Holy Living, Holy Dying
2 Corinthians 4:16 – 5:9; Romans 14:7-9
April 10, 2005

In recent months our nation has entered into the intimate and painful struggle of one family regarding medical treatment for a family member. While opinions differ about how the situation was handled, perhaps the most important redeeming factor is the awareness raised in the public eye of the need to have conversations and make decisions before any of us might suddenly find ourselves in similar circumstances.

Because these issues deal with matters of life and death, of values and ethics, it is important that communities of faith be a party to the conversation. As people of faith, our Christian beliefs are the primary guide in all of our living and our dying. I share some thoughts today in the hope that it might inspire your own conversations and provide some guidance in these matters. We begin with some fundamental affirmations of our Christian understanding of life, illness, and death.

We believe that human life is created by God. "We are not the authors of our own existence, but receive our lives as gifts from God."[1] The divine purpose of life is to love God and one another. Thus we see all of life as holy, sacred, belonging to God.

Because life is a gift, our lives do belong to God. They are shared with us in trust, that we might be stewards, caretakers of the time, talent, health, abilities, and resources entrusted to our care.

Human life is vulnerable to illness, accident, and death. Oftentimes these arise from natural causes, but too frequently our human sins of exploitation, indifference, and violence exacerbate our exposure. Through Jesus' death, we know that God enters into our suffering even to the point of death. God does not leave us to suffer alone; in our weakness, we still belong to God.

From the ministry of Jesus, we have received the task of ministering to the sick, relieving any suffering possible, and sharing the burden with those who do suffer. The mandate from Jesus is to tend to all the needs of the sick: physical, emotional, social, and spiritual needs. The Christian community must be engaged in promoting health, healing suffering, and being present with the dying.

We know that every human life will ultimately end in death. Death is never a sign that God has abandoned us, no matter what the circumstances of the death might be. As Christians we believe that death is not the end of

life but a transition into full union with God. The pain of dying is like the labor pains that lead to birth. Death is our birth into a resurrected life of healing, wholeness, and holiness. Compassionate care for the dying is part of our stewardship of God's gift of life. Sharing in the midwifing of a person from this life into eternal life have been some of the most intimate and profound experiences of my ministry. As life is holy, so also shall our process of dying be holy, sacred.

A solid grounding in our faith and practice in applying our faith to everyday life will make our trust in God a natural resource when we face crises of any kind in our lives.

We stand with gratitude and awe before the great advances in modern medicine in the last century. In the late 1800s, scientists developed anesthesia and antiseptic surgery. In the 1920s, modern antibiotics arrived with the first sulfa drugs and the discovery of penicillin. During World War II, refined penicillin and blood-transfusion techniques saved thousands of lives. The '40s brought more effective medicines, antibiotics and chemotherapy. In the '50s, polio led to more sophisticated breathing machines and the first intensive care units (ICUs). CPR has saved countless lives since its arrival in the '60s. And over the past 40 years we've benefited from high-tech advances in surgical procedures, dialysis and organ transplants.[2] Medical science has done much to prevent disease, cure illness, and provide treatment to extend meaningful life.

Given the advances of medical technology, we may be faced with difficult choices about potentially life-prolonging medical decisions. Chaplain Hank Dunn suggests four common questions that require decisions about medical treatment.

1) Shall resuscitation be attempted?

2) Shall artificial nutrition and hydration be utilized?

3) Should a nursing home resident or someone ill at home be hospitalized?

4) Is it time to shift the treatment goal from cure to hospice or comfort care only?[3]

My purpose today is to give us some handles for wrestling with these questions when we are faced with them. It is helpful to first establish the intended goal of medical care. What outcome can reasonably be expected from medical treatment, given the current condition of the patient? Let's look at three possible goals.

One goal is cure. Most health care today is directed toward the prevention or cure of disease. A second goal is stabilization of functioning.

Many diseases cannot be cured, but they may be temporarily stopped from getting worse so that the patient can function at a level acceptable to him. A third goal is preparing for a comfortable and dignified death. At some point, medical treatment will no longer be able to offer us an acceptable quality of life. At such a time, a decision may be made to switch to comfort care only or palliative care to keep the patient free of pain and comfortable as the end of life approaches. The goals of a particular situation often change as the patient's condition changes.[4]

One way to determine if a treatment can accomplish a hoped-for outcome is to try it for a period of time. This is a "time-limited trial" to attempt to cure or stabilize a patient. It may also allow time for family to arrive to participate in decision-making or to say good-bye. At the end of the trial, hopefully with more information, the situation can be reassessed and the goals may change.

Seventeen years ago my mother was in a severe car accident. The injuries she sustained could have been fatal. Given the nature of her injuries, standard medical procedure at the hospital was to put her on a ventilator, a breathing machine. We understood that this would allow the medical team time to assess her injuries and determine a prognosis. She remained in intensive care on the ventilator for three weeks, during which time the medical team was hopeful, and she eventually returned to a normal life. We were grateful for the medical technology that saved her life at that time. In recent years, however, her health had deteriorated to a point that she requested that no heroic medical intervention be taken in an emergency. We did not have to make that decision for her, but I was well aware of her wishes.

A continuing question to ask in medical situations is: What is the goal of treatment, given the patient's current condition? Possible options are cure, stabilization, or comfort care to prepare for a dignified death.

It is helpful to have some basic information about the treatment being considered. I can't go into depth today, but I have ordered some resources to have available for you should you like to explore these areas further. Let me lift up a few important facts.

The survival rate for all patients who have CPR attempts averages 15.2 percent. Resuscitation attempts are most successful on patients who are generally healthy with the cardiac or respiratory arrest or a specific kind of abnormal heart rhythm as the only medical problem. It is the standard assumption of every emergency medical team, nursing home or hospital that every patient whose heart stops will receive CPR. Patients or their decision-

makers may request from the physician an order not to attempt resuscitation.[5]

Feeding tubes can help many patients get through temporary times of eating difficulties. Some patients choose to use a feeding tube permanently after they have lost the ability to swallow, because they can still maintain a meaningful quality of life. Permanently unconscious patients can be sustained for years with a feeding tube. There are several risks related to feeding tubes. Hospice Chaplain Hank Dunn says, "To withhold or withdraw artificial feeding is to allow a natural death to occur. When a person dies after the withholding of artificial food and fluids, the death is from the condition or disease that made the patient unable to eat, not from the removal of artificial feeding. Nothing is introduced to 'kill' the patient, but the natural process of dying is being allowed to progress. Choosing not to force-feed a person is choosing not to prolong the dying process."[6]

Dr. William Lamers, Medical Consultant for the Hospice Foundation of America, notes that "For persons in the final phase of illness, the withholding of food and fluids is not painful. To the contrary: the administration of food and fluids to dying persons can extend their general discomfort and frustrate their desire to just let go and allow nature to take its course….Dehydration is not a painful process…There is a side effect of starvation and dehydration in which one's metabolism changes and the resulting elevated level of ketones produces a mild sense of euphoria, so that hunger and thirst are not the problem we would imagine."[7]

Our United Methodist *Book of Resolutions* states that the use of medical technologies "requires responsible judgment about when life-sustaining treatments truly support the goals of life, and when they have reached their limits. There is no moral or religious obligation to use them when the burdens they impose outweigh the benefits they offer, or when the use of medical technology only extends the process of dying. Therefore, families should have the liberty to discontinue treatments when they cease to be of benefit to the dying person. However, the withholding or withdrawing of life sustaining interventions should not be confused with abandoning the dying or ceasing to provide care."[8] Comfort care in the forms of pain relief, companionship, and support must continue in the hard and sacred work of preparing for death.

It is important to get the most accurate information possible about the medical treatments available and their possible impact upon a particular situation. Knowledge can empower us to act in the healthiest ways possible.

The Terry Schiavo case has certainly lifted up the importance of having conversations about these issues with our family members, authorized decision makers, physician, pastor, and close friends. "At present, approximately 90 percent of deaths are anticipated, usually as the result of one or more chronic disease that have been treated for an extended period of time. Only 10 percent of deaths are sudden and unanticipated."[9] Right now we have the gift of time to discern our personal desires and share them with those who are likely to care for us. We have the opportunity to ask those for whom we may be responsible what their wishes are for the last phase of their lives.

These conversations are often difficult to have. Our culture lives in a denial of death. But among the gifts of Pope John Paul II have been his openness about his disease, his model of aging with dignity, and his transparency about the process of dying. Here are some ways in which we might open caring conversations with one another.

What concerns do you have about your health or future healthcare?

What are your fears regarding the end of your life?

What do you most value about your physical or mental well being (being outdoors; being able to read or listen to music; awareness of surroundings and people with you)?

If you could plan it today, what would the last day of your life be like?

What would you like to do and who would you like to see before that last day?

What gives your life meaning and purpose?

What will you want for comfort and support as you journey near death?

Where do you want to be and what things do you need to be comfortable during your last phase of life?[10]

How would you describe an "acceptable quality of life" for you?

How do you feel about what the doctors have told us?

Should difficult decisions ever need to be made about your medical treatment, it is best to have your desires documented. A living will is a document that takes effect while the person is still living but can no longer speak on his or her behalf. It basically declares that if I have a terminal condition with no hope of recovery, I do not want my life prolonged by artificial means.

A different document is an Advance Directive that allows you to state in advance your wishes regarding treatments that may prolong your life and to name a person to make healthcare decisions for you. A difference is that

most living wills apply only when you are terminally ill; an Advance Directive becomes effective whenever you lose your ability to make and communicate decisions.

These documents should be completed as legally required with appropriate witnesses. Then copies might be shared with your family members, your designated decision maker, your doctor, even your pastor, if you wish.

As your pastor I am available to share the journey of decision-making regarding medical treatment. Oftentimes it is helpful for a family to have a consultation with doctors, a social worker, and a pastor to assess a patient's condition and chart the next steps.

The most important thing is to have conversations about medical treatment and the last phase of your life. When we do so in the context of our Christian faith, we need not fear death.

Ethicist Rubel Shelly has written, "Death is not always the ultimate enemy and is not always to be resisted. The real enemies to the patient are disease, trauma, degeneration and pointless pain….Death is sometimes an ally instead of an enemy. Perhaps death itself needs to be reconsidered by all of us. It is not an absolute evil. It is sometimes an instrumental good for those without reasonable hope of recovery. Sometimes the real evil lies in forcing someone to endure existence that is no longer really life."[11]

We have heard the promise of the scripture: "We do not live to ourselves, and we do not die to ourselves. If we live, we live to the Lord, and if we die, we die to the Lord; so then, whether we live or whether we die, we are the Lord's" (Romans 14:7-9). Given that hope, we can trust that the travail of death leads to continued life with our Lord. As Easter people, we believe in the triumph of hope over despair, light over darkness, and life over death. Whether we live or whether we die, we are the Lord's. Thanks to be God.

Pastoral Prayer

God of Power and Might, we come to you as Easter people, trusting in your promise to bring life even in the face of death. We witness in the ministry of Jesus his desire to give new life to those who are hurting and broken. In his own death, we see his solidarity with those who are dying. Throughout his ministry, we see the mark of your ever faithful presence.

You are with us, O God, in the changing seasons of life. We see your fingerprint as bright blossoms spring forth from barren limbs. We feel your warmth in the summer sun. We sense your hold even as the leaves fall from

the trees. In the barrenness of winter, we know that you are still at work in hidden, mysterious ways.

As our personal lives change day by day, sometimes moment by moment, remind us that you are a firm rock upon which we can stand. Uphold us with your love and grace.

May your blessings of solace rest upon all who grieve for loved ones. Walk with those who approach the final phases of their lives and lead them to eternal life with you. Be with family members who care for loved ones, offering them wisdom and strength for their ministries.

Hear our prayers for your creation, O God. Even as we enjoy the beauty of springtime, we are mindful that the health of the environment is in danger. We pray for world leaders seeking to bring stability and peace to broken lands. We pray for your people, struggling to make a living, worrying about how to care for their children. May your resurrection power of new life be let loose throughout the world and upon your people everywhere, bringing the transformation you desire.

We pray in the name of our Risen Lord, Jesus Christ. Amen.

United Methodist Social Principles on Faithful Care for Dying Persons

While we applaud medical science for efforts to prevent disease and illness and for advances in treatment that extend the meaningful life of human beings, we recognize that every mortal life will ultimately end in death. Death is never a sign that God has abandoned us, no matter what the circumstances of the death might be. As Christians we must always be prepared to surrender the gift of mortal life and claim the gift of eternal life through the death and resurrection of Jesus Christ. Care for dying persons is part of our stewardship of the divine gift of life when cure is no longer possible. We encourage the use of medical technologies to provide palliative care at the end of life when life-sustaining treatments no longer support the goals of life, and when they have reached their limits. There is no moral or religious obligation to use these when they impose undue burdens or only extend the process of dying. Dying persons and their families are free to discontinue treatments when they cease to be of benefit to the patient.

We recognize the agonizing personal and moral decisions faced by the dying, their physicians, their families, their friends, and their faith community. We urge that decisions faced by the dying be made with thoughtful and prayerful consideration by the parties involved, with medical, pastoral, and other appropriate counsel. We further urge that all

persons discuss with their families, their physicians, and their pastoral counselors, their wishes for care when they are not able to make these decisions for themselves. Even when one accepts the inevitability of death, the church and society must continue to provide faithful care, including pain relief, companionship, support, and spiritual nurture for the dying person in the hard work of preparing for death. We encourage and support the concept of hospice care whenever possible at the end of life. Faithful care does not end at death but continues during bereavement as we care for grieving families.

[1] "Faithful Care for Persons Suffering and Dying," *The Book of Resolution of The United Methodist Church* (Nashville: The United Methodist Publishing House, 2004), p. 322.
[2] "The Changing Role of Medicine and Our Changing View of Death," *Decisions*, Sacramento Healthcare Decisions.
[3]Hank Dunn, *Hard Choices for Loving People: CPR, Artificial Feeding, Comfort Care, and the Patient with a Life-Threatening Illness* (Herndon, VA: A & A Publishers, Inc., 2001), p. 6.
[4]Ibid., pp. 7-8.
[5] Ibid., p. 16.
[6] Ibid., p. 21.
[7] William Lamers, M.D., *Nutrition and Hydration*, Hospice Foundation of America, 2005, retrieved from www.hospicefoundation.org April 3, 2005.
[8] "Faithful Care for Persons Suffering and Dying," *The Book of Resolutions of The United Methodist Church* (Nashville: The United Methodist Publishing House, 2004), p. 323.
[9] William M. Lamers, M.D., "Life-Threatening Illness," *Clergy End-of-Life Education Project* (Florida Dept. of Elder Affairs & Hospice Foundation of America, April 2003), Part II-A Medical Perspectives, p. 5.
[10] *Caring Conversations Workbook* (Kansas City, Missouri: Center for Practical Bioethics, 1999) retrieved from www.practicalbioethics.org April 1, 2005.
[11]Dr. Rubel Shelly, "In grueling situation such as these, death is not always the greatest enemy," *The Tennessean*, March 23, 2005.