Physical and Spiritual Care of the Terminally Ill

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In the nine years that I have been a Christian, I have come to believe that the validity of my thoughts, actions and words are directly related to their consistency with God's revealed character. That is, they become pleasing and honoring to Him as they coincide with His character. As these things deviate from His character, they deviate into sin.

As an oncologist, I treat cancer patients with powerful medication. Obviously, these people are sick. Many are sick unto death. What we as physicians and others involved with these patients must do first is to decide if this involvement is a valid interaction. More clearly stated for us as Christians:

"Does our interaction with and care of sick and dying patients honor and please God?"

That seems overly simplistic, but everything that follows depends upon our answer. History is somewhat ambiguous.

On the one hand, cults and others have said that the sick have brought their problems upon themselves because of their sin. They should be left to fend for themselves. On the other hand, some have believed that sickness has no correlation with sin. Therefore, all illnesses are acceptable on the same basis and there is no need to bring spiritual matters into their care. You will recognize these positions as extreme, but we still must find the validity of care for these patients in God's revealed character.

Any such validity will be demonstrated by Him in both commands and examples:

"Does God interact with people who are physically sick and dying? Does this interaction please Him?"

The answer is clearly, "Yes!" As we turn to Scripture, we find both Old and New Testament examples. In these we will find that God participates through an intermediary with both believers and unbelievers. Therefore, the position that we should minister either physically or spiritually to believers only and not to those who are dying outside of Christ is false. I have chosen a few examples, but Scripture is replete with others.

Numbers 21 describes the situation in which thousands were being bitten by snakes, but salvation (healing) was provided through the intermediary, Moses, who lifted up the bronze serpent. All those who looked upon it were saved.

In I Kings 17, Elijah is used by God to resurrect a young man who has died.

In II Kings 4, Elisha does a similar work.

In Mark 5, Jesus heals the mad man of the Gadarenes.

Matthew 9 provides the resurrection of Jairus' daughter.

Luke 17 describes the ten lepers who came to Jesus.

As we review these examples, the validity of our interaction with the sick and dying becomes clear. Once that standard is known, we must determine the valid characteristics of that interaction that are unchanging. We recognize four.

First, these interactions are personal. Because this aspect is un changing, however, we must not become fuzzy in our thinking and conclude that its manifestations do not change. For example, I love my eightyear-old son, but during a period of corporal discipline he certainly does not believe that I love him! My love has not changed, but my manifestation of it has. Thus, God's interaction with the sick and dying is relative and relevant for each circumstance. Sometimes an intermediary is used and other times direct communication is used. The message for us is that our being there is always valid. How we do things in a given situation, however, will vary. The need for our presence never changes. We have been summoned there.

Second, these interactions always involve communication with two parts: command and comfort. As a physician, I can demonstrate with the doctor-patient relationship. When I discuss with patients about their problems and what we might do, I am giving comfort by giving command. For example, if a patient's mouth is sore because of thrush (an overgrowth of fungus) as a side-effect of my treatment, my command is to use a particular medication and they will receive comfort. (The intended result is both from my command that it is so, as well as the effect of the treatment.) This double effect is always present. When Moses lifted up the bronze serpent, the command was to look on it in order to be healed. Some refused his command and they died. If the 6 o'clock news had been there, Moses would have been interviewed as the healer. Admittedly, his therapy was a little bizarre, but it worked! The news people and their audience would only see Moses, not his God who made the healing possible.

Thus, Moses provided both command and comfort. With command only, one becomes a totalitarian physician. Let me illustrate.

> "You will take this treatment that I have prescribed."
>
> "But, doc, what about these other things that are needed."
>
> -or
>
> "Doctor, mom looks worse."
>
> "Well, she's not."

In these examples, command has been provided without comfort. Instead, we might have:

> "Doctor, these things doing don't seem to be working very well."
>
> "I know, I know. I just don't know what we are going to do."

In this situation, I have responded at a purely emotional level. I have attempted to give comfort without command.

Before we move to the next characteristic, we must realize that our command is not our own. Our authority comes from God and His Word or it is only a human-human interaction. This fact underscores the necessity that we understand the ways that God has interacted with people.

Third, these interactions must always include contact with at least one of our human senses. With the serpent, the contact was visual. With the lepers, it was touch. With Elijah, contact was quite close: mouth to mouth, hand to hand and foot to foot. The interaction loses much validity when physical contact is not present. It is extremely important to the sick and dying. For them, there is a sense of being extracted and set apart. Life goes by without them. God always had a visual or tactile interaction directly or through an intermediary.

Finally, such interaction always has two levels: the physical and the spiritual. A cure at the former level is not always possible, but the latter offers a complete cure. This offer was not always taken. Of all those who were cured by Moses' snake, only two went into the Promised Land. Of the ten lepers, only one came back to Jesus.

I have gone over these characteristics in some detail because your interaction as you walk into a patient's

room, either in the hospital or at home, must have these four characteristics to reflect God's image in yourself. As He interacts through you, His character is honored and displayed.

Further, these characteristics were displayed over time. His interaction was not a split-second response. It was always as the presence of an instrument that God chose to use in service to others and the manifestation of His glory. Even Jesus said that He came to serve and be served for His Father's glory. Moses on the 6 o'clock news would have said that his act was both to help others and to reveal God's glory. In whatever setting that we find ourselves, we should attempt to have attitudes that lead to those actions. Neither the honor of the medical profession nor the experimental protocol should be paramount in our attitudes and actions. We are present as a physician or simply as a friend to serve others for the glory of God. In this manner, we honor or dishonor God Himself. We do it even in extremely difficult circumstances.

As a student, intern or resident who has little control over the manner in which rounds are conducted, you do have control over what your face displays (avoiding those smirks that communicate that you belong to the "all-knowing" group), what words come out and whether you go back to visit with the patient later. Too often, as a physician, you become what you have been in your training. I know from personal experience. The undoing of such training is difficult.

To re-iterate, it is the presence of these characteristics in our interaction that is absolute, not their manifestations. We are summoned to communicate in a certain manner, to act a certain way, to have a certain attitude and to touch in certain ways.

Touching does something for me and for patients. It makes contact. It says that I still consider them to be alive. We intrinsically have an aversion to touch things that are dead. If I walk into a room and avoid physical contact, the patient and any others in that room are cut off from me. Contact can be easily made if I simply sit down and hold someone's hand. Is that so complicated or difficult?

Let's admit our discomfort. I get nervous in almost every patient's room. Even with people I know. I do not know what my interaction will bring. I may say things that I will have to go back and retract or soothe later. This discomfort, however, does not allow us to avoid the contact to which God summons us.

We are summoned for verbal communication. Again, the manifestations are not absolute. Sometimes, silence is the best approach. Sometimes, Scripture is the best communication, even with non-believers, because it is quite familiar to many of them. For believers, Scripture communicates at deep levels of comfort. Sometimes, you may want to write. Leave notes. Send cards. Write letters. Send word through other people when you are not able to go yourself. All these modes are important and communicate in a different way.

God's Word is extremely important. While I have not worked out all the details, sometimes it is appropriate to sit down and go over the Gospel in some detail right from the beginning. You may sense God's leading to do so. Sometimes, the Gospel should be presented later. I do not present the Gospel to everyone, but it should be presented to every patient by someone. No one should die without hearing it. No one!

Scripture can also be used to give comfort or to bring conviction. People who are dying are no different in their spiritual needs than the rest of us. They need to remedy some things, but they just have less time to do so. Conviction, however, is necessary for real life-changes to take place. Only in this way will patients and their family members be released from the hurts and guilts that have accumulated over the years. It is a tragedy for death to occur and reconciliation not have taken place.

You have to be direct with people who are dying. They know that they are dying. A significant difference between cancer patients and someone run over by a truck is that the former have time to think about their death. My patients think about many things. Often, they are quite willing to talk about these things and want to do so. They may have some reluctance because they are not accustomed to such communication, but they are facing things that those of us who are well put in a

closet. Believers and nonbelievers alike are willing to talk about them. You will generally find receptivity with these patients that you do not find elsewhere. You can be direct and you can be open. Being sensitive to what God would have you talk about is important.

At whatever level the patient responds, you must give comfort. A Christian lying in bed scared stiff, doesn't need the Gospel presented in the sense of his or her own sin. He needs the Gospel presented in the sense of ultimate comfort. A recent 82-year-old patient of mine, however, was secure that his way to heaven was prepared by his Sunday School teaching for 60 years. He was surprised to find that eternal life was a gift. His teaching did not stack up to Christ's work on the cross. This understanding provided the comfort that he needed. Thus, different patients have different spiritual needs and these are not met at once but over a period of time.

The sick and dying are all around us. If during the last year you have not been one of these or someone close to you has not been, then you are rather unusual. These problems will continue to be with us. But now you know what God summons you to, including the characteristics of that summons and the interaction involved. It has both a physical level as well as a spiritual level.

For the moment, let me turn my attention to those physicians in training. During this time something happens to us that we have to get beyond. I realize that these words may hurt, but I offer them without apology. I speak now as a physician and not as an oncologist. In medicine we have something called a cure. We also have some things called comfort and compassion.

Sometimes, they overlap. Sometimes, they do not. We are called to the one and not to the other. One is a summons from God, the other is His alone.

Eighty to one-hundred years ago, a surgeon named Halsted started a different way of thinking. He developed a procedure, the radical mastectomy, for breast cancer. His idea was that physicians could cure people in this way. It took until 1957 for physicians to realize that his premise was false. By then, however, as a friend recently reminded me, the phrase, "A chance to cut is a chance to cure," had become ingrained. It spilled from the surgical side of medicine in the 1940s and gained added momentum from the medical side with the advent of antibiotics. We saw pneumococcal pneumonia, previously almost a certain killer, go away. Until then, we sat at the bedside to see what God would do. Now, we did! We cured. Or so we thought.

This pneumonia was the first "biggie." And it felt good! Now, we cure all kinds of things: Hodgkin's disease, leukemias, TB and most life-threatening infections. We do so to the exclusion of our original summons to comfort.

If you think that I carry my thinking too far, I bring up two recent developments. First, an article appeared in the New England Journal of Medicine.1 It created a furor in the National Cancer Institute. It reported that since the war on cancer was signed and activated by Nixon in the 1960s, the cure rates for the major life-threatening cancers remains unchanged. As an oncologist, I am here to tell you that that report is true with lung, breast and colon cancer. Now, was cure what we were supposed to be doing? I don't think so.

Second, you make your mark in specialty training as you cure people. It has to do with batting averages and how many people you get out the door alive and cured. I had to face this reality early in my training because cure did not happen that often. If cure is my goal, then that is what I strive for. If that's how I see my business as a physician, whether as an oncologist, an infectious disease consultant or a surgeon, then I have missed the boat entirely.

Cure has always been God's prerogative. If you disagree, answer these questions for me. Why do some patients who get penicillin for pneumococcal pneumonia die anyway? Why do 1-2 percent of patients with stage I-A Hodgkin's disease die, when all the others are cured? I become guilt-ridden if cure is my job. As physicians, we become crippled if we see ourselves in that way. Interaction with patients and their families becomes a mess because you were supposed to cure. Further, all communication is limited to the aspect of cure.

Let me qualify to some extent what I have said. Sometimes cure is the manner in which comfort and compassion are administered, as is usual when we treat Hodgkin's disease and pneumococcal pneumonia. God was pleased to allow us to develop penicillin in the 1940s, but He must also be pleased to cure when it is administered. The same is true for Hodgkin's disease, leukemias, testicular cancer and some forms of lung cancer (to name only a few). God is pleased to cure sometimes. That's not my job. My job is to give comfort.

To those of you in training, I recommend that you begin to think about this situation. To those of you who will get disease or have it affect someone close to you, I recommend that you also begin to think about it. What are you asking of your physician? Are you asking him or her to play God by your expectation of a cure? Or, are you asking for compassion and comfort? The former is God's prerogative alone. The latter is the right thing to ask of your physician. It is what God summons physicians to give.

Thus, the communication that occurs in the setting of sick patients is entirely different. I am there to give comfort and compassion. We are both there to see what God will do. The experience is mutual rather than one acting while others watch to see what will happen. Together we can experience God's work in our lives through a difficult situation or we can watch an engineer work on a piece of machinery. Slowly, medicine is headed in the latter direction. It is time that we put a stop to it. We must leave the idea that cure is our prerogative and return to comfort as our summons. Cure is not and never was ours to give.

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References:

1 Bailar, John C. and Elaine M. Smith. "Progress Against Cancer?" The New England Journal of Medicine 314 (May 8): 1226-1232, 1986.