

The use and non-use of life support systems and/or treatment termination—When? Ever? Under what circumstances?

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Introduction

The family is called into the hospital waiting room. The doctor gently but firmly informs them that there is no hope of recovery. Successful treatment appears virtually hopeless. The family is confronted with several alternatives: long-term intensive care, or continued temporary life support at all costs, or temporary life support but without intensive treatment of new complications or the discontinuance of respiration, heart stimulation, and so forth which allow the patient to die.

The family then tries to discern with each other and with their physician and pastor what to do. If you are in or close to a family of one critically ill, you may be a part of the process of facing a life-death decision. You may be called upon to give guidance from God's Word to the patient himself, or if he is comatose, to the family. You may have to do some caring for disturbed members of the family. You may be involuntarily drawn into this web of critical decision making where mistakes in moral judgment are not easily back-tracked.

Out of such situations have come the considerations of "the right to die," of "death with dignity," of "a living will," of "euthanasia," of "the use and non-use of life support systems," of "treatment termination." While death is believed by some to be a step into oblivion - the end of everything; to others, most notably Christians, it is a step from temporal life to eternal life. But even for Christians who look forward to eternal life, who believe that "to be absent from the body is to be present with the Lord (2 Cor. 5:8)", death itself may hold no fear but the process of dying is terrifying and brings with it many moral questions in light of modern medicine and medical technology.

This paper is the opinion of one person who firmly believes that life is a gift from God. That God alone gives life and God alone has the right to end life, but who believes that in the "dying process" there is a "gray area" which involves the use and non-use of life support systems and/or treatment termination. And who, in his brief ministry, has been called upon twice to counsel from God's Word concerning the use and non-use of life support systems and treatment termination.

By assignment this paper is entitled *The use and non-use of life-support systems*. I have taken the liberty to qualify the subject by adding *and/or treatment termination*.

The Dilemmas of Life Support Systems and/or Treatment Termination

The following is a two column comparison which displays competing trends in life support or end-care reasoning. The first column sets forth factors many think should make the non-use of life support or treatment termination acceptable. The second column raises doubts and objections.

Should treatment be terminated?

Yes, if:

Yes, if there is informed consent of all relevant parties (Patient, physician, hospital, and family.)

Yes, if there is a permanent loss of all cognitive function, all ability to understand; when the family and attending physicians agree that there is no hope of regaining the capacity to think or experience normal human consciousness.

Yes, if there is “irrefutable evidence that biological death is imminent” (AMA, House of Delegates Declaration).

Yes, if there is great suffering or unrelievable pain.

Yes, if there is a lack of the will to live, total demoralization, or wishing for death.

Yes, if continued hopeless treatment involves unconscionable cost to the family or society; if it places grave burdens such as potential impoverishment on those who care for the hopelessly dying.

Yes, if there is an immediate limited availability of life support equipment or heavy stress on intensive care facilities. This situation is similar to the procedure of triage, where combat casualties are divided into hopeless cases who get no medical attention, and more hopeful cases who receive medical attention.

Yes, if the next of kin are unwilling to provide long-term care for a hopelessly ill patient.

No, because:

No. All parties conceivably agree to an unjust or unwise termination; if, for example, there were only limited physical impairment that would not justify discontinuance even if all parties consented. So although consent is important, it does not stand alone as an absolute indicator of discontinuance.

No. Because “it’s happened before.” Prognosis, the prediction of the future of the illness, is an inexact science. Besides, if you terminate “low quality of life” patients, where do you draw the line? Would not senile, retarded, and genetically handicapped persons be endangered by the same rule?

No. Imminence of death is a tricky, variable, predictive calculation that would differ from physician to physician. Anyway, does it mean hours, days or months? The simple fact that death is near would not, by itself alone, justify termination of treatment in every case. You would not, for example, withhold respiration from a fully conscious dying patient who wishes to remain conscious.

No. Medications can relieve the pain. Counseling and supportive therapies can help with mental anguish. In the Western religious experience, suffering is understood as a potential means of special grace and spiritual learning. Further, if suffering justifies the ending of life, then obviously suicide is morally acceptable. This cannot be.

No. Every doctor and pastor knows that some people face periods of demoralization and depression. The person’s judgement is not always in his or her best interests during such low periods. The physician’s and pastor’s duty extends to protecting the person from the misjudgments of his own depression.

No. For at what point does the value of life become a budget item? Anyway, most cases are covered by insurance arrangements, which should be humanized in the light of newer life-sustaining technology.

No. In most cases nearby medical facilities are available. Anyway, triage is an ethic of exceptions under conditions of emergency during warfare. You cannot build a general set of normal guidelines on exceptions.

No. The value of that person’s life does not depend, according to law and common moral decency, on whether his relatives are willing to care for him.

These are just a few of the dilemmas involved in the use and non-use of life support systems and/or treatment termination. In the next two parts of this paper I shall attempt to draw together what I perceive is the best of both sides of the above arguments and reject the excesses of both.

These arguments show that it is impossible to answer the question of the use and non-use of life support systems and/or treatment termination with a simple “yes” or no. It requires a closer look into specific circumstances and details. A rigid rule or formula which states, “Keep every person alive at all costs,” is no more adequate than the thoughtless, callous, and immoral conclusion to end the life of another with a clear conscience without any thought or moral obligation to Him who is the Source of life.

One added thought at this time. We are prone to think that these dilemmas are new, the result of life support systems and modern medical technology. However, this is not entirely the case. The inestimable value of life has not changed since God created Adam and Eve. The duty of love to relieve suffering has not changed as Christ pointed out throughout His healing ministry and -in the story of the Good Samaritan. It is when the duty of love to relieve suffering clashes with the value of life itself that the dilemmas arise. Technology itself has not fundamentally changed these moral dilemmas.

Who Decides?

Who has the legal and moral right to determine whether life support systems should or should not be employed and/or treatment terminated? Legally, “you have a right to refuse treatment to the extent permitted by law if you are conscious and competent (2).” As a competent, conscious person you have the legal, and I feel moral right to a degree, to refuse treatment. For instance, you have the right in a nonterminal or terminal illness, to decide whether it is to your best interest to undertake surgical risks or to what extent you want to submit yourself to a vigorous hospitalization. It is neither legally nor morally wrong to not have a hernia repaired through surgery or your tonsils removed.

It is in this area that I was involved in one of the situations I mentioned earlier. A woman was suffering from terminal cancer. She had had both breasts removed, had undergone extensive chemotherapy and radiation therapy; yet the cancer had spread throughout her body. By common consensus of all physicians involved, death was imminent. One arm was particularly affected. The attending physician said amputation would perhaps prolong her life (or suffering) an additional month, two at the most. Amputation would mean probable hospitalization from the present time until her death. At the present time she was receiving only pain medication no further therapy was possible—was with her family, functioning as well as possible. She had accepted and prepared for death. She asked me if as a Christian she was morally required to consent to the surgery. After talks with her, her family and the physicians, I counseled her, “No, it was not morally necessary for her to undergo the surgery and the loss of her arm only to remain terminally ill with cancer.” She refused the surgery.

What of the incompetent or unconscious? Immediately our thoughts turn to Karen Ann Quinlan. “Prior to the Quinlan case (1976) there was no legally sanctioned procedure for terminating treatment, although physicians throughout history have practiced “benign or judicious neglect” of patients for whom further treatment was hopeless (3).” In the Quinlan case the New Jersey Supreme Court noted that “physicians distinguish between curing the ill and comforting and easing the dying; they refuse to treat the curable as if they were dying or ought to die, and they have sometimes refused to treat the hopeless and dying as if they were curable (4).” The article goes on to say, “The Massachusetts Supreme Judicial Court took a similar stand when, in authorizing the non-treatment of an incompetent leukemia victim, it wrote “Physicians have begun to realize that in many cases the effect of using extraordinary measures to prolong life is only to prolong suffering, isolate the family from their loved one at a time when they need them the most, and/or result in economic ruin for the family.”

While each situation will differ, and while legal does not necessarily mean moral, I feel that the courts have carefully thought through the issue of who decides for the unconscious. The guidelines they have established are as follows: (1) The person’s consent must be implied. This may be determined by opinions or directions offered by the person while in a conscious and well state. (2) The family, guardian or next to kin

must consent if any treatment is to be terminated. (3) The attending physicians must have come to a responsible conclusion that “there is no reasonable possibility of return to cognitive and sapient life” and that “there is irrefutable evidence that biological death is imminent.” (4) If all these parties concur then a hospital ethics committee, “composed of physicians, social workers, attorneys, and theologians, which serves to review the individual circumstances of ethical dilemma” must also concur. (5) While this may appear to be a burdensome array of parties to consult before any treatment termination occurs, it does offer some protection to the unconscious from less than worthy motives of family or physicians.

One added thought to the question of “Who decides?”

There is a strong movement by the “right to die” people to assert that individual rights or self-determination are absolute. They contend that the individual has an absolute right over his own body even to the point of ending life if so desired. Dr. Milton D. Heifetz states in his book, *The Right to Die*, “I feel not only should they be given the courtesy of respecting the desire to die, but actually should receive medical assistance if they wish to have it (6).” He goes on to say, “A person in distress should have the right to die painlessly, at a time of his own choice, with that sense of decency, self-control and personal dignity every free person should feel (7).”

Christians, of course, cannot and will never condone such damnable contentions, for the 5th Commandment, “Thou shalt not kill,” addressed to oneself just as much as to any one else. Washington’s Father Wendt also dismisses the notion of “death with dignity” by saying, “This notion of ‘death with dignity’ that is being taught is preposterous. There is nothing dignified about death (8).”

By what guidelines?

Should treatment ever be terminated? Should support systems always be initiated? Is death to be avoided at all costs? Must an expensive medical program be pursued that can at best delay death for a few hours, days, or months? If we answer, “No, not ever,” to the first question and, “Yes, always,” to the others this paper is concluded.

But if we answer cautiously, “Seldom, but yes under some circumstances,” then we must determine under what circumstances—“By What Guidelines?” Here I propose only one criterion—when there is no hope of recovery, death is imminent.

By “death” I mean when the heart stops beating and the individual stops breathing. However, because both heart beat and respiration can be sustained artificially, I would add “brain death.” Brain death can be determined by a sensitive machine called the electroencephalograph or EEG for short. The EEG tests the presence or absence of brain activity. A flat EEG is regarded as an indication of brain death—the brain has stopped functioning. Were the artificial means suspended or interrupted, then the heart would stop beating and the individual would stop breathing.

“When there is no hope of recovery.” Although I do not agree with his statements concerning the use of the electroencephalograph, I do concur with Pastor Louis Meyer, Jr. on a proper and moral course of action when there is no hope of recovery. I quote, “I believe that mostly all the pastors here would agree with me that our religion and the expressions of it should contain head and heart. If it is all heart then we might lose ourselves emotionally in expressing ourselves religiously as the Pentecostal-type churches; if it is all head, then we can very easily come to a dead orthodoxy. Religion should have some head and some heart. I believe the subject before us should have some heart, too. I therefore feel that if a patient, according to one or several doctors, has no chance of recovery and seems to be in great pain, that the family could express the wish to the doctor that the person be left to pass away peacefully, that pain-killing drugs be given, but that they not continue the person’s agony, if according to the best human judgment, death seems imminent. I do not believe that it would be displeasing to a merciful God to allow someone to pass away who seems to be in extreme pain and who, according to the knowledge He has given to man, seems to have no hope of recovery (9).”

This, of course, leads to the natural question, “How?” “How are we to ‘allow someone to pass away’?” The obvious is to refuse any heroic or life support systems to be initiated at the onset, using, rather, only

standard medical practice to treat the patient. Homicide and suicide are ruled out on the basis of God's command. "Thou shalt not kill." These involve direct acts with the intent purpose of ending another's or one's own life. I am also uncomfortable with "pulling the plug" or "direct discontinuance" of life support systems which calls for making the patient as comfortable as possible, but immediately withdrawing all artificial life support systems and thus allow the irreversible illness to take its course. Although in the case of "brain death" this may be justified.

I would prefer and have counseled once a practice called "benevolent crisis acquiescence." Other names for this practice are "Judicious or benign neglect." Benevolent crisis acquiescence (BCA) calls for continuing painkilling drugs, but not actively treating new emergencies or complications so as to allow death to take its course when the next major crisis arises. Life support systems already begun would be continued, but new crises would be met with "judicious neglect."

Although through my study of God's Word and my personal experience in the health care profession I have come to this conclusion independently, I would like to share with you some reasons for benevolent crisis acquiescence from Thomas C. Oden's book *Should Treatment Be Terminated?* which express my own convictions. I quote (10):

1. Benevolent crisis acquiescence continues to supply food, pain killing medicine, and all possible forms of comfort to the moribund patient during his final struggle, rather than abruptly terminating life.
 2. Benevolent crisis acquiescence does not in any way hasten death or attempt to prolong life by means of treatments other than those already instituted. By means of a benevolent passivity amid new crises or emergent complications, it simply acquiesces to incipient death...without the withdrawal or withholding of treatment or life support previously provided.
 3. If the patient is in an irreversible condition and if all reasonable hope of recovery is gone, and if death is a near-term probability, then the length of time of irreversible suffering is likely to be short in any event. This is a crucial point since the argument for direct disconnection usually centers on the advantage of shortening the length of time of irreversible suffering
 4. Whereas disconnection of life support arguably is a cause of death, BCA does not do anything to hasten death or take any direct, active intervention which could arguably be viewed as the cause of death.
 5. Although it may take longer for death to ensue, it is less subject to widespread abuse than is the more arbitrary act of "pulling the plug."
 6. It proceeds under a more organic understanding of medical care (and I add, reliance on God) than does the mechanical disconnection of electrical equipment as the final ignominious event in the person's life.
- I am of the firm conviction that there is a definite distinction between prolonging life and prolonging death. The irresponsible use of life support systems and the implementation of treatment at any cost more often prolongs death than does it prolong life.

Respect for life

Whenever we consider any aspect of the use and non-use of life support systems and/or treatment termination we dare not lose sight of respect for life. God the Creator, as sovereign and legitimate authority over all life and creation, alone has the authority to give and take away life. In Deuteronomy 32:39 God Himself says. "...I kill, and I make alive..." In Ecclesiastes 8:8 He says, "No one has power to retain the spirit, or authority over the day of death." Life is God's precious gift given to the individual to use and not abuse. No one has the absolute right of self-determination over even his own life, much less the life of another. Let us also bear in mind that life is not to be used only for pleasure, to be discarded when pain comes nor when another judges the "quality of life" to be meaningless. When the "sanctity of life" and "equality of life" is replaced by "quality of life" or "vegetative or meaningless life" we face the horrors and damnable abuses of Nazi Germany under Adolf Hitler. Euthanasia centers will proliferate as do abortion clinics today. Then what will become of the deformed, retarded, imbeciles, old, senile, and others who are judged a burden upon or useless to society.

However wretched at times, life is not something to be disposed of arbitrarily by human hands. Suffering inevitably comes to all who are alive. Job learned this and accepted it. When told by his wife to curse God for his suffering he replied, “You are talking like a foolish woman. Shall we accept good from God, and not trouble (Job 2:10)?” Paul, likewise, learned this from God. When he prayed for release from his suffering, the Lord told him, “My grace is sufficient for you, for My power is made perfect in weakness (2 Cor. 12:9).” Let us be mindful of the “refining” value of suffering. Scripture clearly states, “Whom the Lord loves, He chastens (Rev. 3:19).” And our God Himself says through the prophet Isaiah, “Behold, I have refined you, but not like silver: I have tried you in the furnace of affliction (Is. 48:10).”

As Christians we hold tenaciously to the gracious promise of our Lord in the face of pain and suffering. “No temptation has seized you except what is common to man. And God is faithful; He will not let you be tempted beyond what you can bear. But when you are tempted, He will also provide a way out so that you can stand up under it.” The Christian believer trusts that promise, realizing that God’s “way out” may be by means of death. And so we turn to the last part of this paper.

The Acceptance of Death

Death comes to all of us. We are never fully prepared for it, but it happens just as surely as life. It does its worst by taking what is best, life. Yet, even death cannot take the Christian’s very best - eternal life. The Bible doesn’t present death as something to be avoided at all costs. The Christian is reminded that “the day of death is better than the day of one’s birth (Eccl. 7:1)”; Psalm 90:9-12 reminds us, “Our years come to an end like a sigh. The length of our days is seventy years—or eighty, if we have the strength; yet their span is but trouble and sorrow, for they quickly pass, and we fly away... Teach us to number our days aright, that we may gain a heart of wisdom.” Paul even looked forward to death, “to be absent from the body is to be present with the Lord (2 Cor. 5:8).”

Confronting death teaches us to receive and view life as an unmerited gift from God. A gift to be used to His glory and the welfare of our fellow men. May we view life as such and teach our members to do likewise. And when confronted with the use and non-use of life support systems and/or treatment termination may we be keenly aware of God’s unmerited gift of physical life and His greater gift of eternal life through Christ our Lord and Savior.

Let us now draw some:

Conclusions

1. God is the Originator and Giver of life. He alone gives life and He alone is the rightful ender of it.
2. There are many moral dilemmas involved with the use and non-use of life support systems and/or treatment termination which dare not be taken lightly.
3. No individual has the right of absolute self-determination over his own life, less the life of another. Christians in general and physicians in particular ought always seek to preserve life.
4. Positively inducing death by murder or suicide is absolutely displeasing to God and never justified.
5. An individual may refuse heroic efforts - life support systems - for himself or another when there is no hope of recovery, death is imminent.
6. Discontinuing life support systems and/or treatment termination already in use is generally unjustified. Where there is no hope of recovery and death is imminent or where brain death has occurred a family may feel differently about this.
7. Benevolent crisis acquiescence proceeds under a more organic understanding of medical care and places the final moment of death in the hands of God rather than in the hands of one who would “pull the plug.”
8. A Christian family in the fear of God may take exception to what has been listed as conclusion number 6. For a terminally ill patient who has lost consciousness and for whom there is no hope of recovery, a law of love and mercy ought also be considered. Let us therefore, as pastors, not take issue with or discipline these Christian who in love and Christian faith have allowed someone to die peacefully. Who do not believe that life

must be sustained at all and any costs by machines and tubes when the body has lost its natural ability to sustain its own life.

None of us lives to himself, and none of us dies to himself. If we live, we live to the Lord, and if we die, we die to the Lord. So then, whether we live or whether we die, we are the Lord's. For to this end Christ died and lived again, that He might be Lord both of the dead and of the living (Romans 14: 7-9)."

End Notes

1. *Should Treatment be Terminated?* Preface, pages x-xiii.
2. American Hospital Association, point 4, 1973 quoted in *The Right to Die*, page 186.
3. *Should Treatment Be Terminated?*, page 9.
4. "Christian Century," March 11, 1981, page 253
5. *The Right to Live, the Right to Die*, page 136, 137.
6. *The Right to Die*, page 91.
7. Ibid, page 98.
8. *Human Life: Controversies and Concerns*, page 102.
9. "A Look at the New Movement-The Right to Die," page 4.
10. *Should Treatment be Terminated?*, page 56-57.

I am indebted to Thomas C. Oden's book *Should Treatment be Terminated?* which I found very useful in the preparation of this paper and from which I paraphrased freely for some portions of this paper.

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