



Should I Have a Living Will?

"Better than a living will, or at least together with it, we should always 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."



A living will (also called an “advance directive”) may seem like a good idea, but it can sometimes end up serving 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 “5 Wishes” offers 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 can not 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 de-

Making Sense of Bioethics

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cline 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 duties, one of which is to be certain that we are using the “ordinary” or “proportionate” interventions needed to maintain our life and health. Those medical treatments, medications, and procedures that offer reasonable hope of benefit without grave burden to oneself or another are ordinary care, and are morally required.

An advance directive can be a “blunt instrument” for another reason. In drafting a living will, we may suppose the ability to 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 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. After looking over the living will, the ethicist told him that he had only one comment: it was too short! Even when we labor exhaustively in the preparation of a living will, we can’t realistically be expected to cover every possibility, and we may miss the one condition or circumstance that does eventually befall us.

Moreover, we don’t always know what a particular situation will really be like before it happens. We may tell ourselves ahead of time that we would never want to be hooked up to a ventilator, for example, but when we find ourselves laboring or gasping for every breath, we may suddenly view things in a very different light.

Better than a living will, or at least together with it, we should always 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 we trust and who loves us. Such a person 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 proxy is a sensible way to prepare for difficult end-of-life situations that may arise. Preparing such a written 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: see the “End-of-Life Guide” under the Publications section of The NCBC website — www.ncbcenter.org].

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