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WITHHOLDING AND WITHDRAWING LIFE-SUPPORT FROM CRITICALLY ILL PATIENTS

by

EKUNDAYO L. KING-MANLEY

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APPROVED BY J. Steven O'Malley
Faculty Advisor

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INTRODUCTION

1.1. A Perspective

John Arras and Nancy Rhoden open their book Ethical Issues in Modern Medicine this way, "Perhaps there were never any 'good old days' when life was simple, but life is certainly more complex now than it once was. And one aspect of this complexity is that it is often more difficult to discern what we ought and ought not to do. This is especially true in medicine and the life sciences in which modern technology has created new possibilities related to life itself entirely unknown a few years ago."[1] In the United States the last three decades have been a successful era in medicine. The physician Charles L. Sprung captures the full impact of this technological revolution that took place in medicine in an article published in the Journal of the American Medical Association.[2] Besides tracing its history, Sprung shows by means of illustrations how the technological revolution has affected physicians' abilities to save lives. He makes a noteworthy point that technology has not only enhanced the physicians' effectiveness as a

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[1]John Arras and Nancy Rhoden, Ethical Issues in Modern Medicine, 3rd ed., (California: Mayfield Publishing Co., 1989) 1.

[2]Charles L. Sprang, "Changing Attitudes and Practices in Forgoing Life-Sustaining Treatments, JAMA 263(16) (25 April 1990): 221-5.

care-giver, but it has made them able to interrupt the normal dying process.

Society is reacting to the technological development in a somewhat ambivalent manner. On the one hand there is resounding joy and praise for a 'high tech' health care system that has tremendous capability of extending life and relieving suffering through care. On the other hand there is a concern for rising costs that are pushing society to requiring health care providers to use the existing resources prudently. The problem of how to produce quality health care while still containing costs is attracting the attention of many scholars, and it is the major issue discussed at many conferences on health-care delivery. Attending to this issue is of utmost importance. The figures tell us why. In forty years the number of Americans in the United States over sixty-five will increase by a hundred percent, but the number of tax-paying wage-earners will only increase by thirty percent. So we are asking ourselves the question "Who will pay the bill?" Society is also concerned about the amount of health care dollars that today is consumed by the elderly. This concern is even greater over the use of life support systems in the treatment of elderly patients who are critically ill. We should mention that the use of such life support systems is no longer limited to the intensive care unit of a large hospital but has been extended to other medical facilities

and even to home care. Their use has generated tremendous expenses for the health-care system. We are spending one percent of the Gross National Product on intensive care. Public outcry over the disbursement of health-care resources has led some to argue that in terms of increased rates of survival and improved quality of life, investment in life support systems is inefficient.

If this is the case, then society ought to seek ways to reduce the utilization of life-support systems. A suggestion would be to require physicians and other health professionals to withhold and withdraw life-support systems from certain critically-ill patients. In such cases, the physician's assessment of the patient's quality of life would serve as a touchstone for judgement. However, there may be instances in which the judgement of physicians in favor of withdrawing or withholding life-support from patients may intentionally cause their death. These cases would be acts of passive euthanasia, which is contrary to the tradition of medical practice. Passive euthanasia is the withholding of certain medical services in order to allow the patient to die, again for benevolent reasons.[3] All evidence indicates a general public consensus that it is inappropriate to employ life-support technologies where no purpose is served but the prolongation of the dying process.

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[3]Robert Wennberg, Terminal Choices: Euthanasia, Suicide and the Right to Die, 108-156.

However, the medical literature reveals that society has experienced difficulty in translating this consensus into practice. The problem of scarcity is moving society to find an ethically reliable basis for distinguishing between acts of passive euthanasia on the one hand, and legitimate decisions to withdraw and withhold life-support systems from critically-ill patients. The difference between them may be whether or not death is intended.

Efficient utilization of resources is not the only concern that leads to the discussion of foregoing life-support systems. There also are several ethical concerns that have nothing to do with scarcity and resources, but are arising instead from the use of life-support systems themselves. Indeed, scarcity is not the issue in the prominent court cases involving the withdrawal of life-support systems from patients like Karen Quinlan, Shirley Dinnerstein and Nancy Cruzan. The nature of the support systems themselves seems sometimes to insulate patients from the normal process of dying. In these cases ethical issues precipitated the decision to terminate their use. The ethical issues centered around the way in which our society understands human freedom, suffering and death. The problem we are faced with is that society does not have a clearly-held view about these moral concepts. Two major strengths from which society derives its morality are Judaism, Christianity and modern American secularism. Experience

shows that these traditions have different views of human freedom, suffering and death. Our task, then, is to find the implications of various conceptions of human freedom, suffering and death for the ethical issues of withdrawing and withholding life-support systems from critically ill patients.

Utilitarianism seems to be most dominant among the philosophies that have currency in the contemporary American secular scene. Consequently, it would be reasonable for us to assume that the utilitarian ethic is pervasive in current medical practice and medical decision-making. However, J.K. Mason in his book Human Life and Medical Practice warned that "the ethical practice of medicine rests upon an uneasy confederation of deontology, religion, utilitarianism and self-determination and being a public service, its pattern is ultimately shaped by public conscience."[4] Although Mason includes religion as one of the forces influencing the current practice of medicine, religion's influence on medicine appears to be parochial. Theological reflection has not been a major consideration in the contemporary practice of medicine, nor has it been incorporated in the statutes regarding health care.

Rev. Dennis Brodeur, a moral theologian, cites three reasons why elected officials, judges and regulations might

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[4]J.K. Mason, Human Life and Medical Practice (Edinburgh: Edinburgh University Press, 1988), 7.

not want to include religious language in health policy: to maintain the separation of the church and the state, to use philosophical and legal language which are more acceptable to pluralistic society, and to avoid the difficulty of translating religious language adequately into public policy. However, he notes that religion can contribute to health policy and health-care decision making. "The contribution of religious and theological experience should go beyond the briefs and legislative activities of national and state groups to the construction of a framework for ethical thinking that precedes the statues or court decision. Too often, public policy is shaped by the immediate case at hand and not by the foundational issues."[5]

Theology has made significant contributions to medicine and bioethics, but its contributions have typically been neglected. Earl E. Shelp and other scholars strongly believe that theological reflection advances made in medical research and technology is critically important. A fuller treatment of this issue can be found in a volume edited by Shelp entitled Exploring the Foundations of Frontier (a collection of articles from seventeen contemporary

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[5]Dennis Brodeur, "Ethical Decision-Making at the End of Life: The Role of Religious Traditions and Public Policy." America vol. 163:11 (20 October, 1990): 207-271.

theologians and theological ethicists).[6] The author's aim is to affirm what theological scholarship has done for medical ethics. The integration of theology and medicine found in this volume is based on the conviction of some scholars[7] that a theological framework is necessary for making certain medical choices. It is premature to expect agreement on a single methodology for this integration. It is our contention that theological reflection must be included in our discussions if we are to find a reliable basis for distinguishing between acts of passive euthanasia and legitimate decisions to withhold and withdraw life saving technologies that are futile and burdensome to the patient. The Bible, as well as later theological writings, can prove helpful here. Theological reflection may also shed light on other ethical issues connected with life-support systems. Indeed, in the face of recent ethical dilemmas created by the use of life-support technologies, many religious organizations and individual are turning to their religious traditions for moral guidance.

Mason includes deontology as another force in

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[6]Earl E. Shelp, Theology and Bioethics: Exploring the Foundations of Frontier. (Dordrecht, Holland: Boston; O. Reidel; Hingham, M.A., U.S.A. Kulwer Academie, 1985).

[7]William K. Frankena believes that theology can contribute to bioethics. In one of the chapters he examines "the Potential of Theology to Bioethics", 49-64; Basil Mitchel did "the Role of Theology in Bioethics", 65-68; Paul Lehmann in "Responsibility for Life: Bioethics in Theology", 283-302, thinks that a non-denominational approach to certain theological concepts will be useful to bioethics.

influencing the current practice of medicine. Deontological theories are different from teleological theories, in that they hold that an act is morally right if it conforms to certain codes of laws or norms. One form of deontology is

exististentialism. Frederick Nietzsche is usually regarded as an existentialist.[8]

First, the search for an ethical framework leads to an examination of human freedom, suffering and death in current medical practice. We shall work with the assumption that utilitarianism predominates in the current medical practice. Second, we shall analyze those same concepts within another framework: denotological ethics. Third, attempting to capture our moral intuitions, all of which are captured by deontology and consequentialism, we shall examine these concepts within a third ethical framework: biblical ethics.

1.2. Life Support Systems

Definition and Ethical Issues

The Encyclopedia of Bioethics defines life-support systems as "heterogeneous collection of administered synthetic, semi-synthetic, and natural agents which by manual or automated means support or substitute for certain

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[8]Howard A. Slaate, A Critical Survey of Ethics (Lanham: University Press of America, 1988), 201-218.

vital functions of a patient during the critical, life-threatening phases of illness or injury."[9]

From this definition, it is obvious that the term life-support system covers a wide range of techniques and technology. The list extends from simple manipulative physical techniques like cardiopulmonary resuscitation techniques to sophisticated technologies like kidney dialysis. They also include mechanical ventilation machines and nasogastric feeding technologies. Despite the fact that they cover such a wide variety, they all serve a single purpose: "to aid and support or supplant a vital function that has been severely impaired."[10]

The vital functions of our body include breathing, feeding, and waste removal.

Often physicians' conceptions of critically ill patients who have lost one or more functions are conditioned by certain other patient characteristics. In a survey of physicians, Crane has discovered that characteristics such as "salvageability" and "damage" affect physicians' perceptions.[11]

A salvageable patient is one who can be restored

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[9]Albert Jonsen and George Lister: "Life-Support Systems" in Warren T. Reich, ed., The Encyclopedia of Bioethics, 4 vols. (New York: Macmillan, 1978) vol 2: 840-848.

[10]Jonsen, and Lister, 840.

[11]Diana Crane, The Sanctity of Social Life: Physicians and the Critically Ill, (New York: Russell Sage Foundation, 1975), 13-15.

> to health or maintained in a chronic condition for an indefinite period, that is, one whose physiological life can be saved. A damaged patient is one who, because of physical or mental handicaps, cannot resume (or assume) the normally expected range of social roles.[12]

The aforementioned patient characteristics are of considerable relevance. Crane stresses that they form the key decision-components as physicians consider whether to initiate aggressive treatment techniques or technologies for patients who are salvageable but have physical damage. While other patients who are also salvageable may receive less active treatment from physicians because they have mental damage, patients who are perceived to be unsalvageable and have mental damage are less likely to receive any aggressive or heroic treatment at all.[13] This gives us a sense of the complex nature of what is involved in the treatment of critically ill. Withholding and withdrawing of life-support are the processes by which various medical life-support interventions either are not given to or are removed from them.

The process of determining what to do with a critically ill patient who needs life-support is a difficult one. An easy way of out of this enigmatic situation could be to use every available technology to save lives. Then the occasion for making such decisions to forego life-support does not

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[12]Crane, 14.

[13]Ibid.

even rise. Providing life-support to every critically ill patient who needs it eases the need to make decisions. In reality this not a satisfactory solution. Walton attempts to justify the need to make decisions withdrawing aggressive therapy including life-support in his book Ethics of Withdrawal of Life-Support Systems. He frames his analysis in the context of critical care, especially in terms of patients in the intensive care unit (ICU). We believe such decisions are paradigm cases, whose analysis is applicable to most clinical decisions involving withdrawing and withholding life-support.[14] Pivotal in Watson's analysis is the distinction between two categories of decisions: (1) Decisions to withdraw or withhold life-support from patients who are already dying. This is well captured as the decision involving irreversibility. (2) Decisions to withdraw or withhold life-support from patients who have the potential of surviving current illnesses, but their lives could become dependent on life-support.[15] Walton cites two cases which we shall rewrite here to illustrate each of his two categories. The first case he cites involves an illustration of the first category.

> Mr. Walden Asbury was a sixty-eight-year-old man who had a stroke and was also suffering from burns over 45 percent of his body. He was awake but not

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[14]Douglas N. Walton, Ethics of Withdrawal of Life-Support Systems: Case Studies on Decision-Making in Intensive Care, (New York: Praeger, 1983).

[15]Walton, 38.

> communicative or very fully conscious during his stay in the ICU. He suffered severe burn-related infections and numerous cardiac arrests. Another man in the same room caught the infection from Mr. Asbury and died. So Mr. Asbury was put in isolation, utilizing a four-bed ICU room by himself....After Mr. Asbury had been undergoing treatment for three months, one physician decided that, at best, the patient would remain a functionless human being and that it was not worthwhile to prolong his dying any further. The other two physicians did not agree, however; and in particular, a burn specialist, was very enthusiastic about continuing aggressive treatments. Yet, when this physician went on vacation, the level of active therapy was reduced, and two weeks later Mr. Asbury died while still on the ventilator.[16]

With regard to this case, Walton mentions five reasons why life-support should have been withdrawn from the patient. Costs, suffering, irreversibility, the patient's choice and disagreement among physicians.[17]

The second case is an illustration of the aforementioned second category of decisions.

> Mr. B. was a sixty-seven-year-old emaciated recluse who was found by his landlady in his room in a slumped, semi-comatose state. He was brought to the Emergency Room, where he was found to be in acute respiratory distress with a blood pressure of 100 mm Hg, pulse rate of 116 beats per minute, rectal temperature of 98.6 deg. F., and respiratory rate of 40 breaths per minute. Measurement of arterial blood gases while the patient was breathing room air indicated a large component of chronic lung disease (arterial Po_2, 55 mm Hg; arterial P_{co2}, 80 mm Hg; and arterial pH, 7.24). A chest x-ray film on admission showed no acute pulmonary infiltrates. Further arterial blood gases measured on the afternoon of admission showed no improvement, and the patient was intubated and placed on controlled ventilation.
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> Following intubation and ventilation, the patient became responsive and partially oriented. All causes

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[16]Walton, 40-41.

[17]Walton, 42.

of acutely reversible lung disease were explored and treated to the best of the abilities of the Respiratory-Surgical Intensive Care Unit (R-SICU) Staff. His pneumonia was treated with antibiotics and controlled ventilation with positive end-expiratory pressure. Excess water in the lung was treated by fluid restriction, albumin, and diuretic agents. The dead space to tidal volume ratio indicated that approximately two-thirds of every spontaneous breath was wasted ventilation (VD/VT, o.68). His malnutrition was treated by tube feedings and food by mouth.

During the ensuing 2-1/2 months repeated efforts were made to wean Mr. B. from the ventilator. Each time the ventilator was stopped and he was allowed to breathe spontaneously, the arterial P_{co2} would rapidly rise to 80 or 90 mm Hg., he would become anxious and frightened, and he would indicate frantically his desire to be returned to the ventilator. On one occasion, a cardiac arrest occurred during a trial of weaning. All efforts to wean him from the ventilator were met. He became extremely dependent and attached to his nurses in the R-SICU. He frequently said he wished to die, although it was not at all clear to those who were caring for him whether his wish to die was an acceptance of his ultimate fate or whether he was extremely uncomfortable and depressed at the realization of his complete dependency on the ventilator.

Many hours of agonizing discussion with his nurses, R-SICU physicians, psychiatrists, and a social worker concerned the issue of discontinuation of mechanical ventilation, which would almost surely result in his death. Since Mr. B. was alert and oriented when his arterial P_{co2} was in the near-normal range, discontinuation of ventilation was a particularly difficult dilemma. During the 2-1/2 month period of his stay in the R-SICU, many other acutely ill patients were denied admission because he occupied a bed. Ultimately, because he could not be successfully weaned from the ventilator, and because a consensus decision to terminate his ventilation could not be reached by all those who were caring for him, he was transferred to a medical floor, where his ventilation was maintained by a volume-constant ventilator. Two weeks later, he died. His hospital care had cost $41,846.14 (not an out of the way figure).[18]

Watson believes that the physicians should have made a

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[18]Ibid.

decision to discontinue the use of life-support.[19] Based upon the preceding discussions, we make the assumption that there are cases in which it is justifiable to withdraw or withhold life support systems from critically ill patients. Such decisions to forego life-support raises ethical problems, which may take different shapes depending on the type of life-support system. Evidently, physicians are still cautious in making decisions when they involve foregoing life-support systems. They are afraid that patients and their families could initiate criminal or civil proceedings against them. Quite apart from legal considerations, physicians are still not sure yet it is ethical to withhold or withdraw life-supports from a critically ill patient. There is a growing consensus that a physician should withhold and/or withdraw them from terminally-ill patients.[20] Another issue that may give rise to ethical concerns is directly related to scarcity of medical resources. The issue here is how can the limited resources like life-support systems be allocated ethically? Who should be asked to carry the financial burden of patients if they are dependent on life-support for the rest of their lives?

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[19]Ibid.

[20]Council Report on Scientific Affairs on Ethical and Judicial Affairs, Presistent Vegetative State and the Decision to Withdraw or Withhold Life Support, American Medical Association (Chicago), 426-429.

These are some of the ethical questions involving life-support systems. A fuller treatment of these issues is beyond our scope.[21] Our task is to see how the various conceptions of human freedom, suffering and death affects decisions to forego life-support. In the next chapter we shall examine how decisions to forego life-support systems are currently made. The aim will be to determine within what philosophical theory fit those underlying conceptions of human freedom, suffering and death pivotal in these decisions.

To be able to get into the mechanics of the current decision-making process, we shall divide life-support systems into two categories: (1) simple life support, e.g., cardio-pulmonary resuscitation, and (2) advanced life-support technologies, e.g., mechanical ventilator and nasogastric feeding techniques. We shall discuss these separately.

1.3 Statement of Problem

The purpose of this study will be to compare biblical, and philosophical conceptions of human freedom, suffering,

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[21]Numerous articles appearing in different medical journals. See (1) Geoffrey Draun, Sheila Adams et al., Withdrawal of life-support from Patients in Permanent Vegative State. Lancet 337:8133, (12 Janury, 1991): 96-98; Nicholas G. Smedera, Bradley H. Evans, Linda S. Gracs, Neal H. Cohen, Bernard Lo et al., Withholding Life-Support from the Critically Ill. New England Journal of Medicine, Vol. 332:5 (1 February 1, 1990): 309-315; Jonsen and Lister: Life-Support Systems in Warren T. Reich, ed., The Encyclopedia of Bioethics (New York: Macmillan, 1978) Vol. 2: 843-848.

and death, and to analyze the implications of these conceptions for making decisions to withdraw and withhold medical treatment.

1.4 Method of Study

This investigation will begin with a review of existing literature on decisions to withdraw and withhold treatment with the intention of identifying: 1) Various ways in which these decisions are made, and 2) the ways in which the underlying conceptions of human freedom, suffering, and death are pivotal in making them.

Next, major conceptions of human freedom, suffering and death, will be individually examined (analytically where explicit, inductively where implicit). Exemplifying a biblical perspective will be the New Testament; and exemplifying a philosophical perspective will be Frederick Nietzsche.

Finally, how biblical and philosophical conceptions of human freedom, suffering and death shape decisions to withdraw and withhold medical treatment will be studied.

CHAPTER 2

DECISIONS INVOLVING FORGOING LIFE SUPPORT: CURRENT PRACTICE

2.1 Introduction

In this section chapter we intend to find out the views of human freedom, suffering and death in current medical practice, especially in decisions involving critically ill patients forgoing life support. We will establish a link between these conceptions of human freedom, suffering and death with actual decisions through an analysis of the reasons physicians cite as justifications for withholding and withdrawing life support. Through this analysis we seek to find out: (1) how the conceptions of human freedom, suffering and death are pivotal in such decisions and (2) what moral principles or theories form the foundation for the decisions.

2.2 Simple Life Support and Do-Not-Resuscitate Orders

The first of such decisions confronting physicians involving critically-ill patients is whether to institute cardiopulmonary resuscitation in the event of cardiopulmonary arrest or to withhold it by employing a do-

not-resuscitate order. As popular as do-not-resuscitate orders have become, guidelines have been developed to facilitate the process by which decisions regarding them could be made. Among voluminous literature that deals with DNR decisions is the book edited by Martin Strosberg, I. Alan Fein and James D. Carroll, Rationing of Medical Care For the Critically Ill. (In chapter one of this book), Robert Baker analyzes the characteristics of exiting "DNR" orders, noting their similarities and their differences. The authors point out that soon after do-not-resuscitate orders were established, they were soon restricted to certain classes of patients. Moreover, they noted that all do-not-resuscitate orders accept brain death as an appropriate reason for withdrawing life-support, and that certain clauses in those guidelines require do-not-resuscitate orders be entered in the patient's records.[1] Again from Baker's article and the medical literature, two types of DNR orders seem predominant. The most prevalent type is conceived as a protocol which ratifies patient's rights to consent and refuse treatment. The second type is protocol that formalizes the physician's rights to determine which therapies are appropriate to the treatment of a patient's conditions and to withdraw and withhold

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[1]Robert Baker, Do-Not-Resuscitate Orders in Martin A. Strosberg, I. Alan Fein and James D. Carroll (ed.), Rationing of Medical Care for the Critically Ill (Washington, D.C.: The Brookings Institution, 1986) 55.

"ineffective, fatal, contratherapeutic treatments".[2] When it comes to explicating the reasons from critically ill patients the majority of authors tend to lump all the reasons together.

> A decision not to resuscitate is considered for a variety of reasons; a request by a patient or family; advanced age of the patient; poor prognosis; severe brain damage; extreme suffering or disability in a chronically or terminally ill patient, and in some instances, the enormous cost and personal commitment as opposed to the low probability of patient recovery.[3]

However, a minority of scholars[4] classify these reasons into three categories: no medical benefit, poor quality of life after cardiopulmonary CPR and poor qualify of life before cardiopulmonary resuscitation. No medical benefit refers to a situation where a physician, after careful analysis of all the factors, decides that the patient is in such a bad shape that he or she will not benefit from CPR. The physician is under no obligation to provide CPR to such a patient. The other two categories are self explanatory. Poor quality of life before cardiopulmonary resuscitation involves the physician's expectations of the patient's condition after treatment. Certainly differences exist between the three distinctive rationales that physicians are using to justify do-not-resuscitate orders. In some ways,

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[2]See Robert Baker, 57.

[3]George J. Annas, CPR: When the Beat Should Stop, Hastings Center Report 12:5 October, 1982, 30-31.

[4]This minority of scholars includes George J. Armas, Tom Tomlinson, and Howard Brody.

they are all based upon quality of life considerations. The most important difference between the first reason and the other two put together lies in the degree to which physicians include patients' values in the decision-making process.

When "no medical benefit" is cited as the rationale for do-not-resuscitate orders, patients' values are irrelevant to the decision-making process. The physician may not have consulted with patients or their families before coming up with this decision. However, in such decisions physicians have no duty to ascertain patients' preferences about treatment. It is a purely medical decision, although it may hide quality of life judgments based upon physicians' subjective views. Here, physicians' conceptions of human suffering and death have a major influence on their decision. For this reason we might put it under the "physician decision-making category".

When making decisions based upon the remaining two rationales--poor quality of life before CPR and poor quality of life after CPR--physicians often request patients' or their family's consent.[5]

Since they are decisions which depend upon assessment of the patient's quality of life, either before or after the CPR, they require the application of a set of values that

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[5]Tom Tomlinson and Howard Brody, "Ethics and Communication in Do-Not-Resuscitate Orders Sound Board" New England Journal of Medicine 318:1 (January 7, 1988): 43-46.

determine whether the benefits of continued life outweigh any associated harm such as pain or disability. But physicians' values may differ from those of the patient or the patient's family acting as proxy, and since the patient has both a legal and moral right to accept or refuse treatment in accordance with his or her values, the values used to make these quality of life determinations are properly the patient's. But the fact the physicians sometimes allow the view of the patients or their proxy, there is a sense of human freedom inherent in the decision. Such conception of human freedoms pivotal in these decisions is expressed in terms of autonomy. The terms we came across, "autonomy" and "quality of life", will be discussed in a later section.

2.3 Decisions Involving Life Support Technologies: Mechanical Ventilation and Nasogastric Feeding Techniques

Generations that lived before us have always believed that the physician knew better about healing than any other person. They were forced to accept clinical judgment as final. The 1970s heralded a new movement which sought to guarantee patients' rights. We identified several reasons for the rise of the patients' rights movement. Most of them are reasons which we discussed earlier while introducing this branch of study. We made mention of recent technological breakthroughs in medicine with its antecedent problems precipitating changes in the medical decision-

making process. Increasingly physicians are no longer seen as infallible friends of the patient, and medical decisions they make are sometimes challenged by patient and/or their families. The physician is no longer the dominant player in medical decision-making regarding the withdrawal and withholding of life support systems from critically ill patients. Rather, in accordance with a thesis put forward by Walton[6], this decision-making process may be likened to a game with two possible outcomes. Applying Walton's thesis, we were able to identify three models of decision-making: physician-based, patient-based, and court-based.

We shall examine each of these decision-making models with the aim of understanding how the decisions are achieved, whose opinions are heard and who makes the final decision. We shall also examine the bases upon which the decisions hinged, considering the source to which the concepts of human freedom, suffering and death are pivotal in reaching these decision.

2.3.1 Physician-Based Decision

Physician-based decisions include all those decisions to forgo life-support in which the doctor is the final arbiter of the decision. The use of life-support systems may have been extended to other units besides intensive care units, even to home care facilities, but the forum in which

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[6]Walton, 211.

physicians decide to withhold or withdraw them from any patient is still the hospital rounds. We must not forget the functioning of various hospital ethics committees who at times are the final decision-makers. The existence of certain hospital guidelines should not be overlooked. Physicians' decisions to withdraw life support may only be a reflection of such guidelines.

The extent to which physicians may be the final arbiter in the decision-making process depends upon the requirements of the personnel matrix within which they are working. If they are the sole persons responsible for the critically ill patient, then their opinions are may be the only ones that count. Increasingly, critically ill patients, especially those cared for in the intensive care unit, have medical teams made up of physicians, medical technicians and other professionals to care for them. Ernest Kraybill explains that in team-work situations senior physicians are not only consulting with experienced nurses and other medical professionals on the team to get their opinion on critical issues, including the ethical issues to which this work is devoted, but also these non-physicians sometimes have the dominant voice in making the decision to withdraw or withhold life support. However, he admits that physicians are still captains of the ICU teams, because they still have

the right to reject such opinions.[7]

Edmund A. Murphy describes the general characteristics of medical decision-making. The most influential of these characteristics on physicians who are making decisions to forgo life-support in judgment is clinical judgment.[8] The literature reveals that some of the prominent reasons which physicians cite for reaching their decisions to forgo life-support are all based upon clinical judgment. These involve severe brain damage, advanced age of the patient, extreme suffering or disability, poor prognosis and various quality of life considerations.[9] Of these brain death and considerations involving quality of life seem to be the most important and prominent. Choosing to explore brain death would also afford us a chance to discuss the concept of death prevalent in decisions involving forgoing life-support. By so doing, we might determine the underlying philosophical framework upon which the concept of death is built.

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[7]Ernest N. Kraybill/Team medicine in the NICU: Ship or Flotilla of Lifeboats? Nancy M. P. King, Larry R. Churchill, and Alan W. Cross, The Physician as Captain of the Ship (Dordrecht; Boston: D. Reidel: Norwell, MA USA Kluner Academic Publishers, 1988), 77-88.

[8]E.A. Murphy, "Classification and its Alternatives in Clinical Judgment: A Critical Appraisal (A.T. Engelhardt, Stuart F. Spuker and Bernard Powers, ed.) (Dordrecht; Holland; Boston; D. Reidel Pub. Co., 1979).

[9]S.H. Wanser, D.D. Ferdman, and S.T. Edelstein, et al., "The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look," New England Journal of Medicine 320 (1989): 844-849.

2.3.1.1 Brain Death

The literature realizes a distinction between clinical and biological death. For instance, the heartsaver manual of the American Heart Association defines clinical death as occurring when "the heartbeat and breathing have stopped." And it adds: "this is best thought of as near or apparent death, and it may be averted or reversed." The same manual defines biological death as permanent brain death due to lack of oxygen. This death is final.[10] The effort to avert and reverse clinical death may involve initiation of life support. Reversal of clinical death with the help of life support is sometimes problematic, especially in cases where the lift-support was initiated sometime after damage had been done to the patient's brain. Physicians do not expect such patients to return to productive lives. Attempts to restore the patient to life may result in lower brain or upper brain damage. Illustrations which we will give later will be helpful to clarify this point.

But first of all let us make a connection between biological death and decisions to forgo life support. We can conclude that medical decision-making within the framework of the biological definition of death maintains that life-support should not be withdrawn or withheld from patients in situations where the patient may suffer partial

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[10]American Heart Association, "Heartsavers Manual".

brain damage. This presents a dilemma especially when the removal of advanced life-support from these patients might cause their immediate death, which could be an act of passive euthanasia. However, numerous observers of medical ethics are saying that at least two more categories of patients should be treated as brain dead: those who have experienced neocortical death and those in a persistent vegetative state. Their basic argument, as we shall see later, concerns the definition of personhood. If this proposal is accepted by the medical community, then physicians would have the right to withdraw some form of life-support from those patients.[11] But the prevailing view of death among physicians is of the whole brain formulation. The view holds that clinical death or cardiac-based death is not final. Supporters advocate initiating life-support to victims, if the patient is clinically dead but as long as biological death has not yet occurred.

Historically, we can trace the whole brain death formulation to the Uniform Determination of Death Act recommendation put forward by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research in 1981. The Commission's publication Defining Death--Medical, Legal and Ethical Issues in the Determination of Death described adequately their

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[11]David Randolph Smith, "Notion of Neocortical Death" in R.M. Zaner (ed.) Death Beyond Whole-Brain Criteria (MA/Dordrecht: Kluwer Academic Publisher, 1988), 111-134.

understanding of death. Critics like John Lachs pointed out that their views are based upon a simplistic assumption: "that there is a distinct difference between the temporal process of dying and death, which is an instantaneous event."[12] Lachs notes that this assumption made it easy for them to define death, because the assumption set death and living as mutually exclusive events. A person is either dead or alive. He observes that the Commission cited the views of some philosophers to support their definition. However, it did not help them relieve the definition from its simplistic nature.[13] Death is still defined as a single event in nature. Richard Zaner comments:

> The kind of patient which the commission and other worth-while brain advocates took as the paradigm for defining human death, however, is distinctly different from those in a persistent vegetative state. For the commission, only associated with the brain stem, are properly regarded as dead: that is, those who have lost not only the higher functions supporting consciousness but also the reflexes controlled by the brain stem (gag reflex, swallowing, the urge to breathe, etc). Even though circulation and respiration in such individuals can be maintained by mechanical means for a short time, what has been listed is the central trait distinguishing between the living and the dead, namely 'the body's capacity to organize and regulate itself.' Death in these terms is that moment at which the body's physiological system ceases to constitute an integrated whole.[14]

In addition, critics have cited a number of assumptions upon

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[12]John Lacks, "The Element of Choice in Criteria of Death" in R.M. Zaner (ed.) Death Beyond Whole-Brain Criteria (MA/Dordrecht: Kluwer Academic Publishers, 1988), 233.

[13]Ibid., 234.

[14]R.M. Zaner, Death Beyond Whole-Brain Criteria, 3.

which this view of death is founded: (1) the brain carries out the most significant function in the physiological system of the human body. (2) The function of the brain is integrator of all other functions including breathing and blood circulation. Therefore, the loss of the brain signifies a loss of integration of the bodily processes. This means death. Death is defined in purely physiological terms:[15]

> In the end, the commission and other whole brain advocates have opted for a philosophical view which identifies human life with strictly organic, bodily conditions: the moment at which the body's physiological system ceases to constitute an integrated whole in the commissions' own words.[16]

Despite the criticism this position is still the dominant view of death.[17]

We now present an illustration involving specific cases which will suffice to give readers a better understanding of the whole brain definition. They will also provide insights into the criticism that has been levied against it and help us understand why some scholars are presenting new arguments for a neocortical definition of death. Case one is a classic example of a brain dead patient.

> This patient has suffered massive destruction of the entire brain, resulting in the loss of both higher and lower functions. In addition to being permanently unconscious, he has lost all ability to organize vital

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[15]Ibid., 9.

[16]Ibid., 6.

[17]Ibid., vii.

> vegetative subsystems, such as breathing, neuroendocrine control, blood pressure, temperature regulation, etc. However, many of these functions can be supported or replaced by skilled personnel and sophisticated technology. After the patient is put on a respirator, the staff monitors his blood oxygen concentration and adjusts the rate and depth of breathing. Blood pressure is checked and supported, if necessary, with vasopressors. Electrolyte and fluid balances are monitored and adjusted when necessary. Nutrition is provided intravenously through a hyperalimentation line. The patient's heart continues to pump blood, which has been oxygenated and loaded with nutrients, to various parts of the body, enabling the continuation of other functions. The skin is warm, the kidneys continue to produce urine, as the hair grows, and the liver continues its many functions, such as the removal of waste products from the blood.[18]

This patient is a classic example of the destruction of the whole brain. Case two is an example of a patient whose higher brain is destroyed.

> Unlike the preceding case, the patient's lower brain structures have been left intact and functioning. Although he can breathe spontaneously and maintain temperature and blood pressure, he has irreversibly lost the functions of consciousness and cognition. Although such a patient requires much less attention and technical support than the first one, he would not survive long without assistance. Liquified food must be placed directly into the stomach through a gastrostomy or nasogastric tube. Because he is incapable of moving on his own, he must be frequently turned to prevent the development of bedsores, which would lead to infection and death. His excretions must also be managed. The patient is unable to do or understand anything at all.[19]

Case 3 is called the locked-in patient. The patient's lower brain has been destroyed.

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[18]Case #1, 2, 3 are taken from Edward T. Bartlett and Stuart J. Younger, "Human Death and the Destruction of the Neocortex" in R.M. Zaner Death: Beyond Whole-Brain Criteria (Dordrecht; Boston; London: Kluner Academic Publishers, 1988), 204-206.

[19]Ibid.

> This patient suffers significant, but incomplete, destruction of the brain. Unlike the Quinlan-like patient in Case #2, the brain portions responsible for consciousness and cognition are intact. All portions of the brain stem and deep cerebral areas responsible for integration of vegetative functions have been destroyed. However, the blood supply and neural connections to the other cerebral areas, as well as the reticular activating system located in the brain stem, have been spared. Although the patient cannot spontaneously regulate respiration, blood pressure, temperature, hormonal balance, and other functions, he is awake and alert. Let us also assume that the brain stem areas responsible for hearing and eye movement remain unaffected, so that he can give meaningful responses to questions by moving and blinking his eyes (e.g., one blink means yes and two blinks mean no).

Like patient #1 with total brain destruction, this patient's life can only be maintained through the full efforts of the Intensive Care Unit Staff.[20]

The whole brain death criteria would consider the patient in Case #1 dead, but would not consider those patients in Case #2 and #3 dead. Because of this, Barlett and Younger call this standard for defining death, "a primarily physiological standard."[21] They believe that the whole brain criteria assumes a purely biological view of human death and life, which fails to consider personhood in its conceptualization. In addition, Barlett and Young note that whole brain criteria portray a one-dimensional view of human life and death.[22] Of course, criteria which

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[20]Ibid.

[21]Bartlett and Younger, 199-216.

[22]Ibid.

perceive human beings only as biological entities would presuppose human life and death to be primarily biological.

Critics say that the disadvantage in defining human essence in purely biological terms lies in the fact that other human dimensions such as the ability to think, reason and have social intercourse could be considered non-essential. Consequently, they will not be considered as factors in the determination of death. But if we consider them to be essential factors, then our concepts of personhood changes. Persons are no longer only biological organisms but organisms that are able to reason, think and relate to each other.[23] We see here that defining death largely hinges on our concept of 'person'. The concept of personhood is crucial to our understanding of death. The Commission failed, however, to define personhood.[24]

The relevance of the concept of personhood in determining death comes out strongly in the publication, Death: Beyond Whole Death Criteria edited by Richard M. Zaner. The book is a critical appraisal of whole brain and neocortical definitions of death. In this volume David Randolph Smith examines the legal issues that have prompted the neocortical definition. And while authors like Robert Veatch, Roland Puccetti, Edward Barlett and Stuart Younger advance arguments against the whole-brain formulation in

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[23]R.M. Zaner, 7-13.

[24]R.M. Zaner, 7-13.

favor of neocortical death definition.[25] Of relevance to us is the troubling question: Is it moral to withdraw or withhold life-support from patients who have lost only their higher brain functions? How are we to perceive and treat irreversibly unconscious patients? These questions are put in clear terms by David Randolph Smith:

> Which analysis for treating the irreversibly unconscious as dead makes sense: withholding or stopping feeding or life support therapy because patients are already dead or terminating treatment or life-sustaining nourishment of living persons because that is what substituted decision-makers suspect the patients would have wanted?[26]

Smith comments further that if the public was to accept the neocortical death definition, substituted judgment would be irrelevant.

We came to our discussion of brain death because physicians use it presently to justify their decisions to withdraw and withhold life-support from critically ill patients. In our effort to find out what they mean by brain death, we came across two different formulations of brain death, the widely accepted whole brain criteria and the recently proposed higher brain formulation. In whole brain death, the criteria currently used to determine death does not seem to have any philosophical basis: deontological or utilitarian. In fact, from our discussion it becomes obvious that resolving ethical questions connected with

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[25]R.M. Zaner, ed., Death: Beyond the Whole-Brain Criteria.

[26]David Randolph Smith, "Notion of Neocortical Death", 124.

brain death will necessitate a conceptual analysis of death. It seems as if any consideration of any ethical question presupposes a semantical one.

2.3.1.2 Quality of Life Considerations

Physicians may decide to withhold or withdraw life-support from critically ill patients for reasons other than brain death. In some of these cases physicians' judgments may involve patients' quality of life. For example physicians might judge that a patient is in such bad shape that after treatment his or her quality of life would be such that it would be advantageous to withhold life support or to withdraw support already initiated.[27] There are enough evidences that considerations of patients' quality of life has been a major factor influencing decisions on whether to withdraw or withhold life-support.[28] When they become the principal factor for making the decision, physicians more often decide to forego life support than decide to use them.[29]

The term quality of life can have several meanings. However, its use in the medical literature is limited to

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[27]Nicholas G. Smedira, Bradley H. Evans, Linda S. Garis et al., "Withholding and Withdrawal of Life Support From the Critically Ill," The New England Journal of Medicine 322, no. 7 (1 February 1990): 309.

[28]Ibid.

[29]R.A. Perlman and A. Jonsen, "The Use of Quality of Life Considerations in Medical Decision-Making," Journal of the American Gerontological Society 33 (1985): 344-350.

three possibilities.[30] "Of relevance to us is the definition of quality of life judgements as 'an evaluation' by an onlooker of another person's life situation."[31] This definition is relevant to the situations with which we are concerned--situations in which physicians make evaluative judgments about patients' conditions that reflect their own personal views. Physicians consider quality of life in this way frequently in the clinical setting, especially in making decisions to withhold or withdraw life-support systems from critically-ill patients.[32] Enough evidence exists to support the assertion that in many quality of life decisions physicians consider age as a factor, when they have to decide whether a critically-ill patient should forego life support.[33] The age factor may sometimes become the deciding component, when the physician thinks that the initiation or continuance of life-support

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[30]Terrie Wettle, Julie Cwikel, and Sue E. Levkoff, "Geriatric Medical Decisions: Factors Influencing Allocation of Scarce Resources and the Decision to Withhold Treatment," The Geriontologis 28(3) (1988), 336-348.

[31]Ibid.

[32]David C. Thomason, Quality of Life Judgements, Treatment Decisions and Medical Ethics, Clinics in Geriatric Medicine, 2 (February): 17-27; R.A. Perlman and A. Jonsen, "The Use of Quality of Life Considerations in Medical Decision-Making", Journal of American Gerontolgoical Society 33 (1985): 344-350.

[33]Terri T. Wetle, "Age As A Risk Factor for Inadequate Treatment," Journal of American Medical Association (July 24/31): 516; Sue Levkoff and Terrie Wetle, "Clinical Decison Making in the Care of the Aged," Journal of Aging and Health 1 (February 1989): 83-101.

would subject the patient to undue suffering.[34] There are instances in which physicians have refused to intubate elderly patients because of their expected quality of life. The justification was that elderly patients cannot hold out against would-be pain that life-support would cause them.[35] Physicians are not only concerned with suffering, when they make quality of life decisions. Sometimes, they do reach such decisions after a careful consideration of mixed combination of factors.[36] Among them are the patient's experience, an estimation of the patient's survival time, and a host of factors based upon social considerations.[37] A significant social factor that usually influences physicians' perceptions of their critically-ill patients is mental health status.[38] An example will illustrate how mental health status may come to bear on what the physician may decide.

> Sharon Siebert was forty-one years old, had been seriously brain damaged in an operation five years previously, and according to her physicians, had a life expectancy of thirty-seven more years. She had a mental age of a two-year-old with no prospects for improvements. She had to be fed artificially because she could not swallow, was confined to a bed or wheelchair, and could communicate only 'slightly' and 'simply'. A DNR order was issued by her physicians,

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[34]Terrie Wettle, Julie Cwikel, and Sue E. Levkoff, 336-343.

[35]Ibid.

[36]Perlman and Jonsen, 1985, 344-350.

[37]Ibid.

[38]Sue Levkoff and Terrie Wetle, (1989), 86.

with the consent of her parents.[39]

This DNR decision was based on quality of life assessment, and the patient's mental health.

Quality of life decision-making should involve two separate categories of factors. First are those connected with the medical aspects of the patient's illness. We are speaking of those assessments which the physician makes of patients that are based upon quantifiable and measurable aspects of disease processes.[40] Secondly, those factors which are not easily quantifiable and measured, which make for "clinical uncertainties" and value judgments.[41]

The criticism that physicians often are reluctant to include the second set of factors has been levied by some authors.[42] If this is the case, then decisions to forego life support system based upon quality of life judgements are less than ideal.[43] In the ideal decision, physicians should attend all of the components. Sometimes, however, physicians face up to the fact that they cannot divorce medical judgement and values. They do involve value judgment in their assessments of patients' quality of life.

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[39]Daniel Callahan, "CPR The Beat Should Stop," Hastings Center Report.

[40]Sue Levkoff and Terri Wetle, 97.

[41]Ibid.

[42]Ibid.

[43]Ibid.

But the problem is that they use "their own subjective values relative to the patient's characteristics".[44] We cannot blame them entirely because we recognize that it is difficult to associate considerations of the quality of life with any objective ethical stance.[45] Perlman and Jonsen put it this way:

> If consideration of quality of life were a clearly defined professional responsibility, it might have correlated with the ethic of social responsibility. And if the consideration of quality of life represented attempts to avoid patients harm or promote patients well-being, it might have correlated as with the ethic of personal conscience. However, as neither ethical stance appeared to be associated with the quality of life, the principled rationale for such consideration is yet undefined.[46]

Besides the lack of an objective ethical standard for determining quality of life, they doubt the accuracy of physicians' assessment of patients' quality of life for two further reasons. First, such assessments depend upon diagnosis and prognosis which are inherently uncertain. Second, the circumstances in which they are made are often situations of tremendous pressure.[47]

A contra-argument is levied by Warren Reich. According to him, the quality of life when used in the context of a morally normative judgment, depends upon an ethical theory

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[44]Robert A. Perlman and Albert Jonsen, 344.

[45]Ibid.

[46]Ibid., 347.

[47]Perlman and Jonsen, 344-352.

of consequentialism.[48]

We accept that it is based upon consequentialism.

2.3.2 Patient Made Decisions

The patient's right to decide to forego life support is based upon the theory of informed consent.[49] The concept of informed consent makes it the physician's duty to inform patients about the benefits and risks of any diagnostic and treatment alternatives. In compliance with the principle of informed consent, physicians are required to give their patients full information about the diagnosed diseases as well as treatment alternatives. They are also required to supply information about the risks and benefits associated with each treatment option presented to the patients.[50] Jay Katz has traced the history and development of the concept of informed consent in an article Informed Consent in Therapeutic Relationships: Law and Ethics. In it he describes informed consent as the process involving physicians informing patients for the purpose of decision-making. Katz cites two basic trends behind the theory of consent. First, modern physicians have become knowledgeable people who have acquired considerable useful information about their specialties. They are aware of new discoveries

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[48]Encyclopedia of Bioethics, Warren T. Reich ed.

[49]Paul S. Appelbaum, Charles W. Lidz, and Alan Neisel, Informed Consent: Legal Theory and Clinical Practice.

[50]Ibid.

in other branches of medicine as well as their own. They possess a certain sense of confidence. Because of this new-found confidence, physicians are much more ready to educate patients about their conditions. Second, there is a tendency in a pluralistic society to think that every individual has a certain value preference. Society wants to guarantee the expression of individual preferences. This can only be done by allowing the individual personality autonomy to decide on all matters that affects him or her. Even decisions pertaining to life and death must be based upon individual values.[51]

Informed consent therefore puts final word in the decision-making process about foregoing life-support in the hands of patients. Their opinions are the most important, especially in cases where critically ill patients are competent enough to make decisions. However, in cases where patients are unconscious or incompetent, they may not be able to voice their opinions. This would have meant that their opinions would not be the decisive factor in decisions that affected them. Advance directives legislation did provide for such scenarios in the form of living wills and durable power of attorneys.[52]

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[51]Jay Katz, "Informed Consent in Therapeutic Relationship: Law and Ethics," in Encyclopedia of Bioethics, Warren T. Reich, ed., vol. 2, 770-778.

[52]K.A. Singleton and R. Dever, "The Challenge of Autonomy Respecting the Patient's Wishes," Dimension of Critical Care Nursing 10 no. 3 (May-June 1991): 160-8.

2.3.2.1 Advanced Directives

The idea behind advanced directives is that adults are capable of setting out their wishes about certain life-sustaining treatments. They can do so in the form of written instructions which could be put to use in times when those persons are no longer able to make their wishes known. The living will is one form of instruction directive. (See appendix for Living Will). There are many versions of living wills, each expressing wishes about a certain kind of treatment, and almost all of them directives indicating preferences about types of treatment which patients consider extraordinary or heroic.

The durable power of attorney is a kind of surrogate directive, in which people give an agent power to make health care decisions for them in situations when they are incompetent. Wide support for both these forms of advanced directive is evidenced by the fact that 42 states and the District of Columbia have enacted living will legislation.[53] A majority of states have enacted legislation that allows individuals to execute a durable power of attorney.[54] Also, there are evidences that both living wills and durable power of attorney are readily

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[53]Terry A. Donner, "LIving Wills and Power of Attorney," Dimension of Critical Care Nursing 10, no. 3 (May-June 1991):

[54]Ibid.

available to the public.[55] However, few people are drafting living wills, durable power of attorney or other advance directives. Congress passed an act to encourage patients to complete advance directives. Starting December 1 this year in the United States, every health care facility will be required (by the Patient Self-Determination Act) to ask patients at admission if they have completed an advance directive or if they would like further information about them.[56] These two types of patient decision-making are forms of informed consent and are based on a view of human freedom in terms of autonomy and respect for persons.

2.3.2.2 Autonomy

Autonomy is the concept of a person as a responsible decision-maker. This concept of a person places an obligation on physicians and the health professionals to respect the values of patients and not to impose their own values about treatment on patients. Autonomy greatly enlarges the kinds and numbers of choices available to human beings. It allows individuals to choose almost everything, including what they eat, where they live, where they work and who will be their leaders. It exalts the notion that individuals are absolutely free to make choices.[57]

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[55]Ibid.

[56]See The Patient Self Determination Act of 1991, U.S.

[57]A.R. Jonsen, M. Siegler, and W.J. Winsdale, Clinical Ethics 2nd ed., (New York: Macmillan, 1986).

From what has been said about autonomy, it would seem as if autonomy is self-determination: that is, the right to autonomy is the right to make one's own choices, and that respect for autonomy is the obligation not to interfere with the choice of another and to treat another as a being capable of choosing.[58] However, the concept of autonomy found in patient-based decisions has more than one meaning. Several authors including Childress and Beauchamp have counted at lest four senses for autonomy, implicit in informed consent, living wills and durable powers of attorney. In the first place, these procedures allow patients to make decisions which are voluntary and intentional. Autonomy is seen here as a free action. Secondly, some patients have knowledge of the consequences of foregoing life-support, have evaluated the options opened to them, and have chosen based upon that evaluation. This autonomy is effective deliberation. Thirdly, through these procedures a person would be able to express his or her 'attitudes', 'values', dispositions and life plans. In the event of the execution of such a procedure the action take would be in conformity with them. Therefore, autonomy can be seen here as a means of authenticity. Fourthly, the procedure may present the opportunity for autonomy to be

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[58]Alan Donogan, The Theory of Morality (Chicago: The University of Chicago Press, 1977); Ibid.

"moral reflection".[59]

The principle of autonomy has received much treatment in the literature, and it has critics as well as proponents. Callahan criticizes the principle of autonomy as being minimalistic and egoistic in nature in its application in the sociocultural context.[60] Childress, having reviewed the charge levied by critics against it, makes a distinction between the principle of autonomy and the principle of respect for autonomy.[61] Speaking about his distinction he says:

> It is important to correct this mistake because many critics seem to suppose that proponents of this principle have an ideal of personal autonomy and believe that we ought to be autonomous persons with autonomous choices. However, the ideal of personal autonomy is neither a pre-supposition nor an implication of the principle of respect for personal autonomy, which obligates us to respect the autonomous choices and action of others.[62]

He deals with the principle of respect for autonomy at length, recognizing its scope, strengths and complexities. He suggests that in making bioethical judgments we should

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[59]Bruce Miller, "Autonomy and the Refusal of Lifesaving Treatment," Hastings Center Report, August 1981, 22-28.

[60]Daniel Callahan, "Autonomy: A Moral Good, Not A Moral Obsession," Hastings Center Report 14 (5): 40-42; Daniel Callahan, "Fundamentalist Ethics," Hastings Center Report 11:5 (1981), 29-15.

[61]For a fuller treatment of "The Principle of Respect for Autonomy, see Tom L. Beauchamp and James L. Childress Principles of Biomedical Ethics, 3rd. ed., (New York: Oxford University Press, 1989), 67-119; James F. Childress "The Place of Autonomy in Bioethics", Hastings Center Report 20 (1) Jan 1990, 12-17.

[62]Ibid.

replace the principle of autonomy with the principle of respect for autonomy. He is aware, however, that this replacement will not solve the complex problems associated with the application of the principle of autonomy involving the ethical issues arising from the decision-making processes.[63]

The realizations that autonomy is limited and that certain other principles besides autonomy are important in moral decision-making lead us to think that perhaps we need to appeal to tradition and philosophies, to find out what principles should be included in solving those ethical issues that arise in biomedical decision-making. Furthermore, autonomy is a principled ethic, which derived from the Greek auto (self) plus logos (law). With autonomy we become law to ourselves. Totally inconsistent to Christian notion of freedom, we have to decide what is right. Autonomy often conflicts with other principles like beneficence, the right to life, justice and confidentiality.[64] Perhaps it is necessary to go beyond these principles to find a moral theory that would enable us to distinguish between passive euthanasia and legitimate acts of foregoing life-support.

2.3.3.1 Substituted Judgment

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[63]Ibid.

[64]T. Beauchamp and J. Childress, 112.

Many of the prominent court cases such as Quinlan, Saikewicz and Brophy were decided using the substituted judgment argument.[65] Substituted judgment is a legal concept, and it is based upon legal rights not to have bodily integrity invaded, one's informed consent, and constitutional rights of privacy.[66] In practice, the patient's will is not known, so the court tries to put itself in the patient's place and figure out how the patient would have decided. The doctrine of informed consent has been discussed earlier, as has the notion of human freedom upon which it is based.

2.3.3.2 Ordinary and Extraordinary Treatment

In some of the decisions such as Quinlan, the courts recognized the distinction between ordinary and extraordinary medical treatment. The logical first step may be to show the distinction between ordinary and extraordinary treatment. Robertson defines ordinary means as all medicines, treatments and operations which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or inconvenience. And he defined extraordinary means as those medicines, treatments and operations, which cannot be obtained or used

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[65]Charles L. Spring, "Changing Attitudes and Practices in Forgoing Life-Sustaining Treatments," JAMA 263 (16), (April 25, 1990): 221-2215.

[66]John D. Arras and Nancy Rhoden, Ethical Issues in Modern Medicine (Mountain View California: Mayfield Publishing Co., 1989).

without excessive exposure or pain or other conveniences of which if used, would not offer a reasonable hope of benefit.[67] Despite the fact that there has been a shift in the types of medical treatment available, a consensus still exists which maintains that the benefit and burden of a treatment in the particular circumstances should play an important role in the ordinary/extraordinary distinction.[68] This principle of comparing cost with benefit is not unfamiliar to health professionals in their day to day practice.[69]

Therefore, in a case in which life-support will in fact entail excessive expense or pain and there is no reasonable hope of benefit, then the life-support may be withdrawn. However, if the life-support involves no excessive pain, and a reasonable hope of the benefit from it exists, then its withdrawal may be seen as intending to commit homicide.[70] In Quinlan, the courts recognized that mechanical ventilation was an extra-ordinary treatment. However, even after her life-support systems were removed in 1975 and she

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[67]Ibid.

[68]Thompson Mason Fuller, "Means of Prolonging Life" in James Bopp, ed., Human Life and Health Care Ethics, vol. 2 (Maryland: University Publications of America, Inc.), 224-239; Ibid.

[69]John D. Arras and Nancy Rhoden, Ethical Issues in Modern Medicine.

[70]Robert N. Wennberg, Terminal Choices: Euthanasia, Suicide and the Right to Die (Michigan: Wm. B. Eerdmans Publishing Co., 1989): 108-156.

did not die, she continued to be provided with hydration and nourishment. Many physicians, along with others, believe that basic, humane care requires that patients always be given food and water.[71] However, there is an intensive debate over whether artificial nutrition and hydration may be classified as medical treatment and also be discontinued if futile or burdensome. Some have tried to distinguish between forms of artificial feeding: intravenous feeding is a common procedure in hospitals, and nasogastric feeding is considered by some as an extraordinary procedure. The courts recently seemed to be abandoning not only the traditional view that food and water are not medical treatment but also the distinction between ordinary and extraordinary treatment.[72] Several courts have allowed the withdrawal of food and fluids from incompetent patients based upon substituted judgment.[73]

2.4 Conclusion

Human freedom, suffering and death are central concepts in decisions to withhold and withdraw life support from

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[71]Ibid., 164. For fuller treatment ofthis argument, see Mellander, "On Removing Food and Water: Against the Stream," Hastings Center Report (December 1984), 11.

[72]Marcia Angell, "Prisoner of Technology: The Case of Nancy Cuzan", The New England Journal of Medicine 332 (26 April 1990): 1226(3).

[73]Lawrence J. Schneiderman and Roger C. Spragg, "Treatment for Old People and People with Disabilities: 1987 Developments", Issues of Law and Medicine 3 (Spring 1988): 333-360.

critically-ill patients. However, these concepts enter decisions by way of certain moral principles and definitions: autonomy, quality of life, and brain death.

It seems as if current decisions ar not made within the context of a moral theory. Rather, certain principles formed the theoretical basis upon which they are made.

CHAPTER 3

CONCEPTION OF HUMAN FREEDOM, SUFFERING AND DEATH IN THE PHILOSOPHY OF FREDERICK NIETZSCHE AND IN THE THEOLOGY OF THE APOSTLE PAUL

3.1 Introduction

My thesis is that a philosophical and biblical analysis of the formal structure of human freedom, suffering and death can provide an essential foundation for determining the ethical dimensions of whether it is justifiable to withdraw or withhold systems of life-support.

My argument is directed toward the following point: in the context of current decision-making practice, the problem of human freedom, suffering and death have not been answered within a single philosophical background, and the manner in which decisions are currently made proves inappropriate as a framework for making such decisions, especially for Christians.

But the care of critically-ill patients necessitates a philosophic and transcendent basis, without which unacceptable patterns of practice may develop/or in the unacceptable decision-making may develop.

Also, a systematic theology/biblical interpretation of human freedom, suffering and death should reform the ways in

which decisions to forgo life-support are presently being made. It would enable patient or proxy to decide each case, not on the basis of individualism or utilitarianism but with theological/biblical principle consonant with Christian beliefs. The potential value of Christian beliefs for this particular bioethical problem is the provision of meaning to the experiences of human freedom, suffering and death. However, the task is to provide suggestions of ultimate meaning and purpose not bound by tradition or denomination, for human freedom, suffering and death. With this proposition in mind, we shall narrow our investigation into theology only to the Pauline Corpus in the Bible.

In this chapter we shall examine the conceptions of freedom, suffering and death of the philosopher Frederick Nietzsche and the apostle Paul, to see what contrasting meanings they assign to these concepts from the standpoint of their anti- and pro-Christian perspectives, respectively.

3.2 Human Freedom, Suffering and Death in the Thoughts of Frederick Nietzsche

3.2.1 Biographical Background

Students of philosophy have interpreted Nietzsche from various perspectives. In order to be able to understand his conceptions on human freedom, suffering and death, a brief summary of his philosophical thoughts should be made. After presenting a brief biographical sketch of Nietzsche, we

shall discuss briefly his views on rationality and knowledge, his world-view and his concept of life. Thereafter, we will interpret Nietzsche's conception of human freedom, suffering and death within this framework.

According to Lawton, Nietzsche credits his philosophy to his long sickness, and he states that Nietzsche calls this period "the teacher of great suspicion".[1] Considering the related concepts of "will to power" and "eternal return" in the light of his concepts of sickness and health, Lawton contends that Nietzsche's philosophy is a reflection of his experiences during his long sickness and his intention to be well.[2] Lawton quotes Nietzsche as follows: "I turned my will to health, life into a philosophy."[3] Indeed Frederick Nietzsche was ill for many years of his adult life. Born in Rochen, Prussia, in 1844, Frederick Wilhelm was the son of Lutheran minister. At the age of 14, he went to boarding school near Naumburg. He was a brilliant student, always at the top of his class. Nietzsche studied theology and classical philosophy at the German universities of Bonn and Leipzig. It was during his time at Leipzig University that Nietzsche discovered the philosophy of the philosopher Schopenhauer and the music of the musician Richard Wagner.

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[1]Phillip N. Lawton, Nietzsche Convalescence Philosophy Research Archives, vol. XIII (1987-88), 152.

[2]Lawton, p. 151-154.

[3]Lawton, p. 160.

They were later to influence his philosophical thoughts. Perhaps a significant event in Nietzsche's life did occur while he served his miliary service. In March of 1868 he fell from a horse and hurt himself badly. He suffered gravely from this injury, and it ended his military career. This accident will later result in his poor health. Nietzsche became a professor at the age of 24. He taught at Leipzig in Germany and Basel University in Switzerland. His works include The Birth of Tragedy 1872, Human, All-too-Human 1878, The Dawn 1881, The Gray Science 1882, Thus Spake Zarathrustra, Beyond Good and Evil 1886, Towards a Genealogy of Morals 1887. Numerous other books were written by him. An important book, The Will to Power consists of some of the notes Nietzsche accumulated from 1884 to 1888. It was published by his sister Elizabeth Foster-Nietzsche after the philosopher's death.[4]

3.2.2 Philosophical Method

No one method dominates philosophical analysis. Rather, many forms of critical methods are pervasive.[5] McIntyre identifies three methods in philosophical ethics

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[4]This brief biography of Frederick Nietzsche was made out from materials taken from "Chronology", p. 20-23, in Walter Kaufmann's The Portable Nietzsche, 1954: The Viking Press.

[5]Alasdair MacIntyre, Three Rival Versions of Moral Enquiry: Encyclopedia of Genealogy and Tradition (Notre Dame, Indiana: University of Notre Dame, 1990), 32-57.

which he calls "three rival versions of moral inquiry".[6] They are encyclopedia, genealogy and tradition. Nietzsche adopted the genealogical method in his attempt to show the inadequacy of traditional metaphysics.[7] Hoy presents a beautiful description of the genealogical method: "Genealogy tends to find an incoherence in our self-understanding (for instance, between our various self-descriptions, or between the way we think and the way we act) and then to show how that incoherence is produced from within us. Rather than confirm the adequacy of our present self-descriptions and the coherence of our practices, genealogy makes us more intelligible to ourselves by showing us the inadequacy of our present self-understandings and practices, and then giving an interpretation of how such an inadequacy could have come about"[8] Hoy contends that it had serious implications on Nietzsche's conceptions of the relationship between reality and reason.[9] Traditional rational inquiry had postulated that all reality could be

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[6]Ibid.

[7]Ibid., 32-57.

[8]David C. Hoy, Nietzsche, Hume and the Geneaological Method in Yirmiyahi Yovel ed. Nietzsche as Affirmative Thinker (Massachusetts: Kliver Academy Publishers, 1986), 20-38.

[9]Ibid.

grasped through reason.[10] Using genealogical analysis to refute this assertion, Nietzsche condemns endeavors to grasp reality through reason. In his opinion they misrepresent reality by imposing a certain perspective upon it.[11] An adequate philosophy, Nietzsche thought, should be able to reveal life from various perspectives. In essence, Nietzsche is saying that truth can be comprehended from various points of view.[12] This leaves us with the notion that "there is no such thing as truth as such, but only truth from one or another point of view". Many commentators have questioned whether Nietzsche held to this multiciplicity of perspective viewpoint.[13] Not only did Nietzsche turn aside from traditional physical methods, he also criticized traditional world-views. He rejected the idea that everything in the world had been designed by God to be of service to man. One who refutes God as the creator and sustainer of life on earth has only to turn to evolution. Nietzsche saw more essence in the theory of evolution than Darwin.[14] Darwinism presented a world wherein individual organisms struggle for their existence.

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[10]Ibid.

[11]Ibid.

[12]Alasdir, MacIntyre, Three Rival Versions of Moral Enqiry, 32-57.

[13]Ibid.

[14]Rose Pfeffer, Nietzsche: Disciple of Dionysus, (Lewisburg: Bucknell University Press, 1972), 155-158.

But in this struggle human beings and other living organisms remain passive to the dictates of the environment. They only try to adapt to it.[15]

Living organisms perform yet another superior role in the Nietzschean world than only to struggle for their existence. They also have the desire to dominate the environment in which they live.[16] This violation to dominate, Nietzsche described as an aggressive "will to power".[17] Despite this added dimension, the Nietzschean world is totally anti-theological. According to his views, the universe is in chaos. But what makes Nietzsche's conceptions unique from other evolutionary theory is the notion we find expressed in the will to war, a will to power and a will to overpower.[18] When speaking about life, Nietzsche presents two unique imports. Firstly life finds expression in the will to power. Secondly, life is made up

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[15]Ibid.; Warren D. Allmon, "What Does It All Mean - The Individual in Darwin's World", Earth Science, (Spring 1990), 38.

[16]Frederick Nietzsche, The Will to Power trans. by Walter Kaufmann and R.J. Holingdale, (New York: Random House, 1967), 218.

[17]Rose Pfeffer, 155-158.

[18]Ibid.; Robert Nola, "Nietzsche's Theory of Truth and Belief," Philosophy and Phenomonological Research, vol. XLVII, no. 4, (June 1987), 525-562.

of a set of forces, both psychic and biological.[19] The question of meaning comes up in our minds after we capture Nietzsche's view of life. For many of us, it is difficult to appropriate meaning to life so defined. With life as defined in terms of biological and psychic forces and a world view which does not uphold any notion of the transcendent, human life would be devoid of meaning. Man becomes an immanent being who has no supernatural gifts or obligations.[20] He is self-sufficient, and he lacks nothing residing in a superior world.[21]

3.2.3 Human Freedom

Woodward advanced the thesis that Nietzsche's philosophy exhibits an "internal consistency" which could be untangled only by putting together Nietzsche's concept of freedom. True indeed, without any understanding of his concept of freedom, almost all of his works will be

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[19]Ibid.; Paul D. Maclean, "Brain roots of the Will-to-Power Zygon," Journal of Science and Religion, vol. 18, (Dec, 1983), 359-374.

[20]Frederick Nietzsche, Genealogy of Morals trans. by Walter Kaufmann and R.J. Holingdale (New York: Vintage Books, 1967), 24-96.

[21]Ibid.

meaningless. Woodward makes this assertion also.[22] In fact, his concept of freedom is tied up with most of the important concepts he elucidated: the revaluation of values, the will to power, eternal rebirth and the Overman.

Of these, there exists a serious link between the concept of freedom and the Overman.[23] Before we proceed any further, let us give a brief description of how Nietzsche perceived the Overman. Bernd Magnus presented a brief description of how Nietzsche perceived the Overman:

> "The Overman represents Nietzsche's nondualistic vision of human perfection. Like Goethe, the Overman is the Dionysian who has overcome his animal nature, has sublimated his impulses, organized the chaos of his passions, lives authentically, and has given style to his character. He is a free human being, joyous, without the master of instructional drives which do not overpower him. He represents the ascending life, self-overcoming and self-possession. In him intelligence, strength of character and will, autonomy, passion and taste are fully integrated. Think of him as Christ's soul in Caesar's body, or as instinct spiritualized."[24]

From the description of the Overman we make the following observation. Nietzsche approached the concept of freedom from an existential perspective. Such a perspective focuses on selfhood and self-realization. According to him, freedom exists for the sake of self-realization. The moral

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[22]Charles Dale Woodward, "Freedom, The Overman, and Style in Nietzsche's Philosophy (Unpublished diss. University of California [abstract]).

[23]Ibid.

[24]Bernd Magnus, "Nietzsche, Hume and the Genealogical Method" in Yirmiyahu Yovel ed. Nietzsche as Affirmative Thinker (Boston: Kulver Academic Group, 1986), 20-38.

task for each person often is to attain authentic selfhood in freedom. To understand his concept of freedom better, let us look into the traditional metaphysical conceptions of selfhood and self-realization. The traditional view puts man's inner being dressed in encasements. Selfhood is described as that state of full awareness and ultimate self. However, to attain this state, man has to cast aside those encasements.[25] This process which corresponds to a reversal of the creation, is possibly only through spiritual discipline.[26] Attained it helps man to possess a more profound relationship with the universe.[27] This view has a science of the universe and of human beings which follows from the hierarchial notion of both the inner being of human beings and the universe.[28] In the traditional view the self has a metaphysical rather than a physical basis.[29] It invites a contrast between the self and the body. And the body is thought of as weighing down, impeding and limiting the true self. The self yearns for its freedom.[30]

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[25]Masterpieces of World Philosophy in summary form, 1961 ed. "Plato Phaedo".

[26]Ibid.

[27]Ibid.

[28]Ibid. For a fuller treatment of Plato's Cosmology and Psychology, see Francis Macdonald Cornford's Plato's Cosmology a translation of "The Timaeus". (London:, 1948).

[29]Ibid.

[30]Ibid.

Nietzsche is an opponent of the notion of the metaphysical self. Individuals, not God, are the source of meaning. Life is what the will to power makes it. Stability is what we put into the world and not what we find there. Because there are no substances, no continuing entities, there are no selves and no god, and even the idea of an individual seems hard to sustain.[31]

The human body is the best picture of the human soul.[32] The metaphysical self becomes the physical self.[33] The physical self in its strife for selfhood is involved in a quest for wholeness.[34] An illustration of this urge is found in one of the main themes in his philosophy, namely the revaluation of values.[35] Nietzsche intends to stimulate his audience to create their own values.[36] Through the process of reevaluation individuals come to find self-integration. They do so by affirming and acknowledging contradictions which exist in human nature.

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[31]Frederick Nietzsche, "Thus Spake Zarathrustra" in The Profitable Nietzsche, trans. Walter Kaufmann, (New York: Penguin Books, 1968), 146.

[32]Ibid.

[33]Ibid.

[34]Frederick Nietzsche, "The Transvaluation of Values. Selections from The Will to Power, The Genealogy of Morals (first essay) and Beyond Good and Evil" in Ethel M. Albert, Theodore L. Denise and Sheldon P. Peterfreund Great Traditions in Ethics 3rd. ed. (New York: D. Von Notrand Co), 253-278.

[35]Ibid.

[36]Ibid.

Human nature is both rational and irrational, good and evil.[37] It is by embracing both opposing qualities of human nature that we become whole.[38] Becoming whole means becoming a new creature with a higher level of spiritual and moral consciousness. We then participate both in the conscious and in the unconscious. Nietzsche calls this new personality "the higher self".[39]

The concept of the higher man is demonstrated in Book IV of Zarathrustra. Zarathrustra searches in solitude for his instinctual "self" from which to control. Once in possession of himself, he affirms oneness with the world by zeroing on life as part of a whole. Zarathrustra comes back to an image created by Nietzsche earlier found in his other works "the free spirit".[40]

From Nietzsche relevant themes of "reevaluation of values", "eternal return" and for the images of the "higher

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[37]Ibid.

[38]Ibid.

[39]Gilles Deleuze, Nietzsche and Philosophy, trans. by Hugh Tomlinson (New York: Columbia University Press, 1983), 164-171; Kathleen Marie Higgin, Nietzsche's Zarathrustra (Philadelphia: Temple University Press, 1987), 203-232; Howard A. Slaatte, A Critical Survey of Ethics (New York: University Press of America, 1988), 209.

[40]Eugen Biser, "The Scales of the Spirit" in Nietzsche's "Battle with the Spirit of Gravity" in Theology of Joy Johannes B. Metz, Jean P. Jossua ed. (Herder and Herder, 1974); Frederick Nietzsche, Beyond Good and Evil: Prelude to a Philosophy of the Future (1886) trans. by Walter Kaufmann (New York: Random House, 1967).

man" and "free spirits", we undertake to formulate his concept of freedom, suffering and death. Freedom is the sense of a release from all moorings and ties and an acceptance of the libertine principle. Conceived as a great emancipation, freedom is understood as absolute self-determination.[41]

By freedom, Nietzsche meant that an individual is able to create his or her own values. It means the "realization of man's authentic being."[42] And this freedom is achieved through education.[43] What renders an individual act free is the existential commitment or the personalization of

experience. That is, the act is free when it springs from the whole personality.[44]

Like other philosophers devoted to existentialism, Nietzsche believes that the possibility of choice is the central fact to human nature.[45] By that he maintained that human beings do not have fixed natures which limit or determine their choices. Rather, it is their choices that

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[41]Shlomo Pines, "Nietzsche: Psychology of Philosophy and Freedom" in Yirmiyahu Yovel ed., Nietzsche as Affirmative Thinker (Massachustts: Kulmer Academic Press, 1983), 147-159.

[42]Eliyahn Rosenow, "Nietzsche's Concept of Education" in Y. Yovel (ed.) Nietzsche as Affirmative Thinker, 127.

[43]Ibid., 119-131.

[44]Jacob Golomb, "Nietzsch on Authenticity" Philosophy Today 34 (Fall 1996), 243-258.

[45]Ibid.

brings whatever nature they have into being. This implies three things: (1) all actions imply choices, (2) although in many of our actions our choices are governed by criteria, the criteria which we employ are themselves chosen, and there are no rational grounds for such choices, (3) we cannot give any explanation for our actions.[46]

3.2.4 Death

Emanating from his thoughts on human freedom is his conception of death. It is an existential view of death. It could also be described as an nontranscedental view of death.[47] Nietzsche's thoughts on Death appear in part one of Zarathrustra and the Twilight of the Idols.[48] Undoubtedly, Nietzsche's ideas on death are influenced by Karl Jaspers.

A review of the traditional non-existentialist view will aid us to understand Nietzsche's views. The traditional view is seen in Plato Phaedo. In it death is an event which brings about a separation of body and soul. The soul, as mentioned earlier, is that it survives after death of the body. The traditional view treats death and life as

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[46]Helmut Thielicke, Living with Death trans. by Geoffrey W. Browley (Michigan: William B. Eerdman Publishing Company, 1983).

[47]Ibid.

[48]A fuller treatment on Nietzsche's view of death and its connections with his doctrine of Eternal Recurrence is found in George T. Stack, "Eternal Recurrence Again," Philosophy Today, vol. 28 (198), 242-264.

mutually exclusive opposites. Life is the opposite to death.[49] Thielicke noted the ramifications of this view of death. "It divides human beings into an authentic part which is an immortal substance that survives death, and an inauthentic part which is an unimportant vessel for that substance which can and should perish."[50] Death in the traditional view means death of our inauthentic part and freedom for authentic existence. And death in the traditional sense suggests a radical incompleteness of philosophy of the person.[51] This dualistic splitting of the human personality which is found in the traditional definition of death is nowhere to be found in Nietzsche.[52] On the contrary, Nietzsche sees death as a limitation to freedom. Wholeness of person is one of the hidden unity and destiny of the personality. In Nietzsche there are two possibilities of living: either as an authentic existence using heideggerian terms, in which the individual faces the limits of human existence and especially in his death, or

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[49]Masterpieces and world philosophy in summary form, "Plato Phaedo", 81-87; Helmut Thielicke, Living with Death trans. by Geoffrey W. Bromley (Grand Rapids: 1983), 63-69.

[50]Helmut Thielicke, Living with Death, trans. by Geoffrey W. Bromley (Grand Rapids: William B. Eerdmans Publishing Co., 1983), 63-69.

[51]Henry Staten, Nietzsche's Voice, (Ithica: Cornell University Press, 1990), 114; Helmut Thelicke, Living with Death trans. by Geoffrey W. Bromley (Grand Rapids: William B. Eerdmans Publishing Co., 1983), 63-69.

[52]Ibid., 126.

the inauthentic existence, in which the individual retreats from death and the of the world and becomes their victim.[53] Freedom is expressed in the sense that we have power to choose between authentic and inauthentic existence.[54] This connection between death and human freedom can have two consequences. Since we are free to choose the type of life we live, we cannot choose to continue to sustain our life indefinitely.[55] Death becomes a limitation to human freedom.[56] Thereby who accepts death as part of living. Helmut Thielicke observes this in his description of the Nietzschean concepts of death as nontranscendental. He commented that this view saw death as part of life and therefore death is an end that comes from within and not from without.[57] If we reflect on Nietzsche's immanentistic world-view, and also on the idea that the authentic being must be able to grasp the opposite aspects of human nature. Then we see that death is not

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[53]Helmut Thelicke, Living with Death trans. by Geoffrey W. Bromley (Grand Rapids: Wm. B. Eerdmans Publishing Co., 1983), 63-69; Ibid.

[54]Ibid.

[55]Ibid.

[56]Henry Staten, 74-75; Helmut Thielicke, Living With Death trans. by Geoffrey W. Bromley (Grand Rapids: Wm. B. Eerdmans Publishing Co., 1983), 63-69.

[57]Helmut Thielicke, Living with Death; Sarah Kaufman Baubo, "Theological Pervision and Fetishism" in Michael Allen Gillespie and Tracy B. Strong Nietzschens New Seas (The University of Chicago Press, 1988).

remote or detachable from life; death is pervasive, and abiding and as present as life itself.[58] We are able to view death in the total context of shared human existence. It is a view that seems to say that man is capable of coping with death. It offers people to approach death in equanimity.[59] This courage in the face of death can be achieved by living authentically. Helmut Thielicke accuses Nietzsche conceptions to be the closest to modern biologism.[60] Nietzsche argues that though man's mortality is of greatest importance for any philosophy of life, the importance of dying is not.[61] In his view the will to die can be countered by the affirmation of life in art and by the heroic acceptance of "external recurrence".[62]

3.2.5 Suffering

The philosopher has made many allusions to sickness. For he views sickness as an organic, but dysfunctional state.[63] According to him then, the dilemma of sickness is internal and the means for curing it must be brought out

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[58]Ibid.

[59]Ibid.

[60]Ibid.

[61]Ibid.

[62]Lawrence Lampert, Nietzsche's Teachings (New Haven: Yale University Press), 221-223, 237-240.

[63]An example is found in Frederick Nietzsche, On the Genealogy of Morals in Basic Workings of Nietzsche.

from within the human situation.[64] However, despite its central character, sickness has the power to debilitate anyone, even the strongest person. It is within the context of his thoughts on sickness and the nature of human life that Nietzsche expressed his general concern for human suffering.[65] A perusal of Nietzsche's work it became apparent that he distinguished between various kinds of suffering. Viewing suffering from the perspective of those who bear pain, Nietzsche was able to make a split between "suffering from superabundance of life" and "suffering from the impoverishment of life".[66] By the former Nietzsche made reference to those who use suffering creatively and positively. The later he referred to those who have a negative view of life in the event of suffering.[67] From the perspective of character aspects of suffering Nietzsche differentiated between minor sufferings similar to emotional hurts and serious suffering similar to severe grief. He did not concern himself with minor sufferings but with the severe suffering type.[68] Severe suffering involves actual life events. A perfect example could be pain and grief

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[64]Ibid.

[65]Ibid.

[66]Gilles Deleuze, Nietzsche and Philosophy trans. by Hugh Tomlinson (New York: Columbia University Press, 1983), 16-17.

[67]Ibid., 16-17, 19-24.

[68]Ibid., 16-17, 19-24.

suffered by a mother who loses a son to a stray bullet in a store robbery. She cannot reduce her pain by thinking through the shooting event. Rather, she might increase her pain if she does.[69] Events similar to this happen too many times in our lives. They are terrible events. In Birth of Tragedy and in Zarathrustra, Nietzsche dealt with it in depth. Based upon his studies of the ancient Greeks, he adopted a triad of metaphors to illustrate three different procedures to cope with severe suffering or tragedy. Relevant to us are the allusions to severe suffering which the philosopher makes. He cautioned those who want to make sense out of situations of severe suffering, that severe suffering can be rationalized.[70] This comes out in Nietzsche again that human beings are imaginative, intelligent, sensual beings, to whom peace in life and death, could come only if they understood and master their essential human emotions. So he recommends that suffering should be treated by applying to one's emotions.[71] To be more specific to the concerns of this

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[69]Kathlee Marie Higgins, Nietzsche's Zarathrustra (Philadelphia: Temple University Press, 1987), 16-39.

[70]Ibid.

[71]Ibid.

study, Nietzsche would recommend that the seriously ill should desire to share their thoughts and feelings about their illnesses and other related matters. Onlookers should allow them to do so. The onlooker must be prepared to deal with the suffering with openness and accommodation. A purely existentialist position, Nietzsche's, it seems, was one that treated suffering as a force without and beyond reason. Suffering is one of life's paradoxes, a basic condition of existence.

Permit me to give a concise summary of Nietzsche's conception of suffering: suffering undermines the human condition, but it is very useful. Suffering is a way of life because it has the potential to reveal life to those who go through it. Suffering is also useful because it unveils truth and shows one's true colors. Suffering is life-preserving, mind quickening and soul testing.[72]

3.3 Human Freedom, Suffering and Death in Paul

We now turn to define the concepts of human freedom, suffering and death set by Paul. However, because of the expanse of Paul's writings, we will do our analysis based upon selections from his writings. We are relying on the scholarship of authorities in that field of New Testament. We start this analysis with insights from Paul's view of

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[72]Ibid.

human beings and the world. The early church fathers interpreted Pauline anthropology within the framework of Greek philosophy.[73] Greek philosophy differentiated between two existing worlds: this world and the other world. It also had a dualistic view of human beings: the soul and the body.[74] Consequently, the Patristic fathers interpreted Pauline anthropology in primarily dualistic terms.[75] Not satisfied with this interpretation, recent scholars of the New Testament sought to reject the Hellenistic framework within which Paul's views were interpreted.[76] Rather than the Patristic fathers dualistic understanding, recent scholars have suggested that Pauline views of man must be understood from Rabbinic framework.[77] Using Judiastic presuppositions to interpret Paul, they came up with a monistic interpretation of Pauline anthropology. Their moves did not settle the questions we face in reading Paul's views. It is our opinion that Pauline anthropology is neither purely dualistic nor purely

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[73]Laeuchi, Monism and Dualism in Pauline Anthropology, Biblical Research 3: (1958), 15-27; George Eldon Ladd, A Theology of the New Testament (Wm. B. Eerdman's Publishing Co., 1974), 364-407.

[74]Ibid.

[75]Ibid.

[76]Ibid.

[77]Ibid.

monistic.[78] Totally in agreement with those scholars who believe that it should be interpreted "in medias res" that is, taken to the midpoint.[79] Paul shows both elements of monism and dualism in expounding his views of human beings.[80] Therefore, we can say that his views were pluralistic.[81] But as those who have taken this position warned, it is not the pluralism of Paul's ideas which form the basis for his anthropology, rather it is his theological concern.[82] Paul was concerned to show that the new self is different from the old natural body. In the chapter "Man Outside of Christ" of the book A Theology of the New Testament, George Eldon Ladd gave insights into Pauline views of the world and man. His thesis is that Pauline views should be understood against the background of "eschatalogical dualism."[83] Paul adopted the two ages scheme of time from Judaism: this age and the age to come. In addition, Ladd cites that Paul has a unique attitude toward the natural world. To Paul, the natural world illustrates the character and power of Almighty God. Not

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[78]Ibid.

[79]Ibid.

[80]Ibid.

[81]Ibid.

[82]Ibid.

[83]George Elden Ladd, A Theology of the New Testament (Michigan: Wm. B. Eerdmans Publishing Co., 1974), 396.

only has God created the natural world, including all that is with it, he created it out of nothing, through Christ.[84] However, Paul explains that creation is no longer in that state in which it was created. Creation has fallen, and it is in need of redemption. Paul wrote about orders of other created beings: angelic beings and demons. And Ladd pointed out that these were not "peripheral" elements or "the result of the influence of extraneous religions concepts upon his views".[85] The Pauline world is different from the Nietzschean world.

3.3.1 Paul on Freedom

According to Robert Adams, Pauline freedom is a characteristic of a wider ethical system of "divine commands". But it is also a dynamic model, "a conception of the subjective freedom with which a person ought to respond to life's occasions". He maintains that the two sides should remain undiscerptible.[86] Richardson's book Paul Ethics of Freedom serves a primer where these two sides are brought out. In some parts of the book Richardson seemed to say that freedom excludes all principles except for its evangelical goals. At other times it seems that freedom is

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[84]Ibid.

[85]Ibid., 403.

[86]Robert M. Adams, "Christian Liberty" in Thomas V. Morris ed., Philosophy and the Christian Faith (Notre Dame: University of Notre Dame Press, 1988), 151-171.

subject to all sorts of limits. These include love, the law of Christ, and the content of the gospel, and the Roman rule. With regard to the first side, human actions are free if they are voluntary.[87] Paul rules out even the slightest presence of coercion in a free action.[88] Irrelevant whether good or evil results from an action, it is morally improper to pressure someone into an action.[89] Having ruled out compulsion, Paul agrees that actions that are moral are those made by free choices of the agent.[90] They must proceed from the heart of the agent. But Paul speaks of a further condition necessary to make a free action morally appropriate. An agent who makes an action must have inner control over his or her desires, and a constant motive, to be able to do a right action.[91] Because of this, it is usual for scholars to interpret the Pauline concept of freedom in terms of utilitarian, consequential thinking.[92] As they see autonomy in Paul's concept of freedom, especially where Paul in I Corinthians Chapter 10, verse 23 said: "Everything is permitted, but not

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[87]Peter Richardson, Paul's Ethics of Freedom, 1st ed., (Philadelphia: Westminster Press, 1979).

[88]Ibid.

[89]Ibid.

[90]Ibid.

[91]Ibid.

[92]Ibid.

everything is helpful."[93] Robert Adams proposes an interpretation of Pauline concept of freedom, in which he says that the Christian is forced from deontology for a teleological ethics.[94] This brings out the second side of Paul's concept of freedom: Paul's freedom is bounded up in an ethical system of divine commands. First of all, we have to distinguish Paul's ideas of freedom from the Greek notion of freedom which is autonomy. The concept of autonomy mentioned earlier empowers an agent to make a choice freely of any external coercion and from any constraint whatever.[95] John Kilner notes that Paul does not conceive freedom as autonomy. Paul's concept of freedom does not allow one to do whatever he or she wants. Rather, it recognizes that the decision-maker faces certain realities within which he or she must make a decision. Consequently, if the decision-maker ignores the reality within which the decision must be made, then he or she will be wrong.[96] Kilner maintains that within the Pauline ethic the decision-maker has the freedom to be wrong. However, he believes that such freedom will not make a "reality-contradiction"

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[93]Robert M. Adams, "Christian Liberty", 155.

[94]Ibid.

[95]Ibid., 155-156.

[96]Kilner, John F., "A Pauline Approach to Ethical Decision-Making", Interpretation: A Journal of Bible and Theology 43 (October, 1989): 366-379.

action ethically justifiable.[97]

3.3.2 Paul on Death

Like Nietzsche whose ideas on suffering and death are influenced by his own long illness, so also are Paul's ideas. They were conceived based upon his reflections on his own suffering and the suffering and death of his master Jesus.[98] In the first chapter of the second letter to the Corinthians, Paul's experience of death is like Jesus.[99] He is being pursued into death by his own people. In the fifth verse he mentioned that the suffering of the Messiah flows over into his life.[100] French theologian and scholar Xavier Leon-Dufour captures Paul's experiences of death in his book Face a la Mort Jesus et Paul.[101] In the second section, Leon-Dufour focuses on Paul facing Jesus on the cross and Paul facing his own death. He carefully analyzed those terms used by Paul in his death discourse. The author claims that Paul interprets Christ's death as a victory over death.[102]

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[97]Ibid.

[98]Xavier Leon-Dufor, Life and Death in the New Testament: The Teachings of Jesus and Paul (Face a la Mort Jesus et Paul), trans. Terence Pendergast, (San Francisco: Harper and Row, 1986), 153-286.

[99]Ibid.

[100]Ibid.

[101]Ibid.

[102]Ibid.

We come to discuss Paul's view of his death. We confine ourselves to his letters to the Romans and the Corinthians and will rely upon the scholarship of authorities in the New Testament Studies.[103] Confident that these authors have done good work analyzing Paul's view of death, in this analysis we shall only examine those relationships which are implied in death. Paul speaks of death in terms of a personal relationship, a relationship with God and with the world. Paul asserts that the "wages of sin is death."[104] He tells us that, "sin came into this world through one man and death through one, and so death spread to all men because all men sinned."[105] Narratives in another portion of his epistles show that Adam was the first man who caused sin, and he expounded on the content of the original sin. So death became a punishment for sin.[106] For the sin which Adam committed was grave. The result is the loss of both "physical corporeality" and "earthly corporateness". These losses involve a present process which is unchallenged.[107] When we view death as

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[103]C. Clifton Black, "Pauline Perspectives on Death in Romans 5-8", Journal of Biblical Literature 3, (September 1984): 413-433.

[104]See Romans 6:23, NIV.

[105]See Romans 5:12-14, NIV.

[106]Murray J. Haris, "Paul's View of Death in 2 Corinthians 5:1-10" in Richard N. Longenecker and Merrill C. Tenney, eds., New Dimensions in New Testament Study (Grand Rapids: Zondervan Publishing House, 1974).

[107]Ibid.

the result of sin, then death becomes more than a natural event. It becomes an event that individuals have caused for themselves. For this perspective, human beings are no longer objects in the path of death but they become subjects.[108] Death becomes an event in which we participate as responsible persons.[109] It becomes an event which individual persons have caused for themselves.[110]

Not only does the Pauline concept of death establish a personal experience of death, it also establishes a relationship between the deceased and the transcendent world. The loss of "physical corporeality" and earthly corporateness does not end life, but death ushers into the afterlife.[111] Murray Harris had this to say about this relationship: "Death allows 'in Christ' corporeality to achieve its goals in consummated 'with Christ' fellowship. Death may terminate the pilgrimage of faults but inaugurates the beatific viso Christi....[112] Thus we notice here two sides to death: as a punishment for sins and ushering us into a new relationship with God. However, when we consider death as a punishment for sin, we should always remember

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[108]Ibid.

[109]Ibid.

[110]Ibid.

[111]Ibid.

[112]Ibid.

that Christ's death is a substituted atonement for our sins.[113] This link, our sins and Christ's death makes the Pauline view of death inseparable with his view of resurrection.[114] So, Paul believes that the power of death has been drawn by Christ's conquest over death.[115]

Summarizing Paul's view of death, our attention is drawn to the two faces of death. On one hand, death seems to initiate a positive relationship between God and a Christian believer. On the other hand, death brings human beings to our closest experience of the Wrath of God. Furthermore, we discovered that death in Pauline writings means more than a natural phenomena. It incorporates the relational aspect of human life.

3.3.3 Paul on Suffering

It is very difficult to seek to say something within a small scope about Paul's thought on any matters. Of course, it is more difficult when it involves one of the central themes of his epistles: suffering. In doing so, we have to understand those assumptions under which Paul expounded on suffering: first, Paul speaks of suffering from his own experience.[116] Second, he assumes that God shares in

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[113]Ibid.

[114]Ibid.

[115]Ibid.

[116]1 Corinthians 4.

human sufferings.[117] Third, Paul views the whole of creation as subjected to futility.[118]

After a careful study of Pauline corpus, we discovered three types of human suffering. The first kind is personal suffering. It occurs when an individual person comes to terms with his or her own human finitude and limitations.[119] The second type we call "suffering at the hands of human injustice", and the third type "suffering at the hands of the power of death".[120] For all practical purposes, we shall consider only suffering at the hands of the power of death.

We start the analysis by pointing to Paul's attitude to this type of suffering. He was realistic about it.

> [18]Consider that our present sufferings are not worth comparing with the glory that will be revealed in us. [19]The creation waits in eager expectation for the sons of God to be revealed. [20]For the creation was subjected to frustration, not by its own choice, but by the will of the one who subjected it, in hope [21]that the creation itself will be liberated from its bondage to decay and brought into the glorious freedom of the children of God.
>
> [22]We know that the whole creation has been groaning as in the pains of childbirth right up to the present

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[117]Joseph Blenkinsop, "We Rejoice in Our Sufferings," in Michael J. Taylor S.J. ed. The Mystery of Suffering and Death (New York: Abba House, 1973), 47-55.

[118]G.E. Ladd, 397, c.f. Romans 8:20.

[119]Joseph Blenkinsop, "We Rejoice in Our Sufferings," in Michael J. Taylor S.J. ed. The Mystery of Suffering and Death (New York: Abba House, 1973), 47-55.

[120]Johan Christiaan Beker, "Suffering and Triumph in Paul's Letter to the Romans," Horizons in Biblical Theology: An International Dialogue vol. 7, no. 2 (December 1985), 105-119.

time.
23Not only so, but we ourselves, who have the firstfruits of the Spirit, groan inwardly as we wait eagerly for our adoption as sons, the redemption of our bodies. 24For in this hope we were saved. But hope that is seen is no hope at all. Who hopes for what he already has? 25But if we hope for what we do not yet have, we wait for it patiently.[121]

Evidenced in these verses is Paul's sympathetic responses to creation's plight of subjection to futility. He is concerned with suffering occasioned by deterioration and degeneration of the creation. A few examples will suffice to clarify the type of suffering Paul was alluding to: human illnesses, the devastation of plant life on earth, the occurrences of natural disasters and disruptions in the animal kingdom.[122] They seem to have no purpose, yet no one doubts their reality. Paul even thinks they are the cornerstone to existence on earth.[123] But when faced with suffering on the personal level, Paul forms an image of a transcendent world in which this type of suffering will be absent.[124] And he calls upon Christian believers to pursue this claim. He admonishes Christians that they are the Sons of God, through who God will save the universe. He tells them that it is through them that God intends to

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[121]Romans 18-30 NIV; Ibid.

[122]Joseph Blenkinsop, "We Rejoice in our Sufferings" in Michael J. Taylor S.J. ed. The Mystery of Suffering and Death (New York: Abba House, 1973), 47-55.

[123]Ibid.

[124]Ibid.

exterminate suffering.[125] Paul gives meaning to suffering. He does so by elucidating their causes: he makes a casual connection between sin, suffering and death.[126] Different interpretations to this connection of sin and suffering which Paul makes. The first is the traditional view. The story starts with Adam, Eve and the Fall. This view says all kinds of suffering came to earth because of sin.[127] Some scholars disagree with this interpretation.[128] The argument is that Paul never said all sins came as the result of sin. The solution captures Paul himself mystified by the mystery of meaningless and purposeless suffering.[129]

Perhaps Paul's words in Romans, Chapter six and First Corinthians, Chapter 15 offers us a better insight into his thoughts on suffering. One thing is clear. Christ has destroyed both sin and death. However, Christians are not yet free from the power of death. We wait for the return of Christ. At His return He will finally bury the power of death.[130] In the meantime, Paul admonishes Christians who are suffering this advice and he summarized in one word:

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[125]Ibid.

[126]Ibid.

[127]Ibid.

[128]Ibid.

[129]Ibid.

[130]Ibid.

hope.[131]

Paul admonishes suffers that God cares for them. God's care comes often through comfort given by other people. Since every human being is liable to suffer, Paul advises those who have received comfort in their own periods of suffering to give comfort to others, who are suffering. Our Savior suffers, and each time we suffer, we share in His suffering.[132] Finally, Paul told Christians that our suffering has the potential means through which God's power can be revealed to many other people.[133]

In closing, let me mention Romans 1:1-5; Phillipians 3: 2 Corinthians 1:5-10; 2 Corinthians 4:7-10. All of these scriptural passages are connected with the "Interchange": that Christ became what we are in order that in Him we might become what He is.[134] Morna Hooker reminds us that what therefore happens to us, as a result of what happens to Him, happens only because we share in His experience of vindication and reversal.[135] We have in these scriptures the mystery of a God who suffers with men from sin and its

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[131]Ibid.

[132]Ibid.

[133]Ibid.

[134]Morna Hooker, "Interchange and Suffering," in William Harburg and Bran McNeil, eds., Suffering and Martydom in the New Testament (Cambridge: Cambridge University Press, 1981), 70-83.

[135]Ibid.

violence against His Son.[136] Though the Bible makes this connection, it does not explain suffering in real, definite terms; rather scripture praises the worth of suffering as a learning and a purifying experience.[137]

As a matter of fact, we Christians have victory of death through Christ, but at the same time we live in a world where sufferings exists. "To believe that Jesus is risen and death has been overcome does not mean suppressing suffering, on the contrary, it means making suffering more painful."[138]

Summary

Both the biblical teachings of Apostle Paul and the philosophical teachings of Frederick Nietzsche gave meaning to human freedom, suffering and death. However, they gave two different sets of meanings to these concepts. Frederick Nietzsche assigned meaning to human freedom, suffering and death within the framework of existentialist categories. Apostle Paul assigned meaning to these concepts within the biblical parameters of Providence, Eschatology and destiny.

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[136]Ibid.

[137]Ibid.

[138]Ibid.

CHAPTER 4

COMPARISON OF TWO MORAL SYSTEMS

4.1 Introduction

Conceptions of human freedom, suffering and death, both in Frederick Nietzsche and Apostle Paul have a background. The former is grounded extentialist' philosophy and the latter in biblical theology. Thus, we are ushered into two different value systems: secular existentialism and the Pauline tradition. Our task then is to find out what approach each of these value systems will take to the ethical issue of withholding and withdrawing life-support from the critically-ill. In this process we shall determine whether the ethical procedures each employ is appropriate for distinguishing between passive Euthanasia and legitimate acts of forgoing life-support.

In the Nietzschean world, God is dead without a creator, human being no longer owe any moral obligation to God. Also they have no special place in the created order of things. We expected someone in such a world to decide different or moral issues than a person who lives in a world in which God is the Creator and man is created in the image of God.

4.2 Nietzschean and Ethical Decision-Making

Frederick Nietzsche distinguishes between true morality and false morality. The Judeo-Christian value system promotes false morality. True morality advances the "will to power".[1] Rather than an ethic which promotes love and rejects life, Nietzschean ethic counsels affirmation and acceptance of life as it is in nature. Stemming from this counsel is a notion which gives the human will superiority over human reason. With an absence of absolute values from any external source in his ethic, the philosopher advises every individual to create their own values. He stresses individual morality meaning that individual persons do what makes life worth living.[2] Within this scheme of things, an individual has a role in moral decision-making. Moral rightness or moral wrongness is entirely the individual's responsibility to decide. On the more subjective level, a person faced with any moral dilemma has to make a choice. If he or she dose not choose, then others will make the choice for him. But those people who allow others to make moral decisions for them do not live authentically.[3] The existential ethic of decision-making of this type is

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[1]Howard A. Slaatte, A Critical Survey of Ethics, 210-210.

[2]Ibid.

[3]Virginia L. Warren, "A Kierkegaardian Approach to Moral Philosophy: The Process of Moral Decision-Making," The Journal of Religious Ethics.

characterized as choosing oneself.[4] Choosing oneself implies that individual persons are in control, he decides the how and what in any decision-making situation. One has to choose oneself as he or she actually is: that is what is meant by "choosing oneself".[5] We can interpret Nietzsche position of choice in two ways. First, we can say choice is both necessary and sufficient condition for being ethical. It means that the specific content of the choice does not matter.

Second, we can say that choice is a necessary condition for being ethical, while choosing the correct content is a sufficient for being ethical.[6] For the physician, passive Euthanasia, and in some cases legitimate acts of forgoing life-support, are created by conflicting duties: the duty to do no harm and the duty to alleviate suffering. The boundaries between passive Euthanasia and legitimate forgoing of life-support become almost indistinguishable, if the right to choose becomes the main component in the decision. The same applies to physicians who are pressed to make choices when confronted with the situation. If they decide to look for an authority on ethical matters to tell them the morally correct action to take before they carry it out, this ethic would see that they are evading their

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[4]Ibid.

[5]Ibid.

[6]Ibid.

responsibilities.[7] This ethical system might perceive them as not acting discriminately, because they fail to recognize their responsibilities of making the decision. In fact, this moral system scorns physicians who when faced with those decisions involving the withdrawal of life-support will consult the patient's family, a hospital ethics committee, or any moral experts.[8] Also appalling to the system would be those physicians who are uncertain about "who should make the decision?" The rationale for this attitude in this ethical system is based upon the notion that to entrust the making of a difficult moral decision to another person is to give away the benefits of "choosing oneself".[9] Physicians who do delegate such a beneficial opportunity, also forgo their chance to understand human dignity and pain, grief and death, and are insensitive to others' feelings and are selfish.[10]

4.3 Paul and Ethical Decision-Making

John Kilner deals with the Pauline moral system, particularly as it involves ethical decision-making.[11] In an article A Pauline Approcah to Ethical Decision-Making,

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[7]Ibid.

[8]Ibid.

[9]Ibid.

[10]Ibid.

[11]John Kilner, "A Pauline Approach to Ethical Decision-Making," Interpretations.

Kilner maintains that the Apostles' approach exhibit three characteristics: "It is God-centered, reality bound, and love impelled."[12] Important in Kilner's exposition of Paul's ethical system is his mentioning that all these three characteristics are intertwined. We cannot focus only upon one of them without recourse to the others. Our study reveals that Paul gave signification to human freedom, suffering and death within the context of providence, dignity and Eschatology. Paul's approach is endowed with certain constraints. Be it either God-centered, reality-bound and love-impelled as in Kilner or providence, dignity and Eschatology as in our study, all of these are "rooted in the consistently trustworthy character and purpose of God".[13]

Those constraints brought to bear on our impending issue of forgoing life support, three ethical centers emerge: sanctity of life, freedom and responsibility.

Let us consider the sanctity of life. "Sanctity of life" holds the view that all human lives, irrespective of their quality or kind, are equally valuable and inviolable.[14] Frequently textbooks use other synonyms such as "dignity of human life" and the "sacredness of human

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[12]Ibid.

[13]Ibid.

[14]Norman L. Geisler, "Sanctity of Human Life," in S. Kantzer Applying the Scriptures (Grand Rapids, Michigan: Zondervan Publishing House, 1987), 139-160.

life". By definition, it seems "sanctity of life" is saying that "every life" and "every moment of life" have absolute and infinite value, regardless of its condition or quality.[15] If this is the case, then it opposes any attempt to remove or withhold life-support from critically-ill patients based upon the quality of life judgments. Furthermore, any form of active killing is ruled out, no matter how compassionate the motives physicians would present. Therefore, taking to the extreme interpretation, "sanctity of human life" holds that physicians should continue normal forms of care and medical efforts for a patient, no matter how ill he might be. This is an absolute form of the sanctity of life ethic.[16] Life-support should not be withdrawn or withhold for any reason whatsoever, given that they are defined as ordinary treatment.

We have seen that Paul gave human suffering, freedom and death meaning within the context of providence Eschatology and destiny. Life has special meaning within that context life story encloses the atoning work done by Jesus Christ, its redemptive power and availability to everyone. Sanctity of life within these parameters defines for us a comprehensive picture of God's purpose for human beings. Not only does it define God's purpose, it also maps out our responsibilities towards God. It is dependent upon

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[15]Encyclopedia of Bioethics, Warren T. Reid.

[16]Ibid.

ethical convictions that extend beyond mere biological life to include social, psychological, mental and other human qualities. In consonant with these characteristics of the "sanctity of life" ethos, J. Robert Nelson detailed eight Christian affirmations which he said belong to Christians of all denominations. He related these to the sanctity of human life, especially as it concerns abortion. Of relevance to this discussion of sanctity of life are the sixth, seventh, and eighth affirmations.

"True humanity is not found in individualization, but in human community. The creator decreed that 'it is not good' for the creature to live alone, and caused life to be relational and communal in its essence". "The definition and identity of human life must be given in terms of personhood and not alone in terms of living tissue".[17]

For Christian faith, the definition of life in terms of personhood is determined by the acknowledgement of Jesus Christ as the true pattern of authentic personhood and as the divine Lord of Life. Our opinion is that within this non-absolutist interpretation of the "sanctity of life", certain situations exist in which the non-preservance of life may be the ethical thing to do. However, the sanctity of life principle acts as the barometer to check whether death is intended in acts of withdrawal and withholding of

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[17]J. Robert Nelson, "What Does Theology Say About Abortion," in Edward Batchelor's Abortion : The Moral Issues (New York: Pilgrim Press, 1982), 55-57.

life-support systems from critically-ill patients. However, it is not the single parameter that should be considered, when decisions are made. Human freedom and human responsibility are two other parameters. Though they may be assigned different meanings as we saw in Paul and Nietzsche, they involve some form of choice. In the case of Nietzsche unlimited choice is under self-determination, and in Paul it is choice under certain constraints: God-centered, reality-bound and love-impelled. Could we say that this characteristic of Paul's approach is act-deontological?

Therefore the Pauline approach combines both teleological and deontological theories. Furthermore, it combines traditional "abstract thought" and choice of the existentialists.[18]

4.4 Summary

At this juncture, let us clarify certain points: (1) The non-absolutist interpretation of the sanctity of life allows life support to be withdrawn or withheld on some occasions. (2) The sanctity of life acts as a barometer to determine the difference between acts of passive Euthanasia and legitimate acts of foregoing life support. (3) Pauline ethic combines both teleological and deontological moral theories, abstract thought and choice. Using Pauline

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[18]Virginia L. Warren, "A Kierkegaardian Approach to Moral Philosophy; Martin E. Marty and Kenneth L. Vaux (ed) Health-Medicine and the Faults Traditions: An Inquiry into Religion and Medicine (Philadelphia: Forbes Press, 1982), 215-228.

approach, we can distinguish between passive Euthanasia and legitimate acts of withdrawing and withholding life-support from the critically-ill.

CHAPTER 5

CONCLUSION

5.1 Summary

Our conceptions of human freedom, suffering and death influences how we make decisions to withdraw and withhold life-support from critically ill patients. These conceptions enter into these decisions through certain deontological and/or teleological principles. Sometimes, though, these conceptions could enter decisions through moral principles which have no philosophical or theological basis.

Evidently, our conception of human freedom, suffering and death are defined by our philosophical and/or theological outlook: utilitarian, secular existential or biblical Christian. The meaning which the Bible ascribes to human freedom, suffering and death provides a moral framework within which satisfactory decisions to forgo life-support can be made, especially when these decisions involve Christian patients.

It touches on the most relevant question that needs to be asked, when considering the withdrawing and withholding of life-support, namely: is death intended? Any value

system which has the basis upon which we answer this question, provides a suitable framework for distinguishing between acts of passive Euthanasia and legitimate acts of forgoing life support.

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