THE "QUALITY OF LIFE" ETHIC AND THE PUSH FOR "LIVING WILLS"

Deborah S. Sturm
Aliquippa, PA

The publicity surrounding the Terri Schiavo case has led many Americans to request copies of the "living will." This document is the primary choice of euthanasia enthusiasts because of the standard form's general presumption for death. The mentality behind the advocacy of the "living will" is that one is better off dead than debilitated or disabled. It is, therefore, dangerous and potentially lethal. The secularist, utilitarian, relativistic, "quality of life" ethic that is at the core of the culture of death, as well as healthcare's preoccupation with cost-effectiveness, is driving the push for "living wills." Pro-life alternatives to the "living will" are readily available that afford more protection to persons in the event that they cannot speak for themselves. The author has over twenty years of experience working in healthcare facilities: twelve years in the field of diagnostics as a radiologic technologist and nine years in the field of nursing. As a registered nurse, she has worked in long-term care, adult mental health, and geriatric psychiatry.

The contentious legal battle between Michael Schiavo and the Schindler family over the fate of Terri Schiavo, a disabled woman who was sentenced to death by starvation and dehydration through the removal of a feeding tube, has sparked a lot of public interest in end-of-life issues. During the final weeks of the legal battle, a lot of media attention was given to the "living will," a type of healthcare advance directive. Reporters touted the document as something that would "prevent what happened to Terri Schiavo." What, exactly, would signing a "living will" prevent—a contentious legal battle or being starved and dehydrated to death?

Before I continue, let me explain that the Terri Schiavo case was not an end-of-life case as the mainstream media had portrayed it. How many times did we hear on radio news reports that Terri Schiavo was on "life support" and "brain dead," as though her life was being cruelly and unjustly extended? Terri Schiavo was in no danger of imminent death, that is, until her feeding tube was removed per Judge Greer's court order. She also had no terminal illness. She was a healthy woman who had suffered a brain injury and had become disabled. She was placed in a hospice facility and lived there for five years before her she was subjected to legal killing. Since hospice facilities are
specifically designed for placement of the terminally ill—Medicare will typically only authorize payment for a six-month stay in hospice—Terri Schiavo’s placement in hospice could only have served as a public relations stunt to mislead the public about her true condition. In addition, Catholic moral theologians such as Kevin O’Rourke, O.P., who supported the removal of Terri Schiavo’s feeding tube, contributed to moral confusion and misled the American public about authentic Catholic teaching.  

The Terri Schiavo case served the purpose of advancing the agenda of the culture of death. Michael Schiavo and his “right to die” attorney George Felos were only interested in establishing a legal precedent whereby it is easier—and more acceptable to the public—to terminate the lives of the disabled and debilitated, those individuals whose care is most challenging and oftentimes more costly.  

The media outlets that advocated signing a “living will” were merely doing the bidding of the proponents of euthanasia. The “living will” is the product of a utilitarian mindset, focused on cost-effectiveness, that has overtaken healthcare. Sadly, many people forfeit their right to treatment and basic necessities such as food and water when they sign it. In addition, forfeiture of treatment is often done unwittingly. The following cases illustrate this point:  

Mae Magourik, an 81-year-old widow from Georgia, was admitted to a hospice facility in March 2005 at the urging of her granddaughter Beth Gaddy. Magourik, who was not terminally ill, had been diagnosed with an aortic dissection, although her cardiologist had determined that this problem was contained and not life-threatening. Gaddy told Magourik’s brother and nephew that “it is time [Grandmama] went home to Jesus.” They raised objections to this course of action, so Gaddy, who had no medical power of attorney over her grandmother—and therefore no medical legal authority over her—sought out a probate court judge who granted her guardianship, giving her absolute authority over her grandmother. Gaddy instructed the hospice facility to withhold food and water from her grandmother. Magourik had signed a “living will” authorizing the withdrawal of food and fluids if she was comatose or “vegetative.” She did not meet the criteria of either of these diagnoses, but this did not matter to Gaddy nor to the hospice facility. They obviously believed that the mere presence of a “living will” in her medical record was sufficient to attempt the procurement of Magourik’s death.  

In a more recent case, Jimmy Chambers, a 79-year-old Arizona resident, faced possible forced, premature death in the state of South Carolina. He was injured by a large fallen tree limb on August 20, 2005
in Naples, Florida, while on a riding lawn mower trying to help his son with yard work. A spinal cord injury left him dependent on a ventilator to assist him with breathing. His wife Viola, appealing to a “living will” he had signed in 1990 when he lived in the state of Iowa, tried to convince him to die by getting him to agree to the removal of his ventilator. According to court documents, Chambers had not been declared incapacitated and was able to speak for himself. Therefore, the “living will” should not have even been regarded as in effect. In addition, sworn affidavits from Chambers’ ten children and their spouses and a notarized letter from his physician testified to his spoken desire to live. As far as the rest of his family members were concerned, then, the “living will” was revoked by Chambers. But a fifteen-year-old, out-of-state document seemed to rule the day. According to Chambers’ son Potter, Mrs. Chambers even tried to deny her husband treatment for pneumonia, ordering him to be given only “comfort care.” Jimmy Chambers died on October 24, 2005 while he was still on the respirator. His family, suspicious about the circumstances of his death, is investigating the incident, as he was found with the tracheotomy tube detached.

The “living will” is, indeed, a dangerous document. Deaths by starvation and dehydration and by withholding life-sustaining treatment occur routinely in healthcare facilities, often with a “living will” document in a patient’s medical record. Oftentimes, killing is accomplished more surreptitiously, for example, through overdosing of medications. The Catholic Church is clear in its condemnation of euthanasia, whether by acts of commission or omission (CCC, #2277). Catholics who are faithful to Church teaching, whether they are healthcare providers, patients, or the family of a patient, often find themselves at odds with a modern day healthcare environment that is hostile to them. The killing of Terri Schiavo would have been another hidden statistic if the Schindler family had not possessed the moral fiber, shaped by their Catholic Christian Faith, to boldly stand up to a pervasive and hostile culture of death. Unfortunately many healthcare professionals and ill-intentioned family members will be emboldened by the court-ordered killing of Terri Schiavo. As they hide behind legality that mollifies their misguided worldview, even more forced deaths of patients will occur. What has caused healthcare professionals and other Americans to develop such killing tendencies, one might ask?

**Paving the Path to Euthanasia**

Throughout the past couple of decades, an insidious but measurable paradigm shift has occurred in the philosophy of medical
ethics. An editorial in California Medicine published in 1970 candidly admits that the traditional Western ethic, which had the blessing of the Judeo-Christian heritage, must be abandoned in order to advance the pro-abortion movement. The Western ethic—consistent with the Hippocratic tradition—which was committed to the “equal value of every human life,” would eventually be replaced by a “quality of life” ethic that placed “relative rather than absolute” value on human lives. This new ethic, the editorial asserts, will be embraced because of “scarce resources.” Interestingly, this editorial also mentions that to “rationalize abortion as anything but taking a human life” requires a “schizophrenic sort of subterfuge.”

Three years later, the Supreme Court Roe vs. Wade decision set the stage to questioning personhood based on level of function and development. This has paved the way to questioning personhood outside of the womb. Additionally, the Patient Self-Determination Act enacted in 1991, originally intended to empower patients and families by affording them more control regarding end-of-life decisions, has actually served to institutionalize moral relativism in healthcare. This has only propelled the euthanasia movement forward at an even faster pace. Prior to the paradigm shift, healthcare professionals treated their patients equally and were motivated to advocate for life-sustaining treatment regardless of their condition.

The California Medicine editorial proved to be prophetic. The traditional Western ethic is indeed virtually non-existent today in healthcare institutions, with the exception of individual pro-life healthcare providers. Many healthcare workers subjectively assess a patient’s “quality of life” before deciding whether or not to advocate for them. One wonders how a patient’s health or sense of well-being could improve if healthcare providers are rationing healthcare at the outset based on their perception of a patient’s “low quality of life.”

Haunting Parallels to Historical Atrocities

Didn’t Nazi doctors employ the expression, “life unworthy of life” (lebensunwertes Leben), terminology hauntingly akin to the expression “low quality of life” to justify killing the mentally ill, the disabled, the “unfit,” and finally, the Jews? James A. Maccaro points out that Dr. Leo Alexander, a psychiatrist and the chief United States medical consultant at the Nuremberg War Crimes Trial, was perplexed by the German medical community’s lack of resistance to the Nazis. After researching German archives, Alexander wrote in an article entitled, “Medical Science Under Dictatorship,” that the Holocaust
actually started with “small beginnings”—a shift in attitude among physicians [which pre-dated the rise of the Third Reich] who accepted a philosophy of healthcare based on how much they perceived patients would cost or benefit the state. The initial targets of euthanasia, then, were the non-rehabilitatable sick whose care was costly. And this philosophy was considered “rational” and “progressive.” Does this not attest to the absurdity and danger of this new “quality of life” ethic? Do we not now live in a society where those who embrace a relativistic worldview—particularly those in the medical field—consider themselves “progressive”?

The “Right to Die” and “Do Not Resuscitate”

This materialistic, utilitarian, “quality of life” ethic is aiding the advancement of an illusory “right to die,” which does not exclude actively procuring death for oneself or another. As Fr. Frank Pavone points out, “A ‘right’ is a moral claim. We do not have a claim on death. Rather, death has a claim on us.” As our society establishes death as a “right,” our God-given right to life is increasingly eclipsed, and the right to treatment at healthcare facilities diminishes. Thus, the “right to die” is moving toward a duty to die. “Futile care” policies are actually being implemented in various healthcare facilities around the country. These policies support the removal of life-sustaining treatment against the wishes of patients and families if a patient’s “quality of life” does not meet the arbitrary standards of the facility. This suggests that the power and control that was originally intended to be the patient's is shifting to the healthcare facilities and providers. This shift is not surprising when one considers that rampant moral relativism leads to confusion and chaos, and finally, tyranny.

The “quality of life” ethic has caused a push in establishing “do not resuscitate” (DNR) orders for disabled and elderly patients, or anyone else regarded as burdensome, even when they do not have a terminal illness. DNR orders, in many instances, are regarded as do not treat. Several years ago, I was caring for an elderly patient who had developed a fever. The physician assistant working on the floor that day hesitated to get an antibiotic order for the patient because of a DNR order on the patient's chart. I also recall caring for an elderly man who did not even have a DNR order. He walked up to the nurse's station and informed me that he had chest pain. I notified the cardiologist, a young physician, in an attempt to get an order for an EKG. After informing him of the patient's age, he declined to give an order, insisting that he was “too old.” Is it not frightening to think that medical personnel are
actually being educated with this mindset, as omissions like the ones previously mentioned can serve to terminate patients’ lives prematurely? As one can see then, the elderly are vulnerable because of this philosophy.

This “quality of life” ethic, obviously embraced by the “right-to-die” attorney George Felos, aided and abetted Michael Schiavo in the killing of his wife Terri. Many years ago, Michael Schiavo had a DNR order put on her chart even though she was young. This helped to forge the connection to “do not treat.” Thus Terri’s condition deteriorated even more as she was denied treatments that would have strengthened her. Many viewed Terri as having a “quality of life” that was inadequate because she was disabled. Since her court-ordered death, many disabled individuals are expressing that they feel threatened, as they live in fear of being denied the most basic care. As Rita Marker has noted, twelve national disability-rights groups filed briefs in the Terri Schiavo case opposing her death by starvation and dehydration. They now believe they are in the crosshairs of euthanasia. One group of disability activists in particular, Not Dead Yet, has created a website articulating their opposition to what was done to Terri Schiavo.

As though seeking Terri’s death through the court system was not already enough, Michael Schiavo is now contemplating further litigation regarding her medical treatment in 2003 when she was hospitalized with a possible severe infection. He believes that she should have instead been “allowed” to die from the infection rather than be treated. If he were to win this lawsuit, what further effect will this have on the treatment of patients with “do not resuscitate orders” posted in their charts? Could this case, through legal precedent, eventually pave the way for the systematic denial of treatment for anyone who has a “do not resuscitate” order?

The “Living Will”: Tool of Euthanasia Enthusiasts

As a result of the Patient Self-Determination Act, the federal government requires that healthcare providers who receive Medicare or Medicaid funding advise patients on their right to refuse medical treatment. If providers do not comply with the government directive, they risk losing federal funding. Incentive for cost-containment, then, exists at the level of the federal government, as well as in healthcare facilities. In addition, health-maintenance organizations also pressure healthcare providers to cut costs. Since death is the most cost-effective outcome of a catastrophic illness or injury, the federal government is actually in the position of supporting the agendas of euthanasia groups.
who are sympathetic to the denial of nutrition and hydration, as well as medical treatment, to individuals who are debilitated. The standard “living will,” a popular type of advance directive, is applauded by, for example, Compassion and Choices—previously called the Hemlock Society—a militantly pro-euthanasia, pro-physician-assisted suicide organization. Anti-life groups are supportive of ambiguous language that sells a hideous agenda to an unsuspecting public. Consider the following item written on a standard “living will” form in the state of California:

(1.2) AGENT’S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here.26

The problem with the above statement is its mention of “artificial” nutrition and hydration. What does this mean? When is food and water “artificial”? Does it refer to nutrition and hydration delivered through an intravenous line or a feeding tube site through the abdominal wall? Could it be interpreted as nutrition supplied from a can of Ensure that a patient drinks by mouth? Depending on their ethical point of view, “artificial” can be deconstructed by a physician to mean just about anything. As Wesley Smith points out, “defining ‘artificial nutrition’ as a treatment instead of humane care was a crucial step in the development of the culture of death.”27 Dr. Ronald Cranford, a euthanasia enthusiast who supported the execution of Terri Schiavo, is on record in the Nancy Cruzan case for considering spoon-feeding as “medical treatment” since he considered the administration of food and water as an obstacle to the procurement of Cruzan's death.28 The bottom line is that nutrition and hydration should never be considered a medical intervention nor as “artificial” and instead, as basic necessities.29

Another dangerous document is “The Dementia Provision,” which can be attached to the “living will.” It is designed to specify which treatments a person wants or does not want in the event of developing Alzheimer’s disease or other type of dementia. Pro-life activists have been concerned for quite some time about persons with dementia being targeted for euthanasia. Because of their confusion, difficulty recognizing their family and friends in advanced stages of their illness, and difficulty eating, persons with dementia become subjected to acts of omission. The Pennsylvania version of “The Dementia Provision” actually lists an item in which a person can specify that they do not want to be fed if they cannot feed themselves. Could this not result in death by starvation and dehydration? Euthanasia enthusiasts disingenuously portray demented persons’ inability to feed
themselves as “lacking in dignity,” when in reality these patients are being subjected to lethal acts of omission based on convenience.

Many “living will” documents have an overall presumption for death and are, of course, the most dangerous. (Note that this document from the State of West Virginia has a presumption for death, as it favors the withholding or withdraw of treatment: http://www.wvbar.org/barinfo/lawyer/forms.pdf. See the third page of the link.) Additionally, a “living will” document often has a list of treatments a patient can accept or deny during the last stage of their life. However, since “living will” documents take effect when a patient is unable to speak for themselves, they might be subjected to denial of treatment when they are not actually at the final stage of their lives. Long-term-care facilities often present these documents to residents upon admission, years before they actually enter the dying process. Oftentimes, persons are not really cognizant of the implications of refusal of treatments that are listed on a “living will.” As an example, a distressed and conflicted woman contacted me last year regarding her uncle, who had gone into a respiratory crisis and could not speak for himself. She was designated as his durable power of attorney, and he had also signed a “living will” many years prior to the current crisis. He had checked off that he did not want to be placed on a ventilator. As a Catholic, the woman understood the moral implications of denying her uncle treatment that would hasten his death. Yet she said, “I want to abide by my uncle’s wishes.” Neither she nor her uncle understood that ventilators are not always extraordinary measures and often are used to correct a temporary problem. Her uncle was finally placed on the ventilator and successfully weaned from it after a couple of days. He was able to breathe on his own afterwards. If she had followed through with denying him the ventilator as he had designated on the “living will,” his life would have been terminated prematurely. “Living wills,” then, are too often signed by patients without proper informed consent.

People often do not know what they really want or do not want in a prospective state of health. Yet this is exactly the situation Jimmy Chambers faced fifteen years after signing a “living will”. It makes sense then, that an advance directive should err on the side of life. What, then, are the alternatives to the “living will” that would provide protection against starvation and dehydration, as well as other positive acts or omissions that could result in the hastening of death?

Pro-Life Protective Documents

One type of advance directive that affords protection against the culture of death is the “Protective Medical Decisions Document”
(PMDD). It involves appointing a healthcare proxy, specifically, a
durable power of attorney for healthcare. It is preferable to a “living
will” primarily because it involves appointing an individual who knows
you well, someone who knows your worldview and values. The proxy
will be someone with whom you have discussed at length your desires
regarding healthcare. Unlike the PMDD, not all “living wills” involve
the designation of a proxy. (See the Pennsylvania Declaration below.
The patient is given the option of foregoing designation of a surrogate to
make decisions for them in the event that they cannot speak for
themselves.) This would leave an “attending physician,” someone who
might be a complete stranger, to withhold or withdraw medical
interventions or nutrition and hydration in the event that you cannot
speak for yourself. He or she might interpret the document in ways that
you did not intend. Also, the PMDD limits the authority of the power of
attorney in one specific way: The designee cannot approve the direct and
intentional ending of your life. A copy of the PMDD can be obtained
from the International Anti-Euthanasia Task Force, P.O. Box 760,

Another type of advance directive is the “Will to Live,” which
National Right to Life calls a “pro-life living will.” It also involves
designation of a durable power of attorney. It specifically highlights and
explains a “general presumption for life.” Through this document, the
patient acknowledges food and water as basic necessities that are to be
administered by any means to preserve one’s life and to ensure optimal
health. The document states that the patient does not want to be judged
or refused treatment based on his or her “quality of life.” The document
also specifies that the patient rejects any tissue or organ of an unborn or
newborn child who has been subjected to an induced abortion. The
patient also rejects treatments involving the use of organs or tissues of
another person obtained in a way that involves hastening the death of the
donor. Special instructions are available for a pregnant woman to protect
an unborn child. A copy of the “Will to Live” can be downloaded from
the National Right to Life Committee’s website (www.nrlc.org).

The American Life League also offers a pro-life healthcare
directive called “The Loving Will,” which also has a general
presumption for life. Like the PMDD, it specifically states that nothing
is to be omitted or done to you with the intent to procure your death. It
specifically declares that you are “not to be denied food or water as long
as [your] body is able to assimilate them.” It also instructs persons
treating you to provide “medical treatment and care if necessary to cure,
remedy, or relieve the symptoms” of your condition. And most
importantly, it forbids anyone from making “quality of life” a factor
when considering your treatment or care.\textsuperscript{33} You can find out more about the Loving Will by contacting their website: \texttt{www.all.org}.

**The Fight for Life on Another Front**

We can fight the culture of death by protecting ourselves and our loved ones through pro-life healthcare directives. In another effort to counter euthanasia, Bobby Schindler, brother of the late Terri Schiavo, is now working full-time for the Terri Schindler-Schiavo Foundation. In August 2005 he spoke to Arizona Right to Life, urging people in the pro-life movement to be just as vigilant about state laws affecting treatment of the disabled as they do about laws regarding abortion. The vision of the foundation appears to include the following elements: Oppose the valuation of persons based on the “quality” of their lives; fight the ambiguous and subjective classification of brain damaged individuals as being in a “persistent vegetative state” and “terminally ill”; and change laws that define assisted eating and drinking via feeding tubes as “medical treatments.”\textsuperscript{34}

**The “Living Will” is a Product of a Worldview Inconsistent with Catholicism**

The “living will” is the product of a bioethical worldview that is inconsistent with the Catholic Faith. Utilitarian ethicists who are influencing attitudes in modern-day healthcare have great difficulty finding value or meaning in human suffering and loathe inconveniences. For them, instead, suffering is a stumbling block, something that must be eliminated. And that means death for those perceived to be burdensome. Through the eyes of our Catholic Faith, illness and disability need not be seen as catastrophic or burdensome, but can be embraced as a blessing and opportunity for spiritual growth, as we learn to relinquish control of our lives to our Father in Heaven. Also, we can grow in the virtues of patience, perseverance, and love, as we engage in corporal works of mercy while caring for the disabled and the chronically ill. For these reasons, why would we sign a document that comes from a worldview so inconsistent with our Catholic Faith?

**Conclusion**

The Terri Schiavo case is only the tip of the iceberg of the horrible reality of euthanasia in the United States. As Catholics concerned about the right-to-life, we can no longer afford to leave the
future of our healthcare to chance or to strangers. We might only be an accident or illness away from leaving medical decisions in the hands of misguided or ill-intentioned healthcare providers or family members. With healthcare environments dominated by a culture of death, can we risk being without the protection of a document with a clear presumption for life? As soon as possible, obtain a copy of a pro-life healthcare directive. If you have signed a copy of a “living will,” send it to the shredder. Contact your family and friends and inform them of the pro-life alternatives that are readily available.

Notes

1. An “advance directive” is a legal document which contains written instructions regarding medical treatment an individual wants or does not want in the event they cannot speak for themselves. The document is placed in a patient’s chart when it is presented to a healthcare facility upon admission.

2. Confusion about authentic Catholic teaching regarding administration of nutrition and hydration to persons like Terri Schiavo diagnosed as “PVS” (explained below) was disseminated both in Catholic circles and in the mainstream media. Mark S. Latkovic, in his article, Kevin O’Rourke, O.P. on the Morality of Tube Feeding PVS Patients: A Critique (forthcoming, Life and Learning XV: the Proceedings of the Fifteenth University Faculty for Life Conference [2005], ed. Joseph S. Koterski, S.J. [Washington D.C.: UFL, 2005]) explains O’Rourke’s influential position, which is essentially that feeding and hydrating PVS patients is non-obligatory. O’Rourke maintains a dualistic stance by asserting that prolonging life is a benefit “only when it gives the person opportunity to continue to strive to achieve the spiritual purpose of life” (quoted in Latkovic, p. 3-4) In taking this dualistic position, Latkovic maintains that O’Rourke borders on a “quality of life” ethic.

3. An “aortic dissection” involves a tear between the outer and middle layers of the wall of a blood vessel, in this case, the aorta, the largest blood vessel in the human body. It is often associated with an aneurysm, the outpouching of a vessel. An aortic dissection can lead to rupture of the vessel, causing profuse bleeding, which can be fatal in a very short period of time.
4. Sarah Foster, Granddaughter Denies Feeding Tube to Grandma, 7 April 2005, <http://www.worldnetdaily.com/news/article.asp?ARTICLE_ID=43688>, (June 27, 2005). “Vegetative” is short for “persistent vegetative state,” often abbreviated “PVS,” a clinical diagnosis whereby the patient is in a deep unconscious state and therefore, their responsiveness to their environment is compromised. Despite the fact that there was no consensus on whether or not Terri Schiavo was in a PVS, this diagnosis played a key role in sentencing her to death.

5. Diana Lynne, Patient Wants to Live, but Old ‘Living Will’ Mandates Death, 20 October 2005, <http://www.worldnetdaily.com/news/article.asp?ARTICLE_ID=46938> According to Lynne, Iowa law says that a ‘living will’ “may be revoked in any manner by which the Declarant is able to communicate the Declarant’s intent to revoke.”

6. Lynne, Patient Wants to Live. The Iowa ‘living will’ indicates that if the patient (Mr. Chambers) has an “incurable or irreversible condition” that will result in death “within a relatively short period of time” it is his desire that his life not be extended by life-sustaining measures. “Comfort care” is synonymous to “palliative care,” and it involves measures to keep a patient comfortable, including pain management, but not to provide a cure.


8. Wesley J. Smith, Culture of Death: the Assault on Medical Ethics in America (San Francisco: Encounter Books, 2000). Smith discusses a growing pervasiveness of a utilitarian “bioethics movement” that is eroding healthcare’s previous commitment to a Hippocratic model of “do no harm” which had been honored for more than two thousand years. He points out, on p.65, that “causing death by dehydration to cognitively disabled people who receive their sustenance medically is legal in all fifty states.” Medical sustenance typically means through a feeding tube, but it could also refer to nutrition and hydration administered intravenously. ‘Living will’ documents typically present a patient with a checkbox by which they can refuse tube feeding or any other invasive form of nutrition (food) or hydration (water.) Checkboxes are also provided regarding other life-sustaining treatments.

10. Pro-life healthcare providers often face hostility in the modern-day healthcare setting, particularly regarding matters of conscience. See Deborah S. Tuttle's article, “Perils of a Pro-Life Nurse,” Journal of Christian Nursing 19, no 1, (Winter 2002): 33-34. See also Nancy Valko, “Are Pro-Life Healthcare Providers Becoming an Endangered Species?”, Voices Online Edition: Medicine and Morality 18, no. 2 <http://www.wf-f.org/03-2-Healthcare.html>, (26 October 2005). See also Donna D. Ignatavicius, M. Linda Workman, & Mary A. Mishler, Medical-Surgical Nursing: a Nursing Process Approach, 2nd ed. (Philadelphia: W.B. Saunders, 1995). This textbook, a popular one, is provided to nursing students. The nurse authors, in a chapter on Ethics,” discuss two ethical theories, “utilitarian” and “deontology” on page 82. They reference Beauchamp, a leading proponent of euthanasia and physician-assisted suicide, in both sections as they describe ethical situations. The deontologists are portrayed as rigid and unbending in a hypothetical example of a healthcare provider telling the truth to a patient even if it causes their death. The authors contrast this with the utilitarian who tells a lie to save a patient. The authors fail to offer a creative alternative that would avoid deceptiveness while sparing the patient unnecessary stress in order to preserve their life. (By the way, there is no mention whatsoever in this chapter, or in the entire textbook for that matter, of the Hippocratic model.) Such rigid portrayals of deontologists, those whom utilitarians would identify as most closely associated with religion and a sanctity of life ethic, help to undermine and marginalize religious views in the field of healthcare. In addition, the nurse authors outline ethical principles to “help the nurse determine what a correct action is for resolving an ethical issue”: “non-maleficence,” “beneficence,” “justice,” and “autonomy” (p. 82). Wesley Smith, on p. 29 in his book Culture of Death, identifies these principles with the modern moral relativistic bioethics movement that has “rejected the equality of all human life, the Hippocratic tradition, religious values in public policy decision making, and the very idea of objective right and wrong.” These modern relativistic principles, he says, almost completely permeate the field of healthcare, even “hospital ombudsmen, hospital administrators, and health insurance executives—indeed, to almost everyone who has taken a course in bioethics in the last twenty years.” (p. 29-30) Although he says there is nothing inherently wrong with the guidelines, they are problematic because they are “unanchored in morality,” “entirely malleable and subject to manipulation in order to obtain a desired outcome.” (p 30)
11. Medical-Surgical Nursing, p. 82, The nurse authors state that “it may be ethically justifiable to facilitate a client's death based on the principle of beneficence and utilitarian theory. However, assisted suicide is not a legal option in most countries” (pp. 82-83). They also state, “Because of conflicts between ethical and legal opinions, people may bring suit in the hopes of overturning current law and establishing a new legal precedent.” (p. 82-83) Indeed, this is exactly what Michael Schiavo and his attorney George Felos have sought in the legal killing of Terri Schiavo.


13. Wesley J. Smith, Forced Exit: the Slippery Slope From Assisted Suicide to Legalized Murder (United States: Times Books, 1997). In a chapter entitled “Creating a Caste of Disposable People,” Smith notes that before the euthanasia mentality infected American society, people had an expectation that disabled people would receive “proper and humane care.” (p. 38). That was when society had an “equality of life” ethic consistent with the Hippocratic tradition. But with the traditional ethic eroded, the disabled are regarded as “pointless and useless burdens to themselves, their families, to society.” Smith implicates even the medical community. (p. 39) Also, David N. Osteen and Burke Balch of National Right to Life, in an article entitled What’s Wrong With Involuntary Euthanasia?, (1995), <http://www.pregnantpause.org/euth/whyin.htm>, (7 February 2006), point out that a “massive push is now underway to ensure that many people with a supposed poor “quality of life”—not only people with disabilities that are congenital, but also with disabilities caused by illness or injury—are “allowed” to die against their will.” They maintain that an abundance of medical literature supports the denial of lifesaving treatment, even against the wishes of the patient and the patient’s family.


15. James A. Maccaro, “From Small Beginnings”: The Road to Genocide, The Freeman 47 no. 7 (August 1997). <http://www.libertyhaven.com/theoreticalorphilosophicalissues/history/fromsmall.shtml> Reprint. (22 October 2005). In Nazi Doctors, Lifton points out that German psychiatrists tended to see themselves more as
servants of the state and less as independent practitioners. He sees this as a factor in their lack of resistance to the Nazi ideology of “curing by killing” (p. 113) This posed a problem of dual loyalty whereby physicians sacrificed patients for the “good of the state.” This same problem exists in the prevailing utilitarian mindset of modern day healthcare, e.g., where incentives are given to physicians by HMO’s for being cost-effective.


18. A “do not resuscitate order” posted in a patient’s chart generally means that medical personnel are not to initiate cardiopulmonary resuscitation if the patient stops breathing or if their heart stops.


20. Wesley J. Smith, Culture of Death. Smith attests to receiving numerous phone calls from distressed individuals whose loved ones, because of their age or condition, were denied treatment from healthcare providers. As an example, he recalls a phone call from someone saying that a doctor was refusing an antibiotic for his 92-year-old mother because “an infection will kill her sooner or later, so it might as well be this infection” (p. 1). Another example was a teenager, Christopher Campbell, who was unconscious after being involved in an automobile accident who was refused treatment for a 105-degree fever. The doctor said that the patient’s life was over because he was unconscious. (p. 2-3)


27. Smith, Culture of Death, p. 64.


29. James J. Drummey, Catholic Replies, Norwood, MA: C.R. Publications, 1995), 375. Nutrition and hydration are generally referred to as ordinary care, which is morally obligatory. But this term should be avoided on a protective healthcare advance directive (discussed later) because it would be open to a variety of interpretations by healthcare providers and a court of law. See also Address of John Paul II to the Participants in the International Congress on “Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas,” Saturday, 20 March 2004, <http://www.vatican.va/holy_father/john_paul_ii/speeches/2004/march/documents/hf_jp-ii_spe_20040320_congress-fiamc_en.html> (21 February 2006). In this address, the Holy Father stated that persons deemed to be in a vegetative state should not be denied food and water, “even when provided by artificial means,” as food and water “always represent a natural means of preserving life, not a medical act. Its use, furthermore, should be considered, in principle, ordinary and proportionate, and as such morally obligatory, insofar as and until it is seen to have attained its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering.”

30. Wesley J. Smith, in Culture of Death, discusses how “informed consent” was a big issue early on in the bioethics movement in its campaign against “medical paternalism.” When society, and hence,
healthcare, began to stress patient autonomy, the “doctor’s duty was now to inform the patient sufficiently about the intended benefits, potential risks, and alternatives of treatment or testing, and to give recommendations.” (p. 84) But these new rules came about when medicine was not in financial crisis, when there was more danger of being over-treated. This is no longer the case, however. In the current climate of healthcare rationing and a utilitarian, “quality of life” ethic, people are more in danger of being under-treated. (p. 85). Patients are often unaware of the philosophy of modern bioethics. Therefore, the problem of a lack of informed consent still exists, and now that lack of consent is proving to be deadly, especially for those who are chronically ill or who have disabilities.

31. The points that are highlighted about the Protective Medical Decisions Document, a multi-state document, can be found in the instruction packet, as well as in the document itself.

32. The Will to Live varies by state. Individuals can download the document by linking to the tab on the website corresponding to their state of residence.

33. The American Life League includes several brochures in their information packet in addition to the ‘Loving Will’ document. Information highlighted regarding this document were taken from one of the brochures, “What You Need to Know about the Loving Will,” published in 2002.


35. If you have established a copy of a ‘living will’ at a healthcare facility, you will need to make sure you have it clearly in writing that you have revoked any previously established ‘living will’ document. You may need to contact a pro-life attorney for advice on how best to revoke the ‘living will.’