

I am the Resurrection and the Life



Annual
HOPE
Appeal

A Resource of
**Catholic Moral Teaching
on End-of-Life Issues**

Rev. Charles S. Vavonese, Editor



A Resource of Catholic Moral Teaching on End-of-Life Issues

Introduction

This guide is designed to explain the moral principles of Catholic teaching with regard to end-of-life decision-making. It is intended to be used as a resource for those in the Church's teaching ministries as well as the Catholic faithful in the Diocese of Syracuse. In addition, this synthesis outlines the options that exist in New York State for advance care planning. To achieve these goals, the editor has reorganized material from the document of the Catholic Bishops of New York State, *Now and at the Hour of Our Death*¹, as well as the publication of the National Catholic Center for Bioethics, *A Catholic Guide to End-of-Life Decisions*² for purposes of pedagogy. The editor expresses his gratitude for the contribution that each of these groups has made to improving Catholic understanding of the moral issues involved with end-of-life decisions. This document is organized to address one decision at a time. The moral principles affecting this area of concern are provided and a number of examples presented to make the document more useable for teachers and others seeking to understand the Church's positions on end-of-life issues.

Finally, the editor gratefully wishes to acknowledge the work of Kathleen Gallagher of the New York State Catholic Conference who has been a valiant leader in the struggle to gain respect for life at all of its stages from conception to natural death and for her PowerPoint dealing with end-of-life issues. Her commitment to the Gospel of Life inspires hope in the hearts of all those who work in the field of legislative advocacy.

Rev. Charles S. Vavonese
Feast of St. Joseph
March 19, 2016

Background

Recent advances in medical technologies have brought with them new means of curing diseases, allowing us to live longer and healthier lives. However, they can also be the source of heightened anxiety.

There is frequently significant patient anxiety and, consequently, these same medical advances bring with them new and complex questions regarding medical treatments and moral decision-making.

Our Catholic faith offers both a long tradition of reflection and Church teaching to guide us through these multifaceted issues. It is important not to let the struggle over such questions during the passing of a loved one eclipse what should be transcendent and grace-filled moments: attending to spiritual needs, healing broken relationships, and saying farewell to loved ones.

continued on next page

1 Catholic Bishops of New York State, *Now and at the Hour of Our Death*, pamphlet, Catholic Bishop of New York State, Albany.

2 The National Catholic Bioethics Center, *A Catholic Guide to End of Life Decisions*, pamphlet, The National Catholic Bioethics Center, Washington, DC.



Difficult decisions about the use of medical technology at the end-of-life may be made easier if we understand the parameters and basis of our Catholic end-of-life moral theology. We should take the time to discuss our wishes with our medical providers and loved ones making end-of-life decisions in our regard based on our discussions with them before illness strikes.

Our Starting Point: Death and Eternal Life

Any discussion of end-of-life consideration for Catholics has as its starting point our acknowledgement that we believe in a better life to come. Eventually, we will all come to a point where we must accept the harsh difficulties of the last illness with our profound Christian hope in the sublime life that is to come. Death is merely a doorway to our ultimate destiny with God.

The Fundamental Moral Principles that Guide Catholics Making End-of-Life Decisions

Principle 1: The Sanctity of Life

The most fundamental of the Catholic moral principles is that life is sacred and we can never directly take an innocent life, including our own. From that foundational principle other moral principles are derived:

1. Life is a gift from God;
2. Human life never loses its dignity;
3. Every life is deserving of respect and protection under the law;
4. We are stewards of our bodies, not their owners; and
5. We are human beings, not human doings.

Principle 2: Ordinary and Extraordinary Means of Preserving Life

Catholic moral theology articulates two different types of life-preserving treatments: ordinary treatments, which are also called ordinary means; and extraordinary treatments, which are known as extraordinary means. In most cases, ordinary treatments are morally required, but extraordinary treatments or extraordinary means are not morally required and may be morally withheld or withdrawn. The distinction between these types of treatments is explained below.

An Example that Illustrates the Difference between Ordinary Means and Extraordinary Means

Today, end-of-life decisions are much more complicated and difficult than was previously the case. This is particularly true when we contemplate the removal or withholding of medical treatment, such as a ventilator or dialysis.



Ordinary Means

Out of a deep respect for the gifts of life, one must always accept that others must provide ordinary medical means to preserve life. Generally stated, ordinary means are those means that offer a reasonable hope of benefit, or that would not entail excessive burden on the patient and the family or the community. Ordinary medical treatments are morally obligatory except in some cases at the end of life where they would not provide benefit to the patients.

As stated by Pius XII, “normally one is held only to ‘ordinary’ means — according to the circumstances of the persons, places, times and culture – that is to say; they do not involve any grave burden on oneself or another. A stricter obligation too burdensome for most people would render the attainment of the higher, more important good too difficult. Life, health, all temporal activities are in fact, subordinated to spiritual goods³.”

Critical Summary Point

Catholics are not morally bound to prolong the dying process by using every medical treatment available, but only those that are considered ordinary means of preserving life.

Example 1: Ordinary Means

Examples of ordinary means of preserving life include:

- Food
- Water
- Hygiene
- Bed rest

Example 2: Extraordinary Means

Perhaps an extreme case will help illustrate the nature of extraordinary means of preserving life. A common treatment for cancer of the jawbone is surgical removal of half of the jawbone, the tongue, and one eye. However, only 25% of patients with this condition who undergo this treatment will survive one year. It is not difficult to see why this procedure is considered an extraordinary means, given the radical nature of the surgery, which most would reasonably consider burdensome, and the limited survival rate, which indicates a very modest benefit from the treatment.

Example 3: In Some Cases, the Same Treatment May Yield Two Moral Outcomes

The following example, concerning use of a ventilator, illustrates how a procedure can result in two different outcomes – both of which are moral, depending on the patient’s condition.

³ Pius XII, 1957.



Assisting a patient's respiration for a short time as they recover from pneumonia, for example, is most often considered ordinary care. However, for a patient in the final stages of lung cancer to be put on a ventilator may offer little hope of recovery and may be unduly burdensome, simply prolonging the patient's imminent death. Under these latter circumstances, the ventilator's use would be considered an extraordinary means.

The question of whether a means of preserving life is an ordinary or an extraordinary means does not depend upon the specific procedure or treatment to be given, but requires a fact-specific analysis that considers the patient's condition and prognosis, the rationale for the procedure or treatment, and the extent of the benefit that may be reasonably expected from such treatment. Thus, the identical treatment in different circumstances may be morally considered ordinary or extraordinary, depending on such factors.

Principle 3: Excessive Burden

What constitutes an "excessive burden," rendering a treatment as an extraordinary means of preserving life that is not morally obligatory in a particular case? The Church suggests consideration of the following factors when making a decision to accept or refuse the treatment:

- the patient's condition;
- whether the treatment provides a reasonable expectation of recovery or is more likely to only prolong the patient's imminent death;
- the type of treatment recommended;
- the treatment's potential side-effects and other potential risks;
- the treatment's cost;
- whether the treatment will be painful and the degree of any resulting pain;
- whether the treatment is readily available to the patient;
- the need to share limited medical resources.

In addition, one must also consider the spiritual and emotional burdens on the patient's loved ones. However, even when death is imminent, ordinary care to the sick person cannot be legitimately interrupted unless the treatment would offer no benefit to the patient or is not readily available to the patient⁴.

Critical Summary Points:

- When death is thought to be imminent, one may refuse forms of treatment that would result in a precarious and burdensome prolongation of life.
- Ordinary care is always morally obligatory, but the refusal of additional treatment when death is imminent is not the equivalent of suicide or murder.
- When death is extremely imminent, even ordinary means often may be omitted.



Guidance

Catholics should seek the guidance of a moral expert who regularly makes judgments on these matters, such as a priest, chaplain or ethicist.

National Catholic Bioethics Center (NCBC) offers a free consultation with a credentialed bioethicist regarding such issues.⁴ Neither the Center's moral analyses nor any of its other projects should be construed as an attempt to offer or render a legal or medical opinion or otherwise to engage in the practice of law or medicine, or other health care disciplines.

The National Catholic Bioethics Center is a non-profit research and educational institute committed to applying the moral teachings of the Catholic Church to ethical issues arising in health care and the life sciences. The Center provides consultations to institutions and individuals seeking its opinion on the appropriate application of Catholic moral teachings to these ethical issues.

Principle 4: The Special Case of Assisted Nutrition and Hydration

A. Background

The Ethical and Religious Directives for Catholic Health Care Services (ERD) 2009 (5th Ed.) has been approved by the Vatican Congregation for the Doctrine of the Faith for use in Catholic hospitals and health care facilities and is the Church's official reference concerning end-of-life issues. It provides guidance to those making decisions regarding such matters on behalf of another or on their own behalf.

The Ethical and Religious Directives for Catholic Health Care Services (ERD) provides the following guidance regarding assisted nutrition and hydration:

- In principle, there is an obligation to provide patients with food and water, including artificial nutrition and hydration for those who cannot receive such sustenance orally. It is an ordinary and proportional means of preserving life, and it is not a therapeutic treatment.
- This obligation is presumed to extend to those with irreversible conditions – e.g., a “persistent vegetative state that is reasonably expected to continue for the rest of the person’s life if given such care.”

B. The “In Principle” Exceptions

The ERD provides the following specific examples for when food and hydration may be omitted:

1. When the patient’s body cannot assimilate or absorb the nutrition;

continued on next page

4 Individuals with a specific time-sensitive question that cannot wait until regular business hours may call (215) 877-2660, 24 hours/day – 7 days/week for a more immediate consultation. A caller should follow the prompts to leave a message and an ethicist will be paged and respond to your call as soon as possible. Catholics are encouraged to enter this number in their mobile phones so that it is easily accessible to the when the need arises. The National Catholic Bioethics Center is a non-profit research and educational institute committed to applying the moral teachings of the Catholic Church to ethical issues arising in health care and the life sciences. The Center provides consultations to institutions and individuals seeking its opinion on the appropriate application of Catholic moral teachings to these ethical issues.



2. When the treatment would not benefit the patient;
3. When the patient is in a remote or poverty-stricken area, making treatment unduly difficult to obtain;
4. When the burdens of a treatment outweigh its benefits;
5. When a patient is terminally ill or the patient's death is imminent;
6. When use of tube-feeding is likely to lead to frequent problems, including infection because the patient is in a confused state and may remove the tubing;
7. When the patient's condition is such that artificial food and hydration would simply prolong suffering without a reasonable likelihood of recovery.

C. Two Difficult Moral Decisions

Two of the most difficult and complex moral decisions that face Catholics making end-of-life decisions are:

1. The use of a feeding tube; and
2. The administration of morphine or other pain medications near the end of life.

In both cases, individuals must use the above-stated principles of moral decision-making.

To do so, an individual must obtain the following information:

1. Accurate information about the patient's condition, including his/her prognosis;
2. The nature of proposed treatments, including their reasonably expected benefits, possible risks and known side effects;
3. Other morally legitimate options that are available to the patient; and
4. The costs of proposed treatment(s).⁵

These considerations — along with the individual assessment of the burdens a treatment is likely to impose on a patient, the patient's family, and the community (e.g., pain, cost, scarcity of resources, etc.) and benefits it can be reasonably expected to provide— will provide for a sound moral decision. Of course, as noted above, a person making such decisions is strongly encouraged to consult with a priest, chaplain or bioethicist when possible.

Example 4: The Administration of Morphine at the End of Life – One action with Two Outcomes

At the end of life, individuals frequently experience serious pain. In many cases, morphine is administered to help such patients manage their pain. However, morphine has the side effect of depressing respiration (i.e., diminishing normal breathing functions,), which may hasten a patient's death. So the question becomes, is it moral for a patient to be in intractable pain when relief from that pain is available through the administration of morphine given this side effect?

⁵ (ERD #27 5th Ed.



When faced with this moral dilemma, individuals may rely on the Principle of Double Effect, which was articulated by St. Thomas Aquinas. St. Thomas reasoned that a person may licitly perform an action that he/she foresees will produce a good effect and a bad effect, provided four conditions exist simultaneously:

- the action in itself from its very object is good or at least indifferent;
- the good effect, and not the evil effect, is intended;
- the good effect is not produced by means of the evil effect; and
- there is a proportionately grave reason for permitting the evil effect.

In both of these accounts, the fourth condition (i.e., the proportionately grave reason) is usually understood to involve a determination of whether the extent of the harm is adequately offset by the magnitude of the proposed benefit.

Relative to the use of morphine and similar pain medications, we can apply the four considerations of the Principle of Double Effect in the following manner:

1. Is the action in and of itself good or at least indifferent?
 - a. Answer: The use of medication to relieve pain is morally good.
2. Is the good effect, and not the evil effect intended?
 - a. Answer: The relief of pain is intended, not the shortening of the patient's life.
3. Is the good effect produced by the evil effect?
 - a. Answer: No; pain medication relieves the pain irrespective of the side effect.
4. Is there a proportionately grave reason for permitting the evil effect?
 - a. Answer: Yes; the pain medication allows the patient to avoid an agonizing death.

Commonly Asked Questions about End-of-Life Decisions

Question 1: What is the Church's teaching on Physician-Assisted Suicide?

The Church has been clear and consistent in its opposition to Physician-Assisted Suicide. In this regard, the Church defines it as:

An action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated.⁶

The Church teaches that each and every human life is an unrepeatable gift, created in the image and likeness of God. It calls on each of us to respect and protect human life because of its inherent dignity, sanctity and value. We understand that life is a sacred trust over which we have been given stewardship, but not ownership. Our life belongs to God, and we do not have absolute power over it. So, while it is entrusted to us, we are called to care for it, preserve it as explained above, and use it for the glory of God.

⁶ Congregation for the Doctrine of the Faith (CDF) Declaration on Euthanasia, 1980.



All those who are sick should rightfully expect, accept, and be provided appropriate food, water, pain management, bed rest, suitable room temperature, personal hygiene measures and appropriate comfort care. These things are not medical treatments, but basic care-giving that is owed to one human being by another. Such basic care is required if we are to truly respect a person's dignity.

The Church also teaches that the suffering of illness and dying can provide a person with an opportunity to find unity with Christ. Suffering can be an instrument of redemption when, in faith, we seek to join our suffering to Jesus in his passion.

For Catholics, death is a doorway to eternal life. In the face of illness, suffering, and death, our faith assures us that we are created for eternal life, as we proclaim at Mass each Sunday, "I look forward to the resurrection of the dead, and the life of the world to come." Thus, we must seek to use these fundamental underpinnings of our faith, derived from Sacred Scripture and our Catholic tradition, to guide our decisions about end-of-life treatment.

There may be a temptation to judge the quality of our own life or the lives of others, using this "quality of life" standard as a guide for medical decisions. However, regardless of the "quality" label used, the sanctity of all human life, from conception to death, must be valued and protected.

Those suffering with a severe illness may be tempted to consider assisted suicide. Assisted suicide is the voluntary termination of one's own life using physician-prescribed medications that are intended to, and which will, cause the patient's death. It is considered active euthanasia because it is the direct and intentional taking of life— whether a person's own life or that of someone else. It is, therefore, gravely immoral – both for the patient who is assisted and for the physician who assists. While assisted suicide is now legal in several states, it is illegal in New York State. However, three bills are pending in the New York State legislature that seek to authorize physician-assisted suicide.

Whatever the motives and means, euthanasia consists of ending the lives of the sick, despairing or dying persons, or persons with disabilities. Regardless of what the civil laws might permit, euthanasia is always, without exception, a grave moral evil.

Question 2: Is it morally permissible for a Catholic to sign a Do Not Resuscitate (DNR) Order?

A Do Not Resuscitate (DNR) order is a medical order that permits healthcare professionals to forego performing Cardio-Pulmonary Resuscitation (CPR) and other emergency measures to resuscitate a person who has apparently died, such as might happen in the case of a person who has suffered a heart attack. The answer, like that concerning so many other moral issues, depends on the facts of a specific case. In the case of an otherwise healthy individual, who is not terminally ill or of



advanced age, CPR would generally be considered “ordinary treatment” and be morally required because it provides more than a reasonable chance of allowing the patient to recover without imposing serious burden on the patient or the family.

However, in the case of a terminally ill patient, CPR may well be considered an extraordinary treatment and, therefore, not be morally required. CPR cannot reverse the terminally ill patient’s prognosis, and can only provide a short-term preservation of life, which may unnecessarily prolong the patient’s suffering. Further, in many cases, CPR will not permit a terminally ill patient to recover consciousness, but may only serve to unnecessarily prolong a terminally ill patient’s death and suffering, and the suffering of the patient’s family, with no apparent benefit.

By way of example, if a person suffering from an advanced case of terminal lung cancer experienced cardiac arrest; CPR may successfully resuscitate the individual, but cannot alter the outcome of the patient’s terminal condition and will prolong the patient’s suffering and only preserve life for a short time.

Likewise, in the case of a person with advanced age, CPR may be considered an “extraordinary means,” because it is unlikely to offer a reasonable hope of returning the person to health and is likely to cause the patient excessive pain without any significant offsetting benefit. Accordingly, CPR in such cases is not morally right and constitutes an extraordinary means.

Question 3: What is considered palliative care for those who are terminally ill?

Palliative Care includes:

- Adequate pain relief (medicine);
- Symptom management;
- Compassion and acceptance;
- Support for the family; and
- Physical, emotional and spiritual care.

Question 4: May a Catholic morally accept the treatment which would be considered an extraordinary means?

When a treatment is considered an extraordinary means, it is morally optional. Hence, patients may morally choose to accept or reject such treatment. Many advances in medical science have resulted from a person accepting experimental techniques or medications, so society may realize a significant benefit from acceptance of such treatments, even when they are unlikely to substantially benefit the patient receiving them. When patients act with a free and informed consent, they may use advanced medical techniques that are experimental and involve risk—but they are never morally obligated to do so. Whether to accept such treatments rests entirely within the discretion of the patient or his/her medical proxy.



Question 5: Are Catholics encouraged to plan ahead to address such issues in case a time comes when they are unable to make healthcare decisions for themselves?

Yes. There may come a time when our ability to reason, or even communicate, is compromised and we will not be able to make our own medical decisions. We have the ability to plan ahead to ensure that our wishes about medical treatments and our religious beliefs are known and honored at that time. Advanced directives are legal documents that take effect when a patient becomes incapacitated and incapable of making medical decisions.

When Catholics are considering an advance directive, it is important that they study thoughtfully and prayerfully the principles of the Catholic faith and prepare the document in accord with Church teaching. It is impossible to cover all possible medical situations in an advanced care directive. Therefore it is important to ensure that there is room for interpretation when a particular medical situation occurs. For this reason the Church recommends the health care proxy as the most morally appropriate advanced care planning tool for those living in New York State.

There are three common advanced planning documents that are recognized in New York State. They are:

- The Health Care Proxy (Recommended for Catholics);
- The Living Will; and
- The MOLST – Medical Orders for Life-Sustaining Treatment.

The Health Care Proxy:

- Permits you to designate an appointed surrogate to follow the patient's wishes in accord with Church teaching;
- Allows you to give special instructions about specific treatments, in accord with religious and moral beliefs;
- Invests the proxy with the power to make medical decisions if you are unable to make them for yourself;
- Permits your health care proxy to interpret your instructions based on Church teaching, when faced with a medical situation that is not explicitly included in your health care proxy;
- Also permits your designate to take into consideration advances in medicine that may not have been known at the time that the health care proxy was signed;
- Allows all decisions, including withholding or withdrawing artificial nutrition and hydration — but only if you have made known your wishes about them; and
- Allows you to cite documents such as The Ethical and Religious Directives for Health Care Services, the Catechism of the Catholic Church, and the Declaration on Euthanasia. These references will be helpful to doctors and



your health care proxy to understand how you would like certain situations to be handled when you are unable to make those decisions for yourself.

Appendix A to this document includes a health care proxy form that Catholics are encouraged to use.

You do not need to go to a lawyer to complete a health care proxy. Simply cut the language from the form, paste it into your word processor, and then fill in the form's fields, taking time to speak with your proxy about your preferences, should you become incapacitated. You are well-advised to provide a copy of the completed and signed healthcare proxy form to your health care proxy and each of your physicians. Finally, bring a completed copy with you if you are to be admitted to a hospital.

Things to Consider When Designating a Person as your Health Care Proxy

- The proxy should be someone of good moral character who knows you well and is familiar with your values and beliefs. Further, the proxy should be someone who operates well under stress.
- It is critical that you tell your proxy, and any alternate proxy, about your end-of-life decisions, particularly those concerning artificial food and hydration. Should you become incapacitated, your health care proxy will not be permitted to make decisions about artificially provided nutrition and hydration, unless you have authorized them to do so and made your wishes known to your proxy in advance.

The Living Will

Many people choose to prepare a living will, which provides instructions about your desires in specific situations, should you become incapacitated. A living will is a very flexible document, but it also has significant limitations. It cannot, for example, take into consideration future potential advances in medical technology, which were unknown to you at the time you completed your living will, or unknown future circumstances in which your end-of-life decisions must be made. It also delegates control over end-of-life decisions in a document, rather than to a person, such as the health care proxy.

While the Church does not prohibit the use of living wills, it does recommend caution in their use. Typically, the health care proxy is a much better alternative.

Medical Orders for Life Sustaining Treatment (MOLST)

The Department of Health has approved the MOLST to assist patients in conveying their wishes concerning life-sustaining treatment, which can be used statewide by health care practitioners and facilities. The MOLST is intended for terminally ill patients or those with advanced, progressive and chronic illnesses with a prognosis of one year or less to live. It transforms a patient's preferences concerning end-of-life issues into medical orders that a patient's health care professionals must follow, unless modified by the patient. A MOLST must be signed by a physician.



The MOLST is not conditioned on the patient losing capacity to make decisions; it applies immediately. It combines all other advance directives, such as DNR (Do Not Resuscitate) or DNI (Do Not Intubate), into one order, and it is the only authorized form in New York State for documenting both nonhospital DNR and DNI orders. In addition, the form is beneficial to patients and providers because it provides specific medical orders and it is recognized and used in a variety of health care settings. However, there are downsides to this form. For example, an individual executing a MOLST may not anticipate advances in medical technology, specific circumstances they may face, and other developments that could affect their wishes. Accordingly, it is not recommended for individuals who are not terminally ill, e.g. have less than a year to live.

The Family Health Care Decision-Making Act (FHCDA)

The FHCDA establishes the authority of a patient's family member or close friend to make decisions concerning health care and life-sustaining treatments on behalf of a patient who lacks capacity to do so personally, and who did not previously provide written instructions concerning such matters or designate a health care agent or proxy.⁷ It applies to patients who are incapable of making their own health care decisions and who are hospitalized or residing in residential health care facilities (i.e., nursing homes).⁸ The statute requires hospitals and residential health care facilities to determine if a patient has a health care agent or proxy or a guardian or a person who can serve as the patient's surrogate. If not, the FHCDA allows a surrogate, selected from a prioritized list, to make health care decisions for the incapacitated patient. The following states the statute's prioritized list of surrogates who are empowered to make medical decisions for the patient:

- A court-appointed guardian (if one already exists);
- The patient's spouse or domestic partner;
- The patient's adult child;
- The patient's adult sibling;
- A close friend or relative familiar with the patient's views about health care; and
- The parent or guardian of a minor, and hospitals must attempt to inform any second parent concerning decisions made under this law.⁹

7 N.Y. Pub. Health Law § 2994-b-1, et seq.

8 The statute uses the term "hospital" to refer to both general hospitals and residential health care facilities. It does not apply to patients who have a designated Health Care agent or proxy, a court-appointed guardian, for whom decisions about life-sustaining treatment may be made by a family member or close friend under Surrogate's Court Procedure Act § 1750-b, or those for whom treatment decisions may be made pursuant to an Office of Mental Health surrogate decision-making regulations.

9 A minor with capacity to decide about life-sustaining treatment must agree with the parents' decision to forego treatment before such a decision can be implemented. An emancipated minor is always allowed to make health care decisions on his or her own behalf.



The FHCDA authorizes such a surrogate to make all health care decisions for the patient that the adult patient could not make for himself or herself. However, a surrogate must make such decisions consistent with the patient's wishes, including the patient's religious and moral beliefs. When a patient's wishes are not reasonably known and cannot, with reasonable diligence, be determined, the surrogate makes decisions in accordance with the patient's "best interests." An assessment of the patient's "best interest" must include consideration of the following:

- the dignity and uniqueness of every person;
- the possibility and extent of preserving the patient's life;
- the preservation, improvement or restoration of the patient's health or functioning;
- the relief of the patient's suffering; and
- any medical condition and other such concerns and values as a reasonable person in the patient's circumstances would wish to consider.

Decisions to withhold or withdraw life-sustaining treatment must be made based on specific criteria, including, for example, whether treatment would be an extraordinary burden to the patient and the patient can be expected to die within 6 months or whether the patient is permanently unconscious, or if the provision of treatment would involve such burden that it would reasonably be deemed inhumane or extraordinarily burdensome under the circumstances and the patient has an irreversible or incurable condition.

When two people within the same category are eligible to serve as a patient's surrogate, but cannot agree who should do so, the clinician should, generally, choose the person best able to speak to the patient's wishes and best interests. If there is no qualified and willing person to serve as a patient's surrogate, and the patient lacks capacity, the hospital must identify, to the extent practical, the patient's wishes and preferences concerning pending health care decisions. The attending physician is authorized to make decisions about routine medical treatment for such patients, but must consult with other health care professionals directly involved in the patient's care, plus a second physician selected by the hospital or nursing home, concerning major medical treatment.

- A decision to withdraw or withhold life-sustaining treatment from such a patient must be made by a court, in accordance with the statute's decision-making standards, or, if the attending physician and a second physician determine that the treatment offers the patient no medical benefit because the patient's death is imminent, even if the treatment is provided, and provision of the treatment would violate accepted medical standards and their religious beliefs, the treatment may be withheld.



Conclusion: Our Hope of the Resurrection

It is hoped that this guidance on the Church's moral teaching regarding end-of-life decisions is helpful to you in understanding the dimensions and factors of such decisions. Christians should approach death with the anticipation of seeing face-to-face their blessed Lord, whom they have loved and diligently served during their lifetimes.

Of course, the faithful are encouraged to receive the Church's sacraments in preparation for this encounter, including Reconciliation, the Eucharist, and the Sacrament of the Sick. If you need to contact a priest while you or someone for whom you care is in the hospital or a nursing facility, please contact the nursing staff on the floor on which the patient is located and ask for the name and contact information of the Catholic chaplain serving at the facility.

Finally, remember that we, the living, have an obligation in charity and justice to pray for the repose of the souls of the faithfully departed – especially for our family members, friends and those most in need of prayer.

Appendix A Health Care Proxy

I, (Name) _____

residing at _____ hereby appoint:

Name

Address

City

State

Zip

Telephone

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

In the event the above-stated person is unable, unwilling or unavailable to act as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise and subject to the below-stated conditions.

Name

Address

City

State

Zip

Telephone

Unless I revoke it or stated in expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (Optional: if you want this proxy to expire, state the date or conditions here.) This proxy shall expire (specify date or conditions):



(Signature)

Date

My health care agent has the authority to make any and all medical decisions on my behalf in the event I am unable to do so for myself. I have discussed my wishes with my agent and alternate agent who shall base all decisions on my previous instructions. If I have not expressed a wish with respect to some future medical decision, my agent shall act in a manner that he/she deems to be in my best interest in accord with what he/she knows of my beliefs. (Ethical and Religious Directives for Catholic Health Care, 5th ed. 2009)

My agent has the further authority to request and receive all information regarding my medical condition and, when necessary, to execute any documents necessary for release of such information. My agent may execute any document of consent or refusal to permit treatment in accord with my intentions. My agent may also admit me to a nursing home or other long-term care facility as he/she deems appropriate and to sign on my behalf any waiver or release from liability required by a physician or a hospital.

As a member of the Catholic Church, I believe in God who is merciful and in Jesus Christ who is the Savior of the World. As the Giver of Life, God has sent us his only begotten Son as Redeemer so that in union with Him we might have eternal life. Through His death and Resurrection, Jesus has conquered sin so that death has lost its sting (1 Cor. 15:55). I wish to follow the moral teachings of the Catholic Church and to receive all the obligatory care that my faith teaches me we have duty to accept. However, I also know that death need not be resisted by every means and that I have the right to refuse medical treatment that is excessively burdensome or would only prolong my death and delay my being taken to God. I also know that I may morally receive medication to relieve pain even if it is foreseen that its use may have the unintended result of shortening my life.

WITNESS ATTESTATION

I declare that the person who signed this Health Care proxy is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed this document (or asked another to do so for him or her) in my presence.

continued on next page



Name of Witness 1 (Print)

Date

(Signature)

Address

Name of Witness 2 (Print)

Date

(Signature)

Address

Appendix B

Additional Catholic Resources for End-of-Life Decision Making

- To view the video “Now and at the Hour of our Death” a statement by the Catholic Bishops of New York State is available at this link:
<http://www.nyscatholic.org/2011/10/bishops-offer-guidance-document-on-end-of-life-decision-making/>
- To download and read a Pdf version of the New York Catholic Bishop’s document, Now and at the Hour of Our Death, go to this link below, and then scroll down to New York State. <http://www.catholicendoflife.org/resources/>

In Depth Reading

- “Vatican Declaration on Euthanasia,” Congregation for Doctrine of the Faith, May 5, 1980; available at: www.usccb/prolife/tdocs/euthanasia.shtml
- Catechism of the Catholic Church, 2nd edition, United States Catholic Conference, 1997, available at: www.vatican.va/archive/catechism/ccc_toc.htm
- Ethical and Religious Directives for Catholic Health Care Services, 5th edition, United States Catholic Conference of Bishops, November 17,2009, available at: www.usccb.org/meetings/2009Fall/ERDs_5th_ed_191118_FINAL.pdf
- O’Donnell, Thomas J. Medicine and Christian Morality. Third revised and updated ed. Staten Island, N.Y. Alba House. 1996

I am the Resurrection and the Life



Annual
HOPE
Appeal

A Resource of
**Catholic Moral Teaching
on End-of-Life Issues**

Rev. Charles S. Vavonese, Editor