

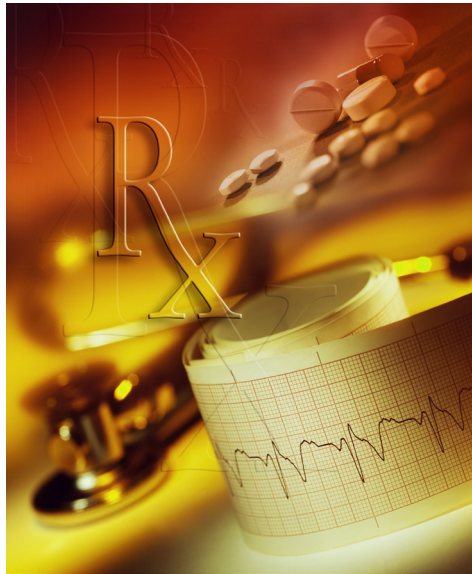
Ventilators, Feeding Tubes, and other End-of-Life Questions

By Linda D. Bartlett and Karen Rehder, M.D.



Most Christians agree that euthanasia and assisted suicide are not God's will and, therefore, never options. However, many of us have some fears about the end of life. We have concerns about health care.

Dealing with illness and dying has never been easy. But in the 21st century, we face medical dilemmas that our grandparents never had to consider. Modern technology with its many options has presented us with choices that most of us feel unqualified to make.



Christians do well to build our responses on the truth of God's Word, which says that:

- (1) Human life is sacred regardless of condition or health;
- (2) God is Lord over all matters of life and death, and we can trust Him to do what is right according to His will;
- (3) God has demonstrated His goodness and love for us in the cross of Jesus, and nothing can separate us from His love; and
- (4) God has a purpose for every life.

If we ignore the Creator and Redeemer of our lives, we are in danger of trying to “be like God,” making our own rules based on what we feel and what we want at any given moment. With this in mind, let's consider the following questions.

Don't we all have the right to “die with dignity”?

Advocates of euthanasia and physician-assisted suicide believe that “dignity” comes when we have the freedom to call our own shots—when we can end our lives before we become “helpless” and dependent on others to care for us. But “death with dignity” is not killing the patient. “Death with dignity” is caring for the patient, supplying

whatever is needed—drugs, oxygen, fluids, nutrients, personal contact, and spiritual encouragement—in order to make death an easier death.

When standing at the bedside of Aunt Millie, we should not ask, “What would Aunt Millie want?” but rather, “How can we care for Aunt Millie in a way that glorifies God?”

Terms like “extraordinary treatment,” “heroic measures,” and “life support” frighten me. As a Christian, why not just dispense with all of this and go on to my eternal home in heaven?

Our destination is sure, but the dying process is not. We should not be surprised by fears about the dying process.

We might feel very uncomfortable, for example, with the idea of “life support measures.” But, we must remember that “life support” is just that! It is support that saves a human life.

Christians who value God’s gift of life have an obligation to give or accept treatment where treatment can reestablish health or save life. Elizabeth R. Skoglund writes: “If a respirator or ventilator can be a bridge back to life, then we have the obligation to try it. If, on the other hand, the respirator is used when death is inevitable, simply to slow the dying process, then it is wrongfully keeping us from being released to be with God.” (*Life on the Line*, World Wide Publications, Billy Graham Evangelistic Association, Minneapolis, MN, 1989; p. 164)

Don’t ventilators only prolong suffering? If I’m hooked up, won’t I be stuck on this kind of life support forever?

We must dispel the notion that the only use for ventilators is to unnecessarily prolong the life of a suffering patient. The fact is, with a few exceptions, almost everyone who has surgery is temporarily placed on a ventilator during the operation. All of us should be grateful for the improved ventilation technology which permits longer and more technically difficult surgeries to be performed.

Another false notion is that patients on ventilators suffer a great deal of pain from the tube in the airway. This is not true since a patient is most generally put to sleep before the tubes are placed in his/her airway. Medication is typically given to help a conscious patient through this time of stress.

A third false notion is that patients who are placed on ventilators will never be able to breathe on their own again. The fact is ventilators

are used to help people recover from a variety of nonterminal illnesses that may be temporarily causing respiratory problems. Ventilators are used to assist in breathing and then removed when healing has taken place. Thus, it is not wise to sign a document like a “living will” that states you do not want to be put on a ventilator in any circumstance.

What about food and water? Is medically assisted nutrition and hydration a form of “treatment” or “care”?

Although frequently debated among ethicists, this question is irrelevant for the Christian. Jesus compels us to treat the sick and to provide loving care in the form of food and water (Matthew 10:42; 25:35). Even when the sick are incurable, they are never untreatable or unable to accept loving care. Regardless of whether we call nutrition and hydration “treatment” or “care,” these must be provided to the sick. The only exception would be if the sickness has compromised the body to the point of not being able to process nutrition and hydration.

What are the benefits of medically assisted nutrition and hydration?

Food and fluids can be life-saving by promoting healing after an illness, surgery, or injury. In cases where the patient has an incurable disease, food and water may not save life or reestablish health but may alleviate suffering caused by hunger and thirst.

The feeding tube itself is neither highly intrusive nor highly expensive. Its use does not require exotic technology. Typically, the tubes are thin and soft as a piece of cooked spaghetti. They are quite comfortable.

Patients are not blind. They see the offering or non-offering of appropriate food and fluids as an expression of love and concern or lack of love and concern.

Tube feeding must never be considered useless or futile if it maintains a person’s life and prevents death by starvation or dehydration.

What are the burdens of medically assisted nutrition and hydration?

Intravenous feeding carries the risk of introducing infection. Nasogastric feeding carries the risk of inadvertently placing fluids into the lungs. However, these risks can be minimized by careful attention to detail in caregiving and are not excessive when compared to the adverse effects of dehydration and malnutrition.

If one method proves burdensome, we should not automatically withdraw all foods and fluid. Other methods of assisted nutrition and hydration may be possible. Some helpless patients are tube fed, not because they can't swallow food, but simply because tube feeding is cheaper and easier for the healthcare provider.

We must provide counsel and spiritual support for the person who has a fear of being supported by feeding tubes so that they may have an appreciation for the gift of life, in spite of possible suffering. Studies show a favorable view of medically assisted nutrition and hydration among patients and families who have actually experienced such procedures.

Do patients in a “persistent vegetative state” (PVS) represent a special case?

First of all, no human being created in the image of God should ever be called a “vegetable.” While PVS may be a correct medical term, it fails to describe the person. We would do better to speak of the patient as what they are: “a person in a coma” or “a patient in a nonresponsive state” or “my Aunt Millie with brain damage.”

Some theologians conclude that an unconscious person cannot advance their spiritual good because they are unable to perform any conscious, free acts. This argument assumes that our worth in God's eyes is based upon what we are able to do or not do rather than God's power at work within us (Ephesians 3:20). Here is something to ponder: Might our Heavenly Father be ministering to an unconscious person even more deeply than He does to a conscious person who is distracted by the cares of the world?

The nature of disease and the prognosis for persistently unconscious patients are not fully understood, and no established test exists which enables physicians to determine in advance which unconscious patients will ultimately wake up. There are many examples of people who “wake

up” after being declared in a PVS. When Minnesota policeman Sgt. David Mack was shot in the line of duty in 1979, Dr. Ronald Cranford diagnosed Sgt. Mack as being in a “persistent vegetative state,” never to regain “cognitive, sapient functioning ... He will never be aware of his condition nor resume any degree of meaningful, voluntary, conscious interaction with his family or friends.” But twenty months after the shooting, Sgt. Mack regained consciousness and nearly all of his mental ability.

Conley Holbrook was in a coma for eight years. On February 25, 1991, he woke up. Were eight years missing from his life? Apparently not. Twenty-six-year-old Conley was able to call each of his relatives by name, including the small children who had been born while he was unconscious. Although he couldn’t communicate, he knew what was happening around him.

Cybercast News Service found more than two dozen cases where published news reports document patients diagnosed as being in a persistent or permanent vegetative state, or coma, “waking up,” including Marcello Manunza (recovery after three years), Peter Sana (recovery after seven years), and Patti White Bull (recovery after eighteen years).

But whether or not recovery from PVS is possible is not the most important question. The most important question with PVS is this: Is the care and treatment burdensome, or is the life of the patient burdensome? Rev. Dr. Richard Eyer writes, “When little can be done to treat the illness successfully, we must keep the patient comfortable, do nothing to cause death, and commend that person and ourselves to God.”

What’s so bad about death by starvation or dehydration?

When the human body is compromised by disease, it naturally begins to shut down. Removing nutrition and hydration at this point is not harmful. Indeed, since the body is no longer able to process these effectively, they may do more harm than good.

However, if a person is not dying, removing nutrition and hydration may have very serious physical effects as the nutrients the body still requires have been suddenly removed.

Whether or not removing a feeding tube will cause suffering, however, is not the critical question. The critical question for the

Christian is whether removing a feeding tube will **cause** someone to die or **allow** someone to die?

Isn't it my body? The decisions I make concerning my life shouldn't affect anyone else.

First of all, our bodies are not our own. They were bought at great price (1 Corinthians 6:19-20).

Second, a decision to cut life short affects a whole network of relationships: friends, family, medical personnel, even casual acquaintances. But a gutsy decision to face suffering head-on forces others around us to sit up and take notice. It's called strengthening the character of society. When one person observes perseverance, endurance, and courage in another, his or her own moral fiber is reinforced.

Even in our dying, we can be a witness for life! Our last moments on earth can be very important ones. Who can know the kind of worship that goes up to God? Who can know the "soul work" that is being accomplished in either the patient or those around him? Who can know how many lives are touched by the living of faith at the end of earthly life? What we do or don't do has a rippling effect on everyone around us.

Don't I have the right to choose when to die?

The Bible clearly tells us that there is a time to die (Ecclesiastes 3:2). The Bible is also clear in reminding us that our times are in God's hands (Psalm 31:15). The Lord is the One who gives and takes life (Job 1:21). This is not our right.

In her book, *When Is It Right to Die?* (Zondervan Publishing House, 1992; p. 73), Joni Eareckson Tada writes, "When we clamor about the sanctity of our individual rights, we may be reinforcing an all-too-human failing, and that is the tendency to place ourselves at the center of the moral universe. We label our desires 'rights' as if to give those willful determinations a showy kind of dignity."

God has our days numbered (Psalm 139:16). We interrupt His purpose and will when we put ourselves in His place.



Don't lots of people die in pain or hooked up to machines or away from their loved ones?

Death for most Americans is peaceful, painless, and with family. A groundbreaking study of 4,000 people age 65 and older determined that:

- most spend the last days in their own homes with family and friends;
- most are alert and in control of their bodily functions;
- one-third die at home while one-half transfer to a hospital shortly before death;
- most maintain active interest in the world;
- most are not depressed;
- many report a feeling of hope, believing they have something to live for.

On the day of death, 51 percent had no difficulty with orientation or recognition of family, 61 percent had no pain, and 52 percent could breathe freely. (M. Powell Lawton, Philadelphia Geriatric Center)

A dying man's wife chose to take care of him with the help of hospice. Pain was effectively managed and he died peacefully at home. She commented, "It is a valuable thing to experience the dying process with a man who believes in the preciousness of life."

When is enough, enough? When do we simply let God take our loved one to Himself?

We can and should allow those who are dying to die. We do not have to attempt to cling to life at all costs. When it appears that God has called the soul from the body—our earthly tent (2 Corinthians 5:1)—there is no point in merely blowing wind through the empty tent with ventilators and machines.

When there is no hope of recovery, the dying process should be allowed to run its course. Loving care—including food and water (if appropriate) and spiritual support should be given to the dying, keeping them as pain-free and comfortable as possible. This is death with dignity.

Is the withholding of medically assisted nutrition and hydration always a direct killing?

Although some propose to do so with the intent of killing the patient, we should not assume that all such decisions are attempts to cause death. Patients who are not fed will eventually die, but sometimes other factors enter in. When death is imminent, withholding or withdrawing food may be done with the intent of relieving the patient of any extra burden during his last hours.

We must truthfully answer the question: What is the purpose for removing assisted feeding? In some cases, nutrition and hydration are withdrawn not because the patient is dying, but because the patient isn't dying fast enough. A friend or family member may point to the patient's low "quality of life," or insist that all of their parents' savings will be eaten up by hospital bills, or sympathize that all of "Mom's best years are being wasted taking care of Dad." Such responses fail to honor God.

Instead, caregivers should ask: What will my decision do for this patient? What am I trying to achieve by doing it? In certain circumstances, providing food and water, whether by mouth or tube feeding, may be futile. Rita Marker of the International Anti-Euthanasia Task Force says that fluids which cannot be assimilated by the body may cause a great deal of discomfort. The same is true for food. The Christian Medical Society affirms this. When a person is truly, imminently dying, we should not think of ourselves and how

we don't want to let our loved one go but of our loved one's comfort and preparation for God's call to come home.

What if I'm concerned about being a burden to my family? Shouldn't I sign a "living will"?

It is good for us to think ahead and plan for our last days. There is nothing wrong with having an Advance Directive when it comes to future healthcare decisions.

One form of an Advance Directive is the "Living Will." However, these did not originate within Christian circles. Before euthanasia would ever be accepted by society, "right to die" advocates knew the climate of society would have to change. In 1967, a Chicago attorney by the name of Luis Kutner introduced a new document designed to bring about that change. The document was called a "Living Will."

In many of the state-authored Living Wills, the language is very ambiguous and may mean signing away the use of unspecified treatment in an unknown situation in the future. It is far better to make our wishes known to a trusted family member or friend and grant them Durable Power of Attorney for Health Care (DPAHC). The DPAHC allows them to speak for us when we cannot speak for ourselves. (Contact Lutherans For Life for more information on DPAHC.)

Because my family knows me well, won't they know what I would like done when my death is imminent?

In a survey of nursing home residents, 80 percent said they would want life support if necessary. However, only 30 percent of their families thought their loved ones would want life support. Anger and disharmony between family members can be eliminated by talking about end-of-life issues and discussing personal wishes. Bible studies which promote discussion of God's will at the end of life equip family members for dealing with difficult decisions in a way that is pleasing to the Creator of each precious life.

How can I do God's will when confronted with decisions at the end of life?

We can begin now by helping to make a difference in the lives of our families, friends, and the medical community—Christian or not. We can:

- stop evaluating people by worldly standards of medical expense, court rulings, suffering, or “quality of life” and, instead, see people the way God sees them.
- help prepare food or offer to babysit for the parents of a child with a physical or mental challenge so that their stress is not so great or their “burden” so heavy.
- influence doctors and nurses trained in medicine, not social welfare or economics, by your behavior at the bedside of a loved one.
- encourage medical personnel to treat life whenever possible and to re-learn the art of comforting the dying.
- influence community by providing pastoral care, remembering that all of us—ordained minister or layperson—have a call to serve one another.
- influence congregations and families by providing Bible studies on life and death issues.
- organize prayer and support groups for families of the dying.
- raise awareness by providing credible information on the growing practice of euthanasia (www.lutheransforlife.org and www.lifeissues.org will assist you).
- comfort others by using the same comfort we have received from God in Jesus Christ (2 Corinthians 1:3-7).
- imitate the good Samaritan who showed love for his neighbor by giving of his own money and time (Luke 10:25-37).

Our Creator Father never intended that we shoulder a load of suffering by ourselves. That's the whole purpose of the Christian community. **“Two people are better than one because together they have a good reward for their hard work. If one falls, the other can help his friend get up. But how tragic it is for the one who is**

all alone when he falls. There is no one to help him get up ... A triple-braided rope is not easily broken” (Ecclesiastes 4:9-10, 12b *GOD’S WORD*).

We are designed to need each other. We are called not only to say “choose life,” but “let me help you choose life.” We are encouraged to rub shoulders with people of hope and faith who speak and act the Living Word of Jesus to meet the needs of one another.

What comfort do I have in my own dying?

Psalms 139 tells us that God knew us, even before we were born. He knows our very thoughts, even when we may be paralyzed or dependent on a respirator. God hears and understands. He is with us even though we may be cut off from those who stand at our bedside.

We have the example of Christ Himself in the Garden of Gethsemane. Jesus left His disciples with instructions to pray. Then, He went off alone: **“Father, if it is Your will, take this cup of suffering away from Me. However, Your will must be done, not Mine”** (Luke 22:42 *GOD’S WORD*). Do you know what happened next? **“Then an angel from heaven appeared to Him and gave Him strength”** (v. 43). If an angel came to minister to Jesus, might we also believe that an angel could come to minister to us in our time of need?

Some Closing Thoughts

Jesus knew Satan hated life. **“The devil was a murderer from the beginning”** (John 8:44 *GOD’S WORD*). Satan does not want us to choose life. He will do anything to get us to choose death. Satan is at work through those in our society who promote death as a solution to the problems of life. Satan also tempts Christians dealing with illness and suffering to buy into the way of the world, the way of death.

But Christians have a better way! Jesus said, **“I am the way and the truth and the life”** (John 14:6 *GOD’S WORD*). Through Jesus, we understand that all human life is sacred. We know that He is Lord over all matters of life and death. His cross assures us that He loves us and nothing can separate us from His love. We know that He gives meaning and purpose to every life.

Dealing with illness and dying is never easy. But we can deal with them because of the kind of God we have.

We have a God who has a history of accomplishing His will regardless of how things may seem or how people may feel.

Although he was not sick, Moses asked God to let him die because of the burdens he carried. God said no because He was not finished with Moses yet.

Elijah cried out, “I have had enough, Lord. Take my life.” But God wasn’t finished with Elijah yet.

Job had boils all over his body. His flesh was eaten by worms. He pleaded with God to crush him and cut him off. But the Lord wasn’t finished with Job yet.



We have a God who gives us what we need when we need it.

“I’m not strong enough to die a martyr,” said Corrie ten Boom to her father. He replied by asking, “When you have to go on a journey, when do I give you the money for the fare, two weeks before?”

“No, Daddy,” replied Corrie. “You give me the money on the day I need it.”

“Precisely,” said her father. “And our wise Father in Heaven knows when we’re going to need things, too. When the time comes to die, you will find the strength you need—just in time.”

We have a God whose wisdom we can trust.

As the children’s book says, “God will decide when I should die, and the time will be just right ... because God is very wise.” (Joanne Marxhausen, *Heaven Is a Wonderful Place*, Concordia Publishing House, 2004)

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