Bioethics & Compassion

Quarterly Bible Study

LEADER'S GUIDE FOR STUDY 5

Pulling the Plug

When is it okay to let go of the terminally ill?

At issue today is when life ends. At first glance, the Christian's high view of life may indicate that any and all steps should be taken to keep a terminally ill person alive as long as possible. But is this really the most loving, humane, and godly thing to do? How might Christians have been influenced by a secular view of death?

Lesson #5

Scripture:
Genesis 2:7, 3:19; Exodus 20:13; Deuteronomy 27:24–25; Job 1:20–22; Proverbs 1:11–12, 15–16; Ecclesiastes 9:3–10; Daniel 3:13–18; Matthew 5:21–22, 26:6–13, 26–29, 36–46, 51–56; Mark 12:30–31; Acts 7:54–60, 17:24–28; Romans 5:12, 13:8–10, 14:7–9; 1 Corinthians 13:4–7, 15:24–26; 2 Timothy 4:6–8; Hebrews 9:27; James 1:5; Revelation 21:3–4

Based on:
"The Inevitability of Death," by Rob Roy MacGregor, CHRISTIANITY TODAY, April 1987, page 24

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PART 1

Identify the Current Issue

Note to leader: Prior to the class, provide for each person the article "The Inevitability of Death" from CHRISTIANITY TODAY (included at the end of this study). Because this is a controversial subject with many valid views, be sensitive to each other's perspectives. Try to learn from each other's views and experiences, rather than coming to a consensus.

Discussion starters:

[Q] What is Dr. MacGregor's conviction concerning medical care in America today?

- How is the view of death changing in our society?
- How do doctors typically approach the application of medical technology?

[Q] Why might legalities and ethics make us hesitant to stop treatment in some cases?

- Who makes the judgments concerning treatment of the terminally ill?
- How does one case relate to another? What happens to absolutes when each case is treated individually?

[Q] How do the attitudes and beliefs of most doctors affect their approach to treating the terminally ill?

- Why might a doctor be unwilling to allow a patient to die?
- What do most doctors believe about their patients' desires for health care?
- How does peer pressure affect a doctor?

[Q] How has society's approach to death today affected beliefs about continuing or discontinuing life support?

- What happens when we avoid dealing with death? What happens when we don't believe in an afterlife?

[Q] What steps does MacGregor give that may help a Christian deal with a terminal illness?

- When should the doctor, patient, and family start discussing the extent of medical care?
- Who makes the final decision?
- What happens if the decision is wrong?

[Q] MacGregor says that doctors have relinquished the judgment process in attempting to sustain life. What are the roles of the Christian doctor and of God in this judgment process?

- How does faith affect the doctor's decision-making process? At what point does the doctor relinquish his role as judge to God?

PART 2

The Scriptures

"A physician's duties are to diagnose, to initiate a treatment, to offer relief of symptoms, and to provide a safe passage."

—Dr. Jacob Bigelow

[Q] According to the Bible, what part does death play in human existence?
a. Read Genesis 3:19 and Hebrews 9:27.

- In what sense is death a natural part of life?
- Read Daniel 3:13–18. What did Shadrach, Meshach, and Abednego believe about God's deliverance?
- Read Matthew 26:6–13, 26–29, 36–46, 51–56. How did Jesus deal with his impending death?
- Read Acts 7:54–60. How did Stephen respond in his last minutes of life?
- Read 2 Timothy 4:6–8. What attitude did Paul have toward death?

[Q] In what sense is death an unnatural event for us? Read the following Scriptures:

- Ecclesiastes 9:3–10: What frustrated the author in this passage?
- Romans 5:12: Why do we have death?
- 1 Corinthians 15:24–26; Revelation 21:3–4: What will ultimately happen to death?
- What adjectives are used to describe death? How is death personified?

[Q] What perspective do the following verses give to life on earth?

- Psalm 39:4–7: How should we view our earthly lives?
- John 11:25–26: What does it mean that Jesus is the resurrection and the life?
- John 14:2–4: How does this verse give perspective to trouble we may now experience?
- Philippians 1:20–24: If you choose as Paul did, to say, "to live is Christ and to die is gain," what difference would that make in the way you think and behave?
- Revelation 21:1–2: How should we view the end of our earthly lives? What is the difference between life on earth and life in heaven?

[Q] Read Genesis 2:7; Job 1:20–22; Acts 17:24–28; and Romans 14:7–9. What control do we have over our own lives?

- Who gave us our lives? Who takes them away?

[Q] What are the differences between killing and ending life support for a terminally ill person? Read the following Scriptures:

- Exodus 20:13
- Deuteronomy 27:24–25
- Proverbs 1:11–12, 15–16
- Matthew 5:21–22
- What are the characteristics of murder common to these verses? How do they differ from the characteristics of terminating treatment as described by MacGregor?

[Q] How can we know God's will when faced with the decision of continuing or discontinuing life support for a terminally ill family member? Read the following verses:

- Mark 12:30–31
- Romans 13:8–10
- 1 Corinthians 13:4–7
- James 1:5
- What attitude must we have toward the ill person before we make a decision? Whom must we rely on to make the choice?

PART 3

The Application

"To confront fears of death is to have an opportunity of growth to new maturity in dealing with those who are now dying, and to prepare for ourselves and for those to whom we are responsible, a better facing of life and death... . If we are not prepared to think out clearly the personal meaning of our deaths, we become the 'victims' of someone else's meaning for our deaths."

—Melvin J. Krant, M.D.

[Q] Divide into small groups of three or four. Discuss how you would feel and act if you were (1) the patient, (2) the doctor, and (3) a family member in each of the following cases.

If you are short of time, assign each group one of the following cases.

Case 1: The patient is an 86-year-old woman who suffered a stroke two years ago. Since then she has been in a nursing home, where she is fed through a feeding tube. Each day she is

given drugs to strengthen her heart and prevent infection. She is unaware of who she is, where she is, and does not recognize family members.

Case 2: The patient is a 29-year-old man who has had leukemia for three years. He is now in intensive care receiving chemotherapy. Life expectancy is three weeks to six months. His mental capacity is normal on the few occasions he is conscious.

Case 3: The patient is a teenager who was in an automobile accident. He is in a coma and only staying alive by being on a respirator. There is no indication that he will ever be able breath on his own.

[Q] After discussing the above cases, come together as a class and share your feelings and beliefs. How has thinking about these examples of terminal illness affected your views of and feelings toward your own death? The death of loved ones? What new insights have you gained into the issue of medical care for the terminally ill?

Note to Leader: *The group may come to very different conclusions as to what the right thing is to do in each of the above situations. Be sensitive to different views and careful to discuss this issue sensitively, with an attitude of learning from each other.*

[✝] Close the class in prayer. Acknowledge God's sovereignty in our human lives and the inevitability of death. Thank him for his gift of eternal life, which eliminates our need to fear death.

ARTICLE

The Inevitability of Death

Why do we have so much trouble letting go?

By Rob Roy MacGregor, for the study, "Pulling the Plug"

As a consultant in infectious diseases at a university teaching hospital, I advise doctors on the management of desperately ill patients and observe their attempts to restore these men and women to health. In the course of my experience, however, I have become increasingly convinced that medical care, American style, is clearly running the risk of extending the dying process rather than prolonging life. Both doctors and patients are losing their sensitivity to the inevitability and the appropriateness of death in certain circumstances.

Because of the powerful tools at our disposal, we doctors sometimes abdicate our traditional role as servant and adviser to the sick and suffering, and become technicians who merely run the machines that sustain "life" (defined in a narrow physiological sense). By so doing, we relinquish the judgment of what should be done for what could be done, and end up applying medical technology wherever possible: Is respiration failing?—Use the respirator. Have the kidneys stopped working?—Start dialysis. Slowly and sadly our attitude is becoming: "If we have the technical capability, we must always use it." And as a result, patients can be drawn into a dehumanizing spiral in which each organ failure is met by still another life-support procedure.

We must never lose sight of the fact that life is precious, a gift from God that cannot, must not, be dismissed lightly. But in understanding our relationship to life, and the extent to which we should fight to hold on to it, we must also come to grips with death. We must ask why technology is so often applied indiscriminately in the U.S. today (an approach interns call the "full-court press"). And why we have so much trouble letting go.

Why the Full-court Press?

Although there are numerous reasons for our prevalent "at all costs" attitude, I shall comment on six that appear to be central.

First, we fear that electing not to pursue all available life-sustaining measures will open a Pandora's box of relativistic decision-making about life and death. But while the withholding of medical treatment can lead to dangerous abuses, potential abuses

also exist in the uniform application of support technology without regard for the likely irreversibility of the patient's condition. Assessment of potential for recovery may seem like a difficult process, but the high frequency with which doctors agree among themselves (and then find that families have independently come to the same assessment) has convinced me that terminal illness is not difficult to recognize. Our difficulty appears to be acknowledging that the patient has reached that point.

Second, the doctor's self-image as "healer of disease" makes death the ultimate defeat, a blow to the self-esteem of the doctor who prides him- or herself on knowing how to cure disease. In contrast, the old-fashioned role of doctor as helper and comforter allowed physicians to be less threatened by this last stage of life.

Third, medical practitioners generally assume that the aggressive, high-tech approach is what patients want and expect. In most cases, this is a misperception. Whereas the majority of patients want to be made as comfortable as possible (and, of course, regain good health), few desire the ordeal that often accompanies the prolonged dying process in a hospital. Many patients now are saying, "If the chances for recovery are not reasonable, let me die in peace."

Fourth, significant peer pressure exists. Both doctors and families believe they are expected to "do everything they can" for the patient. Withholding treatment could appear to be uncaring or irresponsible. In addition, doctors do not wish to appear uninformed in the eyes of their colleagues. To defer a diagnostic test, or not use a life-supporting technology, might suggest lack of familiarity with the newest advances in medicine.

Fifth, many doctors and patients' families have not come to grips with death personally. The pragmatic, day-at-a-time philosophy toward life espoused by our society offers little or no solace in the face of death.

Sixth, because death is seen by most as the end of personhood, people ask: "Why not go all out? What is there to lose?" Modern medical education encourages such pragmatic questions, but devotes little time to answering them. But the families of many patients have learned firsthand that there is much to lose: the dignity of a loved one sustained by a machine, the days spent in anguish and uncertainty, and the resources spent in maintaining "mechanical" life.

As powerful as these six pressures are, they should be resisted. Loved ones, instead of asking "What *can* be done?" when presented with overwhelming illness, need to ask, "What *should* be done?"

Between the Lines of Scripture

Here is where we can look to the Scriptures for guidance.

Obviously, this was not much of an issue in biblical times. Only in the last 50 to 75 years have advances in medical science allowed us to prolong life in the face of even temporary organ failure. Nevertheless, several general Christian principles have clear relevance to the question.

First, the overriding teaching of the New Testament is love; love for God and love for neighbor. Thus, the Christian question should be: "What is the loving thing to do in this circumstance?" Is it loving to prolong suffering with next to no chance for significant recovery? Is it loving to maintain hope when realistically there is none? Is it loving to pursue a course likely to be dehumanizing even for a patient who survives?

A second consideration is the so-called Golden Rule: "Always treat others as you would like them to treat you" (Matt. 7:12, neb). Jesus said all of God's law and the teaching of the prophets were built on this profound principle. When considering its application to medicine, it may be surprising to learn that many doctors share the average layman's fear of a lingering death, and instruct their families that they want no "heroic measures" to be used when their own time comes.

Third, Scripture teaches that love between God and man is "better than life" (Ps. 63:3). Thus, God does not tell us that earthly life is to be valued as the highest good, nor have the apostles, martyrs, and saints lived this way down through the centuries. Paul said: "For to me to live is Christ, and to die is gain" (Phil. 1:21).

Fourth, the biblical statement "just as it is appointed for men to die once, and after that comes judgment" (Heb. 9:27) is a reminder to modern medicine that normally people prepare "to die once." However, when trying to do all we can for the dying patient, we put many through a psychophysiological tug-of-war with death because our technological interventions repeatedly "rescue" the patient from the inevitability of death. In his last hours, the distinguished physician Sir William Osier is reputed to have said: "I am too far across the river now to want to come back and have to do it all over again."

Finally, the words of Jesus, "You will know the truth, and the truth will make you free" (John 8:32), seem to be applicable. The truth can set one free both from false guilt and from the need to utilize unwarranted therapeutic maneuvers. Appropriate care balances a respect for the sanctity and uniqueness of each human life with respect as well for the process of dying. The physician and family can elect to make a patient comfortable without resorting to costly procedures that prove, in the end, to be fruitless and even punishing.

Of course, I do not advocate a position that would deny any patient the best help available. But I would maintain that the *best* does not necessarily mean the *most*. When disease has progressed to the point where death appears to be a release, we must avoid making the death more punishing by a slavish adherence to simplistic

principles such as "while there's life there's hope." Rather, we must attempt to discern the Christlike response to each situation.

Anticipating Death

How, then, might Christians approach life-threatening illness?

Early in the course of an illness, the patient, family, and doctor should talk about their attitudes regarding the appropriate extent of care. Then, when faced with a progressively downhill illness, doctors must give the patient and family their best assessment of the situation. (Families have the right to request this information.) It should include a discussion of what measures could be taken to sustain life, what the odds of success appear to be, and what that "success" might mean in terms of the patient's ability to function. Afterward, the doctor needs to render his or her advice: weighing the pros and cons, what he or she thinks should be done.

After giving this advice, the doctor must step back and let the family decide. If the choice is to pursue an aggressive treatment course, doctors must do their best to carry out these wishes. But if the family chooses to withhold potentially life-sustaining (or death-prolonging) measures, they can do so with the reassurance that the doctor has recommended this course as one he or she considers to be merciful and loving. The whole process must be entered into prayerfully.

Finally, we must accept the fact that, on rare occasions, assessments will be incorrect; a patient who has been judged to be irreversibly ill might rally in response to a do-everything-possible approach, However, this possibility must not prevent us from facing these decisions. For, if we indiscriminately use all of the life-sustaining modalities at our disposal, we also err by punishing the 99 patients whose process of inevitable death is merely prolonged, in order to extend the life of one.

The Christian community and Christian doctors are in a unique position to act because of our view that God is in control of life. Thus, our ultimate call is not always to cure disease, but rather to minister regardless of the outcome. Jesus himself did not heal all of the sick, but he set the powerful example of consistent compassion for their suffering. Our own personal walk with Christ and the support of the fellowship of believers can empower us to emulate his compassion rather than be driven by the technological imperative.

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"The Inevitability of Death," by Rob Roy MacGregor, CHRISTIANITY TODAY, April 1987, page 24

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LEADER'S GUIDE FOR STUDY 6

National Health Care: A Good Idea?

The Judeo-Christian teaching that human life is valuable drives us to consider health care that may not be cost effective.

Is national health-care insurance a benefit whose time has come? The rapid increase in the cost of medical care seems to be thrusting us toward such insurance. But lurking behind this question is a more important one: Have our decisions concerning life and death become so secularized that we are blindly worshiping at the altar of physical existence where the length of life is a higher priority than its quality?

Lesson #6

Scripture:
Genesis 20:1–13; 2 Chronicles 16:1–14; Ecclesiastes 3:1–2; Matthew 4:1–4; Luke 4:1–4, 8:40–42, 51–55, 9:24, 12:25; Romans 14:8; 2 Timothy 3:10–12, 4:6–8

Based on:
"Is Health Care Spiritual?" by G. Timothy Johnson, CHRISTIANITY TODAY, September 1990, page 29

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