Briefing

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EDITOR

Cultural factors influence how society, including healthcare professionals, view death and the dying process. In the United States, four factors have particular impact: the high value Americans place on individualism and autonomy, the fact that many people die in institutions, the dominance of technology in medical care, and cultural pluralism. The first article in the special section, based on Part I of the Catholic Health Association's (CHA's) document *Care of the Dying: A Catholic Perspective*, describes how these cultural factors affect the ways providers care for terminally ill persons. The article examines the link between these factors and society's interest in legalized euthanasia and assisted suicide, as manifested by legislative initiatives such as the recently defeated California Proposition 161 and the number of people seeking Dr. Jack Kevorkian's help to kill themselves.

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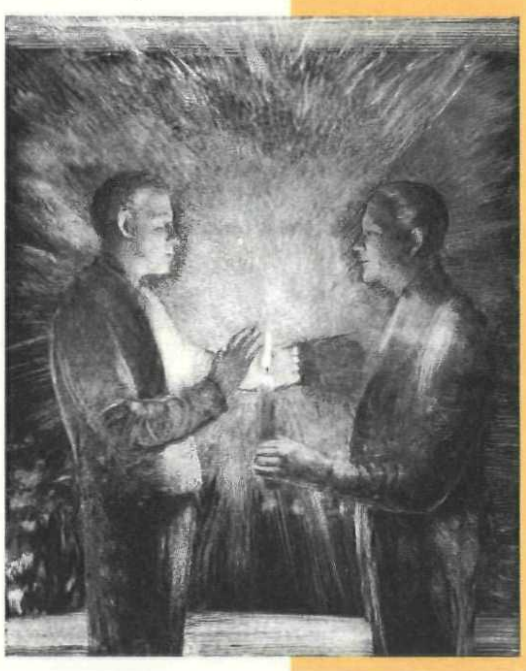
In the section's second article, Rev. Michael D. Place continues the discussion of the cultural dimension of efforts to legalize euthanasia. He argues that the euthanasia debate is only an aspect of larger questions society must answer about the sacredness of human life and the importance of community.

Nancy W. Hooyman examines the risks for patients, physicians, and the medical profession if doctors participate in suicide or euthanasia. Her clear analysis will help all healthcare professionals struggling to balance patient autonomy with the right to forgo treatment or to request euthanasia or assistance in committing suicide. Another source of help in making treatment decisions at the end of life is Tobias Meeker's decision tree (pp. 50-51). With case studies, Meeker demonstrates how families and staff use the model to decide whether to forgo life-sustaining treatment.



Until healthcare professionals provide effective pain management, however, arguments against assisted suicide and euthanasia will not be persuasive. Society will not resolve the issue as long as there are cases like that of Jack Miller, who committed suicide in January with the aid of Kevorkian because he could not bear the pain of metastatic bone cancer. This caveat runs through the special section and reflects concerns raised in CHA's report on pain management, which appeared in the January-February 1993 issue of *Health Progress* (reprints available).

Integrated Delivery of Care

Continuing our series on integrated delivery networks, Philip J. Karst clarifies how IDNs would function under CHA's working proposal for healthcare reform. Less clear is how providers will resolve a number of operational issues inherent in delivering care through a network. Karst identifies the questions that will challenge providers in any reformed delivery system. Some forward-looking providers are already facing these operational concerns as they form collaborative network arrangements. In the coming months *Health Progress* will describe how they are handling these tough issues.

Assembly Preview

Through participation in the Federally Qualified Health Center (FQHC) program, hospitals can deliver a range of primary care, preventive, and ancillary services to their communities and receive 100 percent reasonable cost reimbursement for Medicaid services (80 percent for Medicare services). But providers must meet strict requirements, caution authors Thomas M. Fahey and Dennis G. Gallitano. They will present more information on FQHCs at CHA's annual assembly in June. Check the program inside for registration information. We hope to see you in New Orleans!