

THE ETHICS OF ADVANCED DIRECTIVES: A RESPONSE TO GILBERT MEILAENDER

A Paper

Presented to

Dr. Jeff Louie

Western Seminary San Jose

In Partial Fulfillment

of the Requirements for the Course

THS 508S, Integrating Theology and Ministry

By

Brian LePort, Box 032

June 20, 2009

The following paper is a short response to the chapter entitled “Who Decides?” in the book *Bioethics: A Primer for Christians* written by Gilbert Meilaender.¹ To begin we will first note the several aspects of Meilaender’s argument that we agree with before we point out the false premise upon which the gist of his argument is built. In essence, we disagree that ‘advanced directives’—the right of someone to put in writing ahead of time what decision should be made by doctors regarding one’s self if something should happen to one’s self that does not allow for that person to make competent decisions—are “an attempt to extend our autonomy into a future time when we are no longer autonomous”.²

We agree with Meilaender that while we may be right to move away from medical paternalism we must be careful to avoid pushing patient self-determination too far.³ There is a reason that medical professionals are called “professionals”. Those who work in the medical field are more aware of how our bodies work and what consequences are involved when we are given particular medications or surgeries. To remove the right of the medical professional to make a decision regarding the patient is to demean this profession and assume that someone who has little to no knowledge about their own body ought to be able to trump someone who does. In addition, the medical professional has the opportunity to make decisions from a more objective position which is often beneficial. For example, a patient may be advised to sacrifice a limb because it has been infected by gangrene. The medical professional had the foresight to know that the patient will need some time to adjust to his loss but that in due time, as with many other patients, this patient will find that living with one less limb was a better alternative to death. At the time of the decision the patient may be emotionally overwhelmed and this could cloud his

¹ Gilbert Meilaender, *Bioethics: A Primer for Christians 2nd Ed.*, Grand Rapids, MI: William B. Eerdmans Publishing Company, 2005.

² Ibid. 80.

³ Ibid. 75.

judgment as to whether or not he wants to live. While it appears that in most cases the law stands on the side of the patient regarding this scenario we do have the right to be concerned about this because it is doubtful that the patient will make a better decision than the medical professional.

If the patient is given full autonomy this will make doctors essentially mechanics of the body. Meilaender is correct to observe that these situations regard two people—a doctor and a patient. The doctor is human as well and the doctor is involved in the process of making medical decisions just like the patient. While the results of the decisions will affect the patient and the doctor differently there will still be an effect upon both.⁴

Meilaender notes that, “Patients need not submit to doctors’ recommendations; doctors need not practice what they consider bad medicine simply because patients want it.”⁵ If both the patient and the doctor are competent there is a possibility that the two will not agree on how to handle a particular medical crisis. This is normal and this is why patients are allowed to get a second opinion from another doctor.

Yet there are times when the patient is not competent to make their own medical decisions. “This may happen for a short time due to the trauma of injury, but more difficult are cases of patients who will be incompetent to help make decisions for the entire course of their treatment—infants and young children, the severely demented, the retarded, the permanently unconscious. In these cases we are forced to ask in earnest, Who decides?”⁶ This is where the ethics of advanced directives are in question.

The advanced directive is in some sense *reduction ad absurdum*⁷ since it is asking a hypothetical question that cannot be answered of an incompetent patient. While we may *wish* to

⁴ Ibid. 75-76.

⁵ Ibid. 76.

⁶ Ibid. 77.

⁷ Ibid. 79.

know what that patient would desire if she could tell us we simply cannot. It is true that what a person may wish prior to an incident would differ from what that person would say if after the incident a decision could be made.

Meilaender plainly states that advanced directives are something that should be avoided. He states that we should be able to avoid advanced directives, saying about those whom we have placed our lives in our hands, that, “Here is a person upon whom I have often been dependent for love and care in the past. Now, when I can no longer participate in decisions about my medical care, I am content to continue to be dependent upon his love and care. Talk with him about what is best for me.”⁸ He argues that, “It is our nearly idolatrous attachment to the language of autonomy that drives us to such lengths, of course, and where the law will permit it we should not hesitate to turn from substantial judgment to an attempt simply to assess what is in the patient’s *best interest*.”⁹

The problem with this perspective is two-fold. First, it *assumes* that everyone has someone who can be trusted this way and that everyone has someone who has taken care of them in the past and whom they can rely upon in the future. While this is ideal it is not universal. There are plenty of people who do not have anyone close enough to them that they can rely upon to make such decisions about their future. This may be because of the nature of relationships or because of something like the death of a spouse or children that leaves a large gap between those close relationships and the nearest one to those. An advanced directive allows these types of people to assist doctors and those who are not very close to them to make decisions without having to do so in ignorance.

⁸ Ibid. 83.

⁹ Ibid. 79.

The second is that this perspective further assumes that the decisions made when preparing an advanced directive are always, by nature, a grasp at extending autonomy. While Meilaender may be correct to critique this aspect of advanced directives we note that his critique cannot apply to those who prepare an advanced directive in the presence of loved ones. It is possible, and even recommended, that if someone does prepare an advanced directive it is done with one's wife and/or children, parents, siblings, or close friends nearby.

The decisions made and written into an advanced directive should be discussed and explained with these people. If someone writes that they do not want to be kept alive by machinery in the case of extreme brain damage or physical paralysis then the reasoning for this decision ought to be spelled out. A loving spouse will usually be willing to listen to and respect the reasoning for such decisions. The same can be said of anyone else who may have had to make these decisions for you if you have not first talked with them about it.

These actions prevent an advanced directive from being a solely autonomous decision. This discussion prevents family and friends from feeling like you did not trust them. And further, it is possible that in having such a discussion you may change your mind regarding some aspect of the advance directive because the discussion does allow you to hear the voice of those who care for you.

The thing that favors the advanced directive the most is that it does allow a decision to be made between loved ones without the pressure of an actual event. If these issues are not discussed ahead of time it *would be extremely difficult for a loved one to pull the plug when they feel they had no idea what their loved one would have decided*. An advanced directive does not rob them of making decisions; it prevents them from making decisions alone, on the spot, while

always wondering what you would have wanted. That loved one will want to know what you would have wanted.

In addition an advanced directive prevents loved ones from acting autonomously on the other side. It is very possible that a spouse would agree when her mind was clear that her husband should be allowed to pass away if in a certain circumstance, but when the fear and pressure of the moment occur, and when the spouse is suddenly faced with the departure of her husband, she may make a decision that she would not have made otherwise. As an example, if a husband and wife discuss full-body paralyzation and it is decided that the loving thing to do would be to let one's spouse pass from this life rather than force them to stay alive by machines (when in any other era of human history that person would have passed away naturally) with no ability to do anything but sit trapped in such a terrible existence it would be good to place this in writing. It could be that once something like this *actually happens* the spouse would fear the prospect of loss and they would hope against reality. In doing this they are acting selfishly in the moment and they are no longer thinking clearly about what they are putting their spouse through.

Meilaender seems to have ignored the fact that others can have moments where they act autonomously as well. If we leave major decisions to our loved ones without making them with them before something actually occurs we forfeit our opportunity to make this decision together. This eventually leads to the same problem Meilaender raises but from the opposite angle.

In summary we note that it is a false premise to argue that advanced directives should be avoided because they are an attempt to secure autonomy. This is simply false. Advanced directives can be made with loved ones. This prevents one's loved ones from the pressure of making decisions alone, hence, in autonomy.