16th General Assembly, 1988, p. 509, Appendix S and 16-83, p. 186.

REPORT OF THE HEROIC MEASURES COMMITTEE
PRESBYTERIAN CHURCH IN AMERICA

I. INTRODUCTION

A distressing irony of the on-going progress in science and related technology is that in many cases welcomed advances in these areas also create profound moral dilemmas. This tension is especially exemplified in the field of medicine. For example, less than fifty years ago the options for the medical treatment of the critically ill were really quite limited, and consequently, so was the moral debate concerning treatment of the critically ill. But now, with the considerable medical and technological advances presently available, there are resources for keeping a seriously ill person alive who, only a few years earlier, would have died because a certain method of treatment had not been developed. However, this increased ability on the part of the medical community to preserve human life also raises the perplexing moral question of whether or not available technology ought always to be used. Does morality demand, in every case, that every medical option available be employed to extend the life of a critically ill or dying person? Or is it sometimes morally correct to refuse so-called "heroic measures" to prolong life and "allow" such a person to die?

Among the duties required by the Sixth Commandment are all "lawful endeavors to preserve the life of ourselves and others by resisting . . . all . . . practices, which tend to the unjust taking away of the life of any" *(Larger Catechism,* Q. 135). Among the sins forbidden is "the neglecting or withdrawing the lawful and necessary means of preservation of life" *(Larger Catechism, Q.* 136). But what kinds of actions in medical cases constitute an "*unjust* taking away of life?" If a person is taken off a respirator and allowed to die, has the sixth commandment been violated because a "necessary means of preservation of life" has been "withdrawn?" Ecclesiastic 3:2 declares that "there is a time to die." But is the Christian morally obligated to insist that the full extent of current medical technology be employed in every case to postpone this time as long as possible? Is there no distinction to be made between prolonging life and postponing the dying process.

Scripture obviously does not give specific instructions in these matters. It does not tell when to stop resuscitating a patient from successive cardiac arrests. It does not say whether or not a severely debilitated parent who suffers from advanced Alzheimer's disease and experiences kidney failure ought to be put on a dialysis machine. Nor does it inform the physician at what point further heroic measures to treat a critically ill premature infant with numerous physical problems prolongs the infant's suffering rather than providing for recovery.

Scripture, however, does offer *principles* which can and must guide decision-making in these cases. Such decisions are made daily in terms of secular viewpoints in hospitals and other types of health care facilities. But the *Christian* community, if it is to obey the sixth commandment, is obligated to work out "the mind of Christ" on these matters. In cases regarding the critically ill or dying person, the Christian's decision must be informed by Biblical principles as well as medical facts.

Further, it is not enough merely to articulate the Biblical principles that are relevant to medical decision-making. These principles must be *applied.* They must be worked out in the actual situations that Christian people face as they deal with the problems of dying and death in their own experience. Thus, Christians need to have practical guidelines for implementing the Biblical principles that address the medical situations that they are increasingly having to face as a result of current medical technological advances.

The following discussion is an attempt both to set forth the Biblical principles relevant to the medical treatment of the critically ill or dying person and to provide practical guidelines for the implementation of these principles.

II. BIBLICAL PRINCIPLES

In the most profound sense of the terms, the Bible is essentially a book about life and death. At Creation God entered into *a covenant of life* with human beings made in his image, by which they might have fruition of Him as their blessedness and reward. They, by their fall, having made themselves "uncapable of life by that covenant, the Lord was pleased to make a second, commonly called the covenant of grace; wherein he freely offereth into sinners *life and salvation* by Jesus Christ" *(Confession of Faith*, VII, iii). To those who by grace respond in faith, he grants *eternal life;* to those who continue in disobedience and unbelief, the ultimate issue is the *second death*—separation from God in hell forever.

The purpose of this report is not to discuss life and death as the ultimate destiny of human beings except in so far as the broader theological framework of the Bible has a direct bearing on the issues of physical life and physical death. It is the latter with which we are concerned in addressing the question of the appropriateness or inappropriateness of "heroic measures" in the practice of medicine.

According to the Scriptures, physical life, that is, the natural, biological life that human beings have, is the gift of God. As it is written, "He himself gives to all life and breath and all things" (Acts 17:25). The physical death of human beings is an abnormality in our world that is the direct penal consequence of the Fall (Gen. 2:17, Rom. 5:12). As a result of sin, "It is appointed unto men once to die, but after this the judgment" (Heb. 9:27).

As God is the giver of life, so he reserves to himself the right to take it (Cf. Deut. 32:39). The power of life and death is his exclusive prerogative. He alone specifies the conditions on which others are authorized to kill. Even after the fall, human life continues to have its high value inasmuch as human beings are created in the image of God and in the Noahic covenant God makes structural provisions for its propagation, sustenance, and defense. (Cf. John Murray, *Principles of Conduct,* p. 109). When man is faithful to follow Biblical design in his stewardship of these provisions, he finds them bountiful. When he ignores God's design, the result is scarcity.

Of particular interest to a theology of dying and death is Question 85 of the Larger Catechism: "Death, being the wages of sin, why are not the righteous delivered from death, seeing all their sins are forgiven in Christ?" The answer is a remarkable summary of the Biblical teaching on the significance of the death of believers:

> The righteous shall be delivered from death itself at the last day, and even in death they are delivered from the sting and curse of it; so that, although they

> die, *yet it is out of God's love,* to free them perfectly from sin and misery, and to make them capable of further communion with Christ in glory, which they then enter upon. (Emphasis added.)

The key text for understanding the death of believers as a manifestation of the love, rather than the wrath, of God is Revelation 14:13, "Then I heard a voice from heaven say, 'Write: Blessed are the dead who die in the Lord from now on.' 'Yes,' says the Spirit, 'they will rest from their labor, for their deeds will follow them.'" Through the work of Christ, the covenant curse has been turned into blessing.

Spiritual death is an absolute evil for human beings, to be avoided by them at all costs (Cf. Ezek. 18:23, 2 Pet. 3:9). *Physical* death, on the other hand, is a relative evil in a fallen world. For the Christian it is not an enemy always to be fought at all costs. "There is a time for everything," says the Preacher, "A time to be born and a time to die" (Eccl. 3:1-2). And, we might add, a time to resist death and a time to cease resisting.

Physical life, while intrinsically valuable as the gift of God and consequently never to be taken away without warrant in God's word, nevertheless is not an absolute or ultimate good. One can glorify God by death as well as by life, knowing that neither can separate the child of God from the love of God in Christ (Rom. 8:38). Our absolute value is the glory of God and should be our ultimate aim, both in life and in death (Phil. 1:20, 2 Cor. 5:9). Christ, in willingly laying down his life for others, has provided the supreme demonstration and example of a death which, motivated by love, glorified God. (Cf. John 12:27, 15:13.)

Granted that there is a time to resist death for the glory of God and a time to cease resistance, also for the glory of God, what principles does the Bible give to guide our decision-making in this critical area? How does one discern the will of God in the complex situations created by the advanced technology of contemporary medical practice?

To begin with the most obvious, life is to be lived out to its full extent in the service of others for as long as God gives the opportunity. The key text for this principle is Philippians 1:19-26. Paul writes from prison with the possibility of death hanging over him. He expects to be delivered (vs. 19), but his main concern is not his deliverance, but rather the exaltation of Christ in his body whether by life or by death (vs. 20). He does not fear death, for to die is gain. How so? To depart this life is to be "with Christ," which he says is "far better." This can only mean a more intimate personal relationship than is possible in this life. Though Christ was certainly "with Paul" and though Paul clearly enjoyed personal fellowship with Christ, yet something more occurs at the death of the saints.

The thing to notice is that Paul's longing for that "far better" estate did not undercut the value and significance of the present life. For Paul to live on in the flesh meant "fruitful labor" for him, and he regarded it "more necessary" for his fellow Christians for him to continue his earthly ministry. So he concludes, "I know that I shall remain and continue with you all for your progress and joy in the faith." (vs. 25). This passage, which, perhaps more than any other, presents the relative desirability of being with Christ in heaven, nevertheless regards the present life on earth as something to be lived to the full extent granted by God for fruitful labor in the service of others.

A second principle is that life is not be abandoned simply on account of suffering. Endurance as well as service finds its place among the purposes which God has for our lives in which He is glorified. This task is vividly set before us in Jesus' words to Peter following his resurrection.

> I tell you the truth, when you were younger you dressed yourself and went where you wanted; but when you are old you will stretch out your hands, and someone else will dress you and lead you where you do not want to go. Jesus said this to indicate the kind of death by which Peter would glorify God. Then he said to him, 'Follow me!' (Jn. 21:18-19).

We are not told in the Bible how this prophecy was fulfilled, so we cannot be certain as to its precise meaning. But it appears that Peter in his old age was to suffer some loss of independence, self-determination, and mobility before his death. This situation no less than his active apostleship was for the glory of God, and Peter once again receives the call to discipleship; "Follow me!" The clear implication is that we should consider the time and manner of our death as an opportunity to glorify God as followers of Christ to the end (Cf. 1 Pet. 2:21). Avoidance of suffering or dependence upon others are insufficient in themselves as legitimate motives for hastening the hour of one's death. Yet, there is no reason to believe that extraordinary means that extend life only by increasing suffering and dependence are always to be chosen as means of glorifying God.

A third principle is that when death is likely to occur within a short period of time, it should be faced with realism and readiness. Here the example of the patriarchs is relevant in spite of their distance from contemporary medical technology. When Jacob saw that he was in the process of dying, he gathered his sons around him to deliver his final blessings and instructions (Gen. 49:1-33). The same is true of Joseph, who when he was about to die held a final interview with his brothers in which he once again reminded them of God's covenant promises (Gen. 50:24-26). Technological intervention in the process of dying could very easily undermine important ministerial functions of the terminally ill in a misguided zeal for prolonging length of days.

III. PRINCIPLES OF APPLICATION

1. "Heroic measures" are extensive medical procedures that involve significant discomfort and expense to the patient. The most widely known of these procedures are cardiopulmonary resuscitation, respirators, kidney dialysis, and organ transplantation. A number of other procedures, however, may constitute heroic measures depending upon the circumstances. These are extensive surgical procedures, the use of drugs or electric shock to treat rhythm disturbances of the heart, antibiotics to treat infections, cancer chemotherapy, intravenous nourishment or feeding tubes.

On the one hand these measures are essential to the practice of modern medicine. In their application many individuals have been healed and restored to health. On the other hand this technology may be applied thoughtlessly, lengthening the dying process while adding suffering and expense for the patient and family.

2. A specific direction for every conceivable situation is impossible. The principles that have been presented here will give direction for all situations, but individuals and families will necessarily have to determine which principles apply to their situation. Decisions will differ. What is decided in one situation will not be the same as that decided in another situation. If direction is not clear, however, then the teaching or ruling elders of one's church should be consulted.

3. Ultimately, no physician extends a person's life or determines his time of death. Only the Triune God is ultimately Sovereign over life and death. Physicians work with a science that is quite limited in its understanding of disease and its treatment. Thus, the information presented by physicians represents their best understanding of the situation, but this information is fallible. Such information should not always determine the course of action. Even so, it is the only information available concerning our physical condition and should be acted against only for clear Biblical reasons.

4. Thus, medical treatment suggested by physicians in these situations must be carefully and prayerfully considered. In some instances a distinction can be made between treatment that will heal or restore a patient and that which only prolongs the dying process. For many reasons a physician will not always make this distinction when he presents various options to patients and their families. Appropriate questions will need to be asked to obtain this information. If the patient or his spouse is unable to inquire, then a family spokesman who is able to ask questions should be chosen. Pastors or other elders with special training might also provide assistance here.

5. On one side of the problem are measures that are "necessary means of preservation of life." First, food, air and water by natural routes, that is, without technical assistance, may not be denied by the patient or anyone caring for him. Second, medical treatment that is clearly efficacious to heal or to restore may not be refused either.

6. On the other side treatments that are ineffective, minimally effective or have frequent and serious side effects are not obligatory. Many diagnostic, medical and surgical procedures in these situations have these characteristics. Doing "everything possible" is usually inappropriate. Specific, effective measures should be chosen with clear-cut goals for the patient's condition.

Several examples will illustrate. Mechanical respiratory assistance is used routinely, but temporarily, after major surgery. It may also be life-saving after certain types of brain injury when normal breathing is expected to resume as the injury heals. Still another use for respirators are in cases of severe pneumonia until antibiotic therapy heals the infection. The same respirator, however, in someone who has respiratory insufficiency due to advanced, incurable heart disease would be a misuse of this technology. Similarly, cardiac resuscitation of an individual who has recently experienced a heart attack (myocardial infarction) may be life-saving while its application to an individual whose heart stops as a result of advanced cancer would be inappropriate.

The "Golden Rule," enunciated by Jesus, "Do to others as you would have them do to you, " (Luke 6:31) and the great summary commandment, "Love your neighbor as yourself," (Rom. 13:9; Gal. 514) provide a helpful perspective in this connection. Surveys have shown that most people want limited treatment for themselves when there is no real hope of recovery. Yet, when called upon to make decisions for others, they frequently want more for others (usually close relatives) than they would do or want done for themselves. Love for our neighbor means that in proxy decision-making, we should apply the same Biblical standards of justice, mercy and faithfulness to others that we want and expect to be applied to ourselves.

7. Ethical choices may become more clearly evident if the goals of medical care in these situations are, first, to heal or restore and, second, to relieve suffering. It is not the goal of medicine simply to prevent death. Thus, the goal of medical care to relieve suffering remains clear even when healing or restoration is not a realistic hope. This goal is likely to prevent the use of technology that prolongs death and often *increases* the suffering of the patient.

8. To intend the death of a patient as a means to relieve his suffering, however, is morally wrong. Much current thought within the medical profession and among medical ethicists considers that life support may be terminated with the intent to relieve the patient's suffering by causing his death. As Christians, we must be cautious never to use suffering as a criterion for the withdrawal or withholding of medical treatment. There are times when medical treatment may be morally withheld or stopped, but the decision must be based upon reasons other than suffering. For example, such a decision may be based upon the improbability that a patient's lungs will re-cover sufficiently to enable his respirator to be removed. A decision in this patient to turn his respirator off with the *intent* to relieve his suffering would be wrong. The relief of suffering is never the reason to shorten a person's life.

9. Euthanasia, or "mercy-killing" of a patient by a physician or by anyone else, including the patient himself (suicide) is murder. To withhold or to withdraw medical treatment, as is being discussed here, does not constitute euthanasia and should not be placed into the same category with it.

10. A decision to withdraw medical support from a patient should be based upon the same medical and ethical considerations as a decision not to initiate it. Of course, the withdrawal of treatment is more difficult when it seems likely that death will be hastened by that decision. Actually, a decision to withdraw life support is often based upon better medical evidence than a decision to initiate life support. Heroic measures are frequently started in an acute situation when physicians must make quick decisions about patients, but with limited information. Over the next few days or weeks, however, with continued observation and additional information, they may discover that a feeding tube or respirator may only be prolonging the dying process, whereas when these measures were started, some hope of recovery was realistic.

11. The expenses of heroic measures are a consideration. These may be directly paid by the patient or his family or indirectly paid by private insurance, Medicare or Medicaid. Our concern here is limited to the direct expenses that the family must face. These are likely to increase with the tightening of federal and state budgets and as the cost of private insurance increases. Two dilemmas may arise.

First, the patient may have an inheritance that he had planned to leave his family, but is faced with medical expenses that could easily diminish or deplete his estate. Second, the patient may not have the funds to pay for his medical care, so payment falls to his family. Few families can meet the expenses of heroic measures without severely affecting their own financial needs.

These dilemmas can usually be resolved by attention to other principles and suggestions here and elsewhere (see Resources). For example, we have seen that neither patients nor families have a moral obligation for medical care where its effectiveness is limited or it is simply prolonging death. In addition home care is often a real alternative to hospitals or nursing homes.

If these other principles do not resolve the issue of cost, families should be careful not to incur large amounts of debt for medical care. One exception could be treatment that would restore a person who is the primary provider for a family. Much counsel and prayer with elders of the church will be needed for these situations.

The family, however, may sometimes face situations in which they would not be responsible for the cost of medical care. The patient's and even the family's wishes will not be honored by some physicians and there may be no other physician available who will treat the patient accordingly. In these instances it may be appropriate for the family to divorce themselves legally from financial obligation (but never morally or physically). Biblically, their authority and responsibility have been thwarted, so the financial responsibility falls to whoever intervened.

Churches also need to consider their responsibility to help families meet the expenses of medical needs. The Bible is clear that the church does have some responsibility (I Tim. 5:3-16). Each church, however, will have to work out its own specifics here.

12. The tendency in these ethical decisions is to make the age of the patient the overriding factor that determines what is or is not done. Our response to babies and young children in distress is greater than that to older people. The Biblical principle, however, is that one life is not more valuable in God's eyes than another (except as all people are divided into the saved and the unsaved).

The age of a person is a factor because the ability of organs to recover their function is generally greater in the young than in the elderly. Thus, efforts may

be stopped earlier in the course of an elderly person because of this difference in potential. This factor, however, is not always dependent on age. The diseased organs of some babies and children will not recover as well as those of many elderly people. Thus, there will be appropriate times to stop treatment in young patients, as well.

13. A patient's spiritual condition must be administered to, as well as his medical needs. Too often, this dimension is neglected in all that is being done medically. First, and most important, is the eternal condition of the patient's soul. There may have been clear evidence of regeneration in the person's life and there may not have been. In the latter case presentation of the gospel is far more important than medical treatment. Second, the patient may have other spiritual problems or questions that need counseling. Certainty of salvation becomes a serious issue for some when they realize that they are close to death. Other issues should be given a chance to surface as well.

Severe chronic or terminal illness can be an opportunity to heal and strengthen relationships, especially within marriages and families. Although the Bible is clear about the intimacy and openness that should exist in Christian families, we often do not live this way. Worse, there are often regrets and unsolved problems that one wishes to have spoken about with a family member before he died. Healing these relationships, is one possible blessing of the "victory" and removal of the "sting of death" (I Cor. 15:55). Practical steps to these ends are given in *Shepherding God's Flock* (see Resources).

14. The Biblical authority for decisions concerning heroic measures lies with the family if the patient is not able to make his own decisions. First, the patient's spouse is responsible. Likely, the difficulty of such decisions will cause him or her to consult with others in the family or his elders in the church. If there is no spouse, then the decision falls to the family. Communication is facilitated if one member is selected to be a spokesman for the patient. Decision-making may be shared among all family members, but reported by the spokesman. Since communication and agreement will vary considerably among families, the elders may be needed to help resolve differences.

According to this family and church-centered authority, living wills are questionable. These documents transfer authority from the patient and his family to the state. Practically, they have limited usefulness, as well. First, living wills bring in an additional party who would not otherwise be involved, further complicating issues that are usually complex already. Second, they are not sufficiently specific to cover all possible contingencies. Physicians, patients and families are frequently left with these difficult decisions even when a living will has been enacted.

15. Patients need companionship. A great fear of dying patients is their being left alone or neglected. Unfortunately, today's medical care often requires isolation of patients, usually in Intensive Care Units (ICUs) or Coronary Care Units (CCUs) in order to provide the "best" treatment. The environment of noisy

machines and blinking lights is substituted for the intimacy of family and friends. There is a place for these units in medical care but it is questionable in patients for whom there is no reasonable hope of physical recovery. Even when it is medically necessary, visiting rules are often insufficient to meet the patient's needs of companionship.

"Do Not Resuscitate" orders are sometimes an appropriate way to avoid heroic measures because hospitals are required to resuscitate all patients who die suddenly unless such orders, written by the attending physician, are on the patient's chart. It is a recognized phenomenon, however, that health care workers and family members frequently avoid patients for whom these orders have been written, at the very time that time when they most need companionship.

For patients who have incurable diseases a discussion of "Do Not Resuscitate" orders with the attending physician is appropriate. Ideally, this discussion should take place prior to admission. If it has not been done then, however, the discussion should take place as soon as possible. Many heroic measures could be avoided in this way. Then, the medical staff and the family should be clearly instructed that the patient needs more support and interaction, not less. Physical contact (touching) is usually one extremely important way to communicate with patients. Rarely do these patients have a disease that could infect others to obviate this expression of caring.

Further, family members are not always those with whom the patient would most like to have at his bedside. Christian brothers and sisters may be the "family" of preference. Pastors and others should discern whether this situation exists when a patient has little or no Christian fellowship with his family members.

16. Analgesics should be used as necessary (Prov. 31:6), but with caution (Eph. 5:18). Strong medications to control pain frequently cause depression of a person's mind. During the last days of life communication with the family and others needs to continue to resolve any problems and to continue fellowship as long as possible.

17. The family is the primary agency responsible for the care of its own (I Tim. 5:3-16). For chronic care the home of the patient or a family member should be considered. Many medical conditions can be managed at home with a little training. The family's church should provide back-up and additional resources for families who care for patients with chronic illnesses in their home. Certainly, not all problems can be managed in the home with its limitations of physical and spiritual resources. With the continuing decrease in third party payments for medical care, however, chronic care will increasingly be shifted to the home.

This shift is not without benefit. Home care is in many ways superior to that of an institution. Patients will get more attention and have more interaction in a

setting where everyone is more comfortable. Serious infections that are a hazard in institutions are avoided. The patient will get more rest away from the frequent intrusion of needles, pills, tests, noisy instruments, and other interruptions that often continue twenty-four hours a day. Numerous studies indicate that hospital care, and even intensive care units, provide little or no medical benefit for some conditions. Careful discernment is needed to determine when to use these facilities and when not to.

18. Christians of any age who have chronic incurable illnesses and a limited life expectancy may ethically refuse "heroic measures" rather than briefly prolong a life which God is clearly drawing to a close. The elderly who have lived their normal expected life span and desire to die quietly may choose not have extensive medical measures. Their wishes may be difficult to ascertain, so elders and pastors may need to inquire in a sensitive manner to know this important and necessary information. Heroic measures mostly benefit people who have not yet reached old age and have a critical illness, yet one from which they can recover or be cured. In such cases intensive medical technology should be used in spite of the associated suffering, particularly if they still have significant responsibilities to their families or other Christian duties to perform.

Even when properly applied, modern medical science is fallible and instances will occur in which individuals who have been resuscitated remain hopelessly ill or severely impaired. These situations, however, still occur under God's sovereignty and the family and church should help to provide compassionate, supportive care.

IV. PREPARATION FOR AN ENCOUNTER WITH HEROIC MEASURES

1. Physicians should be chosen with these principles in mind. During routine medical visits desires of the patient and/or family can be made known to him. Such discussion has some urgency when admission to the hospital occurs. Although no one likes to talk about possible untoward events that may occur, they are not uncommon during hospital stays, even for routine problems. A major decision concerns "Do Not Resuscitate" orders. A physician can write these in the patient's chart and often avoid the application of heroic measures (see discussion under 111.15).

Appropriate legal documents should be prepared immediately by all PCA members. This action may be the one most likely to prevent the many dilemmas that occur with terminally ill patients. A durable power of attorney is necessary for a time when they might become mentally incompetent from an illness or accident. Legal tangles can be lengthy and expensive if this document is not prepared. Instructions about heroic measures should be clearly given to the person who will have the durable power of attorney if mental incompetence occurs. In many instances this decision will be the most important one to prevent inappropriate heroic measures and possibly to avoid the unnecessary decimation of one's estate by the costs of such measures.

Life, disability and health insurance policies should be reviewed and updated or changed where necessary. Special counsel should be sought from those who are familiar with expenses associated with present medical practices. For example,

nursing home care is rarely covered by insurance policies and is covered only for a few weeks under Medicare. Medicaid will pay for nursing home care only after the patient's estate is entirely exhausted.

4. Spouses must talk over what they desire concerning heroic measures. Untoward events are more likely in the elderly, but all couples should discuss these matters' because they do occur in all ages.

5. 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.

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