
**A CATHOLIC GUIDE
TO END-OF-LIFE'S
CRITICAL DECISIONS:
ADVANCE DIRECTIVES**



This pamphlet is published to provide help for Catholics when completing an Advance Directive. Catholic tradition and teaching offer helpful guidance when facing end-of-life decisions. This Guide will assist Catholics to knowledgeably and comfortably complete an Advance Directive. First published in 2007.

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Completing Your Directives

PART ONE

***We look for the resurrection of the dead,
and the life of the world to come***

[The Nicene Creed]

I believe:

- God created me for eternal life.
- My life is a precious gift from God.
- I am created in God's image and likeness.
- These truths inform all my decisions about health care.
- I have a duty to preserve my life and to use it for God's glory.
- Acts that intentionally and directly cause my death, e.g., physician-assisted suicide and euthanasia, are never morally permissible.
- Death is an inevitable part of life and is a transition to eternal life.
- Death has been redeemed by Christ and I do not need to resist it by any and every means.

I understand that:

- Medical treatments may be foregone or withdrawn if they offer no reasonable hope of benefit, are excessively burdensome, and only prolong my dying.

- There should be a presumption in favor of artificial nutrition and hydration (ANH) unless it is of no benefit to me.
- I can use medications and treatments that bring comfort and relieve pain, even if they indirectly and unintentionally shorten my life.
- When I am ill, I ask that all efforts be made that I receive the Sacraments of Reconciliation, Anointing of the Sick and the Eucharist.
- I do not want to be deprived of consciousness without a serious medical reason.

PART TWO

***Invoke the help of Christus medicus,
Jesus, the Physician and entrust your work
to the protection of Mary,
Consoler of the sick and Comforter of the dying
[John Paul II]***

Guiding Values

Some key values in the Catholic tradition are especially helpful in addressing issues of health care:

- **Sanctity of Human Life**
 - Respect for human life from conception until death is a fundamental commitment of the Catholic Church.
 - Human life is sacred. We need to do what is reasonable and what is beneficial to protect it.
- **Human Dignity**
 - Every person has an inherent and inalienable dignity or worth by the very fact that all persons are created in the image and likeness of God, redeemed by Christ, and destined for eternal life with God.
 - Inherent human dignity is central to all moral issues in health care.
- **Stewardship and Justice**
 - An individual is never an isolated person. Human beings are social by nature and exist in a variety of relationships. Persons live “in community.” We never enjoy unrestricted autonomy.
 - We are called to use God's gifts responsibly and with care.
 - We are stewards of what has been given to us, i.e., natural creation, our lives, and our bodies.

- o We do not have the right to take our own lives, or to directly bring about the death of any innocent person. Euthanasia and physician-assisted suicide are always immoral attacks on human life.
- **Care for the Poor and Vulnerable**
 - o The Scriptures reveal a God who is always on the side of the disadvantaged and marginalized.
 - o We must have a special concern for those who are poor, vulnerable, and on the margins of society.
- **Care for the Whole Person**
 - o We must treat all persons as a unity of body and spirit. Human beings are physical, spiritual, and social and should not be reduced to only one dimension.

PART THREE

***Christ's redemption and saving grace
embraces the whole person, especially in
his or her illness, suffering, and death***

[John Paul II]

Advance Directives

- The *Ethical and Religious Directives for Catholic Health Care Services* (2001) from the United States Conference of Catholic Bishops, speak about the “rights, under the laws of their state, to make an advance directive for their medical treatment.” However, a Catholic health care institution “will not honor an advance directive that is contrary to Catholic teaching.” (no. 24; also no. 25)
- An advance directive provides a person the opportunity to give direction on end-of-life care.
- An advance directive is a “Living Will” that states your intentions about your end-of-life care; or a Durable Power of Attorney for Health Care (sometimes called a Proxy Directive), which also states your intentions, but gives someone of your choice the legal authority to make health care decisions should you not be able to do so yourself. You trust this person to make the most prudential decisions possible in light of your own wishes.
 - o When choosing a person as your agent for medical decisions, discuss the specifics of your advance directive. You can also choose an alternate agent should your primary agent be unable to act on your behalf.
 - o Allow your agent and physician latitude to offer you appropriate care based on your actual end-of-life condition.
 - o Periodically review your advance directive.

- o Distribute your signed and witnessed advance directive to your agent(s), physician, any hospital or care-giving institution where you might be treated, and anyone else you think appropriate.
- o A Durable Power of Attorney for Health Care is “durable” because it remains in effect after a person is no longer able to make medical judgments.
- o Although not absolutely necessary, it is helpful to have both a Living Will and a Durable Power of Attorney for Health Care.

PART FOUR

***The Resurrection was like an explosion of light,
of love, that ushered in a new and transformed
dimension of being, of life***

[Benedict XVI]

Specific Concerns

- **Artificial Nutrition and Hydration (ANH)**
 - When a patient is unable to eat or drink on his or her own, or with the help of others, artificial nutrition and hydration (commonly called “tube feeding”) is a substitute. ANH is administered by a physician or qualified technician, e.g., through the nose, throat, esophagus, chest, stomach or intestine. Some of these procedures require surgical insertion.
- **Persons in a Vegetative State**
 - The *Ethical and Religious Directives for Catholic Health Care Services* present this guidance: “There should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patient.” (no. 58)
 - (1) In March 2004, John Paul II addressed ANH for persons in a persistent vegetative state (PVS). The Pope called ANH “comfort care” and not a “medical act.” He taught that ANH should always be presumed unless there is evidence to the contrary. Specifically, he said that ANH is “in principle” ordinary and proportionate, unless ANH is not nourishing PVS patients, is not alleviating their suffering, or is not available. “No one may ever decide

in good conscience to withhold medically assisted nutrition and hydration from persistently unconscious patients because their lives are deemed too burdensome or of too low a quality to be maintained." (no. 5)

- (2) In a September 2007 statement, approved by Pope Benedict XVI, the Congregation for the Doctrine of the Faith upheld the teaching of John Paul II: ANH is basic care and morally obligatory for PVS patients except when it no longer nourishes the patient and becomes useless, becomes excessively burdensome for the patient, or is not available; and ANH cannot be discontinued even if competent physicians judge that a PVS patient will not recover consciousness.

- **Ventilators**

- o A ventilator pushes air and oxygen into the lungs and often saves lives.
- o It may be decided that the use of a ventilator for a particular patient becomes extraordinary or disproportionate because it no longer achieves its perceived outcome.

- **Resuscitation**

- o When a person's circulation stops, death occurs. If a person's heart stops, a person will die unless circulation is restarted quickly. The procedure of resuscitation is called cardiopulmonary resuscitation or CPR. One of the decisions a person makes in an advance directive is whether or not you want to be resuscitated if your heart stops beating.

- o Your indication “do not resuscitate” [DNR] is frequently called a “no code order.” The omission of CPR after cardiopulmonary arrest results in death. The decision to write a DNR order should be based on two crucial considerations:
 - The judgment that CPR is unlikely to restore normal cardiac rhythms.
 - The judgment that CPR amounts to medical futility, i.e., it is not beneficial.
- o CPR may be medically futile in the final stages of a terminal illness; or when it procures only a short-term survival.
- **Life-saving and life-prolonging procedures**
 - o The use of such procedures as dialysis, chemotherapy, radiation therapy, invasive surgery, heart-lung resuscitation, and antibiotics call for critical decisions in one’s life.
 - o These types of procedures may be judged morally extraordinary or disproportionate if they offer no true benefit to the patient. If there is doubt about whether a treatment will be beneficial or not, a time-limited trial is often useful. It is important, however, to define the time limit before starting a treatment.

PART FIVE

**Lord, for your faithful people
life is changed, not ended.
When the body of our earthly dwelling
lies in death we gain
an everlasting dwelling place in heaven**
[Preface for Christian Death]

Catholic Teachings and Decision-Making

Ordinary and Extraordinary Means of Health Care

- **The *Ethical and Religious Directives for Catholic Health Care Services*:**
 - “A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community.” (no. 56)
 - “A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient’s judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community.” (no. 57)
 - “There should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patient.” (no. 58)

- **The *Catechism of the Catholic Church*:**
 - o “Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is refusal of ‘over-zealous’ treatment. Here one does not will to cause death; one’s inability to impede it is merely accepted. The decision should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient whose reasonable will and legitimate interests must always be respected.” (no. 2278)

Benefits and Burdens

- The benefits sought through medical care are the preservation or restoration of health and the alleviation of pain.
- Medical care does not always improve or restore health or prolong life; however, it might circumvent, abate, or alleviate the effects of an illness or disease but not eliminate it.
- The benefit of medical care enables one to pursue the physical, psychological, social or spiritual goods of life which are all ordered toward the ultimate good of friendship with God.
- Questions often arise: Will this surgery or treatment improve my overall well-being? Will it allow me a more pain-free life? Will it permit me to return to work?
- The burdens of medical care might be economic, physiological, psychological, social, or spiritual. They might be extreme or excessive pain, the risk of losing one's life, or a great subjective repugnance to a medical treatment.
- What seems to be an excessive burden to one person might not be considered as such for another person.
- The *Declaration on Euthanasia* from the Congregation for the Doctrine of the Faith (1980) states: "Today it is very important to protect, at the moment of death, both the dignity of the human person and the Christian concept of life, against a technological attitude that threatens to become an abuse . . . [All persons have] the right to die peacefully with human and Christian dignity. From this point of view, the use of therapeutic means can sometimes pose problems. In numerous cases, the complexity of the situation can be such as to cause doubts about the way ethical principles should be applied. In the final analysis, it pertains to the conscience either of the sick person,

or of those qualified to speak in the sick person's name, or of the doctors, to decide, in light of the moral obligations and the various aspects of the case." (IV)

When speaking about ordinary or proportionate means of preserving life, the *Ethical and Religious Directives for Catholic Health Care Services* likewise point out that it is "the judgment of the patient" that must be considered of first importance. (no. 56)

- What might not seem burdensome at one particular time may become burdensome over a period of time.

Medical Futility: Non-Beneficial Treatment

- "The possible decision either not to start or to halt a treatment will be deemed ethically correct if the treatment is ineffective or obviously disproportionate to the aims of sustaining life or recovering health." (John Paul II, 2004)
- Medical futility characterizes those treatments that must not be used because they are of no medical benefit to the patient.
- Hospitals have policies on "Medically Ineffective Treatment." It is important that the patient and family be helped by the physician and hospital pastoral staff and chaplains to properly understand the meaning of medical futility.

Stopping Treatment

- Sometimes people believe or feel that it is murder to stop treatment, e.g., a feeding tube or ventilator.
- Even if these treatments have been in place for a period of time, the treatment may be withdrawn if it is deemed extraordinary or disproportionate, i.e., it no longer benefits a patient. If such a decision is made to withhold or withdraw a treatment, the patient dies of his or her underlying medical condition, and not from the ending of treatment.

PART SIX

For to me to live is Christ, and to die is gain

[Philippians 1:21]

Controlling Pain

- Good pain management almost always controls your pain throughout the course of your illness.
- Medications to control pain aim at relieving your pain with minimal or tolerable side effects, e.g., constipation, drowsiness, muscle twitching.
- Patients should normally not have to accept permanent sedation or coma in order to be comfortable.
- Pain medications can cause you to breathe a little less effectively and even hasten your death. The Church's teaching is an important guide: "Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die. Since a person has the right to prepare for his or her death while fully conscious, he or she should not be deprived of consciousness without a compelling reason. Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to hasten death." (*Ethical and Religious Directives for Catholic Health Care Services*, no. 61)
- The *Ethical and Religious Directives for Catholic Health Care Services* add that "Since a person has the right to prepare for his or her death while fully conscious, he or she should not be deprived of consciousness without a compelling reason." (no. 61)

PART SEVEN

***None of us lives as our own master and
none of us dies as our own master.
While we live we are responsible to the Lord,
and when we die we die as Christ's servants.
Both in life and in death we are the Lord's***
[Romans 14:7-8]

Concluding Reflections

- Health is not merely the absence of disease. In their *Pastoral Letter on Health and Health Care* (1981), the United States Conference of Catholic Bishops reminds us that health is wholeness and well-being, the very fullness of life. The *Ethical and Religious Directives for Catholic Health Care Services* also teach that health care “is not limited to the treatment of a disease or bodily ailment but embraces the physical, psychological, social, and spiritual dimensions of the human person.”
- Illness, suffering, and death are a part of life. There comes a point when we must accept their hold on us and our own inevitable decline. We believe that the Easter mystery proclaims victory over death. We believe that in our vulnerability we encounter Christ. Illness can be a time of grace. Faith lets us glimpse meaning in our decline. Faith tells us that God is present in the midst of illness, suffering, and death. There is no place where God will not go to be with us.
- The *Ethical and Religious Directives for Catholic Health Care Services* remind us that “The task of medicine is to care when it cannot cure. Physicians and their patients must evaluate the use of technology at their disposal. Reflection on the innate dignity of human life in all its dimensions and on the purpose of medical care is indispensable for formulating a true moral judgment about the use of technology to

maintain life. The use of life-sustaining technology is judged in light of the Christian meaning of life, suffering, and death. Only in this way are two extremes avoided: on the one hand, an insistence on useless and burdensome technology even when a patient may legitimately wish to forgo it and, on the other hand, the withdrawal of technology with the intention of causing death." (Part V)

- Catholic theology allows for the donation of organs and bodily tissue for ethically legitimate purposes, e.g., as a gift to another person, or for research after death (*Ethical and Religious Directives...*, nos. 63-66).
- Palliative care is given to a patient when it is decided that further medical treatment is burdensome and useless, e.g., comfort care, pain management.
- Hospice is a type of care normally available to dying patients and their families. While some communities have a designated hospice facility, the majority of hospice care is provided to patients and families in their own homes, whether a private residence or nursing home. Hospice care is also available to patients and their families in the hospital itself. Hospice care emphasizes physical comfort, pain relief, and symptom management, and addresses a patient's spiritual, psychological, social, and financial needs. Bereavement care for the family is also an integral part of hospice care. Dying patients and their families should always seek out hospice care to comfort them during the dying process.

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