CATHOLIC END-OF-LIFE MORAL MEDICAL DECISIONS

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Sponsored by
The Diocese of Syracuse
and St. Joseph's Health

ST. JOSEPH'S HEALTH
A Member of Trinity Health
PRAYER FOR THE NEEDS OF THE SICK

God of all goodness
Look with kindness of all who suffer any kind of infirmity, sickness, or injury, that they may be comforted.
When they are fearful, ease their fear and anxieties.
When afraid, give them strength and courage.
When they feel alone, send them someone to listen and to care.
When they are in pain, ease their suffering.
When they despair, give them hope.
May your healing presence be always with them.

We ask this through Christ, our Lord. Amen.

Assured of God’s loving presence in our lives, let us place our petitions before the Lord.
Our response today is: Lord Hear our Prayer.

That all who suffer any form of illness may find relief from their pain, meaning in their struggles and healing in body, mind and spirit, we pray to the Lord.

That the palliative care that patients receive will enable them to live their lives to the fullest, we pray to the Lord.

That the human dignity of those with chronic illnesses may always be upheld and affirmed, we pray to the Lord.

That those who are dying may be filled with serenity and peace, we pray to the Lord.

That family and friends who care for their loved ones may be strengthened and supported in their service, we pray to the Lord.

God of gentleness and love,
we entrust to your care all those in need of any form of healing,
and ask that you guide and sustain all who offer them healing and hope.
That doctors, nurses and other professional caregivers may be guided by wisdom, strength, skill and generosity.

We ask this through Christ our Lord. Amen.
HEALTH CARE PROXY

(1) I, ____________________________________________________________

hereby appoint _____________________________________________________

(name, home address and telephone number)

________________________________________________________

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.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint _____________________________________________________________

(name, home address and telephone number)

________________________________________________________

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an 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):

________________________________________________________

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. (If you want to limit your agent’s authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.) I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions (attach additional pages as necessary):

________________________________________________________

In order for your agent to make health care decisions for you about artificial nutrition and hydration (nourishment and water provided by feeding tube and intravenous line), your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.
(5) **Your Identification** *(please print)*

Your Name ____________________________

Your Signature _________________________ Date ____________

Your Address __________________________

(6) **Optional: Organ and/or Tissue Donation**

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues ____________________________

☐ Limitations ________________________________________________

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature ____________________________ Date ____________

(7) **Statement by Witnesses** *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document 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 (or asked another to sign for him or her) this document in my presence.

**Witness 1**

Date ________________________________

Name *(print)* __________________________

Signature _____________________________

Address ______________________________

**Witness 2**

Date ________________________________

Name *(print)* __________________________

Signature _____________________________

Address ______________________________
HEALTH CARE PROXY

I, (Name)______________________________________, residing at (Address)__________________________________________, on (Date)________________________, hereby create a Health Care Proxy and designate Name __________________________ Address __________________________
Telephone __________________________

to be my health care agent for making any and all health care decisions on my behalf should I ever become incapacitated. If my agent is ever unable or unwilling to act as my agent, I hereby designate Name __________________________ Address __________________________
Telephone __________________________

to be my alternative health care agent.

Signature __________________________ Date __________________________

My health care agent has the authority to make any and all medical decisions on my behalf should I ever be unable to do so for myself. I have discussed my wishes with my agent (and with my alternative 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 interests in accord with what he/she knows of my beliefs.

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 licensed health care agency or facility as he/she deems appropriate and 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 a 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 we have a duty to accept. However, I also know that death need not be resisted by any and every means and that I have the right to refuse medical treatment that is excessively burdensome or would only add to my suffering as I face inevitable death. I also know that I may morally receive medication necessary to relieve my pain even if it is foreseen that its use may have the unintended result of shortening my life.

Witness __________________________ Date __________________________ Witness __________________________ Date __________________________

I affirm that the principal is at least eighteen years of age, of sound mind, and under no undue influence.

I affirm that the principal is at least eighteen years of age, of sound mind, and under no undue influence.

When initialed here ______, the Advance Medical Directive on the reverse shall be considered an extension of this document. The Advance Medical Directive on the reverse may also be completed independently of this Health Care Proxy.
I. THE THEOLOGICAL VISION OF LIFE AND DEATH

“The Catholic health care ministry faces the reality of death with the confidence of faith. In the face of death – for many, a time when hope seems lost – the church witnesses to her belief that God has created each person for eternal life...The truth that life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owners of our lives and, hence, do not have absolute power over life. We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute...” ERD Part Five, Introduction, p 29-30

“All human beings must live their lives in accordance with God’s plan. Life is given to them as a possession which must bear fruit here on earth but which must wait for eternal life to achieve its full and absolute perfection.” Euthanasia, CDF, 1980

II. THE CATHOLIC VISION OF END-OF-LIFE CARE

“The task of medicine is to care even when it cannot cure. Physicians and their patients must evaluate the use of the technology at their disposal. ... 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 or 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.” ERD Part Five, Introduction, p 29-30

“While life Is to be regarded as God’s gift, it also is true that death in unavoidable. We must be able; therefore, without in any way hastening the hour of death, to accept it with full consciousness of our responsibility and with full dignity for death, indeed puts an end to this earthly life but in doing so it opens the way to undying life.” Euthanasia, CDF, 1980

III. A MORAL OBLIGATION TO USE ORDINARY MEANS

“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.” ERD, 56, p. 31

IV. NO MORAL OBLIGATION TO USE EXTRAORDINARY MEANS

“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.” ERD, 57, p. 31

“In our day it is very important at the moment of death to safeguard the dignity of the person and the Christian meaning of life, in the face of a technological approach to death that can easily be abused. Some even speak of a ‘right to die.’ By this they mean, however, not a right of persons to inflict death on themselves at will by their own or another’s hand, but rather a right to die peacefully and in a manner worthy of a human being and a Christian...When death is imminent and cannot be prevented by the remedies used, it is licit in conscience to decide to renounce treatments that can only yield a precarious and painful prolongation of life....This rejection of a remedy is not to be compared to suicide; it is more justly to be regarded as a simple acceptance of the human condition or a desire to avoid the application of medical techniques that are disproportionate to the value of the anticipated results or, finally, a desire not to put a heavy burden on the family or the community.” Euthanasia, CDF, 1980
V. WHO MAKES THE DECISION?

"In the last analysis, the decision rests with the conscience of the sick person or those who have a right to act in the sick person's name or of the doctors, who must bear in mind the principles of morality and the several aspects of the case... in making this decision, account should be taken of the legitimate desire of the sick person and his or her family as well as the opinion of truly expert physicians. The latter are better placed than anyone else for judging whether the expense of machinery and personnel is disproportionate to the foreseeable results and whether the medical techniques used will cause the sick person suffering or inconvenience greater than the benefits that may be derived from them."  

Euthanasia, CDF, 1980

VI. THE USE OF PAIN MEDICATION

"It is worth recalling here a statement of Pius XII that is still valid. A group of physicians had asked: 'Is the removal of pain and consciousness by means of narcotics permitted by religion and morality to both doctor and patient even at the approach of death and if one foresees that the use of narcotics will shorten life?' The pope answered: 'Yes -provided that no other means exist and if, in the given circumstances, the action does not prevent the carrying out of other moral and religious duties...death is by no means intended or sought, although the risk of it is being incurred for a good reason; the only intention is to diminish pain effectively by use of the painkillers available to medical science.'"  

Euthanasia, CDF, 1980

VII. ARTIFICIAL NUTRITION AND HYDRATION

"In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally...The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching."  

ERD, 58 and 59, p 31

A. For the dying patient

Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be "excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed. For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrient and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort.  

ERD, 58, p 31

"...[W]e should not assume that all or most decisions to withhold or withdraw medically assisted nutrition and hydration are attempts to cause death. To be sure, any patient will die if all nutrition and hydration are withheld. But sometimes other causes are at work—the patient may be imminently dying...from an already existing terminal condition."  

Nutrition and Hydration: Moral and Pastoral Reflections, USCCB, 1992

B. For the patient in a "persistent vegetative state"

This obligation [to provide food and water] extends to patients in chronic and presumably irreversible conditions (e.g., the "persistent vegetative state") who can reasonably be expected to live indefinitely if given such care.  

ERD, 58, p 31

"In particular, I would want to emphasize that the administration of water and food, even when it is provided by artificial means, always represents a natural means of preserving life, not a medical intervention. Its use is therefore considered to be, according to the principle, proportionate, ordinary and as such, morally obligatory, in the degree to which and until it has been demonstrated to attain its own proper finality, which in this instance consists in providing nutrition to the patient and alleviating their suffering."  

Pope John Paul II on Life-Sustaining Treatment and the Vegetative State (March 20, 2004)

### Medical Orders for Life-Sustaining Treatment (MOLST)

**The patient keeps the original MOLST form during travel to different care settings. The physician or nurse practitioner keeps a copy.**

**Last Name/First Name/Middle Initial of Patient**

**Address**

**City/State/Zip**

**Date of Birth (MM/DD/YYYY)**

**Date/Time**

**Signature**

**Print Name of Decision-Maker**

**Print First Witness Name**

**Print Second Witness Name**

**Who made the decisions?**

- [ ] Patient
- [ ] Health Care Agent
- [ ] Public Health Law Surrogate
- [ ] Minor’s Parent/Guardian
- [ ] §1750-b Surrogate*

**Physician or Nurse Practitioner Signature for Sections A and B**

**Physician or Nurse Practitioner Signature**

**Physician or Nurse Practitioner License Number**

**Physician or Nurse Practitioner Phone/Page Number**

**Section D - Advance Directives**

Check all advance directives known to have been completed:

- [ ] Health Care Proxy
- [ ] Living Will
- [ ] Organ Donation
- [ ] Documentation of Oral Advance Directive

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**Do-Not-Resuscitate (DNR) and Other Life-Sustaining Treatment (LST)**

This is a medical order form that tells others the patient's wishes for life-sustaining treatment. A healthcare professional must complete or change the MOLST form based on the patient's current medical condition, values, wishes, and MOLST Instructions. If the patient is unable to make medical decisions, the orders should reflect patient wishes, as best understood by the health care agent or surrogate. A physician or nurse practitioner must sign the MOLST form. All health care professionals must follow these medical orders as the patient moves from one location to another, unless a physician or nurse practitioner examines the patient, reviews the orders, and changes them.

**MOLST** is generally for patients with serious health conditions. The patient or other decision-maker should work with the physician or nurse practitioner and consider asking the physician or nurse practitioner to fill out a MOLST form if the patient:

- Wants to avoid or receive any or all life-sustaining treatment.
- Resides in a long-term care facility or requires long-term care services.
- Might die within the next year.

If the patient has an intellectual or developmental disability (I/DD) and lacks the capacity to decide, the doctor (not a nurse practitioner) must follow special procedures and attach the completed Office for People with Developmental Disabilities (OPWDD) legal requirements checklist before signing the MOLST. See page 4.

**Section A - Resuscitation Instructions When the Patient Has No Pulse and/or Is Not Breathing**

Check one:

- [ ] CPR Order: Attempt Cardio-Pulmonary Resuscitation
  - CPR involves artificial breathing and forceful pressure on the chest to try to restart the heart. It usually involves electric shock (defibrillation) and a plastic tube down the throat into the windpipe to assist breathing (intubation). It means that all medical treatments will be done to prolong life when the heart stops or breathing stops, including being placed on a breathing machine and being transferred to the hospital.

- [ ] DNR Order: Do Not Attempt Resuscitation (Allow Natural Death)
  - This means do not begin CPR, as defined above, to make the heart or breathing start again if either stops.

**Section B - Consent for Resuscitation Instructions (Section A)**

The patient can make a decision about resuscitation if he or she has the ability to decide about resuscitation. If the patient does NOT have the ability to decide about resuscitation and has a health care proxy, the health care agent makes this decision. If there is no health care proxy, another person will decide, chosen from a list based on NYS law. Individuals with I/DD who do not have capacity and do not have a health care proxy must follow SCPA 1750-b.

**Check if verbal consent (Leave signature line blank)**

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*If this decision is being made by a §1750-b surrogate, a physician must sign the MOLST.
The patient keeps the original MOLST form during travel to different care settings. The physician or nurse practitioner keeps a copy.

Section E: Orders for Other Life-Sustaining Treatment and Future Hospitalization

When the Patient has a Pulse and the Patient is Breathing

Life-sustaining treatment may be ordered for a trial period to determine if there is benefit to the patient. If a life-sustaining treatment is started, but turns out not to be helpful, the treatment can be stopped. Before stopping treatment, additional procedures may be needed as indicated on page 4.

**Treatment Guidelines**

No matter what else is chosen, the patient will be treated with dignity and respect, and health care providers will offer comfort measures. **Check one:**

- **Comfort measures only** Comfort measures are medical care and treatment provided with the primary goal of relieving pain and other symptoms and reducing suffering. Reasonable measures will be made to offer food and fluids by mouth. Medication, turning in bed, wound care and other measures will be used to relieve pain and suffering. Oxygen, suctioning and manual treatment of airway obstruction will be used as needed for comfort.
- **Limited medical interventions** The patient will receive medication by mouth or through a vein, heart monitoring and all other necessary treatment, based on MOLST orders.
- **No limitations on medical interventions** The patient will receive all needed treatments.

**Instructions for Intubation and Mechanical Ventilation** **Check one:**

- **Do not intubate (DNI)** Do not place a tube down the patient's throat or connect to a breathing machine that pumps air into and out of lungs. Treatments are available for symptoms of shortness of breath, such as oxygen and morphine. (This box should not be checked if full CPR is checked in Section A.)
- **A trial period** Check one or both:
  - Intubation and mechanical ventilation
  - Noninvasive ventilation (e.g. BIPAP), if the health care professional agrees that it is appropriate
- **Intubation and long-term mechanical ventilation, if needed** Place a tube down the patient's throat and connect to a breathing machine as long as it is medically needed.

**Future Hospitalization/Transfer** **Check one:**

- **Do not send to the hospital unless pain or severe symptoms cannot be otherwise controlled.**
- **Send to the hospital, if necessary, based on MOLST orders.**

**Artificially Administered Fluids and Nutrition** When a patient can no longer eat or drink, liquid food or fluids can be given by a tube inserted in the stomach or fluids can be given by a small plastic tube (catheter) inserted directly into the vein. If a patient chooses not to have either a feeding tube or IV fluids, food and fluids are offered as tolerated using careful hand feeding. **Additional procedures may be needed as indicated on page 4.**

**Check one each for feeding tube and IV fluids:**

- No feeding tube
- No IV fluids
- A trial period of feeding tube
- A trial period of IV fluids
- Long-term feeding tube, if needed

**Antibiotics** **Check one:**

- **Do not use antibiotics.** Use other comfort measures to relieve symptoms.
- **Determine use or limitation of antibiotics when infection occurs.**
- **Use antibiotics** to treat infections, if medically indicated.

**Other Instructions** about starting or stopping treatments discussed with the doctor or nurse practitioner or about other treatments not listed above (dialysis, transfusions, etc.).

**Consent for Life-Sustaining Treatment Orders (Section E)** (Same as Section B, which is the consent for Section A)

**Signature**

**Date/Time**

**Print Name of Decision-Maker**

**Print First Witness Name**

**Print Second Witness Name**

Who made the decisions?

- **Patient**
- **Health Care Agent**
- **Based on clear and convincing evidence of patient's wishes**
- **Public Health Law Surrogate**
- **Minor's Parent/Guardian**
- **S1750-b Surrogate**

Physician or Nurse Practitioner Signature for Section E

**Physician or Nurse Practitioner Signature**

**Print Physician or Nurse Practitioner Name**

**Date/Time**

*If this decision is being made by a S1750-b surrogate, a physician must sign the MOLST.*

DOH-5003 (12/18) p 2 of 4

This MOLST form has been approved by the NYSDOH for use in all settings.