

***Faith, dignity, and integrity:  
Conversations about end-of-life issues***

*A resource for parish study  
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*Participants edition*

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developed by the School of Ministry*

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## ***Faith, dignity, and integrity: Conversations about end-of-life issues***

The intent of this study is to encourage reflection about our faith as it pertains to the end of life on earth; and within that framework of faith, to reflect upon medical and legal realities as they may influence our own wishes when faced with end-of-life decisions. An outcome of this study may be to reaffirm decisions previously made, or to make decisions and act upon them especially in terms of advance directives regarding health care.

This course consists of six sessions:

- Session 1: *The stories we tell: An introduction to the conversation*
- Session 2: *Issues of faith*
- Session 3: *Issues of medicine*
- Session 4: *Family and legal issues*
- Session 5: *A time for clarification*
- Session 6: *Decisions and prayer*

Each session consists of text plus questions for reflection and discussion.

Two books stand out as valuable for your further reflection.

- The first is Cynthia C. Cole, et.al., *Faithful Living Faithful Dying: Anglican Reflections on End of Life Care* (Harrisburg: Morehouse Publishing, 2000). In a 1997 resolution, the General Convention of the Episcopal Church called for the creation of a working group to “study the theological and ethical implications of end of life issues.” The work of the resulting task force led to this book, which contains essays on many of the themes of this study, along with a useful appendix of various parish resources.
- The second is by the Committee on Medical Ethics of the Episcopal Diocese of Washington, *Toward a Good Christian Death: Crucial Treatment Choices* (Harrisburg: Morehouse Publishing, 1999). In this book this diocesan group examines the Anglican moral vision and raises important questions about the choices we might make.

This study seeks to provide experiences that are participatory, encouraging both deeper understanding and transformative reflection among a broad adult audience. Through a positive respectful conversation, we hope this study will contribute to strengthening the sense of community; affirm the biblical foundations of our faith; assist in developing practices to live into the new humanity offered to us through Christ; and challenge participants to relate study and reflection to action in the name of Christ. The format is based on the model for covenanted conversations used at the diocesan convention in 2005. We commend the *Covenanted listening; covenanted conversations* prayers and covenant that appear on the next page to you.

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## ***Covenanted listening; covenanted conversations***

*The School of Ministry encourages study groups to engage in covenanted listening and conversation. These prayers and covenant are adapted from Good News: A Congregational Resource for Reconciliation, by the Rt. Rev. Steven Charleston.*

### **An Opening Prayer**

O God, we stand on the border to your Kingdom. We pray that your Holy Spirit will be with us to guide us in our discussions. Grant us an openness to hear you in the words of those around us, and courage to proclaim you in our own words, though the love of your Son, our Savior, Jesus Christ. Amen.

### **A Covenant**

As we gather in the name of Christ to share our thoughts, feelings, and ideas we accept this Covenant to guide our conversation along his path of love:

- We will allow each person an equal amount of time to speak.
- We will listen to each person without interruption or comment.
- We will speak in a respectful way without criticism or rancor.
- We will honor the feelings of others as genuine and sincere.
- We will disagree without threats or accusations.
- We will agree that we are all seeking the mind of Christ.

### **A Closing Prayer**

Dear God, thank you for the presence of your Holy Spirit in this conversation. We ask that the Spirit will go with us as we leave this place to be your ministers. Give us grace to be healers of what hurts us and heralds of what makes us whole. In the blessed name of Jesus, we pray. Amen.

**Session 1**  
**The stories we tell:**  
**As introduction to the conversation**

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**Readings:** Jesus said to her, “I am the resurrection and the life.  
Those who believe in me, even though they die, will live,  
and everyone who lives and believes in me will never die. John 11:25-26

Do you not know that all of us who have been baptized into Christ Jesus were baptized into his death?  
Therefore we have been buried with him by baptism into death, so that,  
just as Christ was raised from the dead by the glory of the Father, so we too might walk in newness of life.  
For if we have been united with him in a death like his,  
we will certainly be united with him in a resurrection like his. Romans 6:3-5

**D**eath is a reality that most if not all of us have experienced. Whether a parent or grandparent who, elderly, dies after a full life, and whose death we mourn but whose life we can celebrate, or younger family members or friends who may die tragically and seemingly “before their time,” we know of death. We may not talk about it much – certainly not about our own to come – but it is there, and we know it and know of it.

People of faith have a distinctive understanding of death. The readings from John’s gospel and from Paul’s letter to the Romans (cited above) capture from Scripture our Christian hope that at death we are, as Paul writes, united with [Christ] in a resurrection like his.” In our burial liturgy in the *Book of Common Prayer* we pray for the deceased’s “entrance into the land of light and joy, in the fellowship of thy saints.”<sup>1</sup>

Consider what the Catechism<sup>2</sup> says:

*Question: What is the significance of Jesus’ resurrection?*

*Answer: By his resurrection, Jesus overcame death and opened for us the way of eternal life.*

*Q: What do we mean by the resurrection of the body?*

*A: We mean that God will raise us from death in the fullness of our being, that we may live with Christ in the communion of the saints.*

*Q: What do we mean by everlasting life?*

*A: By everlasting life, we mean a new existence, in which we are united with all the people of God, in the joy of fully knowing and loving God and each other.*

*Q: What, then, is our assurance as Christians?*

*A: Our assurance as Christians is that nothing, not even death, shall separate us from the love of God which is in Christ Jesus our Lord.*

The broad question before us, in this first session, is to consider how we incorporate the teachings of Scripture and the Church into our lives as we face the complexities of end-of-life decisions. When do we continue to strive for life? When do we relinquish the fight and accept death? How do we do this for others as well as for ourselves, specifically turning to our faith for guidance?

One way to enter into these questions is to share the stories we have, and so as an introduction to the conversations of the next few weeks, we invite you simply to talk together.

**Questions for Reflection and Conversation**

- When you think of death and dying, what images, thoughts, associations and feelings do you have?
- How does your belief about the resurrection, as the Bible and the teaching and liturgy of the Church convey it, affect the way you look at death and dying?
- What end-of-life issues seem most important or critical to you, especially given your faith understandings?

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<sup>1</sup> *Book of Common Prayer*, 1979, p. 470.

<sup>2</sup> *Ibid.*, pp. 850, 862.

**Readings:** For everything there is a season, and a time for every matter under heaven:  
a time to be born, and a time to die...

Ecclesiastes 3:1-2

The case of Terri Schiavo in 2005 is not the focus of this study, and we hope that the politics surrounding that case will not become a focus of your conversations either, for it can be distracting from faithful conversations about your own decisions. Nevertheless, it is worth acknowledging that the attention Terri Schiavo's life and death drew has been a stimulus for meaningful discussion about end-of-life issues in and out of the Church, much as did Karen Ann

Quinlan's life and death from her unconsciousness in 1975 until her death in 1985. Both cases – and no doubt the personal experiences of some of us – have challenged us to reflect about what the sanctity of life means, and about how our faith can guide us when deciding about treatment and its discontinuation for ourselves or for another.

In particular, we are seeking to reflect on questions such as these:

- Is it acceptable to not want to live in a debilitated state?
- Do we have an obligation to continue to keep a person alive if they are in a persistent vegetative state?
- Is it acceptable for a person to choose not to have treatment that can prolong one's life?
- What does the Church teach about end-of-life issues such as these?

**General Convention resolution on  
the sacredness of life**

In 1991 the General Convention of the Episcopal Church passed a resolution (1991-A093) to "*set forth the following principles and guidelines with regard to the foregoing of life-sustaining treatment in the light of our understanding of the sacredness of human life.*" The final text deserves careful reading:

1. Although human life is sacred, death is part of the earthly cycle of life. There is a "time to be born and a time to die" (Ecclesiastes 3:2). The resurrection of Jesus Christ transforms death into a transition to eternal life: "For as by a man came death, by a man has come also the resurrection of the dead" (1 Corinthians 15:21).

2. Despite this hope, it is morally wrong and unacceptable to intentionally take a human life in order to relieve the suffering caused by incurable illness. This would include the intentional shortening of another person's life by the use of a lethal dose of medication or poison, the use of lethal weapons, homicidal acts, and other forms of active euthanasia. Palliative treatment to relieve the pain of persons with progressive incurable illnesses, even if done with the knowledge that a hastened death may result, is consistent with theological tenets regarding the sanctity of life. However, there is no moral obligation to prolong the act of dying by extraordinary means and at all costs if such dying person is ill and has no reasonable expectation of recovery.
3. In those cases involving persons who are in a comatose state from which there is no reasonable expectation of recovery, subject to legal restraints, this Church's members are urged to seek the advice and counsel of members of the church community, and where appropriate, its sacramental life, in contemplating the withholding or removing of life-sustaining systems, including hydration and nutrition.
4. We acknowledge that the withholding or removing of life-sustaining systems has a tragic dimension. The decision to withhold or withdraw life-sustaining treatment should ultimately rest with the patient, or with the patient's surrogate decision-makers in the case of a mentally incapacitated patient. We therefore express our deep conviction that any proposed legislation on the part of national or state governments regarding the so called "right to die" issues, (a) must take special care to see that the individual's

rights are respected and that the responsibility of individuals to reach informed decisions in this matter is acknowledged and honored, and (b) must also provide expressly for the withholding or withdrawing of life-sustaining systems, where the decision to withhold or withdraw life-sustaining systems has been arrived at with proper safeguards against abuse.

5. We acknowledge that there are circumstances in which health care providers, in good conscience, may decline to act on request to terminate life-sustaining systems if they object on moral or religious grounds. In such cases we endorse the idea of respecting the patient's right to self-determination by permitting such patient to be transferred to another facility or physician willing to honor the patient's request, provided that the patient can readily, comfortably and safely be transferred. We encourage health care providers who make it a policy to decline involvement in the termination of life-sustaining systems to communicate their policy to patients or their surrogates at the earliest opportunity, preferably before the patients or their surrogates have engaged the services of such a health care provider.
6. Advance written directives (so-called "living wills," "declarations concerning medical treatment" and "durable powers of attorney setting forth medical declarations") that make a person's wishes concerning the continuation or withholding or removing of life-sustaining systems should be encouraged, and this Church's members are encouraged to execute such advance written directives during good health and competence and that the execution of such advance written directives constitute loving and moral acts.
7. We urge the Council of Seminary Deans, the Christian Education departments of each diocese, and those in charge of programs of continuing education for clergy and all others responsible for education programs in this Church, to consider seriously the inclusion of basic training in issues of prolongation of life and death with dignity in their curricula and programs.<sup>3</sup>

<sup>3</sup> *Journal of the General Convention of...the Episcopal Church, Phoenix, 1991* (New York: General Convention, 1992), p. 383.

## General Convention resolution on organ donation

The main thrust of this study resource is to assist us in reflecting upon our own hopes and needs, in the light of our faith, as we approach end-of-life issues. However, what we may do for others remains a constant in our faith, and organ, eye and tissue donations certainly involve decisions at the time of death. We therefore commend this subject for your reflection as well.

At our General Convention in 1982, the Episcopal Church passed a resolution (1982-C024) to "Encourage Christians to Become Organ, Blood and Tissue Donors." The resolution reads simply:

*Resolved*, the House of Bishops concurring, That The Episcopal Church recognize the life-giving benefits of organ, blood, and tissue donation and encourage all Christians to become organ, blood, and tissue

*This Church's members are encouraged to execute advance written directives during good health and competence.... The execution of such advance written directives constitute loving and moral acts.*

*General Convention of the Episcopal Church resolution 1991-A093*

donors as part of their ministry to others in the name of Christ, who gave his life that we may have life in its fullness.<sup>4</sup>

## Understanding the terms

These General Convention resolutions touch on virtually all of the critical faith questions which this study seeks to address:

- Organ donation
- Termination of treatment
- Removal of life support
- Euthanasia
- Decisions made for ourselves vs. decisions we make for others

We will return to points 4, 5 and 6 of the "Sacredness of life" resolution and to organ donation in later

<sup>4</sup> *Journal of the General Convention of...The Episcopal Church, New Orleans, 1982* (New York: General Convention, 1983), p. C-147.

sessions, and point 7 is precisely that toward which this study seeks to make a contribution. Our focus in this session, then, is points 1-3.

To appreciate these faith concerns fully, it is crucial that we understand the terminology, for oft-times terms are misunderstood or used inappropriately, and it confuses the conversation. Here are some definitions:

**Artificial means of sustaining life:** What is considered “artificial” is open to some debate, but in general this refers to therapies – such as equipment assistance to breathe or to maintain hydration – the absence of which would lead to death. In brief, as the patient is unable to maintain life on his or her own, “artificial” means are used.

**Assisted suicide:** A situation in which a patient seeks the assistance of others (not necessarily a physician; see *physician assisted suicide* below), asking that they provide the means or information to allow the patient to end his or her life.

**Brain death:** Often confused with *passive euthanasia*, brain death occurs when the entire brain has irreversibly ceased to function. Some argue that since such patients are dead, the removal of life support cannot bring about death, and therefore such an action cannot be construed as euthanasia.

**Coma:** A prolonged state of unconsciousness from which the individual cannot be awakened, in which the individual responds minimally or not at all to stimuli, and initiates no voluntary activities.

**Euthanasia:** The act of directly bringing about a patient’s death, for example, by a physician’s injecting a patient with a lethal dose of a drug such as morphine. Several “types” of euthanasia qualify this general definition:

**Involuntary euthanasia:** A situation in which a person who is competent to consent has been killed without requesting the death, perhaps because a family member is moved by his or her suffering.

**Passive euthanasia:** A situation in which the intention is to allow the patient to die by not treating a condition that, left untreated, will cause death.

**Non-voluntary euthanasia:** A situation in which a patient who is incapable of requesting death

(i.e., is *not* competent to consent; contrast with *involuntary euthanasia* above) is killed, such as a child, someone who is mentally ill or who is unconscious.

**Voluntary euthanasia:** A situation in which an informed and competent patient has requested death.

**Extraordinary means of sustaining life:** Here the question is whether a given treatment is excessively burdensome in relation to expected benefits. Synonymous with the term *disproportionate means*, the term recognizes that there is always a duty to provide “ordinary” care to a patient. Such *ordinary treatment* is sometimes referred to as *proportionately beneficial treatment*, meaning that benefits exceed burden.

**Life support or life-sustaining systems:** These include such equipment as ventilators, dialysis machines, and feeding tubes for artificial nutrition and intravenous fluids for hydration, which “support” or “sustain” life when the body itself cannot do so.

**Organ donation:** The act of giving your organs, eyes and tissue at the time of your death to save or improve the lives of others who receive them through transplant.

**Palliative treatment:** Treatment to relieve the pain of persons with progressive incurable illnesses.

**Physician-assisted suicide:** A situation in which a physician provides the means or information to allow a patient to end his or her life.

**Right to die:** This term (related to the phrase *dying with dignity*) refers to various issues around the death of an individual when that person could continue to live with the aid of life support or in a diminished capacity. Most often, the idea of the right to die is related to a person’s wish that caregivers allow death – for example, by not providing *life support* or vital medication – under certain conditions when recovery is highly unlikely or impossible. It may also refer to issues regarding *physician-assisted suicide*. It may be called *passive euthanasia* in cases where the patient is unable to make decisions about treatment.

**Termination of treatment:** Often confused with *passive euthanasia*, this refers to cases where medical treatment is no longer indicated and all treatment except palliation (food, water, pain relief) is withdrawn. The intention is not to cause death, but

rather to recognize that death can no longer be effectively resisted.

**Vegetative state:** A condition resulting from a severe brain injury in which arousal is present, but the ability to interact with the environment is not. This state is considered persistent (*persistent vegetative state*) when the vegetative state lasts more than one month.<sup>5</sup>

## *Life is God-given and has intrinsic sanctity, significance and worth.*

*Lambeth Conference resolution 1.14 in 1998*

### **Questions for Reflection and Conversation**

You have been reading, then, two things: One, a statement of how the Church understands end-of-life issues especially regarding the “foregoing of life-sustaining treatment in the light of our understanding of the sacredness of human life;” and two, terms that help to make concrete and real those choices that may be before us as we consider both public policy and personal decision. (Our concern in this study is primarily about faithful personal decisions rather than public policy, but we acknowledge that no sharp line can be drawn between the two.)

As we draw these “medical” specifics and our theology together, we are likely faced with many questions. Here are several, which we pose by drawing from the first three points of the General Convention resolution. We commend them to you for your reflection and conversations:

- How helpful is it to you, really, to hear the Church speak of death as “part of the earthly cycle of life” and of “the resurrection of Jesus Christ [as] transforming death into a transition to eternal life,” when you are considering end-of-

life decisions about what you might wish for yourself or for those you love?

- Do you agree that it is morally wrong and unacceptable to intentionally take a human life in order to relieve the suffering caused by incurable illness? Why or why not?
- Do you agree that there is no moral obligation to prolong the act of dying by extraordinary means and at all costs if such dying person is ill and has no reasonable expectation of recovery? Why or

why not?

- Would you turn to the church community for advice and counsel if you were contemplating the withholding or removing of life-sustaining systems? Why or why not?

### **The Lambeth Conference: Bedrock Principles**

As a final stimulus for your thoughts and conversation, we draw your attention to study and action on euthanasia at the Lambeth Conference (the gathering of bishops from throughout the Anglican Communion) in 1998.

The resolution itself (1.14)

- affirms that life is God-given and has intrinsic sanctity, significance and worth; ...
- resolves that euthanasia, as precisely defined, is neither compatible with the Christian faith nor should be permitted in civil legislation; [and]
- distinguishes between euthanasia and withholding, withdrawing, declining or terminating excessive medical treatment and intervention, all of which may be consonant with Christian faith in enabling a person to die with dignity....

It may be helpful to know what they finally enacted, above, but it is the statement of “bedrock principles” and the theological reflection that emerged from their study group which we especially commend to you. Here are the principles:

*As bishops of the Anglican Communion, part of the one, holy, catholic and apostolic Church, we believe that there are five bedrock principles upon which the discussion of euthanasia and related issues rest:*

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<sup>5</sup> The definitions for brain death, euthanasia and its types, physician-assisted suicide, and termination of treatment are adapted from the Task Group of Faith, Worship and Ministry Committee of the Anglican Church of Canada, *Care in Dying: A Consideration of the Practices of Euthanasia and Physician Assisted Suicide* (2000) ([www.anglicanjournal.com/126/03/canada02.html](http://www.anglicanjournal.com/126/03/canada02.html)). Definitions for coma and for vegetative state come from the Brain Injury Association of America ([www.biausa.org/Pages/coma.html](http://www.biausa.org/Pages/coma.html)). The right to die definition comes from Wikipedia ([http://en.wikipedia.org/wiki/Right\\_to\\_die](http://en.wikipedia.org/wiki/Right_to_die)). The American Psychological Association’s glossary has proved useful as we refined our definitions ([www.apa.org/pi/eol/glossary.html](http://www.apa.org/pi/eol/glossary.html)).

- life is God-given and therefore has intrinsic sanctity, significance and worth;
- human beings are in relationship with the created order and that relationship is characterised by such words as respect, enjoyment and responsibility;
- human beings, while flawed by sin, nevertheless have the capacity to make free and responsible moral choices;
- human meaning and purpose is found in our relationship with God, in the exercise of freedom, critical self-knowledge, and in our relationships with one another and the wider community;
- this life is not the sum total of human existence; we find our ultimate fulfilment in eternity with God through Christ.<sup>6</sup>

**The Lambeth Conference:  
A Theological Reflection**  
*(quoted from the Section 1 Report)*

The manner in which human beings treat one another should be a reflection of the dignity which God in Christ has conferred upon them. That dignity may be cherished as much in the way we care for the dying as in the preservation and well being of the living. This is also why intentionally foreshortening another person's life is so alien to the Christian position.

It is because Christians recognise the sanctity and dignity of human life, one of the sharpest theological questions we face in the euthanasia debate is the problem of suffering. Put starkly; how can the idea that God is a God of love be consonant with a world in which there is so much suffering? The problem of theodicy has taxed the Church since its earliest days. This is not the place to attempt a comprehensive review of all the possible answers to this question. We do however want to draw attention to one profound Christian insight: God suffers in Christ within our own suffering and ultimately redeems and transforms it upon the Cross, giving us new life and unending hope.

In Christian theology, the sovereignty of God is not found in divine impassivity or indifference. Rather it is expressed when God as divine love enters into our suffering. As the prophet Isaiah has said, "He was wounded for our transgressions, he was bruised for our iniquities: the chastisement of our peace was upon him and with his stripes we are healed" (Isaiah 53:5). To try to think of God as a wounded healer is to

<sup>6</sup> From Resolution 1.14, Lambeth Conference, 1998 (<http://www.anglicancommunion.org/lambeth/1/sect1rpt.html>).

reach that point of understanding where language bends and fractures under the strain of what it is trying to convey. This is not a puzzle that we can solve, but a mystery that is only understood as we enter it and live within it.

The belief in a sovereign but suffering God who redeems, a theology of God's sovereignty which contains suffering, and the mystery of redemption, is expressed through the care which all Christian people are called to offer to those in need. Despite our failures, we are compelled through God's love in Christ to try to live with open and compassionate hearts.

The other major theological problem is the question of personal autonomy. As bishops, we believe that humanity is created in the image of God, and that personal autonomy and freedom, are gifts of God to be cherished and advanced. In euthanasia, however, where life is terminated intentionally, the exercise of personal autonomy is precluded by two things. Firstly, it is precluded by the acknowledgement that God alone has sovereignty over life and death, and secondly, by our recognition that personal, moral autonomy is inextricably bound up with the autonomy, rights and responsibilities of others. Moral decisions are not made in a vacuum, they are always made in a communal context; personal choices have social consequences.

In the debate on euthanasia, it is the duty of the Church to ensure that its theology of God, of suffering and of personal autonomy, is explored with intellectual rigour and seriousness by everyone involved. It is also our duty to ensure that the most compassionate and Christ-like care is given to those facing death or making life and death decisions.<sup>7</sup>

**A Question to Keep Before You**

In light of your understanding of your faith and the teachings of the Church, what do you wish for yourself and for those you love when facing end-of-life decisions?

<sup>7</sup> From the Section 1 report, "Called to Full Humanity," in *The Official Report of the Lambeth Conference 1998* (Harrisburg: Morehouse, 1999), pp. 101-106, used by permission of the Secretary General of the Anglican Consultative Council.

**Readings:** Blessed be the God and Father of our Lord Jesus Christ,  
the Father of mercies and the God of all consolation,  
who consoles us in all our affliction, so that we may be able to console those who are in any  
affliction with the consolation with which we ourselves are consoled by God.  
For just as the sufferings of Christ are abundant for us,  
so also our consolation is abundant through Christ. 2 Corinthians 1:3-5

One of the challenges of discernment about end-of-life issues is that our faith perspectives (which we considered in the previous session) may sometimes lead us to make assumptions about the realities of medicine (addressed in this session) and of the law (addressed in the next session) as they apply to our choices, assumptions that may prove ultimately not to be grounded in fact. As people of faith, we properly place our calling and our faith-based decisions before

other concerns, but we err if we ignore the fact that health care also has ethical principles which health care professionals are called to respect.

#### **Bio-ethical Principles in Health Care**

Consider these terms, which have a deep influence upon decision-making from a medical perspective:

**Autonomy:** Self-determination; a person's right to decide to accept or reject treatment options.

**Beneficence:** Doing good; a duty to attempt to do good.

**Confidentiality:** A person's right to privacy.

**Consent:** The process by which the patient has an opportunity to participate in his or her health care decisions, to *consent* to procedures and choices. Consent is seen these days as an active and mutual process, by which truth-telling and clarity about choices and alternatives are present. Several "types" of consent qualify this general definition:

**Implied consent:** Sometimes called *presumed consent*, this circumstance emerges when the patient may be unconscious or incompetent and no surrogate decision maker is available. Where the boundary lies is not always clear. For example, a patient's presence in a hospital would not lead to the *presumption* or *implication* that he or she has consented to all treatment and procedures, though previous choices during a prolonged illness might lead to the presumption of consent. A particular dilemma arises when

health care personnel must choose between the principle of autonomy (obligating personnel to do their best to include the patient in health care decisions that affect his or her life and body), and the principle of beneficence (requiring personnel to act on the patient's behalf when his or her life is at stake).

**Informed Consent:** This is the process by which a fully informed patient can participate in choices about his or her health care. It originates from the legal and ethical right the patient has to direct what happens to one's body and from the ethical duty of the physician to involve the patient in health care.

**Fidelity:** Faithfulness to the best interest of the patient in the physician/patient relationship over other relationships.

**Justice:** Fair to all, equal treatment – also often related to fair distribution of health care resources, an issue also addressed on a societal level through public policy.

**Non-maleficance:** Doing no harm, to cause no unnecessary harm.<sup>8</sup>

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<sup>8</sup> The definitions of informed and implied consent are adapted from the University of Washington School of Medicine (<http://eduserv.hsccer.washington.edu/bioethics/topics/consent.html#ques1>); others are from a handout prepared by Bob Hamilton, one of our authors.

## The Goal of Medicine

The terms defined above are critical indicators of the issues faced in principled relationships between health care professionals and patients. While there is often, these days, a critical stance taken by the public toward health care in the United States – and there are certainly things to critique – the terms alone should remain as important signs of the search for right relations in providing health care, a search undertaken by physicians and nurses and other caregivers as well as by the general public.

That search can be enhanced by a deeper understanding of health care itself. “The primary goal of medicine,” writes an End of Life Task Force from our General Convention, “is not just to treat or ameliorate a particular physical or psychological condition, to cure an injury or illness, to extend human life, or to relieve suffering – although these are important goals. Decisions to treat or not to treat, and then about how to treat, are made for the sake of the human person. Thus, the primary goal of medicine is to promote human health, not in the narrow sense of physical well-being or mental cohesiveness, but in the sense conveyed by the literal meaning of the term *health* – wholeness. The purpose of medicine is to honor and enhance the wholeness of the human person, the health of the person.”<sup>9</sup>

What this means is that end-of-life decisions, whether by physicians or by yourself, engage a broad vision of human wholeness, yet... at the moment of a health crisis, we rarely have the luxury of reflecting deeply about theology and ethics with decisions needing to be made, and often made, immediately. In the next session we will talk more about ways we can make our wishes known; suffice it to say now that medical personnel must, in life-threatening emergencies, find their way through such sometimes-conflicting principles of beneficence and non-maleficence and autonomy and consent and justice in immediate, difficult, concrete ways.

## Questions for Reflection and Conversation

In this resource we have felt it appropriate, and doable, to encourage parishes to identify communicants within their parishes or neighbors in their communities who live the realities of end-of-life concerns as doctors, nurses, or other health

professionals, and to invite them to share their experiences and answer your questions. Here are some for them, and you, to consider:

- What are end-of-life issues from a medical perspective? For physicians, what are the indicators and what are the issues to be considered?
- How do goals of treatment and care contrast with available treatment options? When a patient or family member asks that “everything be done,” how should the request be understood and what are health care professionals’ options for responding to it?
- What are important considerations when helping family members decide what is best for their family member? When physicians have to decide for someone who is without a legal surrogate, what are some of the considerations for deciding?
- And, from point 4 of the General Convention resolution,<sup>10</sup> what is your level of confidence that the decision to withhold or withdraw life-sustaining treatment does or will ultimately rest with the patient, or with the patient’s surrogate decision-makers, in today’s health system?

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<sup>9</sup> Cynthia C. Cole, et.al., *Faithful Living Faithful Dying: Anglican Reflections on End of Life Care* (Harrisburg: Morehouse Publishing, 2000), pp. 40-41.

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<sup>10</sup> See pp. 4-5.

**Readings:** “Come to me, all you that are weary and are carrying heavy burdens, and I will give you rest. Take my yoke upon you, and learn from me; for I am gentle and humble in heart, and you will find rest for your souls. For my yoke is easy, and my burden is light.” Matthew 11:28-30

**H**ow do we know what to do? What does our family wish us to do? What does the law allow us to do and not do? What constitutes “a life worth living”? In earlier sessions we have talked about our own experiences, have sought to ground our potential decisions in our faith, and have examined the medical world’s realities as they, patients and families together make end-of-life decisions. Now we turn to legal issues, our own autonomy in making legal decisions, and the

role of our families in addressing treatment and cessation of treatment decisions when we are unable to make those decisions for ourselves (and sometimes when we are!).

We need to say at once that we do not presume to provide legal advice. Instead, what we are setting out to do in this session is to outline generally some of the key avenues available to us to ensure that our wishes are honored.

As in the previous session, we have felt it appropriate, and do-able, to encourage parishes to identify lawyers who are communicants within their parishes or neighbors in their communities and who have expertise in terms of end-of-life directives and decisions from a legal point of view, and to invite them to share their experiences and answer your questions.

### **Legal Terms Associated with Health Care**

Consider these terms, which are essential for us to understand as we consider end-of-life decisions from a legal perspective:

**Advance directive:** An instruction from a competent person about his or her choices about future medical treatment in the event the person becomes unable to make decisions. It may specify which treatment a person consents to or refuses, designate a surrogate decision-maker, or both.

**Do Not Resuscitate (DNR) order:** Also known as a “no code” order and “AND = allow natural death” order, this is a directive by a physician (entered into with the agreement of a patient or surrogate) to

withhold cardiopulmonary resuscitation in the event that a patient experiences cardiac or respiratory arrest.

**Durable power of attorney for health care:** A document in which a person designates a surrogate for health-care decisions. This can be used for a broad range of health decisions, not just withholding or withdrawing life-sustaining treatment.

**Living will:** A document in which a person gives directions regarding medical care, especially in the event of a terminal illness or, perhaps, a persistent vegetative state. It often indicates a patient’s intention to refuse medical treatment, releasing health care providers from liability.

**Substituted judgment:** A legal standard for surrogate decision-making, by which the surrogate makes the decision on the basis of what is known about the patient’s personal values and preferences.

**Surrogate:** A person who makes health care decisions for us when we are not competent to do so ourselves.<sup>11</sup>

### **Advance Directives: A Living Will**

First, why do it? These points may seem obvious, but it may be worth the reminder:

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<sup>11</sup> Definitions adapted from Committee on Medical Ethics, Episcopal Diocese of Washington, *Toward a Good Christian Death: Crucial Treatment Choices* (Harrisburg: Morehouse Publishing, 1999), pp. 135-41; and from [www.legal-definitions.com](http://www.legal-definitions.com), cited in the Diocese of Washington’s *Washington Window*, May 2005.

- Without a living will, your intentions are simply unknown to family and doctors should you become unable to express your wishes yourself;
- Your family – not knowing your wishes – may disagree among themselves as to what to do when you cannot speak for yourself;
- Even if they do agree among themselves, without a living will you have left them with difficult decisions when you fail to express your wishes; and
- Since living wills offer legal protection for doctors and hospitals, the absence of an advance directive often means that medical personnel “err” on the side of *extraordinary means* to keep you alive, even though you might not wish them to do so.

Under the Right to a Natural Death Act, North Carolina law declares that you can execute a living will and that it will be honored.

We do not suggest below what it is you may wish to say in a *living will*; instead, our intention here is to provide a sense of what these things might look like.

That said, what tends to be in a *living will*?

1. Having declared yourself to be “of sound mind,” you proceed to say, with whatever qualifications you wish to impose, that you decline aggressive life support if you’re close to death.
2. Qualifications might include defining your wishes based upon whether (a) your condition is “terminal and incurable” or (b) you are in a persistent vegetative state.
3. Under either or both of those circumstances, you may ask that (a) only extraordinary means be withheld or discontinued or (b) artificial nutrition or hydration as well as extraordinary means be withheld or discontinued.
4. You may declare such things without affecting your right to secure pain relief.

You then sign the living will before a notary and before witnesses (probably not relatives or your doctor).

Having done so, it is important for you to talk with your family and doctor about your decisions, and to provide them with copies of your living will. You might also consider giving a copy to your rector and to the hospital you’re likely to use. The checklist for copies, then, is

- Your physician;
- Family members;
- Your rector;
- Your likely hospital;
- Your nursing home, if applicable.

The office of the Secretary of State for North Carolina maintains an Advance Health Care Directive Registry. Their website makes standard living will forms available. You may also register your living will with them, though you are not required to do so.<sup>12</sup> See below for more about the service the Registry provides.

Speaking with your own lawyer may be the direction you wish to take. You may also find draft living wills available on websites. Searching “North Carolina living wills” leads to several sites for documents to purchase. We make no recommendation as to what course you should choose.

Keep in mind that you can change your mind! You may revoke or cancel a living will. (Make sure you inform your family and doctor.)<sup>13</sup>

### **Advance Directives: *Five Wishes***

*Five Wishes* is a rather unique document among living wills, in that it permits you to declare, in what seems like a more “personal” way, your wishes should you be unable to speak for yourself. Originated with support from the Robert Wood Johnson Foundation, the *Five Wishes* document addresses your medical, personal, emotional and spiritual concerns, allowing you to name five “wishes”:

1. Which person you want to make health care decisions for you when you can’t make them;
2. The kind of medical treatment you want or don’t want;
3. How comfortable you want to be;
4. How you want people to treat you; and
5. What you want your loved ones to know.

While there are a few states in which *Five Wishes* does not yet meet legal requirements, it is legally recognized in North Carolina.

<sup>12</sup> See [www.nclifelinks.org/ahedr/](http://www.nclifelinks.org/ahedr/).

<sup>13</sup> Some of these suggestions come from Kate Mewhinney, a clinical professor at Wake Forest University School of Law and the managing attorney for its Clinic for the Elderly, in <http://www.lawyers.com/>. Click on “Research legal topics,” then search for “living will.”

The Learning Place Online website<sup>14</sup> provides the text of *Five Wishes*, so that you can gain a sense of what the document is like. To execute a legal document, you are asked to request a copy from Aging with Dignity, which provides them for a nominal charge.<sup>15</sup>

### **Advance Directives: Durable Power of Attorney**

As noted above, with a *durable power of attorney* you are designating someone to act on your behalf if you are no longer able to make health-care decisions yourself. What tends to be in such a document?

1. Having declared yourself to be “of sound mind,” you proceed to name someone to make health care decisions for you.
2. You may name others to serve in that capacity if the one you named is not “reasonably available or is unable or unwilling to act” as your agent.
3. You then define the authority you have granted to that person. That might include (a) securing medical information; (b) employing or discharging health care providers; (c) admitting you to hospital; (d) consenting or withdrawing consent for various procedures; and (e) carrying out your wishes regarding disposition of your body, including organ donation or use of your body for medical purposes.
4. You may expressly authorize your patient advocate to make decisions to withhold or withdraw life-sustaining treatment.

Note that the *Five Wishes* document’s first “wish” names the person you wish to make health care decisions for you.

Note also that the North Carolina Advance Health Care Directive Registry website makes standard Health Care Power of Attorney forms available.<sup>16</sup>

Sometimes the person named as holding “health care power of attorney” or “durable power of attorney,” called “patient advocate” or “health care agent” – all of these terms are interchangeable – may be asked to formally accept that responsibility. Whether he or she is or not asked, it may be helpful to name some of the rights and duties that person is often seen to assume on your behalf. Here a summary from the sample durable power of attorney form from the

University of Michigan Health System<sup>17</sup> may be helpful:

1. The person you name as your health care agent has no responsibilities unless you are unable to participate in treatment decisions;
2. Your health care agent cannot exercise powers concerning your care, custody and medical treatment that you, if you were able to participate in the decision, could not have exercised on your own behalf;
3. Your advocate may make a decision to withhold or withdraw treatment which would allow you to die only if you have expressed in a clear and convincing manner that your advocate is authorized to make such a decision;
4. While your agent will not receive compensation for the performance of his or her authority, rights, and responsibilities, your advocate may be reimbursed for actual and necessary expenses incurred;
5. Your agent shall act consistent with your best interests, defined by your known desires expressed or evidenced while you are able to participate in medical treatment decisions; and
6. You may revoke your designation at any time or in any manner sufficient to communicate an intent to revoke, *and* so can your advocate.

<sup>14</sup> See [www.learningplaceonline.com/stages/together/wishes/wishes-1.htm](http://www.learningplaceonline.com/stages/together/wishes/wishes-1.htm).

<sup>15</sup> See [www.agingwithdignity.org/5wishes.html](http://www.agingwithdignity.org/5wishes.html).

<sup>16</sup> See [www.nclifelinks.org/ahcdr/](http://www.nclifelinks.org/ahcdr/).

<sup>17</sup> See [www.med.umich.edu/1libr/aha/umlegal02.htm](http://www.med.umich.edu/1libr/aha/umlegal02.htm). We should add, with reference to point 2, that in many states health care agents may make decisions on your behalf only if your illness is terminal and incurable or if you are in a persistent vegetative state. North Carolina law, however, permits the agent to make *any* health care decision you could make if you were competent unless you have explicitly limited the agent’s powers.

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## Sample Health Care Power Of Attorney

*To get a glimpse at what one might actually look like,  
here is a sample, edited from the State of North Carolina.<sup>18</sup>*

**1. Designation of Agent.** I, being of sound mind, hereby appoint \_\_\_\_\_ (with address and phone numbers) as my health care attorney-in-fact (herein referred to as my “health care agent”) to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document.

If the person named as my health care agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint the following persons (each to act alone and successively, in the order named), to serve in that capacity: \_\_\_\_\_. Each successor health care agent designated shall be vested with the same power and duties as if originally named as my health care agent.

**2. Effectiveness of Appointment.** Absent revocation, the authority granted in this document shall become effective when and if the physician or physicians designated below shall determine that I lack sufficient understanding or capacity to make or communicate decisions relating to my health care and will continue in effect during my incapacity, until my death. This determination shall be made by the following physician or physicians: \_\_\_\_\_. For decisions related to mental health treatment, this determination shall be made by the following physician or eligible psychologist: \_\_\_\_\_.

**3. General Statement of authority granted.** Except as indicated in section 4 below, I hereby grant to my health care agent named above full power and authority to make health care decisions, including mental health treatment decisions on my behalf, including, but not limited to, the following:

- A. To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information.
- B. To employ or discharge my health care providers.
- C. To consent to and authorize my admission to and discharge from a hospital, nursing or convalescent home, or other institution.
- D. To consent to and authorize my admission to and retention in a facility for the care or treatment of mental illness.
- E. To give consent to and authorize the admission of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as “shock treatment”.
- F. To give consent for, to withdraw consent for, or to withhold consent for, X ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, or podiatrist. This authorization specifically includes the power to consent to measures for relief of pain.
- G. To authorize the withholding or withdrawal of life-sustaining procedures when and if my physician determines that I am terminally ill, permanently in a coma, suffer severe dementia, or am in a persistent vegetative state. Life-sustaining procedures are those forms of medical care that only serve to artificially prolong the dying process and may include mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and other forms of medical treatment which sustain, restore or supplant vital bodily functions. Life-sustaining procedures do not include care necessary to provide comfort or alleviate pain. I DESIRE THAT MY LIFE NOT BE PROLONGED BY LIFE-SUSTAINING PROCEDURES IF I AM TERMINALLY ILL, PERMANENTLY IN A COMA, SUFFER SEVERE DEMENTIA, OR AM IN A PERSISTENT VEGETATIVE STATE.
- H. To exercise any right that I may have to make a disposition of any part or all of my body for medical purposes, to donate my organs, to authorize an autopsy, and to direct the disposition of my remains.

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<sup>18</sup> Edited from [www.nclifelinks.org/ahcdr/](http://www.nclifelinks.org/ahcdr/). The document at this website also includes guidance, which has not been included here.

- I. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

**4. Special provisions and limitations.**

- A. In exercising the authority to make health care decisions on my behalf, the authority of my health care agent is subject to the following special provisions and limitations. *(Here you may include any specific limitations you deem appropriate such as: your own definition of when life-sustaining treatment should be withheld or discontinued, or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs, or unacceptable to you for any other reason.)*
- B. In exercising the authority to make mental health decisions on my behalf, the authority of my health care agent is subject to the following special provisions and limitations *(Here you may include any specific limitations you deem appropriate such as: limiting the grant of your authority to make only mental health treatment decisions, your own instructions regarding the administration or withholding of psychotropic medications and electroconvulsive treatment (ECT), instructions regarding your admission to and retention in a health care facility for mental health treatment, or instructions to refuse any specific types of treatment that are unacceptable to you.)*

**5. Guardianship provision.** If it becomes necessary for a court to appoint a guardian of my person, I nominate my health care agent acting under this document to be the guardian of my person, to serve without bond or security.

**6. Reliance of third parties on health care agent.**

- A. No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me, my estate, my heirs, successors, assigns, or personal representatives, for actions or omissions by my health care agent.
- B. The powers conferred on my health care agent by this document may be exercised by my health care agent alone.... All acts performed in good faith by my health care agent pursuant to this power of attorney are done with my consent and shall have the same validity and effect as if I were present and exercised the powers myself.... The authority of my health care agent pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends and others.

**7. Miscellaneous provisions.**

- A. I revoke any prior health care power of attorney.
- B. My health care agent shall be entitled to sign, execute, deliver, and acknowledge any contract or other document that may be necessary, desirable, convenient or proper....
- C. My health care agent... [is] hereby released and forever discharged... from all liability and from all claims or demands of all kinds arising out of the acts or omissions of my health care agent pursuant to this document, except for willful misconduct or gross negligence.
- D. ... Any person, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this health care power of attorney may interpose this document as a defense.

**8. Signature of Principal.** By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

*(witnessed and notarized)*

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## Advance Directives: Organ Donation

Organ donation is usually not seen as a central concern among end-of-life issues, but it is life-giving to others, and belongs in the category of advance directives.

At the time of this writing, some 2,900 people in North Carolina (nearly 90,000 in the United States) are awaiting donations of such organs as kidney, liver, pancreas, heart and lung. In North Carolina in 2004, 250 patients died while waiting for organ donations; in the U.S., 6,324.<sup>19</sup>

Note that the North Carolina Advance Health Care Directive Registry website makes the Declaration of an Anatomical Gift (Organ Dinner Card) form available. In North Carolina, this advance directive does not need to be notarized, but it does need to be witnessed.

### The North Carolina Advance Health Care Directive Registry

We have referred to this registry, established by the Secretary of State of North Carolina, above. Registering advance directives is voluntary. It is, however, to be commended, as it is one additional way (sharing copies as suggested above is another) of ensuring that your views will be made known if you are unable to express them yourself.

The forms they provide may be either filled out online and printed for notarization, or alternatively, opened in Adobe Acrobat and printed for your use. You are not, however, required to use their particular forms. You may use others, such as *Five Wishes*. Moreover, you may register whatever forms you use, not just the ones they provide. (There is a small fee for registering each.) Do note that the act of registering your advance directives does not assure that they meet legal requirements. The office of the Secretary of State does not review your directives; it only registers them.<sup>20</sup>

The registry website also has “helpful links,” which leads to further resources on end-of-life issues.

## Quality of Life

Our study thus far has affirmed that we have choices – faithful *and* legal ones – as we consider end-of-life decisions. In one sense, those decisions do have to do with the often-used phrase, *quality of life*. But, it is worth noting that quality of life is much more encompassing, a consideration of that which brings goodness and meaning in life, a sense of happiness and well-being. We can talk of our psychological, social, and spiritual, as well as our physical, well-being,<sup>21</sup> and thus “lay claim” to that which we feel is essential for a meaningful life. We can *say* those things to ourselves, and to others; the problem is that ultimately we may not be able to ensure them.

Remember the teaching on euthanasia:<sup>22</sup> Our faith does not permit our ending our lives “in order to relieve the suffering caused by incurable illness.” If that is so, it certainly does not permit such an act because we can no longer retain the quality of life for which we pray. Moreover, facing new limitations in our lives, we may well prove capable of affirming life anew.

Reflecting on that which defines *quality of life* for us may be interesting and helpful – a contribution to our discernment of what is truly important and meaningful – but it is a matter of degree as to whether quality of life characteristics can legitimately influence end-of-life decisions. Decisions to discontinue treatment when faced with incurable disease have a great deal to do with our quality of life values; faithful decisions when faced with, say, prospects of dementia ultimately cannot. We need to appreciate the difference, and the limits.

### Decisions

It should be clear by now that our faith teaches us of life and death; both the Church and our health care system encourage us to make faithful and appropriate decisions about our wishes at the end of our lives; and the law permits us to do so.

What if we don't? Decision-making when we are incapacitated is governed by state law, which defines

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<sup>19</sup> From [www.carolinadonorservices.org](http://www.carolinadonorservices.org).

<sup>20</sup> See [www.nclifelinks.org/](http://www.nclifelinks.org/) for further information.

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<sup>21</sup> As do B.R. Ferrell and M. Grant in *Quality of Life Model* (Duarte, CA: City of Hope National Medical Center, 2000).

<sup>22</sup> See above, pp. 4, 7.

who is entitled to serve as your surrogate *in the absence of a living will*. (Remember that a surrogate is a person who makes health care decisions for us when we are not competent to do so ourselves.)

In North Carolina, generally the person who may legally make decisions for us – our surrogate – *when we are deemed to be incompetent to make them for ourselves and when there is no living will* is

- first of all, our health care power of attorney; in other words, the person *we* have named to make decisions for us;
- if there is no health care power of attorney, then a guardian; in other words, another who is legally entitled to act on our behalf;
- if there is no health care power of attorney or guardian, then our spouse;
- if none of the above exist, then “majority relatives of first degree;” in other words, parents and/or adult children, with a majority of them deciding on a particular course of action on our behalf;
- if none of the above exist, then the attending physician.

However much an extended family may choose to talk about decisions together, family members such as brothers and sisters and grandparents are not included in the order.

Again, a living will and durable power of attorney take precedence – which has been the point of this session. We therefore encourage you to reflect upon

these readings and conversations, and to discern what you would like to do, what you would like say.

### ***The Question***

Consider this week whether you have already addressed decisions about advance directives in the way you wish. If you have not, examine options and forms for the following advance directives:

- A living will (including the *Five Wishes* option);
- Organ donation; and
- Durable power of attorney.

Make those choices you are comfortable making, and note any questions you still have. If the facilitator of your study plans for a session in which you can speak individually about your remaining questions, plan to engage in those conversations. Otherwise, take steps to have your remaining questions answered.

Plan to bring your completed documents to a final session, to be signed, notarized and witnessed. And, remain for a brief liturgy affirming our study, reflection and action.

In addition – and perhaps as an aid in this process – you might like to note some thoughts you have had as you have gone through this study. On the next page is a sheet that you might find helpful to use, either simply to focus your own thinking, for yourself., or as something to share with others.

*Our faith teaches us of life and death;*

*both the Church and our health care system encourage us to make faithful and appropriate decisions about our wishes at the end of our lives;*

*and the law permits us to do so.*

*What do we wish to do?*

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*A personal worksheet*

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*What I believe about the end of life as a result of this study:* \_\_\_\_\_

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*What I still have questions about:* \_\_\_\_\_

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*What I would like my family (or doctor or priest) to know:* \_\_\_\_\_

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*Session 5*  
*A time for clarification*

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**Readings:** Teach me, O Lord, the way of your statutes,  
and I will observe it to the end.  
Give me understanding,  
that I may keep your law and observe it with my whole heart.  
Lead me in the path of your commandments,  
for I delight in it. Psalm 119:33-35

**I**n this study we are now approaching time for decision. You may decide that you are not yet ready to sign any advance directives, and if so, that is fine. We hope that you have found the conversations meaningful. You may have taken steps regarding advance directives before, and have therefore decided that nothing further needs to be done. For you we hope that this study has been helpful in reaching that conclusion. Or, you may have found this study and your

conversations valuable in pointing toward action on advance directives. For you the way may now be clear, and in the final session you are encouraged to bring forms for signature, witness, and notary.

It's possible that you have some remaining questions or concerns. If so, and if the facilitator of your study plans for the coming session to be one in which you can speak individually about any remaining questions you may have, plan to engage in those conversations. If not, please use this week to consult with an

attorney or with whomever else you wish to resolve the questions you may have.

If your questions and concerns have been resolved, as noted on the previous page plan to bring your completed documents to the final session, to be signed, notarized and witnessed. And, remain for a brief liturgy affirming our study, reflection and action.

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*A prayer for guidance*

*Direct us, O Lord, in all our doings with your most gracious favor,  
and further us with your continual help,  
so that in the decisions we now make,  
we may glorify your holy Name,  
and finally, by your mercy, obtain everlasting life;  
through Jesus Christ our Lord.  
Amen.<sup>23</sup>*

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<sup>23</sup> A prayer for guidance, adapted from the *Book of Common Prayer*, 1979, p. 832.

**Readings:** For none of us has life in himself,  
and none becomes his own master when he dies.  
For it we have life, we are alive in the Lord,  
and if we die, we die in the Lord.  
So, then, whether we live or die,  
we are the Lord's possession. Romans 14:7-8

**T**his session is largely devoted to witnessing and notarizing any documents members of the study group wish to sign. However, we encourage the group first to offer prayers and thanksgiving for the time together, for the conversation, the study and reflection, for discernment, and for our seeking together to act in accord with God's will. What follows is a brief liturgy, for both the study group and for your own purposes.

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The Lord be with you.  
*And also with you.*  
Let us pray.

Look with mercy, O God our Father, as we approach increasing years. Be present with us as we anticipate that time of our lives, that our decisions now may help to provide us with homes of dignity and peace. Give us in those times understanding helpers, and the willingness to accept help; and, as our strength diminishes, increase our faith and our assurance of your love. This we ask in the name of Jesus Christ our Lord.  
*Amen.*

A reading from the Book of Job (19:25-27):

As for me, I know that my Redeemer lives  
and that at the last he will stand upon the earth.  
After my awaking, he will raise me up;  
and in my body I shall see God.  
I myself shall see, and my eyes behold him  
who is my friend and not a stranger.

That this day may be holy, good, and peaceful,  
*We entreat you, O Lord.*

That your holy angels may lead us in paths of peace and goodwill,  
*We entreat you, O Lord.*

That we may be pardoned and forgiven for our sins and offenses,  
*We entreat you, O Lord.*

That there may be peace to your Church and to the whole world,  
*We entreat you, O Lord.*

That we may depart this life in your faith and fear, and not be condemned before the  
great judgment seat of Christ,  
*We entreat you, O Lord.*

That we may be bound together by your Holy Spirit in the communion of all your  
saints,  
entrusting one another and all our life to Christ,  
*We entreat you, O Lord.*

#### A General Thanksgiving

*Accept, O Lord, our thanks and praise for all that you have done for us. We thank you  
for the splendor of the whole creation, for the beauty of this world, for the wonder of  
life, and for the mystery of love.*

*We thank you for the blessing of family and friends, and for the loving care which  
surrounds us on every side.*

*We thank you for setting us at tasks which demand our best efforts, and for leading us  
to accomplishments which satisfy and delight us.*

*We thank you also for those disappointments and failures that lead us to acknowledge  
our dependence on you alone.*

*Above all, we thank you for your Son Jesus Christ; for the truth of his Word and the  
example of his life; for his steadfast obedience, by which he overcame temptation; for  
his dying, through which he overcame death; and for his rising to life again, in which  
we are raised to the life of your kingdom.*

*Grant us the gift of your Spirit, that we may know Christ and make him known; and  
through him, at all times and in all places, may give thanks to you in all things. Amen.*

Let us bless the Lord.  
*Thanks be to God.*

The grace of our Lord Jesus Christ, and the love of God, and the fellowship of the Holy  
Spirit, be with us all evermore.  
*Amen.*<sup>24</sup>

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<sup>24</sup> The collect is adapted from a prayer for the aged, from the *Book of Common Prayer*, 1979, p. 830; the litany is adapted from Evening Prayer II, p. 122; and the General Thanksgiving is from p. 836.