's breathing issues come with other serious problems, what hospital personnel call *multiple co-morbidities* (more than one problem that might kill someone). Sometimes *having multiple co-morbidities* is used as a synonym for *dying*, since it is typical for someone in this condition to die before long.

II. *Legal background information:*
   A. The *intensivist* in this situation is a doctor who works full time for the hospital. Even though Bob probably has a personal physician—the doctor he sees for checkups—it is unlikely that the personal physician will oversee Bob's care in the hospital. Starting around 2000, it became economically difficult for private-practice doctors to see their patients in the hospital. Insurance companies and government-funded health plans simply stopped paying private doctors to go to the hospital. So in the hospital, it is now most likely that the only doctors Bob will see are those employed by the hospital. Intensivists are staff physicians who oversee the care of people in intensive care units (sometimes called *wards* or *units*); *hospitalists* are staff physicians who oversee the care of sick people "on the floor" (in regular hospital rooms).
   B. At the same time that the number of staff physicians overseeing patients' care was increasing, there was a growing effort to define medical care that is "futile." Although medical technology is often an amazing blessing, there are times when it accomplishes very little. At times, the medical personnel and the family of the person in the bed can disagree about the value of continuing to use the technology. Usually the disagreement is between medical personnel who know how little good the machines are doing and families who are holding on to a loved one and overestimating what the machines are doing. Because the law in most states leaves it to sick people (or their families as speaking for them) to decide what medical care to start or stop, medical personnel have

been legally obligated to continue supporting the use of machines that are at best doing nothing. In 2005, the state of Texas passed legislation allowing physicians to overrule a family's wishes about continuing "futile" care. Two physicians with no financial interest in the outcome could agree that the care was "medically futile," allowing the hospital to discontinue the treatment after helping the family find another hospital that would accept their loved one as a transfer. Even in Texas, however, very few physicians or hospitals take the legal steps to discontinue treatment, no matter how seemingly futile. The summary maxim is simple: "Dead people don't sue, but their families do."

III. *Pastoral background information:*
   A. Intensivists and hospitalists are often acquainted with the private physicians of the people they are attending in the hospital, but typically the staff doctors are strangers when the sick people first meet them in the hospital. Adding to the challenge, staff physicians usually rotate "on" and "off." So if Bob stays in the hospital longer than a few days, it is likely that a new intensivist will introduce herself or himself to Bob as the doctor now overseeing Bob's care.
   B. Bob's children have been regular visitors in the hospital. Even though the ICU rules keep the visits short and involve only a few people at a time, they come in pairs with friends from church. Bob is often confused while they are there, but he enjoys hearing them talk about their lives and having them pray for him and each other.
   C. If Bob were to leave the hospital and return home, "home" would be his youngest daughter's house. She has said that she is willing to have him live with her "until his time comes and he goes to be with Jesus." Bob's other children have agreed to share the expenses of his care in their sister's home: in-home respiratory support, an adjustable bed so that he can sleep on an incline, and some nursing help.

FOR DISCUSSION

I. Is Bob biblically required to maintain the use of the hospital breathing support until he dies from some other cause?
   A. The Bible calls Bob not to take his own life.
   B. If Bob were trying to kill himself by discontinuing the use of the breathing support, then it would be biblically wrong.
   C. Bob is not biblically required to use ineffective or greatly burdensome medical means to keep himself alive.
   D. In-hospital respiratory support includes the *burden* of being relatively isolated from family and friends. It is also much more expensive than in-home breathing devices.
   E. Fifty years ago, Bob would not have had any choice in the matter: this kind of respiratory support had not been developed.
   F. If the in-hospital breathing equipment cost a million dollars a day, no one would think that Bob was biblically required to bankrupt his family or rob a bank to pay for the treatment. So the use of the in-hospital breathing machine cannot be biblically required regardless of other factors.

II. Bob's daughter believes that her father should stay on the hospital's machines "to give God time to heal Dad miraculously." Is this a biblically sound approach?
   A. Bob's daughter is right that God could heal her father completely despite his medical challenges.
   B. Everyone—including Bob—should be praying for his healing.
   C. But God does not need our help to give him more time to do all that he purposes to do. (It is likely that Bob's daughter would see this right away if she were not rightly concerned about her father's failing health. She is not saying, "I don't think God can heal Dad unless we help him." She is probably just saying, "If medicine isn't going to be the answer, we should call upon the Lord. Leaving the hospital would mean that we are giving up on Dad!")
   D. Bob would not be giving up on life if he left the hospital. He would be choosing where he wants to live his last days before going to glory.
   E. God could well heal Bob in a wondrous way while he is living at home.

III. What is *hospice care*, and is it effectively a death sentence?
   A. If Bob's doctors have determined that he is *terminal* (for insurance purposes, this means that someone in his condition will die within six months), then he will be eligible for hospice care.
   B. Hospice care usually includes regular home visits by a team of nurses and other medical specialists. The goal of this team's work is maximizing the comfort (sometimes called *quality of life*) for a person who is close to death.
   C. In some places thirty or more years ago, receiving *hospice care* in a hospital meant being moved to a wing or hall where the medical attention and care was limited. Although this kind of hospice-as-death-watch is now rare, memories and rumors about it continue.
   D. Accredited, insurance-funded hospice care now is almost always a tremendous blessing to everyone involved. It is a blessing to sick people because they are able to live at home and still receive high-quality comfort care. And it is a blessing to families because hospice workers recognize that the families also need support, information, and relief.
   E. The most common thing that people say about hospice care today is "I wish we had gotten hospice involved earlier."

IV. If Bob is discharged from the hospital, he is likely to die at home. What steps do Christian physicians want families to take to prepare to have a family member die at home?
   A. Answers here will depend on the person's illness(es) and likely prognosis.
   B. Getting routine attention from qualified medical personnel will take some planning and some expense. Taking steps to line up medical visits and figure out what can be afforded will limit the anxieties when the loved one returns home.
   C. It is important that the primary caregiver (in this case, Bob's daughter) *not* be left to handle everything. She will need others to give her regular, predictable time away, along with help with some of her other responsibilities (children, work, etc.).

D. A plan is needed for keeping track of questions to ask medical personnel when they visit, and to keep records of their recommendations.
E. Spiritual care for everyone involved needs regular attention as well. Rather than waiting for pastors or other counselors to figure out that there is a need, the family should be seeking out regular visits.

PRINCIPLES

I. Faithful stewardship of our earthly life ordinarily includes using medical means (as feasible) to extend it.

II. But long life is not the only biblical good that we might pursue. It isn't even the most important good.

III. It is biblically permissible to decline or withdraw medical treatment that compromises the honest pursuit of other biblical goods, and especially spiritual goods.

SECOND SESSION

Choosing for Loved Ones

BIBLICAL REFLECTION #3: GENESIS 25:7–8; 1 CORINTHIANS 15:50–57

The Old Testament treats death as an inevitable feature of the fallen world. It is a source of grief, but not of despair. In Genesis 25, we are told of the death of Abraham at the age of 175. He died "in a good old age, an old man and full of years." While we are not told how Abraham died, we are assured that his life had been full. Dying is not pleasant, but at the end of a long life of a believer walking at peace with God, death is not something to fear. Abraham was "gathered to his people," meaning that his body was buried near his loved ones and that his spirit joined the company of those who had gone before into direct fellowship with God. By the time of Jesus' earthly ministry, this place of rest for those who had died at peace with God was called "the bosom of Abraham." In Luke 16:19–31, Jesus told of Lazarus, a poor man who had died and been "carried by the angels to Abraham's bosom" (16:22 NKJV). Abraham and Lazarus enjoyed fellowship with God as they awaited Jesus' return and resurrection unto life with a glorified body.

Physical death can be painful and unpleasant, but it is not the greatest evil. The greatest evil is spiritual death: being cut off from the light of God's countenance and being consigned to hell. Physical death has been defeated by Christ's work. Isaiah 25:6–8 looks ahead to a time when God will swallow up death forever. First Corinthians 15:50–57 explains that Isaiah's prophecy will be fulfilled when we put on our glorified bodies, and that the victory over death was won by Jesus Christ. People trusting in Christ's finished work should celebrate their victory over death even as they walk through the difficult choices that are common as physical death draws near.

CASE #3

Mildred is 70 years old and has a history of diabetes and hypertension. She was admitted to the hospital with a heart attack nearly two months ago and had coronary artery bypass surgery four days after admission. She has been in the intensive care unit since surgery because of multiple complications, mostly involving her lungs. At one time, she was off the ventilator for a few days, but it had to be resumed. Her pulmonary status has recently worsened in spite of continued full treatment. The ICU doctor (the intensivist) is convinced that she will not be able to be weaned from the ventilator and is recommending a do-not-resuscitate (DNR) order.

Mildred's ability to communicate is seriously limited by the ventilator, and even during her brief periods off the ventilator she was not able to give consistent answers to questions about her care. She does not have an advance directive. She is a believer, and a recent widow. Her two adult children are divided about what should be done.

FOR DISCUSSION

I. Would it be biblically permissible for the children to approve the DNR request?
   A. (It is very likely that the doctors or nurses involved will say yes to this question. If they do not, you will want to probe for the specific feature of Mildred's situation that prevents them from saying yes.)
   B. Mildred is biblically permitted to approve the DNR request, so her children are permitted to approve it *if they believe that it is what Mildred herself would choose*. The central question is not what the children want *for* Mildred. It is only what they believe Mildred would choose if she could.
   C. God's Word permits Mildred to say either yes or no to the request. Mildred is obligated to serve Christ faithfully with all her resources of time, talents, and opportunities. In her condition, a resuscitation attempt would be unlikely to restore to Mildred the ability to serve Christ's purposes in the way that she has been doing before now. She is permitted to take this into consideration when deciding what it will mean to serve Christ faithfully if her heart stops.
   D. If they focus on what Mildred would choose about how to serve Christ if she were able to speak, the children should be able to agree about how to answer the doctor's request.
   E. In most states, the children will have to agree about what Mildred wants in order for it to be legally clear what the doctors should do. If the children do not reach a consensus, many doctors will be cautious, "doing everything" rather than risking a lawsuit from the child or children who insisted that Mildred would want "everything" done.

II. What would happen to Mildred if she was "full code" and arrested?
   A. (The medical professionals will be able to answer this in detail. It is best to encourage a longer rather than a shorter description *to overcome the distorted picture given on TV of this being a simple event*.)
   B. A full resuscitation attempt looks like a serious assault: pounding on the chest hard enough to break ribs; chemicals pushed into the bloodstream to make the body speed up everything; jolts of electricity powerful enough to raise the body in one thump; and so on.

III. Who (which doctor) would be asking the children to approve the DNR order, and how would the conversation go?
   A. (The doctors can probably describe a time when they tried to talk a family through a decision like this. Accounts of real conversations are the most memorable way to prepare people for facing such questions.)
   B. The doctor asking is *physician of record* or *attending physician*. There is one doctor who knows that she or he is the last word on Mildred's care, and all the other medical personnel will defer to that doctor.
   C. In this case, the doctor asking is the intensivist.

IV. What would happen if the children refused the DNR order and the physicians thought their decision was medically wrong?

A. (States differ on what the law allows doctors to do in this case; hospitals differ in their policies; and individual doctors have their own style within the legal and policy restrictions. Having the doctors say what *they* would do is crucial.)
B. Every state has a legally defined way that family decisions about a family member's care can be overridden. In many states, the concurring opinion of another licensed physician is sufficient to override family insistence. But in many others, the matter ultimately ends up in court (and the family's word almost always prevails).
C. The most likely thing that will happen in this case is that the physician will ask the hospital ethics committee to get involved. The ethics committee does not have the power to transfer the decision-making authority to the physician. Instead, the committee will work to set up a meeting during which all the stakeholders can be heard and a consensus sought.

BIBLICAL REFLECTION #4: EPHESIANS 6:1–4; 1 PETER 2:18–25

The biblical authority to make choices for people who cannot do so is grounded in God's design for the family and, by extension, other relationships of loving oversight and grateful submission. The authority of parents to make choices for their minor children is asserted in the fifth commandment ("Honor your father and your mother") and assumed in Paul's application of the fifth commandment in Ephesians 6:1–4. Paul commands fathers not to incite anger in their children because the biblical authority to direct and discipline carries with it the possibility of harshness.

The authority of spouses to choose for each other when one is decisionally incapable rests on their one-flesh union (Gen. 2:23; Matt. 19:6). The Bible says less about children's having the authority to choose for their parents, but there is biblical warrant for the practice. The legal/covenant solidarity of families is assumed throughout the Old Testament narrative, and is on particular display in Exodus 13:19, which recounts that Moses fulfilled Joseph's advance directive from four hundred years earlier that he wanted his bones carried from Egypt to the land of promise (Gen. 50:25). Further warrant for giving children the authority to choose for their parents is found in following the legal hierarchy of surrogacy prescribed in state and federal law. Romans 13 and 1 Peter 2 direct Christians to obey those in authority, including the secular legal authorities. And when children are unavailable to explain what someone would choose, existing law authorizes Christians to have a nonrelative who knows our values to speak for us.

CASE #4

The following statements have all been made about assigning someone to be an *agent* for health care decision-making. *What should be said in response by a biblically serious, loving fellow believer?*

I. I want to be a burden to my loved ones, and making hard choices for me when I cannot is part of being united as a family.

A. This is what Gilbert Meilaender says that we all should be willing to say in an article in First Things.[1]
B. American culture prizes independence and thinks that it is shameful to be a burden to others, even to family members. This attitude is not biblical.

II. My husband is my legal agent. I don't want him to worry about what I would choose. I want him to choose what he thinks is in my best interests even if he's pretty sure I would disagree.
   A. While this sounds noble (and may even seem like what a "submissive" wife should say), it is not a biblically appropriate attitude. Wives—like husbands—are responsible to make choices as faithful stewards of the resources that Christ has given them. Spouses should be talking about what Christ has for them to do with their resources, and each should choose as the other would choose if he or she could speak.
   B. No one should accept the task of being the agent under these terms. Agents should seek to understand what the person they are speaking for would choose if she or he could.

III. I sure hope my mother lives a long, long time. Because I am the oldest child, it is my biblical responsibility to be her health care agent. My little brother—a doctor!—would be much better prepared to act as her agent, but the Bible makes it my job.
   A. Although most human civilizations have given special authority to the oldest male child, the Bible does not clearly teach that the oldest male child has an obligation to take the responsibility of speaking for the parents if the parents cannot. (The Bible describes this practice among Israelites and others, but it does not make the practice obligatory.)
   B. A younger sibling with medical training would be a wonderful resource when medical decisions needed to be made, but medical training is not a decisive reason for the younger son to be the agent in this case.
   C. Whichever of the sons knows best what their mother would choose if she could make the choice herself should be the agent that she chooses to speak for her.

IV. I'm not assigning an agent. Whatever doctor is taking care of me when I'm about to die will know what is best. Doctors are trained to deal with medical matters, and this is a medical matter.
   A. Just as the son who is a doctor is not necessarily the best choice as an agent, it is inappropriate (and unkind to the doctors involved) to leave the choices to whichever doctors happen to be available when choices are needed. The best agent knows what the one who is incapable would want; the doctors can lay out the medical options, but they cannot say which would be most valued by the person in the bed.

1. "I Want to Burden My Loved Ones," *First Things* (March 2010), http://www.firstthings.com/article/2010/03/i-want-to-burden-my-loved-ones.

B. Forgoing assigning an agent because the medical personnel will know what to do places an enormous (and unwanted) burden on the medical personnel and very likely deprives loved ones of the clarity they might have about how decisions are to be made that express someone's wishes.

V. I wouldn't want to put this kind of pressure on my wife. I'd rather have a stranger who lives down the street making choices for me when I'm dying.
   A. It is true that serving as an agent can be stressful, but this is a kind of stress that we may ask our loved ones to bear.

PRINCIPLES

I. We should presume that a DNR order request from a trusted physician is warranted.

II. God's Word does not require us to ask to be resuscitated in every circumstance.

III. It is an act of love to our families to assign an agent to speak for us if we become unable.

IV. A faithful agent chooses what the person for whom the agent is speaking would choose even if it is not what the agent would choose for herself or himself.

THIRD SESSION

Completing an Advance Directive

BIBLICAL REFLECTION #5: DEUTERONOMY 34:4–7; JOHN 19:28–30

These two passages describe godly people who died long before their bodies were infirm and falling apart. While neither is at all an ordinary person—Moses was God's instrument to deliver Israel from Egypt, and Jesus is God incarnate—their deaths tell us that spiritual aims can outweigh the obligation to make physical life last as long as possible. At the end of Deuteronomy, some writer later than Moses (likely the author of Joshua) and under the inspiration of the Holy Spirit reports that Moses was still in good health when he died on Mount Nebo, looking down into the promised land. "His eye was undimmed, and his vigor unabated" (Deut. 34:7), and he had the strength to climb the mountain on foot. God took him while he was still healthy. We are not told all of God's purposes in this, but it is clear that staying alive as long as possible was not the top priority for either Moses or the Lord.

Jesus went to the cross in the prime of life. He endured physical beatings and unrelenting mocking, and then used his last reserves of physical strength to fulfill what the Scriptures had said and announce, "It is finished." We know that as the willing sacrifice for our sins, Jesus in his death secured an infinitely valuable spiritual good. But it was secured by laying down his physical life before disease or old age undermined him. The Scriptures show us that physical life is not the ultimate good, and that even though physical human life is wonderfully precious to God, sometimes spiritual goods are even more important.

CASE #5

George is 81 years old, is a spiritually mature Christian, and until a recent stroke has lived a full and active life. Since the stroke, he has been seriously confused, he has developed pneumonia, and his kidney function has dramatically declined. He is unable to take food by mouth (because of an inability to swallow), and it is medically unlikely that his condition will improve. He is currently in the hospital in stable condition on a ventilator and receiving dialysis.

George has an advance directive stating that he does not want medical devices or treatment used to extend his life unless they can maintain or restore his ability to enjoy the ordinary means of grace: to understand God's Word, at least at a child's level, and to partake of the Lord's Supper. He has told his family that the spiritual burden of going without those delights would be very great and that the benefit of merely living longer in the hospital would be, for him, very small. George's wife, Anne, is his legally appointed agent.

FOR DISCUSSION

I. Is George biblically permitted to value the spiritual goods of ordinary communion with God more than the physical goods of extending his earthly life?
   A. Yes. The spiritual blessings of ordinary fellowship with God are great in ways that the world cannot begin to imagine.
   B. George's physical and mental condition will not allow him to enjoy fellowship with God in an ordinary way. It is possible that he is communing with God in prayer and is able to understand more than others can tell, but he is not obligated to do everything possible to sustain his physical life just to maintain this *possibility*.
   C. George has the authority as Christ's servant to devote his resources to pursuing other biblical goods rather than spending his energy, time, and money on life-sustaining medical treatment, and since his instructions are known, they can be followed.

II. Is Anne biblically permitted to ask the doctors to keep George comfortable but turn off the machines?
   A. Yes. Anne is both biblically and legally empowered to speak for George when he cannot.
   B. George's advance directive makes it clear what George wants, so Anne may ask the doctors to make the goal of George's care comfort only and not also the aggressive use of machines to keep him alive.

III. What would most doctors think of this directive?
   A. The doctors who have reviewed these instructions—both Christian and non-Christian—have found these instructions puzzling. The Christians typically see what is being asked and agree with the goal. Non-Christian doctors are intrigued, mostly because they are used to Christians' wanting "everything" to be done.
   B. The puzzlement or concern mostly goes away when it is clear that Anne understands what George wants and is willing to make the decisions that put the instructions into effect.
   C. Attorneys who have reviewed these instructions say that it would be easier for everyone if the conditions were specific enough to be interpreted by a non-Christian physician: able to understand the Bible at a first-grade level, and able to be transported into a worship space and take small amounts of bread and wine by mouth.

IV. How might the details of this case be changed to make the biblical permissibility of George's request different?
   A. If it is medically likely and financially feasible that George can be restored to the ability to make decisions for himself, then Anne should probably ask to have life-sustaining treatment continued.
   B. If Anne has good reason to believe that George changed his mind about what he wants between the writing of the advance directive and his current crisis, she may need to give instructions according to his current wishes. Reviewing advance directives routinely will make this complication less likely.

BIBLICAL REFLECTION #6: PHILIPPIANS 1:18B–26

Paul was in prison when he wrote his letter to the church at Philippi. He knew that he would be "delivered," and he eagerly hoped that Christ would be honored even if that deliverance came by his death. He did not want to be ashamed (Phil. 1:20), but instead wanted either to live and continue in "fruitful labor" (v. 22) or to die and depart to be with the Lord (v. 23). Paul found it hard to choose between these two unashamed possibilities. Staying alive would allow him to serve others, which would be good for them. Dying would mean being with Jesus, which would be better for Paul. So even in prison with death a real possibility, Paul saw himself in a win-win situation. He summarized this in verse 21: "For to me to live is Christ, and to die is gain."

Paul was not seeking to die. He was ready either to live in order to serve others or to die and realize the joy of fellowship with Christ. In this case, whether Paul lived or died was in the hands of those who had him in prison. Paul was not considering refusing to eat so that he would die quickly. The courage he wanted was probably the courage to maintain his profession of faith even if persecution came with it, that he would not be ashamed of the gospel. But while the heart of Paul's desire here was to remain a faithful witness even unto death, his reasoning highlights that staying alive would be for the sake of fruitful labor. Staying alive was not an end in itself apart from serving others. Paul was not allowed to take his own life, but he was not obligated to stay alive as long as possible just for the sake of staying alive. As Christ's servant, he was permitted to allow death to take him when fruitful labor was no longer an option.

CASE #6

Judy is a 46-year-old believer with a history of untreated seizures. Six years ago while walking, she was struck by a pickup truck. She was convulsing when paramedics arrived, and her seizures continued for a few days in spite of aggressive treatment. Over the next several weeks, she progressed to a persistent vegetative state and was transferred to a nursing home with a diagnosis of severe brain injury caused by the trauma of the accident and worsened by lack of oxygen during the prolonged period of seizure activity. She has remained stable and has not required rehospitalization.

Judy's nurses report that her eyes are open part of the time but that she does not track. She does not appear to have any awareness of her environment (no smile, no recognition). She is fed via PEG tube and still has a tracheostomy for suctioning her airway. A DNR order was written soon after Judy's admission to the nursing home. In a recent conversation with her doctor, her two sisters agreed that they "have accurate reason to believe that Judy would not want to prolong artificial feeding and fluids in her current condition based on our knowledge of her life goals."

FOR DISCUSSION

I. Would it be biblically permissible for the family and doctor to discontinue artificially administered nutrition and fluids?
   A. The answer to this question depends crucially on Judy's prospects for recovery and what Judy's sisters report about what Judy would want.

B. Judy has the biblical authority to decline force-feeding through tubes, as long as the feeding is not part of a medical plan that is (humanly speaking) likely to restore her ability to make decisions for herself. (If tube-feeding is not part of a regimen likely to restore her, then it is only serving to extend Judy's physical life. We are not biblically obligated to use medical means merely to extend our physical lives; also, the tube-feeding includes significant burdens along with the benefit of being kept physically alive.)
C. If Judy's sisters have good reasons to believe that Judy would decline the tube-feeding if she were able to make the decision, then it would be biblically permissible for the family and doctors to discontinue the tube-feeding.
D. Judy is not, however, obligated to decline the feeding. If her family believes she would choose it if she could make the decision, they should continue the tube-feeding.
E. It would be easier for everyone involved if Judy had left an advance directive stating her wishes about end-of-life treatment.

II. What steps should the physician take (tests, etc.) before making a final decision about this?
A. The physicians will know best what steps should be taken to determine the medical likelihood that continuing the tube-feeding would contribute to Judy's being restored.
B. Those with the responsibility to speak for Judy should be eager to hear what is medically likely in Judy's condition. A sober estimate of Judy's prospects should guide the decisions they make on her behalf.

III. If the nutrition were discontinued, would it mean starving Judy to death?
A. No. "Starving someone" means denying the person food that she or he either wants or needs in order to live a faithful life. It means causing suffering—both physical and psychological—by combining hunger with malicious neglect. No one would be doing that to Judy if the tube-feeding were discontinued.
B. If Judy's family had reason to believe that she would want tube-feeding, then they should work to fulfill that request. Judy is permitted to want food and to leave instructions that she wishes to have it delivered by tube.
C. In this case, however, Judy's family has good reason to believe that she would not want it. Because Judy doesn't want food and does not need it forced into her in order to live a faithful life, it would not be starving her to discontinue it.
D. Also: in her condition, it is unlikely that Judy will feel hungry after the tube-feeding stops.

IV. If fluids were discontinued, would Judy die a painful death of thirst?
A. No. If all are careful to keep Judy's mouth moist—a part of ordinary oral hygiene—she will not feel thirsty.

PRINCIPLES

I. Earthly, natural benefits and burdens are important, but spiritual benefits and burdens should also be considered.

II. Care should be taken, but discontinuing *artificial* nutrition and hydration may be medically and biblically appropriate if they are not supporting comfort or recovery.

FOURTH SESSION

Supporting the Sick

BIBLICAL REFLECTION #7: MATTHEW 25:31–40; 2 CORINTHIANS 12:7–10

These passages are about how Christ would have us think about and deal with weakness. What Jesus said about the sheep and the goats in Matthew 25 indicates that Jesus' sheep—those whom he knew and who knew him—were those who took active steps to care for the weak. The goats—those who heard Jesus say, "Depart from me, you cursed, into the eternal fire"—were those who did not. Both the sheep and the goats expressed surprise that they had been caring for or neglecting Jesus himself in their treatment of the weak, but Jesus described their service to him in their service to the weak in explaining the fate that each received.

The actions that Jesus commended by his sheep would have been even more countercultural in first-century Roman Palestine than they are today. Jesus' first audience would have been quick to care for the strong, honoring them with food, drink, welcome, and attention. Jesus said, instead, that his sheep are those who provide for the weak. In the context of health care, Jesus commended *visiting* the sick. He didn't say that his sheep had *healed* them or *kept them alive by medical means*. Using medical knowledge and skill to promote healing and prolonging life are certainly good things, but Jesus' sheep do something that everyone can do: they draw near to the sick and make sure that they are not neglected.

Near the end of 2 Corinthians, Paul worked through his own struggle with health and weaknesses. Although we do not know for sure what Paul's "thorn in the flesh" was, we know that Paul prayed fervently that it be taken away. We also know that God chose not to take it from him. In Paul's case, the unwanted challenge was God's instrument to remind Paul to trust in Christ's sufficiency rather than his own. This should encourage us not only to look for ways to minister to the sick in their weakness, but also to be careful that we do not trust in our own strength in ministering to them. Christ's power is made perfect not only in the weakness of the sick, but also in the weakness of those who care for ("visit") the sick. By our prayers, our presence, and our loving care, we make Christ's love for the weak visible.

CASE #7

Marvin is 52 years old, is a faithful member of your church, and has worked in construction all his adult life. Ten days ago, Marvin fell from a ladder on a jobsite and suffered a closed-head injury. Since the injury, he has been unconscious. He is now in stable but critical condition in the ICU at the local hospital. Marvin's wife, Kitty, and his three daughters—all members of your church—have been taking turns staying at the hospital in pairs. Two of the daughters are in college, and one is in high school.

FOR DISCUSSION

I. What are the most helpful steps that church members can take to support Marvin and his family at this time?
   A. Pray for them.
   B. As directed by Kitty or someone handling this for Kitty, take turns visiting Marvin, but not in greater numbers or more frequently than Kitty thinks best.
   C. Again as directed by Kitty or Kitty's designee, reduce as many practical burdens as they can from Kitty and the children: delivering meals, washing clothes, driving people around, and the like.
   D. As directed, help Kitty manage whatever updates she wants others to receive about Marvin's condition.

II. How should church members pray for Marvin and his family?
   A. For restoration to health.
   B. For peace in making decisions.
   C. For wisdom and skill for the medical team.
   D. For provision of all their needs, health and otherwise.

III. What do the physicians and nurses at the hospital want church members to know or do before they attempt to visit Marvin in the hospital?
   A. The physicians will know best what members should know or do, and will likely have stories about church members who did well or poorly at visiting.
   B. It is likely that the physicians can explain the ICU visiting-hour rules for the local hospitals.

IV. What should church members do if they visit Marvin while he is in his ICU bed?
   A. Say who you are and that you have been praying for Marvin.
   B. Pray quietly.
   C. *Before going*, find out from Kitty or her designee what Marvin would like. Some people like to have something read. Others want to hear about the lives of those visiting (even if they seem not to be able to hear). Some like to have visitors sing. But anything beyond praying should be done only with explicit permission.
   D. *Do not touch any* of the medical equipment.

V. What should church members do (or say, or sing) when they sit with Marvin's family at the hospital?
   A. Do only what the family asks for.
   B. Steer clear of questions that ask for information (about Marvin's condition, prognosis, or goals) that has not been offered.

VI. What should church members say (or avoid saying) to Kitty and the children?
   A. That you know why this is happening.

B. That you know that God will work a miracle.
C. That God wants them to be strong, be brave, or just have faith.

VII. Is it best to stay away from the hospital at this time? Should the church members leave it to the pastoral staff to do the visiting?
A. Pastoral staff, elders, and deacons should be able to give good advice about this.

BIBLICAL REFLECTION #8: PROVERBS 23:22–25; ROMANS 12:9–10

The book of Proverbs makes it clear that showing honor to our parents is wise. By heeding our parents' instructions and protecting them from poverty and embarrassment, we not only serve them and please God, but also serve ourselves and provide for our own future. We serve our own good by training our hearts to value what is truly valuable. Even when the surrounding culture can't see the point of caring for the sick and weak, we know from God's Word that they are precious. Flourishing as God designed us to flourish depends on loving what is truly lovely, since only that will satisfy our true and deepest desires. Caring for our parents and other loved ones when they are weak and sick is part of living a satisfying life.

Our joy is not completed, however, simply by caring for our parents. In Romans 12, Paul includes "outdo[ing] one another in showing honor" as one of the implications of Christ's saving work on our behalf. In the Roman world of Paul's day, this would have been considered foolishness. Everyone "knew" that honor was showed only to those who could hurt you. A great man was one who didn't need to show honor to anyone else, so showing honor to the weak was an admission of failure. Christ's willingness to be thought foolish and weak by the world was crucial to our salvation, and we are to be like Jesus, pouring ourselves out for others as he did for us.

CASE #8

Hilda is 84 years old, and she has been walking with Jesus since she was 9 years old. Three years ago, Hilda's husband of fifty-seven years passed away, and since then Hilda's health has been declining. She continues to live by herself with twenty-four-hour nursing care, and she is visited twice a week (on average) by her son, who lives in Atlanta. For the past four months—when she had surgery following a hip injury—Hilda has been unable to attend church even in a wheelchair. Because of other health difficulties, it is unlikely that Hilda will ever be strong enough to attend church again.

Hilda requires oxygen assistance and tires easily, but her mind is as sharp as ever. Her diet is restricted in many ways because of lifelong allergies and drug-interaction complications. She continues to read (but never for long stretches), and she enjoys hearing about the lives of her grandchildren and the children of her friends (although many of her childhood friends are no longer alive). Hilda and her husband were careful to plan financially for their retirement, and Hilda has the means to pay for all her care and the upkeep of her house and grounds, as well as to give generously to the church and other causes.

FOR DISCUSSION

I. What are the most helpful ways that church members can care for and support Hilda?
   A. Work at including Hilda in the life of the church even though she cannot leave her home:
      1. Groups could coordinate to send information to Hilda about church activities in a form that she will see and use (cards, e-mail, phone calls).
      2. Members could send Hilda prayer requests, keeping her updated on the outcome of prayers.
   B. Hilda still has wisdom to share with the church. The youth group could make a project of interviewing Hilda by phone (or in person, as possible) about her life and her current walk with Christ.

II. What cautions or advice would physicians give to church members who wanted to spend time with Hilda or do something nice (such as make a meal) for her?
   A. The physicians and other health specialists in the group can talk about the limitations that Hilda's condition imposes on visitors.
   B. Suggestions for determining dietary needs and restrictions may be discussed.

III. If Hilda is able to pay others to care for her, is it still important for church members to volunteer to help?
   A. Hilda can pay people to do all sorts of things for her, but the spiritual and psychological nourishment that comes from things offered in love cannot be purchased.
   B. Hired services also cannot show Hilda that she remains a valued member of the church. Only acts of friendship can show her that she has not been forgotten.
   C. As important as pastoral visits are, church friends who provide a simple meal or volunteer to serve Hilda out of love are also precious. American culture sends the loud message that people who are not economic *producers* are valuable only for what they buy. Acts of loving service to Hilda work against that depressing message.

IV. What should church members do if they visit Hilda?
   A. Visitors should do things that Hilda enjoys, which may involve asking people who know her for suggestions or simply asking Hilda herself.
   B. Visitors should be careful not to exhaust Hilda, be on the lookout for signs that she is tiring, and look for a graceful way to set up time for another visit.

PRINCIPLES

I. We should move toward rather than away from those limited by sickness or age.

II. Moving toward those in need in a helpful way involves learning how to do it from those who know how.