Christ Episcopal Church

Sermon for September 6, 2026

The Rev'd Deacon Nancy Sartin

Good morning!

It is difficult for me to believe that on September 11th, I will celebrate my 16th anniversary as a deacon and on September 10th I will celebrate my 15th year at South Ga Medical Center. I could not have had one without the other. It was during deacon school that I had to complete a unit on chaplaincy and I was mentored by Father Steven Norris during that time. To my surprise I found that I loved chaplaincy work and I was lucky enough to apply and be hired as a PRN Chaplain. I have learned more about being a Christian and experienced more spiritual growth during my time at the hospital than at any other place.

As a deacon I am called to bring the needs of the world to the church. Today's scripture is rich, but I will not be preaching on it. Instead, I will be speaking on a matter that God has placed on my heart for quite some time.

Let me start with a true story where the names have been changed, but I assure you this story repeats itself over and over again in hospitals everywhere.

During one of my shifts a 68-year-old man, Mr. M, is brought to the ER in respiratory distress. He was found down in his backyard by a neighbor who checks on him frequently. His oxygen rates are in the low 80s; heart is just under 150 bpm. He has a gash on his head from the fall that continues to bleed. I am called to locate family and let them know that their loved one is in the hospital and we need them to come as soon as possible. The nurse finds his wallet and hands it over for identification. They check medical records and find that the first contact is the neighbor, Mrs. G, who found him. The backup contact is a son that lives 2 states away. Meanwhile, the medical team has found that he has sepsis and is very close to multi-organ failure. The records also show that he has been at SGMC before, many times. He has stage 3 kidney failure, congestive heart failure and diabetes.

Mrs. G, his neighbor, arrives and is placed in the consult room. I am able to obtain more medical history for the doctors. She tells me Mr. M has not been compliant with his medication and has started canceling doctor appointments that she will gladly drive him to. He seems to be slipping mentally too and she relates stories about finding him at her door at 2 am confused and babbling. His wife died from coronavirus in 2021. He does have a son, but she has only seen him once when he came to his mother's funeral. She tells me that Mr. M and his son do not get along and are estranged.

I try to contact the son and no one answers the phone. It goes to voicemail and I hear a recording that the mailbox is full. I go back to the trauma bay and find that Mr. M has been intubated, has multiple IVs running and staff is continuing to take blood to check labs. They take Mr. M to do a CT scan and he codes on the way back to the ER.

Now the team is doing chest compressions. I know we have all seen patients having CPR done on TV and I am here to tell you that it is nothing like that in real life. On TV, patients have a little CPR done and the next morning they are sitting up in bed having a full breakfast and chatting with family about their "near death" experience. Real CPR breaks bones, the sternum and ribs. Staff line up to take turns because of the amount of force being used wears the person out after 2-3 minutes. Drugs are injected into IVs to restart the heart and raise blood pressure. Mr. M regains a heartbeat briefly and then loses it again and the process starts over. After 10 minutes, his heartbeat returns and he appears to be a little more stable. Results from the CT come in and he has had a stroke on the right side of his brain.

One of the doctors goes to the consult room to update the neighbor and see if she has any more information to share about Mr. M. She says, "He would not want all of this…He told me multiple times that he had nothing left since his wife died. He was looking forward to being with his wife again in heaven one day."

Now I know that I have just overloaded you with information and I did that because I wanted you to get the feel of what a crisis like this is entails. The team in the ER is there to save lives. They will do everything possible to stabilize a patient and move them to the ICU for treatment to continue. And with today's technology, medicine and excellently trained doctors and staff they can do just that, for a time anyway.

This crisis repeats daily. Sometimes there are no family members and sometimes there are almost too many family members discussing what the next best plan of action should be. Everyone in the room has an opinion of what their loved one would want during this crisis.

So, what can help at a time like this? Who or what can speak for the patient and honor their wishes?

An Advance Directive… you know that thing your PCP asks if you have during your checkup? Right after he asks you if you have fallen down lately?

An Advance Directive puts you in control of medical decisions before you even need to think about it or when you may be incapacitated. It lets your family know exactly what kind of treatment you may want and what kind of treatment you do not want.

An Advance Directive has 4 parts.

Part one lets you choose a health care agent to speak for you. It includes 2 backup agents in case the first one cannot be located. This may be need updating from time to time.

Part two covers your treatment preferences. It covers what types of treatment you may or may not want. It is very important that you discuss this part thoroughly with your family members and health care agents. Perhaps you would not want to be placed on a ventilator, you need to make sure they are willing to uphold your wishes.

Part three is about guardianship. It allows you to appoint a person to be your guardian if you should need one.

Part four is signatures. The entire document depends on signatures, yours and two witnesses.

When you complete your Advance Directive, do not stash it in your safety deposit box! Give a copy to your PCP, your family members or healthcare agents and your area hospital. DO not keep it in your home and make a family member dig through during a crisis to find it.

There are multiple ways this case could end…

Chaplains go into detective mode to locate son…though Facebook, police in the city where he lives. But there is no guarantee that he will want to make decisions about his father's healthcare if they are estranged. Many times, this ends with a do not call me about this again.

Mr. M can linger in ICU for weeks never regaining consciousness again. If he codes again the team will do CPR again.

A hospital ethics committee can meet to offer suggestions and discuss who has been contacted. Based on medical results they may decide to make him a DNR and if his heart stops again, he will mercifully pass.

I have seen patients put on vents, then after 2 weeks a trach and feeding tube are placed and the patient waits for a place they can be discharged to from the hospital. The patient is not brain dead, but they will remain in a vegetive state as their body slowly breaks down.

I believe in death with dignity and peace; for the patient and the family. I believe our maker knows our time of death. I believe our loved ones should have the right to make their own choices about how this happens.

If you would like to review a copy of the Ga Advance Directive, all you have to do is google it. Print several copies and began to read over it with your family members and friends.

Website editor's note: you can find this GA Advance Directive on the website for the Division of Aging Services in the Georgia Department of Human Services by following this link:

https://aging.georgia.gov/document/document/georgia-advance-directive-health-care-07pdf/download