END OF LIFE COMFORT MEASURES: A Realistic Assessment

The Dark Side of Medical Technology

In the right circumstances, modern critical care saves lives. The moments when I have lifted my most raw and heartfelt praise to the Lord have occurred within the walls of the intensive care unit, when I have witnessed his grace and mercy made manifest in the recovery of a child battling a widespread infection, a man fighting for his life after a motorcycle crash, or a woman whose heart strains in the throes of a heart attack.

Yet medical technology harbors a dark side. When an illness cannot be cured, aggressive interventions prolong dying, incur suffering, and rob us of our ability to speak with loved ones and with God in our final days. Ventilators steal both voice and consciousness. Resuscitation looks a lot like assault. In the ICU we often awake in panic and find ourselves physically strapped to a foreign bed, deprived of the familiarity and comfort of home. We clamber for air, only to find we have no freedom and no voice.

When our critically ill loved ones cannot speak to us, we wrestle with impossible decisions of whether to press on or to withhold treatment, all while we yearn to hear a beloved voice again. Such dilemmas thrust us into grief, doubt, fear, anger, and even guilt as we struggle to reconcile a web of hospital instruments with a mother's voice, a father's laughter, or a child's smile.

While we wrestle, concerns about faith also haunt us. *What is God's will? we ask. Why is God allowing my loved one to suffer? What does the Bible allow in this scenario?* Such questions tap into our deepest anguish, a pain that echoes from our origins as image bearers torn from God. Death is the wages of our fallenness, and the final enemy (Rom. 6:23; 1 Cor. 15:26). Even Christ wept in the face of death (John 11:35).

Death Is Not the End

Yet as Christians, we cling to the hope that *death is not the end*. Our faith in Christ assures us of a restoration of our bodies and a new order where no sickness, infirmity, or death blots the glory of God's creation (Rev. 21:4). Silhouetted against this promise, our frantic strivings with contraptions that rob us of moments with those we love seem all the more futile, a chasing after the wind (Eccles. 2:11). While the Bible guides us to protect life (Exo. 20:13), it does *not* require us to endure aggressive interventions that inflict suffering but offer minimal hope for recovery.

Comfort Measures Is Not Withdrawal of Care

While we all yearn for the home that has shaped our memories, when critically ill we are often too sick to survive an ambulance ride home from the hospital.[1] As a result, even when treatment is futile and we discontinue aggressive interventions, many of us remain in the ICU until death.[2]To guide us through these moments, ICU physicians shift their focus from cure to comfort. In "comfort measures only" (CMO), physicians discontinue interventions that induce pain and agitation and in their place provide treatments to control symptoms. Continuous infusions of narcotics to treat pain and alleviate shortness of breath are a mainstay, as are intermittent medications to relieve anxiety.

As severe illness incapacitates our loved ones, the responsibility for decisions about comfort measures often falls on our shoulders. This burden can seem unbearable. The inappropriate but often-used term "withdrawal of care" conveys a sense of abandonment that repulses us. We worry that once organ-supporting technologies are discontinued, medical staff will lose interest in our loved ones, deserting them in their hour of most dire vulnerability.

In our consternation we may further confuse comfort measures with euthanasia or physician-assisted suicide, both unbiblical interventions that intentionally speed death. However, a critical distinction between euthanasia and comfort measures is the *intent.* Euthanasia intends to end life, usually through lethal injection. **Comfort measures**, in contrast, **seek to *discontinue interventions***

that prolong suffering without benefit. When a medical team approaches comfort measures properly, *care always continues.* Intensive, compassionate, and personalized medical attention never stops; its focus only shifts away from aggressive and futile technology and toward peacefulness as death nears.

What to Expect in the ICU

We need to remember that intensive-care technology, although it can preserve life in the right circumstances, can rob us of speech and mental clarity at the end of life. When patients transition to comfort measures in the ICU, they rarely have opportunities to communicate. Final conversations with loved ones or time spent in prayer to reconcile ourselves to God seldom occur. This lack of closure can strip all involved of their resolve and hope. It can steal from us the opportunity to examine the trajectory of our lives, settle unfinished issues, heal fractured relationships, and set our eyes upon the new heavens and the new earth (Isa. 65:17; 2 Pet. 3:13).

In comfort measures, nurses stop all blood draws and other maneuvers that cause pain. Pressors and other cardiovascular medications are discontinued, as is dialysis. For those of us on minimal ventilator support, the endotracheal tube is often removed to maximize comfort and permit communication. When we require high levels of ventilator support, however, approaches vary. Death can occur rapidly after tube removal if we depend upon the ventilator for survival, and in some cases continuing the ventilator but reducing its settings to improve comfort may avoid traumatic air hunger at the end of life. In other cases, physicians prescribe sufficient doses of medications to alleviate distress after tube removal, enabling discontinuation of the ventilator even in severe respiratory failure.

Oftentimes ICU staff lift certain visiting restrictions for those receiving comfort measures, allowing family members to remain in the room for as long as they choose. Nurses turn off all monitors and alarms in the room, although such screens continue to project at the nursing stations so that clinicians may respond to any changes indicative of pain, fear, or agitation.

Key symptoms that surface as death nears are pain, anxiety, and shortness of breath. Difficulty breathing occurs as levels of acid rise in the bloodstream, compelling us to breathe faster to clear carbon dioxide and restore a normal acid-base balance. To guard against such distress, physicians often prescribe a morphine infusion. Morphine not only treats pain but also slows breathing and relieves the sensation of breathlessness. Nurses carefully monitor not only any signs of pain but also quickened breathing and will fine-tune the infusion accordingly.

In the ICU, people near death often suffer from delirium and somnolence, and families may fear that narcotic infusions will lethally sedate their loved ones. Although morphine does sedate, rarely does an infusion quicken death.[3] Unlike cases of physician-assisted suicide, in comfort measures the aim of narcotics is to *palliate symptoms, not to speed demise*.

In the final hours and minutes before the end, patients adopt unusual breathing patterns that can unsettle us. They lapse into cycles of deep, sometimes rapid breathing followed by a period of shallow breaths, and then up to two minutes without taking a breath. Patients may gasp as these cycles recur, and secretions in the upper airway can create an alarming rattling sound.

Reading about such symptoms is disturbing, but it might be comforting to know that they occur when death draws very close **and the patient is already unconscious. While to onlookers we may appear to gasp for air, in fact, we are drawing close to our Savior.**

Out of the Depths I Cry to You

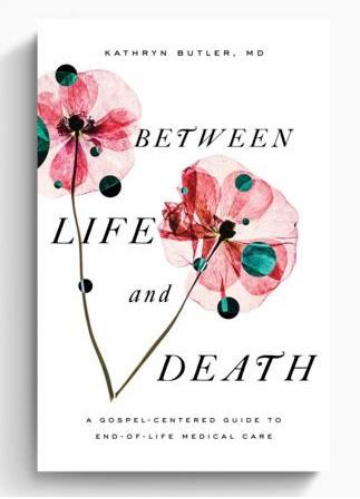
As our bodies fail, we need to lean ever more fervently upon God—our rock, our salvation, the edifice upon which we rest our hopes (Ps. 18:2). Lord willing, we recognize our own mortality before it seizes us and enjoy days still rich with God's workmanship, seek him prayerfully, and continue to serve him with our remaining breath (Phil. 1:22–26). Open and frequent dialogue with clergy and with primary doctors about our goals can aid us in **living well while we can** and in seeking hospice if eligible.

For those of us who spend our last days surrounded by the unfamiliar, and for the loved ones whom we leave behind**, hope in Christ Jesus is all the more precious. However terrible the toils of this world, and however gravely death's shadow unsettles us, the Lord remains steadfast in his love for us** (Ps. 136:1). While our time in this world crumbles away, **we rest assured of the promise of a new heavens and a new earth, when the calamity of disease no longer reigns (Rev. 21:4). Death does not signal the end. Not even its sting can separate us from the love of God through Christ (Rom. 8:38–39).**

Notes:

1. Liz Hamel, Bryan Wu, and Mollyann Brodie, "Views and Experiences with End-of-Life Medical Care in the U.S.," The Henry J. Kaiser Family Foundation (April 2017), accessed January 4, 2018, http://files.kff.org/attachment/Report-Views-and-Experiences-with-End-of-Life-Medical-Care-in-the-US.
2. Paula Lusardi, Paul Jodka, et al., "The Going Home Initiative: Getting Critical Care Patients Home with Hospice," Critical Care Nurse 31, no. 5 (2011): 46.
3. Craig D. Blinderman and J. Andrew Billings, "Comfort Care for Patients Dying in the Hospital," *New England Journal of Medicine* 373, no. 26 (2015): 2549–61.

This article is adapted from Between Life and Death: A Gospel-Centered Guide to End-of-Life Medical Care *by Kathryn Butler, MD.*



https://www.crossway.org/articles/end-of-life-comfort-measures-a-realistic-assessment/

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