# Value Profile for Advanced Directives-a Christian Perspective

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## II. A Spiritual Basis for Living Through Dying

One text which provides a basic principle for approaching the discussion of death and dying from a Christian perspective is Romans 14: 7-9. Applications can be drawn from Paul's discussion of the principle of Christian responsibility one in relation to another. From this text we draw the basic premise that our intentions and the behavior that flows from those intentions cannot be reduced or isolated to 'self'. This Pauline passage attests to the affect that one's intentions, motives, and behaviors have upon the relationship that others have with Christ as well as the impact on one's own relationship with God. A foundational statement is made by the writer of Romans in this context:

> Romans 14:7-9 For none of us lives to himself alone and none of us dies to himself alone. If we live, we live to the Lord; and if we die, we die to the Lord. So, whether we live or die, we belong to the Lord. For this very reason, Christ died and returned to life so that he might be the Lord of both the dead and the living.

### *A. Romans 14:7-9: foundation of relationships*

The importance of the 'living' and 'dying' as living and dying in '**relationship'** is highlighted in this text by the following observations:

1. The use of the pronoun of negation "no one" in conjunction with the use of a reflexive pronoun "himself" intimates a impossibility of living in isolation. This notion is contrary to the Christian whose life affected those around him. It is applicable in distinction to the radical autonomist (Derek Humphrey) of our time who reduce all experience including dying to one's own self.

2. The author is very clear in his matter of fact statement regarding our existence, be it living or dying, it is living or dying in relationship to the one who commands and sustains its 'being,' the Lord. This is clear through the use of the grammatical structure (genitive of relationship)

3. In Romans 14:8 the last phrase "we are of the Lord's" use of the stative verb "are" (εστι) in concert with the genitive of relation "the Lord's (του) which describes the relevance of our living and dying as relevant only in relation to the Lord of both processes-living and dying.

Humanity's relationship with the Christ whom we cannot see is reflected by our actions and attitudes of those that we can see in the here and now (cf. 1 John 4:20). Here then is the context of developing a life of Christ-like intention "putting on Christ" and exhibiting it in relationship with other people (cf. Romans 13:14). *Through the thou the man becomes an I.*[1]

### *B. An example of their effect upon operating norms*

Often those of the pro-life movement appeal to an absolute sanctity of life principle when addressing medical issues such as foregoing life-sustaining treatment. This principle has often been interpreted as a binding biological norm where physiological life should be preserved at all costs. An approach based upon a relationship representing Christ by living and dying well in Him contravenes such vitalism. A shift away from a biological sanctity of life norm to a more transcendental sanctity of life norm in Christ is a shift from objectifying sanctification toward relationalizing sanctification.[2] Such a shift exacts its price on patients, physicians, clergy, and communities of faith.

Quality of life becomes part and parcel of sanctity. Biological lives in end-stage of their physical narrative retain their spiritual worth. The waning phenomenal vitality provide the final opportunity for a person to 'represent' God. It becomes incumbent upon the health care professional to utilize all of his/her skills to enable the dying person to fully actualize this last opportunity. This means resistance to pressures to hasten death due to managed care profit structures, pleas for physician assisted termination of life, or vitalistic interventions. The leadership of the caring community must garner its resources to enable the dying one to be free of undue burden and care of those left behind, financial encumbrances, unresolved conflicts, and of course fostering of their spiritual well being as they draw nearer to their earthly exit. In this context the quantitative norms of biological life are brought into harmony with qualitative norms of emotional and spiritual life. Such harmonization calls upon cooperation of physicians, nursing, social workers, psychologists, and clergy.

Taking these notions into consideration we come to the guiding fundamental moral norm, common to both moral and systematic theology: "The chief end of man is to glorify God and live with Him forever." This guiding precept is the outcome which the Holy Spirit empowers the person in their life of transformation to achieve. It is the metamorphosis described in 2 Corinthians 3:18. All our actions in relationship to others when contemplating health care decisions ought to conform this norm. However, it must be

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[1] Buber, Martin: *I and Thou.* (New York: Scribner Press, 1958) 2nd edition, p. 28.

[2] Wernow, Jerome R.: "Saying the Unsaid: Quality of life criteria in a Sanctity of Life Position," in *Bioethics and the Future of Medicine,* edited by John Kilner. (Eerdmans, July 1995) pp. 93-111.

pointed out that this norm only alludes to disposition. How that disposition is to be worked out in each individual health care context is subject to contextualization.

### *C. An example of their effect upon operating values*

The effect on valuation is quite similar. Using the preceding example, value weighting is done in the context of principles revealed in Scripture, outcomes in relation to those principles, and proportional analysis. Biological life is of great value but it does not assume the position of the overarching value. That is reserved for the emulation of a Christ-like behavior in each particular clinical context. This precludes an axiology that is merely subjective since the decision making agent has placed themselves under the Lordship of Christ in their decision making relationships. The overarching question becomes: does the medical intervention appear to maximize the persons relationship to Christ through the self as a moral agent and through the other(s) coming in contact with them during the living/dying process?

## *2. Appointing a health care representative:*

Appointing a health care representative requires serious introspection regarding one's personal world view. The pastor of your church is one of the most appropriate persons to clarify important aspects of your world view. There are two primary foundations for world views in the United States when considering health care decisions (check one):

- naturalism
- supernaturalism

The naturalistic approach emphasizes a moral discourse predicated upon the interpretation of material facts. The positive side of this approach is that conditions and issues have objectifiable aspects associated with them which can be quantified in decision making. The negative side is when the entirety of the human person is reduced to or medicalized into merely objective data.

The supernaturalistic approach emphasizes aspects of the moral discourse that goes beyond merely material facts. The positive side of this approach is the recognition of the emotional and spiritual components of human existence. On the other hand, when this approach overemphasizes the non-material realities at the expense of the medical data, superstition can interfere with prudent decision-making task.

I prefer an approach which permits the voicing of both the material and no-material expressions of the human person, e.g. the corporeal-psychological and spiritual aspect with a voicing in their appropriate spheres. An example of this approach is reflected in the dominant voicing of a physician's decision in the area of his/her expertise in matters of certitude of physiological futility. Likewise, the patient's voice receives paramount consideration in decisions involving their quality of life judgments.

It should be obvious that one basing their world view on a naturalistic position has no necessity to found their health care decisions on anything but material evidence. One with a supernaturalistic world view will need to weigh material evidence along with the metaphysical implications on norms and values derived from their belief. In regard to choosing a health care representative, physician, and institution; the greater the correspondence to one's would view, the greater the likelihood of compatibility patient-physician-surrogate-institution compatibility when difficult choices are to be made.

### *B. A Values Profile for Discussing Substitutionary Judgment*

The Christian community relies upon the fundamental moral norm discussed previously when embarking upon various constructions of an advanced directive. In doing so, the constant consequence sought by each decision should be the glorification of God. The repeated question raised should be: "Does this decision and its consequences add weight to the Holy Name of God before believer and non-believer?" Let us consider how this norm might effect decisions regarding the seven categories of value judgments and the five most prevalent categories discussed during the dying process.[3]

#### 1. Health Care Categories of Value Judgment

**a. Terminal Condition**: This category places the projected longevity of one's life in the context of the five categories of treatment. The categories of intervention include cardio-pulmonary resuscitation, life-sustaining treatment, supportive care, symbolic care, and euthanasia. We explore patient preferences in their personal narrative for medical intervention from these five categories in the context the patient's projected time left for survival. The question of prognostic certitude as well as the means through which someone has arrived at the certitude for survival is important in this consideration.

**Survival intervals are subjective but include the following:**

- imminent death (2-3 weeks),
- less than one month,
- less than six months,
- less than one year.

Issues of sanctity of life, quantitative futility, and quality of life often appear in this discussion. It is a decision-making sphere where the outward expression of world-view is quite evident. It is a context of decision making where spiritual, psychological, and medical discussion should exhibit clear and frank interactions.

**b**. **Pain and Suffering**: This category takes into consideration the level and tolerability of pain in concert with the best interest of each particular patient. Sociological, cultural, psychological, and religious factors play a part in understanding the patient's desires in this sphere of consideration. Of particular importance is the attitude of those involved in the care *nexus* toward amelioration of pain in relation to induction of drowsiness and confusion. This aspect must be carefully weighed when considering the place of suffering, relief, and Christian witness.

**c. Mental Incapacity**: Degrees of mental deterioration are taken into consideration in this category. Treatment decisions of all five categories are weighed in regard to the extent and projected duration of mental incapacity. This category is one of the most controversial because of its use as a prominent quality of life criterion for termination of care and rationale for euthanasia. Mental incapacity presents difficulties in the Christian analysis in cases of persistent vegetative states, permanent vegetative states, and in profound senile dementia. Issues regarding the five treatment categories often take into account the ability to read, understand written materials, and the ability to interact with loved ones. The issues of sanctity of life, resource allocation, and quality of life all bring their weight to bear upon

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[3] I have drawn upon the value categories laid out by Norman Cantor in his legal discussion of advanced directives. Cantor, Norman L.: *Advanced Directives and the pursuit of death with dignity*. (Bloomington: Indiana University Press, 1993) pp. 166-170.

interventions and treatments which indeed glorify God or may detract from His witness in faith and practice.

**d**. **Physical immobility**: The issue of physical immobility is associated with one's perception, willingness to accept, and willingness to tolerate non-ambulatory states such as the necessity to use a wheel chair, use of the toilet, or being confined permanently to their bed. Notions of quality of life intersect with sanctity of life in these cases. Decisions regarding medical interventions in such states require an understanding of the person's narrative, spiritual maturity, socialization, and psychological state.

**e. Physical helplessness**: Human dignity is part and parcel of the discussion of this category. Independence versus reliance upon the caring community raises treatment decisions based upon one's understanding regarding the capability of a person to feed themselves, cloth themselves, and maintain their personal hygiene (e.g. bowel habits).

**f. Interest of others**: The issue of emotional burden, financial burden, and needs of others constitute this category. The depletion of assets due to care expenses, emotional strain upon those bearing the constant care of the patient, and the expenditure of resources which might be better utilized in other cases bring the aspect of future generations into the medical decision. This is a place where Christian service and sacrifice emulate the contrast community which Christ has called the Church to be.

**g**. **Living arrangements**: Some circumstances are considered undesirable and thus have led to directives to withhold or withdraw treatment. Such circumstances such as living at home with full time help, living permanently with children, living in a long term care facility, or hospitalized with little hope of leaving are considered under this category. The world view upon which family, community, and society are based will determine the prominence that this category has in one's advanced care directives.

## 2. Treatment Categories

### a. Cardio-pulmonary resuscitation

This category contains decisions surrounding a patient who is verifiably chronic post-competent condition and who is facing an irreversible, irreparable condition which according to reasonable medical judgment, will cause death with or without medical intervention. The medical health care representative should be empowered to direct **the withholding or withdrawal** of the following medical interventions in an event necessitating cardio-pulmonary resuscitation if they deem it in the patient's best interest:

All interventions associated with cardio-pulmonary resuscitation when with <u>reasonable</u> medical judgment the prognosis suggests that the patient has (check one):

- uncertain longevity,
- less than one year to survive,
- less than 6 months to survive, or
- less than 14 days to survive

### b. Life-sustaining treatment

Definition: Withholding and withdrawal of life-sustaining interventions are the processes by which various medical treatments either are not given to or are removed

from patients in circumstances outside of acute crises with the expectation that they will die without such interventions.[4]

It should be noted that the categories in the boxes below are only to be used to facilitate discussion between the patient and their physician in a specific context. It is by no means to be used as a "cookie cutter" formula to direct treatment. The medical health care representative should be empowered to direct **therapeutic trial, the withholding, or withdrawal** of various medical treatments being aware that if such treatments are not given to or are removed from patients in circumstances outside of acute crises that the individual will likely die. The categories for discussion might include:

| CATEGORY | THERAPEUTIC TRIAL | INTERVENTION WITHHELD/WITHDRAWN |
|---|---|---|
| Chemotherapy | | |
| Mechanical Ventilation | | |
| Vasopressors | | |
| Nasogastric feeding | | |
| Blood Transfusions | | |
| Organ Transplant | | |
| Dialysis | | |
| Total parental nutrition | | |
| Positive end-expiratory pressure | | |
| Antibiotics | | |
| Antiarrythmic drugs | | |
| Intravenous fluids | | |
| Surgical Intervention | | |

Further the individual is incompetent and experiencing intractable pain which cannot be managed by therapeutic intervention, the medical health care representative should be empowered to direct **the withholding, withdrawal, or only therapeutic trial** of various medical treatments being aware that if such treatments are not given to or are removed from patients in circumstances outside of acute crises that the individual will likely die.

| CATEGORY | THERAPEUTIC TRIAL | INTERVENTION WITHHELD/WITHDRAWN |
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| Positive end-expiratory pressure | | |
| Antibiotics | | |
| Antiarrythmic drugs | | |
| Intravenous fluids | | |
| Surgical Intervention | | |

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[4]Luce, John M. and Raffin, Thomas A., "Withholding and Withdrawal of Life Support from Critically Ill Patients, *Chest.* (September 1988) v. 94/3, p. 623. Much of my definition was taken from their text.

If the patient is assessed with reasonable verification and certitude to have permanently lost their capacity to direct medical decisions and are confined to

- a hospital with little prospect of ever leaving
- a nursing home with little prospect of leaving

The medical health care representative should be empowered to direct **the withholding, withdrawal, or only therapeutic trial** of various medical treatments being aware that if such treatments are not given to or are removed from patients in circumstances outside of acute crises that the individual will likely die.

my surrogate has been empowered to do the following if they deem it in my best interest:

| CATEGORY | THERAPEUTIC TRIAL | INTERVENTION WITHHELD/WITHDRAWN |
|---|---|---|
| Chemotherapy | | |
| Mechanical Ventilation | | |
| Vasopressors | | |
| Nasogastric feeding | | |
| Blood Transfusions | | |
| Organ Transplant | | |
| Dialysis | | |
| Total parental nutrition | | |
| Positive end-expiratory pressure | | |
| Antibiotics | | |
| Antiarrythmic drugs | | |
| Intravenous fluids | | |
| Surgical Intervention | | |

## 3. Supportive care

| CATEGORY | SUPPORT WITHHELD | SUPPORT WITHDRAWN |
|---|---|---|
| Supplemental oxygen | | |
| Hydration and Nutrition | | |
| Maintenance medication | | |
| Pain Medication | | |
| Physical Therapy | | |
| Nasogastric Tube | | |

If the patient should loose their decision making capacity, is concerned about alleviation of extreme pain, the medical health care representative should be empowered to direct the medical personnel to participate in the following if they deem it in the patient's best interest (check any of the following choices that applies):

- To permit medication with analgesics even if death might be hastened as a side effect
- To permit medication with sufficient analgesics to relieve pain even if it exacerbates confusion
- To permit medication sufficiently to make pain tolerable yet wish to maximize apparent alertness
- Prefer not being medicated

### 4. Symbolic care

If the patient should loose decision making capacity, the health care representative should be empowered to request the following on the patient's behalf if they deem it in the patient's best interest to:

- Instruct those to provide religious service in accordance with the patient's faith and tradition, e.g. anointing with oil, laying on of hands, and communion
- Instruct those to provide ordinary care which would demonstrate mercy although medically futile, e.g. providing water orally

### 5. Euthanasia

If the patient should loose decision making capacity, and is concerned about extreme suffering and indignity, the medical health care representative should be empowered to maintain the following position on my behalf:

- strenuously reject any form of physician assisted suicide, mercy killing, or euthanasia and if their is any evidence of such actions, direct the patient's legal counsel to investigate and seek prosecution of all parties involved to the full extent of the law including homicide and accessory to murder.

## Conclusion

For those of the Judeo-Christian perspective the goal of the decision is the glorification of God. Advanced directives and the actions issuing from them will be oriented toward with this disposition and objective.