

DEPARTING IN
PEACE

BIBLICAL
DECISION-
MAKING
AT THE
END OF LIFE

BILL DAVIS

Foreword by Joel Belz

“I’m thrilled to see the publication of this book by Bill Davis, not only because it fills a real gap in the literature, but also because Dr. Davis is uniquely qualified to write such a book. While we can be very thankful for the various lifesaving and life-preserving technologies that have been developed over the last half-century, they raise taxing ethical questions that Christians in previous eras never had to grapple with. As a seminary professor who teaches a required ethics course, I’ve discovered that students find end-of-life issues especially challenging to navigate, often leaning on gut instincts or vague appeals to divine providence rather than on careful and consistent biblical reasoning. From now on, I will direct those students to Dr. Davis’s excellent and comprehensive treatment, which expertly combines biblical principles with real-life practical counsel. *Departing in Peace* deserves to become the go-to book for those seeking solid guidance on difficult end-of-life decisions.”

—**James N. Anderson**, Associate Professor of Theology and Philosophy, Reformed Theological Seminary, Charlotte

“Though we are supposed to glorify God in all that we do, when we are staring death in the face, that calling is usually not at the front of our minds. Having stared death in the face and gotten a reprieve, I had a change in my sense of priorities. I am glad Bill Davis has taken the time to write this book because it is not an easy topic, nor is it a topic that one considers at the moment that it most needs to be considered. I know this firsthand. But the advice in this work is sound, and the wisdom is timeless. We will all one day wonder whether we are making the right end-of-life decisions for our loved ones. This book fills a void in preparing us for that time.”

—**Erick Woods Erickson**, author, *Before You Wake*; editor, *The Resurgent*

“This book is a fine reflection on crucial issues of life and death. As we would expect from Bill Davis, it is careful, thoughtful, and biblical, and it will be genuinely helpful to families and pastors.”

—**W. Robert (Bob) Godfrey**, President and Professor of Church History, Westminster Seminary California

“This book is a gift for anyone—adult child, parent, pastor—having to wrestle with, or counsel others through, end-of-life decisions. Davis offers clear, biblically grounded principles for navigating these decisions, and he shares a number of real-life case studies that illustrate poignantly both how complicated these decisions can be and how biblical principles can be applied to them. His approach is both immensely practical—supplying the reader with commentary on his case studies and helpful study questions and definitions throughout—and deeply pastoral. His wise, humble, and compassionate manner make clear that he is no stranger to these difficult matters. I know of no better guide for the Christian who faces the very daunting decisions that surround the end of life.”

—**J. Derek Halvorson**, President, Covenant College

“There are good books on dying well in the comfort of Christ. But this book combines mature biblical teaching with the brass-tacks practical questions that we all face with the death of loved ones. These are the things that we don’t usually think about until they happen. I highly recommend *Departing in Peace* as essential preparation.”

—**Michael Horton**, J. Gresham Machen Professor of Systematic Theology and Apologetics, Westminster Seminary California

“Bill Davis clearly loves three things: critical thinking, biblical authority, and the bride of Christ. In this practical volume, he brings these loves together. As a well-trained philosopher, he helps us carefully navigate through end-of-life issues, even as he draws on Scripture, always seeking the goal of Christian faithfulness. Davis wants God’s people to live wisely and well, even when we face some of the most heartrending decisions. Thankfully, with his help we can prepare ourselves, our families, and our churches for the complex theological and practical difficulties that arise in these hard situations. I strongly recommend this book specifically to pastors, who are often placed in the difficult position of giving advice to parishioners who must make end-of-life decisions for loved ones.”

—**Kelly M. Kopic**, Professor of Theological Studies, Covenant College; author, *Embodied Hope: A Meditation on Pain and Suffering*

“Bill Davis has provided a remarkable guide to address one of the most sensitive aspects of life. *Departing in Peace: Biblical Decision-Making at the End of Life* clearly imparts needed wisdom so that believers in Christ can complete their lives with the faithfulness that affirms the sanctity of life, yet avoids the perplexity of extending life at any cost.”

—**Peter Lillback**, President, Westminster Theological Seminary

“With such rapid advances in medical technology, together with a ‘culture of death’ that predominates in the West, life-and-death decisions are becoming increasingly complex. Thanks to Bill Davis for bringing both his intellectual acumen and his practical experience to bear on such a timely and crucially important topic. Pastors and elders would be well advised to let this book help guide them in decisions of life and death in their churches. Every Christian will be helped by the clarity and counsel that Davis gives to these discussions.”

—**K. Scott Oliphint**, Professor of Apologetics and Systematic Theology, Westminster Theological Seminary

“As a Reformed Christian who has practiced medicine for six decades, read and studied medical ethics for most of that time, and written extensively on such issues, I rejoice in Dr. Bill Davis’s book on end-of-life issues. The most distressing dimension of my experience has been the purposeful omission or superficial application of biblical reasoning by evangelical Christians to these ethical problems. Dr. Davis has made a very serious attempt to be fully and accurately biblical, especially concerning the withholding or withdrawal of medical treatments and the responsible application of personal and family economic principles. Considering the complexity of such issues, I cannot agree with all that Dr. Davis has said. Yet his book greatly advances biblical medical ethics, as well as the vital discussion and attention that both Christians and non-Christians need to face these difficult decisions.”

—**Franklin E. (Ed) Payne**, MD, Associate Professor of Family Medicine, Augusta Health Sciences University (retired); primary author, 1988 PCA Report on Heroic Measures

“Departing in Peace is an excellent road map for preparing to deal with difficult end-of-life issues. Although it is written from a beautifully Christian orientation, the core of the material applies to most people. People of faith will come to treasure its wisdom. People not firmly anchored in faith will find much to hold close. The later chapters on the nuts-and-bolts and money matters are very worthwhile.

“Dr. Davis is an exemplary teacher and guide. His personal experience with end-of-life issues and his experience as a guide to others are invaluable for those who want to be ready.

“As a critical-care physician and colleague of Dr. Davis on a hospital ethics committee, I have come to know and highly regard his opinions. This book is worthwhile for everyone because no one escapes death, and we should be prepared for it.”

—**Richard R. Pesce**, MD, MS (ethics), FCCP, FACP, Medical Director of Critical Care, Memorial Hospital, Chattanooga, Tennessee

“Professor Bill Davis has written a book that needs to be part of our seminary curriculums and certainly in the hands of pastors and elders. Just a few months ago, a young man in my congregation called from his father’s bedside as he and his family struggled to know whether it was right before God to remove him from life support. By taking the discussion into the realm of faithful stewardship of all that God has given us, and realizing that our ultimate enjoyment in the world comes from our spiritual connection to God and his means of grace, Dr. Davis has moved the discussion of end-of-life decisions on to a firmer biblical foundation than merely being pro-life. After more than twenty years in pastoral ministry, I am grateful to the Lord Jesus that he has equipped Bill to write a book that I have needed and I’m sure many more do as well. Take, read, pray, and apply.”

—**Kevin M. Smith**, Senior Pastor, New City Fellowship of Chattanooga (PCA)

“With *Departing in Peace*, Bill Davis has provided a thorough and excellent resource for Christian believers seeking a consistent biblical

approach to the bewildering challenge of planning for the end of life. Davis provides thoughtful insights from his own personal experiences with a family member and others who have approached death. With strong opinions (some subject to debate), Davis brings a wealth of knowledge from his work on hospital ethics committees and in teaching at a Christian college. Most useful is his practical, step-by-step guide to completing an advance directive. This book will be helpful both in my medical practice and to individuals and families asking these questions.”

—**R. Henry Williams**, MD, FACP, Board Chair, Tennessee
Center for Bioethics and Culture

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AT THE END OF LIFE

BILL DAVIS



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For Lynda

Download free, complete lesson plans for Sunday school classes and church discussion groups from the *Departing in Peace* page on P&R's website, www.prpbooks.com.

CONTENTS

| | |
|---|------|
| Analytical Outline | ix |
| Foreword by Joel Belz | xi |
| Preface | xiii |
| 1. Introduction | 1 |
| 2. Foundational Considerations | 25 |
| 3. End-of-Life Treatment Decisions: Challenges | 73 |
| 4. Putting Biblical Principles into Practice: True Stories | 115 |
| 5. Advance Directives | 170 |
| 6. Money and End-of-Life Decisions | 198 |
| 7. Hospital Realities: Making the Most of Them | 227 |
| 8. Things to Do Now | 243 |
| Appendix A: Principles Identified, Defended, and Applied | 257 |
| Appendix B: Sketch of the Lesson Plans for “Ask the Doctors” | 263 |
| Appendix C: Sketch of the Lesson Plans for “Leaving Instructions” | 269 |
| Glossary | 275 |
| Bibliography | 285 |
| Index of Scripture | 293 |
| Index of Subjects and Names | 297 |

ANALYTICAL OUTLINE

1. Introduction
 - a. My Father's Death
 - b. God's Law: A Gift to God's People
 - c. The PCA Report on Heroic Measures
 - d. Terms and Methodology
 - e. A Pressing Need

2. Foundational Considerations
 - a. Two Fundamental Biblical Obligations
 - b. The Authority to Make Choices
 - c. Biblical Permission to Do Less Than Everything Medically Possible
 - d. Declining Treatment Is Not a Form of Suicide
 - e. Praying for Healing without Planning on a Miracle

3. End-of-Life Treatment Decisions: Challenges
 - a. The Conditions That Force Hard Choices
 - b. Treatment Options
 - c. Tube-Feeding (Artificial Nutrition and Hydration)

4. Putting Biblical Principles into Practice: True Stories
 - a. Story 1: Distressing Dialysis
 - b. Story 2: Praying for a Miracle
 - c. Story 3: Evelyn's Heart
 - d. Story 4: Triplets in Peril

- e. Story 5: Pastor with Parkinson's
 - f. Story 6: Tammy's Heart and Lungs
5. Advance Directives
- a. The Sections Explained
 - b. Section-by-Section Recommendations for Completing an Advance Directive
6. Money and End-of-Life Decisions
- a. Limiting Treatment because of Lack of Resources
 - b. Limiting Treatment Even When Money Is Available
 - c. Money and Medical Treatment for Children
 - d. The Ultimate Place of Money in Treatment Decisions
7. Hospital Realities: Making the Most of Them
- a. The Distorted Picture from Hospital Dramas
 - b. Expect to Deal with Strangers
 - c. Getting the Big Picture
 - d. Using the Long Waits Well
8. Things to Do Now
- a. Blessing Our Families
 - b. Blessing Our Churches
 - c. Blessing Our Communities
 - d. Praying

FOREWORD

I was a young man—still in my mid-30s—when I learned that I had been named executor of the estate of an elderly couple in my church who had just died. Bone cancer had taken Nell about a month earlier. Then, quite unprepared for the shock of living alone, George dressed for church on a Sunday morning, but succumbed to a heart attack before getting out the door.

Nell was pretty much ready for death—George considerably less so. But the fellow they'd asked to look after their affairs? He didn't have a clue.

Death, even for a Christian, tends to be something of a mystery. That's the case on a number of fronts. The departure of our souls from our bodies and all that's associated with breathing our last—well, let's just say that it can be a bit “spooky.” The medical decisions that we're called on to make can border on the heartless. And the high cost of dying can leave surviving families surprised, embarrassed, and sometimes broke.

And it all comes at you so fast that you're bound to ask, “Why didn't someone warn me?”

Well, here is that warning. But it comes at you here in gentle, helpful terms. Dr. Bill Davis's bedside manner is one that you will cherish the rest of your life.

This isn't primarily a step-by-step manual to equip you to deal with doctors, lawyers, and undertakers. It comes instead from the very practical mind of a philosophy professor who is gifted in helping his students take basic principles and apply them to the hard issues of

life. And always, Professor Davis insists that those basic principles be thoughtfully and helpfully anchored in the great themes of Scripture.

Sooner or later, you're likely to find yourself helping to look after the affairs of a loved one who is close to death or who may even have just died. Or you may be trying to order your own affairs to make things easier for those who must look after you. In either case, you will thank Bill Davis for helping you work so thoughtfully through such important matters.

Joel Belz
Founder, *WORLD* magazine

PREFACE

This book is for people who suspect that they may eventually die. It is also for those who have faced death up close. Anyone who has been close to a loved one making end-of-life medical decisions already knows that principled advice is valuable. All of us can do ourselves and our families a big favor by thinking these things through long before the crisis hits. Only healthy people who die suddenly will avoid making hard decisions about end-of-life medical treatment. The rest of us will have to make these decisions, and waiting to think about it will only make things harder. It is not easy to think clearly when we are sick. Disease and dysfunction may even deprive us of the ability to make decisions about our own care. Our family, our friends, or our doctors will be left to make those decisions. If we leave no instructions about our goals and values, their grief over our illness will be compounded by distress and uncertainty.

Christians will be most comfortable with this book's approach to moral reasoning, but other readers should find the discussion helpful as well. Most people have serious convictions about the value of human life, the close relationship between responsibility and agency, and the inappropriateness of prolonging pointless suffering. These convictions are fundamental to end-of-life ethics. They are taught by the Bible, but also by other religious and ethical systems.

This book appeals explicitly to Scripture because Bible-believing Christians are too often persuaded that the Bible requires us to use medical means to extend physical life as long as possible. I will be arguing against this supposed requirement. My argument is built both

on general ethical principles and on what the Bible teaches. The Bible does not require doing *everything* as death approaches; instead, the Bible requires something else. This “something else” locates our obligations about end-of-life decisions inside our more general obligation to serve God’s glory and our neighbors’ good in all that we do with our resources of time, energy, opportunity, and wealth.

The central ethical argument of this book is given in chapter 2. Working from Jesus’ teaching in Matthew 25, I establish that all our decisions are made as servants. Our aim is not merely to do what is *right* rather than what is *wrong*; it is also to be found *faithful* rather than *unfaithful*. The question, “Is it wrong to turn off the ventilator that is keeping Gladys breathing?” is more helpfully stated, “Would Gladys be an unfaithful servant of her Master if she had the machine turned off?” Put this way, the issue is then about a Master-servant relationship: “Does the Master require his servant, Gladys, to keep the ventilator on as part of her service to him?” The decision is not about Gladys’s conformity to an abstract rule in isolation from the details of her situation. It is about her relationship with her Master and using all her resources to honor him.

Framing end-of-life decisions in the biblical idiom of faithful service shows the appropriateness of paying close attention to Gladys’s specific circumstances. Does faithful service mean using medical treatment that is ineffective? No. Would her Master require her to suffer merely to stay alive a few days longer, dramatically limited in her ability to serve others? Seen this way, it is hard to say yes. What if Gladys’s treatment offers only the benefit of a slightly longer life in the hospital and imposes the burdens of physical pain, social isolation, drained finances, and spiritual deprivation? Might faithful service for Gladys allow discontinuing the treatment? I will argue that in some situations Gladys can faithfully discontinue the burdensome treatment even if it means that death will overtake her sooner. It is never faithful for Gladys to use medical or other means to hasten her death, and it is always part of faithful service for Gladys to pray that she be restored to health. But she can faithfully decline ineffective or excessively burdensome medical treatment.

These conclusions about what faithful service means follow the lead of a study committee report adopted by the Presbyterian Church in America in 1988. The report identifies a number of biblical principles and applies them to the medical realities of the late 1980s. This book expands and details the biblical basis for the report's principles and advice, answers common objections to the report's findings, and applies its guidance to the medical practices current in 2017. While consistent with the report's findings, my discussion goes beyond the report by highlighting the spiritual burdens imposed by most life-sustaining treatments. The first half of chapter 2 builds the biblical case for the principle that we may decline ineffective or excessively burdensome treatment. The second half of chapter 2 focuses on answering common objections to this principle. I affirm that suicide of any kind (including physician-assisted) is biblically forbidden, and I insist on the value of prayer even as I argue that it is inappropriate to use medical means to "give God time to work a miracle." God does not need that kind of help.

Chapter 3 continues to develop biblical principles to inform end-of-life treatment decisions, first by considering four medical conditions that call for discussions about limiting treatment and then by discussing four kinds of treatment options that might be limited. The structure of this chapter follows the lead of the many state legislatures that have devised forms to guide people in leaving useful instructions about what they want done if they become unable to direct their own care. "Advance Directive" forms (which used to be called "Living Will" forms) have been available in every state since 2010. They provide an excellent way for people to make their values available to family members and medical professionals. In chapter 5, I use the biblical principles from chapters 2 and 3 to explain how I filled out my own (Tennessee) advance directive.

Most of the advice offered in chapter 3 is uncontroversial. People regardless of religious identity now agree that performing CPR on a person who is permanently unconscious is not morally required and may impose great and needless burdens. CPR is the first of the three kinds of medical treatment options discussed; permanent unconsciousness is the first of the four medical conditions discussed. Other recommendations offered as biblically warranted are more controversial.

I affirm the importance of defending all life because everyone is made in the image of God. Along with that affirmation, however, I argue that I may faithfully decide in advance that I do not want to be force-fed through a tube if I am permanently confused. While it is inappropriate to remove life support from me if I want it and can afford it, Christ does not require me to be force-fed to stay alive if I am no longer able to enjoy spiritual goods and serve others.

Chapter 4 tells six true stories about people making end-of-life decisions. The stories place the reader in the position of a friend who is being asked for advice about what to do. The narration is periodically suspended to ask a specific question, to offer three possible responses from which to choose, and then to explain the merits of each option. Most of these questions were asked of me when I was the friend giving advice in the midst of the actual crisis. In teaching this material to college, seminary, and Sunday school classes, I have used these stories as a way to start our discussions. Students are often surprised that anyone really faces questions like these. Medical professionals know that they are sadly common. Each story concludes with an epilogue that briefly explains how the story continued after the decision crisis passed.

Chapter 6 is about money. The original design of the book did not include this chapter, and I am grateful to John Hughes and the editorial staff at P&R Publishing for insisting that it be added. (This is not my only debt to John and the editorial staff, but it is an important one. Their direction and support have been outstanding. Karen Magnuson's detailed attention to the footnotes and thorough copyediting have been an especially great help.) I wanted to avoid financial matters entirely because I have never been part of an end-of-life decision involving real people in which adding money to the conversation made things better (clearer, more biblically illuminating, more faithful). Writing chapter 6 helped me to see that it is not money itself that corrupts the discussion. What undermines end-of-life discussions is distrust. Money focuses distrust and makes it seem reasonable even when it isn't. Families who distrust medical professionals find it easy to believe that the doctors care *only* about money. Family members who distrust each other find it easy to say that the others are greedy and not loving. Money is

purposely left out of discussions about end-of-life care on the ethics committee at the hospital where I volunteer as an ethics consultant, and that has seemed like the best approach.

But placing considerations about finances inside the task of faithful service to Christ makes a big difference. Instead of being a discussion-ender, it puts money alongside time, energy, and opportunity as resources that we might use faithfully or not. Medical care near the end of life is expensive, but money is not the only cost involved. Living longer may cost great pain, spiritual deprivation, and burdens borne by others. Devoting resources to living longer may mean *not* using those resources to realize other great goods. Putting money in its proper place made me realize the biblical necessity of dealing with every decision inside the task of making faithful use of all our resources.

The final two chapters are even more practical. Chapter 7 describes how changes in American hospital practice affect the task of making end-of-life decisions. Twenty years ago, most people were talking to personal physicians whom they had known for years when they made the fateful decisions about care. Today, most decisions are made in consultation with doctors and nurses employed by the hospitals. This change means that the medical care is more specialized and less likely to be delayed by misunderstandings about hospital policy, but it also means that sick people and their families are talking to strangers. The chapter focuses on getting the most out of this system, and especially on the crucial task of getting the overall medical picture. Chapter 8 addresses what we might be doing now *before* we are in the hospital, facing end-of-life choices for ourselves or our loved ones. Some of the things we might be doing now call for difficult family conversations. Others call for church or community educational efforts. All of them will have the payoff of diminishing the awfulness of making choices when the time comes.

The biblical analysis and practical advice offered in this book have been road-tested, both in the hospital and in the classroom. **Sometimes the practical advice makes observations about legal matters, but I am *not* a licensed attorney and these observations should not be construed as legal advice. Concerning legal matters, readers are**

encouraged to seek the advice of qualified legal counsel. I am also not trained in medicine. My qualifications are only as a philosopher and teacher with experience and some training as a hospital ethics consultant. With this background, I am grateful to the leadership at Lookout Mountain Presbyterian Church (PCA) for allowing me to lead Wednesday-night discussions and Sunday school classes through this material. The curricula for these educational events are available through the P&R website. The Wednesday-night discussions depend on the availability of doctors and nurses willing to talk through and answer questions about specific cases. The four-week Sunday school curriculum is driven by scripted dialogues acted out by class members. The expertise of medical professionals is not required for the Sunday school curriculum, but when they are present, it helps a lot. I am also thankful to the leadership of Chattanooga Valley Presbyterian Church for inviting me to teach the Sunday school material to their adult class.

My students at Covenant College and Reformed Theological Seminary Atlanta also contributed to refining the argument of this book. My Bioethics class at Covenant helped focus the stories and questions in chapter 4. My Christian Mind students at Covenant proofed and commented on the first complete draft. The Pastoral & Social Ethics class at RTS Atlanta reviewed and corrected the thirty-three biblical principles that are developed in the book and summarized in Appendix A. The thirty teaching and ruling elders on the session at Lookout Mountain Presbyterian Church also vetted these principles.

The administration and my faculty colleagues at Covenant College also played an important role in making this book possible and shaping its contents. I enjoyed a semester-long sabbatical from teaching in 2014 to do research, and the administration funded my trips to the PCA General Assembly to lead seminars on aspects of the book in 2013 and 2016. John Wingard (philosophy), Bill Tate (English), Hans Madueme (theology), and Brian Crossman (physical education) all pestered me about progress and pushed back when my ideas were foggy (or worse). I am grateful to all of them for their thoughtful help and encouragement. Also at Covenant, the Philosophy Department

work-study aide, Caroline McLeod, did excellent work in compiling the glossary of terms.

I am indebted to many other people for their help with this book. They answered questions, read drafts, and gave thoughtful responses to the principles I recommend. Some are physicians: Robert Goldman, MD (palliative-care specialist, Memorial Hospital, Chattanooga, Tennessee), and John Risley, MD (urgent care medicine, Chattanooga). Others are nurses: Christine Dominguez, Karen Frank, and Jerry McCrary. Some are hospital chaplains (Betsy Kammerdeiner and Father Fausto Kevarengai), teaching elders in the PCA (Paul Bankson, Dan Gilchrist, Frank Hitchings, Joseph Novenson, Brian Salter, and Len Teague), or ruling elders at Lookout Mountain Presbyterian Church, PCA (Frank Brock, Tommy Gifford, Robert Hufaker, and Donald B. Kent).

Friends and colleagues have been especially helpful with comments on drafts and by praying: Barby Gifford and Hollie Kent. I am also indebted to Carl Middleton at Catholic Health Initiatives (Denver, Colorado) and Sister Eileen Wrobleski, the former vice president for mission integration at Memorial Hospital, as well as the other members of the ethics committees at Memorial Hospital, and the Alexian Brothers PACE program in Chattanooga. The board, administration, and faculty of Covenant College granted me a sabbatical in the spring of 2014 to do research on this project.

Many of my Covenant College and Reformed Theological Seminary students have been involved: Joshua Alford, Ben Benson, Chris Blackman, Grace Brown, Jason Cunningham, Terry Dykstra, Meagan Fernsler, Daniel Freman, Isaiah Gordon, Emma Grimes, Alex Kim, Michael Kirkland, Joanna Kolkman, Michael Lancour, Jimmy Latham, Lorette Mathe, Caroline McKissick, Mark Miller, Michael Morris, David Newberry, Morgan Nix, Matthew O'Sullivan, Noah Rallo, Sally Anne Russell, Luis Sanchez, Libby Scott, Anna Stogner, John Tremann, Hannah Umhau, Roy Uptain, Sophie Westbrook, Annalisa Yew, Joshua Youssef, and Kristie Zeigler.

Finally, I must thank friends and family for their input and support. Dr. R. Henry Williams, internal medicine, and ruling elder at Lookout

Mountain Presbyterian Church, provided uncommonly detailed and insightful questions about many aspects of an early draft of this book. Dr. Rich Pesce, the chief intensivist at Memorial Hospital, Chattanooga, has been my best-informed resource about the many medical matters discussed in the book. His command of the medical and ethical literature is encyclopedic, and he has endured my numerous ignorant questions with patience and provided consistently helpful answers. Karen Frank, DNP and head of safety and security at Memorial Hospital, has walked me through best practices for getting the big picture. If I'm ever in the hospital, I want Dr. Pesce overseeing my medical care and Karen as my case manager. And if I can't make decisions for myself, I want my wife, Lynda, making them. We have discussed all manner of distressing end-of-life cases. Her sense of what faithfulness calls for in these cases has been clear when mine was cloudy. I have complete confidence in her judgment, but I hope she never has to use it to make decisions about my care. I would prefer that Jesus return before those decisions are necessary. Because this book will be useful only if Christ tarries, I hope it is never used by anyone.

1

INTRODUCTION

MY FATHER'S DEATH

During the first week of June 2014, my earthly father died in a hospital bed in Wenatchee, Washington. My twin brother and I were in the room when he died, and we had participated in his decision to stop using the mask that was forcing air in and out of his lungs. Rather than staying on the mask and struggling to breathe, he decided to focus instead on being comfortable. He knew that it would mean that he would die before long, but he had been fighting a gang of physical challenges for a week. Together we agreed that his fight to get better had been faithful, and that he was never going to leave the hospital. While it was very sad to lose him and difficult to accept that his time had come, it was not difficult to decide to stop doing everything that medicine could do to extend his life. The decision was not difficult in part because my father had decided long before his final illness that he did not want to be kept alive on a ventilator and did not want to be resuscitated if his heart stopped. He had put these wishes in a legally sound form and explained them to me. I did not have to wonder whether he would want to have either of these means used to keep him alive.

A summary of my dad's final hours that I wrote for my family shows another reason that the decisions involved were not difficult:

Friends,

Last night at 9:45 my dad went home to be with the Lord. The end came much more quickly than I thought possible, but

it was peaceful and may have happened exactly as he would have scripted it.

At 11:00 A.M. yesterday, my dad spoke his last clear word. He had fallen asleep earlier in the morning during the family conference with the doctors, his wife, Carolyn, two of my siblings, and me. At that conference we came to the conclusion that (a) he would never be strong enough to leave the hospital and (b) all of the ways forward involved fatal risks. Even the BiPap mask pushing his oxygen involved the risk of making him nauseated to the point of vomiting. And vomiting into the oxygen mask would bring a rapid and painful death by aspiration. Discontinuing the mask would be much more comfortable, but without it his carbon dioxide level would rise, eventually to a fatal degree. But the slow buildup of CO₂ would not be uncomfortable provided he had morphine to manage the air hunger drive. In light of all this, the family decided that he would want to have the mask removed and to be made comfortable.

Before changing his treatment level, we asked the doctors to let us discuss it, this time including Dad in the conversation. (The only unsatisfying part of the medical care Dad received was the last hospitalist's unwillingness to take the time to try to explain Dad's situation *to Dad*. The hospitalist had decided that Dad was too out of it to direct his own care. Neither Carolyn, nor Russ, nor I agreed with the hospitalist's judgment about Dad's ability to follow and participate. The hospitalist had been on the case only a couple of hours, and he did not make a serious attempt to wake Dad up to talk to him.) So with the doctors out of the room, we slowly explained to Dad what we had learned about his condition (that the attempts to restore his breathing capacity were not working), his prognosis (that he would never be strong enough to leave the hospital and that continuing to use the mask involved risks), and his options (to stay on the mask and accept the discomfort and the risks involved or to change the goal of his care from curing his many illnesses to maximizing his comfort). When we were convinced that he understood enough of this, we said we thought he would want to focus on being comfortable and to take off the mask. He visibly summoned

his strength, looked each of us (Carolyn, Russ, and me) in the eye, and said “Okay” through the mask. It was a great blessing to have him confirm the decision.

At 1:30 P.M. the equipment and specialists were assembled. They turned off the monitors. They started an IV morphine drip to make sure he would not have unmanageable pain. After 10 minutes on the morphine, they took out all the other IVs, took off the oxygen mask, and put on the nasal cannula (high-flow oxygen). He did not struggle to breathe, but it did take 15 minutes to find a comfortable position in the bed.

When my dad was settled on the initial dose of morphine, the palliative-care specialist, Dr. W, started to leave the room, insisting that the nurse, Greg, was fully able to supervise the process of finding the appropriate level of morphine. I did not doubt Greg’s competence at all, but I did not want Dr. W to leave the room. So I stood in the doorway and asked if he could stay. As he had been throughout his time caring for my dad, he was willing to meet my needs as well as my dad’s: he stayed to oversee the process. Morphine is a powerful pain suppressor, and it is wonderful for controlling the air hunger drive. The morphine would enable my dad to sleep easily for the first time in days. But morphine also suppresses breathing, and I did not want the morphine to be the cause of my dad’s death. I wanted him to be comfortable, but not to be terminally sedated. With patience and careful monitoring, the specialist would be able to find a dosage high enough to end the pain and anxious struggling but low enough for him to continue to breathe.

Over the next 45 minutes the morphine drip rate was slowly increased under the supervision of the palliative-care specialist. We watched for signs of struggle or restlessness, confident that if he could go 15 minutes without jerking, grimacing, or crying, his pain and anxiety were under control. Three times the specialist directed Greg to give Dad a shot of morphine and to increase the drip rate on the IV slightly. After each increase, we watched for signs of discomfort. After the third increase, he went 15 minutes breathing steadily and showing no signs of distress.

After switching from curative care to comfort care, my dad rested as Russ, Sarah, and I talked about our children. He would open his eyes from time to time and smile. It is likely that he was listening almost all the time. His breathing was not regular like he was asleep, and sometimes he would shake his head and smile at a funny turn in a story. He never opened his eyes, but we could tell he was with us.

Between 3:30 and 8:00 P.M. I went to the hotel and slept. Russ and Sarah stayed with Dad and continued to talk. His breathing was consistent and on the few occasions when he furrowed his brow or squirmed, the nurse would give him a 1 mg shot of morphine on top of the drip.

At 9:00 P.M. they moved him out of the ICU to a comfort-only room on another floor. He did not open his eyes during the rather complicated move, but his breathing remained steady and strong at 16 respirations per minute. Russ was about to go back to the hotel and get some sleep. I was settling in for a night of watching and reading the Psalms to Dad. But with Dad breathing steadily, Russ and I started talking about Richard Feynman's lectures on quantum physics. We lost track of time. At 9:43 Russ noticed that Dad's breathing pattern had changed. We went to the bedside (all of four feet away) for a closer look. His breathing was very shallow, and now about 2 breaths per minute. I went to find a nurse to see if something needed to be done, although Dad was not struggling and looked like he was sleeping peacefully.

The nurse came a couple of minutes later. She examined him and said, "He has passed. I'll get another nurse to confirm it." We were shocked at how quickly it had happened, and a little unhappy that we hadn't noticed that his breathing was decreasing as we talked. But on reflection I believe that Dad would have wanted to drift out of this life listening to his children enjoying each other's company. When Russ and I were seven years old, Dad would help us get to sleep by playing recordings of Dr. Edward Teller explaining Einstein's theory of relativity. I'm sure Dad did not mind being helped in his final sleep by our talking about physics. He was a nuclear engineer

most of his life. He may have thought that the loop was closing in an appropriate way.

My dad made arrangements to be buried at sea. We found a card in his wallet with a number to call, and they (the Neptune Society) took care of everything concerning the disposition of his body. I'll see him again when the sea gives up its dead.¹

Thanks for all your prayers and friendship.

In many ways, it is clear to me that God was merciful to my dad, my brother, and me. My dad may have continued breathing for days, or even weeks, probably never waking up and possibly in some pain. If he had continued to breathe, we would have had to figure out whether to set up a schedule to keep watch over him. It may have been necessary to find a facility that could care for him in a minimally conscious state. Every day would have given us the opportunity to second-guess our decision. As it happened, we could see that he was comfortable, and we were there when he breathed his last. We have not had to wonder whether he died for lack of close attention or someone's mistake. It was a more peaceful passing than I could have invented with a blank sheet of paper.

The final decision was not difficult because Dad had left crucial instructions. Its difficulty was also diminished by my own preparation for making biblically appropriate end-of-life decisions. I am a philosophy professor with no formal medical training. While I teach bioethics at Covenant College and Reformed Theological Seminary, what I know about morphine, palliative care, oxygen-delivery options, and the difference between hospitalists and nurses comes from serving for seventeen years as a volunteer community member on the ethics committee at Memorial Hospital and with the PACE program in Chattanooga, Tennessee. I have an MA from Westminster Seminary

1. Rev. 20:13. The Neptune Society is a cremation service; see <https://www.neptunesociety.com/>. I believe that cremation is biblically permissible, and I am sure that those cremated will be bodily raised without difficulty. When financially feasible, however, burial provides a way of visibly proclaiming our confident hope in the resurrection.

California and a PhD in philosophy from the University of Notre Dame.² That training prepared me to think through the biblical principles that informed the final decision for my dad. Without the years of experience on the ethics committee, including serving as an ethics consultant on cases at the hospital (always with at least one doctor and one nurse), I would not have known how to connect the biblical principles to the practical demands of decision-making in a hospital context.

Since 2013, I have served as a ruling elder at Lookout Mountain Presbyterian Church (PCA), pastored by Joe Novenson. In that role, I have had the difficult privilege of advising families faced with end-of-life decisions about their parents and their children. One of the more recent cases involved the decision not to resuscitate a 2-year-old who had suffered a global brain injury but still had a functioning brain stem. Between the ethics committee work and cases referred to me by PCA churches, I have talked, walked, and prayed with people through more than thirty end-of-life situations. Every one of these cases has been emotionally taxing, but it has been an honor to be a part of each one.

This book is driven by the most common source of anxiety expressed by Christians as they have faced end-of-life decisions. Desiring to honor God's Word and obey his commandments, they have often thought that they were obligated to do everything medically possible to extend earthly life as long as possible. It is common for sincere believers to say something like this: "Because life is precious to God, I must be called to do everything possible to keep my loved one (or myself) alive." Medical technology is now able to extend earthly life in ways that would have seemed miraculous even fifty years ago. Very often it is *possible* to extend life for a long time even though there is no human reason to think that the person will ever regain consciousness. Sometimes the medical means are available but come only with great

2. John Frame's course The Doctrine of the Christian Life was especially important in shaping my thinking. This course was the basis for Frame's *The Doctrine of the Christian Life*, A Theology of Lordship (Phillipsburg, NJ: P&R Publishing, 2008).

pain, confusion, isolation, and radically diminished spiritual opportunities. Even when the gains from medicine are meager, sincere believers find it hard to resist the conclusion that they must seize every medical treatment because God requires it.

GOD’S LAW: A GIFT TO GOD’S PEOPLE

If I believed that God’s Word required us to use every means available to extend life as long as possible, I would not have agreed to removing the BiPap mask from my dad. And I would have urged him not to accept a do-not-resuscitate order when asked by his doctors. It would be foolish to trust my own understanding more than God’s law. God’s law is perfect and the only inerrant source of guidance. God’s revealed will is for our good at the beginning of life, at the end of life, and at every moment in between. God’s Word speaks to every area of life as well. While we can ask questions that God’s Word does not answer in detail—such as “Should I ask my boss for a raise?”—it shines light on the path ahead of us with warnings, principles, and direction. Even when I do not understand how God’s law is for my good, I know that it is. As the world around us grows less and less curious about God’s design for our good, followers of Christ should continue to look to God’s Word as our rule of faith and life.

Because the culture around us is increasingly comfortable treating life as cheap, Christians are right to be suspicious about trends away from fighting for every life. In 1985 I moderated a panel discussion on end-of-life care at Mercy Hospital in San Diego. I was a seminary student at the time, and I was eager to speak boldly for the protection of life. One of the physicians on the panel was not a believer, and he was openly frustrated by my resistance to discontinuing treatment that was not showing any benefit. When I asked him whether he was “playing God” when he turned the machines off, he said, “Of course I’m playing God. That is what doctors are paid to do.” It was not a helpful response. I assumed (wrongly) that he was saying what any doctor would say, and it led me to think that Christians must double their resolve to extend life regardless of the obstacles. Without studying

what the Scriptures have to say about life and death, I set out to defend what I thought the Bible must be saying.

My confident presumption that I knew best led me next to disagree forcefully with a Christian doctor in my home church. In casual conversation about a friend who was in the hospital but in decline, he said that the decision to turn a life-support machine off is ethically the same as the decision not to turn it on in the first place. This seemed dangerously incorrect to me. Turning a machine off would mean *kill- ing* someone. Not turning it on would be merely *letting the person die*. I argued (proud of my insight and holiness) that turning on a machine to keep someone alive implied a promise to keep it on as long as it was doing its job. His response was simple, and I now know that it is decisive: if turning a machine on brings with it a promise to keep it on, then first responders (paramedics, ER personnel, etc.) will be forced to make long-term promises without vital information. Often, no one knows what effect a course of treatment will have. It might be just what the person needs, but it might also do very little good and even cause great pain, isolation, and spiritual deprivation. If ineffective or greatly burdensome care cannot be withdrawn when the true impact of the treatment is finally known, then emergency workers will have to see the future or make promises that everyone will regret. As I will show in chapters 2 and 3, I am now sure that this Christian doctor's reasoning was both biblical and sound. At the time, however, I insisted that he was rebelling against God's Word, duped by the world's indifference to the sanctity of life.

In the thirty years since loudly taking these positions, I have served on three different ethics committees. Most hospitals now have ethics committees because it is expected by the Joint Commission that accredits hospitals to receive government funds. Some hospitals don't make much use of these committees, but I have had the pleasure of volunteering for three that were active. All three did "consults," working with caregivers to sort through contentious decisions. Two of them made and reviewed hospital policies about informed consent, privacy, and how to limit medical treatment that was excessively burdensome. The one on which I currently serve does all that and also works hard

at educating everyone about ethical challenges—sick people and their families, doctors, hospital staff, and the local community. Each of these committees on which I have served spent well over 75 percent of its time on end-of-life decisions. The decisions involved are momentous, urgent, medically complex, and typically plagued by communication breakdowns. As a philosophy professor, I find the committees' deliberations fascinating. As a follower of Christ, I find that they make my heart sick. The ravaging effects of the fall cluster together as death, fear, greed, and broken relationships combine to make an awful stew.

In part from serving on these committees, I became friends with many excellent physicians and nurses, both Christians and non-Christians. To my surprise, most of the non-Christian doctors and nurses have been zealous for the defense of human life. While the business and legal folks on the committees were sometimes willing to give up on sick people near the end, the physicians and nurses rarely did. They are trained to heal, and not to give up. The Christians have been even more solidly and actively pro-life. Some are leaders in the antiabortion effort; others are career medical missionaries; and all are respected by their medical colleagues. To my surprise (and chagrin), I also discovered that every last one of these people—including the Christians—disagreed with both of the principles that I had insisted were biblical. The Christian medical professionals have all believed that God's Word allows us to stop using treatment that is greatly burdensome, even if it is extending physical life. And they have been even more sure that God's Word does not obligate us to continue treatment once it is started.

Finding so many sincere, Bible-believing Christians who disagreed with my opinions about what the Bible teaches should have been enough to drive me back to Scripture. Sadly, it wasn't. It was working on the ethics committees that forced me to look carefully at what God's Word says about life and death. Reading the details of what it takes to extend sick people's lives medically was disquieting. Seeing and smelling the realities of what it meant for people to have the medical means used on them was even more moving. Resuscitating someone whose heart has stopped looks like a violent assault. Maintaining someone's

breathing on a ventilator looks like a miracle when it makes recovery possible. But for a person with no medical prospect of ever leaving the ICU, it looks much more like a prison sentence. Cancer treatments often involve drugs or methods just short of fatal: killing the cancer means nearly killing the person. For people already weak for other reasons, the physical, psychological, and spiritual toll can be devastating without being likely to succeed. If God's Word taught that we must do everything medically possible to extend life, then I would have to learn how to deliver that hard word in a gentle but firm way. First, though, I needed to be sure that God's Word demanded it.

Chapters 2 and 3 of this book summarize what I learned when I returned to the Scriptures, applying the tools I had gained at Westminster Seminary years earlier. (I realize that I should have been searching the Scriptures from the outset. I regret the years of being a pain or a bore to my Christian medical friends, thankful only that I did not do too much damage on the ethics committees before admitting that I had not carefully studied what the Bible says.) The order of the topics in chapters 2 and 3 follows the pattern I use when I teach the principles to adult Sunday school classes and to students at Covenant College and Reformed Theological Seminary. Teaching end-of-life decision-making to biblically serious Christian adults has shown me two crucial things about this difficult material. First, the discussion must stay connected to what the Bible says about life, death, stewardship, and the significance of spiritual benefits and burdens. Discussions that wander away from the Bible's teaching on these things will generate anxiety rather than confidence. Second, everyone has a personal connection to the practical challenges involved. These people need to be encouraged to tell their stories. Often, the stories are full of sorrow, confusion, and even regret. People who are living to serve Jesus and obey God's Word are often hurting because they think they gave up on a loved one too soon. They also think they displeased Christ by giving up. The principles presented in chapter 2 can help them deal with their complicated grieving, but they can also benefit from drawing the rest of the class into their story. Their grief has often been lonely precisely because they thought they had failed God's law.

THE PCA REPORT ON HEROIC MEASURES

The testimony of Christian medical professionals, together with what I saw while volunteering on the ethics committees, and my own study of God’s Word, led me to believe that the Bible does not require us to do everything medicine offers when the medical treatment either is ineffective or imposes an excessive burden on the person who is nearing death. Only after reaching that conviction did I learn that my own denomination—the Presbyterian Church in America (PCA)—had appointed a committee in the late 1980s to study what God’s Word says about end-of-life care. The PCA had adopted the committee’s findings in 1988, but I did not learn of its existence until 2013. I read the report eagerly (and with a little apprehension). The report’s central finding is that God’s Word does not require us to use ineffective or burdensome treatment to extend our physical lives. This can be stated as a biblical principle, and it is the most important principle in this book:

Permission to Decline Treatment: God’s Word permits us to decline life-sustaining medical treatment that is ineffective or that we, as servants of Christ, judge to be excessively burdensome.³

The 1988 PCA Report on Heroic Measures reaches its conclusions by using the Word of God as its standard. God’s Word does not change, and the principles recommended by the report are still valid and helpful. American society and medical practice, however,

3. The exact wording of this principle in the PCA Study Committee Report on Heroic Measures at the End of Life is as follows: “treatments that are ineffective, minimally effective or have frequent and serious side effects are not obligatory” (§ III.6). I have replaced “serious side effects” with “excessively burdensome” to reflect the terminology commonly used in hospital practice and to emphasize (as the report intends) that side effects are “serious” when they are greatly burdensome to the person who must endure them. The authors of the report were William Hall, James Hurley, Reginald F. McLelland, PhD, F. Edward Payne, MD, and John Van Voorhis. The full text of the report can be accessed at <http://pcahistory.org/pca/2-378.html>. From here on, this report will be called the “1988 PCA Report on Heroic Measures.”

have considerably changed since 1988. Those changes make the report practically difficult to use today. The language used in the report is not just outdated. Some of its key phrases now mean something very different. The report makes assumptions about a doctor's role that would seem quaint or even dangerous today. Most importantly, the report discourages believers from using "Living Will" forms for reasons that no longer apply to today's legal environment and hospital practice. (Living wills—now called *advance directives*—are today more standardized, better understood, and more likely to be welcomed by physicians as a source of guidance.) This book aims to make a more detailed biblical case for the principles found in the 1988 PCA Report on Heroic Measures, and to give more practical guidance about how to apply those principles, especially in the hospital setting of today.

The final recommendation of the 1988 PCA Report on Heroic Measures drives the writing of this book:

A person or committee in each church should be designated for special study concerning the terminally ill. The seriousness of the issues and their complexity require more than a casual or wait-until-something-happens approach. Further, virtually everyone will face some facet of these problems with some family members. A resource is needed locally to offer Biblical advice and options to those involved. It is doubtful that every pastor will have the time necessary to devote to this particular area. Formal teaching sessions and distribution of literature for the congregation should also be arranged. Physicians in the congregation should be involved as well.⁴

The recommendations about end-of-life medical decisions given in the 1988 PCA Report on Heroic Measures are sound, but the biblical support for its principles is not developed in detail. My goal is to provide a "resource" that can be used by believers to "offer Biblical advice and options," and to give pastors and other leaders the biblical basis for the principles they will need to assist believers and their families

4. *Ibid.*, § IV.5.

when medical decisions must be made. My experience in teaching these principles to adults in PCA churches has helped me to see where the reasoning needs to be especially attentive to the text of Scripture. Those teaching opportunities also helped me to see the importance of illustrations that match what people are facing in the hospital context today. I would be very pleased to learn that this book helped to fulfill the recommendation that “literature for the congregation should . . . be arranged.”

In addition to recommending biblical principles and preparing people for practical hospital realities, this book follows the 1988 PCA Report on Heroic Measures’ emphasis on the role that *spiritual implications* should play in end-of-life decisions by and for believers. Christian reflections about our approach to death often highlight the spiritual delights that await believers in an endless life in Christ’s presence. I will do nothing to diminish that grateful anticipation or dim that glorious truth. Instead, I hope to focus on the spiritual burdens that are endured by many who are kept physically alive by medical treatments that offer no natural prospect of recovery. We too easily forget that the greatest joys that this life affords are spiritual. To the world, spiritual joys look paltry. We should know better. The delight of reading God’s Word and hearing it preached, the unity found in taking the sacraments with other believers, the peace and involvement known in corporate prayer, and the thrill of singing God’s praises together with God’s people are more fulfilling to our whole selves than anything else on earth.

Today’s medical treatments can extend earthly life, but often only by cutting people off from all these spiritual joys. In chapter 5, I use my own advance directive to illustrate a step-by-step approach to completing a legally effective document to make sure that your wishes are known if you become too sick or injured to speak for yourself. At the heart of the instructions I have left with my doctor is the desire not to have medical means used to keep me alive *unless* the means are humanly likely to restore to me the ability to enjoy “the ordinary means of grace.” These ordinary means are the spiritual goods just mentioned above: access to God’s Word, the sacraments, corporate prayer, and worship. Living cut off from those things is a great spiritual

burden. It would be a burden much greater than the benefit of being alive in a hospital bed or permanently confused. I would rather be at home with the Lord.

TERMS AND METHODOLOGY

Why There Are No “Patients” in This Book

The words we use to describe things affect the way we feel about them. Talking about medical choices can be distressing even when all the words are carefully chosen and we know what they mean. For most of us, the language of medicine is a foreign tongue. Medical training and constant use give hospital workers a large vocabulary for describing body parts, bodily functions, and rapidly changing range-of-treatment possibilities. Even with more than twenty years of experience on hospital ethics committees, I regularly have to ask for explanations of words that everyone else at the table clearly understands. Throughout this book, I intend to use medical jargon only when it is necessary, and to explain the technical terms when they can't be avoided.

Technical terminology can be unnerving for anyone visiting a hospital. It has to be even more distressing for the person who is seeking medical attention. Inside the hospital, anyone seeking medical attention is called a *patient*. It is a compact and clear way of referring to a person under the medical staff's care, but using the term *patient* involves some risks. Recent critics of hospital practices have warned that Western medicine has grown too comfortable in treating sick people as mere objects for medical science.⁵ Merely using the word *patient* does not dehumanize sick people, but continuing to use it runs the

5. The most compelling of these critics is Michel Foucault, especially in *The Birth of the Clinic* (London: Routledge, 1963; repr., New York: Vintage Books, 1994). Paul Ramsey's *The Patient as Person* (New Haven, CT: Yale University Press, 1970) was an early voice inside the world of medicine warning against seeing sick people as mere puzzles or problems and instead remembering that each one is a person. The move away from a paternalistic model (doctor = father, nurse = mother, patient = child) toward the autonomy of sick people to direct their own care is one of the fruits of these warnings.

risk of thinking of sick people as “them” rather than “us.” Calling a sick person a *patient* (one who suffers or waits) makes it easier to put that person at an emotional distance. A *patient* can be a featureless stick figure in a bed or attached to an IV stand. But this is not why hospital workers use the term. *Patient* for them is the universally approved term for someone under medical care. They are aware of the threat of reducing people to nothing more than a set of symptoms and behavioral challenges. Most hospital workers take steps to maintain an appreciation for the humanity of those needing their attention. Yet the danger remains.

This book discusses the choices that people face in the hospital. Using the word *patient* in this book the way hospital workers do would be efficient and make sense. The 1988 PCA Report on Heroic Measures uses the word *patient* fifty times in the space of eleven pages. With the efficiency, however, would come the continued risk of obscuring the humanity of those in the midst of their own personal health crises. Instead of *patient*, I will use *sick person*, *person in the bed*, and similar phrases. Often, this will make the descriptions feel clunky. Yet the advantage of using the other terms is evident even in their clunkiness. Reading *sick person* instead of *patient* encourages us to picture a real person. A *sick person* was once healthy, and probably wants to be healthy again. A *sick person* has loved ones who are often anxious and sometimes hurting.

Using someone’s name is much better than using either *patient* or *sick person*. Whenever possible, including in fictional illustrations, I will use the name of the person involved to reinforce the habit of focusing on an individual human being rather than a set of symptoms or a kind of problem. The differences between *patient*, *sick person*, and *Mindy* are large enough to aim for consistency in avoiding the use of *patient* in this book.

The Power of Stories

Making ethical decisions can be agonizing. As the true stories in this book will illustrate, the decisions that we are asked to make about medical care can be daunting, overflowing with complexity and

values that cannot all be honored. Over the last two hundred years, the approach to ethical decision-making taught in Western schools has emphasized formulas and rules. This “modern” approach holds that the right formulas and rules will make the one right answer obvious to *anyone*. Godliness and the wisdom that comes from experience might be nice to have, but they are now thought to be unnecessary, even when the decisions are difficult. God’s Word treats decision-making very differently. Although no one can say that lack of godliness and wisdom is an excuse for not obeying God’s law, the Bible says that “the fear of the LORD is the *beginning* of wisdom” (Prov. 9:10). We are encouraged to heed the instructions of our parents and older people (the “hoary head” of Leviticus 19:32). The law of God is certain, pure, and a light to our path; but we are not told that it is simple to apply in every situation.

The recent focus on formulas and rules replaced thousands of years of emphasis on wisdom and the role of godliness in making good choices. The law of God is not just a set of rules. It is the way of blessing, life, and fellowship with God and peace with our neighbor. Decision-making in the Bible is most often a matter of recognizing a similarity of the current challenge to a challenge described in Scripture. Consider just three examples:

Proverbs 6:6–11: “Go to the ant” To recommend hard work over laziness, the teacher says, “Be like the ant.” Godly industriousness is not easily expressed as a rule, such as “Work until you are sweating for at least eight hours a day.” It is instead shown by an example or an analogy. Lazy people who don’t see how the example of the ant helps will not be helped by a precise rule to follow.

Matthew 6:25–34: “Consider the lilies” Rather than only giving the rule “Do not worry,” Jesus directs our attention to birds and lilies. They do not fret, and God provides for them abundantly. Before and after pointing to the birds and lilies, Jesus says, “Do not be anxious.” Jesus uses the analogies to show us what to do instead of worrying.

First Timothy 5:17–18: “You shall not muzzle an ox” To teach Timothy about the honor (and pay) due to pastors, Paul refers

to what Deuteronomy 25:4 says about feeding beasts of burden. Paul is not saying that pastors are little more than dumb oxen. He is using an analogy between pastors and oxen to show that since even oxen deserve support, so do pastors.

Before the rise of the modern fascination with formulas and rules, reasoning by analogy was the most common way of helping Christians make difficult decisions. Should I forgive my brother? Jesus answers with a story about a servant forgiven of a great debt who refuses to forgive a small debt. Should David repent of murder and adultery? Nathan tells a story of a wealthy man and a poor man. These stories do not replace the prohibitions and obligations given in God's law. They show how the commandments apply in difficult situations by highlighting the similarity to situations in which the choice is more obvious. Applying God's Word by using analogies helps everyone see the factors that should matter most, often drawing attention to things that might otherwise be overlooked. Another benefit of giving advice by way of analogy is the help it gives in making sense of the decision long after it has been made. "We chose this path because we were facing a situation like this other situation (in which the choice would have been easy)." One of the most important parts of giving godly advice is showing people how to weave what they are facing into the larger story of their walk with Christ. Advising by analogy not only helps people make more confident decisions, but also helps them make sense of the difficult time when they reflect on it later.

As with the sterile application of formulas and rules, advising by analogy can be abused. An illustration should help to show both the value and the potential risks involved in advising by analogy. Starting in the Netherlands in 1994 and now including U.S. states such as Oregon and Washington, laws have been changed to allow physicians to prescribe lethal doses of sedatives to people who want to die "in a humane and dignified manner."⁶ These laws aim to give a medically managed way of escape for people who are terminally ill and likely

6. This is the phrase used in the Oregon Revised Statutes (ORS) (https://www.oregonlegislature.gov/bills_laws/ors/ors127.html). Oregon law in 2015 includes a

to spend their last days of life in great pain. By allowing doctors to assist people with such grim prospects, the laws intend to help people who are eager to die to do it efficiently and painlessly rather than in a messy, possibly unsuccessful way. Some people have supported these changes in the law out of compassion for people who are facing a horrific end. It is appropriate to have our hearts break for people in pain. They bear the affliction of the fall in ways that many of us do not. And if we see physician-assisted suicide only as a way to diminish someone's pain, it is hard to see how it could be wrong. Comparing physician-assisted suicide to relieving someone in pain is moral advice by analogy. If relieving pain is the only consideration, then we should be in favor of physician-assisted suicide. But of course, it is not the only consideration. The fastest way to see that more is involved is to tell another story.

Imagine that dangerous levels of toxic mold and asbestos have been discovered in the basement of your house. The upper floors and attic are not affected, but the basement is irreparable. The insurance company will pay to have the house completely demolished and a new house built on a different site, so you hire a demolition crew and tell them to destroy the house. As the crew is looking around the attic to see where to begin, they find two paintings. An amateur historian working on the crew recognizes them as Rembrandts. Pinned to the frame of each is a note: "On loan from the Louvre." The leader of the demolition crew says, "Because these are in a toxic-hazard site, it will be hideously expensive to save these paintings. It will set the work back for months." In light of the great hassle involved, would it be okay for the crew to destroy the paintings along with the house?

The obvious answer is "No!" The paintings are masterpieces. They do not belong either to the demolition crew or to you, the owner of the house. Even though it will be a massive headache for you to rescue and return the paintings, it would be wrong for you to destroy them,

clause that insists that dying from a physician-prescribed overdose is *not* suicide (ORS 127.805 § 2.01; ORS 127.880 § 3.14). Officially, then, it is not "physician-assisted suicide," because according to the law it is not suicide at all.

and it would be wrong for you to ask the demolition crew to use their expertise to destroy them. The paintings are not yours, and they are not trash.

Physician-assisted suicide is even more like crew-assisted painting destruction than it is like helping to relieve someone's pain. We know this because God's Word tells us that human life is precious in his sight, and that it belongs to him and not to us. Even if you see the paintings (or your life) as a huge obstacle to getting what you want (a new house, or relief from pain), the paintings (and your life) are still valuable. Wise friends would encourage you to learn about the value of the paintings and to think harder about what it means to be a borrower rather than an owner. People facing a painful last illness need people to draw close to them to cherish the value of what they have. They do not need people confirming their sense that their life is pointless and that the pain is the only reality.

For someone seriously seeking to commit suicide, a fictional story about paintings in an attic is not likely to be persuasive. But it ought to be helpful to someone trying to decide whether to help someone else end his or her life. Believers who are eager to see what God's law says about our good should find it even more persuasive. It should help us remember what God has revealed about his glory and our good.

These competing analogies about physician-assisted suicide highlight both the power of advice by analogy and the importance of taking steps to limit the risks involved. In the hands of unscrupulous or wicked people, *every* approach to moral advice can be used to justify wickedness. Cost-benefit (utilitarian) reasoning can ignore the costs imposed on the weak or the poor. Duty or rights-focused (deontological) reasoning can treat the rights to sexual expression as more important than all other rights. Advice by analogy can offer analogies that ignore crucial ways that the situations are *not* alike, sowing confusion rather than clarity.

A memorable story can make bad moral advice seem better than it should. When we find a moral analogy compelling, it is wise to take steps to limit the risk that the story is making a biblically inappropriate choice attractive. The most important of these steps is to seek godly

counsel. Spiritually mature believers are likely to see that the story is leading us astray. People older in the Lord may see that we are overlooking clear biblical teaching. We should trust them to open our eyes to passages of Scripture that we need to take into account. Spiritually mature brothers and sisters can often give advice from their own experience. Sometimes they will tell us about a choice they faced that is more similar to our situation than the choice faced by the fictional hero of the analogy that we are considering. At other times they will propose a different analogy from the one that seems so helpful to us. This new analogy may reinforce the recommendation of the original analogy, but it may also encourage a different choice. Either way, the road ahead will be easier to see. Finally, godly fellow believers can help us see where our own immaturity may be getting in the way. If someone else used the analogy to support bad advice, they will be able to help us see who ought to be trusted. If, instead, we are embracing the story because we are ignorant, confused, or in love with the wrong things, they can alert us to the danger we are in.

Stories about choices in analogous situations can give clarity and comfort. This book uses both true and fictional stories to reinforce recommendations. Applying these stories to other situations should be done prayerfully and with the advice of wise friends.

A PRESSING NEED

Two recent occurrences made it clear to me that this book could be helpful. The mother of a good friend passed away after a full life. The final days of her life involved many questions about starting or stopping medical treatments. When I met my friend in the receiving line at the memorial service, my friend said, “Thank you [for what you taught in Sunday school]. Mom had lost the ability to enjoy the means of grace. Medicine could not do anything to restore it. I could say no [to some options without worry].”

Finally, as I was trying to decide whether to pursue publishing this book, a woman told me that she wanted a Christian philosopher’s help with a problem. She had been recently diagnosed with an aggressive

form of breast cancer for which there is no known treatment. Her oncologist told her that she was likely to live only five more months. The oncologist also told her about an experimental drug trial that she might enroll in. If all went well, she would live seven more months rather than five. The experimental drug came with serious side effects, however. She would be sick to her stomach, bloated, confused, and lethargic as long as she was on the drug, and that could be for four months. She knew what she *wanted* to do: she wanted to decline the drug and focus on making the most of her five months of mostly gradual decline. But she also wanted to obey God's Word. If God was calling her to endure discomfort and confusion in order to stay alive as long as possible, she was willing to trust him through it.

The choice that this dear woman was facing was hard. It was made even harder when she started looking for biblical advice about how to make it. She described to me the approach she had taken to finding sound biblical counsel. She had regularly prayed for guidance. She had talked to pastors. She described sophisticated approaches to library and Internet resources she had used. What she had found was discouraging. Sources serious about the authority of God's Word either said nothing about her situation or said that she was obligated to do everything possible to live as long as possible. Life is precious to God, so any cost is worth it. The sources not serious about the authority of God's Word generally recommended that she minimize her pain by whatever means possible. A distressing number of those sources described in detail how she could end her life painlessly before the symptoms became unpleasant. She did not find any sources with a high view of Scripture that addressed her situation and said that God's Word allowed her to decline participation in the experimental trial.

As she was telling me about her situation, I assumed that she had heard that I was working on this book. She might have heard that I taught bioethics at Covenant and expected me to know what she had not read. Or maybe she had heard that I served on the ethics committee downtown. When she finished her story, however, I learned that she did not know anything about me, my research interests, or my activities. She only knew that I was a Christian who taught philosophy.

I was able to suggest some books that might help her,⁷ but what she had found in her highly motivated research is accurate: very few books or websites are helpful for people serious about the authority of God's Word and facing hard decisions about burdensome medical treatment. This book aims to provide the biblical principles needed to answer this woman's question.

KEY TERMS

advance directive
 casuistry
 do-not-resuscitate (DNR) order
 heroic measures
 1988 PCA Report on Heroic Measures

STUDY AND *DISCUSSION QUESTIONS

1. What decisions had the author's father made before his final health crisis that decreased the author's distress in making his own crucial decisions?
2. What difference did the palliative-care specialist make in the sequence of choices?
3. How long did the author's father live after the *decision* to move to comfort care only?
4. *Did the author make the right decision about discontinuing the use of the BiPap support for respiration? Why or why not?
5. How is God's law a gift to God's people?
6. What reasons are given for thinking that withholding and withdrawing medical treatment are morally equivalent?

7. David VanDrunen, *Bioethics and the Christian Life: A Guide to Making Difficult Decisions* (Wheaton, IL: Crossway, 2009); Gilbert Meilaender, *Bioethics: A Primer for Christians*, 2nd ed. (Grand Rapids: Eerdmans, 2005); Kenneth P. Mottram, *Caring for Those in Crisis: Facing Ethical Dilemmas with Patients and Families* (Grand Rapids: Brazos, 2007).

7. What pattern did the author discover about end-of-life challenges through his work on hospital ethics committees?
8. *Was the author too quick to agree with the physicians who urged him to see withdrawing and withholding as equivalent?
9. What are the principal findings of the 1988 PCA Report on Heroic Measures?
10. Why is the 1988 PCA Report on Heroic Measures difficult to use today (in 2017)?
11. *What role should the findings of the 1988 PCA Report on Heroic Measures play in the decision-making process of a PCA church officer? Of a PCA church member? Of a Christian who is not a member of a PCA church?
12. Why does the author not use the term *patient* to refer to people who are sick?
13. What reasons are given for the extensive use of stories in advancing the argument of this book?
14. *Why does dictionary.com define *casuistry* (which technically only means “the application of general ethical principles to particular cases,” usually by appeal to analogous cases) as “specious, deceptive, or oversubtle reasoning, especially in questions of morality”?
15. *Should true stories matter more than fictional stories in forming biblical moral principles?
16. *What advice should be given to the woman with breast cancer about pursuing treatment?

FOR FURTHER READING

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DECISIONS AT THE END OF LIFE create deep anxiety for those involved. But it *is* possible to find peace and comfort amid the hard choices.

As a church elder and hospital ethics consultant, Bill Davis has talked, walked, and prayed with many people in end-of-life situations. Employing varied case studies and biblical, ethical insight, he guides you in making decisions for yourself and others, preparing advance directives, taking financial concerns into account, and navigating new realities in American hospitals.

“This book combines mature biblical teaching with the brass-tacks practical questions that we all face with the death of loved ones. These are the things that we don’t usually think about until they happen. I highly recommend *Departing in Peace* as essential preparation.”

—**MICHAEL HORTON**, *J. Gresham Machen Professor of Systematic Theology and Apologetics, Westminster Seminary California*

“Dr. Davis is an exemplary teacher and guide. His personal experience with end-of-life issues and his experience as a guide to others are invaluable for those who want to be ready.”

—**RICHARD R. PESCE**, *MD, MS (ethics), FCCP, FACP, Medical Director of Critical Care, Memorial Hospital, Chattanooga*

“This book by Bill Davis fills a real gap in the literature. . . . *Departing in Peace* deserves to become the go-to book for those seeking solid guidance on difficult end-of-life decisions.”

—**JAMES N. ANDERSON**, *Associate Professor of Theology and Philosophy, Reformed Theological Seminary, Charlotte*

“This book is a fine reflection on crucial issues of life and death. As we would expect from Bill Davis, it is careful, thoughtful, and biblical, and it will be genuinely helpful to families and pastors.”

—**W. ROBERT GODFREY**, *Professor Emeritus of Church History, Westminster Seminary California*

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