When Flesh and Heart Fail:
Why Believers Should Consider Advance Directives

JUNE 5, 2018 | **KATHRYN BUTLER**

In December 2017, Stand to Reason (STR) cofounder Melinda Penner suffered severe traumatic brain injury following an accident. In the months since the tragedy, STR staff have urged believers to pray for their beloved colleague, whose wit and theological insight have been instrumental to their ministry. A gifted apologist who for years has dedicated her talents to defending the faith, Melinda now struggles to move and speak. The need for prayer is ongoing and crucial.

Even while she fights to recover, Melinda continues to bear witness to the gospel. In a recent blog post, STR's founder and president, Greg Koukl, reprinted an excerpt from Melinda's advance directive, in which she outlines her wishes for care in the event of life-threatening injury. Her words not only challenge us to approach our medical choices with discernment, but also vividly embody a steadfast love for Christ:

> *If I am permanently disabled but not certified terminal, I wish all care provided to sustain my life and alleviate my physical discomfort. . . . I wish my life and death to be a testimony of the intrinsic value of all human beings which God has given us by virtue of our creation in his image, and of my absolute faith and trust in my salvation through my Lord and Savior Jesus Christ. I have absolute confidence that I will be with God in heaven upon my death and anticipate that time joyfully. Therefore, my life should not be artificially prolonged. However, neither is my life to be artificially shortened based on a functional or instrumental view of life.* (reprinted with permission)

Melinda's advance directive offers a stunning example of how we may walk in faith even when illness and injury incapacitate us.

As her words illustrate, in an era of increasingly complex medical care we can't afford to ignore life's end, or to divorce our medical decisions from our Christian values. Even amid the sophisticated gadgetry of the intensive care unit, "God is our refuge and strength, a very present help in trouble" (Ps. 46:1).

Careful delineation of our wishes through an advance directive ensures that when life-threatening illness overwhelms, the gospel remains central.

Changing Landscape

Few people in the United States follow Melinda's example. In a recent national survey, only 26 percent of more than 7,000 adult respondents reported having completed an advance directive.

As a culture we prefer to ignore questions about death until the need arises, and to limit our conversations to poetry. We all long to "go gentle into that good night" and "to die, to sleep." We soften the vulgarity of death with the phrase "pass away," as if life were a gauzy breeze, a whisper that pirouettes in the air before vanishing.

Although we cling to euphemisms, the realities of dying are much more complicated.

Although we cling to euphemisms, the realities of dying are much more complicated. In 1908, 86 percent of people in the United States spent their final days at home, in the spaces that forged their memories. A century later, more than 70 percent of Americans still envision their last days this way.

Yet in this era of advanced intensive care medicine, *only 20 percent* of us die at home. Most of us now spend our last days in institutions, facilities that run the gamut from nursing homes to acute

care centers. Twenty-five percent of people older than 65 spend their final days in an intensive care unit, surrounded by machinery and removed from adored friends and glimmers of the past.

These statistics hint at the shifting landscape in end-of-life care. Medical progress over the last 50 years has equipped doctors with technologies that can save lives, but which have also transformed death from an event into a process.

Death occurs not in a finite moment, but rather in fits and starts, in a slow disintegration of life, distant from the view of families and the consolation of home. While poetic metaphors may appeal to our hearts, they falter when we meet a mechanical ventilator, chest compressions, and feeding tubes.

Where our faith is concerned, we struggle to understand how the numbers and equipment reconcile with our knowledge that "my flesh and my heart may fail, but God is the strength of my heart and my portion forever" (Ps. 73:26).

Dangers of Silence

Few of us relish in-depth discussions about these issues. Even physicians admit to avoiding conversations about end-of-life care with their patients, out of concern for inciting emotional distress.

Unfortunately, as intensive care medicine becomes increasingly sophisticated, our silence risks hurting those we love, as well as subjecting ourselves to interventions counter to our values. Rarely can we delay discussion "until the need arises," since severe illness itself alters consciousness. It disorients, and can afflict sufferers with paranoia and hallucinations.

Additionally, the critical care interventions required to support life can deprive us of a voice. Support on a breathing machine requires passage of a silicone tube through our vocal cords. To tolerate the tube, we require sedating medications, which often eliminate our ability to communicate nonverbally. Given these difficulties, when tragedy befalls, few of us will be able to articulate our priorities, let alone prayerfully consider God's will.

Given the barriers to speaking for ourselves in critical illness, when we also remain silent about end-of-life care ahead of time, we can burden those we love with impossible decisions.

When we remain silent about end-of-life care ahead of time, we can burden those we love with impossible decisions.

"I just wish I knew what he'd say," a soldier's son once lamented to me as we discussed his dying father. In an adjacent ICU room, the father he loved lay restrained on a bed. His limbs were mottled with bruises, his abdomen tense with widespread cancer. I laid out the grim details—each organ failing, each number falling—and with every data point his son's face darkened with anguish. His grief was compounded by the uncertainty of what to do.

"He never talked about any of this stuff," he said through tears. "He's a simple, tell-it-like-it-is, God-fearing man and a fighter. But he'll also cuss just at the mention of doctors and hospitals. What would he tell me to do? I keep praying for an answer, but I've got nothing."

Sadly, this conversation isn't unique in critical care. In one study of 4,000 people at the end of life, nearly half required loved ones to make medical decisions for them. When doctors can't communicate directly with us, they reach out to our next of kin for medical decisions, many of whom feel ill-prepared for this role. Studies show that loved ones of patients who die in the ICU suffer high rates of depression, anxiety, complicated grief, and even post-traumatic stress disorder for up to a year afterward. Avoidance of conversations about death has ramifications extending far beyond ourselves.

Benefits of Advance Care Planning

"Advance care planning" is the process of documenting our wishes for medical care in the event we can no longer communicate. Documents include health-care proxy forms to designate surrogate decision-makers, and physician orders for life sustaining treatment (POLST) or living wills, to outline our treatment preferences. The goal is to ensure care consistent with our values in the event that life-threatening illness incapacitates us, and it equips our loved ones to act on our behalf.

The power of this process isn't just hypothetical. Studies show that completion of advance directives increases the probability that care will proceed according to our principles (Silveira; Detering). The practice also guides physicians and caregivers when death nears, and prevents them from implementing futile treatments that prolong death (Silveira; Detering).

Careful delineation of our wishes through an advance directive ensures that when life-threatening illness overwhelms us, the gospel remains central.

Further, studies reveal less depression, anxiety, and stress among loved ones when we provide them with care instructions (Wright; Detering). Even while they grieve, family members voice relief that the decision was not their own. "It was unbelievably heart-wrenching to watch her die for two days," one friend recounted to me after her mother's death. "But at least I knew her wishes. The choices were hers, not mine."

As Melinda Penner teaches us, advance care planning has even deeper value for us as Christians. It offers us spiritual preparation, to lay up for ourselves treasures in heaven (Matt. 6:20). The focus on our final days allows us to prayerfully consider our lives, and to infuse our moments with seeking the Lord: "I will meditate on your precepts, and fix my eyes on your ways" (Ps. 119:15).

With the span of our lives receding behind us, we can offer up praise for his mercies, thanks for his blessings, and pray about the shadows that linger, the darker crevices that remain unresolved in our hearts. We can intentionally focus on God's saving work through Christ (Col. 3:23–24).

Scripture as a Light to Our Path

As we compose our advance directives, our goals mustn't begin and end with our own worldly desires, but instead reflect our identity in Jesus (Eph. 1:5; 2:19; 4:24). Our pursuit of a Christ-centered, God-honoring approach to end-of-life care begins with faithfulness to his Word. As medical technology progresses, the potential challenges we face become increasingly convoluted and unpredictable. Rarely can we anticipate every potential medical calamity in our future.

Even while they grieve, family members voice relief that the decision was not their own.

We *can*, however, clearly outline biblical principles to guide decisions. In particular, a gospel-focused approach to end-of-life care requires attention to the following truths.

1. Mortal life is sacred.

Our lives are a gift from God (Acts 17:25). We are made in the image of God, and each one of us has inherent dignity and value (Gen. 1:26; Ps. 139:13). We are to treasure the life God has granted us and strive to glorify him in everything (Ex. 20:13; 1 Cor. 10:31; Rom. 14:8).

The sanctity of mortal life mandates that we advocate for the unborn and safeguard against physician-assisted suicide. It also requires that when struggling with an array of medical options, we consider treatments with the potential to cure.

2. God has authority over life and death.

When faced with the grief and uncertainty of life-threatening disease, fear may drive us to resist death at all costs. We may chase after aggressive interventions even when such measures promise no hope for recovery.

Yet this side of the fall, no one escapes death (Rom. 5:12; 6:23). When we blind ourselves to our own mortality, we deny the resurrection.

When we blind ourselves to our own mortality, we deny the resurrection.

We ignore that our times are in his hands (Ps. 31:15; 90:3), and dismiss the power of his grace in our lives. We disregard the truth that the Lord works through all things—even death—for the good of those who love him (John 11; Rom. 8:28).

3. We're called to love one another.

God calls us to love our neighbors as ourselves and to minister to the afflicted (Matt. 22:39; John 13:34; 1 John 3:16–17). As God so loved us, so we must extend ourselves in empathy and mercy toward one another (Luke 6:36; 1 Pet. 3:8; 1 John 4:7; Eph. 5:1–2).

Mercy doesn't justify active euthanasia or physician-assisted suicide. However, it does guide us away from aggressive, painful interventions if such measures are futile, or if the torment they inflict exceeds the anticipated benefit. Scripture doesn't compel us to doggedly chase after treatments that inflict agony if they offer little hope of recovery.

4. Our hope resides in Christ.

We needn't fear death! Even as our lives draw to a close, we cherish the promise of new life (Ps. 23:4; 1 Pet. 1:3–4; 1 Thess. 4:13–18; 2 Cor. 4:17–18). We rest assured in Christ's sacrifice for us and in the awe-inspiring depth of his love (Rom. 8:38–39; John 11:25–26). Christ's resurrection transforms death from an event to be feared into an instrument of God's grace as he calls us home to heaven. Although we die, we're alive in Christ (1 Cor. 15:54–55).

We're to preserve life when illness is recoverable, but also to accept death when it arrives.

These tenets guide us to seek treatments when they offer hope of recovery, but they do *not* compel us to accept interventions that prolong death or inflict suffering without benefit. We're to preserve life when illness is recoverable, but also to accept death when it arrives. Our hope, above all, resides in Christ's sacrifice and resurrection. "Our help is in the name of the LORD, who made heaven and earth" (Ps. 124:8).

On Suffering

The Bible guides us to seek interventions that promise to save life, and to accept the inevitability of death when treatment is futile.

A vast middle ground, however, spans these extremes. Too often medical treatment offers not complete recovery, but rather life with new infirmity. We may leave the hospital, but remain bed-bound and dependent on others for daily life. We may survive, but never regain consciousness. We may recover from life-threatening illness, but never return home, and never regain the ability to breathe independently, or to speak. We may live, but with pain that distorts life beyond recognition.

The path forward in such scenarios hinges on questions of suffering, which do not conform to a universal mold. Our experience of suffering, and our steadiness as we pilot its swells, depends on the unique circumstances, temperaments, and histories that shape us.

As we outline our wishes for the end of life, we must be honest: What can we endure, and what would irrevocably drown us in despair?

While God may engage with suffering to strengthen, discipline, and instruct us, in his mercy he does not condemn us wallow in unbearable pain without purpose.

Scripture teaches that hardship riddles the path of the believer (Mark 13:13; Luke 14:27; John 16:33; Rom. 8:18; 1 Pet. 4:12–19; 2 Tim. 3:12), but that God orchestrates suffering to enact good (Gen. 50:20; John 9:1–3; Rom. 8:28). Even while we toil through the gloom, our Father sees us, knows us, loves us, and draws us closer to him. "The LORD is near to the brokenhearted," writes the psalmist, "and saves the crushed in spirit" (Ps. 34:18). Also, from Romans 5:3–5:

Not only that, but we rejoice in our sufferings, knowing that suffering produces endurance, and endurance produces character, and character produces hope, and hope does not put us to shame, because God's love has been poured into our hearts through the Holy Spirit who has been given to us.

These verses reveal that suffering can refine us and deepen our faith. And yet, we serve a God who abounds in love and mercy (Ex. 34:6; Ps. 86:5; 103:8). He knows each of us individually, and loves us as a Father cherishes his children (Jer. 1:5; Isa. 41:10; 43:1–3; Ps. 46:1; 94:18–19; 147:3). While God may orchestrate suffering to strengthen, discipline, and instruct us, in his mercy he does not condemn us to wallow in unbearable pain without purpose. As a father wouldn't torment his children, so God doesn't delight in our crushing (Lam. 3:31–33; Ezek. 33:11). He doesn't require us to pursue medical treatments that would ravage us.

Guiding Questions

Questions of suffering, then, are deeply personal, and our advance directives should reflect this complexity. How much disability can we bear? How do we continue to serve God at the end of life? How do we understand the gospel even in suffering?

Statements that summarize the following questions can guide loved ones when a clinical situation falls outside the checkboxes.

1. What are my goals for the end of life?

This question pertains to how you wish to spend your final days. What matters to you as your life ends? Who matters? What places and people are most precious to you?

2. How can I continue to serve God at the end of life?

Think back to moments in your life when you reveled in the joy of the Lord. Consider the times you have praised him, thanked him, or endeavored to serve him. What did you require in those moments?

3. How much suffering is too much?

As you envision periods of pain and dependence, what would constitute undue suffering? What would so burden you as to strip away your ability to serve God with joy? What would be intolerable?

4. What trials are you willing to endure to achieve your goals at the end of life?

What are you comfortable sacrificing, and what would be unacceptable? As an example, if you aim to spend your final days at home with family, would you be willing to have a ventilator at home to enable this? Would you endure medical treatments that impair consciousness to extend life, or is it important to be in command of your mental faculties, even if declining treatment quickens the end?

Above all, anyone drafting an advance directive should talk openly with trusted physicians and *ask questions*. Frequent and candid dialogue with a pastor can also be life-giving during such heavy deliberations.

In advance care planning the documents help, but they compose only one component of a greater process. Open communication with loved ones, especially those who may have to make decisions for us, guards against anguish as we fix our eyes on Jesus.

An End, but Not *the* End

In this disconcerting era that blurs boundaries between life and death, we must strive always to respond with love and mercy, and to walk humbly with our God (Mic. 6:8).

As Penner beautifully illustrates for us, in end-of-life care the best answers are those that point toward God's grace manifest in Christ (John 3:16). May we rest in the assurance that however total our heartbreak, and however devastating the path before us, God has triumphed over sin.

Even when life-threatening illness grips us, even when it distorts our lives beyond recognition, our identity in Jesus—beloved, redeemed, made new—endures.

This broken world isn't the end. God's love for us in Christ Jesus surpasses all understanding, and no respirator, or monitor, or frightening disease can wrench us from his grip.

Even when life-threatening illness grips us, even when it distorts our lives beyond recognition, our identity in Jesus—beloved, redeemed, made new—endures. As Paul declares,

Neither death nor life, neither angels nor rulers, nor things present nor things to come, nor powers, nor height nor depth, nor anything else in all creation, will be able to separate us from the love of God in Christ Jesus our Lord. (Rom. 8:38–39)

Author's note: To view your state-approved forms for living wills and other advance directives, visit the National Hospice and Palliative Care Organization at https://www.caringinfo.org

Article Source: https://www.thegospelcoalition.org/article/believers-consider-advance-directives/