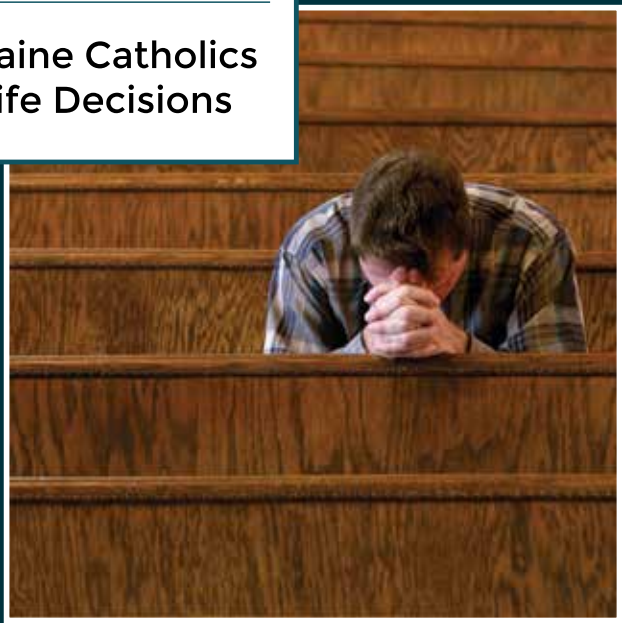
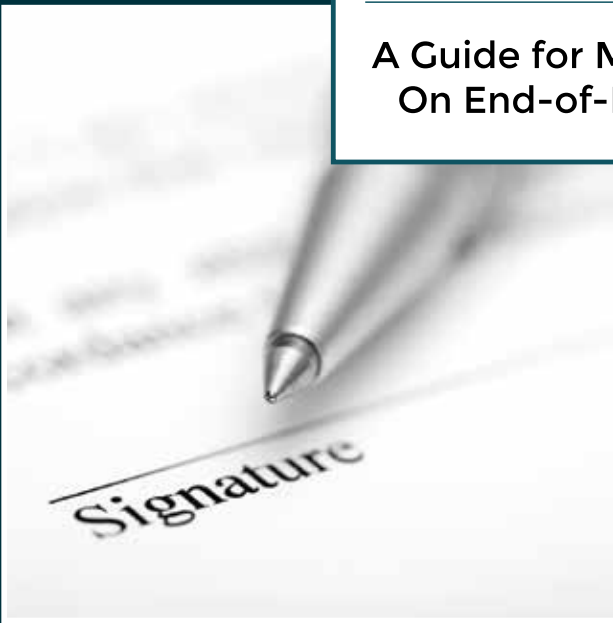


Three Beliefs

A Guide for Maine Catholics
On End-of-Life Decisions

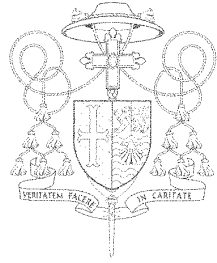


Name _____

Address _____

Phone _____

Parish _____



January 4, 2017

Dear Brothers and Sisters in Christ,

Advances in medicine and technology have provided new means for curing diseases, offering palliative care, and enjoying healthier and longer lives. Such new discoveries, however, can make decisions about the appropriate care for loved ones with painful and progressive illnesses far more complex, prompting anxiety and questions.

Making the difficult choices surrounding end-of-life medical care and sharing them with family and friends now can ensure that your beliefs about the sanctity of human life, the appropriateness of medical care, and the dignity of the dying process are known in advance so they can be met in the future.

As members of the human family, it is also incumbent upon all of us to extend compassion and mercy to protect our sisters and brothers. Your proactive decisions can serve to offer comfort and protection for loved ones who might speak on your behalf if you are unable to express your own intentions in life's critical moments.

With this in mind, the diocese would like to share helpful guidance with Maine Catholics in Three Beliefs. This guide offers spiritual support, legal options, and answers to common questions facing those who are prayerfully discerning their wishes for end-of-life care. In addition, advance directive documents and wallet cards to notify health care providers are also included.

The principles at the heart of the Church's moral teaching on end-of-life decisions are important expressions of Christian reverence for the gift of human life and our eternal home: "For if we believe that Jesus died and rose, so too will God, through Jesus, bring with him those who have fallen asleep." (1 Thes 4:14)

It is my heartfelt hope that these materials, which are being provided to your priests as well, will allow for honest, faithful discussions about these critical issues within our families, parishes, health care institutions and communities. If you have any questions, please do not hesitate to contact Suzanne Lafreniere, director of Public Policy, who will be happy to assist you.

With assurance of my prayers for you and your loved ones, I remain

Sincerely yours in our merciful Lord,

Most Reverend Robert P. Deeley, JCD
Roman Catholic Bishop of Portland



Introduction

Modern medicine has accomplished things that would have seemed miraculous even just a few decades ago. Constant new discoveries of ways to cure disease and treat illness allow us to live longer and healthier lives, but they also bring with them many complex questions. How much medical treatment or care is enough? Is it ever right to stop medical treatment or care if that means the patient will die? Who can make decisions for me if I am not able to make them for myself?

As Catholics, we are fortunate that we do not have to wrestle for answers to these sorts of questions on our own. We can turn for guidance to our Catholic faith tradition, which has developed by prayerful reflection over the course of two thousand years. It is important not to let these difficult questions eclipse what should be grace-filled moments in the dying process, allowing time for patients to attend to their spiritual and emotional needs.

This Guide is designed to help Maine Catholics make their own wise decisions about end-of-life health-care. We hope you find this booklet to be helpful as you think about the instructions that you wish to share with people who will be responsible for your health-care if there comes a time that you cannot make your own health-care decisions. Difficult decisions about care at the end of life may be made easier if we take the time to express our wishes about end-of-life treatments before the time comes that we are unable to express our own intentions.



Part One: What the Catholic Church Teaches about End-Of-Life Decisions

When we think about end-of-life decisions, there are three basic Catholic beliefs that are the foundation for everything that we do.

The first belief is that **each one of us has been created in the image and likeness of God**. The fact that we have been created by God gives each human being a priceless dignity, value, and purpose in life. This is why we are called to respect and protect human life and be good stewards of this gift. While it is entrusted to us, we are called to care for it, preserve it, and use it for the glory of God.

The second belief is that **stewardship of life should avoid the opposite extremes of the deliberate hastening of death and the overzealous use of treatment or care to extend life artificially and prolong the dying process**. All those who are sick have the right to expect, accept, and be provided with appropriate food, water, pain control, bed rest, suitable room temperature, personal hygiene measures, and comfort care. These are not medical treatments but the sort of basic care that is owed by one human being to another.

The third belief is that **for the Christian, the suffering that comes from illness and death is a way of being deeply united with the death and resurrection of Our Lord, Jesus Christ**. We know that death is not the end; it is the doorway to eternal life.

With these basic beliefs in mind, we can better understand how the Church looks at some of the issues that arise when people are making their end-of-life decisions.

How Much Medical Treatment or Care is Enough?

One of the most common questions that people face when they are making end-of-life decisions is whether it is ever acceptable to withhold or stop medical treatment, even if that means the person will die. The teaching of the Church on this question revolves around the difference between two ways of considering life-sustaining treatment and care: **“ordinary medical means”** and **“extraordinary medical means.”** The decision whether something is ordinary or extraordinary and thus whether it is morally required or morally optional is based on the particular condition and circumstances of each patient.

“Ordinary means” are forms of treatment or care 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 (sometimes you will see “ordinary means” referred to as “proportionate means”). **Out of deep respect for the gift of life, we must always accept ordinary means of preserving life, and others must provide us with ordinary means of preserving life.** Ordinary means of medical treatment or care are morally obligatory. From a Catholic perspective, this includes various forms of care that may be judged ordinary for a particular patient even when death is near.

But Catholics are not bound to prolong the dying process by using every medical treatment available. **Allowing natural death to occur is not the same as killing a patient.** Some forms of treatment or care may be considered **“extraordinary” (also known as “disproportionate”) means**. These are things that in the patient’s judgment do not offer a reasonable hope of benefit or that entail an excessive burden or impose excessive expense on the family or the community. Catholics are not morally bound to use “extraordinary means” of medical care.

There are no lists of treatments that are morally optional or morally required. Instead, determining whether life-sustaining treatment and care is ordinary or extraordinary is based upon the particular condition and circumstances of each patient – the patient in this bed, on this day, and with these medical conditions.

So how do you determine whether a particular treatment or form of care is “ordinary” or “extraordinary?” An example may be of assistance: A person who is expected to make a good recovery from major surgery and is on a ventilator may need to continue to be on the ventilator for a few days in order to be restored to full health. In consideration of these and other circumstances of the patient’s condition, the ventilator may be judged to be ordinary and therefore morally required. That same ventilator treatment can be seen in a very different light, however, when it is being used for a patient in the final stages of lung cancer, where the treatment may have no reasonable hope of benefit or is excessively burdensome and where it will prolong the patient’s process of dying. In such a circumstance, the ventilator may be judged to be extraordinary care and the patient morally might decide to do without that treatment.

General factors that may be considered in making the determination that a treatment or form of care is ordinary, or morally obligatory, include examining whether the treatment or form of care:

- will adequately achieve its purpose;
- is not expected to pose a significant risk relative to the expected outcome;
- is not likely to cause serious medical complications;
- is not expected to cause any other significant burden for the patient, including unavoidable intense distress;
- does not involve excessive expense;
- is undertaken when death is not imminent and impending.

General factors that may be considered in making the determination that a treatment or form of care is extraordinary, or morally optional, include examining whether the treatment or form of care:

- will not adequately achieve its purpose;
- poses significant risk relative to the expected outcome;
- likely will cause serious medical complications;
- is undertaken when death is imminent and impending;
- would cause unavoidable intense distress on the part of the patient;
- involves excessive expense.

When making a decision to accept or refuse a treatment or form of care, the Church suggests that we should take into consideration such factors as:

- All reasonable information about the essential nature of the proposed treatment or care and its benefits;
- the risks, side effects, and costs;
- any reasonable and morally-legitimate alternatives, including the option to decline the particular treatment;
- how painful or complicated the treatment or care is;
- the likelihood that the treatment or care will maintain or enhance the life of the patient; and
- whether the treatment or care will entail an excessive burden or impose an excessive expense on the family or the community.

These questions are as important as any that we will ever come across in our lives, and they will rarely be easy to answer. Weighing the burdens and benefits of particular medical treatment or form of care for each individual requires us to be prudent and thoughtful in order to choose the right path. This is not a practical exercise of weighing the costs and benefits to our physical health – this also is a decision that affects our spiritual health. Because these decisions can be sensitive and complicated, Catholics may wish to seek guidance from a person with knowledge of Catholic teaching on these types of matters, such as a priest or hospital chaplain.

Is it Ever Permissible To Stop Giving A Person Food And Water?

Another question that often comes up is whether there is a moral requirement that food and water in the form of medically-assisted nutrition and hydration (“MANH”) through a feeding tube must be used in all circumstances when a person cannot swallow. Sometimes, there is a suggestion that this medically-assisted nutrition and hydration should be stopped in order to bring about a person’s death because the person is permanently unconscious. The person may be in a condition that appears to be irreversible, such as a condition known as a “persistent vegetative state” (PVS).

From a Catholic perspective, food and water are two of the most basic forms of care that we can provide to anyone, especially to someone who is sick. When MANH is considered in general and apart from the particular circumstances of patients, there is in principle an obligation to use MANH. This general obligation needs to be assessed in the particular circumstances of each patient. If MANH has a reasonable hope of benefit for a person and will not pose an excessive burden, then there is an obligation to use it. This assessment applies equally to the person in a PVS. If MANH has a reasonable hope of sustaining the PVS patient and does not pose an excessive burden, then simply being permanently unconscious cannot by itself be a reason to withdraw or withhold MANH. Even the most severely debilitated patients never lose their full dignity as human beings. This dignity requires that other people provide the basic care that is judged to be ordinary care for that patient.

What are the circumstances under which medically-assisted nutrition and hydration may be considered excessively burdensome or have no reasonable hope of benefit? The most common example of this is when the patient enters into the dying process and the body can no longer properly assimilate food and water, even through a tube. When death is only days away, or when a feeding tube may cause unavoidable side effects such as severe agitation, physical discomfort, aspiration into the lungs, severe infection, or another excessive burden, any foreseeable benefits of maintaining the tube likely will be outweighed by the burdens imposed by the tube. Note that when medically-assisted nutrition and hydration is withheld or withdrawn under those circumstances, **death occurs as a result of the underlying illness, not as a result of starvation or dehydration.**

This is an important point that should always be remembered. In the Catholic view, it is never morally permissible to withhold or remove a feeding tube (or any other form of life-sustaining treatment or care) with the intention of ending the patient’s life. And it is never morally permissible to stop or withhold any form of care or treatment based on a belief that the patient’s life no longer holds value.

“Food and water are two of the most basic forms of care that we can provide to anyone, especially to someone who is sick.”

Assisted Suicide

God has called us to defend life and stand up for those who are weak or in need, not to deliberately and directly cause the death of an innocent person. As Pope Francis has said, “Health is certainly an important value, yet it does not determine a person’s value . . . the lack of health or the fact of one’s disability are never valid reasons for exclusion or, and what is worse, the elimination of persons.” *Message to the Pontifical Academy for Life*, February 19, 2014. Contrary to what the proponents of assisted suicide claim, it is not designed to end the suffering; it is designed to end the patient.

Assisted suicide (or “euthanasia”) is a grave evil. It is *always* morally wrong. This point cannot be made strongly enough. **In the Catholic view, there is never a situation where it is right to either assist in someone else’s suicide or to arrange for it on one’s own behalf.**

In Maine, as in almost every state, assisted suicide is a criminal act. It is true, of course, that a small number of states have passed laws legalizing assisted suicide. But euthanasia has not been made *morally* right by the passage of those laws, even in the states where these laws have been enacted (by way of comparison, slavery was not made morally right in this country prior to the Civil War simply because there were laws in place supporting slavery). There is a better approach – what Pope John Paul II called “the way of love and true mercy.” It is a readiness to surround patients with love, support, and companionship, providing the assistance needed to ease their physical, emotional, and spiritual suffering. Such care is provided in palliative and hospice care, which the Church has encouraged and promoted in various ways.

Palliative Care

The word “palliative” comes from the word “palliate”, which means “to ease,” “to lessen,” or “to alleviate.” It is a philosophy of care that prevents and relieves suffering and attends to the emotional as well as spiritual needs of patients. Palliative care should be made available for all patients with a serious illness, not only those facing the end of life. For those diagnosed with a terminal illness, however, effective palliative care allows patients to devote their attention to the unfinished business of their lives and to arrive at a sense of peace with God, with loved ones, and with themselves. Pope Benedict XVI stressed “the need for more palliative care centers which provide integral care, offering the sick the human assistance and spiritual accompaniment they need. This is a right belonging to every human being, one which we must all be committed to defend.” *Message of His Holiness Benedict XVI for the Fifteenth World Day of the Sick*, December 8, 2006.

Chaplains and social workers connected to a palliative care service can provide spiritual and emotional support to patients and families to help accept and cope with the changes and stages of illness. A palliative care team can help determine if care is provided in the proper setting with the most appropriate services for the patient, uplifting the dignity of the patient and providing support for family caregivers. A palliative care team also may provide services to alleviate pain and other symptoms.

Further Resources

The following resources may provide additional helpful information. Please visit www.portlanddiocese.org/threebeliefs for these documents and additional resources.

- *Evangelium Vitae (The Gospel of Life)*
- *Vatican Declaration on Euthanasia*
- *Catechism of the Catholic Church*
- *Ethical and Religious Directives for Catholic Health Care Services*

“In the Catholic view, there is never a situation where it is right to either assist in someone else’s suicide or to arrange for it on one’s own behalf.”



Part Two: Planning in Advance: Legal Options in Maine

The Maine Advance Health-Care Directive

For some of us, there may come a time when we are not able to make medical decisions for ourselves. We do have the ability, however, to plan in advance to insure that our religious beliefs and our wishes about medical treatments or care are known and honored by the people who will be responsible for our care. Maine law allows these wishes to be put into documents called “**Advance Health-Care Directives.**” The section of the Maine statutes that creates the rules for these advance directives is 18-A MRSA §5-801 through §5-818, the Maine Uniform Health-Care Decisions Act. It can be found online at <http://legislature.maine.gov/statutes/18-A/title18-Ach5sec0.html>.

With an Advance Health-Care Directive, a person gives someone else the authority to act on his or her behalf (the person who receives the authority is called the “Agent”). The document can also include specific instructions about the kind of care the person wants or does not want, including if and when life-sustaining treatment or care should be provided. **We recommend that Maine Catholics complete Advance Health-Care Directives** because they are a useful way to ensure that someone will direct your health-care in accordance with your wishes.

Choosing an Agent

The person you choose as your Agent under an AHCD will have the power to make health-care decisions on your behalf. This Agent can make all decisions that you would be able to make, including decisions about withholding or withdrawing life-sustaining treatment or care. It is important, then, that you choose as your Agent a person who will advocate for the sort of health-care that is consistent with your moral and religious beliefs. Your Agent should be someone who knows you well, cares deeply about you, is familiar with your religious beliefs, has the ability to understand medical information, who operates well under stressful conditions, and who will be sure that end-of-life decisions made on your behalf are made in accordance with the Church’s teachings. You should have periodic conversations with your Agent about your preferences while you are healthy and competent, because the Agent will be interpreting your wishes as medical circumstances change, and the Agent could be called upon to make decisions that you may not have predicted.

In addition to naming your Agent, you can also include specific written instructions that the Agent must follow. In order to ensure that those decisions are made in a way that is consistent with Catholic teaching, it is useful to cite official Catholic documents as places to which someone can turn if there are any questions about your desires. Documents such as the *Catechism of the Catholic Church*, the *Vatican Declaration on Euthanasia*, and the *Ethical and Religious Directives for Catholic Health Care Services* are quite appropriate, and they are available online at the locations noted in the resources section of this Guide.

The AHCD form we have included in this Guide is consistent with Catholic teaching on end-of-life issues and with Maine laws concerning advance directives. We have used much of the optional advance directive form that is published by the Maine Department of Health and Human Services. Note, however, that we have replaced Section 2 of that form with a different set of instructions that are reflective of Catholic teachings, because certain sections that are contained in the generic form may not be flexible enough to reflect later advances in medicine or changing circumstances that may appear with an illness diagnosed several years later. They may allow for your health care to be carried out in ways that are not consistent with Catholic teaching.

You are encouraged to utilize our sample AHCD form, but you are under no obligation to do so. Whatever form of advance directive that you decide to use, you should carefully review all of the sections of the document to ensure that they are consistent with Maine law and that they adequately reflect your desires concerning end-of-life care. This Guide is not intended to provide you with legal advice, so you also should consider seeking the advice of an attorney before completing an advance directive.

Remember that the best time to create an advance directive is now. Take time to reflect on your beliefs and to have conversations about those beliefs with your family members, loved ones, and healthcare providers. Completing an advance directive should be the end point of a series of conversations with these individuals.

Health-Care Surrogate

For those patients who cannot make their own decisions and who have not prepared a valid advance directive or do not have a guardian available, MRSA Title 18-A§5-805 allows a **surrogate decision maker** to make health-care decisions for you, including decisions concerning life-sustaining treatment.

Do not assume that the person empowered as surrogate to make medical decisions for you if you become incapacitated will be someone you trust. **Without someone you name to oversee your care or written instructions from you, your preferences, moral values, and religious beliefs may not be followed as you near the end of life.** This is one reason why it is important to complete an AHCD.



The surrogate law establishes a protocol for a health-care provider to use that prioritizes the persons who can make decisions for you should you become incapacitated. The surrogate decision makers who have legal authority to make medical decisions for you, ranked in priority order by the law, are:

1. The spouse, unless legally separated;
2. An adult who shares an emotional, physical and financial relationship with the patient similar to that of a spouse;
3. An adult child;
4. A parent;
5. An adult brother or sister;
6. An adult grandchild;
7. An adult niece or nephew, related by blood or adoption;
8. An adult aunt or uncle, related by blood or adoption; or
9. Another adult relative of the patient, related by blood or adoption, who is familiar with the patient's personal values and is reasonably available for consultation.

Under the surrogate law, the surrogate must make health-care decisions in good faith and in accordance with your best interests, including your personal values (which would include your religious and moral beliefs), provided that these are known.

The law was passed because, while all persons have the right to execute an advance directive, not everyone takes advantage of that right. The State desired to create a process to ensure that health-care decisions could be made in a timely manner by a person's relatives or loved ones without having the need for getting an order from a court. Remember, however, that if you fail to execute an advance directive, someone may be named to make medical decisions for you who is not familiar with your wishes for your end-of-life care, including your religious beliefs. Therefore, **it is preferable for Catholics to appoint a health-care agent through an AHCD** in order to guide their agent in adhering to their religious beliefs.

Do Not Resuscitate (DNR) Directives

A "Do Not Resuscitate" (DNR) Directive is a medical order that, in the event that the person's heart or breathing stops, no action should be taken to restart the heart or breathing (this means that CPR will not be performed).

CPR (cardiopulmonary resuscitation) is life-sustaining treatment and as such should be morally evaluated in the same way as is any other type of life-sustaining treatment. If it is judged that CPR will either not have any reasonable hope of benefit or will be an excessive burden, then a DNR directive is morally justified because it prevents what would be the use of extraordinary or ethically disproportionate means. For example, for a frail, elderly, sick individual or for a terminally ill patient, signing a DNR directive may be a morally appropriate thing to do if it is prudently judged that CPR will not have any reasonable hope of benefit or will be an excessive burden. But for a patient who is not terminally ill, successful CPR may constitute a form of ordinary care which allows an individual to resume his or her previous lifestyle.

POLST

Another advance care planning tool now in use in Maine is called POLST, or Provider Orders for Life-Sustaining Treatment. POLST proposes broader application of the DNR concept in that it is a medical order extending beyond the decision to use or not use CPR to the use of other life-sustaining measures such as the administration of antibiotics and medically-assisted nutrition and hydration.

A POLST form converts a person's end-of-life treatment preferences into immediately actionable medical orders signed by a health-care provider. POLST orders are intended for persons who are near the end of their lives; indeed, POLST was developed specifically for use by patients whose life expectancy is one year or less. And for these patients, the form can be a useful and morally appropriate tool.

"POLST orders are intended for persons who are near the end of their lives."

Extreme caution is urged, however, with regard to POLST orders. A POLST order should not be used in advance of a fatal diagnosis because a person's theoretical decisions about what care they should or should not receive may be radically different than decisions made in the context of a real disease at the present moment. Even for those who are terminally ill, caution should be exercised to be certain that POLST orders are not utilized to allow nontreatment in a way that constitutes euthanasia. POLST orders should be signed by the patient while the patient is competent to do so or by the patient's health-care agent under an AHCD.

POLST forms are voluntary, and no individual is required to complete one. These forms should be used only with great care.

Part Three: Frequently Asked Questions

1. What is meant by "ordinary means" of care?

Answer: Ordinary means are judged in the particular circumstances of the patient. Means that in the judgment of the patient provide a reasonable hope of benefit based on the patient's condition, what the health providers expect, and how the patient responds to the care are considered to be ordinary and morally required as long as they do not impose an excessive burden on the patient or expense on the patient's family or the community. Depending upon the particular circumstances of a patient, anything from surgery to palliative care may be judged to be ordinary means of care.

2. What is meant by "extraordinary means" of care?

Answer: "Extraordinary means" are those forms of care that have no reasonable hope of benefit because, for example, they will not adequately achieve their purposes or they carry significant risk relative to the expected outcome, or because death is imminent and impending (which means that death could be expected to occur in a matter of just a few days, despite life-sustaining care). Care is also considered "extraordinary" if it will cause an excessive burden, such as serious medical complications or unavoidable and intense distress for the patient, or if it poses an excessive expense on the patient's family or community. An example of "extraordinary means" would be treatment for end-stage cancer that is not effective against the disease and has side effects that pose a burden for the patient. Catholics are not morally obligated to use extraordinary means of care.

3. If I executed an advance directive in another state using a form different from the one used in Maine, is that advance directive valid in Maine?

Answer: As long as your advance directive is valid in the state where it was executed, it is considered valid in Maine (18-A MRSA §5-802(h)).

4. What happens if I become incapacitated and cannot make my own medical decisions, but I do not have an advance directive in place?

Answer: A health-care provider will try to determine if there is a relative or friend available to make health-care decisions for you and serve as your health-care surrogate. Maine law has created a priority list of the people who may be chosen to act on your behalf, beginning with your spouse. If you do not have a spouse, the law moves to additional categories of relatives and other persons who may serve as your surrogate. There is no guarantee, however, that the person or persons available to serve as your surrogate will be the person you would have chosen to be your agent to make health-care decisions on your behalf. You also may not have spoken with the chosen surrogate or surrogates about your wishes and religious beliefs. Preparing an Advance Health Care Directive is the best way to insure that the health-care decisions that are made for you are the same ones that would be made by you.

5. Are “do not resuscitate” (DNR) directives acceptable for Catholics?

Answer: A “do not resuscitate” (DNR) directive is a medical order that instructs medical personnel not to attempt CPR if a patient’s heartbeat or breathing stops. Like all decisions about medical treatment or care, determining whether to execute a DNR directive requires weighing whether CPR has a reasonable hope of benefit or will pose an excessive burden on the patient.

Resuscitation techniques at times may constitute extraordinary (and therefore morally optional) means of sustaining life. For example, for a frail elderly or a terminally ill patient, signing a DNR directive may be a morally appropriate thing to do if it is carefully decided that resuscitation would be of no significant benefit to the patient. It may be that CPR only would prolong the dying process and cause significant harm. For other patients, it may be that CPR has a reasonable hope of benefit and would not cause an excessive burden. In such a case, CPR would be morally obligatory.

Before deciding about a DNR directive, it is preferable that you speak with your doctor first and then to others such as a priest, family members, and Agent about the burdens and benefits of CPR in specific situations. Talking with a doctor first will provide you with important information you need in order to have informed conversations with others.

6. What does the Church say about organ donation?

Answer: Catholics are encouraged to become organ donors. *The Catechism of the Catholic Church* calls organ donation “a noble and meritorious act.”

“Resuscitation techniques at times may constitute extraordinary (and therefore morally optional) means of sustaining life.”

7. Who can I name as my Health-Care Agent?

Answer: Your Health-Care Agent can be an adult family member or any other adult person you wish, except that it cannot be someone who owns, runs or works at a long-term care facility where you are receiving care, unless that person is a relative of yours. You should consider also appointing an alternate, who would serve as your Agent in the event that the person that you designate is not available. Be sure to ask the people you are considering designating as Agents whether they would be willing to accept the appointments before you prepare your AHCD.

8. When does an advance directive take effect?

Answer: If you wish, you can authorize your Agent to make health-care decisions for you beginning immediately. If you want to allow the AHCD to take effect only after you are no longer able to make your own decisions, however, the advance directive will not take effect until a determination has been made by your physician or health-care provider that you lack the capacity to make health-care decisions. At that point, it is the responsibility of your Agent to make a good faith effort to act in accordance with what your desires would be. The Agent will be able to draw on information such as the instructions you put in the advance directive, your advance conversations with the Agent, and your known religious and moral beliefs. In that situation, if you regain your capacity to make health-care decisions, the Agent’s authority is terminated.

9. Can I revoke a designation of someone as an Agent or change or revoke an advance directive once I have signed it?

Answer: Yes. Once you have signed an advance directive, you can change or revoke it by means of a written and signed notice or by personally informing the supervising health-care provider. 18-A MRSA §5-803. (Note that this can only be done if you have the capacity to take that action.) The best way to do it is to issue a new advance directive and note in the new one that the old one is revoked.

10. From a Catholic perspective, is there any difference between withdrawing a form of care and not starting it in the first place?

Answer: No. As Catholics, we apply the same standards in deciding whether to start a form of treatment as those we apply when we are deciding whether to stop a form of treatment: is it an ordinary means or an extraordinary means? Thus, the mere fact that a treatment has been started does not make it more difficult to withdraw that treatment later.

11. A priest is coming in to administer the Sacrament of the Anointing of the Sick. Does this only happen when a person is near death?

Answer: Not at all. The Sacrament of the Anointing of the Sick is intended to provide grace and strength to any person who is seriously or chronically ill or frail. Our practice of praying for the sick and anointing them with oil goes back to the Church of the New Testament. In recent centuries, this sacrament became known as “extreme unction” or the “last rites,” and it became the custom to use this anointing only when a person was about to die. The Second Vatican Council, however, restored the original meaning of this powerful sacrament, and it is once again available to those who are sick but perhaps not so sick that they are at the point of death. This sacrament is yet one more sign of the special place that the sick and the suffering have in the eyes of the Church and more importantly, in the eyes of God, our all-compassionate Father.



Part Four: An Advance Health-Care Directive for Maine Catholics

The form that follows here is a Catholic version of the State of Maine’s generic Advance Health-Care Directive Form. This Catholic version uses the generic form that is published by the State of Maine Department of Health and Human Services (<http://www.maine.gov/dhhs/>) and is based almost entirely on the optional format that is set forth in 18-A MRSA §5-804. However, we have revised Part 2, the Special Instructions portion of the form. Without the changes we have made in those Special Instructions, your agent could arrange for health-care on your behalf that might be inconsistent with Catholic teachings. Making these sorts of changes is permissible, because the Maine law allows you to use any language you want to use when you are establishing the Special Instructions to be used in your Advance Health-Care Directive.

The form below may be executed without making any changes other than to fill in the appropriate blanks. However, it is essential that you review this entire document carefully and that you feel free to make any changes that you wish to make. It is important that the final product be an accurate reflection of your wishes.

Advance Health-Care Directive Form

PART 1–SELECTION OF MY AGENT (Durable Power of Attorney for Health Care)

1. DESIGNATION OF AGENT: I designate the following individual as my Agent to make health-care decisions for me:

Name of individual you choose as agent: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

***OPTIONAL:** If I revoke my Agent’s authority or if my Agent is not willing, able or reasonably available to make a health-care decision for me, I designate as my first alternate Agent:

Name of individual you choose as first alternate agent: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

***OPTIONAL:** If I revoke the authority of my Agent and first alternate Agent or if neither is willing, able or reasonably available to make a health-care decision for me, I designate as my second alternate Agent:

Name of individual you choose as second alternate agent: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

2. AGENT’S AUTHORITY: My Agent is authorized to make all health-care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here or in Part 2 of this form:

(Add additional pages if needed.)

Authority under HIPAA: I intend for my Agent herein appointed to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. I grant to my Agent the power and authority to serve as my Personal Representative for all purposes under the Health Insurance Portability and Accountability Act of 1996 and its regulations (“HIPAA”), 42 USC 1320d and 45 CFR 160-164.

3. WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: [check one box]

My Agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions.

OR

My Agent's authority to make health-care decisions for me takes effect immediately and continues after I am no longer able to make decisions for myself.

4. AGENT'S OBLIGATION: My Agent shall make health-care decisions for me in accordance with this power of attorney for health care, any specific instructions I give in Part 2 of this form and my other wishes to the extent known to my Agent. To the extent my wishes are unknown, my Agent shall make health-care decisions for me in accordance with what my Agent determines to be in my best interest. In determining my best interest, my Agent shall consider my personal values to the extent known to my Agent.

You have the right to revoke Part 1 of this form at any time. You must do so in writing or by personally notifying your primary physician. 18-A M.R.S.A. § 5-803

PART 2 - SPECIAL INSTRUCTIONS (Catholic Version)

I have intentionally opted not to use the version of the Special Instructions contained in the optional form set forth in 18-A MRSA §5-804, and I have intentionally opted instead to use the following Catholic Version of the Special Instructions, which I hereby adopt as my Special Instructions:

I wish to follow the moral teachings of the Catholic Church. A Guide for Maine Catholics on End-of-Life Decisions, in its entirety, together with my instructions under this Section 2, contain my additional instructions and limitations regarding the authority of my Agent to act on my behalf with respect to all medical decisions including the provision or withholding of life-sustaining treatment and the administration or withholding of medically-administered nutrition and hydration.

- 1. I want to receive all forms of treatment and care that have a reasonable hope of benefit for me AND which will not cause an excessive burden.
- 2. I do not want any care or treatment that does not have a reasonable hope of benefit or constitutes an excessive burden.
- 3. My Agent's judgment on these matters and any other matters addressed in this document should be made in light of A Guide for Maine Catholics on End-of-Life Decisions; the Catechism of the Catholic Church; The Vatican Declaration on Euthanasia; and Ethical and Religious Directives for Catholic Health Care Services, and as these documents may be revised.
- 4. Even if my Agent judges that a particular form of treatment or care should be withheld or withdrawn, I still want to receive any other form of care or treatment already in use that does have a reasonable hope of benefit AND will not be an excessive burden.
- 5. Even if all other forms of treatment or care are withheld or withdrawn, I still want all appropriate palliative care.

You may revoke all or portions of Parts 2 to 5 of the advanced health care directive at any time and in any manner that communicates an intent to revoke. 18-A M.R.S.A. § 5-803

PART 3 - DONATION OF MY ORGANS (Sections 9 and 10)

9. UPON MY DEATH: [check one box]

I do not wish to donate any organs

OR

I give any needed organs, tissues or parts.

10. IF I HAVE DECIDED TO DONATE ORGANS, MY GIFT IS FOR THE FOLLOWING PURPOSES: [check all that apply]

Transplant

Therapy

Research

Education

Any of the above

Other:

PART 4—CHOICE OF PRIMARY PHYSICIAN (Section 11)

11. I DESIGNATE THE FOLLOWING PHYSICIAN AS MY PRIMARY PHYSICIAN:

Name of physician: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

**OPTIONAL:* If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

Name of physician: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

PART 5—NOMINATION OF GUARDIAN (Section 12)

12. IF A PROBATE COURT JUDGE FINDS THAT A GUARDIAN MUST BE APPOINTED TO MAKE DECISIONS FOR ME: [check one box]

I nominate the Agent designated in Part 1 of this form to be my guardian. If that Agent is not willing, able or reasonably available to act as guardian, I nominate the alternate Agents whom I have named, in the order designated.

OR

I nominate the following person to serve as my guardian:

Name of proposed guardian: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

PART 6—SIGNATURES

YOUR SIGNATURE: [required]

Sign your name *Date*

Print your name

Address: _____ City: _____ State: _____ Zip: _____

SIGNATURE OF WITNESS 1: [required]

Signature of Witness 1 *Date*

Print Witness 1 name

Address: _____ City: _____ State: _____ Zip: _____

SIGNATURE OF WITNESS 2: [required]

Signature of Witness 2 *Date*

Print Witness 2 name

Address: _____ City: _____ State: _____ Zip: _____

A copy of this form has the same effect as the original. 18-A M.R.S.A. § 5-812

NOTARY ACKNOWLEDGEMENT: [optional]

Personally appeared before me the above-named _____ who took an oath and acknowledged this Advance Health Care Directive, including durable power of attorney for healthcare, as his/her free act and deed.

Date: _____ Commission Exp.: _____

Print Name: _____ Notary Public State of: _____

