PASTORAL SUPPORT AND THE CLASH OF CULTURES

This is Part III in a seven-part blog series analyzing a resolution coming to the PCUSA General Assembly on the end of life. The paper titled, "Abiding Presence: Living Faithfully in End of Life Decisions," forms the rationale of the resolution and is offered to the church as a pastoral guide to end of life conversation. Click to read Part I or Part II .

I am not a pastor, but I found this part of the paper to be educational and helpful. I found little to criticise so will summarize with few words of response (italics).

Section B of the End of Life Pastor's Guide explores two key questions pastors may have about their role in supporting congregation members making end of life decisions in the healthcare environment. The first question posed for pastors is: **"What does it mean to live faithfully and die well, and how can I contribute to this task as a spiritual leader?"**

At the end of Part II in this blog series I complained that I had yet to find the distinctive voice of the Christian church—that hope of eternal life we hold even as our physical lives end. I am so glad I continued reading because I did find that hope expressed in this part of the paper. Here is my attempt at a summary.

"All persons are beloved by God, . . .and become whole by God's grace in spite of whatever diseases or disabilities we have." For that reason, pastors should "advocate for equal treatment of persons without discrimination based on limitations or disabilities."

Even death, cannot "separate us from the love of God in Christ." That knowledge does not mean we should not make preparations to die faithfully. Pastors are encouraged to engage congregations in conversations about advance care planning. Such forethought can help patients refuse interventions "that needlessly increase our pain and suffering without providing any discernible, offsetting benefit." Pastors can also provide assistance in facilitating conversations between patient and family members before a crisis occurs.

We live in a society that prefers to deny death and that sometimes makes conversation about it uncomfortable. Pastors can help by listening when patients may feel isolated but have need to "review their lives" and "measure their lives."

The word hope is not confined to "hope for a cure." "Christians, ...proclaim hope in the faithfulness of our God who created us and will never desert us, even as we are dying." "Paul reminds us that "[we] may not grieve as others do who have no hope" because we have Jesus' assurance that, while death changes our existence, it does not end it." (I Thess. 4:13) ". . .[D]eath does not have the final word. Instead, our God—Creator, Redeemer, and Sustainer—holds the final word, and that word is eternal life in God's presence."

Pastors can help patients explore palliative care and hospice options. Authors of the paper encourage pastors to help patients understand these options as ways to promote life rather than "giving up," noting that "a multidimensional approach to the management of both physical pain and existential suffering has been shown, in some circumstances, to actually extend life even beyond that achieved through aggressive treatment with chemotherapy and/or radiation."

The paper includes no word of caution here that hospice policies differ widely from oneÂÂÂÂÂ program to another. Patients and their families (and pastors) need to be sure they understand what treatment if any will be combined with pain management and comfort care and whether nutrition and hydration will be given. Hospice and palliative care are dealt with more extensively later in the paper.

Pastors can "practice the presence of Christ with dying persons" best by listening to their experience and affirming God's presence and abiding love.

The second question dealt with in the B section of the paper on Pastoral Support for End of Life Care, is **"How can I as a pastor fit in to the healthcare setting?"** Authors begin with a review of those who form a healthcare team and their roles.

Ethics consultants or committees serve in an advisory role "where ethical/moral issues are not yet clearly resolved". They may also server in the role of arbiter when there are conflicting values among the caregiving team members.

Chaplains assist patients in addressing questions that go beyond "concerns of physical deterioration and death." They help patients resolve questions of meaning, purpose, leave-taking, afterlife and legacy. Chaplains should not replace the individuals own community of faith but may serve to add another voice of comfort and "messenger of God's love and grace."

Social workers are professionals prepared to assess the needs of a person and connect them to appropriate resources.

A **patient advocate** can help patients and families navigate the complexities of the health system and also may mediate conflicts regarding the levels and types of care or billing issues.

Nurses are in a close and personal care relationship with the patient. Patients may have high levels of discomfort about their deteriorating physical body. Nurses can be a source of education to help families understand what to expect in the dying process. They are uniquely knowledgeable about the patient's care and concerns and within the limitations of the law may be able to provide insight to pastors about the daily "joys and struggles" of the individual.

Physicians involved in a patient's care may be many. Often a "hospitalist" who may not have been known to the patient until he/she enters the hospital coordinates care. Communication is not always of good quality between physicians and misunderstandings may occur. An engaged pastor may have opportunity to identify and address bias, facilitate understanding, and even meet with ethics committees to enhance listening among members of the care team.

The writers of the paper provide a window into the guiding principles of the healthcare community: the four principles that guide them (autonomy, beneficence, non-maleficence, justice), their focus on virtues less than particular actions, and their intolerance of ambiguity. The pastor can be the connection between the healthcare team and the faith community and help to alleviate some of the sense of isolation patients may feel in hospital situations.

Section C of the paper explores the pastor's role within the community of faith in raising end of life issues and encouraging members of the congregation to do advance preparation. Regret over decision-making at life's end is more likely when individuals and families have not been intentional about advance planning. Engaging in thinking about end of life together in the community of faith means we are not alone at the end of life even when family is distant.

Authors point to a 1981 document "The Nature and Value of Human Life" which describes as sin "our inability to live in a relation of trust and obedience to God, seeking instead to take charge of our own destiny and guarantee our own life." We are reminded that it is God who sustains us and who gives us ultimate victory over death. They affirm that "the sacred nature of human life emerges from the claim that humans are created in the image of God," and explain that in the medical community most doctors hold the view that they should not "act deliberately to end a human life." The question is then raised, "[D]oes our belief that God is the giver of life mean that under all circumstances we are morally obligated to postpone death as long as possible?" This is the question that often brings conflicts among families in the ICU. It is beneficial if pastors can help congregation members think through such questions in advance. The medical community is guided by a "war on death" metaphor which perceives death as "defeat." So, some doctors may "keep fighting at all costs" when there is "no credible hope for survival, let alone a return to health." When a patient is not prepared their true values and desires may not align with prescribed treatments. Section C ends with this sentence:

"So the challenge for Christians concerns how to approach the inevitability of death faithfully, and that approach includes planning for how we wish to die."

There seems to be an unstated undercurrent here that implies objection to the strong protection of human life ethic of the medical community. Is it a problem that doctors want to preserve and extend life? Are the writers saying only that there are times when treatment is not beneficial and death should be allowed to come naturally or is this laying a foundation for advocacy of treatments that hasten death? Perhaps it will become clear as we read on.

I write this a few hours before I will leave to be present with a dear friend whose husband died unexpectedly this week. I cannot help but reflect that for all our planning we may have no choice at all in how we die. It is wise to remember that our times—beginning and end—are in the hands of God. While it is good to plan in advance so that our families and healthcare givers know our desires, it is better to remember that both our lives and our deaths are safest in the hands of God.