Leaving Instructions

Adult Sunday School Curriculum

Leaders' Notes

🅭 2017 by Bill Davis

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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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Leaders' Guide

General Introduction

THE AIMS OF THIS FOUR-LESSON SERIES

- To make believers familiar with the value of family discussions about end-of-life wishes long before the need arises.
- To acquaint believers with biblical texts that bear on the difficult questions that surround end-of-life decisions about medical care.
- To make believers comfortable with the jargon and the emotional heaviness of talking about the end of life and making end-of-life choices.
- To instill a confidence and eagerness that will lead believers to follow through and prepare advance directives for their families to use when the time comes.

THE ELEMENTS OF THE LESSONS

Central Question

- A question is set out that the lesson aims to answer on the basis of biblical teaching and a discussion of current health care realities.
- Leaders may choose to add secondary questions on the basis of perceived needs in the class.

Prelude

- A passage (or passages) of Scripture is provided to read and reflect on.
- Considerations are given that will set up and inform the remaining discussion while allowing latecomers to settle in.
- Space is provided for elders to explain (with prior permission) the health-related prayer concerns for members of the congregation.
- After the first lesson, a brief review of principles or implications discovered/discussed in previous lessons is set forth.

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Case Study/Sketch

- For the first three lessons, a scripted dialogue is provided to illustrate some of the challenges involved in making decisions about end-of-life medical care.

- The parts are to be read by members of the class, ideally with the readers gathering in a part of the room where all will be able to hear the scripted conversation.

- Leaders will need to devise a method for assigning parts. Choosing readers capable of speaking clearly and projecting sufficiently to be heard will enhance the subsequent discussion. Asking class members whether they would be willing to read, and providing them with their scripts at the beginning of the class hour, may be helpful.

- Each of the dialogues has at least one break during which the rest of the class will be asked to do something together before the dialogue continues. Leaders should be ready to give instructions at those breaks.

- In the discussion after the scripted dialogue, it can be effective to ask each of those who read parts to suggest how it probably would have *felt* to be the person in that position. Referring to the characters in the dialogue by gesturing toward the class members who read the parts will help the class recall the characters' situations, enhancing the quality of the discussion. (Pretending that the class members who read the parts are really *like* the characters they portrayed can add a welcome degree of levity to discussion that might otherwise be somewhat grim.)

- The time immediately after the case study/sketch is when class members are most likely to be thinking about similar things they have faced or seen in their own lives. Asking the class whether "two or three of you" could describe their own experience would give some an outlet for their memories and would reinforce the practical value of thinking through the case study.

Biblical Reflection

- Passages are suggested that may inform efforts to answer the central question.

- Leaders will need to decide how to use the passages listed. Some options:
  - Having members of the class read the passages aloud and having a discussion about each passage and its application to the question.
  - Assigning groups of three (or so) to each of the passages and then asking someone from each group to report what they learned.
  - Reading (or having someone read) only two or three of the passages, discussing only those as a group, and recommending that the class consider the other passages listed as part of their devotional reading during the coming week.

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Discussion Questions

- The questions are listed in an order likely to keep the focus on the central question and the issues that need to be considered in order to answer it.

- But if the class wants to jump around in a different order, that will work.

- Leaders should add or sidestep questions based on what they know of their class members' needs.

Principles and Applications (for the first two lessons)

- While I believe these principles are biblically sound, it would be reasonable for class members (or leaders!) to resist some of them.

- Leaders should encourage class members to question or push back against the principles they see on their handouts.

- Leaders should be comfortable with the class's unresolved disagreements about these principles. The primary aim of these lessons is to encourage and equip believers to think through their own end-of-life wishes in the light of what the Bible says. That aim can be realized even if class consensus is not achieved.

- When consensus is not reached (and it is evident that it will not be), it is sufficient for the leader to say something like this: "We don't have to agree about this. I can see biblical reasons for reaching different conclusions. I am comfortable thinking [whatever the leader thinks], but I can see why some of you end up somewhere else. That's OK. Why don't we move on to the next principle . . ."

For Further Consideration (Homework)

- Class members who think through these questions during the week will find the next week's discussion more helpful.

- But some of these "homework" questions can be unsettling, especially for people who have recently lost a loved one or who are walking alongside a family member near the end of life.

- No one should be chastised for not trying to answer the questions during the week, and it would be counterproductive to have a system that would draw attention to those who chose not to think about them.

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CHALLENGES AND OPPORTUNITIES IN LEADING THESE LESSONS

Stories That People Want to Tell

- If encouraged, people will want to talk about end-of-life situations that they have gone through.
- Sometimes the stories they tell will be long, complicated, and even sad.
- Cutting people off quickly will be painful to them *and probably to most other people in the class*.
- Thanking people for their willingness to share is crucial.
- *You want to encourage people to share*. The principal goal in these sessions is to convince people to act sooner rather than later to provide their loved ones with the information they will need to make choices if the need arises. Every story will illustrate the value of taking action!

Encouragement for Those Caring for Declining Loved Ones Now

- Some of the people in the class will be in the midst of making difficult decisions or—even more likely—going through the protracted challenge of caring for those who can no longer care for themselves.
- Again, descriptions of their current challenges should not be cut off quickly.
- Asking someone else to pray right now for the needs of the people involved is a way to comfort, help, and gain closure before moving on.

Highlighting Expertise Already in the Room

- In addition to people who are caring for loved ones, there are likely to be people with medical training, social work experience, and legal expertise.
- When aware of people with training that can augment everyone's understanding, look for a way to ask these people for specific help. The leader does not need to be an expert on any of these technical matters; seeking help is what we should all be willing to do.
- If qualified experts would prefer not to speak *as* experts (physician, attorney, nurse, etc.), do not press them to change their minds. They likely have good reasons for deferring, and they don't owe anyone in the class an explanation.
- If corrected by a class participant with expert knowledge, be grateful for the help and say so. (This is not always easy. Do it anyway.)

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Tensions about Some Matters

- It is very likely that people in the class will disagree with you, with the recommendations made by the handouts, or with each other. That's OK. (It isn't easy, but it's OK.)

- Be comfortable saying, "I think we've heard each other out on this, and it is OK if we agree to disagree. These are difficult matters. The world is watching how we handle death and everything near it. They need to see that even when we disagree about some things, we love each other and we are all doing our best to obey God's Word."

WHAT IS INCLUDED FOR EACH LESSON

- A handout master for making copies to distribute to class members.

- A Leaders' Guide: an expanded version of the handout with the material on the general class handout underlined and everything else offered as suggestions for the leader to use.

- For the first three lessons, a script for each character in the case study/sketch with that character's part in bold print. For the fourth lesson, a case study for one class member to read aloud to the class.

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Lesson One

OVERVIEW OF THE AIMS FOR THE FOUR-WEEK SERIES OF LESSONS

- To make believers familiar with the value of family discussions about end-of-life wishes long before the need arises.
- To acquaint believers with biblical texts that bear on the difficult questions that surround end-of-life decisions about medical care.
- To make believers comfortable with the jargon and the emotional heaviness of talking about the end of life and making end-of-life choices.
- To instill a confidence and eagerness that will lead believers to follow through and prepare advance directives for their families to use when the time comes.

CENTRAL QUESTION

What does the Bible teach about the value of living as long as possible?

PRELUDE: PSALM 116:1–19

The psalmist calls upon the Lord as "the snares of death encompass" him. He suffers "distress and anguish." But from the very beginning, he trusts that the Lord hears him and that God is caring for him in the midst of his troubles. It is important that even as the psalmist is praying for restoration, peace, and salvation, he acknowledges that he will be precious to the Lord even in his death. "Precious in the sight of the Lord is the death of his saints" (v. 15) states a promise for all of God's people. Even when it is God's will that we die, we are precious to the Lord. Death is not the ultimate enemy, and as God's precious children we can talk through the details of our own eventual deaths without dread or despair.

CASE STUDY/SKETCH

Kathy, 66 with a cancer diagnosis, and Pastor Mike, discussing whether the Bible calls Kathy to join an experimental trial.

Leader's Opening: Over the next few weeks, we will be discussing the medical choices that arise near the end of someone's life and some of the biblical principles that can inform those choices. To help us see how these choices might be difficult, we will begin each discussion with a case study, often in the form of a scripted dialogue. Today's case study is a dialogue between two people, Kathy and Pastor Mike. I will read the part of the narrator,

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and I need volunteers to read the parts of Kathy and Pastor Mike. [After selecting volunteers, have them come to the front so that they can seem to be talking to each other as they read.]

[Roles: Narrator/Leader, Kathy (K), and Pastor Mike (PM)]

Narrator/Leader: Kathy is a spiritually mature 66-year-old widow. She has been an active member of the church for over thirty years, serving as a Sunday school teacher and on the finance committee. Kathy has two grown children—both believers—who live on the other side of the country. Pastor Mike is the only pastor of the small evangelical church that Kathy attends. He has been serving the church for twelve years. He knew Kathy's husband, Fred, and presided over Fred's funeral after he died in a car accident seven years ago. Both Kathy and Pastor Mike have been active supporters of pro-life causes with their time and their money.

Kathy: Thank you for seeing me, Pastor Mike. I have a difficult decision to make, and I know your time is valuable.

Pastor Mike: I can't think of anything more important than talking with you right now. I heard yesterday afternoon that your oncologist gave you bad news. Does your decision have to do with that?

K: Yes. The news was bad. Tests confirmed that I have stage 4 pancreatic cancer . . .

PM: Oh, no! That's a really aggressive kind of cancer, isn't it?!

K: Very aggressive. My doctor said that no treatment is known to be effective in stopping it.

PM: I'm so sorry. Would it be OK if I prayed right now that God would stop it?

K: Yes, I would like that.

Narrator/Leader: Pastor Mike prays, asking God to touch Kathy and remove the cancer if that is God's will. He also prays that God would give Kathy wisdom to make choices about her health that please and honor God. Finally, he asks God to give Kathy physical and spiritual strength in the midst of this situation.

K: Amen. I was also praying for peace. I hope it is OK to admit that I'm scared right now.

PM: Of course it is OK. You know better than I do what "cancer" means. Is this cancer somehow connected to the cancer you beat eleven years ago?

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K: I don't know. I thought that my breast cancer was completely removed with the surgery and therapy. The doctors said that it could return, but after I was clear for five years, I thought it was finally over. I guess not . . .

PM: You fought that illness so bravely; it is really lousy that you are facing cancer again. Is there really nothing that the oncologist can do?

K: Nothing ordinary, and that leads to the question I need your help to answer. My doctor said she knows of an experimental drug that might slow the cancer's growth and give me more time. She wants to know if I want to be part of an "experimental trial" with this drug.

PM: With your last cancer, you tried everything the doctors suggested. Why wouldn't you do the same now?

K: Maybe it should be easy to say yes to the experimental trial, but it isn't. Do you think the Bible *requires* me to do everything the doctors recommend?

PM: No, I'm not saying that. But why wouldn't you want to live longer?

K: Of course I want to live longer, but it would be a hard way to live. My doctor says that if I do not participate in the trial, I will live from three to six months. It is possible that the experimental drug would allow me to live nine to twelve months instead, but it is also possible that it wouldn't extend my life at all.

PM: Is it the uncertainty that would be hard about it?

K: No. I don't need to know exactly how long I have left. What would make it hard is the side effects. The doctors don't know if the drug will help, but they are pretty sure about the side effects. The drug would make me nauseous almost all the time, I would be constantly tired, and I would probably find it hard to concentrate.

PM: None of that sounds pleasant. But you made it through chemotherapy last time. Won't this be like that?

K: I don't think so. In that case, the drugs weren't experimental. The side effects weren't fun, but I knew that they were part of what it took to get better—to beat the cancer! In this case, the drug will only be slowing the cancer down. And the side effects will be worse. Not only am I older and weaker, but these side effects are worse.

PM: You seem to want my permission to say no to the experimental drug. Is that it?

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K: I guess so. But I don't want to say no if the Bible teaches that I must say yes. What I want is God's permission to say no.

[The Narrator/Leader should ask the class to talk in groups of two or three to figure out what Pastor Mike should say next. After a couple of minutes and when the hubbub of talking wanes, the Narrator/Leader should say, "Let's see what Pastor Mike said . . ."]

PM: That is a hard question. I think I need to know more about your situation before I try to answer. Do you mind if I ask some questions?

K: Please do. I'm sure I am not thinking about this clearly. Your questions should help me focus on what matters.

PM: OK. First, did your oncologist say what the chances are that the experimental drug would make a difference and give you more time?

K: She said she couldn't be sure, but she guessed it had about a 30 percent chance of giving me more time.

PM: Hmm. I sure wish the chances were higher. Second: What would you do with your time if you were not taking the experimental drug?

K: I should have mentioned this earlier. If I'm on the drug, I will have to stay in town to be monitored and tested. If I'm not on the drug, I would want to visit my children.

PM: But if you have only a few months to live, would that be possible?

K: My oncologist says that I will get steadily weaker as the cancer grows. But if I travel soon, I should have the strength to visit both my children—and my grandchildren! I could spend about a week with each family before I had to come back here.

PM: I understand wanting to see your children and grandchildren. Couldn't they come here?

K: Maybe, but it would be much easier for me to visit them. And by the time they got here, I would probably be too sick to make much of the time with them. If I visit right away, we all can enjoy the time.

PM: I see . . . It seems that you have thought this through pretty carefully. Is your doctor urging you to go with the experimental drug?

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K: I think it's what she wants me to do, but she isn't being pushy about it. I think I would say no if I could be sure that it would be OK. But I can't think of anyplace where the Bible explains what I ought to do in this situation. I was hoping you would know, but you still haven't talked about what the Bible says.

PM: I'm sorry I took so long to get there. In your case, I think the Bible teaches that you have options. There are things you may not do—like giving up in despair—but I don't think the Bible says, "Here is the only thing you are allowed to do." It doesn't say that you must take the drug, and it doesn't say that you must not take it.

K: So the Bible can't help me here?

PM: I'm not saying that. The Bible gives us principles that will help a lot. But in this case, the principles don't leave only one permissible option.

Narrator/Leader: Here the discussion turned to considering some of the biblical principles that Pastor Mike had in mind. We will hear the rest of Kathy's story after talking about some of them.

[Here the leader might ask whether anyone has a friend or relative who faced a similar choice. It would be productive to hear two or three (short) stories about how others dealt with a situation like Kathy's.]

[The leader might ask whether any doctors or nurses are present and whether they can shed light on Kathy's medical situation given the limited description she gave Pastor Mike. It will be OK if none of the medical professionals think they know enough about her condition to add any details. But letting the class members know that medical professionals are present will give them a resource for asking medical questions as they arise.]

BIBLICAL REFLECTION

Consider the following passages. [The leader might assign one of these passages each to groups of two or three, asking them to consider how their passage might apply to Kathy's situation before looking at the others. This would make it likely that all the passages would play some role in answering the discussion questions that follow.]

- Genesis 2:7—God is the Giver of human life.
- 1 Kings 3:5–14—Wisdom is more valuable than long life, riches, or power; Solomon is blessed with all three for choosing wisdom.
- Psalm 91:1, 16—Long life is a blessing for the righteous.

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- John 15:13—It is an act of righteous love for Christ to lay down his life for us, his friends.

- Acts 6:8–7:60—Stephen is rewarded with a vision of Christ himself when he chooses to testify of Christ's lordship rather than clinging to his earthly life (6:8–7:2a, 47–60).

DISCUSSION QUESTIONS

The bulleted items suggest observations that the leader may make to advance a discussion about the answers to the questions.

[The answers in brackets suggest a direction for the discussion to head.]

1. Is human life more valuable than animal or plant life? [Yes] Why? [Because we are made in God's image and in this life relate to and are accountable to God for our choices.]

    - Human life is more valuable because humans are made in the image of God.
    - Among other things, this means that God has chosen to use humans to exercise dominion over the rest of creation.
    - Humans relate to God as servants tasked with carrying out his will by their choices.
    - Humans are held accountable for faithfully using their opportunities to glorify God and serve others.

2. The Bible refers to "life" over four hundred times. Physical, earthly life in the body is only one of the things that "life" means in the Bible. What else might "life" mean in the Bible? [Spiritual life; eternal life; the blessing of God's favor.]

    - In the Old Testament (a little more than half the uses of "life"), almost all the uses refer to physical life.
    - Often in the Old Testament, "life" is associated with the blessing of being in the promised land.
    - In the New Testament, almost all the uses of "life" refer to spiritual life and the blessing of everlasting life.
    - In John's Gospel and first epistle, "life" is used over fifty times, with all but eight referring to eternal life. Seven of the other eight refer to Jesus' laying down his physical life to purchase spiritual life for his sheep.

3. Does the Bible teach that long life *in itself* is a blessing? [No; long life in fellowship with God is a blessing, and it is fellowship with God that is most important.]

    - The Bible teaches that long life itself can be a burden.
    - The wicked are envied for living a long time (when they do), but they are not considered blessed.
    - The promises of long life as a blessing are connected to living in fellowship with God (in the promised land or in heaven).

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4. Deuteronomy 30:19–20 calls on Israel to "choose life"! Does this mean that it is always God's will that we do whatever it takes or costs to extend life as long as possible? [No. The command in Deuteronomy is to choose life as God's obedient people rather than the futile lives of idolaters, who will be cut off from God's blessings. Israel is called to choose spiritual life rather than spiritual death.]

5. What does the Bible teach is more valuable than living a long life? [Wisdom, our salvation, the preaching of the gospel, at least.]

    - Solomon values wisdom more than long life and is commended for it.
    - Jesus values our salvation more than living a long life.
    - Stephen values testifying to Christ's lordship more than living a longer life. (Stephen could have lived much longer simply by keeping his mouth shut when challenged about who Jesus is. He risked his life—and lost it—in order to proclaim the gospel.)

PRINCIPLES AND APPLICATIONS

1. Life is a gift from God and should be cherished (and not merely thrown away).

2. The Bible does not *require* us to treat living as long as possible as our first priority.

3. So the Bible does not require us to seize any way to live as long as possible no matter what else it will cost us.

4. We can be fully committed to a biblical view of the value of human life and still decline excessively burdensome treatment that might extend our life a bit.

5. The Bible allows us to choose a shorter life over a longer one in order to honor God and serve others.

    - The shorter life cannot be chosen for its own sake (because we are tired of life, or because we want to be dead).
    - The choice of the shorter life must be forced on us by an external necessity from the fall (disease, others' sinfulness).
    - Our aim must be glorifying God and serving others (and not our own selfish or wicked desires).

SPECIFICALLY FOR KATHY IN HER SITUATION

6. The central question for Kathy is "How can I honor God and serve others with the time I have left?" Kathy can honor God and serve others in more than one way in her situation.

7. The Bible allows Kathy to choose either to take the experimental drug or not to take the experimental drug.

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[For discussion only if needed because some in the discussion expect the Bible to provide a unique answer to every question we might ask: Often the Bible *narrows* our options without saying that there is only one righteous option. Sometimes the Bible permits us to choose among many righteous options even when some options are forbidden. Consider a fairly mundane example. George has a good job as a software developer. He enjoys the work; it pays him enough to care for his family and to give generously; and the work is consistent with godliness. George is invited to leave his job and to take his family to serve as missionaries in a closed country. His computer skills have opened the door for him and his family to enter the country, where it would be possible to present the gospel if others started the conversation. George then wonders, "Does the Bible say that I must leave my job and go?" George searches the Scriptures for guidance and does not find a clear answer. This is because George can righteously choose either to stay or to go. It would be wrong for him to stay just because he loved his own comfort more than the gospel, and it would be wrong for him to go merely out of a desire to be praised for being a missionary. The Bible forbids George from indulging in some things (selfishness, vainglory), but it does not limit his options to only one, excluding all the others. Decisions about medical care are often like this: we are permitted to choose between many righteous options.]

8. Kathy may choose to glorify God and serve others by taking the drug, bearing with the side effects bravely, and using her remaining strength to pray for others and to testify of God's goodness to her caregivers.

9. Kathy may choose to glorify God and serve others by declining the drug, loving her children, and then using her remaining days to pray, testify, and face the end with grace.

10. No matter what Kathy decides to do about the experimental-drug option, she and others can and should continue to pray that God would heal her completely.

    - We are to pray for what our hearts desire, submitting to God's superior knowledge of his purposes and our good. (Tim Keller's summary of God's answers to our prayers is apt: God always answers our prayers exactly the way we would want *if* we knew all that he knows and loved all that he loves.)
    - If Kathy is pursuing God's glory and serving others, it is faithful to ask for healing even if she is not using the experimental drug.

THE REST OF KATHY'S STORY

Pastor Mike told Kathy that it would be biblically OK for her to say no to the experimental therapy. He said that a biblical commitment to the sanctity of life did not mean treating physical life as the greatest good of all. The Bible teaches that God's glory and service to others can be more important, and in Kathy's condition it would be OK

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for her to choose a slightly shorter life that included spending meaningful time with her children. She and Pastor Mike prayed together for wisdom and peace about the decision, and again that Kathy would be directly healed. Kathy told her doctor that she wanted help in maximizing her strength and vitality without the experimental drug. Her doctor accepted her decision (with some sadness) and helped Kathy manage her symptoms while she traveled to visit her children. When Kathy returned from her trip, she enrolled in a hospice service that helped her stay comfortable until she died. Kathy died four months after her conversation with Pastor Mike, at peace with her children and with God.

ANOTHER CASE STUDY (IF TIME PERMITS)

Marla is 31 years old. She and her husband, Jim, have three children, 7, 4, and 2. Marla has been diagnosed with breast cancer, and her doctors recommend that she undergo a radical mastectomy and pursue a course of chemotherapy. The chemotherapy that they are recommending has a documented success (five-year survival) rate of over 60 percent. The side effects that will come with the chemotherapy are hair loss (probably total), fatigue, and periods of nausea. While Marla's situation is similar to Kathy's in some ways, it is much harder to conclude that Marla is permitted to decline the treatments that her doctors are recommending. Although the cancer may end up taking Marla's life, she has reason to believe that the treatments will be effective. Medically speaking, she is likely to live for a long time yet. In addition, Marla's family depends on her in ways that Kathy's family does not. As extreme as the mastectomy and the chemo side effects might seem to her, it is hard to see what righteous motive she could have for saying no to them. *Marla should agree to the treatment plan that her doctors are proposing*. Fellow believers should do all they can to help her through this trial, since a biblical concern for her life and her opportunities should lead everyone to use medical means to pursue her physical restoration. This will start with prayers for Marla's healing and strength, and will continue with finding ways to support Marla and her family with acts of service, generosity, and love.

For discussion: Does Marla have a biblical obligation to agree to the treatment plan?

FOR FURTHER CONSIDERATION (HOMEWORK)

1. What do you most fear regarding your own death?

2. Where do you want to die (if you are allowed to choose)? In the hospital connected to machines? At home with family nearby?

CLOSING PRAYER

Including thanks to God for the gift of life, and a request for wisdom for those facing hard choices about medical care.

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Lesson Two

CENTRAL QUESTION

What does the Bible teach about refusing life-sustaining treatment?

PRELUDE: MATTHEW 25:14–30

The last parables that Jesus tells before he is arrested are about being ready for judgment. In the parable of the talents, the focus is on making faithful use of the time between the master's going away and his final return. Three servants are given enormous sums of money, each "according to his ability." (Even one talent was a fortune, the value of at least 75 *pounds* of gold. In 2017 dollars, one talent would be worth $1.3 *million*. No one would have felt sorry for the third servant, even though he was given merely one talent.) When the master returns, he rewards the servants who made what they could with their time and talent(s). Those who worked faithfully "enter[ed] into the joy of [their] master." The one who hid his talent in the ground was cast "into the outer darkness."

The parable's main point, of course, is that we are to be working diligently with what we have while we await our Master's return. The parable also makes clear that our relationship with Christ is always one of Master and servant. In every choice we make—from how we raise our children to whether we make use of life-sustaining medical treatment—we are called by Christ to use what we have to serve his purposes. Living a long earthly life is a good thing in Jesus' eyes, but it is not his only aim. Even when making decisions about medical treatment, we should be looking to serve Christ with our time, energy, money, and opportunities.

REVIEW OF THE PRINCIPLES DISCUSSED AT THE LAST SESSION

1. Human life is valuable to God because humans bear the image of God, which in this life includes our physical bodies.

2. Extending physical life as long as possible is not the ultimate good, coming behind (at least) God's glory, our salvation, and wisdom.

3. The Bible permits us to choose a shorter life over a longer one in order to glorify God and serve others.

CASE STUDY/SKETCH

Dialogue between Sam, his children, and a friend.

[Roles: Narrator/Leader, Sam (S), Hannah (H), Tim (T), and Belinda (B)]

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Narrator/Leader: Sam is a spiritually mature 81-year-old widower. He is visibly in decline: much thinner than before, stoop-shouldered, with shaky hands and voice. He retired from his work in marketing ten years ago, in part because of health difficulties. After retirement, he traveled with his wife, Louise, until her mental health challenges forced them to stay close to home. She died three years ago after suffering a stroke. Hannah and Tim are Sam's grown children. Hannah is 57 years old. She lives in town with her husband and three children. Tim is 49 years old, is divorced, and lives four hours away by car. Tim has come to town—for the first time since his mother's death—to talk through Sam's plans for his medical care. Belinda is a friend of Sam's from church who is also a nurse practitioner. She is 61 years old and worked as a hospice nurse until moving to emergency medicine at the local hospital.

The gathering begins with Sam's introducing Belinda to Hannah and Tim. Then Sam gets down to business.

Sam: As you all can tell, I am not doing well physically.

Hannah: I don't know what you're talking about. You look much stronger than you did yesterday.

Tim: Come on, Hannah, open your eyes. Dad is only a shadow of his former self.

S: That's one thing we don't need to fight about. My body is falling apart, but my mind is fine. I want to talk to all three of you because I need your support.

H: You know we'll support you, Daddy.

T: (*put out*) Let's wait and see what he wants.

S: (*ignoring Tim's remark*) I've asked Belinda to join us because she knows my medical situation and can answer questions about what I can expect. Belinda, how am I doing?

Belinda: You are still mentally sharp, but you have more than one physical problem. The most serious problem is congestive heart disease. Your heart is not strong, which means that you will be weak and that any traumatic event could be more than it can take.

T: So his heart could stop during this conversation?

B: Probably not on its own. If his heart were his only problem, we might be looking into surgery or a transplant. But with his other problems, those aren't viable options.

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H: But if he is really careful not to overdo it, he'll be OK, right?

B: Being careful is best, but he has other problems. Your father is also dealing with some breathing issues and increasing challenges from his Parkinson's disease. You've probably noticed that his tremors are more severe.

H: Yes, but I was hoping he was just nervous about this conversation.

B: He may have been a bit nervous, but what you see in his hands and hear in his voice is part of a gradual loss of muscle control. It contributes to his trouble breathing, making it more and more likely that he will choke and have to fight to breathe. That fight will eventually be more than his heart can take, and it will quit.

H: (*sobbing*) No! We can't let that happen.

S: None of us can keep it from happening. And when it does, I want you to let me go to be with Jesus in peace.

H: But surely if I called 911, they would get here in time to save you.

S: I don't want that. I want you to stay close to me and let me go. You could sing hymns if you wonder what I would want you to do.

T: So you want us to let you die?

S: If my heart stops, yes. I have set my affairs in order. All the details—who to call about taking care of my body, what to do with my finances, all of it—are in the large envelope in the top drawer of my desk. As you know, I'm in a hospice program. They will know what to do.

T: How soon is this going to happen?

S: Belinda?

B: We can't know for sure. It could be months, but it could also be this week. Your father's condition is quite fragile.

H: (*to Sam*) But you seem so full of life right now. Surely there is something the doctors can do to prevent your heart from stopping.

S: I would have thought so, too, but my doctors agree that they have done all they can.

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H: (*with new energy*) Wait a minute. I know that the EMTs could restart your heart if you would let them. It happens all the time on TV shows. They use the paddles; there is a big thunk, and the heart starts again. After a stay in the hospital, the person is well enough to go home.

S: I've been talking to Belinda about that. She says it is a misleading picture.

B: Yes, and it makes most nurses angry. So many people end up with unrealistic expectations. In the first place, what they show on TV makes it look like all it takes is one or two jolts. In reality, resuscitating someone whose heart has stopped is much more like a violent assault. In order to restart your father's heart, they would have to pound on his chest so hard that they would break some of his ribs. They would force drugs into his bloodstream. And they would almost certainly have to push a tube down his throat to force air into his lungs. Even if your father were in good health otherwise, his chances of ever leaving the hospital still wouldn't be good. For someone as weak as he is with other health problems, resuscitation would be very unlikely.

T: So a resuscitation attempt would fail, right?

B: Depends what you mean by "fail."

S: I think it is up to me to decide what counts as "failing" in this case. From what I hear from my doctors, they might restart my heart. But it would take so much out of me that I would probably have to be hospitalized. And I would likely never be strong enough to leave the hospital. I don't want to die in the hospital.

T: Sounds like you've thought this through. What do you want from us? Are you unsure if this is the right decision?

S: I want you to support my decision not to be resuscitated. I have talked with the pastor. He was sad that the end seems near, but he thinks the Bible permits someone in my condition to say no to a resuscitation attempt.

Narrator/Leader: Let's take a straw poll before we hear more. How many here think that the pastor's advice is correct (that the Bible allows someone in Sam's condition to decline resuscitation)? [Record the vote tally for Yes, No, and Unsure. Allow one Yes voter and one No voter to each give a reason for his or her vote.]

H: But it sounds like you are giving up on life, Daddy. How can it be biblical to give up on life?

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S: It would be wrong to give up on life, but the pastor said that I would simply be choosing *where* I die. I am still praying that God will heal me of all my diseases. But if that is not God's will, then I will die soon no matter what. I would rather die at home than die in the emergency room or in a hospital bed.

H: (*growing agitated*) Why are you making us think about this?

S: Because I need to know that you understand what I want and that you will allow it to happen that way.

T: Makes sense to me. I'll support your decision.

H: But maybe I don't want to! What if I'm not ready to lose you?

S: Hannah, it means so much to know that you want me here.

(*pause*) Belinda, what would happen if Hannah does not agree with my plan?

B: Probably the doctors would follow her instructions.

T: But couldn't he write down what he wants and have a lawyer make it official?

S: Actually, I've already done that. My instructions are in the envelope in my desk with the other papers.

T: So why do you need Hannah to agree?

B: Because no matter how clear the instructions are, the doctors will have to protect themselves against a lawsuit. If Hannah is the only family member available, the law will tell the doctors to look to her to make decisions. And if they follow his instructions over hers, she might sue them.

T: But she'd lose in court, wouldn't she?

S: My lawyer says she would probably lose, but I would have machines keeping me alive while they sorted it out. I don't want that.

H: So you want me to promise not to fight your instructions?

S: Yes, that is what I want.

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H: Can I take some time to think about it?

S: Of course. Let's talk about this again tomorrow.

Leader: Before we look at some passages of Scripture for guidance, I'm curious what some of you thought about the attitudes of the children, Tim and Hannah, in this scenario. What did you think of Tim's attitude? What did you think of Hannah's?

Leader: Some of you here may know of people who have been in Sam's condition. It would help if you could fill in the picture for us. What can you add?

BIBLICAL REFLECTION

Leader: The handout lists six passages. We will discuss the first three before considering the others. [The discussion of these passages needs to be managed carefully to leave ample time (at least twenty minutes) for the discussion questions that follow.]

Isaiah 25:6–8

Death is not the ultimate victor: it is defeated by the Lord and swallowed up.

John 10:17–18

Jesus claims for himself the authority to lay down his life and take it up. We know from Romans 4:25 that Jesus did not raise himself from the dead. He laid down his life in order to accomplish the great good of our redemption. He could have lived a longer earthly life if he had avoided going to the cross. Jesus here says that faithfulness may involve living a shorter earthly life in order to realize a greater spiritual good.

Philippians 1:18b–23

Paul is in prison when he writes his letter to the church at Philippi. He knows that he will be "deliver[ed]," and he eagerly hopes that Christ will be honored even if that deliverance comes by his death. He does not want to be ashamed (v. 20), but instead wants either to live and continue in "fruitful labor" (v. 22) or to die and depart to be with the Lord (v. 23). Paul finds it hard to choose between these two unashamed possibilities. Staying alive allows him to serve others, which is good for them. Dying means being with Jesus, which is better for Paul. So even in prison with death a real possibility, Paul sees himself in a win-win situation. He summarizes this in verse 21: "For to me to live is Christ, and to die is gain."

Paul is not seeking to die. He is 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 lives or dies is in the hands of those who have him in prison. Paul is not considering refusing to eat so that he will die quickly. The courage he wants is probably the courage to maintain his profession of faith even if persecution comes with it—that he would not be ashamed of the gospel. But while the heart of Paul's desire here is to

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remain a faithful witness even unto death, his reasoning highlights that staying alive is for the sake of fruitful labor. Staying alive is not an end in itself apart from serving others. Paul may not take his own life, but he is not obligated to stay alive as long as possible just for the sake of staying alive. As Christ's servant, he is permitted to allow death to take him when fruitful labor is no longer an option.

Genesis 25:7–8

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 dies "in a good old age, an old man and full of years." While we are not told how Abraham dies, we are assured that his life was 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 is "gathered to his people," meaning that his body is buried near his loved ones and that his spirit joins the company of those who have gone before into direct fellowship with God. By the time of Jesus' earthly ministry, this place of rest for those who have died at peace with God was called "the bosom of Abraham." In Luke 16:19–31, Jesus tells of Lazarus, a poor man who died and was "carried by the angels to Abraham's bosom" (v. 22 nkjv). Abraham and Lazarus enjoy fellowship with God as they await 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.

2 Samuel 1:1–16

David executes an Amalekite who claims that he killed Saul at Saul's request. We are not permitted to take our own lives.

Ecclesiastes 3:1–8

There is a time for everything, including a time to die.

DISCUSSION QUESTIONS

1. Is Sam asking his children to help him commit suicide?

No. Sam's various physical challenges are bringing him to the end of his life. Sam is not trying to get his heart to stop working, and he will not try to bring on the choking/coughing spell that is so likely to signal the end. If he were to ask for help in stopping his heart or breathing, *then* he would be asking for help in committing suicide. In that case, his children should refuse to help.

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2. Ethicists typically hold that (active) killing and (passive) letting die are very different things. Is this distinction biblical?

   Yes. The Bible is clear that actively causing someone's death is murder (unless it is a just execution or a necessary act in a just war). In order to see that passively letting someone die may not be a sin, consider how Jesus responded to the request that he hurry to the side of Lazarus when Lazarus was sick. In John 11, we learn that Jesus delayed going to Bethany and that Lazarus died. Jesus had the power to keep Lazarus from dying, but he didn't use it. Because we know that Jesus was sinless, we know that allowing Lazarus to die was not a sin. We do not have Jesus' power to heal, but like Jesus we may at rare times accept that other purposes are more important than keeping someone alive as long as possible. Those purposes must be Christ's purposes—such as enabling someone to spare himself and his family the physical, emotional, and financial burdens of a resuscitation attempt and to focus his remaining days on serving others with his time and money.

3. Does Sam's plan violate the sixth commandment?

   A likely place to start in answering this question is to consider what the Westminster Standards say about the sixth commandment, "Thou shall not kill":

   Westminster Larger Catechism, Question 136: What are the sins forbidden in the sixth commandment?

   Answer: The sins forbidden in the sixth commandment are, all taking away the life of ourselves, or of others, except in case of public justice, lawful war, or necessary defense; *the neglecting or withdrawing the lawful and necessary means of preservation of life*; sinful anger, hatred, envy, desire of revenge; all excessive passions, distracting cares; immoderate use of meat, drink, labor, and recreations; provoking words, oppression, quarreling, striking, wounding, and: Whatsoever else tends to the destruction of the life of any.

   Sam is asking his children to neglect a lawful way to preserve his life. Does this mean that he is asking them to violate God's law?

   While the Westminster Catechism is an outstanding teaching tool and an excellent expression of the system of doctrine taught in the Bible, it is a product of its times in ways that the Bible is not. (The Holy Spirit inspired the Scriptures, preserving the human authors from error and working in, through, and in spite of the limitations of the authors' culture, class, etc.) If the Bible included language as specific as the Westminster Catechism about "neglecting or withdrawing the lawful and necessary means of preservation of life," then it would be sinful ever to refuse or turn off life-sustaining treatment that we could afford. (Using treatment without the ability to pay for it would not be a lawful use.)

   When the Westminster divines explained the meaning of the sixth commandment, it was the middle of the 1600s. At that time, none of the medical techniques now used to keep

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someone alive (or resuscitate someone) were available. (CPR, mechanical ventilation, and kidney dialysis have been available in any form only since the 1950s or later.) The catechism's framers correctly explained the meaning of the sixth commandment in the seventeenth century. What they probably had in mind was forms of suicide (hanging oneself or starving oneself to death) or murder by neglect (starving someone else). A PCA study committee report in 1989 found that withdrawing mechanical life support does *not* violate the sixth commandment as it is explained in the Westminster Catechism.

More importantly, the sixth commandment condemns murder, the willful taking of life other than as an act of executive authority (just war or punishment). Sam is asking his children to help him avoid a painful, invasive, expensive attempt to restart his heart. In his condition, the CPR attempt is likely only to result in his dying in the hospital and in spending money that could be put to faithful use elsewhere.

4. How might the situation be changed so that it *would* be wrong for Sam to make this request of his children?

If Sam had good reasons to believe that a resuscitation attempt would restore his ability to serve Christ faithfully, then it would be wrong—faithless stewardship—to make these plans and to ask for their help in carrying them out. It is important in this case that Sam's health is deteriorating (from Parkinson's), that he knows all too well what a resuscitation attempt involves (including the pain and other burdens), and that he has his doctors' clear account of what is likely to happen to him. Someone who was just tired of living would not be able to make this request faithfully. Such a person should instead be encouraged to consider ways that he or she could still serve Christ with time, talents, and resources.

5. Is Hannah required to go along with Sam's plan because she ought to "honor [her] father . . ."?

Yes—or at the very least, she should not work against Sam's wishes. Sam is not asking Hannah to do something sinful. He is asking her to do something *hard*, and it will probably make Hannah uncomfortable. Hannah can honor her father by helping him, but she can also honor him by asking lots of hard questions to see whether he has thought through what he is requesting. She can honor him by making an appointment to talk to her father's doctor to get a better picture of his health and prognosis. She can honor him by talking to his pastor or elder to see whether her father has sought godly counsel about the plan. But since he is asking for something biblically permissible and has made his decision carefully, then Hannah should pray that she will have the courage and strength to support the plan.

6. What should a Christian's attitude be about death? (Fear? Avoidance? Worry?)

The answer here is so obvious that the question may seem silly. But it is worth slowing down and realizing how scary death is when we are dealing with it as a present and pressing possibility. We know from Scripture that death has been defeated in Christ. We know that Christ has paid for our sins completely by his death on the cross. And we know that we have

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peace with God in heaven as our destiny in Christ. All these truths are fully warranted by Scripture. This knowledge may answer all our intellectual questions, but it doesn't dispel all doubts and surely does not quiet our bodily desire to live. Fear of a despairing (hopeless) kind is inappropriate, but fear as apprehension and a strong desire not to die are in keeping with our finitude. When people are fearful about facing death, what they need is compassion, for others to join in their suffering. They do not need a lecture. Our attitude about death should be *hope*. This is not the world's sappy positive thinking that refuses to deal with reality in a broken world. It is rather fixing our eyes on Jesus and claiming the promise that like Christ, we, too, will be raised to life everlasting in his presence.

7. Last week's handout suggested "further consideration" about what we fear about our deaths and where we want to die.

    a. What if I am worried about the impact that my death would have on my loved ones?

    Concern about the welfare of loved ones should lead us to take prudent steps to provide for their care if we die. Insurance policies, explicit arrangements with family and friends about care, and thoughtful financial planning are all appropriate. What we must not do is indulge the false idea that we are indispensable to God in achieving his purposes in the world. One of his purposes is caring for our loved ones. We should not worry. Instead, we should be one of the instruments that God is using to care for them now and after we die.

    b. What if I am afraid that I will be kept alive by machines and forced to linger just short of death?

    An officially designated *agent* (by advance directive, durable power of attorney for health care decisions, or other legal document) can be ready to speak for you, making it much less likely that you will be left to linger. Talking with your agent about what you want to avoid is an important step in preparing an advance directive. An agent's statement that "we discussed this sort of thing extensively, and I know she would not want aggressive measures used now" will almost certainly be sufficient to prevent you from being kept alive by machines.

    c. Is it OK to want to die at home?

    It is certainly OK, but cultural practices have shifted away from dying at home. The shift in practices is not a reason to think it is wrong to want to die at home. The shift does mean that some medical personnel and many family members may resist an effort to leave the hospital in order to die among family surrounded by familiar things. The hospice movement has helped to restore cultural acceptance of dying at home, but it is still wise to talk clearly with family members about what we want *long* before we lose the ability to think and speak clearly.

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PRINCIPLES AND APPLICATIONS

- We have the authority to say no in advance to life-sustaining medical care in some circumstances.
- There is a time to die, and Christ has defeated death for us.
- We are permitted to pursue a peaceful death when death is near.
- It is loving to honor others' instructions about allowing a peaceful death.

FOR FURTHER CONSIDERATION (HOMEWORK)

1. Who do you want to make medical decisions for you if you cannot make them?
2. What activities of your daily life do you value most (and why)?

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Lesson Three

CENTRAL QUESTION

What does the Bible teach about deciding for others and about suffering?

PRELUDE: THE BIBLICAL BASIS FOR SURROGATE DECISION-MAKING

Issue: Every state has laws that empower family members to speak for another family member who is unable to speak for herself or himself. Wives may speak for their decisionally incapable husbands; parents may speak for their children; and children may speak for their decisionally incapable parents. What—if anything—is the biblical basis for allowing family members to make decisions in these cases?

Golden Rule as Basis

- Matthew 7:7–12
- Luke 6:31

Covenant Basis

- Exodus 20:12
- Ephesians 5:22–33

The most common justification given for surrogate decision-making authority by an agent (see terminology below) is the "Golden Rule": do unto others as you would have them do unto you. This rationale is suggestive, and it is compelling to secular lawmakers because it is an uncontroversial maxim of moral seriousness. It is not, however, the strongest biblical grounds for honoring a family member's decisions. In the first place, Jesus gives the Golden Rule as a guide to how we are to treat our *enemies*. Family members—and especially not family members unable to make decisions for themselves—are not supposed to be thought of as enemies. Second and more importantly, Scripture throughout and the fifth commandment in particular assumes that families are bound by ties of covenant obligations and corresponding rights. The covenant connection between parents and children binds them in a way that they are called to speak for the others as *loved ones* when decisions must be made for those who are decisionally incapable. Even more than this, the covenant bond between husband and wife authorizes each of them to speak for the other when necessary. Indeed, in the case of husband and wife, as one flesh each speaks for *them*.

Terminology

- A person has *decisional capacity* if he or she is able to understand what is being asked, evaluate the options in light of his or her system of values, and communicate his or her wishes.

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- *Decisional capacity or incapacity* is determined by a licensed medical provider on the basis of a conversation with a person.

- If a person is determined to be decisionally incapable, then his or her medical care will be directed by a *surrogate* or *agent*.

- An *advance directive* is a written document that names an agent and/or expresses preferences regarding end-of-life care.

REVIEW OF THE PRINCIPLES DISCUSSED AT PREVIOUS SESSIONS

1. Human life is valuable to God because humans bear the image of God, which in this life includes our physical bodies.

2. Extending physical life as long as possible is not the ultimate good, coming behind (at least) God's glory, our salvation, and wisdom.

3. The Bible permits us to choose a shorter life over a longer one in order to pursue spiritual goods.

4. We have the authority to say no in advance to life-sustaining medical care in some circumstances.

CASE STUDY/SKETCH

Roles:

- Miriam (Nora's daughter)

- Lucy (in Miriam's small group at church)

- Sally (a friend of Miriam's who attends a different church and is a nurse)

Issue: What to do about Nora's struggles with kidney dialysis.

Note: The events in this story are true. They occurred in 2010, which may explain some of the limitations on access to dialysis. The challenges that arise, however, are still all too common. Decisions often have to be made about the use of burdensome life-sustaining treatment. Balancing the benefits gained with the burdens endured is difficult, and the estimate of when the burdens greatly exceed the benefits is rarely obvious without prayer, counsel, and reflection. It is important for the leader to give participants the freedom to be grieved by the events in the story. Some participants will have faced situations similar to those described. If they express a desire to tell *their* stories, the leader should encourage

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them to share. The experiences of fellow participants are typically very helpful in showing the complexity of what can happen and the great blessing of having conversations about those possibilities before the ability to make our wishes known is lost.

[Roles: Narrator/Leader, Miriam (M), Lucy (L), and Sally (S)]

Narrator/Leader: Miriam is the middle-aged daughter of Nora. Miriam needs help in deciding how to answer a question about Nora's medical care. Lucy is another member of the church small group that Miriam attends. Lucy and Miriam know each other well, and both are spiritually mature women. Sally is a Christian friend of Miriam's who attends a different church. Sally is also a nurse who works as a case manager at the local hospital. Miriam has asked Lucy and Sally to join her for tea to talk about the situation facing her mother, Nora. After they exchange pleasantries, Lucy prays that God would direct the conversation, that God would heal Nora of her difficulties, and that Miriam would be at peace.

Miriam: Thank you, Lucy, for your prayer. And thank you both for agreeing to help me think through what is happening.

Lucy: We wish we had a happier reason for getting together.

Sally: I agree. What is happening with your mother?

M: She is not doing well, and the main problem is her maddening behavior at the dialysis clinic.

L: Is dialysis necessary?

M: Yes. Her kidneys are not doing well, so she needs to spend a few hours twice a week at the dialysis clinic. She had a minor stroke three years ago and she is physically declining, but her doctor says that with dialysis, she is likely to live for another nine to twelve months. Sometimes she says that she knows it is important, but every time we've been to the clinic, it has been a nightmare.

S: Are the people at the clinic unkind?

M: No, they're great. The problem is my mother. Since her stroke, she is often confused. But when we are at the clinic, she becomes hostile. She resists the staff's efforts to get things started, and she tries to pull the tubes out—if they ever get them in. The clinic now says that something has to change before they will see her again.

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L: Can you tell what makes her resist the treatment?

M: She doesn't explain at all. As we are driving to the clinic, she gets agitated—and then once we are there, I can't control her.

S: We see this sometimes in the hospital. People with confusion and kidney trouble get paranoid as the time for dialysis approaches. The buildup of toxins that the dialysis will remove adds to confusion. It makes it easier to believe that others want to hurt you.

L: So the need for dialysis makes it harder for her to accept it?

S: It would seem so.

L: Couldn't the clinic hold her down while the dialysis is cleaning up her blood?

S: No. The clinic does not have the legal authority to place people in restraints, even for their own good. Only doctors in a hospital setting can put patients in restraints.

M: I know that firsthand. The second time I took my mother to dialysis, she fell and cut her forehead while struggling with a technician. There was blood everywhere, and we were taken by ambulance to the hospital. The ER doctor had my mother put in restraints because she was violent. While she was there, they gave her dialysis while waiting for a surgeon to come to stitch up her head. When the dialysis was over, she was no longer paranoid.

L: It sounds as if dialysis really helps. Could she go to the hospital to get the dialysis? They could restrain her, and it sounds like that is what she needs.

M: I don't know. (*looking to Sally*) Would the hospital do that?

S: It would be unusual. The hospital is not a dialysis clinic, and they would be reluctant to use restraints that often.

M: And even if the hospital allowed it, I don't think I could do that to my mother. She struggles to understand what is happening to her as it is. Imagine how awful it would be for her to be tied down and forced to have needles jabbed into her. To her, it would seem like she was being tortured twice a week.

L: Oh, dear. But she needs the treatment. Is there no other way she can get it? Can they do the dialysis at home? Maybe in familiar surroundings, she wouldn't be afraid.

M: They can't do the kind of dialysis she needs at home.

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S: At least not yet. It may be possible before long, but not soon enough to help Miriam's mother.

M: Because she needs dialysis, the doctors said that they see only two real options. First, they could give her antianxiety pills to take the day before and the day of her visits to the clinic. The pills would control her paranoia, and the clinic would allow her to come back for dialysis.

S: Did the doctors mention the side effects from these pills?

M: Yes, and they are discouraging. When she takes the pills, Mom is likely to be lethargic and mostly out of it. And on the days when she's not taking the pills, she will still be down. So on the pills she can get dialysis, but she won't be able to enjoy much of the rest of the time.

L: I guess I'm back to my first question: Is the dialysis necessary? What would happen if she didn't get dialysis?

M: That's the second option the doctors mentioned. If she doesn't get dialysis, she will probably die sometime in the next two months.

L: What would her condition be during those two months?

S: Because she gets paranoid only when she is away from the familiar surroundings of her home and family, she would probably not get fearful or upset. She could continue in her routine—going to church, watching her grandchildren, puttering around the house—as she got more confused and weaker. Eventually she would be too weak to get out of bed. And as the toxins in her blood reached critical levels, she would slip into a coma and die.

M: You make it sound simple and peaceful.

S: I don't know that it would be all simple and peaceful. But I'm sure it would be more peaceful for her than either of the other options with dialysis.

M: (*to Lucy*) Do you think I should give up on her, too?

Narrator/Leader: Before we hear Lucy's answer, do you think that the option of discontinuing the dialysis is a biblically acceptable option? [Discuss reasons for and against thinking so, possibly with reference to the principles discussed in previous sessions.]

Narrator/Leader: Let's pick up with Miriam's last question.

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M: (*to Lucy*) Do you think I should give up on her, too?

S: (*jumping in*) I'm not saying that anyone should give up. I'm only saying that I don't see a way for your mother to get the dialysis without a lot of other complications.

L: I don't think it would be giving up if you discontinued the dialysis. I think you would be choosing one kind of life for your mom over another kind of life. One is longer but dominated by things she wouldn't like. The other is a bit shorter and could be peaceful.

S: The main question, though, is "What would your mother want?" I know that is the question the doctors hope you can answer. Did you ever talk about anything like this with her?

M: I didn't know this kind of thing was *possible* before now, so I'm sure my mother didn't talk to me about it.

S: Do you know whether she has an advance directive?

L: What is that?

S: It is a document describing what you want medically if you are unable to speak for yourself. Does your mom have a lawyer?

M: I don't think so.

L: Would an advanced direction . . .

S: (*correcting*) Advance direct*ive*.

L: Sorry; would an advance directive make this simple?

S: Something in writing about this situation would be ideal, but it isn't necessary. The law directs the doctors to find someone who can speak for your mother, someone who can represent your mother's values.

M: I think I have a good idea what my mother values: time with her family, serving and worshiping at church, and the predictable string of little things that make up life at home.

L: Those values suggest that she would prefer to live in her normal routine rather than organizing everything around getting the dialysis twice a week.

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M: I see that. But I also know that she values the Bible and wants to obey its commandments. Wouldn't she be breaking God's law she if stopped fighting to live as long as she could?

Leader: With a partner, determine what you would say to Miriam if she asked what you thought she should choose for her mother in this scenario.

BIBLICAL REFLECTION

- Genesis 17:1–8—God's promise to Abraham extends to his children.
- Proverbs 23:22–24—Do not despise your mother when she is old.
- Matthew 15:1–6—For the sake of your tradition, you disobey the law to honor your father and mother.
- John 19:28–30—Jesus gives up his spirit, stressing that the biblical authority is with the one choosing.
- Romans 12:9–10—Love and honor each other in the Lord.
- Colossians 3:20—Children, obey your parents *in everything*.

A common theme in these passages is the deep and vital connection between parents and their children. These connections are far more than emotional. In Scripture, the connections are covenantal, which means that in addition to affection for one another, family members are peculiarly responsible for one another. These responsibilities bring with them the authority to speak for family members who cannot.

DISCUSSION QUESTIONS

1. What *goal* should Miriam have for her mother's medical care? In the hospital, the goal of care is "cure/restore," "keep comfortable," or, in some hospitals, "peaceful death." Is one of these the right one?

   There are ways to add to the story that could make "cure/restore" a lively option. If Nora could receive the dialysis treatment at home, it might be possible to manage her kidney function in a way that allowed her to live for months in adequate comfort, spending time with her loved ones and even going to church. It is also possible that antianxiety medicines have been developed since 2010 that would make it feasible for Nora to go to

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the dialysis clinic without being constantly woozy and listless in between visits. But in 2010, "cure/restore" (and even "maintain") was not medically and financially feasible. "Keep comfortable" is the best way to think about the overall goal for Nora's condition. "Peaceful death" should be a consequence of "keep comfortable," but it is better to focus the efforts on comfort.

2. Is it ever biblically permissible to make "peaceful death" our goal?

   Sometimes death is coming soon despite all that medicine can do. In some cases, this short timeline is still a challenge because the pain cannot be completely managed. While techniques for pain management ("palliative care") have made significant advances in recent years, some diseases still inflict pain that cannot be managed as death approaches. In these circumstances, "peaceful death" is a biblically permissible goal. Pain and suffering are not the same thing. A physical therapist helping someone recover from an injury must at times push the person to do things that hurt as part of the recovery process. But because the pain involved makes sense, the person enduring it does not *suffer*. A peaceful death is possible even when the physical discomfort (pain) is intense if the pain can be woven into a narrative of being loved and cared for. This is not easy, but for those facing a painful death, it is a blessing to be surrounded by loved ones aiming to make their death peaceful by their kind attention, prayers, and faithful presence.

3. Dialysis for Nora involves some suffering. Does the Bible obligate us to suffer in order to preserve our lives?

   The Bible obligates us to care for our lives and to be faithful stewards of our gifts of time, talents, resources, and opportunity. We are especially obligated to use our strength to advance Christ's purposes in the world as we are able. But the Bible does not obligate us to suffer *merely* in order to live longer. Our physical life is not an end in itself. Our lives are ours for the purpose of bearing the image of God, exercising spiritual and temporal dominion as our circumstances allow, glorifying God, and serving our neighbors. When uncomfortable medical treatment can do no more than keep us physically alive without the ability to serve others, we are not obligated to make use of those medical treatments.

4. What are the benefits and burdens of dialysis for Nora in her condition?

   Nora's combination of health challenges makes the benefits of dialysis meager (living longer with very limited opportunities to serve others) and the burdens serious (alternately confused and fearful, rarely able to make sense of the pains and restrictions required to administer dialysis in a strange setting).

5. How might Miriam figure out what her mother would want in this case? (What might she remember, or where could she go for insight?)

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Miriam should work to recall what Nora has said about others in situations at all similar to the one that Nora herself is in. Miriam could look through Nora's photo albums for help in remembering how other family members lived out their last days and what Nora said about their choices and conditions. She could ask Nora's surviving friends whether they remember Nora's talking about such things. Miriam could look through Nora's bookshelves for titles that she remembers Nora talking about that had to do with aging, disease, limitations, and what it means to care for loved ones. And Miriam should pray that God will lead her to people and things that enable her to see the options in the way that Nora would see them, and that the Holy Spirit will give her peace when it is time to decide.

6. Is the dialysis an *effective* treatment for Nora? Is it *excessively burdensome* for Nora?

   The answer to this will depend on the answer to the questions above about the goal for Nora's care and how Nora would probably estimate the benefits and burdens. In the actual case, Miriam determined that dialysis was ineffective as part of keeping Nora comfortable and that the burdens greatly exceeded the benefits.

7. What would you want your spouse or children to choose for you if you were in Nora's place?

   God's Word permits us to choose either to continue the dialysis (along with the antianxiety medications) or to discontinue the dialysis. We are not permitted to take our own life, but declining the dialysis is choosing a shorter life during which we are able to enjoy the company of family over a longer life of confusion and distress.

FOR FURTHER CONSIDERATION (HOMEWORK)

- How does your family resolve deep differences about what ought to be *done*? (This is not the same thing as how your family handles differences of opinion when no action is required.)
- Who would you want to join the discussion if your family was disagreeing about what to do?
- Are you willing to leave written instructions for your family about the medical care you would want if you couldn't make the decisions?

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Lesson Four

CENTRAL QUESTION

Why is it important to complete an advance directive for end-of-life care?

PRELUDE: PSALM 25:6–10

"The greatest *chesed* one can give his children is a clear advance directive." Rabbi Zev Schostak, "Holding On or Letting Go: Aggressive Treatment or Hospice Care? Making End-of-Life Medical Decisions" (December 4, 2008), http://www.yutorah.org/.

Read Psalm 25:6–10. This psalm of David calls on the Lord to remember his covenant promises in the midst of David's distress and Israel's need. David asks a lot. He trusts the Lord to show him the Lord's ways (vv. 5, 8–10), to remember him but *not* his sins (vv. 6–7, 11, 16), to be his friend (v. 14), to protect him in times of trouble (vv. 17–19, 22), and to deliver him from shame (vv. 1, 20). The basis for David's confidence that God will provide all these things for him is God's "steadfast love"—God's *chesed*. This word appears over two hundred times in the Old Testament, and over a hundred times in the Psalms alone. (Twenty-five of the occurrences are in Psalm 136, which recounts the works of the Lord on Israel's behalf and ends each verse with "for his *chesed* [steadfast love/loving-kindness] endures forever.") As is evident in Psalm 25, this kind of love is not God's general love for all people. It is God's specific covenant-keeping love for his own people. *Chesed* is an aspect of God's faithfulness to the promises that he made to Israel. His love is steadfast, showing itself in protecting Israel and delivering her from shame—not because Israel deserves it, but because God has promised to be her God.

The quote from Rabbi Schostak is taken from a lecture at Yeshiva University in 2008. He is trying to convey to his students the importance of preparing an advance directive about end-of-life care that is clear and can be found when it is needed. When he uses *chesed* to describe the act of completing an advance directive, he is digging as deep as a Jewish rabbi can to commend it. *Chesed* in his understanding is the greatest possible love: it is the love that Yahweh has for Israel. We don't have to be Jewish to appreciate what Rabbi Schostak is claiming. His point is that parents who love their children deeply will complete an advance directive.

REVIEW OF THE PRINCIPLES DISCUSSED AT PREVIOUS SESSIONS

1. Human life is valuable to God because humans bear the image of God, which in this life includes our physical bodies.

2. Extending physical life as long as possible is not the ultimate good, coming behind (at least) God's glory, our salvation, and wisdom.

3. The Bible permits us to choose a shorter life over a longer one in order to pursue spiritual goods.

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4. We have the authority to say no in advance to life-sustaining medical care in some circumstances.

5. Family members have a covenant responsibility and duty to choose for loved ones who cannot speak for themselves, making biblically permissible choices according to the loved ones' values.

6. We may be called to suffer for the gospel, but we are not required to suffer merely to stay alive.

JARGON THAT THE MEDICAL TEAM MAY ASSUME WE KNOW: IMPORTANT TERMINOLOGY THAT CAN BE CONFUSING

- An *advance directive* is a written document that:
  - Names an agent who will make decisions for someone who cannot (or will not) make them; and/or
  - Expresses preferences regarding end-of-life care for someone who is permanently unconscious or terminally ill.

- A *durable power of attorney for health care* names an agent without instructions.

- A *living will* or an *advance care plan* typically does exactly what an advance directive does.

- Decisions about someone's care may be informed by one of the following orders from a physician (M.D.):
  - *DNR (Do Not Resuscitate)* order, usually in force only during a hospital stay.
  - *POLST (Physician's Order for Life-Sustaining Treatment)*, in Georgia, which travels with someone between sites and visits.
  - *POST (Physician's Order Scope of Treatment)*, in Tennessee (like a Georgia POLST).

- A person is in a *terminal condition* if he or she is determined by a physician to be in an incurable or irreversible condition that is likely to result in death in a relatively short time. (To qualify for insurance-covered hospice care, the physician must determine that death will result within six months.)

CASE STUDY

The challenge facing the children of Wilfred, age 81.

Note: The point of this case study is that the families of people without advance directives can end up in very difficult situations even when the families are not dysfunctional. What happens to Wilfred's family in this story is all too common for people in American hospitals today. Unlike in some other countries where government officials make decisions about continuing

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life-sustaining treatment (for financial stewardship/justice reasons), in America these decisions are left to families and physicians. Because physicians have a reasonable fear of being sued by even one family member who thinks treatment was discontinued too quickly, in states that do not specify how family disagreements are to be settled, an impasse is likely to mean continuing care longer than the dying person would have wanted.

While the other sessions had class members reading parts of a dialogue from a script, this is a story simply to be read for all to hear. A class member who has shown an aptitude for reading clearly and smoothly might be asked to read this narrative. The leader may mark places where the reader should stop along the way to see whether people have questions.

Wilfred Johnson is an 81-year-old Christian. Until only four years ago, Wilfred was the pastor of a vibrant Bible-believing church. Six years ago, Wilfred lost his wife of fifty-two years to skin cancer. Their five children and their spouses all live within an hour's drive of the family home, where Wilfred lived until ten days ago when he suffered a heart attack during the birthday party for his youngest grandchild. The children called 911, and the EMTs got Wilfred's heart started again and took him to the local hospital. Leaving the grandchildren with their spouses, all the children followed the ambulance to the hospital. Wilfred has not regained consciousness since he collapsed, but after he was stabilized in the hospital, his heartbeat remained strong and he continued to breathe on his own. The children were not sure how long he had been unconscious before the EMTs arrived, but they knew that it was for at least ten minutes. Wilfred was placed in the ICU to be monitored. In addition to the monitors, Wilfred was given an IV to provide fluids, a nasogastric tube to deliver nutrition, and the ordinary devices for his eliminative functions. Wilfred has not exhibited any signs of being in pain since being settled in the ICU.

After five days of close observation and care, the medical team asks to speak to the children together. The doctors have determined that it is medically unlikely that Wilfred will regain consciousness, and they want to know what Wilfred would want concerning his medical care. A neurologist has run tests and concluded that Wilfred is unlikely ever to regain consciousness. The heart attack deprived his brain of oxygen, and the damage is significant. He is not brain-dead, and his heart and lungs are doing their job on their own. But he is not going to wake up. Even though all the children were present when Wilfred was admitted to the hospital, none of them knows whether he has an advance directive. In fact, none of them can remember their father talking about what he would want done if he was unable to speak for himself.

The doctor leading the family conference says that she thinks a do-not-resuscitate order is appropriate. If his heart stops again, she says, another attempt to restart it will almost certainly fail. The children are somber, but agree to the DNR order. One remarks, "I'm sure he wouldn't want to go through *that* again."

After signing the DNR order, the doctor asks what should be done about *feeding* Wilfred. The tube running through his nose into his stomach is not a long-term solution and is already causing difficulties. Along with increasing the risk of infection, this method

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of feeding complicates breathing and could lead to food being aspirated (going into his lungs). In order to maintain his calorie intake, the doctor recommends surgically inserting a tube directly into his stomach (a "PEG" tube). The surgery is simple, and fewer risks would be involved in feeding him that way.

The children ask for time to discuss the options, and even before the doctor leaves the room, the youngest of the five children says, "I'm sure he would want the PEG tube. He wouldn't want us to give up on him!" In the conversation that follows, the children learn that the youngest is the only one who thinks their father would want the PEG tube. The four older children are confident that their father would not want to live his final days in an ICU, being kept alive by machines. They are each sure that if he is not going to regain consciousness, then he would consider it a great burden to be stuck in a hospital bed, cut off from interactive fellowship with anyone. The youngest sibling thinks Wilfred would want them all to be praying for a miracle. He (the youngest) concedes that there is no medical reason for hope, but he insists that their father had prayed boldly for others to be healed. Why wouldn't he want that for himself? The PEG tube would give them more time to pray that he will be restored despite the doctors' gloomy prognosis.

After forty-five minutes of increasingly heated discussion, the children are not able to agree about the PEG tube. In the absence of either an advance directive or consensus from the children, the medical team is effectively stuck. (Even a simple document naming one of the children as Wilfred's agent would have been sufficient. The agent would have been wise to consult with the siblings, but in the end the child named as the agent would have been empowered to speak for Wilfred.) Two doctors could have agreed to take over the decision-making responsibilities from the children, but they really don't want to do that. What they want is for the children to agree.

BIBLICAL REFLECTION

- Genesis 48:21–49:33—Jacob's final pronouncement on his children before his death.

- Deuteronomy 33:1–29—Moses' blessing of Israel, tribe by tribe, before his death.

Both of these passages describe leaders of Israel who make a concerted effort to bless their children before death overtakes them. It is evident in both cases that their words of blessing are also prophetic, pointing ahead to the fulfillment of God's promises to Israel to send a Ruler/Redeemer. We cannot presume to be *fore*telling in our thoughtful last words to our families, but we can aim to be reconciled to them and thus to *forth*-tell the truth of the gospel. Along with leaving instructions about what we want regarding our medical care, we should also be seizing the opportunity to seek forgiveness for unrepented wrongs. We should be looking to bring estranged loved ones closer together as well. When death approaches, the attention of our family members will be unusually focused on what is being said, and they will be more likely to see the folly of nurturing petty disputes or being selfish. Writing an advance directive is a great blessing because it removes doubts and divisions about what we wish. But it is only one part of meeting death in a way that shows love to

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our families. Everyone should know the importance of leaving a financial will, but other preparations are just as important.

DISCUSSION QUESTIONS

1. Are the children justified in agreeing to the DNR order?

   Yes, it seems that they are. They have no specific information about what Wilfred wants to happen if he is unable to make this decision. He beat the odds in being resuscitated by the EMTs, but the chances of a second attempt succeeding are much lower. The pounding that his body took in the first attempt has left him even weaker and more vulnerable. The doctor would not have recommended the DNR order if Wilfred had a serious chance of being resuscitated after another heart event.

2. Are the children biblically permitted to decline the PEG tube option?

   Wilfred is permitted to decline treatment that would be either ineffective or greatly burdensome (when the burdens would greatly outweigh the benefits), so the answer to this question depends on the answer to these questions:

   a. Will the PEG tube be *effective*? (Note: The answer depends on the *goal* of his care. Would Wilfred want the goal to be *curing* him or restoring him to health *even though that is (humanly speaking) unlikely*? Or would he want the goal to be keeping him comfortable during his final hours?)
   b. What are the benefits that Wilfred will enjoy if the PEG tube is inserted? It would keep him alive longer in the hospital bed.
   c. What are the burdens that he will bear from it? He is more likely to die from choking on aspirated food. He will be unable to enjoy any spiritual goods—worship, the Word of God, the sacraments—in the ordinary way. He will be delayed in going to be with Jesus.
   d. Will the PEG tube be greatly burdensome to Wilfred *as Wilfred would evaluate things*?

   If the children are confident that Wilfred would want the goal to be the medically feasible aim of keeping him comfortable and that the burdens of having the PEG tube would greatly exceed the benefits he would realize, then they are biblically permitted to decline the PEG tube.

3. Doesn't the law say what should happen when children disagree?

   Most state laws give the children the power to decide for their parents, but most states do not specify how disagreements among the children are to be settled. In those states, hospital policies are in place to guide decisions, but reasonable fears of legal action often prevent those policies from being followed. One child who is unhappy and willing to sue is likely to lead the medical team to continue care even if hospital policy gives them a way to override a demand that the care continue.

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4. Does it matter for the decisions whether the doctor is a Christian or not?

   It matters a great deal for the doctor's spiritual future, but it does not make a practical difference in the weight that the children should give to the doctor's assessment of Wilfred's condition and prognosis. If the physician expresses disdain for Wilfred or a desire to see people like him die quickly, that is a reason to ask for another physician's opinion. But unless there is clear evidence of incompetence or hatred, Christian and non-Christian doctors can be trusted to give the medical advice that the children need to speak for Wilfred and make decisions as they are needed.

5. Does it matter for the decisions whether Wilfred is a Christian?

   This question is more complicated. In this case, Wilfred's faith in Christ's work on his behalf makes it much easier for his children to count as a significant burden his being kept alive, unconscious, deprived of the ordinary means of grace. Being delayed in being at home with the Lord is also a burden. Declining the PEG tube is likely to be easier if the children know that Wilfred knows Jesus. If Wilfred were not a Christian—did not know and trust Christ—and his children were believers, the children might count any prospect of regaining consciousness and the opportunity to turn to Christ as worth the burdens involved. If they were choosing what was in Wilfred's overall best interest, they might agree to the PEG tube on the grounds that eternity apart from God should be avoided as long as possible. What makes this question especially difficult, though, is the kind of decision that the children are supposed to make. They are not choosing what Wilfred *ought* to choose. They are choosing what Wilfred *would* choose if he were able to make the decision. Wilfred's faith or lack of it will make a big difference in the emotional heaviness of the decision, but the children should choose as Wilfred himself would choose.

6. The children in this case disagree about what the goal should be for Wilfred's care. Can you tell from the scenario what he would want the goal to be? (Cure/restoration? Comfort? A peaceful death?)

   From the information given in the case study, it is not possible to say with certainty what Wilfred would choose. The children will need to work together to remember all that they have heard their father say about people in similar circumstances.

7. Could Wilfred have left biblically appropriate instructions that would have given his children (and the doctors) an adequate idea of what he would want in this situation?

   Easily. Every state-approved advance directive form now has a section specifically about tube-feeding (IV or artificial nutrition and hydration). Completing one of these forms *and explaining it to his children* would have made this disagreement unlikely. And even if one of the children didn't remember, understand, or agree with those instructions, the form would have identified someone as the agent to make the decision. The lack of consensus among the

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children would not have delayed the decision. (The lack of consensus would still be a source of grief among the children, however. Good pastoral care would recognize that ongoing difficulty and take steps to bring them together.)

8. Why might someone be reluctant to leave an advance directive?

The main reasons for not completing an advance directive are:

a. Confidence that surely it won't be needed for years.
b. Unease in imagining being close to death and probably beyond the help of medicine.
c. Concerns regarding making children sad about having to think about aging and death.
d. Anxiety that the existence of the directive will lead doctors and family members to give up too soon.
e. Theologically misguided expectations about living to see Jesus' return.

None of these is a sufficient reason to put off completing an advance directive. All are based in unbiblical beliefs about our control of the future (a, e), ignorance about how a directive is used (d), or an imprudent avoidance of facing difficulty now (b, c).

9. What should someone do with his or her advance directive to make sure that it will be used if needed?

- Put one copy in the same file/folder/envelope/desk drawer as your last will and testament and your life insurance records.
- Give a copy to the doctor who performs your physical exam each year.
- Give a copy to everyone you name as a possible agent.
- Give a copy to the hospital that you are likely to be in when the document is needed.

FOR FURTHER CONSIDERATION (HOMEWORK)

Find a form that you are comfortable using to leave instructions for your loved ones in case you cannot make medical decisions yourself. Such forms can be found at:

- http://www.noah-health.org/en/rights/endoflife/adforms.html (Links to every state's AD forms)

- http://www.agingwithdignity.org/forms/5wishes.pdf (The Five Wishes form to preview only)

- http://www.agingwithdignity.org/five-wishes.php (The Five Wishes form to purchase and print)

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- http://www.tiftregional.com/documents/Advance%20Directive/advance%20directive.pdf (Georgia AD Form)
- http://www.alabar.org/members/advdirective.pdf (Alabama AD Form)
- http://health.state.tn.us/AdvanceDirectives/index.htm (Tennessee AD Forms collection)

Detailed instructions for completing an advance directive are given in chapter 5 of Bill Davis's *Departing in Peace* (Phillipsburg, NJ: P&R Publishing, 2017).

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