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Bible study ***3***

Dr Florence DEPEURSINGE (CH)
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Translation : Kathy WEBB-PEPLOE

When the patient can't make the decision themselves, I ask for wisdom and discernment.

'Whatever you did for one of the least of these brothers of mine, you did for me.' (Mt 25; 40)

34 Then the King will say to those on his right, 'Come, you who are blessed by my Father; take your inheritance, the kingdom prepared for you since the creation of the world. 35 For I was hungry and you gave me something to eat. I was thirsty and you gave me something to drink. I was a stranger and you invited me in. 36 I needed clothes and you clothed me. I was sick and you looked after me. I was in prison and you came to visit me. 37 Then the righteous will answer him. 'Lord, when did we see you hungry and feed you, or thirsty and give you something to drink? 38 When did we see you a stranger and invite you in, or needing clothes and clothe you? 39 When did we see you sick or in prison and go to visit you?' 40 The King will reply, 'I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me.'

These acts of human kindness are accessible to everyone, they happen spontaneously, without expectation of reward. We have absolutely no excuse for neglecting those in need, we must not excuse ourselves from this responsibility. Jesus asks us to involve ourselves personally in doing good to others. Such a love for others gives glory to God and is a reflection of our love for Him. When we encounter the starving, the thirsty, the stranger the sick person, it is Christ who we are meeting.

'For we are God's workmanship, created in Christ Jesus to do good works, which God prepared in advance for us to do.' (Ephesians 2; 10). The aim is not to do good works in order to be saved, but to do the works which have been prepared for us to do, for we have been blessed.

In the same way, the righteous have not acted in order to be saved, they have acted because they were saved. The righteous man before God is the man who is so inhabited by grace that he is one: in him faith, being and actions are but one.

Our patient cannot decide for themselves, because they are a child, someone with mental handicap, with a psychiatric illness or cognitively impaired: what a responsibility!

Médecine de la Personne requires of the doctor two qualities: scientific competence when it comes to diagnosis and treatment and humanitarian competence when it comes to their patient's self-fulfillment as a person, above and beyond their healing. Everything relies on the quality of the encounter between patient and doctor, the encounter with God which lies concealed behind all our encounters, seeing the other with the eyes of God. Paul Tournier even talks about the 'flash', the spiritual element of the encounter felt as a communion with the other.

That the patient cannot make their own decisions does not detract in any way from the spiritual encounter.

We will undertake scientific work doing investigations guided by the patient's presenting symptoms and signs, suggest a diagnosis and institute treatment recommended by evidence-based medicine. The choice of treatment is located at the intersection of 3 circles, one containing the scientific proof underpinning the rationale for this treatment, the second circle representing the doctor and his competencies and the third, the patient, their individual situation and their preferences. **In our case, the patient is incapable of telling us their preferences in a detailed manner.** Even so, we do not have the right to eliminate this circle, we need to gather as much information as possible in order to understand what the patient might say if they could.

It is also about defining our objectives: healing, increasing the chance of survival, relieving symptoms, increasing quality of life?

We will enter into a relationship with the patient, whatever their situation, person to person, as described in **Colossians 3; 12 : 'Therefore, as God's chosen people, holy and dearly loved, clothe yourselves with compassion, kindness, humility, gentleness and patience.'**

Soren Kierkegaard tells us; 'In order to really help someone, we need first to take care to meet them and start where they are. It's the secret of the art of helping. Whoever is incapable of doing this is deluding themselves if they believe they can be useful to another. To really help someone, I must be better informed than him, but first of all I must understand what he understands, without which my expertise is useless to him.'

We will therefore introduce ourselves, make ourselves available, in the sense of a **therapeutic presence,** that is to say create an inner zone of availability, put to one side our personal preoccupations, separate ourselves from our theories and our a priori ideas, orient our whole person towards the encounter, in an attitude of profound respect, of non-judgementalism and acceptance. We will address ourselves to the patient convinced of their capabilities and their dignity. It is a matter of explaining the true situation to them in simple and reassuring words, adapted to their condition.

We will ask him to talk to us about himself, his needs, his desires, even if they are irrelevant, we will tell him that we need to know more in order to choose with him the

best treatment, that we have need of him. And thus, we ask him the question: **'What do you want me to do for you?' (Luke 18; 41).** It is about carefully safe-guarding all that is human in their account, their lived life, their emotions and also ours rather than it just being a series of events. In his work; 'Dementia and resilience', Thierry Collaud reminds us that patients suffering from Alzheimer's disease feel emotions and feelings which they are often not able to express, and that their need to be surrounded by tolerance and by love is real enough. The existential losses that they suffer (loss of memory, of coordination, of knowledge) compromise that which is necessary to a person to maintain their identity. Let us not forget what remains and keep hoping for a growth towards a new reality. Just like any other human being, these patients have internal resources: spiritual, existential, personal and well as practical competencies. We need to make sure that they have access to external resources: familial, religious, community and social. The challenge of the carer, in the spiritual dimension of care-giving, is to know how to communicate that you are there for them. The persistence of a being in all their dignity is possible thanks to the respect given to them, both unconditional and at the same time individual. Taking the time to meet a person, is to let them talk about themselves in order to communicate their narrative identity, in due course helped by their relatives who can assemble the pieces of the puzzle of their existence and to allow the mystery of the Transcendance to act. It is opening a tiny door through which, maybe, light and life can enter. Having the courage to exist in the absurd.

The encounter should concentrate on the present, not confronting the person yet again with their handicapped memory, but bearing witness to their reality, what they are living at the present moment. We would like to establish a relationship of trust.

Gathering the witness of relatives.

Looking for advance directives, someone with power of attorney for health.

We want to be aware of what resonates in us in this situation, which could help us or, on the contrary, interfere with our reasoning.

We must be careful of the emotions which we experience.

Be aware of our limits, accept them, having thought about our limits, and in other terms, having reassured ourselves of the maturity of our faith (A. Grün). The path leading to a mature faith passes via a sincere encounter with oneself to allow oneself to change and to become the unique and special person envisaged by God from the beginning. When the Spirit of God acts in us, He shows himself by the fruit of the Spirit, characteristics of an adult faith: **'love, joy, peace, patience, kindness, faithfulness, gentleness and self-control.' (Galatians 5; 22)**

We also need to refer to bioethics:

Applying the 4 principles of bioethics which have as objective the respect for the person in as much as they are a subject.

This is a philosophy of doubt, of interdisciplinary discussions, reasoning, interpretation, conflicts of values, where there is no answer in the scientific annals.

The first principle is that of autonomy; the patient has the right to decide for themselves, in agreement with their beliefs, their values, the plans they have for their life. Each individual exercises their autonomy within a complex network of social relationships, psychological states, cultural influences and spiritual or religious

convictions. Fear and guilt are very bad counsellors and are amongst the principle obstacles to autonomy. There can not be full autonomy without true communication. In order to best respect the autonomy of the patient, we readily resort to advance care planning; clarifying priorities, wishes, the fears of the patient and their relatives. Making a decision about therapeutic objectives. Regularly reviewing these attitudes. Informing partners. This is known to reduce the stress, the anxiety and depression in relatives.

In our case, by definition, autonomy cannot be respected as it should, because of lack of discernment.

The 3 other principles of bioethics all have their place, and need to be known:

- Beneficience: positive acts, strategies which have as their aim helping the patient and their relatives and reducing their suffering.
- Non-maleficience: not harming or doing ill to anyone, primum non nocere.
- Justice: every decision or offer of care must be taken on a collective level, aiming for equality and equity of access to care.

We can also call upon the ethics of Emmanuel Lévinas, a Lithuanian philosopher educated in the Jewish tradition, the ethics of Transcendance… For Lévinas, 'God' is to be found in the face of the other, whoever we call God, whatever our religion. Who is this God? For Christians, it is precisely what is contained within verse 40 in chapter 25 of the gospel of Matthew, or in the Tibetan greeting, 'Namaste' which means 'I greet you, I honour the God who dwells within you.' In a reciprocal manner, the light of God which shows me the face of the other makes me unconditionally responsible.

What Lévinas calls face, is that little extra which means that the other is more than themselves, that which one can't describe, their soul, their dignity, all that which is at the same time communal and individual. As soon as he turns to face me, the other person's face makes me responsible and leads towards God. The caregiver, the relative, gives asylum to the face of the patient who can thus live again, that is to say accept their weaknesses and have them accepted by others. The patient is kept company as they look upon themselves. The other person's face talks to me, calls to me, orders me to serve him, just as God expects us to put ourselves at His service. The face talks and I reply 'Here I am.' It is in this response to that call that I am me, that is what forms my identity. Cain killed his brother Abel and **'the Lord said to Cain, 'Where is your brother Abel?' 'I don't know' he replied. 'Am I my brother's keeper?' (Genesis 4; 9).** For God, each is appointed to be responsible for the other by the Other, before they have even chosen to do so.

The sense of relationship with another is to render oneself capable of respecting all that is different in the other which shows itself in their face and in their mystery…the face is exposed, it is naked, expressive and cannot be reduced to a mere description.

The face tells us 'you will not kill.'

Naturally, the other fascinates us, provokes sympathy or on the contrary irritation or even rejection. We want their company. In spite of relationship difficulties, this need for otherness makes us exist, only the 'other' makes sense of 'I'.

Aaron Antonovsky, an Israeli sociologist, studied people who had been deported to concentration camps and their need to make sense of what they had lived through. He defined three concepts as **'salutogenesis',** that which promotes health (in contrast to pathogenesis):

- Confidence in our fundamental ability to understand the world
- Confidence that we have at our disposal the necessary resources to deal with life's challenges
- Confidence that there is some meaning to what is happening.

The importance of each of these three concepts allows us to evaluate what he called the sense of 'coherence' which contributes to salutogenesis.

How does this apply to those amongst our vulnerable population of patients who cannot decide for themselves, their understanding, their confidence in themselves? There is no one answer.

Even in a healthy population, these concepts are perceived in a very individual manner, but the vulnerable may not be aware of it or be able to express themselves on this subject or maybe they are more aware of it even than us? It's enough to give one vertigo, but thankfully we are not alone as we accompany them, God is with us. These considerations are nonetheless fundamental to 'healing' and the doctor has no competency or hold on that aspect of the future of the patient.

The time has come to offer the person a therapeutic alliance, in the image of the Alliance which God makes with us.

It is still a question of creating a multidisciplinary team around the patient's situation, where each should have been involved every step of the way.

We want to take time to be silent, to meditate, to pray.

And finally, to make the decision which seems the least bad, the best adapted to the situation of this patient, knowing that we may have got it wrong.

'Whatever you did for one of the least of these brothers of mine, you did for me.'

Amen

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