

EUTHANASIA



PALLIATIVE CARE

A GUIDE FOR CANADIANS



*Uniting Evangelicals to bless Canada
in the name of Jesus*

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INTRODUCTION

Canada is grappling with how it will usher in euthanasia and physician-assisted suicide at the very same time as we face a widely-acknowledged shortage of quality palliative care options for those who are dying.

Faith Today, Canada's Christian magazine published by The Evangelical Fellowship of Canada, has examined the implications of physician-assisted suicide – and the issue of palliative care and how we live and die in Canada – through different angles in recent issues.

We have interviewed experts, practitioners and thought leaders to shed light on one of the most important and nation-shaping issues our country is facing.

Here we gather together a selection of those articles, for the first time accompanied by discussion questions, to help you and your church better understand what is at stake with physician-assisted suicide; what is needed in the area of palliative care; and what we as Christian Canadians can do to offer loving, respectful and life-honouring care to our neighbours and those we love.

Faith Today, January/February 2016

GLOSSARY

KNOWING THE TERMS

Hospice palliative care

Care that aims to relieve suffering and improve the quality of life.

Integrated palliative approach to care (community-integrated palliative care)

Care that focuses on meeting a person's and family's full range of needs – physical, psychosocial and spiritual – at all stages of a chronic progressive illness. It reinforces the person's autonomy and right to be actively involved in his or her own care – and strives to give individuals and families a greater sense of control. It focuses on open and sensitive communication about the person's prognosis and illness, advance care planning, psychosocial and spiritual support and pain/symptom management. As the person's illness progresses, it includes regular opportunities to review the person's goals and plan of care, and referrals, if required, to expert palliative care services.

Home care

Includes an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for family caregivers.

Physician-assisted suicide

A physician knowingly and intentionally provides a person with the knowledge or means or both required to end his or her own life, including counselling about lethal doses of drugs, prescribing such lethal doses or supplying the drugs. This is sometimes referred to as physician-assisted death.

Euthanasia

Knowingly and intentionally performing an act, with or without consent, that is explicitly intended to end another person's life and that includes the following elements: the subject has an incurable illness; the agent knows about the person's condition; commits the act with the primary intention of ending the life of that person; and the act is undertaken with empathy and compassion, and without personal gain.

Palliative sedation

The use of sedative medications for patients who are terminally ill with the intent of alleviating suffering and the management of symptoms. The intent is not to hasten death, although this may be a foreseeable but unintended consequence of the use of such medications. This is not euthanasia or physician-assisted death.

Withholding life-sustaining interventions

Withdrawing artificial ventilation, nutrition and similar interventions that are keeping a patient alive but are no longer wanted or indicated are not forms of euthanasia or physician-assisted death.

SOURCES: FIRST THREE DEFINITIONS FROM *THE WAY FORWARD NATIONAL FRAMEWORK- A ROADMAP FOR AN INTEGRATED PALLIATIVE APPROACH TO CARE* (WWW.HPCINTEGRATION.CA).
LAST FOUR DEFINITIONS ADAPTED FROM THE CANADIAN MEDICAL ASSOCIATION, "EUTHANASIA AND ASSISTED DEATH UPDATE 2014" WWW.CMA.CA

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Faith Today, March/April 2015

AT ISSUE

Palliative care

As the issue of euthanasia and assisted suicide captures the attention of Canadians, a national palliative care strategy still does not exist in a country with an aging population and a shortage of end-of-life care options

There are approximately 9.6 million people in Canada between 46 and 65 years old. Most of these Baby Boomers will die in the next 25 to 40 years.

The reality in Canada in 2015 is that:

- There are too few hospital beds.
- Elderly patients are sometimes given few compassionate care options in their dying days.
- Canada only has 86 residential hospices.
- A shortage of palliative care beds exists in almost all Canadian hospitals.
- The House of Commons passed a motion in 2014 calling the government to “establish a Pan-Canadian Palliative and End-of-life Care Strategy” (www.theEFC.ca/M456)

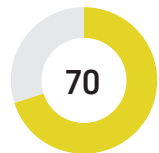
What exactly is palliative care?

Dr. Camilla Zimmermann, head of Palliative Care Services at Princess Margaret Hospital in Toronto, says many Canadians misunderstand palliative care. “The big myth is if you go to see a palliative care physician, you’ll be talking about dying. We don’t really do that. We talk about how we can help you with your symptoms, your pain, your family, helping you cope really with what is happening, and providing resources,” says Zimmermann. “It’s about helping people cope with their cancer or whatever life-threatening illness they have. If they want to talk about dying, [that’s] great, but we don’t need to do that.”

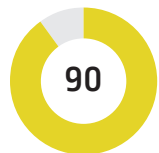
The World Health Organization defines palliative care as “an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain

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PERCENTAGE OF CANADIANS WHO HAVE ACCESS TO PALLIATIVE CARE
WWW.CSPPCR.CA



PERCENTAGE OF CANADIANS WHO DIE IN HOSPITAL, ALTHOUGH MOST CANADIANS WISH TO DIE AT HOME
WWW.CHPCA.NET



PERCENTAGE OF CANADIANS WHO COULD BENEFIT FROM HOSPICE PALLIATIVE CARE
WWW.CHPCA.NET

“We believe life is a gift from God which should be respected and protected through all of its stages. Each human life has inherent worth, regardless of age or physical, mental or other abilities. Care for the sick and the elderly is part of God’s call for Christians.”

–Palliative Care and End of Life Therapies, an EFC position paper (www.theEFC.ca/palliative2012)

and other problems, physical, psychosocial and spiritual” (www.who.int).

Right now in Canada where you live matters, says Zimmerman. “There are different types of access to palliative care depending on where you live, which is not fair, obviously. That is the reason for a national strategy. We have to have certain standards of care that are applied to the whole country.” **FT**

What can you do...

- Speak to your Member of Parliament about the need for a national palliative care strategy.
- Investigate the options in your own community. Perhaps there is an opportunity to volunteer in a palliative care ministry or service.
- Support the EFC’s efforts to help craft a national palliative care strategy

www.theEFC.ca/PalliativeCare

Faith Today, January/February 2016

AT ISSUE

Taking a stand against assisted suicide

Canadian religious leaders stand together in their call for better palliative care as euthanasia draws near in our country

Religious leaders as diverse as an imam from the Prairies to the president of Associated Gospel Churches have signed a *Declaration on Euthanasia and Assisted Suicide*, presented on Parliament Hill in late October 2015.

The declaration has been endorsed by over 30 Christian denominations, 20 Jewish and Muslim leaders, and a growing number of other Canadians who have signed it online (www.euthanasia-declaration.ca).

The Evangelical Fellowship of Canada, along with the Canadian Conference of Catholic Bishops, initiated the statement in light of the decision by the Supreme Court of Canada to dismantle the laws against physician-assisted suicide.

The court decision “has brought this issue to the forefront of public discussion and compels each of us as Canadians to reflect upon our personal and societal response to those who need our

“We, the undersigned, each from the basis of our sacred teachings and enduring traditions, affirm the sanctity of all human life, and the equal and inviolable dignity of every human being. This is an affirmation shared by societies and cultures around the world and throughout history.”

—Declaration on Euthanasia and Assisted Suicide

compassion and care,” states the declaration.

The joint statement insists Canada’s “health care systems must maintain a life-affirming ethos. Medical professionals are trained to restore and enhance life,” as “any action intended to end human life is morally and ethically wrong.”

The declaration urges legislators to improve access to quality home and palliative care across the country.

In November 2015 the EFC appeared before a federally appointed panel looking at legislative options. The Supreme Court gave Parliament one year to amend the *Criminal Code*.

The EFC, along with other groups opposed to euthanasia in Canada, called the government to ask the Supreme Court for an extension. A six-month extension has been requested to allow the government to consult with Canadians and parliamentarians on this issue. /FT

What can you do...

Visit the bilingual website www.euthanasiadeclaration.ca to add your name to the growing list of Canadians who have signed the document. Visit www.theEFC.ca/WebinarArchive to listen to EFC President Bruce J. Clemenger interviewed on euthanasia.

Faith Today, January/February 2016

SOCIAL POLICY

Gently into the arms of Jesus

Palliative care, done well, leaves no need for doctor-assisted suicide

BY KAREN STILLER

In one of the final photos taken of Lucetta Howard of Uxbridge, Ont., she perches on a wrought iron chair carried by two hardy-looking grandsons. The shot was taken at her granddaughter's wedding reception. Lucetta beams, as grandmothers do, clearly revelling in the moment and the attention of her grandsons who carried her – seated on this chair – wherever she wanted to go throughout this great family celebration.

Her life was about to end. She knew that. She died six weeks later, at 92, of bone cancer.

Lucetta loved birds and was a passionate gardener. The family set up a hospital bed in the living room, with a view of the birds and the flowers.

“My mom did not want to go to the hospital. She decided to stop all her meds. She died on a Tuesday morning,” remembers her daughter Cathy Bacon. She slipped away in the few moments it took for Bacon to step out of the room. “My prayer had been that she would go gently into the arms of Jesus,” says Bacon. And she did.

Lucetta died at home, cared for by Bacon and a caregiving team that included her doctor, nurses, community care workers and of course other family members who took turns and relieved her daughter from her bedside vigil.

The final weeks of Lucetta's life were an expression of palliative care done well. Lucetta was able to die peacefully, almost pain-free, and the family received the support they needed from the broader medical and spiritual community.

My afternoon with Cathy Bacon is just weeks after the Supreme Court of Canada struck down the ban on physician-assisted suicide. I am curious what she thinks, having now walked beside both her parents in their dying days, at their bedside in their last moments.

Like many caring Canadians she finds the issue complicated. Perplexing. “I don't know that unless you're in it, that you can say

it’s wrong,” she admits. “As a Christian I know that’s probably not the right thing to say,” she quickly adds.

I’m glad she is so honest.

This is a thoughtful woman trying to figure out this question of how we are to die in Canada – and what compassion in the last of our days looks like.

BACON IS not alone in her mixed feelings about the new reality of euthanasia and physician-assisted suicide in Canada. In fact, 77 per cent of Canadians support physician-assisted death, according to the most recent poll.

The response from Canadian churches in general – and not surprisingly – has been strongly critical of the Supreme Court’s move to strike down the ban against physician-assisted suicide (see sidebar: Where we are with the law).

The Evangelical Fellowship of Canada (EFC), in partnership with the Canadian Conference of Catholic Bishops, recently responded with a *Declaration on Euthanasia and Assisted Suicide*.

Along with the Christians who signed it are Jewish and Muslim leaders, all affirming the sanctity of life, and calling for the protection of the vulnerable and compassion for those near death. It presents a theology of protection, a passionate case for not killing people, even when they ask for it (www.euthanasiadeclaration.ca).

The EFC has also called for a national palliative care strategy to offer better and more consistent end-of-life care across our country, where only an estimated 16–30 per cent of Canadians have access to palliative care.

What is the connection between palliative care and physician-assisted suicide?

The vast majority of palliative care physicians in Canada are against physician-assisted suicide.

Dr. Michael Koke of Kitchener, Ont., is one of them.

“My first thought was terror,” Koke says of the moment he learned of the Supreme Court’s decision. “It caught me off-guard. I thought I had joined a practice that was relatively safe. I thought euthanasia would come, but it would be years down the road.”

Koke, who splits his practice between oncology and palliative care, is especially troubled by the introduction of physician-assisted suicide when such a high percentage of Canadians are yet to have access to good palliative care.

“We’re offering physician-assisted suicide to people who have not received the gold standard of treatment in palliative care. It’s



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AVERAGE AGE OF
DEATH IN CANADA

wrong to introduce something when the gold standard has not been optimized,” he says.

Most palliative care doctors, he says, “are against physician-assisted suicide. When it comes down to it, when I hear about 80 per cent of Canadians wanting physician-assisted suicide, what I hear is they don’t want pain and suffering when they die. If we address it with good palliative care, then I think it goes down to one or two per cent.”

Sharon Baxter is executive director of the Canadian Hospice Palliative Care Association (www.chpca.net). Bringing good palliative care to more Canadians is what their organization is all about. *The Way Forward* is their latest initiative, a “roadmap for an integrated palliative approach to care.”

It opens with these lines: “Imagine a time when hospice palliative care is available to Canadians when and where they need it; where living well until death is the goal of care.”

Baxter concedes, “It would be a tragedy if Canadians signed up for it [physician-assisted death] without even having a consultation on pain management, on hospice. We want to make sure they have access to hospice palliative care, and have a pain consultation, and do all those things we think are necessary before anyone would proceed to that end.”

Baxter’s organization did not enter the physician-assisted suicide debate in Canada. “We thought it would be confusing to people who might think that physician-assisted death would be part of hospice. It won’t be.”

Baxter’s caution is an undercurrent that reverberates through the palliative care movement in Canada. Those who provide palliative care do not want to be categorized in anyone’s mind with physician-assisted suicide.

What is good palliative care?

Good palliative care, contrary to popular opinion, does not begin with a death sentence and end on a deathbed.

WHERE WE ARE WITH THE LAW

In February 2015, the Supreme Court of Canada struck down the federal law prohibiting physician-assisted dying. The ruling applies to a competent adult who clearly consents to the termination of life and has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.

The court gave governments one year to consider the development of new laws and practices for physician-assisted dying, and the government asked for a six-month extension beyond that deadline. –KS



It needs to start earlier, say the advocates – the moment the person is first diagnosed with a life-limiting condition. It is always multidisciplinary – involving doctors, clergy or other spiritual support, community care and of course family and friends.

And if it's going to happen in Canada, it must involve training more doctors in more places to understand a life-affirming management of the end of life – especially when it comes to managing pain.

Clearly a fear of dying in excruciating pain lies beneath many people's tacit agreement with assisted death.

Dr. Mike Harlos is clinical team leader for the Canadian Virtual Hospice, an online resource for palliative care, loss and grief (www.virtualhospice.ca), and medical director of adult and pediatric palliative care for the Winnipeg Regional Health Authority. He is also professor and section head of palliative medicine at the University of Manitoba.

He says his speciality is “about living, not dying. We are about reclaiming living as you are dying.”

There is a man Harlos remembers who was in his early 70s and had cancer. “It was eroding his chest wall,” he says. “He was bed-ridden with pain. His physician didn’t understand the complexity of his pain. He was in bed, waiting to die. After one visit, within five days he was up and doing things.”

The situation was straightforward for Harlos, trained in end-of-life pain management, but the man’s doctor had not been trained in palliative care. “The man wrote me a letter thanking me for saving his life, and he died a month later.

“I didn’t save a life,” says Harlos. “I saved his living.”

The heavy cost of palliative care shortages

Harlos worries about his doctor peers in remote parts of Canada, and how the introduction of physician-assisted suicide will impact them and the care they can offer.

“You go out of the main centres and you cannot find a palliative care expert. What this will ultimately result in is a legislated right to be killed to reduce suffering, but no legislated right to see an expert.

“You go up north and see someone with that horrible pain like the story I told, the whole conversation would be, ‘I can’t keep living this way.’ And a doctor would say, ‘I’ve done all I can, but I can kill you.’

“We’re not about death, we are about living. If you look at recent surveys of palliative care physicians, three-quarters of them don’t think they should be involved, but we fear it will be lumped in too.”

The bar for palliative care in Canada, says Harlos, is currently way too low, both for those who need care and those who give it.

It’s time to demand more, he says.

“I would encourage people to inform themselves about what they should expect from their health care provider regarding palliative care and end-of-life care. They should raise the bar. You should expect your health care team to know what they are doing in regards to pain management, and to be available and attentive to your needs.”

Life and death in a residential hospice

Above the fireplace at the Red Deer Hospice in Red Deer, Alta., hangs a large print of vivid yellow sunflowers springing up from a field of muted greens.

There are sunflowers in other spots in this home away from home, captured in stained glass and in wall hangings that add colour and light. A large comfortable-looking armchair – the kind



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PERCENTAGE OF CANADIANS WHO DIE IN HOSPITAL, ALTHOUGH MOST SAY THEY WANT TO DIE AT HOME

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PERCENTAGE OF CANADIANS WHO BELIEVE THAT A PALLIATIVE APPROACH TO CARE SHOULD BE AVAILABLE EARLY IN THE COURSE OF A DISEASE

“If we can assure people we have the ability to manage their pain, then I think we’d have a different conversation going on.”

–Cheri Purpur, nurse manager at Red Deer Hospice in Red Deer, Alberta

you find in Canadian family rooms everywhere – sits beside a hospital bed covered with a plaid blanket.

The chair is ready for family and friends to visit whoever is living, and dying, at the hospice. This hospice has ten beds and admits on average 150 patients a year. The Red Deer Hospice is one of only approximately 76 residential hospices registered in Canada.

“We are a house of multiple losses,” explains Cheri Purpur, nurse manager. “People come here with the understanding this is the last stop.” The average length of stay is 31 days.

People enter a palliative residential hospice like this one to die. And to die well, surrounded by their family who are fully welcomed and included in the care.

“We do feel we admit the entire family when we admit a resident,” explains Purpur. “We have counsellors on staff five days a week. It’s their job to make connections with the resident and all family members, providing psychological-social care.”

The job of the hospice team, says Purpur, is to “provide as much physical comfort as we can, pain and symptom relief, and as much emotional comfort as they will allow us to provide.”

Purpur fears for what may happen to such families as euthanasia and assisted suicide become an option for the dying in Canada.

She worries about the family grief process if death is decided suddenly and then quickly scheduled. Purpur questions the idea of pain that cannot be controlled, something rare when people die in Canada with good palliative care available.

“If we have intractable pain or symptoms like nausea and vomiting that we cannot get under control – which is very rare, by the way – or extreme anxiety and emotional distress that cannot be resolved in the short time we have, there is an opportunity for that person to be rendered unconscious with sedation and allow their body to simply get on with the job of dying.”

This process allows the family and loved ones to “come to a place of acceptance and willingness to let go,” says Purpur. “When we do

it suddenly and in a planned way, I think we may well be messing up a normal grieving process that allows a normal transition of life to take place for the loved ones left behind.”

Purpur, who was once a midwife, believes what makes euthanasia seem attractive to Canadians is “fear of the process of dying. They are afraid of the pain they may experience, the symptoms, the general discomfort and strangeness. If we can assure people we have the ability to manage their pain – and if need be their consciousness, though we don’t do that often because it’s rarely necessary – then I think we’d have a different conversation going on. It’s the unknown they are afraid of.

“We are all going to die,” says Purpur. “None of us are going to get out of here alive. Every single dying human being deserves this kind of care at end of life.”

Enriching palliative care in Canada

Michael Koke loves his job. So does Mike Harlos. Cheri Purpur clearly does too.

They say caring for the dying has impacted their own living. “You have to be comfortable with your mortality to do palliative care,” observes Koke. “I’m hoping that the courage I’ve seen on the part of my patients will affect how I die too. It really normalizes things for me. This is a part of life.”

For Harlos it has to do with “the very foundation of reality. It is people in the worst situation they have ever been in, family and patient. You can cut through any kind of fluff and focus on just being there to help.”

It was actually in Canada where the term palliative care was born. Dr. Balfour Mount coined it – to palliate means to improve quality – after starting a new kind of care at Montreal’s Royal Victoria Hospital. It was a hospice-like ward – a palliative ward – dedicated to providing holistic care to the dying, inspired by a 1973 visit he made to study hospice care in England.

It was the first hospital wing of its kind in Canada.

Dr. Mount, known as the father of palliative care, did not feel well enough to be interviewed for this article. He has lived for years with the effects of heart problems and cancer of the esophagus.

The Globe and Mail interviewed Mount in 2013 and asked, “How are you going to die?”

This was his answer. “I have had a permanent tracheostomy for seven years. With each breath I take, I realize that I may not be able to take the next one because it takes a remarkably small amount of secretions to block the tube.

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PERCENTAGE OF
CANADIANS WHO
SUPPORT HOSPICE
PALLIATIVE CARE

“I realize that when I become unable to care for myself, the question gets a lot more interesting. What I would never ask, even if the legislation changes, is for a doctor or anybody else to end my life intentionally. . . . The goal isn’t to kill, but to improve quality. It is a palliative goal.” /FT

1

Reflection questions

1. Death and dying are not topics most Canadians want to think about. What do you think might be the impact of trying to shut out these inescapable events in life? How does Scripture treat death and dying?
2. “I don’t know that unless you are in it, you can say it’s wrong. As a Christian I know that’s probably not the right thing to say.” This is the honest confession of a Christian grappling with the issue of physician-assisted suicide. Did this statement surprise you? Do you think we can know what is right or wrong without being in a situation ourselves? How does personal experience change our perception of an issue like this? How does our faith inform our understanding and experience? What are your own questions or concerns about euthanasia and physician-assisted suicide?
3. This article points out most palliative care doctors are against euthanasia. Why do you think that would be? What could be experienced in supporting someone at the end of their life that these doctors would find meaningful? What is the disconnect between offering palliative care and offering euthanasia?
4. Cheri Purpur believes euthanasia seems attractive to Canadians because of fear of the process of dying, fear of pain and fear of the unknown. Others have identified a fear of losing control. What role does our faith play in facing these fears?
5. Reflect on Psalm 139 in light of these discussions. How does this passage speak to these issues?

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Faith Today, March/April 2014

PALLIATIVE CARE

How Canadian Christians are caring for the dying

Insights on bringing comfort and providing palliative care

BY PATRICIA PADDEY

“Into the darkness we must go. Gone, gone is the light.”
 –from Steve Bell’s “Gone Is the Light” by Gord Johnson

Whenever I hear the phrase “death with dignity” – and I’ve been hearing it a lot lately as our country has debated euthanasia and assisted suicide – I think of my father’s dying.

Dad had no medical interventions designed to hasten his death. And while the palliative drugs minimized his physical suffering, I know he did suffer. In a different way, so did all those who loved him as we witnessed his life ebb. It’s the worst kind of ache and exhaustion to provide around-the-clock care for someone you love, knowing they’re slipping away. There’s nothing you can do about it, except to offer ice chips when their mouth gets dry, cool cloths when their forehead gets clammy, and just enough morphine at just the right intervals to keep them comfortable.

But it’s also an immense privilege. And in helping to give that kind of care to my father, I witnessed the dignity that permeated the final days of his life.

It was 14 years ago – on February 29, 2000 – that my father breathed his last. He was 70, old enough to have lived a full life, but not so old that he’d lived all he wanted, or all that we wanted him to live. I felt a little bit cheated when he died.

I also felt gratitude. Dad had a good death, if death can ever be described that way – in his home, in a hospital bed in the living room, my mother at his side. She was holding his hand.

After almost five torturous months in hospital, battling to regain his health and strength following surgery for colon cancer, my dad learned his bones were full of the disease. Knowing there was no treatment that would make him well, he wanted to go home to die. So my mother, my three siblings and I became his

Dr. Mielke’s gift of time and compassion taught me that sometimes care for the dying means caring for those who love them, whose lives have been turned upside down by a terminal diagnosis.

care team 24/7, supported by extended family, visiting palliative care workers, VON nurses and his doctor. Two weeks after being carried home by ambulance to live out whatever days he had left, he was gone.

Even now, heaviness settles in my chest whenever I recall that time, a heaviness that makes it just a little harder to breathe. But there is also a feeling of calm assurance. His dying had dignity. My family’s care for him – and the care of the team that supported us – helped that to happen.

“A designation of ‘palliative’ opens the doors for more care,” says Dr. Cornelia Mielke, the family physician in Hamilton, Ont., who visited my father at home during the last days of his life. “I’m not under any illusions that [the palliative care system] is perfect. But there is help available, and when people look for it they can find it.”

When my mother determined to take my dad home from the hospital, she sought help in the form of a physician willing to make house calls. Dr. Mielke seemed heaven sent. I remember the day she took several minutes to sit with us, looking at family photos of my dad. I had felt compelled to introduce her to the man he’d been, not just the frail patient he was, and she honoured that.

“Did I really do that?” she exclaims, surprised, when I express gratitude for her kindness in lingering over those photos all those years ago. A professing Christian, Dr. Mielke says, “I think it’s so important to acknowledge the person beyond the diagnosis.”

Dr. Mielke’s gift of time and compassion taught me that sometimes care for the dying means caring for those who love them, whose lives have been turned upside down by a terminal diagnosis. Casseroles dropped off by church friends, visits from the pastor, and supportive phone calls during the stressful months of my father’s illness were all welcomed reminders he was loved. And so were we.

“People’s needs, though expressed differently, remain beyond the strictly physical.”
—*Dame Cicely Saunders, Christian, nurse, social worker, physician and founder of the modern hospice movement*

AS THOSE who believe life is a gift given by God, that all human beings are created in God’s image, and that we are called by God to love one another, it’s not surprising Christians are often on the front lines of compassionate care when someone is dying.

Dr. Beverley Smith – a Salvation Army officer, family physician with a focused practice in palliative care, and assistant professor in the division of palliative care at the University of Toronto – says that throughout history the Church has been in the vanguard of caring well for people at the end of life.

Hospices, which provide physical, emotional and spiritual care for people in the final stages of terminal illness, date back as far as the 4th century “when Christians in Europe provided care to the sick and destitute,” according to the website of the Canadian Hospice Palliative Care Association.

But modern-day palliative care also has a strong Christian connection. It came about “because a young lady [in England] called Cicely Saunders had an incredible conversion experi-

PALLIATIVE RESOURCES

The Evangelical Fellowship of Canada offers the 2012 background paper *Palliative Care and End-of-Life Therapies*, among other resources.

www.theEFC.ca/ResourcesOnEuthanasia

The Canadian Association for Parish Nursing Ministry website includes a comprehensive list of books, videos, fact sheets and other resources.

www.capnm.ca

Room 217 Foundation offers therapeutic music resources suitable for use across the life span, as well as music designed specifically for end-of-life care.

www.room217.ca

Canadian Virtual Hospice provides information and support on palliative and end-of-life care, loss and grief. Offers resources, discussion forums, articles and helpful information on topics ranging from the physical symptoms that accompany dying to the physical changes that occur to a body after death. Videos demonstrate a range of practical how-to topics including how to administer medications and how to make a bed with someone in it.

www.virtualhospice.ca

The Canadian Hospice Palliative Care Association is the national voice for hospice palliative care in Canada. Advancing and advocating for quality end-of-life/hospice palliative care in Canada, its work includes public policy, education and awareness. Offers links and resources tailored to the needs of family caregivers, spiritual advisors, personal support workers, doctors, nurses and others.

www.chpca.net

Advance Care Planning offers guidance, resources and tools helpful for preparing and planning end-of-life care.

www.advancecareplanning.ca

ence in university,” says Smith. “[Saunders] came to know Jesus Christ personally, and set out to obey His guidance.” Building on already established traditions of religious care, Cicely Saunders wound up defining the principles for – and creating – modern hospice care, ensuring pain relief, maintaining dignity, and enhancing the remaining period of the dying person’s life, however brief.

Today countless Canadian Christians care for the dying in meaningful ways, whether as individuals, families or through institutions. In *choosing* to walk through the valley of the shadow of death, these caregivers demonstrate reverence for life. In doing this, they make a lie of the notion that the surest way to secure death with dignity is to legalize euthanasia and assisted suicide, or as the Quebec government labels it, “medical aid in dying.”

Janice Buck is both a parish nurse at Cobourg Alliance Church in Cobourg, Ont., and national co-ordinator of parish nurse ministries for her denomination, the Christian & Missionary Alliance in Canada. She’s helped to care for four terminally ill people in her congregation over the last eight months.

Parish nursing is not “hands-on nursing,” she explains but “health-focused spiritual care. You bring all of your nursing experience to the role, combined with spiritual and pastoral care.” Parish nursing arrived in Canada just over two decades ago, and the ministry is growing for good reason. “Parish nurses can do a lot that pastors don’t have the time for,” says Buck. “They [pastors] typically can’t sit with someone for three or four hours. I’ve sat in emergency or hospital rooms with people for up to ten or 12 hours,” she adds.

Buck feels honoured to help care for the dying. “It’s just that it’s a very intimate part of their life,” she explains, “and to be welcomed in to share, that feels like a very sacred time.”

In the small Eastern Ontario town of Perth, the O’Dacre family also provides care at the end of life. They operate a funeral home, and they’re supporting an initiative to bring a hospice to their community. Janey O’Dacre and her husband John both worked as nurses who provided palliative care prior to entering their present field, one Janey describes as offering “death care.”

“Our focus is supporting families with end-of-life decisions,” she explains. “But we’re not just there for families when there is a death. We know exactly what it’s like to be caregivers to the dying too, how emotionally, spiritually and physically exhausting it can be to be in that role.”

They look forward to the day when local families who can’t tend to dying loved ones at home can select hospice care, rather than hospitals or long-term care facilities.



“Christ never changes. In birth, living and at the end of life, God is the same ... Whatever our losses, He is with us and He’s with us as caregivers to be able to be who the dying person needs us to be at the time.”

–Maj. Margaret Evans, executive director of Sunset Lodge, Victoria, B.C.

On the West Coast, Maj. Margaret Evans, 61, has spent her entire career caring for people at various stages of their life journey. Currently the executive director of Sunset Lodge in Victoria, B.C. (a Salvation Army residential care facility for people needing complex care), she previously gave leadership to Rotary Hospice House (owned and operated by The Salvation Army in Richmond, B.C.). Evans has been present at dozens of deaths, and says ministry in end-of-life care is a special calling.

“It’s a sacredness,” Evans explains. “You are the hands and feet of Christ. It’s God who gives you what you need to minister.”

Asked to share theological insights she’s gained through caring for the dying, Evans says that God is the same, yesterday, today and always. “Christ never changes. In birth, living and at the end of life, God is the same ... Whatever our losses, He is with us and He’s with us as caregivers to be able to be who the dying person needs us to be at the time.”

As co-ordinator of spiritual and religious care at Markham Stouffville Hospital in Ont., chaplain Donald Shields is part of a palliative care team that cares for anywhere from ten to 15 patients at a time. He agrees that providing spiritual care to the dying “is a calling.”

“Everybody looks at us and says, ‘Your life must be hard.’ It’s not. I think we’re given a measure of grace that lets us stand in the gaps with an individual.”

He speaks philosophically when discussing his work, interpreting the Great Commission as involving “incarnational theology.” But he speaks practically when asked what makes a good death. “People die the same way they live,” he says. “We have this fantasy that the end of life comes, and all the dots will be connected and everyone will gather around the bed and sing *Kumbayah*.”

But it doesn't always work out that way. Death is death, and dying can be painful. Says Shields, "There's a profound sadness when people die, and it doesn't matter if they're 100 or 50 [years old]."

It's an often-cited fact that psychological pain at the end of life can be just as great – or greater – than any physical pain. And sometimes, Shields says, people need help getting over their anger.

Vera Kuranji has helped many people get over that kind of anger at the end of life. A Canadian citizen born in Serbia, she returned there in the early '90s with her husband as missionaries sent by the Christian & Missionary Alliance in Canada.

Eight years ago she felt compelled to launch a hospice ministry. In a country with poor publicly funded health care and poverty-level pensions, a terminal illness can devastate a family. "The needs are so great," says Kuranji. "Dying can become a very lonely, lonely place."

Each day she visits from four to five families, offering friendship, sharing spiritual hope, and addressing practical needs. "Some people need wheelchairs or crutches. Some need diapers or medicine or hygiene items." Funded entirely by individuals who have heard about her efforts and believe in what she is doing, Kuranji's hospice ministry has cared for 2,000 dying people and their families to date.

Whether here in Canada or around the globe, in hospitals and hospices, long-term care facilities and private homes, Canadian Christian nurses and doctors, orderlies and housekeepers, pastors and parishioners, social workers and psychologists, friends and family members who are motivated by their faith in Christ bring comfort to the dying.

Why? Perhaps it's because believers hold the conviction that this life is not our own. As God's gift we acknowledge life is sacred – so sacred that even waning life has value and ought to be honoured and protected. That does not mean it must be artificially prolonged. But neither should it be artificially hastened.

...believers hold the conviction that this life is not our own. As God's gift we acknowledge life is sacred—so sacred that even waning life has value and ought to be honoured and protected.

I'LL FOREVER be grateful for the privilege of helping to care for my father during his last days. As his life ebbed, he continued to communicate love for his family, and to receive the love we offered through our care. That exchange of love was a final, precious and intimate gift.

And when he died, we found solace knowing that we would see him again, and that we had eased his final journey. In blessing my father, we had been blessed.

I learned recently that the blessing extended beyond our family. When I spoke to Dr. Mielke for the first time since my father died, she shared that that day remains etched on her memory too. “And that’s not the norm for me,” she said.

“That afternoon . . . it was a busy day. It was one of those days that you’re fully booked, and you have no time, and the waiting room is full, and you’re just hoping you can get home for dinner,” she recalled.

“In the middle of that, there’s a call that someone has passed away, and of course you have to go and pronounce them. At that point, you stop and think, *OK, how am I going to manage the rest of my day?*”

“My staff is good about rebooking things,” she said, “but what they can’t manage is [the turmoil that’s] happening inside of me.”

Arriving at my parents’ home, she described being struck by the contrast between her own thoughts and the scene that greeted her. “You were all so relaxed,” she said. “You were sitting around. You were thankful. There was a sense of rightness. There was a sense of gratitude. There was a sense of ‘this is ok,’ rather than anger or fear, which is what we see a lot of the time.” At this, Dr. Mielke paused, remembering.

Then she added softly, “That honestly ministered to *me*.”

Sometimes, it seems, God can use ministry to the dying to minister to the living as well. /FT

2

Reflection questions

1. Patricia Paddey talks about the pain (and exhaustion) of watching her father die and caring for him on his deathbed, and also the immense privilege it was. What has been your experience with palliative care? If you haven't yet been in a palliative care situation, what are your fears and concerns about the idea of standing alongside a loved one who is dying? How can our faith offer direction or comfort in these times?
2. What does a Christian view of the sanctity of life bring to the experience of dying? The dictionary defines "dignity" as being worthy of respect. How does the Bible speak about the source of our worth and dignity? How do these ideas contradict society's view of "death with dignity?"
3. How are you challenged by the biblical view that life has immense value, and does not ultimately belong to us? What does this mean for our day-to-day lives? As Donald Shields says, "There's a profound sadness when people die..." Grieving is the natural response to death and loss. How does our faith speak to us in our grief? Have you experienced God's comfort and help in the midst of grief?
4. Major Margaret Evans describes her ministry as being the hands and feet of Christ. Patricia Paddey describes the ways her family was supported during her father's last weeks. Are there tangible ways you are able to show Christ's love to those at the end of life?
5. Major Evans explains that "It's God who gives you what you need to minister." Donald Shields describes it as a measure of grace to stand in the gap. Is there a time you experienced God's help to do more than you were capable of doing on your own?



3

Faith Today, January/February 2013

SOCIAL POLICY

Choosing to end a life

As our courts again consider calls to allow assisted suicide, a new EFC report offers insight and hope

BY DEBRA FIEGUTH

When physicians discovered in November 2012 that Scott Routley, the 39-year-old London, Ont., man who has been in a “persistent vegetative state” for 12 years, could communicate with them, the news was rightly seen as a medical and scientific breakthrough. Significantly, Routley was able to reassure the doctors he feels no pain.

And when 15-year-old Amanda Todd took her own life after years of what she felt was unbearable bullying, her tragic death caused an outpouring of compassion and increased talk of the importance of suicide prevention for teens. No 15-year-old should have to endure such severe emotional and mental anguish.

But when Gloria Taylor, a B.C. woman with ALS (Lou Gehrig’s Disease), lobbied for her right to have a physician assist in her death, she was seen by many as a courageous leader and advocate of an individual’s right to die when and how she chooses. Taylor died naturally of an infection in October, but her cause remains in the legal arena.

The media has treated these events as separate issues. But all of them have something in common. They have brought into sharper focus – and greater confusion – the issues surrounding the end of life and whose decision it is to determine it.

Canadians benefit from medical advances that prolong life and alleviate physical pain, but ironically there is a parallel push in society to end life sooner because of psychological and social suffering, or what many health professionals now refer to as “existential suffering.”

Contrary to popular assumptions, most dying patients do not experience intolerable pain, says Vancouver palliative care physician Dr. Margaret Cottle. For example, “ALS patients tend to die a more peaceful death. They don’t suffocate, they don’t choke to death.”

What terminal patients experience is fear: fear of abandonment, fear of being a burden to their loved ones, fear of losing control over their bodies, fear of the *possibility* of pain at the end.

Our confusion around these issues is compounded because “We’ve medicalized suffering,” says Sister Nuala Kenny, a Halifax pediatrician and bioethicist at Dalhousie University.

It helps to consider emotional and physical pain separately. One person may be “dying and have no suffering,” while another may “have very little physical pain and have huge suffering.”

“If you have chest pain,” Kenny explains, “I’ve got stuff I can do for you. If you have heartache because your son is on the street prostituting himself for drugs in Vancouver, I should recognize the pain in your heart. But I have no prescription for that.”

Kenny’s research found “psychological distress and care needs” are by far the greatest factors for patients requesting assisted death.

New EFC report

That research highlights a fundamental question – “Why do people request assisted suicide?” – notes Faye Sonier, legal counsel at The Evangelical Fellowship of Canada (EFC) and its Centre for Faith and Public Life in Ottawa. Recently she supervised research for a new EFC discussion paper called *Palliative Care and End of Life Therapies* (free at www.theEFC.ca/ResourcesOnEuthanasia.)

The EFC paper suggests if something can be done to meet the underlying needs and fears of a patient, there will be fewer requests to end life prematurely.

While patient autonomy is touted as one of the reasons for choosing the time and method of death, autonomy is difficult to measure, says Larry Worthen, a lawyer in Dartmouth, N.S., who is now executive director of the Christian Medical and Dental Society. Patients are always influenced by others such as hospital staff, family members and physicians. In the past we believed the virtuous thing was not to hasten death. “Do we want to have a society where it becomes virtuous to end your life?”

Euthanasia and other forms of physician-assisted death (PAD) are illegal in Canada. Bill C-384, a private member’s bill to legalize euthanasia and assisted suicide, was defeated 228-59 in April 2010. But in June 2012 a British Columbia Supreme Court judge ruled in

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the *Carter* case Canada’s law against assisted suicide was unconstitutional, and granted Gloria Taylor an exemption. In August the federal government launched appeal, to be heard in March. The EFC will participate as an intervener (details at www.theEFC.ca/carter).

While proponents of PAD insist there is no “slippery slope,” and there are enough safeguards available to prevent abuse, many Christian doctors and ethicists see it differently. Thirty years ago, notes Cottle (the Vancouver physician), people were being kept alive longer than was natural. Heroic measures were being taken to prolong life. “I actually feel it’s the other way around now, especially with older people,” she says. “We’re giving up on people sooner than we did, and sooner than we should.”

“It’s a recipe for elder abuse,” she adds. “There’s a big problem with elder abuse, and it’s growing”

Alex Schadenberg of London, Ont., executive director of the Euthanasia Prevention Coalition, agrees. He recently authored a publication called *Exposing Vulnerable People to Euthanasia and Assisted Suicide* (available at www.epcc.ca) in which he cites numerous European, Canadian and American studies that show physicians don’t always follow the guidelines in settings where assisted suicide is legal (Belgium and the Netherlands, as well as in Washington and Oregon). Among his findings:

- Patients are being euthanized without having made an explicit request. (A study from the Flanders region of Belgium shows one-third of euthanasia deaths are without explicit request.)
- Nurses are illegally administering lethal drugs.
- Between 2003 and 2011 the number of euthanasia deaths in the Netherlands doubled.
- In one Belgian study half the euthanasia deaths went unreported.
- Older people were more likely to be victims of unreported euthanasia deaths.

“We have to learn how to speak into our own culture in ways that they can understand. If we just say, ‘The Bible says not to kill,’ they don’t really care.”

–Dr. Margaret Cottle, palliative care physician, Vancouver, B.C.

The unreported cases were determined by an anonymous questionnaire sent to several thousand physicians, Schadenberg explains.

Cottle has seen the research, and is alarmed how “the guidelines are just being completely discarded.” What’s more, she says, “There have been some screw-ups in Washington and Oregon.” People have lived for several days after a lethal injection, or vomited the pills they have swallowed. Death does not always come quickly.

Whose life is it?

Twenty years ago Sue Rodriguez asked the memorable question, “Whose life is it, anyway?” Rodriguez was the British Columbia woman who requested assisted suicide before the symptoms of ALS got too difficult for her to bear. Her quest for autonomy, for controlling your own destiny, has only gotten stronger in society today.

(The EFC intervened in the Rodriguez case, and its arguments formed a key part of the court’s decision in recognizing the value Canadians place on the “sanctity of life” in understanding the “right to life” mentioned in section seven of the *Charter of Rights and Freedoms*.)

But Rodriguez was wrong in assuming her life was her own, says Cottle. “The Christian knows it’s God’s life.”

Responding to the issues requires some careful approaches for Christian professionals. “Faith-based arguments are dismissed” in the public square, says Kenny, who moves in both the secular and religious worlds. The ethics and health policy advisor to the Catholic Health Alliance of Canada has always worked in secular rather than Catholic institutions. “We need to make these arguments more generally accessible,” she says.

Cottle agrees. “We have to learn how to speak into our own culture in ways that they can understand. If we just say, ‘The Bible says not to kill,’ they don’t really care.”



THE HIPPOCRATIC OATH

I swear to fulfill, to the best of my ability and judgment, this covenant:...

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures which are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humility and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

One way is to point out the discrepancies in our society. Kenny and Cottle both mention capital punishment as an example. "We do not allow the death penalty in this country, and we're proud of this fact," says Kenny, a naturalized Canadian who came here from the United States, "partly because of the ethical underpinnings of the Canadian system."

Why then, if "we don't even allow killing of people who are hardened criminals," asks Kenny, would we want people to die because they experience emotional and psychological suffering?

"We have a very intricately balanced ecosystem of compassion and caring for one another," says Cottle. If a patient wants a physician-assisted death, that ecosystem is disrupted. A doctor has to make the death happen, "and we all have to participate in it — which is why we voted out capital punishment."

On a practical level, several things are being done to engage Canadian society in the battle against euthanasia. Larry Worthen of the Christian Medical and Dental Society is busy making presentations to educate medical students, doctors and churches, particularly in eastern Canada. Nuala Kenny continues to present her findings that most requests for physician-assisted deaths are due to psychological and emotional reasons rather than physical pain. Alongside the EFC's intervention in the appeal of the Carter case, the Euthanasia Prevention Coalition and the Christian Legal Fellowship are also set to intervene.

Dr. John Patrick, a retired Ottawa physician and educator, is calling for medical students and physicians to take the Hippocratic Oath seriously once again. Society is in danger of having physicians with no moral integrity, he says, and there needs to be provision for those who wish to follow the Hippocratic principles of doing no harm.

"Our society has lost its moral consensus and cannot therefore agree on the kind of medical care to provide, nor the ethical basis of medical care," he says. So Patrick set up www.hippocrat-

“Our society has lost its moral consensus and cannot therefore agree on the kind of medical care to provide, nor the ethical basis of medical care.”

–Dr. John Patrick, a retired Ottawa physician, educator and founder of www.hippocraticregistry.com

icregistry.com, and he encourages physicians to join. Further, he suggests forming groups of physicians and medical students who will take the Hippocratic Oath, a practice already followed by some medical practitioners.

But while the battle is being waged in the public sphere, there are still things Christians can do to ensure no one has to feel abandoned at death.

“The biggest thing we need to do in churches is get the theology of suffering figured out,” says Margaret Cottle. “We live in a fallen world. Suffering is something that is going to come to us.” Sometimes, she says, all we can do is to follow what Mary did at the foot of Jesus’ cross. “All she did was stand there and bear witness.”

“The Christian community has to realize that there’s an importance of being with the ‘other,’” adds Alex Schadenberg. Visiting those who are sick, especially if they are alone, is an important ministry. “If there are people who actually care about you, you are fairly more likely to say that my life does have value,” he notes.

The EFC’s discussion paper confirms that. “The will to live is inextricably linked with maintaining a sense of meaning and connection to one’s world,” it says.

However difficult it might be for Christian medical professionals as well as laypeople to navigate the dark waters of euthanasia and physician-assisted death, it is imperative they do, says Cottle. Otherwise, “As the culture gets darker, are we really shining more, or are we being swallowed up?” /FT

3

Reflection questions

1. "Contrary to popular assumptions, most dying patients do not experience intolerable pain," says Vancouver palliative care physician Dr. Margaret Cottle. For example, "ALS patients tend to die a more peaceful death. They don't suffocate, they don't choke to death." What terminal patients experience is fear..." This excerpt from Debra Fieguth's article speaks directly to some of the misconceptions around the issue of assisted suicide and our normal, human fears of suffering and dying. Are you surprised to read those words? Relieved? How can medical facts alleviate some of the fears we and our loved ones have?
2. Research shows, and this article confirms, that when the fears and psychological and spiritual needs of patients are met, the requests for euthanasia decrease significantly. What does that tell us about the true needs of patients, and our ability to meet them as individuals and as the Church?
3. What meaning and what ministry can we find in suffering?
4. "We need to speak into our own culture in ways that they can understand. If we just say, 'The Bible says not to kill,' they don't really care," says Dr. Cottle. How far apart do you think Christian beliefs are from the wider culture on this issue? What do you think underlies these perspectives? How can Christians speak about the end of life in a way that the culture can understand?
5. Why do Christians believe that our lives are not our own, that they belong to God?

4

Faith Today, January/February 2014

PROFILE

J.I. Packer on aging and weakness

*Do Christians have a different approach to weakness in a world that values independence and strength? Evangelical theologian J.I. Packer, author of the classic book *Knowing God* and professor at Regent College in Vancouver since 1979, draws wisdom on this issue from 2 Corinthians in his book *Weakness Is the Way* (Crossway, 2012). As he nears the end of his own life (he was born in 1926), he also explains how he has personally struggled with weakness in recent years*

BY J.I. PACKER

My own recognition that the Christian way of life and service is a walk of weakness, as human strength gives out and only divine strength can sustain and enable, may well be rooted in my youth.

A solitary and rather somber child, I had to wear at school, for ten years, a black aluminum patch covering a hole in my head, the result of a road accident, and hence I was unable to play outdoor games. During those years I felt out of most of what mattered, which is of course one form of the feeling of weakness.

This sense of things, sinful as it is in many ways, has hovered in the background throughout my life, and it has certainly been deepened over the past three years by the experience of a hip disintegrating (two years of hobbling and wobbling discomfort, leading to a year of steady but slow recovery from its surgical replacement).

I was told that since the surgery was invasive, its initial impact would be to shock the system – like being knocked down in the street by a truck – and full recovery for mind and body would take time, with creativity (in my case, power to write) at first noticeably in abeyance.

During these three years, my firsthand awareness of physical and cognitive weakness has grown, as has my acquaintance with Satan's skill in generating gloom and discouragement. My appreciation of 2 Corinthians has also grown, as I have brooded on the fact that Paul had been there before me.



Weakness and vocation

Weakness is a state of inadequacy, or insufficiency, in relation to some standard or ideal to which we desire to conform. It takes many forms. There is physical weakness, which keeps us from excelling in sports; there is weak health, which makes us vulnerable to all sorts of diseases; weak capacity limits us as employees, business people, and entrepreneurs; weakness of memory keeps us from becoming top-notch teachers or managers; weakness of character



J.I. Packer

unfits us to be leaders, parents, trainers, team captains, and perhaps team members too; and so on.

Subjectively, the sense of being weak, which the weak yet intelligent person can hardly avoid, generates feelings of inferiority – the Charlie Brown syndrome – and of uselessness and worthlessness, along with consequent gloom and depression – not at all happy feelings to live with. The sense of weakness casts a cloud over one's existence.

In this fallen world, where original sin in the form of pride, ambitious independence, and deep-level egocentricity has infected everyone, we all crave to be admired for strength in something, and the expectation that it is not going to happen makes one feel like a punctured balloon and plants bitterness in one's heart.

The gospel message, however, calls on us all to be realistic in facing and admitting our sinfulness, our weaknesses, our actual transgressions, and our consequent guilt before God; and then it addresses us, in God's name, substantially as follows:

Look to Christ as your loving Sin-Bearer and living Lord. Embrace him as your Saviour and Master. And then in his presence resolve to leave behind the old life of conscious self-service, marred as it was by bitterness, self-pity, envy of others, and feelings of failure, in order that you may become his faithful – that is, faith-full – disciple, living henceforth by his rules under his care.

Love Christ, in unending gratitude for his unending love to you. Labour to please him in everything you do. Let his love constrain, compel, command, comfort, and control you constantly, and, like Paul, stop regarding human approval as in any way important. (Earlier he wrote to the Corinthians, "With me it is a very small thing that I should be judged by you . . . It is the Lord who judges me," 1 Cor. 4:3–4). Live and love the way Paul did before you, and aspiring eagerness will replace gloom and apathy in your heart.

Lean on Christ and rely on him to supply through the Holy Spirit all the strength you need for his service, no matter how weak unhappy circumstances and unfriendly people may be making you feel at present. As part of his response to being berated as "weak" by the Corinthians and their "superapostles," Paul reveals that Christ has set him to live with an unhealed "thorn" (pain, disability) in his body and has told him, "My grace is sufficient for you, for my power is made perfect in weakness" (2 Cor. 12:7–9).

We need thus to take to heart his triumphant concluding comment on this aspect of his life situation: "Therefore I will boast all the more gladly of my weaknesses, so that the power of Christ may rest upon me. For the sake of Christ, then, I am content with weaknesses, insults, hardships, persecutions, and calamities. For when I am weak, then I am strong" (vv. 9–10).

So lean on Christ, the lover of your soul, as Paul did, and in all your ongoing weakness, real as it is, you too will be empowered to cope and will be established in comfort and joy.

We should recognize that the fierce and somewhat disabling pain with which Christ in due course required Paul to live, and which Paul clearly accepted as a weakness that would be with him to his

When the world tells us, as it does, that everyone has a right to a life that is easy, comfortable, and relatively pain-free, a life that enables us to discover, display, and deploy all the strengths that are latent within us, the world twists the truth right out of shape.

dying day, had in view less the enriching of his ministry than the furthering of his sanctification.

The clues are there: Paul refers to increase of humility in face of privileged revelations (12:7), deepened dependence on Christ in face of Satanic discouragements and distractions (vv. 7–9), and a robust readiness to welcome whatever other forms of suffering might come his way in the future (v. 10). He demonstrates a sustained recognition that feeling weak in oneself is par for the course in the Christian life and therefore something one may properly boast about and be content with (vv. 6, 9–10).

In this, Paul models the discipleship, spiritual maturity, and growth in grace that all believers are called to pursue. When the world tells us, as it does, that everyone has a right to a life that is easy, comfortable, and relatively pain-free, a life that enables us to discover, display, and deploy all the strengths that are latent within us, the world twists the truth right out of shape.

That was not the quality of life to which Christ's calling led him, nor was it Paul's calling, nor is it what we are called to in the twenty-first century. For all Christians, the likelihood is rather that as our discipleship continues, God will make us increasingly weakness-conscious and pain-aware, so that we may learn with Paul that when we are conscious of being weak, then – and only then – may we become truly strong in the Lord. And should we want it any other way? What do you think?

Christ and the Christian's hoping

The Bible speaks directly to our weakness, setting before those who are Christ's a destiny that reaches beyond this world to a kaleidoscope of wonders, enrichments, and delights to which it gives the generic name "glory." This destiny is big and exciting, and the New

...contemplating that glory will brace minds and hearts to resist the weakening effect, the down-drag into apathy and despair, that pain, hostility, discouragement, isolation, contempt, and being misunderstood – and all the rest of the suffering – might naturally have on us otherwise.

Testament writers show that they felt it to be so.

As having something big and exciting to look forward to – a major family holiday, say – will keep children alert and on tiptoe for quite some time before it happens, so the big and exciting future for Christ's faithful disciples that Paul looked forward to undoubtedly kept him at full apostolic stretch through all the adverse experiences to which he alludes in 2 Corinthians.

Indeed the New Testament writers as a body, with the Lord Jesus himself, clearly expect this promised destiny to bring excitement and awe and amazement and joy into the hearts of all Christian people.

2 Corinthians is a good example. For all that Paul is writing out of a situation of weakness and, without doubt, a sense of weakness more intense than we meet in any other of his letters, he is not lapsing into self-pity or voicing gloom and doom, but he is expressing his sense of ongoing triumph in Christ in face of all obstacles. And he is declaring his sure and certain hope of glory when his course through this world reaches its end.

It is this hope for his personal future – a hope which, to echo Bunyan's Mr. Stand-fast, lies as a glowing coal at his heart – that determines his attitude toward all the pressures of the present.

Supernaturalized living

We are on our way home, and home will be glorious. And contemplating that glory, however inadequately we do it, will brace minds and hearts to resist the weakening effect, the down-drag into apathy and despair, that pain, hostility, discouragement, isolation, contempt, and being misunderstood – and all the rest of the suffering – might naturally have on us otherwise.

Ministers of Christ will keep on keeping on, no matter what. The watching world may well wonder where they find the energy to do so, but the puzzlement of outsiders is no concern of theirs. What animates and propels them is the power of their hope as they “look not to the things that are seen but to the things that are unseen. For the things that are seen are transient, but the things that are unseen are eternal” (4:18).

This is how, by grace, the God of grace supernaturalizes the natural, bodily, mortal life of all who through faith are in Christ, united to him by the Holy Spirit for endless power and joy. God-taught hoping leads to God-given strengthening. When, humanly, we are weak, then in the Lord we are strong. So it was for the apostles and their colleagues two millennia ago, and so it can and should be today for you and me.

What is it, then, that we have to look forward to? Second Corinthians 5:1–8 sets before us in picture language that aspect of our hope which will counter, cancel, and consign to far-off memory “this light momentary affliction” – bad health, crippled limbs, bodily pains; minds, memories, relationships, personal circumstances all going downhill; insults, cruelties, and whatever else.

This hope fills us with wondering joy that everything can be so good. We shall be given a new dwelling place, says Paul, new clothes, and a new home life in the company of our Lord. It sounds marvelous, and so indeed it is.

None of us knows as yet what it will be like, experientially, to leave this world. But one day we shall all have to do that, and it is wonderful to know that somewhere in the process of transition out of the body into the next world, Christ himself will meet us, so that we may expect his face to be the first thing we become aware of in that new order of life into which we will have moved.

Looking forward to this is the hope that will sustain us, as evidently it sustained Paul, while we grow older and our weaknesses, limitations, and thorns in the flesh increase. “So we are always of good courage” (2 Cor. 5:6). May it ever be so. /FT

This essay adapted from *Weakness Is the Way* by J.I. Packer, ©2013. Used by permission of Crossway, a publishing ministry of Good News Publishers (www.crossway.org).

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Reflection questions

1. This article by J.I. Packer does not directly relate to palliative care, but it contains important insights on how Christians view suffering and weakness. “We are on our way home, and home will be glorious,” writes Packer. “And contemplating that glory, however inadequately we do it, will brace minds and hearts to resist the weakening effect, the down-drag into apathy and despair, that pain, hostility, discouragement, isolation, contempt, and being misunderstood – and all the rest of the suffering – might naturally have on us otherwise.” Do you agree with Packer that “contemplating that glory” can help brace the Christian to live through suffering and times of weakness that could lead to despair? Is the hope of a glorious future a significant part of your faith or church life? Do you think it should have a greater emphasis? Why or why not? If so, what might that look like?
2. Packer also writes: “None of us knows as yet what it will be like, experientially, to leave this world. But one day we shall all have to do that, and it is wonderful to know that somewhere in the process of transition out of the body into the next world, Christ himself will meet us, so that we may expect his face to be the first thing we become aware of in that new order of life into which we will have moved.” What a beautiful vision of dying and death. How can Packer’s reminder of what lies in store give us strength to endure suffering and death? How can it renew our strength to minister to our loved ones as they go before us? Why do we not end our lives to get there sooner?
3. Packer describes how to find meaning in the face of weakness and diminished capacity. How is this different from our culture’s perspective? Is there a way to communicate this meaning to our culture in terms people will understand?
4. Reflect on 2 Corinthians 12:7-10. Packer encourages us to lean on Christ in our difficult circumstances. How do we lean on Christ in day-to-day life?

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Faith Today, September/October 2012

HOW TO

I was sick and you visited me

We may worry visiting sick or dying people will feel awkward, especially if they aren't friends or family. But visiting can make a profound difference

BY KATHY BETHUNE MUNROE

I remember the first time I visited someone who was sick. I was a teenager at the time, and a girl in my class had ended up in hospital after an unintentional overdose. Although I hardly knew her and was desperately shy at the time, I decided to go visit her.

I didn't do things very well. I remember sitting by her bed like the proverbial bump on the log, not really saying much at all and then, when other visitors arrived, quietly leaving.

The familiar words "I was sick and you visited me" come from Matthew 25, where God judges the "sheep" and the "goats," and says the sheep are "blessed" because they fed and clothed the hungry, thirsty and poor, were hospitable to strangers, and visited prisoners and sick people. Even as a teenager it seemed to me if visiting was important enough to be included on this list of charitable works, then clearly it should be important to us too.

Why visit the sick?

Frequent hospital visitors report many patients, particularly the elderly, often feel lonely and left out. Earl Levasseur of the Brantford Worship Centre has done a lot of visiting in nursing homes and retirement centres. He observes that often "the residents do not have many visitors."

Yes, there are "professional visitors" such as chaplains and senior pastors and elders, but an amazing number of family, friends, lay visitors, and volunteers are also active visiting needy people across the country. Yet even more are needed.

Some people who make regular visits are initially inspired by personal experience. Rod Martens of Calgary, a volunteer visitor for Centre Street Church, was a hospital in-patient some years ago, saw the need for visitors and sought to fill it. Other frequent visitors

“I listen while I’m talking to somebody to see if there isn’t something that’s moving out towards God in what they’re saying.”

–Rev. John Vlainic, chaplain at Hamilton General Hospital, Hamilton, Ont.

may have had a loved one die in palliative care or a hospice and want to “pay back.”

Once you’ve seen how much visits can mean to patients, it’s hard to forget.

What would I do?

Many people avoid visits because of potential awkwardness. They may worry they wouldn’t know what to do or say, and are afraid they might say something upsetting or make the patient feel worse.

Levasseur says, “If only they would realize all that is really needed is their presence.”

Visitors who want to make a visit special might bring a few flowers from their garden or, if the patient is willing, offer to read the Bible or another book aloud. But normally visitors don’t need to do much, particularly if the patient is very ill.

What qualities should I have?

The most helpful visitors have “a calm compassion and a listening ear,” says Colleen Clancy, development and communications manager for the Salvation Army’s Agape Hospice in Calgary.

Listening to a patient is very important, agrees Marji Krahn, former palliative care chaplain at Intercare’s Southwood Care Centre, also in Calgary. She says visitors should go without having any agenda but to follow the patient’s cues.

With someone who is dying, such cues may be as simple as the patient’s eyes turning away.

“You have to be so sensitive to them. They sometimes hardly have the strength to speak,” says Krahn.

Many Christian churches and ministries can offer training in visitation. Even those of us who begin regular visits without training learn all sorts of things about themselves. Most eventually learn how to make visits more effective.

Anyone can learn through training and practice.

What should I say?

Seeing a visitor arrive with a big black Bible can intimidate some patients. Marji Krahn says there are “other ways to be Christ to people.” Going in as an encourager is one such way. People who have been in hospital for a long time sometimes begin to wonder if anybody cares anymore.

Henry Thiessen of Ontario attends Guelph Bible Church and often visits sick and dying people. His main goal is to encourage those he visits. Just talking with them, he says, is enough to let them know they’re not forgotten.

Whether a visitor should talk about the illness or only about spiritual matters will depend on the patient. Again, cues should come from the patient.

Earl Levasseur freely admits, “There have been times when I had no idea what to say, so I would ask how they were doing and let the visit go from there.”

And he adds, “Don’t be afraid to ask a person if you can pray for them” – not right away, but near the end or middle of the visit. Almost no patients refuse prayer from a visitor who has already spoken to them for a while and found out how they are doing.

Rev. John Vlainic is a chaplain in Ontario at Hamilton General Hospital. “I listen while I’m talking to somebody to see if there isn’t something that’s moving out towards God in what they’re saying.”

So, if he hears thankfulness in a patient – the patient may or may not have mentioned God – Vlainic responds, “Would you like me to offer a prayer of thanks?”

Or sometimes he hears the beginnings of a cry for help when a patient shares bad news. Then he says something like, “Would you want me to pray for you about that?”

“If we listen well, we will often hear that they’re already on the road to prayer. Our role may then be to help them express it more fully – if they let me pray with them.”



TIPS FOR VISITING HOSPITAL PATIENTS

BY JOHN VLAINIC

1. Whenever possible, pull a chair alongside the bed and sit down. This allows eye-level contact, and gives the message you have come to be with them and have time for them.
2. Be sure you are not sitting with a window behind you or the glare of the light can make it hard for the patient to see you.
3. Let the patient share their understanding of their illness and do not ask probing questions about their diagnosis.
4. Be sensitive to the needs of the patient and adjust the length of your visit accordingly. For example, a shorter visit might be best with a post-operative patient.
5. If you pray with the patient, stay for a while afterward to address any personal concerns which may have arisen in the patient’s thoughts through prayer, or any emotions that may have surfaced.

It's often best for the visitor to say, "Can I pray?" instead of "Can we pray?" because the patient may feel too weak to contribute or unsure about their own relationship with God.

Will my visit make a difference?

As well as visiting for Centre Street Church, Rod Martens visits at a long-term care facility close to where he lives in Calgary. He says the patients are very receptive and appreciative of the visits. He also finds satisfaction that God uses him in this way.

Earl Levasseur remembers making a difference with one particular dying man. "The family requested that I not say anything about death, as they did not want to frighten dad. As I was walking down the hall to his room I could hear this man gasping for air. I spoke with the family and told them what I was going to do. I read Scriptures, then prayed for their dad."

Reading Scripture is often a surprisingly profound blessing – it is really letting the Holy Spirit move through the words.

"As I was praying I said that Jesus was waiting for him, saying, 'Come home, my son.' By the time I finished praying for him, his breathing had settled down to the point where we had to really look to see if he was still breathing. About 10 minutes later, he went home to be with the Lord."

Clearly, Christians who avoid visiting are missing out. Drawing on the wisdom of others – and of course praying to ask for God's help – can help us past the obstacles that hold us back. When I was a teen wanting to visit my classmate all those years ago, I wish I had asked some others about visiting. Even though I would still have had a lack of confidence, the visit would have gone better.

Learning how to visit the sick and be as helpful as possible can make us, whatever age we are, a blessing to those who need it most. /FT

Reading Scripture is often a surprisingly profound blessing – it is really letting the Holy Spirit move through the words.

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Reflection questions

1. Writer Kathy Bethune Munroe says, “Even as a teenager, it seemed to me if visiting was important enough to be included on this list of charitable works [in Matthew 25], then clearly it should be important to us, too.” Read Matthew 25:31-46. Where do you find yourself in this parable? How is God speaking to you through this parable?
2. This article has a different feel than the others, because it is a practical guide to how we as individuals can make a practical and profound difference in the lives of those who are ill or lonely in the hospital. Why do you think people don’t visit? Is this a practice you or your church could embrace? How does this kind of visiting fit within a Christian calling? How could you add this practical outworking of Christ’s love into your life?
3. Is there a time you have visited someone or been visited and felt God at work? Does God work through our actions even when we don’t feel it at the time?
4. As we advocate on the national level for excellent nation-wide palliative care, what role do you see for the practices explained in this article?

NEXT STEPS

A call to care

As Christians we believe all humans are created in the image of God and have inherent worth and dignity, regardless of their abilities or capacities. Life is a gift from God. We are stewards of all that God has given us. This compels us to promote and protect human life throughout all its stages.

Now more than ever, we need to live in ways that affirm the value of life. In our daily routines, in our interactions with others, in how we treat both friends and strangers; we are called to celebrate life and to affirm the dignity and the inestimable worth of everyone. And during those seasons of life when we or those we know are facing death, we respond with compassion.

Those who suffer need care and companionship. They need to know they are loved and their lives have meaning.

Visiting the sick and caring for the dying are hallmarks of Christianity. They are expressions of our love for God and our neighbour, and manifestations of our theology and worldview, which have marked Christian practice since the time of Jesus.

Care for the dying involves more than what the healthcare system can provide. Care is fully expressed when communities embrace those who are sick and dying, manifesting the love of God to them and their loved ones in practical ways. We need also be mindful to care for the caregivers.

As our legislators, medical practitioners and health care providers consider whether they should at times hasten death, now is the time for those who reject assisted suicide to stand up and be counted. Neither governments nor citizens nor the Church should pause in the whole care of the whole person as they walk through the valley of the shadow of death.

Regardless of what is decided by courts and legislatures in Canada, people need our care and tangible expressions of love. Let us be known as Christians by our love, especially extended to people at the end of life. Let us encourage, comfort and support those who suffer.

Find the places in your community where you are needed to support people at the end of life. As you make yourself available to be the hands and feet of Jesus, you will discover his purpose and blessing. /FT

—BRUCE J. CLEMENGER, PRESIDENT OF THE EVANGELICAL FELLOWSHIP OF CANADA

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