CENTER NEWS

The Bishops’ Workshop for 1987

The Pope John Center is pleased to announce its Bishops’ Workshop for 1987 for the hierarchies of the Caribbean, Canada, Central America, the United States of America, and the United States of Mexico. The sixth bishops’ workshop, now a regular feature of the Center’s works, will again be funded by a grant from the Knight of Columbus, and once more will be held in Dallas, Texas, February 9-13, 1987.

This year’s conference will be conducted at the Fairmont Hotel, a change necessitated in part by the increasing number of bishop participants.

The theme of the 1987 Bishops’ Workshop is SCARCE MEDICAL RESOURCES AND JUSTICE. Among the notable speakers are the following: Archbishop Fiorenzo Angelini, President of the Pontifical Commission on Health Care, Dr. Jerome Lejeune, Nobel Prize Winner and prominent geneticist who discovered the genetic abnormality, Trisomy 21, as the cause of Down’s Syndrome, Dr. David Kinger from Harvard’s School of Public Health, and Dr. Marc Siegler, well known physician-ethicist.

Inequity in Health Care Delivery

Health care has experienced rapidly increasing costs during the past 10 years. Almost concurrently, the ability of medicine to cure, correct or alleviate numerous diseases and disorders which heretofore had to be borne with silent resignation has made marvelous advances. No question that with the help of modern high technology the human condition for some people has become less burdensome.

Tragically, however, this progress in the delivery and quality of medical care has not uniformly benefited all peoples. Even within the same nation, the discrepancy in treatment received between the socio-economically favored and those not so favored is painfully apparent. A significant sector (in some regions perhaps the majority) of the population are simply not receiving adequate medical care, indeed in many instances not even the most rudimentary and basic care.

While this situation has been always with us (along with the poor), the dissimilarity in health care has been increasing in recent years. In our present economic situation and with the precariousness of international affairs, many of the agencies which heretofore were able to provide some minimal care for the poor and less favored now have had to reduce or abolish their services. As a consequence, those who have the economic resources, or are in positions of relative power, are able to command the required medical attention. The not-so-favored are increasing in numbers with the result that more persons are experiencing a downward movement of the quality of their health and ability to work and enjoy what few amenities they may be able to obtain. In the midst of this distressing situation, the Church and her leaders wonder how they can effectively intervene. Recognizing the complexities of both the economy and the delivery of health care, bishops are often reluctant to intervene in the public domain lest their well-intentioned efforts lead to more suffering for those whom they are trying to serve.

Information and Guidance

Hence, this workshop on scarce medical resources and the requirements of justice was conceived as a means of providing information and guidance through the complex and hazardous minefield of health care and its delivery. The bishops will be offered the guidance of the appropriate experts who will provide, not merely information, but the deep and balanced understanding of their subjects coming from their years of research and activity in the relevant fields. With the experience of the workshop, the bishops will be in a better position to evaluate the current scene, to know helpful resources, and to take effective action towards remedying inequitable conditions.

The Anatomy of “Living Wills” — Part II

Synopsis

Part I of this article outlined the basic requirements of “living will” statutes and the various arguments cited in favor of, or in opposition to, such legislation. It ended by a brief review of some of the problems which a “living will” may occasion for the physician.

From the patient’s perspective, a number of problems with the living will arise. One is simply that many patients will fail to inform the hospital of the existence of the will until after therapy has commenced. Such therapy may result in a lessening of the patient’s ability to communicate. A related problem is that the terminal diagnosis of many patients, especially the elderly, will not be made until after their condition has caused their competence to be reduced. If they then wish to revoke the will, they will be unable to do so.

Another problem occurs in those states which permit execution of the will by proxy (by a relative) for an incompetent person or a minor. It is impossible to be sure the proxy is acting in the patient’s best interests. Another argument that has been made is that there are serious problems of record-keeping about who has a living will and who has revoked it.

Perhaps the most important objection that has been raised, however, is the danger of misuse and misinterpretation. Many people may make these wills — especially if the idea gains much media attention and becomes a vogue — without really being aware of what they are for or how they might be used. Some might feel pressured to sign such a document because of the view being promoted so determinedly by some prominent commentators and experts that the elderly and terminally ill should spare society the burden and expense that caring for them will involve if they continue living (see Action Line, July 12, 1985). Dr. C. Everett Koop, the U.S. Surgeon General, has contended also that the danger exists that medical personnel may interpret the existence of a living will to mean...
that the patient does not want his life prolonged even by ethically ordinary means. The above suggest that prudence must be an important consideration when thinking about living wills.

At a time when we have a massive number of abortions performed annually, the starvation and withholding of treatment from handicapped newborns (apparently, on a fairly substantial scale), and a general lessening of respect for the dignity of innocent human life, living will legislation may be unwise because of the undesirable effect it could have on attitudes in the general public and health care community — even though the concept per se may be morally unobjectionable. (see Gerry, Martin H. “The Civil Rights of Handicapped Infants”, Issues in Law and Medicine. July 1985, pp. 15-16).

Unresolved Questions

Some unresolved questions further contribute to the problematic nature of the living will. One is the uncertainty (in at least some cases) arising from a misunderstanding about where ethically ordinary means ends and ethically extraordinary means of sustaining life begins. There is some doubt about what is to be included under the category of ethically extraordinary means. Is the provision of artificial sustenance to be included? Another question is that, even while most of the existing living will statutes provide no criminal penalties for the failure of health care personnel to honor the document, it is uncertain as to whether they could not still be successfully sued by the patient (or family) for failure to do so.

Horan and Marzen state that living will legislation “has value to the extent it clarifies patient choice, or educates the terminally ill patient about his rights and interests, or relieves the family and physician from decision-making,” but this must be set off against the problems and complications it causes. As has been argued, how much it even accomplishes these objectives is questionable and it certainly is not without difficulties. As the Pope John Center’s Handbook on Critical Life Issues insists, any living will legislation must be careful to clearly and precisely define terms such as “artificial means of life support,” expressly limit withdrawal of treatment to cases of terminal illness, and limit proxy consent. Also it must expressly prohibit “mercy killing” and assisted suicide, refuse to permit withdrawal of ethically obligatory nourishment or ethically ordinary medical care, apply only in terminal cases, and be genuinely voluntary.

Conclusion

The above suggests that living will legislation must be approached cautiously. Its acceptability hinges on the care with which its language safeguards the dignity and right to life of the terminally ill patient and respects the responsible judgment of the physician and other health care professionals. There is much valid criticism of current legislation. There is also good reason to question whether living wills are necessary and can be feasibly employed, and whether their increased use might not open the door to easy abuse.

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Christmas Greetings

In a year that has witnessed so many terrorists acts, involving the killing and wounding of hundreds of innocent victims, the hearts of all peace loving people yearn for that tranquility of order which St. Augustine wrote was constitutive of peace. But a secular order presumes a more fundamental order — the submission of the human heart to God’s loving and merciful will. Ever expressive of the Father’s abiding concern for us is the birth of his Son incarnated in a human nature. Jesus is not only the birth of his Son incarnated in a human nature. Jesus is not only the way to peace, he is our Peace.

Filled with gratitude for God’s unending gift to us, on behalf of the Board of Directors of The Pope John Center and the President, Father William M. Gallagher, all of us at the Center unite our hearts and minds in wishing you a blessed Christmas and a joyous New Year.

The people who walked in darkness have seen a great light; Upon those who dwell in the land of gloom A light has shone . . . For a child is born to us, a son is given us; His dominion is vast and forever peaceful . . .

from Isaiah 9