The Northwest Center for Bioethics

Commentary
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Advanced Directives: On having your end-of-life wishes honored ©
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Hospitals offer a large load of forms to sign before admission. Did you know that one of them is a “living will,” that if signed thoughtlessly could place your end-of-life decisions squarely in their hands. In Oregon the ‘living will’ comes by way of federal and state law. Oregon law recognizes two types of advanced directives used to address your end-of-life wishes. The first is found in “Part C: Health Care Instructions” of ORS 127.610 (1991 Edition). Contents of this type of document are based upon “the living will” and came from the Euthanasia Education Council in 1972. The Council used the “living will” in hopes of changing public perception of and our laws regarding assisted suicide. The “living will” gained favor in the public eye during that time partly due to a ‘fee for service’ medical system that was perceived as financially benefiting from extraordinary intervention at the end of life that did not let a person die in peace. Because of this public perception, the “living will” provided instructions with language slanted toward forgoing life support, life sustaining treatments, and CPR.

Times have changed and health care profit is, more often than not, dependent upon restricting care rather than providing it. This new economic environment has lessened the protection provided by a “living will” if not even making it perilous by ‘tying the hands’ of physicians in medical crises. High costs of a life-sustaining procedures can lead to a health care provider’s interpretations of a “living will” that is outside the patient’s wishes. The language used in Oregon’s “Part C” appears to have adopted content slanted toward forgoing treatment and mirrors much of the content of the “living will.” I, personally, am uncomfortable with this approach and do not recommend its use.

In light of this, you might be asking: “Are there prudent and beneficial actions that should be exercised regarding end-of-life planning?” “Is there a legal document that provides greater assurance that my treatment wishes will be respected? Is there a legal instrument that would spare me unwanted intervention while assuring that I will receive adequate treatment?”

The answers depend upon the type of document used, your value compatibility with your health care representative, and your state of health. If you are healthy, you and a close member of the family have value compatibility, you have a physician who holds to your values, and your hospital has a value system compatible with yours, you probably do not need any document. If any of these conditions are absent, it is prudent to designate a trusted representative to act on your behalf should you lose the capacity or competence to make health care decisions.

Oregon provides for such representation offering the option of the second type of advanced directive. It is found in all of Oregon's advanced directive forms and is entitled: *"Part B: Appointment of Health Care Representative."* This second type of can protect your end-of-life wishes and honor your personal values. If you choose this option, it is best to make sure that your world-view and life values are clearly compatible with your chosen representative. Because Oregon has specific statutes that explain how the specific form is to be completed and criteria that health care representatives must meet, it is recommended that you consult with legal counsel before signing your document. This gives you the best assurance that your document will be honored.

It is also good to set up a short meeting where your representative, your primary care physician, and you can discuss various medical issues. The discussion should include decisions about nutrition and hydration, as well as, resuscitation. A clear understanding that distinguishes (1) sanctity of life from vitalism, (2) killing from letting die, (3) life-support from life-sustaining procedures, (3) imminent death from a terminal condition, and (4) prognostic certitude from medical opinion is essential in this discussion. Value compatibility of the parties must be addressed since it is better to uncover possible conflicts in conscience before any pressure of immediate treatment decisions appear.

All this being said, if your health is good, description of specific interventions should be avoided since judgment will only be likely in a rapidly changing medical crisis that usually necessitates frequent quick decisions i.e. serious accident or sudden onset of an unexpected life-threatening medical crisis.

The most important circumstance for the use of a *Part B* is when there is a serious change in your health i.e. diagnosis of cancer or heart disease. Again value compatibility with your health care representative is essential. It is important to note that your treatment goals may change during the progress of your disease. Goals and wishes should be made that are appropriate to the different stages of your disease. It is in your best interest to conduct clear and understandable discussions with your chosen representative(s) and the health care practitioners in charge of your care when planning treatment goals. If your diagnosis is terminal, make sure your goals are individualized. Some may wish treatment interventions to prolong the dying process until they have addressed unresolved life issues while others may feel at peace to forgo the prolongation of the dying process and request only to be made comfortable while dying. Whatever the case, Paul's advice in Philippians 1: 19-26 serves as an example of how to approach death as a good witness to Christ. Paul's vision for death now is his life with Christ in the future, his vision for his dying-life now, is his labor for a life in Christ for others in their future. Selah