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END OF LIFE CARE

When Prolonging Life Means Prolonging Suffering

A trauma surgeon on when letting go of our loved ones is the most God-honoring thing we can do.

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His wife found him in the garden. He did not awaken to her touch.

When paramedics arrived, they jammed a tube into his windpipe and supported his breathing with a bellows, shoving air into lungs already taut with scars from cigarette smoke and Allied gunpowder. Most people require sedation to tolerate such tubes, however, he neither coughed, nor flinched, nor gagged. His peacefulness was ominous. Although his heart still beat, his brain had receded into stillness.

In the emergency room, a CT scan confirmed a ruptured aneurysm. Blood crowded out his brain and thrust it downward, through the narrow aperture at the base of his skull. The pressure was strangling his brain.

I met his son in the conference room of the intensive care unit (ICU). Through the window behind him, the Boston skyline weaved a starlit backdrop. He faced me with his arms braced across his chest, his jaw set. Only his thumb and forefinger, grimed from the grease of machinery, worried the weave of his sweatshirt and betrayed his heartache.

I explained that his father was dying. We could not save him.

"The best we can do for him now is to ensure he is comfortable and surrounded by those he loves in his last hours."

He stared at the floor in silence. "No," he finally whispered. Then, louder: "Nope. It's not going to happen that way. Dad's a fighter. He's also prayed every day of his life. With God, all things are possible." When he met my gaze, indignation hardened his eyes. "Keep going."

Such scenarios, which serve as daily fodder for ICU practitioners, penetrate to the core of our understanding of and relationship with God. Loved ones wrestle with grief, doubt, fear, anger, and even guilt as they struggle to reconcile a web of hospital instruments with a mother's voice, a father's laughter, or a child's smile. Doctors agonize over the distinction between measures that salvage life and those that prolong suffering. Nurses fight tears as their patients grimace with yet another turn, yet another dressing change, yet another needle stick. *How long, O Lord?* we inwardly cry (Ps. 13:1).

Despite their currency in the most fundamental of spiritual issues—life and death—modern medical systems offer scant context for a faithful response. Instead of Scripture, medical professionals navigate these storms with ethics committee consults. We entreat palliative care specialists for help, and rely upon mantras of patient autonomy and quality of life. Leaning forward in our crisp white coats, we discuss resuscitation and feeding tubes, offer a hand squeeze and a sympathetic ear, and ask, "What would your loved one want?"

The question "What is God's will?"—although it may trouble us privately—never reaches the air of the ICU conference room. We offer chaplaincy services as a conciliatory afterthought, and burden families with the responsibility of "choosing" the course for their loved ones, rather than partnering with them in lifting patients up to the Lord.

The divorce between physical and spiritual care at the end of life unsettles us further when we consider how frequently death occurs in hospitals. In 1908, 86 percent of people in the United States spent their final days at home, Robert Wells writes in his book *Facing the "King of Terrors."* By the end of the 20th century, that number had dropped to just 20 percent. In our current era of high-technology critical care, 25 percent of patients over the age of 65 years old die in an ICU, according to the Center for Disease Control. Death has passed from the domain of families, pastors, and the quiet of home, to sterile rooms that resound with alarms.

The secular environment in hospitals can unmoor Christians already grappling with despair and uncertainty. An informed, Christ-centered approach to end-of-life care requires fluency in Scripture, comprehension of the disease processes at work, and recognition of the goals and limitations of life-sustaining measures. The goals are to equip individuals facing end-of-life circumstances with peace and discernment, and to ensure we care for patients according to God's will. As always, wisdom begins with the Word.

The Sanctity of Mortal Life

Christian disapproval of such highly politicized issues as abortion and the "right to die" movement originates in our honoring of life as a gift from God. The Bible teaches that human life bears intrinsic worth. He created us in his image, to steward his creation and to serve him. (Gen. 1:26; Gen. 2:19–20). He directs us to protect and value life. Furthermore, our lives are not our own, but belong to him (1 Cor. 9:19–20). As each of us represents the work of his hand, he ultimately lays claim to our lives.

The Lord entrusts us with life and charges us to cherish it. In broad strokes, we should provide and accept life-sustaining medical treatments with the potential for *cure*.

Sanctity of life does not refute the certainty of death. We err when we resist death at all costs. "I know she's dying, but I want you to continue the ventilator, because I'm waiting for God to perform a miracle," loved ones often tell me. Although such statements reflect sincere faith, this thinking misleads us and does not reflect biblical teaching. God does not require a ventilator to perform a miracle. More importantly, death, although abhorrent to God, is a necessary consequence of the Fall. It overtakes all of us. In his sovereignty, God determines the manner and timing of our death. Even Christ, who defeated death, suffered through it in submission to the Father (Matt. 26:36–45). When we blind ourselves to our own mortality, we reduce God to an imaginary genie in a bottle, rather than Lord of all. Rather than accept his will as perfect, we convince ourselves that if we pray fervently enough, he will yield to *our* will.

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As Christians, we need not fear dying. Christ's resurrection assures us that "death has been swallowed up in victory" (1 Cor. 15:54–55). So vast is God's love for us, so breathtakingly superb his sacrifice, that nothing can pry us from him. Even as we suffer, we revel in the news that death has relinquished its permanence upon us. We savor the promise of the resurrection of the body, and the hope of eternal union with Christ. Although God directs us to honor the life he has created, he also ordains that our earthly lives will end.

Preserving or Prolonging?

God calls us to love our neighbors, to minister to the downtrodden and the afflicted (Micah 6:8). While mercy does not justify active euthanasia (i.e., administration of toxic medications to speed death), it does guide us

away from aggressive, uncomfortable interventions to prolong life if such interventions are futile. When we inflict suffering upon patients unnecessarily, we fail in our mandate to love one another. The call to relieve suffering bridges the expanse between the sanctity of life and the inevitability of death.

A Scripture-informed approach to end-of-life care requires us to seek cure, but also to accept death when it arrives and to alleviate suffering when possible. Distinguishing between these conditions—which appear stark on paper, but are tangled and messy in reality—hinges upon a key question: "Will life support in this scenario *preserve life* or *prolong death?*"

Medical technology, while sophisticated, is man-made and therefore imperfect. Life support is *supportive*, not curative. Doctors force air into the lungs, constrict blood vessels with potent drugs, filter the blood when kidneys fail, compel the heart to pump harder, and in experimental cases even bypass liver function. None of these maneuvers cure disease. They only buy time.

Life-sustaining treatment intends to buoy organ function long enough to correct the underlying illness. Physicians use such techniques to support patients while they manage the widespread infection, the occluded coronary vessels, or the stroke. If the inciting disease process is treatable, then life support is indeed "life-saving," because it maintains the body systems long enough for patients to recover. However, if the core illness is irreversible, life support prolongs the dying process.

God calls us to love our neighbors and to minister to the suffering. Life-sustaining technology actively inflicts suffering. Patients who survive critical illness report high rates of post-traumatic stress disorder (PTSD). Cardiopulmonary resuscitation (CPR), the chest compression technique that medical professionals perform with gravity and television actors with flair, breaks ribs. Patients undergoing mechanical ventilation report panic, anxiety, and fear of suffocation. Prolonged bed restriction breaks down tissue over joints, promotes contractures, and induces pain with simple repositioning.

Hope for recovery, with resultant preservation of life, warrants such extreme measures. Without expectation for survival, however, these interventions constitute cruelty. The challenge for practitioners and lay people alike is to decipher when medical treatment has crossed the threshold from life-saving to death-prolonging.

Inviting Christ to the Bedside

Physicians train in objectivity, and few will volunteer for a spiritual dialogue. However, asking a patient's care team specific, focused questions can illuminate where a condition falls along the spectrum between life and death:

- What is the condition that threatens my loved one's life?

- Why is it life-threatening?
- What is the likelihood for recovery?
- What about my loved one's previous medical conditions influences his or her likelihood for recovery?
- Can the available treatments bring about cure?
- Will the available treatments worsen suffering, with little chance of benefit?

Some conditions so devastate patients that the certainty of death is obvious to all. More frequently, a patient's course fluctuates. Families and practitioners alike should return to this inquiry recurrently, as recovery or decline may evolve over time. Furthermore, individuals should feel empowered to seek second opinions, should they distrust the assessment of a treating physician.

Paramount throughout end-of-life challenges is to couple contemplation with ardent prayer for clarity. Grief, anger, and anxiety may obscure the path that God prepares for us. Compassion must galvanize our actions, and our souls must find their root in the Word. Only then can we minister to one another when calamity lures us into an ICU conference room, facing the limitations of our loved ones' mortality.

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