

Should I Have a Living Will or Designate a ‘Health Care Proxy’

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Many people believe they can exercise better control over their own destiny by filling out a living will, also called an “advance directive.” They may have concerns about becoming caught in a tangle of tubes, wires and technology as they are dying, unable to break free and extricate themselves. They hope that by signing on the dotted line, they may be able to breathe their last “easily and peacefully.”

At first glance, an advance directive may appear to address many of our end-of-life concerns, and hence, can seem like a good idea. But it often tends to serve as a rather “blunt instrument” when it comes to handling complex and nuanced end-of-life situations. Moreover, living wills are sometimes used to buttress or justify some of the morally problematic decisions being made in health care settings today.

One of the major difficulties with some living wills is that they may be written using broad and imprecise language, giving rise to the idea that all treatment options are morally equivalent. One widely available living will called “Five Wishes” offers questionable options and morally dubious choices to the patient by including, as but one example, the following series of check-boxes:

Permanent And Severe Brain Damage And Not Expected To Recover: *If my doctor and another health care professional both decide that I have permanent and severe brain damage, (for example, I can open my eyes, but I cannot speak or understand) and I am not expected to get better, and life-support treatment would only delay the moment of my death (Choose one of the following):*

I want to have life-support treatment.

I do not want life-support treatment. If it has been started, I want it stopped.

I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

The various options presented above cannot be morally legitimate for every case of severe brain damage, even though they are offered as if they were. Severe brain damage affects different people differently, but even when likely to cause a permanent disability, or otherwise lower the individual’s “quality of life,” this does not imply that we always have a valid moral option to discontinue life-support. Many people live in compromised, less-than-ideal situations, yet are valuable members of our families and communities.

Some have argued that the loose language of many living wills has the effect of setting up a “glide path” into euthanasia or physician-assisted suicide. Too often, people imagine that the choice to accept or decline a particular medical intervention can be made in a kind of vacuum, as if every decision were equally acceptable, since we are “free to choose.” But the freedom to make our own health care decisions implies that we have moral obligations and duties, one of which is to be certain that we are using all the “ordinary” or “proportionate” interventions necessary to maintain our life and health.

To put it simply, those medical treatments, medications, and procedures that offer reasonable hope to protect and preserve life without grave burden to oneself or another are ordinary care, and are required as part of our duty to care for ourselves.

An advance directives has another flaw that makes it a rather “blunt instrument” in end-of-life situations. When we sit down to draft a living will, we suppose that we can foresee, predict or somehow imagine what our particular medical situation will be like in the future, maybe 10 or 20 years down the road. This is clearly an exercise in speculation, and we might actually fare better in the stock market or in Las Vegas than in an exercise of this sort.

I recall hearing about a man who asked his friend who worked as a Catholic ethicist to review his living will and see if there was anything in it that would be in conflict with good ethics or Catholic teaching. The document was a full 26 pages long, covering as many scenarios as the man could imagine or dream up. A few days later, he called the ethicist and asked whether he had looked over his living will yet.

The ethicist replied that he had, and that he had only one comment: it was too short! The point of the story is that even if we labor exhaustively in the preparation of a living will, we can’t realistically cover every possibility, and we can easily miss the one condition or circumstance that may eventually befall us. Another story involves a businessman who had diligently filled out his living will, indicating that if he were to suffer a serious injury or sickness, he wouldn’t want any tubes or mechanical assistance with breathing. He just wanted to be let go. One day he had a heart attack, and was struggling to breathe. The ambulance rushed him to the local hospital.

In the emergency room, they showed him his living will, which they had on file, and said, “You didn’t want us to do anything, according to your advance directive.” He blurted out, “Look, I don’t care what I wrote there - I can’t breathe, and I want you to help me now!” We don’t always know what a particular situation will really be like beforehand, or how we will approach urgent life and death decisions when they arise. There is a better choice available to Christians than a living will. We can choose a *surrogate*, a living person, who will make health care decisions in real time on our behalf if we are rendered unable to do so. The proposed surrogate (also called a “health care proxy”) is someone who cares deeply about us, who loves us, and is reasonably able to make decisions in accord with our known wishes and with our best medical and spiritual interests in mind.

Filling out a form to designate our health care proxy is something that each of us should do as a sensible way to prepare for difficult end-of-life situations that may arise. Preparing such a document can also prompt us to begin discussing these important topics more effectively with our families and loved ones. Forms are available to assist with selecting a health care proxy. Visit the “End-of-Life Guide” under the Publications section of The NCBC website, www.ncbcenter.org. *Rev. Tadeusz Pacholczyk, Ph.D. earned his doctorate in neuroscience from Yale and did post-doctoral work at Harvard. He is a priest of the diocese of Fall River, MA, and serves as the Director of Education at The National Catholic Bioethics Center (NCBC) in Philadelphia. See www.ncbcenter.org*