

The Inescapable God

Psalm 139: 1-18

Romans 14:7-8

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I remember two boyhood experiences that shaped my understanding of death and dying.

First there was the death of my older brother's scoutmaster. Doug was probably 13 or 14 at the time and the adult scoutmaster, who I did not know, died of a sudden heart attack in his forties. When Doug came home from the funeral, my mother asked how it went. Doug completely broke down in her arms, sobbing and crying.

I learned from that experience that death can be sudden and frightening, even when the deceased is someone who is not a family member or a close friend. The first experience of death for young people can be shattering in an almost physical sense.

The second memory I have is from several years later when the same older brother was in his early 20s. Doug had completed a tour of combat duty in Vietnam and was stationed at an Army base in North Carolina. That was a long way away from our suburban Philadelphia home in the days before jet travel. Our maternal grandfather, a veteran of World War I, died of cancer in his early seventies. My mother in her grief made the decision to leave our younger siblings out of the funeral service and not tell Doug until afterwards. Doug was understandably upset that he had not been given the opportunity to participate. I remember writing a letter to him attempting to explain on behalf of my mother how and why this oversight happened. Doug as the veteran of the family was later given the folded flag from the military funeral.

From this second experience, I learned that as terrible as death is, it is also a holy moment that people want to experience and honor. There are many kinds of unhappy deaths. In this case a family member was not given the opportunity to say goodbye properly. Goodbye is a 16th century contraction of the phrase "God be with you."⁽¹⁾ My grandfather and my brother were unable to pass memories across the generations and exchange final blessings.

This morning I would like to share a few thoughts about death and dying. I recently took a seminary course on the subject with a group of adult students that included several pastors and chaplains. This is my attempt to integrate what I learned about death and dying with my own life experiences and theology in front of an audience that knows me well.

Death is inherently difficult to talk about because it is the final event of human life. Although death is all around us (about 2.4 million people die each year in the U.S.)⁽²⁾, our culture avoids the subject whenever possible for several reasons.

Medical science has lengthened our life span and pushed life expectancy significantly higher in the last 100 years. In developed countries like the U.S. the average life

expectancy has increased from approximately 47 years in 1900 to 77 years in 1998. The improvement is primarily due to changes in the way we die. Epidemics from infectious diseases such as diphtheria, whooping cough, and smallpox have been eliminated by successful public health measures including vaccines and antibiotics. Degenerative diseases such as heart disease, cancer, and stroke have emerged as the leading causes of death. As a result of these changes, infant and early childhood mortalities have declined, and death occurs more frequently in old age. That makes death less intrusive as a day to day experience in American life.

The decreased visibility of death and dying following the elimination of infectious diseases has been abetted by changes in medical technology that ward off degenerative diseases at the end of life. The treatment of progressive and debilitating illness occurs primarily in hospitals, nursing homes, and other medical institutions. In the United States and Great Britain, 70% to 80% of deaths occur in hospitals and other institutions rather than at home. That's a complete reversal in the place of death since the first half of the twentieth century, when death happened at home. (3) Coupled with the expanded role of the funeral industry, which manages viewings, funerals, and burial on behalf of the family, the typical American no longer experiences death as a natural activity which happens in a family setting, but as an institutional experience managed by others outside the home, often at great expense. It is easier to avoid dealing with death when it happens somewhere else.

The trends in the medical world that have altered our perspective on death have been complemented by pastoral trends in the church. Death and dying are discussed infrequently in church, and clergy do not typically receive formal training during or after seminary in ministering to those who are seriously ill or dying.

According to a new book on death and dying by Rev. Martha Jacobs of the Health Care Chaplaincy, an organization that provides chaplains to hospitals in the metropolitan New York City area, two thirds of regular churchgoers say that clergy at their places of worship do not speak out on end of life issues. In a Gallup poll, only 36% of respondents believed that clergy would be especially helpful at the time of death, compared to 81% who cited friends. Gallup described this situation as a "wakeup call to the clergy," suggesting that ministers need to find better or more consistent ways to meet spiritual needs at the end of life. "Clergy must help people frame their lives in the large context, so that death is understood in a larger perspective."(4)

As it happens, the ministers of our church, the Presbyterian Church of Mount Kisco, perform good work around death and dying. During our weekly prayer of joys and concerns, the most common and heartfelt requests for prayer support come from those who are caring for sick people or experiencing death and dying among family and friends. The small number of church members who are at any time living between life and death are prayed for continuously over a period of weeks and months. During their medical crises these individuals become the spiritual center of congregational life.

I nevertheless believe that we can do more in this area as a whole church. An expanded ministry is consistent with our religious beliefs and well-suited to the talents and gifts of a faith community. And while end of life ministry is filled with challenging situations leading to death itself, I also want to suggest that this mission work is personally rewarding and a vivid way to live out our daily faith.

I want to be careful about summarizing what our beliefs are, because this is an educated congregation from an eclectic faith background that includes people from all walks of life. What I want to offer first is the perspective of the people who provide care to the dying as doctors, nurses, and chaplains. Very broadly these women and men, who themselves come from a variety of religious and non-religious backgrounds, define the meaning of life in the face of suffering in a theological way that's helpful and appealing.

Partnership with the Dying, a book by a retired religion professor named David H. Smith, is based on interviews with 30 medical professionals who work with seriously ill patients. Smith summarizes their fragmentary, sometimes inconsistent thoughts on death in two strands.

First, these conscientious, thoughtful people seem to share a belief in a transcendent God. As one nurse commented: "Part of this job has taught me that as humans we are so fragile. We can't do it all. And by nature, we try so hard to. And life is just so much bigger than us. And through watching patients go through dying and watching their families, there's definitely a source bigger than any of us that's in control." (5)

Smith notes in his discussion of divine transcendence that "the key contribution of the relationship to God is simply the relationship itself." In the midst of life and death medical situations, a relationship with God allows acceptance, recognition of the inevitable, and a search for help in coping. The acceptance of God's sovereignty permits "a kind of letting go, a recognition of the limits of human power and responsibility." This perspective offers sanity to doctors and nurses because it gives them the strength to process what's happening when medical treatments are unable to reverse the course of degenerative disease. (6)

The second theme that Smith identifies among medical caregivers is the idea that God is not only powerful, but walks with us in life as a comforting presence. God identifies with us and shares the experience of those who suffer. We "are not alone in our suffering. Indeed as those we love suffer and die we are in community, or in communion with God." Salvation from end of life medical challenges comes when people recognize that they are not alone. (7)

I share these two perspectives on death and dying to underline the fact that those who work in medicine turn to theology rather naturally to understand what's happening to patients and themselves. I also find it compelling that their understanding of God – as a divine presence above us all, yet present in our daily lives – is wonderfully close to the understanding of God we share in this Presbyterian Church.

Our first scripture reading this morning is from Psalm 139. In my NRSV edition this Psalm is entitled “The Inescapable God.” God is described as someone who searches us up and down, who knows our thoughts, and who in particular created our bodies and knows our physical form. God hems us in with his presence. If we ascend to heaven, God is there. If we descend to Sheol, the realm of the dead, God is there also. God is with us in life and after life is over. In verse 18 the Psalmist concludes: “I come to the end – I am still with you.”

The Inescapable God of Psalm 139 provides a theology for death and dying. If we were to take this up as a congregation, what would that mean and what would kind of mission could we offer?

One way to start is to learn something about hospital chaplains and how they go about their work. Three former members of our congregation have validated ministries as hospital chaplains – Cathy Garner, Doug Phillips, and Dan Mena.

Chaplains are underappreciated professionals. They are ordained ministers who work in a clinical setting in which, wearing neither clerical collars nor medical white coats, they are almost invisible. Think of all the television shows you have watched over the years in a medical setting – ER, Grey’s Anatomy, House, and so forth. There are two characters you never see in a hospital drama. One is the cashier. The other is the chaplain.

In a parish setting, a minister can offer religious faith and solace to a church member who is dying. In an ecumenical hospital setting, it is unethical for chaplains to proselytize. No worship, no sermons, no scripture or prayers unless they are asked for, and no interactions with patients and families that aren’t directly requested. What is left for chaplains to do?

The answer is that hospital chaplains provide presence. At a time when patients are facing imminent death, enduring physical pain, struggling with hospital bureaucracy and procedures, often unable to make important medical decisions, and dealing with families who are equally unprepared and overwhelmed, chaplains offer grace and forgiveness. They sit, they listen, and they bear witness. They do not speak in platitudes and they do not provide easy answers to people who are confronting death or dying. As one chaplain says, “I make a fairly good living not knowing what to say next.” (8)

Hospitals are not a place of joy. They are a place of sadness. And chaplains are associated with that sadness in the popular mind. Yet they are sometimes the only person in a hospital setting that has the time and the temperament to listen with no agenda to patients and families who are vulnerable and afraid. And because they are (unlike everyone else in the hospital) not focused on a medical cure, chaplains are able to offer something else that has great value at the time of death -- healing and peace of mind. Their job is to quietly support the patient’s needs and desires even when they are strange or unusual.

The chaplain who taught my seminary course tells the story of a wealthy philanthropist who was anxious and uneasy in his dying days. In spite of his financial generosity over many years, he was unable to forgive himself for stealing a candy bar as a boy during the Great Depression. The chaplain encouraged the philanthropist to believe that God had *probably* forgiven this lapse and that he should forgive himself, too. She did not cure a disease or postpone death. She offered grace – and promoted healing.

Chaplains offer many practical insights into how to properly care for those who are dying. Please pay attention to the following rules:

Don't overstay your hospital visit - five or ten minutes is plenty.

Never sit on the patient's bed - you'll mess up the tubes and spread your germs.

Never touch the patient without permission - you may cause physical pain.

When touching the patient with permission - don't rub the back using a circular motion. Place a hand on the shoulder and hold it still - that communicates "I am here for you."

When someone is crying, don't offer Kleenex. That says "please stop crying," when in fact tears are a gift from God

Don't offer a prayer as an exit strategy to leave the hospital room – too many pastors do that already!

Based on what I know about our culture, the world of medicine, Reformed theology, and the lessons of chaplaincy, here is how I would go about encouraging this congregation and others to provide additional support to the seriously ill and dying:

The most important thing our church has to offer is community. As disciples and believers, we should be able to confidently assure the ill and dying that they are known and not alone. In the second scripture reading from Romans, the apostle Paul writes that we neither live alone nor die alone. "If we live, we live to the Lord, and if we die, we die to the Lord; so then, whether we live or die, we are the Lord's. For to this end Christ died and lived again, so that he might be Lord of both the dead and the living."

I am not proposing an evangelical campaign to bring Jesus Christ to the death and dying. I am using Scripture to remind us that we are well-positioned as a faith community to offer grace and presence to those who need a non-judgmental friend during terminal illness. None of us here are chaplains. But the church can offer and should offer reconciliation, forgiveness, healing, and blessings.

The second element of our proposed ministry is ritual. Good ritual has two characteristics: it is meaningful, and it is to some extent habitual.⁽⁹⁾ We have had so many deaths in the congregation in the last few years, it would not be inappropriate to

offer adult education seminars, moments of silence, prayers of remembrance, an occasional sermon, or even an annual service in which the congregation is given a liturgical opportunity to remember those who have gone before and pray for those who are dying now.

The tone of what I have in mind comes from a prayer that is included in a Reform Jewish prayer book *The Gates of Prayer*. It's a prayer for the dead called "We Remember Them." Here are the last few lines:

"When we are weary and in need of strength, we remember them;
When we are lost and sick at heart, we remember them;
When we have joys we yearn to share, we remember them;
So as we live, they too shall live, for they are now a part of us, as we remember them."

The last building block of our new ministry is education. Presbyterians have always placed great importance on the value of education. We have an opportunity to help prepare church members and community residents for end of life issues by teaching about advance directives. "An advance directive is a declaration, while the individual is still competent, about what treatment they would or would not want if they lost their decision making capability." (10)

There's a fairly wide consensus about what a good death looks like. It's quick, painless, at home, and surrounded by family. (11) The main reason why a good death is hard to achieve is that modern medicine is deeply and primarily committed to saving and sustaining life. The goal of medical cure is so deeply ingrained in the medical world that it has been difficult to refocus the discussion at the end of life on care that is not directed toward a cure, but toward palliation and the management of suffering. (12)

It's also fairly clear what patients would like to receive at the end of life:

- 1) pain relief, which is actually a legal right, not just the humane thing to do
- 2) no inappropriate prolongation of life
- 3) a sense of control over medical decisions
- 4) relief from the burden that's place on loved ones, and
- 5) strengthened relationships with loved ones through better communication about dying. (13)

In my seminary course, pastors, chaplains, and elders were encouraged to promote conversations with church members about end of life wishes. The information needed to help an individual think about a good death can be gathered with a list of personal and medical questions that can be answered in about a half hour. After that we were

encouraged to help people complete living wills and, more importantly, health care proxies, that will allow those wishes to be observed.

Advanced directives like living wills and health care proxies are important. In New York State, hospitals are not legally permitted to withdraw artificially administered nutrition and water from a patient in a permanent vegetative state on their own. If we want to avoid the fate of Karen Quinlan or Terri Schiavo, we need to engage in conversations with our loved ones to discuss a different outcome, and provide written instructions to allow our chosen proxy to intervene legally on our behalf.

So -- now that our ministry for the dying has been outlined in the form of community, ritual, and education, there's only one more thing to do before we get started. We need to become comfortable thinking about our own mortality. It will be hard to provide presence to the terminally ill if our own issues and reservations about death are allowed to get in the way. For many people, this is the toughest part of all.

The theologian Paul Tillich made the famous point that doubt is not the opposite of faith but an element of faith. How can we calmly persuade ourselves that death is not the opposite of life but just the last earthly part of a longer journey?

At Robin Theurkauf's funeral last month at Yale, I ran into Bill Weisenbach, the pastor of the Katonah church, who suggested that we think about death in the following way. When a baby is in the womb, he or she is warm, well-fed, and secure. It's a pretty satisfactory environment – why would you ever want to come out? What the baby cannot imagine in any way is the rich experience of human life that will be provided outside the womb in the years ahead. Bill went on to say: suppose death is like that. We fear death because the life we are leaving is understood and familiar, and because we have no conception whatsoever of what happens on the other side. What if death is more wonderful than anything we can conceive of now? What if death is not an end but a passage way to something else?

A professor of preaching once said to his seminary students: "I've got doubts of my own, don't tell me yours when you preach. Tell me what you believe!" My own thoughts about death are simple: When you are alive, you honor those who have gone before, and do your best all along the way. Then, in the fullness of time, you hand things over to God. Not any old God, but the God of Psalm 139, who watches over us ceaselessly during life and after life, too.

It is vitally important to have God nearby as we struggle to understand the meaning of death. Certainly my older brother, who taught me many things years ago, continues to struggle as well as teach. Doug is currently in his early 60s, a successful attorney in Akron, a good father, married like all Godshall men to someone significantly more intelligent. Last month Doug wrote a letter to the Akron Beacon-Journal on the occasion of the death of Robert McNamara, former secretary of defense to Kennedy and Johnson during the Vietnam war.

Doug wrote about his time in Special Forces where he spent a year in reconnaissance with indigenous troops in areas controlled by the enemy in parts of Southeast Asia where the U.S. was “not there,” including Laos, Cambodia, the demilitarized zone and North Vietnam. His unit suffered more casualties any other unit in the U.S. Army since the Civil War – 50 percent were killed. The survivors averaged two wounds each. His unit received a Presidential Unit Citation belatedly in the 90s, as a result of the secret nature of the operations.

Doug described two military engagements in a one week period that took the lives of two friends. One was from LA and one was from Detroit. In the first battle more Green Berets were killed than any other single day in the war.

After writing publicly about his personal experiences in Vietnam for the first time, Doug then turned his attention to the behavior of McNamara, who famously announced in a book written in his old age that the war was “wrong, terribly wrong.” McNamara made this determination before Doug’s comrades were killed but did nothing at the time to share his view and stop the war. 58,000 Americans died while the secretary of defense in charge of the war kept his reservations to himself.

Here are my brother Doug’s ending sentences:

“My faith requires me to forgive those who trespass against me. I will pray that the Lord forgive Robert McNamara for his sins.

I will not. I cannot.”

This is what all of us can hope for in the midst of death and dying – that our deepest needs and shortcomings will be taken up by the Inescapable God.

Amen.

Footnotes:

1. Celia Engel Bandman, “A Medical Humanist Says Good-bye,” *Journal of the American Medical Association* Vol 300, no.2 (2008): 150.
2. Rebecca Vesely, “How Will It End?” *Modern Healthcare* (July 20, 2009): 30.
3. Philip M. Kleespies, *Life and Death Decisions: Psychological and Ethical Considerations in End-of-Life Care*, (Washington, D.C.: American Psychological Association, 2004), 11-12.
4. Martha R. Jacobs, *Death is Not the Enemy: A Clergy Guide to End of Life Care*, (Cleveland: Pilgrim Press, forthcoming), 90.

5. David H. Smith, *Partnership with the Dying: Where Medicine and Ministry Should Meet*, (New York: Rowman & Littlefield, 2005), 46.
6. Smith, 47-49.
7. Smith, 52.
8. Smith, 26.
9. Smith, 113.
10. Kleespies, 35.
11. Charles Meyer, A, *Good Death: Challenges and Care Options*, (Mystic, CT: Twenty-Third Publications, 2000), 1.
12. Kleespies, 16.
13. Kleespies, 17.

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