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# Comfort and Consolation

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Care of the Sick and Dying

A PASTORAL LETTER  
FROM THE CATHOLIC BISHOPS OF MARYLAND



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## **ACKNOWLEDGMENTS**

We are grateful for the revisions to this pastoral letter from general editor Fr. J. Daniel Mindling, OFM Cap., academic dean, Mt. St. Mary's Seminary, Emmitsburg, Md., and consultant to the U.S. Conference of Catholic Bishops Committee for Pro-Life Activities; and from the law firm of Gallagher Evelius and Jones.

*Comfort and Consolation was originally published by the bishops of Maryland in 2007.*

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“Even the weakest and most vulnerable,  
the sick, the old, the unborn and the poor are  
**MASTERPIECES OF GOD’S CREATION,**  
made in his own image, destined to live forever,  
and deserving of the utmost reverence  
and respect.”

Pope Francis, July 7, 2013

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**“There is no human life more sacred than another, just as there is no human life qualitatively more significant than another. The credibility of a health care system is not measured solely by efficiency, but above all by the attention and love given to the person, whose life is always sacred and inviolable.”**

Pope Francis, September 20, 2013

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# Comfort and Consolation

A PASTORAL LETTER  
FROM THE CATHOLIC BISHOPS OF MARYLAND

Dear Brothers and Sisters in Christ,

The advance of modern medicine enables us to live longer, healthier lives. Great progress has been made in conquering and preventing disease. We are grateful for the life-saving treatments now available to so many people. But with improved medical technology comes challenges. We want to respect life, but fear prolonging a painful or expensive dying process.<sup>1</sup> In times of serious illness or imminent death, we are called upon to make wise choices about whether to initiate, continue or even discontinue life-sustaining treatment. We might need to make such decisions for ourselves or for loved ones. These can be among the most complex and difficult decisions of our lives.

## **Reasons for this Letter**

As bishops serving the state of Maryland, we want to reflect on these difficult decisions, decisions that are faced at one time or another by almost every family we serve. In addition, changing national and state health care policies demand that Catholics be well-informed about sound moral principles. In 2007, the bishops of Maryland first issued *Comfort and Consolation*. In order to face changes in medicine, care of the seriously ill and dying, and in the law, and especially to encourage conversations on end-of-life decision-making, we have revised and reissued this pastoral

letter. At the federal level, a 1991 law requires most health care facilities to inform patients of their right to indicate the kinds of treatment they would desire or want to forgo should they become incapacitated. On the state level, the Maryland Health Care Decisions Act (amended in 2012) regulates advance directives for health care.<sup>2</sup> As believers, we must exercise the rights we have as citizens in the light of our faith. In this public forum, we face many challenges. We must recognize the increasing tendency of our society to devalue human life — especially the lives of those who are most vulnerable. In some states this has sadly taken the form of legalizing physician-assisted suicide. The bishops of the United States have produced a clear and compelling response to this latest challenge to the Gospel of Life.<sup>3</sup> We are each called to bear witness to the surpassing value of human life in the decisions we face and actions we take in caring for loved ones as well as in our witness as faithful citizens.

### **To Whom this Letter Is Addressed**

With this in mind, we want to share with everyone the helpful and comforting guidance that the Church offers about medical decision-making in time of serious illness.

- Health care professionals in particular have expressed a need for sound ethical guidance as they assess various forms of treatment available to the patients they serve; we want to offer them positive and practical moral guidance in their service to the sick.
- Because families often call upon clergy to assist them when they are facing a terminal illness or imminent death, we want to assist priests and their associates in pastoral ministry in their vitally important role.
- And because caring families and individual Catholics seek to understand and reflect upon these issues before they face them and as they face them, we offer these guidelines on the Church's teaching for their prayerful reflection.



### **Principal Points of this Letter**

We cannot provide a ready-made answer for each situation; this is not our intent. Our purpose is to share with you as clearly as possible the Church's teaching on respect for human life in the context of sickness, terminal illness and disabling conditions, and dying. First, we shall speak about our common duty to care for the sick, for that is the setting in which the Church's teaching is most readily understood. Next, we shall explain the principles at the heart of this teaching that must guide medical decisions in cases of serious illness. Then we shall show how to apply these principles to decisions about seriously ill or dying patients. We also shall explain how these principles shed light on advance directives for health care, including the written or oral appointment of an agent to make health care decisions and the execution of a living will. These principles also provide ethical guidance regarding Medical Orders for Life-Sustaining Treatment (MOLST) forms.



# COMPASSION

## The Church's Ministry to the Sick

The Gospels speak of Jesus' great concern and love for the sick.

On several occasions, He went out of His way to respond to the needs of one in need of healing. We read how He cured the sick and restored them to friendship with His Father.<sup>4</sup> The Church continues Jesus' ministry of caring for the sick with deep compassion and respect for human dignity.

The Gospels also reveal our Savior experiencing the depth of human suffering and death itself. Jesus suffered and died for our sake in loving obedience to His heavenly Father; that is how He redeemed us. "Dying, He destroyed our death; rising, He restored our life."<sup>5</sup> By suffering, dying, and rising, the Lord gave the mystery of human suffering and death a profound and salvific meaning. Seen in the light of Jesus' redeeming love, sickness can bring believers into close proximity with this immense love and overcome all that separates them from God. Through this union with our suffering Lord, people of faith often experience deep inner healing and reconciliation; they can help others to open their hearts more fully to Him.

To be sure, the Church teaches the importance of preserving life, and prays for the health and healing of its members. The Church also teaches that futile or excessively burdensome


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## **The Church continues Jesus' ministry of caring for the sick with deep compassion and respect for human dignity.**

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treatments may be withheld or discontinued with an upright conscience. Through this balanced and compassionate teaching, the Church provides guidance and helps us make morally sound decisions about the course of our health care even as it helps us prepare for death with the unwavering hope of eternal life.

The Church continues Christ's ministry to the sick and dying through Catholic health care services and through the many Catholic laymen and women who devote themselves to the care of their sick brothers and sisters. Christ's love of the sick and suffering also is continued through the sacraments. In offering the Sacrament of Reconciliation, the Anointing of the Sick, and Holy Communion, the priest brings to those who are ill the loving and redeeming touch of Christ. In these moments rich with grace, the priest, acting in the Person of Christ, brings to the patient forgiveness, inner healing, and strength for what lies ahead. Together with deacons, religious, lay ministers, and volunteers, the priest shares with the patient, and with the patient's family, the Good News of Jesus, the Gospel of Life and salvation. And of course the Christian family – the domestic church – ministers to their sick family members and friends through their kind words, helpful deeds, and loving presence. Through God's grace, patients are enabled to unite their sufferings with the Lord's so as to share His everlasting joy and glory. The Church proclaims the Gospel of Life with its message of hope to those who must make difficult decisions in the face of serious illness.



**The Church offers a balanced and compassionate teaching.**

# PRINCIPLES

## Christian Reverence for the Gift of Human Life

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.

We believe that each person is created in God's image. By taking on our human nature, that is, by fully sharing our life, the eternal Son of God taught us how precious each human life really is in His Father's eyes. Our God in heaven knows and loves each one of us. What happens to us on this earth matters to Him. The Lord is especially close to the vulnerable and suffering. Contemplating our crucified Savior, we can regard no human life as useless or burdensome. Each person is precious in God's eyes and called to eternal life and joy.

Human dignity is an undeserved gift, not an earned status – it flows from who we are, not what we can or cannot do.

*The dignity of life springs from its source. We are brought into being by the loving action of God the Creator. "What are humans that you are mindful of them, mere mortals that you care for them? Yet you have made them a little less than a god, crowned them with glory and honor" (Psalm 8:5-6). The dignity of life is beyond price. We have been ransomed not with perishable things such as silver or gold, but with the precious blood of Christ (1 Peter 1:18-19).*

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*The dignity of life is clear from our calling.* God's plan for human beings is this, that they should be "conformed to the image of his Son" (*Romans 8:29*). "For God created man for incorruption, and made him in the image of his own eternity" (*Wisdom 2:23*).<sup>6</sup>

This is the basis for the Church's teaching on the dignity of the human person and our duty to foster and sustain human life. Our faith teaches us to see human life as a precious gift from God; we are not its owners but its guardians. As such, we must oppose direct attacks on innocent human life.<sup>7</sup> In that spirit, the Church proposes the following moral principles to guide our choices about medical care and treatment in time of serious illness and imminent death.

**1 | Our most basic God-given right is the right to life.**

God's gift of human life is the foundation for all His other gifts. The most basic right of each person includes the right to preserve his or her life. The Church teaches that human life remains "the first right of the human person" and "the condition for all the others."<sup>8</sup>

**2 | We do not have the right to take our own lives, nor to directly bring about the death of any innocent person.**

Since we are stewards, not owners, of the life God has given us, we do not have the right to take our own lives by suicide, assist the suicide of another, or take another's life by euthanasia. Euthanasia is sometimes deceptively called "mercy killing." It refers to actions (such as giving a lethal drug) to

cause or deliberately hasten death in order to end suffering. Euthanasia also refers to the deliberate withholding of basic care and medical treatment for the same deadly purpose.

We can readily understand how a person in prolonged agony, with no hope of recovery, might view death as a release from suffering. Prayer for a peaceful death for oneself

or another is praiseworthy, even a prayer that God quickly call a suffering loved one to Himself. The Hail Mary asks our Blessed Mother to intercede for us at the hour of our death. St. Joseph has traditionally been the patron of a happy death as one who exemplifies a grace-filled, peaceful death. The Church lovingly and confidently entrusts the seriously sick into God's hands. But no one must ever presume to adopt a course of action or inaction which is intended to cause death, even if the motive is to alleviate suffering. No matter how good the motives might seem, euthanasia is always an immoral attack on human life and a false compassion that is unable to see the abiding dignity of the human person in all conditions and circumstances.<sup>9</sup>

**Prayer for a peaceful death for oneself or another is praiseworthy.**

The growing acceptance of euthanasia in our society is deeply disturbing. As believers and citizens, we need to resist efforts to legalize euthanasia and physician-assisted suicide. Neither civil government nor any human authority has the right to recommend or legalize either of these attacks on human life. (A 1999 Maryland law made assisted suicide a crime and euthanasia is prohibited under the state's general homicide laws.) We need to have a clear understanding of what distinguishes euthanasia from morally upright decisions about accepting or refusing medical treatments in time of grave illness and imminent death. The principles that follow aim to make this distinction clear.

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## Patients and their families may need help in deciding what level of care fulfills the God-given duty of respect for life.

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### 3 | Each of us is obliged to care for the gift of life and health that God has given us.

We are not free to neglect ourselves; on the contrary, we are obliged to make reasonable efforts to preserve our health and to prevent illness. In times of sickness, we must take sensible steps to restore our health.

Such efforts often include appropriate care by medical professionals. This does not mean that all possible remedies must be used in each circumstance. Patients and their families may need help in deciding what level of care fulfills the God-given duty of respect for life. Those who are sick depend on physicians and other professionals to explain the nature of their condition and the remedies that may offer some relief, as well as the burdens they may impose. Similarly, those making complex moral decisions often require consultation with a priest, hospital chaplain, or

**Medical information alone is not enough for an informed moral decision.**

others in pastoral ministry. Some forms of medical intervention are designed to cure diseases; others relieve symptoms, retard the progress of a disease, or compensate for the failure of a bodily function. When patients consent to medical interventions, they expect some sort of benefit, whether a complete cure or temporary relief. However, medical information alone is not enough for an informed moral decision. It is also important to understand and apply the principles contained in the Church's teaching; to do so it is often helpful and necessary to consult with those who are charged with faithfully sharing the Church's teaching in its fullness.

## 4 | **No patient is obliged to accept or demand useless medical interventions.**

Common sense tells us that no patient is obliged to accept or demand medical care or treatments that have no beneficial effect; indeed, the application of useless medical interventions can be wasteful and detrimental to the common good. But what is a “useless” medical intervention?

A medical treatment is “useless” to a particular patient if it cannot bring about the effect for which it is designed.

Such an intervention is both ineffective and medically inappropriate. For example, if a patient is given a drug to fight an infection, but subsequently the infection proves resistant to the drug, this proposed remedy is useless and need not be provided.<sup>10</sup>

Similarly a particular surgery or a continued cancer treatment protocol may be judged to be medically ineffective and inappropriate.

A medical treatment, procedure or even care should not be deemed useless, however, because it fails to achieve some goal beyond what should be expected. For example, a feeding tube is used to provide nutrients to a patient no longer capable of eating; the tube is useful when it delivers these nutrients to the patient who, in turn, absorbs them. It is useless if the patient becomes incapable of absorbing the nutrients the tube delivers. A feeding tube should not be described as useless because the nutrients it provides are unable to cure an underlying pathology; the feeding tube should not be expected to restore the patient to consciousness or to remove any other debility not related to the need for nutrients.

Patients and their loved ones need to rely on health care professionals who can help them decide which forms of treatment are effective and thus useful, and which treatments are ineffective and thus useless. However, no one — including the patient, family members, medical professionals, or

**We are stewards, not owners, of the gift of human life.**



members of the clergy – ever has the right to decide that a patient’s life is useless, even when a patient is no longer able to perform basic human functions or interact with awareness. We are stewards, not owners, of the gift of human life – no one has the authority to decide that a certain life is not worth living.

**5 | There is no moral obligation to employ useful but excessively burdensome medical interventions; however, the meaning of “excessively burdensome” must be properly understood.**

A seriously ill patient is not necessarily obliged to employ every possible medical means, even those that promise some benefit. In many cases, there is no obligation for patients to accept interventions that impose serious risks, excessive pain, prohibitive cost, or some other extreme burden. While the most basic principles of Christian morality oblige us to preserve human life, nonetheless, individuals need not undertake excessively burdensome efforts to preserve their lives. Whether a given treatment is necessary or useful to a particular patient is a medical question requiring the expertise of health care professionals. Whether a particular treatment is excessively burdensome to an individual patient, the patient’s family, and community is made from the perspective of the patient, and raises a moral question requiring the application of clear Catholic teaching.<sup>11</sup> Often this requires the advice of a priest. Individual patients and their families, health care professionals, and Catholic medical facilities should actively seek the guidance of the Church in these serious matters.

A patient may make a morally correct decision to forgo a potentially beneficial medical treatment proposed by his or her doctor because the treatment itself is too burdensome. For example, a person may judge in good conscience that the pain and difficulty of an aggressive treatment for terminal cancer is too much to bear, and thus decide to forgo that difficult treatment. Here, the ethical judgment to be made is whether or

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**“In a frail human being, each one of us is invited to recognize the face of the Lord, ...[a]nd every elderly person, even if he is ill or at the end of his days, bears the face of Christ. They cannot be discarded, as the ‘culture of waste’ suggests! They cannot be thrown away!”**

Pope Francis, September 20, 2013

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not the benefits of a proposed treatment justify the significant difficulties and suffering that it may bring to a particular patient.

Conversely, we should not stop medically useful interventions because we are tired of living, feel we no longer have a contribution to make, see ourselves as helpless or believe our dependency on others is too great a burden to them and, thus, would like to hasten the end of life. Nor can we in good conscience elect to forgo ordinary medically beneficial treatment in order to avoid the suffering which the disease itself brings. And just as we cannot rightly decide that our own lives are too burdensome to be continued, so also we cannot rightly make such a decision regarding the life of a person for whom we may have legal responsibility.

As Pope Francis said in his September 2013 Address to the International Federation of Catholic Medical Associations, “In a frail human being, each one of us is invited to recognize the face of the Lord, ...[a]nd every elderly person, even if he is ill or at the end of his days, bears the face of Christ. They cannot be discarded, as the ‘culture of waste’ suggests! They cannot be thrown away!” The value and dignity of human life rests not on our awareness, independence, productivity, or achievement but on a spiritual reality. We are created in the image of God, endowed with a soul, graced by the saving action of Christ, and

destined for eternal beatitude. This is the true quality of our life, the only creature on earth that God has willed for its own sake.<sup>12</sup>

In short, patients may morally decide that a particular form of treatment is excessively burdensome; but they may never morally decide that their very lives are so burdensome or the quality of their life is such that they may forgo the normal medical means of sustaining their lives.<sup>13</sup> Nor may anyone ethically make such a decision for anyone else.



## 6 | Christian faith and human suffering

We must never be indifferent to human suffering. As believers we reach out in love to suffering persons because we see Christ in them. Furthermore, our faith enables us to see the suffering that serious illness entails as an opportunity to share in Christ's redemptive suffering.<sup>14</sup> The Church encourages

Pain management is critical in the appropriate care of the dying.

us to pray and dedicate our pain and fear to help others and ourselves — to offer our dependency, helplessness and suffering to God on behalf of others.<sup>15</sup> With the help of medical science, however, we try to bring to the suffering as much comfort and relief as possible — but never through euthanasia. "One of the primary purposes of medicine in caring for the dying is the relief of pain and the suffering caused by it. Effective management of pain in all its forms is critical in the appropriate care of the dying."<sup>16</sup>

The Church endorses programs of pain management, palliative care and hospice care in accord with Catholic ethical principles. Saint John Paul II reaffirmed the 1957 teaching of Pope Pius XII on the appropriate use of medications for pain management.<sup>17</sup> **The Catholic Declaration for Health Care Decision Making** provided with this letter notes that if a person's condition includes physical pain, he or she may request pain-relieving medication in dosages sufficient to manage the pain. If the person is dying and pain management should require increasingly greater dosages of medication, the patient or a health care agent may ask that the dosages be increased in increments sufficient to manage the pain, even if the patient is made less alert or responsive, or if this increase should, as a side effect, hasten death. Pain medication, however, must never be given for the purpose of hastening death.

# PRUDENCE

## Applying the Virtue of Prudence

Catholic morality always acknowledges the differences that exist between general principles and the application of those principles to individual lives.

No general statement of principles can take into account all the particular facts and circumstances of every possible case; universal moral principles require application to particular situations. This is not to say that the principles are vague or uncertain; rather, the same principles may lead people to different courses of action in light of their particular conditions. For example, the level of care and the kind of treatment that medical professionals might provide in a hospital setting are not what would be given to someone who is receiving adequate care at home. And costs and availability of medical treatment vary from place to place. It is important to see that in diverse settings, differing courses of action may be consistent with the same moral principles.

But what enables us to have some assurance that we are correctly applying the principles of the Church's teaching to our situation? First, we should always pray for the guidance of the Holy Spirit in seeking moral truth. In particular, we should pray for an increase of the Christian virtue of prudence. For many people, prudence

simply means being cautious; but in the Catholic tradition, prudence implies much more. A gift of God's love, prudence helps the Christian in the face of moral dilemmas. Prudence is a virtue that helps us to judge rightly all the factors involved in a complex decision, to determine their relative importance and, without undue delay, to enact a sound judgment. This virtue also helps us account for the impact of such decisions on ourselves and on others, especially loved ones. Prudence enables us to weigh all the factors involved in making an informed medical decision for another person. When doubt persists, the prudent person will continue to pray to the Holy Spirit and seek the counsel and advice of wise persons well trained in Church teachings. In times of serious illness or imminent death, priests and their pastoral associates are often called upon to be those prudent and loving advisors.

**Prudence helps the Christian in the face of moral dilemmas.**

### **Making Decisions for Ourselves**

We all tend to defer thoughts of serious illness and death until the last possible moment. Yet throughout our lives, reflecting on the tremendous gift and fragility of human life promotes a spirit of gratitude and a greater desire to care for this gift. We should prayerfully cultivate the virtue of prudence and reflect on the deep truths of our faith about the value of human life and our calling to life everlasting. We need to know the Church's moral teaching on the sanctity of life and understand the principles that derive from that teaching. We do all this with hope for everlasting life; the Church continues to urge us to pray for the grace of a happy death. From time to time, it is helpful to discuss these matters with a parish priest or a spiritual director.

Clearly, we are not entirely free to do whatever we wish when we make decisions about the care of our own life and health. We are called to preserve and protect our lives with prudence for the service of God, family, and neighbor. When professional medical care is needed, we must consent to the reasonable use



of appropriate services so that we do not neglect our own well-being and the spiritual and family obligations that are ours. Beyond these normal efforts, we are at liberty to employ or to refuse the techniques of modern medicine that may entail excessive difficulty or risk. As noted above, it is morally acceptable to interrupt such treatments when they are no longer beneficial or have become disproportionately difficult.

### **Making Decisions for Another**

We know, of course, that some serious illnesses make it impossible for many people to make or communicate decisions about their own medical treatment. For this reason, communication with loved ones about end-of-life care is among the most important things we can do to equip them to make decisions on our behalf.

At times we may have the responsibility of making decisions for loved ones who can no longer do so. An important part of attentiveness to the sick is making morally sound medical judgments in their stead. We are called upon to put ourselves in the place of those dear to us and to take account of their God-given obligations. Christian love calls us to be just as attentive to their needs as we would be to our own. In the extreme case of a pregnant woman in a persistent vegetative state, we are attentive not only to her life, but to the life of her unborn child as well.

In making decisions for others we must prudently apply the same principles that we should use if we were making those decisions for ourselves.

While it is true that one should take into account the attitudes and beliefs of the sick person, no one should agree to act against clear Church teaching. Let us suppose, for example, that a husband tells his wife that he would refuse any sort of treatment should he ever suffer an extreme illness or injury. If this happens and renders him no longer able to communicate, his wife is not morally bound to honor wishes that are inconsistent with Church teaching. Rather, she is obliged to determine what sort of treatment is appropriate for her stricken husband, treatment that is respectful of his previously stated wishes and guided by current medical information and moral principles.

We also need to be alert to the difference between what civil laws permit and what is morally acceptable. It may be legal for an individual to choose a course of minimal or no treatment; indeed, it may be legal for an individual to honor such a choice made by another. However, it remains morally wrong for a guardian to honor a patient's wishes that disregard the God-given value of human life itself. If what is being requested clearly violates Church teaching, the conscientious surrogate or agent ought not authorize it, and may have no choice but to resign. What the patient cannot choose morally, another cannot choose on the patient's behalf.

### **Judging the Impact of Burdensome Treatments on Loved Ones**

Whether we are deciding the course of our own health care or making decisions for another, we should take into account the impact that a potentially useful but burdensome treatment may have on one's family. For example, in a particular case it may be prudent and ethically acceptable for a father facing grave illness to decide to forgo a potentially beneficial treatment if he judges that this treatment will completely impoverish his family. Indeed, the various hardships that such treatment might impose on his family can be regarded as part of the burden borne by this patient. While the economic impact of medical treatments should not be the primary consideration, neither can costs be ignored.





Suppose he becomes permanently unconscious without having communicated his wishes about his medical treatment to his wife. Now his wife must reach an informed judgment. She is obliged to consider all the factors her husband would have considered, including his God-given obligations as a Christian believer, spouse, and parent. Among other things, she would need to consider the impact of the proposed treatment on family members. Just as parents are frequently required to sacrifice in everyday matters for the well-being of their children, so also they can be called to show that same generosity in ultimate matters of life and death.

That same spirit of sacrificial love may prompt a patient to choose advanced and aggressive treatments which do in fact impose severe burdens on him or her. For example, a patient with a rare disease may accept an experimental treatment, even though it involves great pain or grave risk, in order to help advance medical science. Or there may be compelling reasons for a parent responsible for young children to endure an extremely painful

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must put themselves in the place of the patient  
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direct his or her health care.**

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and risky treatment in the hope of surviving long enough to take care of his or her family. In these ways, too, physical suffering enables a patient to embrace a spirit of Christian sacrifice, "filling up what is lacking in the afflictions of Christ on behalf of his body, the Church" (*Colossians 1:24*). While Jesus' death on the cross was a complete and infinite atoning for all humankind, St. Paul reminds us that God in some mysterious way allows us to share in Christ's redemptive suffering.

Often family members are called on to make medical decisions for loved ones who are no longer able to do so. Family members may find themselves facing both emotional and economic hardships brought about by the prolonged illness of the loved one. In such circumstances, they may have the responsibility to decide whether to initiate or end a form of treatment involving significant burdens for their loved one. Family members serving as proxies are bound in conscience to reach such judgments carefully. They must not act out of emotional distress, self-interest, or in the hope of material gain. They must put themselves in the place of the patient and consider the factors the patient rightly would have to take into account if he or she were conscious and able to direct his or her health care. Care may require months or even years of continuous assistance as in cases of Alzheimer's disease or severe mental illness, care which imposes a real burden to families. Nevertheless, it would be wrong to abandon such patients in their time of need.<sup>18</sup>

# END STAGE

## Imminent Death vs. Progressive Diseases

The preceding general principles guide decisions about medical treatment in time of serious illness — when death is not an immediate threat, and when it is imminent.

They reflect the 1980 *Declaration on Euthanasia* issued by the Congregation for the Doctrine of the Faith, which states: “When inevitable death is imminent in spite of the means used, it is permitted in conscience to make the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted.”<sup>19</sup> Of course, this provision does not in any way permit us to abandon one who is dying. While we may not be obliged to subject them to aggressive treatments, we are obliged to make them as comfortable as possible, to express our love and concern, and to pray with them and for them. Priests and their pastoral associates have a special role to play in caring for the sick as death approaches, and in comforting their families. Care providers as well help the sick person find peace in death. It is a grace-filled moment to keep company with a dying person.

These same principles apply to long-term, irreversible conditions such as ALS and Alzheimer’s disease. As we shall see,

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**Unlike a patient in a terminal condition,  
a patient classified by the law in an  
end-stage condition does not face imminent  
death, although the condition is  
“advanced, progressive, and irreversible.”**

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current Maryland law uses the phrase “end-stage condition” to describe such progressive illnesses which sooner or later result in death. Unlike a patient in a terminal condition, a patient classified by the law in an end-stage condition does not face imminent death, although the condition is “advanced, progressive, and irreversible.” And unlike a patient in a persistent vegetative state, the law explains that a patient in an end-stage condition does not suffer a total loss of consciousness, although the condition may have resulted in “severe and permanent deterioration.” Patients classified in “end-stage condition” who suffer from such diseases are often especially vulnerable; in fact, it may be legal to withdraw treatment from such patients in circumstances when morally it should be maintained.<sup>20</sup> Respect for their human dignity forbids any act or omission intended to end their lives.

# INTERVENTION

## Medically Assisted Nutrition and Hydration

Tube feeding (such as PEG tubes or J-Tubes) and other types of medically-assisted nutrition and hydration have given rise to difficult ethical and legal questions.

The ethical guidance the Church offers addresses three distinct situations:

- cases in which the patient is terminally ill but not near death;
- cases of patients who are dying and near death; and
- the special case of the patient diagnosed in a persistent vegetative state (PVS).

Must every terminally ill patient who cannot take food and water orally be given medically-assisted nutrition and hydration? No one can provide a universal answer to this question, appropriate for all possible cases. However, there is a clear presumption in favor of supplying food and fluid to such patients. The principles we have already discussed offer sound guidance to those who must face decisions about medically-assisted feeding and hydration. These principles first tell us that because human life is a precious gift of God, we use medical interventions to preserve it. Again, there is no reason to employ useless measures or measures that impose excessive hardship on the patient. In particular cases, good moral decisions can ordinarily be made

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only when one sees how an intervention will affect an individual patient. One can only determine what is useful or useless for a patient in light of specific, clinical facts such as the imminence or nearness of death, or the presence of a medical condition that renders medically-assisted feeding and hydration useless or the rare case where it may be excessively burdensome for the patient due to some complication with the means employed.<sup>21</sup> Thus, medical expertise reveals the pertinent clinical facts; but the Church's moral expertise guides decisions so that they respect the dignity and sanctity of human life which comes from God and is destined for His honor and glory.

We consider it both morally and medically inappropriate to make a universal statement that medically-assisted nutrition and hydration must be given to all who cannot feed themselves. Likewise, it is misleading to make a universal statement that all gravely ill persons should not be provided with medically-assisted nutrition and hydration. Rather, the prudent course of action is to consider the facts of the particular case and to determine whether a patient's need for nourishment and fluid can be met effectively through a medical intervention which use does not impose excessive burdens on the patient. Patients or those who represent them (their proxies) should choose medically-assisted nutrition and hydration except when the patient can no longer absorb them or when, having sought good counsel, the patient or the proxy judges it excessively burdensome to the patient.

The presumption, however, is always in favor of providing



nutrition and hydration. This presumption recognizes that denial of nutrition and hydration can itself add to the suffering of a patient and cause death independently of any underlying pathology.

### **MANH and the Terminal Patient Who Is Not Near Death**

Consider the patient who is terminally ill but not near death, such as a woman with congestive heart failure. Hospitalized with a stroke, she has become unable to take food or liquid orally.

Now in hospice care,

she is not expected to live more than six months. Her doctor and her nephew who is her health care agent, in consultation with the hospital chaplain or ethics committee, may determine that medically-assisted nutrition and hydration are the best course for her care. She may be able to absorb the tube-fed nutrition and liquid and its provision would not be burdensome to her. However, a different patient, for example one with cancer in the bowel who is not expected to live more than six months, may not even now be able to absorb medically-assisted nutrition and hydration effectively, and so the prudent judgment may be to discontinue tube feeding already begun. Another patient may have a condition which makes effective tube feeding so burdensome that the prudent judgment would be to discontinue it.

## MANH and the Terminal Patient Near Death

Patients who are very near to death often cannot take food and water orally. Are those responsible for such patients obliged to initiate or to continue medically-assisted feeding and hydration? There is no moral obligation to continue to provide nutrition or hydration that cannot be absorbed. Remember that although nutrition and hydration are often spoken of as though they were one choice, it is possible that a patient may be able to absorb liquids, but not nutrition. Each case should be considered

according to the best medical information available.<sup>22</sup>

**The decision should neither intend or cause death of the patient.**

Yet even if it can be absorbed, those who are near death need not be given medically-assisted nutrition and hydration. Decision makers might reasonably conclude that such care unnecessarily adds to the burden of the dying person. We should ask if, in the best medical judgment available, it is likely that the person will soon die of his or her illness or injury regardless of such feeding and/or hydration. If such an imminent death is likely, then a choice not to initiate or even to discontinue medically-assisted nutrition and/or hydration is morally permissible; the choice neither causes nor intends the death of the patient.

## MANH and the Persistent Vegetative State Patient

The clear teaching of Saint John Paul II (2004) on medically-assisted nutrition and hydration of patients in this condition, echoed in 2007 by the Congregation on the Doctrine of the Faith, makes two central points. "First of all, that the provision of water and food, even by artificial means, is in principle an ordinary and proportionate means of preserving life for patients in a 'vegetative state.' It is therefore obligatory, to the extent to which, and for as long as, it is shown to accomplish its proper finality, which is the hydration and nourishment of the patient. Secondly, this ordinary means of sustaining life is to be provided also to those in a 'permanent vegetative state,' since these are persons with their fundamental human dignity."<sup>23</sup>





Saint John Paul II explains this teaching in terms of the rights of the sick and the duties of others. "Medical doctors and health care personnel, society and the Church have toward these persons moral duties from which they cannot exempt themselves without lessening the demands both of professional ethics and

human and Christian solidarity. The sick person in a vegetative state, awaiting recovery or a natural end, still has the right to basic health care (nutrition, hydration, cleanliness, warmth, etc.), and to the prevention of complications related to his confinement to bed. He also has the right to appropriate rehabilitative care and to be monitored for clinical signs of eventual recovery. I should like particularly to underline how the administration of water and food, even when provided by artificial means, always represents a natural means of preserving life, not a medical act. ...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 evaluation of costs can outweigh the value of the fundamental good which we are trying to protect, that of human life" (no. 5).

Saint John Paul II further explains that this applies even when there is little expectation that the condition will be reversed. "The evaluation of probabilities, founded on waning hopes for recovery when the vegetative state is prolonged beyond a year, cannot ethically justify the cessation or interruption of minimal care for the patient, including nutrition and hydration. Death by starvation or dehydration is, in fact, the only possible outcome as a result of their withdrawal. In this sense it ends up becoming, if done knowingly and willingly,...euthanasia by omission" (no. 4).

Accordingly, no one should authorize the refusal or withdrawal of medically-assisted nutrition and hydration for oneself or for another merely because of a diagnosis of persistent vegetative state.<sup>24</sup>

**The person in a vegetative state has the right to basic health care.**

# D N R / D N I

## “Do Not Resuscitate” and “Do Not Intubate” Directives

These directives are an increasingly common feature of advance health care directives and the MOLST form.

By means of such orders medical personnel are instructed not to use resuscitation techniques in an attempt to restore heart and lung functioning after these have stopped. What guidance do the principles already described offer us about these directives? The decision of whether or not resuscitation or intubation should be attempted should be based on the patient’s actual medical condition and wishes. Though a DNR/DNI may be justifiable at times, it often can be inappropriate for individuals to stipulate in advance that they are not to be resuscitated under any circumstances. In fact, the appropriateness of these directives and medical orders hinges on answers to these important questions.

### **Let us explore DNR in particular:**

#### **1. Is resuscitation a medically useful intervention?**

For example, CPR is generally appropriate in the case of an unexpected heart attack or during surgery which was anticipated to benefit the patient.

#### **2. Is resuscitation medically futile?**

CPR may well be futile in the final stages of a terminal illness when death will soon follow no matter what means are used.

### 3. Is resuscitation unduly burdensome to the patient?

For example, would it procure only a precarious, short-term survival? At the same time, there can be special reasons why a patient may want to endure such burdensome treatment in order to survive for a period of time, for instance, to settle personal affairs or to seek the sacraments.

For many of us, it is difficult to predict the answers to such questions prior to an actual medical crisis. Often, the factors that must be taken into account do not really become clear until medical personnel can assess firsthand the patient's condition and determine what results would likely follow if resuscitation is attempted. A DNR directive, however, may well be appropriate in cases where it is prudently judged in advance that resuscitation will secure only a short-term, precarious, and burdensome prolongation of life.<sup>25</sup> In a similar fashion, these same sorts of questions should be asked to guide decisions regarding the ethical appropriateness of DNI orders.



# MARYLAND LAW

## Health Care Decisions Act

We need to be familiar with the complex provisions of Maryland's Health Care Decisions Act so we can make and make known prudent, morally sound decisions about health care.<sup>26</sup>

The law intends to ensure the legal right to personal health care decision-making and to recognize that in our society every individual's life has worth in itself and is not to be devalued by a person's incapacity or perceived diminished quality of life. The law reaffirms already existing prohibitions against mercy killing and euthanasia. The main provisions of the law include:

### **Advance Directives**

Two types are recognized in the law:

- 1. A written appointment of a health care agent** to make health care decisions for the patient (sometimes referred to as a "durable power of attorney for health care") which may also include written instructions regarding one's future health care decisions;
- 2. Written instructions (commonly called a "living will")** authorizing the provision, withholding, or withdrawal of life-sustaining procedures if the patient is in a terminal condition and death is imminent, or if the patient is in a persistent vegetative state or if the patient has an end-stage condition.

## Oral Directives

Maryland law allows the patient to give an oral statement to his or her physician, either leaving instructions about the course of his or her health care or the appointment of an agent. The law stipulates that such a statement must be made to a physician, a physician-assistant or nurse practitioner, and must be witnessed by one other individual.

The directive is to be recorded in the patient's medical record and signed and dated by the medical professional and the witness. Usually, an oral directive is made when one is facing a serious medical problem without an advance written directive, or when an individual for some reason finds it difficult to prepare a written directive. Patients who elect to make an oral declaration should exercise the same prudent judgment as those preparing a written advance directive — either to appoint an agent or to direct the course of their own health care. No one should make an oral directive without proper forethought, wise counsel, and an awareness of the consequences of such important decisions. The patient must exercise much care to ensure that the physician and witness have truly understood his or her wishes. In general, written directives appointing a responsible agent are preferable.

**Written directives appointing a responsible agent are preferable.**

## Surrogate Decision-Making

For a patient who has not appointed a health care agent, a surrogate (guardian, spouse, adult child, parents, adult brother or sister or another relative or close friend) may make decisions about health care. The law stipulates that such decisions are to be based on the wishes of the patient, if known, or, if unknown or unclear, on what is judged by the surrogate to be in the patient's "best interest."

# DIRECTIVES

## Preparing Advance Directives in Light of Catholic Teaching

The Church's teaching on the sacredness of life governs all decisions concerning the preservation and care of life from conception until death.

Whether we make decisions for ourselves or for another person who is incapacitated, every Catholic should follow clear Church teaching. In view of the provisions of the Health Care Decisions Act and in light of the principles of the Church's teaching, we wish to offer the following information and guidance about preparing advance health care directives.

Advance directives are legal documents through which individuals guide the course of their own medical treatment even after they can no longer make decisions or inform others of their desires. There is no standard form for the living will. At the end of this pastoral letter we have provided a model we recommend, the *Catholic Declaration for Health Care Decision Making*.

It is important to examine any advance directive you may be offered by a health care professional or by your lawyer to be sure that it calls for decisions that are morally appropriate. Good decisions are based on the actual condition of the patient. It may be the case that treatment prudently chosen at one point in a progressive illness may become ineffective or unduly burdensome



when one is imminently dying and therefore no longer morally obligatory. Be sure any advance directive allows decision makers to decide based on your actual condition.

Some advance directives may be offered to you at some health care institutions and by some physicians and attorneys that may permit authorization of actions that do not respect the God-

given value of human life as the Church instructs us. Prudent discernment is always necessary. Thus we should use great caution in choosing any standardized directive. It is important for you to know its provisions well and to determine whether or not the directive allows for morally sound medical judgments to be made in the varying stages of serious illness. All advance directives require such scrutiny.

Maryland law suggests several legally permissible advance directive approaches. The Maryland law gives criteria for drawing up advance directives. If those legal criteria are met, medical professionals may rely on such directives without fear of liability. It is possible, however, that a particular physician or health care facility may refuse to comply with a particular directive for reasons of conscience. In that event, the designated agent (or proxy) may seek a physician or health care facility willing to honor the provisions of the directive.

It is not difficult to revoke an advance directive, and revisions may be made in writing or by an oral statement to a health care practitioner, or by executing an entirely new directive which replaces the previous one. It is worthwhile to review any advance directive you may have executed years ago, to keep them current, to discuss their content with loved ones, especially in the light of the principles contained in this letter.

**Good decisions are based on the actual condition of the patient.**

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**In most cases, however, the written appointment of a health care agent is preferable to a living will or to an oral directive.**

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### **Appointing a Health Care Agent**

Under Maryland law, a patient may appoint a health care agent to make decisions if the patient can no longer do so. The appointment can be made orally, or in a written document.

Is it wise to give such authority to another? Again, it is impossible to give an answer that is right for everyone. In most cases, however, the written appointment of a health care agent is preferable to a living will or to an oral directive. Let us look at some of the advantages to the written appointment of an agent and then consider some practical guidance for drawing up such a document.

The chief advantage of appointing a health care agent is that it leaves decision-making in the hands of a person of your own choosing. In the event you are no longer able to communicate your wishes, a reliable person whom you have empowered to be your agent can discuss your present medical situation and available treatments with your doctor. Your agent can then reach an informed decision, based on current medical facts and sound moral principles, in keeping with the Church's teaching. The agent has the legal authority to consent to or refuse medical treatment on your behalf. Please note, however, that you can also restrict the scope of the authority of your agent, should you deem it best to do so.

It is important to know that the Maryland law authorizes "surrogate decision-making" for a patient who has not appointed a health care agent. This allows the surrogate to make health care decisions; the law says that such decisions are to be based on the known wishes of the patient, or in the patient's "best interest" if



his or her wishes are not known or are unclear. Obviously, there is no guarantee that a surrogate will make such decisions in accord with Church teaching. It is therefore wise to appoint an agent in advance whom you can trust to make morally sound medical decisions on your behalf.



### **Criteria for Health Care Agents**

**If you choose to appoint an agent, you may want to consider the following points:**

- You should appoint someone who has the strength of character to make good judgments in challenging circumstances.
- You should appoint someone whom you know you can trust to make decisions on the basis of Church teaching. The prudent person will select an agent who will act as he or she would act in whatever circumstances evolve.
- No one should agree to act as an agent for another person if that person would expect or require the agent to make decisions that disregard Church teachings. It is not morally acceptable to authorize, approve, or carry out immoral decisions on behalf of someone else. No agent and no health care

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**You should include a provision asking that spiritual care, including the sacraments, be provided for you as you prepare for death or face serious illness.**

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provider should ever feel obliged to act contrary to their well-formed consciences, even at the request of another person.

- You should appoint someone who is likely to be available to care for you in the foreseeable future. It also may be advisable to name alternate agents, in the event that your first choice proves unable or unwilling to act for you when the need arises.
- Above all, discuss the specifics of your directive and especially your faith convictions about health care with the person whom you wish to choose as your agent. A form is not a substitute for a conversation. It should rather be a document which embodies that conversation. Talk over the specifics with your physician as well. You should also talk to an attorney if anything in the form you are using is confusing or does not meet your needs.
- You should generally avoid:
  1. stating that you wish to reject certain treatments under all circumstances. You may wish to state, however, that you do not want certain treatments if your death is near, the burdens of a particular treatment are disproportionate to its benefits, or if your medical condition at some future time makes such treatments futile.
  2. stating without qualification that you want medical remedies restricted in the event that you become permanently unconscious or terminally ill. Such stipulations can amount to providing a premature self-diagnosis. You should allow your agent and physician latitude to offer you appropriate care based on your actual condition, and the effectiveness of treatment as well as its potential burdens.

- You should include a provision about treatment at the time of imminent death. Recall that the Church allows a person on the verge of death to refuse treatment that would result only in a burdensome prolongation of life. Your advance directive should authorize your agent to observe this norm. Such an authorization will bring much comfort and reassurance to your loved ones in a time of emotional stress; it is also an expression of your profound Christian hope in the life to come.
- You should include a provision asking that spiritual care, including the sacraments, be provided for you as you prepare for death or face serious illness.
- You should periodically review the provisions of your advance directive. After discussions with your agent, priest, physician, and other appropriate persons, you may want to revise or renew the document to ensure that it accurately states your wishes.
- You should make copies of your directive, sign each as an original in the presence of two witnesses, and distribute



them to your agent, your physician, any hospital or caregiving institution where you might be treated, and anyone else you deem appropriate. Should you decide to revise your directive or replace it with another, be sure that all obsolete versions are destroyed.

## Living Will

A living will is a written instruction you can prepare to provide for your own medical treatment at the end of life when you are no longer able to make decisions for yourself.

A living will document, as regulated by the Health Care Decisions Act, enables an individual to make decisions in advance about the delivery of life-sustaining procedures if the individual's death from a terminal condition is imminent, or the individual is in a permanently unconscious state (persistent vegetative state) or the individual is suffering from an end-stage condition.

The Health Care Decisions Act offers an optional form for a living will. Women of child-bearing years who are executing a living will may include specific instructions in the event of pregnancy. In that optional form, and in other forms modeled on it, a person may select from three legally available options for treatment should he or she reach a terminal state or persistent vegetative condition or be suffering from an end-stage condition:

1. no provision of life-sustaining procedures, including medically-administered nutrition and hydration;
2. no provision of life-sustaining procedures, except for the administration of nutrition and hydration;
3. provision of all available medical treatment in accordance with accepted health care standards.

As stated previously, it is definitely preferable to appoint a prudent health care agent who will follow Church teaching rather than to draw up a living will. Often it is difficult to predict what one's actual medical condition will be when decisions will have to be made about medical treatments. A living will, nonetheless, may be of assistance in particular circumstances. A person who is unable to appoint a health care agent, or a person on the verge of a final illness, may want to execute a living will. Care should be taken that a living will not become a means of refusing a morally required treatment or of removing prematurely some life-sustaining procedure. We provide the form we recommend at the end of this pastoral letter.

# M O L S T

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

Maryland law (since 2013) authorizes a legal form called MOLST for medical orders regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient.

It is valid in all health care facilities and programs throughout Maryland, and it is to be kept with other active medical orders in the patient's medical records. The patient's or authorized decision maker's participation in the preparation of the MOLST form is always voluntary. If either one has not limited care, except as otherwise provided by law, CPR will be attempted and other treatments will be given. The patient (or agent) does not sign this form, only the physician, nurse practitioner, or physician's assistant.

Section 1 of the MOLST form deals with CPR. The remaining sections deal with other life sustaining treatments such as antibiotics, dialysis, transfusions and the like. MOLST is not an advance directive, rather it is physician's orders. The form is portable, that is, it goes with the patient to hospital, rehabilitation assisted living, and back home. It is honored by doctors, nurses, and emergency medical service personnel. MOLST orders do not expire. Because MOLST goes with the patient and is valid wherever the patient goes, MOLST orders are said to continue "across the continuum of care." By law, a copy or the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.<sup>27</sup>

**We have explained the principles which guide medical decisions.**

**Here are further suggestions we would offer regarding MOLST:**

- The MOLST form clearly states that the orders it contains are the result of the informed consent of the patient, agent, or surrogate or are based on the instruction in the patient's advance directives. However, since patients do not sign MOLST or other physician's orders, care should be taken to be sure that decisions it contains accurately embody the moral principles outlined in this pastoral letter, especially as it regards emergency resuscitation (section 1), ventilation (sec. 2) and medically-assisted nutrition and hydration (sec. 7). Remember, patients and agents must be given a copy of MOLST within 48 hours or sooner if the patient is discharged or transferred.
- Since these orders endure, and because they use a "check box format," review of these orders may be especially important to be sure that what they order corresponds to the patient's actual condition and to the morally-appropriate assessment of the benefit and burden of life-sustaining treatments. Sustaining one's life, even for a short time, may be of great value. The refusal or withdrawing of life support may be ethically appropriate. In every case, the specific condition of the patient must be the starting point of moral deliberation.
- MOLST is new. Experience will help us see how this form helps patients and their care providers in putting moral decisions into practice across the continuum of care. MOLST is not an advance directive, but it does direct life-sustaining care. As such, it must be used with attention to the sanctity of life and always respect the conscience of patients and care providers alike. Patients and their agents are best served by having a conversation about their health care and especially care at the end of life, and by documenting that conversation with the **Catholic Declaration for Health Care Decision Making** found at the end of this letter. This can then be included as supporting documentation in the patient's medical records and guide the treatment decisions in the MOLST form.

# CONCLUSION

## A Catholic Vision for End of Life

We bishops offer these reflections at a time when all of us are strongly challenged to witness to the worth and dignity of human life.

**W**e believe our pastoral concern is best expressed by offering compassionate guidance for decision-making in keeping with the wise and loving teaching of the Church. We are convinced that this teaching reflects the wisdom and love of God, the Author and loving Sustainer of all life.



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**“Set your minds on things that are above,  
not on the things that are on the earth.  
For you have died, and your life is hidden with  
Christ in God.”**

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As believers, we do not deny the reality of suffering or despair at the approach of death. Faith in Christ eases the pain of human separation and anxiety over our mortality. For we are daily challenged to listen to the words of St. Paul: “Set your minds on things that are above, not on the things that are on the earth. For you have died, and your life is hidden with Christ in God” (*Colossians 3:2-3*). “We would not have you ignorant, brethren, concerning those who are asleep, that you may not grieve as others do who have no hope. For since we believe that Jesus died and rose again, even so, through Jesus, God will bring with him those who have fallen asleep. ... and so we shall always be with the Lord. Therefore comfort one another with these words” (*1 Thessalonians 4:13-14*). We know that Jesus, the Bridegroom, is coming for each of us at the hour of His choosing. We await and prepare for His arrival, not in fear, but full of expectant hope.

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**We are confident that at His gentle approach every tear will be wiped away by the One who has conquered sin and death and made us heirs to eternal glory.**

Most Rev. William E. Lori, *Archbishop of Baltimore, Chairman*  
His Eminence Donald Cardinal Wuerl, *Archbishop of Washington*  
Most Rev. W. Francis Malooly, *Bishop of Wilmington*  
Most Rev. Martin D. Holley, *Auxiliary Bishop of Washington*  
Most Rev. Barry C. Knestout, *Auxiliary Bishop of Washington*  
Most Rev. Denis J. Madden, *Auxiliary Bishop of Baltimore*

November 2014



## Endnotes

- 1 See the New York Catholic Conference document, "Now and At the Hour of Our Death" (2011). <http://www.nyscatholic.org/wp-content/uploads/2011/11/End-of-Life-booklet-final.pdf>.
- 2 The Maryland Attorney General has posted the text of the law and a summary along with other materials. <http://www.oag.state.md.us/Healthpol/HCDAsummary.pdf>.
- 3 See the US Bishops' policy statement, "To Live Each Day with Dignity" (2011) on Physician-assisted Suicide. <http://www.usccb.org/issues-and-action/human-life-and-dignity/assisted-suicide/to-live-each-day/>.
- 4 Msgr. Javier Lozano, President of the Pontifical Council for Pastoral Assistance to Health Care Workers, offers 20 Gospel accounts of the healing miracles of Jesus, with commentary, at the website of the Pontifical Council: [http://www.vatican.va/roman\\_curia/pontifical\\_councils/hlthwork/documents/rc\\_pc\\_hlthwork\\_doc\\_23041997\\_gospel\\_en.html](http://www.vatican.va/roman_curia/pontifical_councils/hlthwork/documents/rc_pc_hlthwork_doc_23041997_gospel_en.html).
- 5 Preface for Easter I.
- 6 *Evangelium Vitae* (The Gospel of Life), encyclical of Saint John Paul II, 1995, no. 7. [http://www.vatican.va/holy\\_father/john\\_paul\\_ii/encyclicals/documents/hf\\_jp-ii\\_enc\\_25031995\\_evangelium-vitae\\_en.html](http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html).
- 7 *Evangelium Vitae* (The Gospel of Life), no. 54. [http://www.vatican.va/holy\\_father/john\\_paul\\_ii/encyclicals/documents/hf\\_jp-ii\\_enc\\_25031995\\_evangelium-vitae\\_en.html](http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html).
- 8 See *The Catechism of the Catholic Church*, nos. 2258, 356. Congregation for the Doctrine of the Faith (CDF), *Declaration on Procured Abortion* (1974), no. 11.
- 9 *Evangelium Vitae* (The Gospel of Life), nos. 64-65. [http://www.vatican.va/holy\\_father/john\\_paul\\_ii/encyclicals/documents/hf\\_jp-ii\\_enc\\_25031995\\_evangelium-vitae\\_en.html](http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html).
- 10 Throughout this pastoral statement, case examples are cited in the interest of making concrete the principles enunciated here. However, the solutions given in these cases are not meant to be followed by everyone in similar situations; they are merely meant to illustrate the legitimate application of the principles in a particular set of circumstances. In a case dealing with medical ethics, we must first have moral certitude about the facts of the case. We must then make certain that we have done every good thing we are required to do. We must carefully and completely avoid intrinsically evil actions such as suicide or euthanasia. Beyond these considerations lies a rather large area of actions that may be taken, but that are not required in all particular cases. It is within this realm of options that many of the cases of which we speak are decided.
- 11 USCCB, Ethical and Religious Directives for Catholic Health Care Services (ERD) (2009) # 56-57. <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf>.
- 12 (CCC 1701 ff.).
- 13 *Evangelium Vitae* (The Gospel of Life), no. 65. [http://www.vatican.va/holy\\_father/john\\_paul\\_ii/encyclicals/documents/hf\\_jp-ii\\_enc\\_25031995\\_evangelium-vitae\\_en.html](http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html).
- 14 *Evangelium Vitae* (The Gospel of Life), no. 67. [http://www.vatican.va/holy\\_father/john\\_paul\\_ii/encyclicals/documents/hf\\_jp-ii\\_enc\\_25031995\\_evangelium-vitae\\_en.html](http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html).
- 15 See, ERD.
- 16 See, ERD, Introduction, #60-61:
- 17 *Evangelium Vitae* (The Gospel of Life), no. 65.
- 18 See CDF commentary on nutrition and hydration of patients in the "vegetative state." [http://www.vatican.va/roman\\_curia/congregations/cfaith/documents/rc\\_con\\_cfaith\\_doc\\_20070801\\_nota-commento\\_en.html](http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_nota-commento_en.html).
- 19 See CDF, Declaration on Euthanasia, Part IV (1980) and the CDF commentary on its 2005 response to the US Bishops regarding nutrition and hydration and the PVS state. [http://www.vatican.va/roman\\_curia/congregations/cfaith/documents/rc\\_con\\_cfaith\\_doc\\_20070801\\_nota-commento\\_en.html](http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_nota-commento_en.html).
- 20 See the Maryland Attorney General's, "Definition of Medical Conditions Specified in the Act." <http://www.oag.state.md.us/Healthpol/HCDAsummary.pdf>.
- 21 The CDF notes "Nor is the possibility excluded that, due to emerging complications, a patient may be unable to assimilate food and liquids, so that their provision becomes altogether useless. Finally, the possibility is not absolutely excluded that, in some rare cases, artificial nourishment and hydration may be excessively burdensome for the patient or may cause significant physical discomfort, for example resulting from complications in the use of the means employed." [http://www.vatican.va/roman\\_curia/congregations/cfaith/documents/rc\\_con\\_cfaith\\_doc\\_20070801\\_nota-commento\\_en.html](http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_nota-commento_en.html).
- 22 See ERD # 58. "For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort.
- 23 CDF, "Commentary" on Responses To Certain Questions Of The United States Conference Of Catholic Bishops Concerning Artificial Nutrition And Hydration (2007). [http://www.vatican.va/roman\\_curia/congregations/cfaith/documents/rc\\_con\\_cfaith\\_doc\\_20070801\\_nota-commento\\_en.html](http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_nota-commento_en.html).
- 24 ERD, #58. <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf>.
- 25 Declaration on Euthanasia, Part IV.
- 26 Annotated Code of Maryland, Health-General Article Sections 5-601 through 5-618.
- 27 Maryland MOLST: <http://marylandmolst.org/>;  
The form itself is found here: <http://marylandmolst.org/docs/MOLST%20MM3%202013%20FINAL%20PROPOSED%2072613%20POSTED%2021714.pdf> .  
See also Maryland Institute for Emergency Medical Systems Services: <http://www.miemss.org/home/publicinformation/dnrdonotresuscitate/tabid/118/default.aspx>.

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**We are  
all masterpieces of  
God's creation.**

Pope Francis, July 7, 2013

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# DECLARATION

On the following pages is the **Catholic Declaration for Health Care Decision Making**. It is an advance directive through which you can appoint a health care agent and express your wishes for spiritual support, medical care and treatment, pain-relieving medication and, should you be unable to take food or drink orally, medically-assisted nutrition and hydration.

This *Declaration* has been prepared in light of the preceding pastoral letter by the bishops serving Maryland, *Comfort and Consolation*, and also in light of Maryland law, the Maryland Health Care Decisions Act.

- Read the *Declaration* carefully.
- Discuss your wishes with a person you would like to appoint as a health care agent and others whom you would consider appointing as alternate health care agents.
- Fill out the *Declaration*, but do not sign it yet.
- Ask two people to be your witnesses when you will sign the *Declaration*; Maryland law requires this. Maryland law does not require that you have the *Declaration* notarized. If you are planning to travel to other states, however, it is recommended that you have the *Declaration* notarized.
- After you have filled out the *Declaration* but before you sign or have it witnessed, you may want to make a number of copies for your health care providers and the facilities to which they might refer you for treatment. Remember, you may need to present the *Declaration* to several hospitals, health care, or living facilities.
- Sign each copy as an original and have each witnessed in front of a notary.

# Catholic Declaration for Health Care Decision Making

## Instructions for My Health Care

My Catholic faith teaches that human life is a precious gift from God. We are not its owners but its guardians. No one must ever presume to adopt a course of action or inaction that is intended to hasten my death, even if the motive is to alleviate my suffering. Having thought seriously about my beliefs and the principles that the Catholic Church teaches about end-of-life decision-making, I have set down the following instructions for my care for those who must make decisions for me should I become incompetent — that is, unable to make these decisions for myself. I have executed this document and intend to revoke any earlier health care directive or living will that I may have executed. I retain the right to revoke this document.

## Spiritual Support

I request that my family, parish community, and friends support me through prayer and sacrifice and that the sacraments of the Church be made available to me as I prepare for death or face serious illness. I wish to see a Roman Catholic priest and receive the Sacrament of the Sick (formerly called the “last rites”), as well as Confession and Communion.

## Medical Care and Treatment

I wish to receive medical care and treatment appropriate to my condition as long as it is useful and offers a reasonable hope of benefit and is not excessively burdensome to me — that is, does not impose serious risk, excessive pain, prohibitive cost, or some other extreme burden. I oppose any act or omission that of itself or by intention will cause my death, even for the purpose of eliminating suffering. I direct that all decisions about my medical treatment and care be made in accord with Catholic moral teachings as contained in such documents as:

- *Care for Patients in a “Permanent” Vegetative State* (Saint John Paul II, March 20, 2004),
- *Declaration on Euthanasia* (Congregation for the Doctrine of the Faith, 1980), and
- *Ethical and Religious Directives for Catholic Health Care Services*, (U.S. Conference of Catholic Bishops, edition current at the time decisions are being made.)

### **Food and Fluids (nutrition and hydration)**

If I am unable (even with assistance) to take food and drink orally, I desire that medically-assisted nutrition and hydration (MANH) be provided to me so long as it is capable of sustaining my life. Even if I am in a persistent vegetative state, MANH should be continued. MANH should be discontinued if it is futile (no longer able to sustain my life). MANH should be discontinued if it imposes excessive burdens to me (serious risk, excessive pain, prohibitive cost, or some other extreme burden). MANH should be discontinued if death is both inevitable and so imminent that continuing MANH is judged futile.

### **Pain Relieving Medication**

If my condition includes physical pain, I wish to receive pain-relieving medication in dosages sufficient to manage the pain, even if such dosages make me less alert or responsive, and even if managing my pain in this way is likely to shorten my life. No pain medication should be given to me for the purpose of hastening my death.

### **Imminent Death from Terminal Illness**

If my death from a terminal illness is near at hand, I wish to refuse treatment that would only secure a precarious and burdensome prolongation of my life, so long as the ordinary care due me is continued.

### **Pregnancy**

If I am pregnant, I wish every means to be taken to preserve and nurture the life of my unborn child, including the continuation of life-sustaining procedures.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_

Witness \_\_\_\_\_

**Note:** *Your appointed health care agent(s) may not serve as a witness to your declaration. One witness may not be someone who will benefit from your death.*

## Appointment of My Health Care Agent

I, \_\_\_\_\_ hereby designate and appoint

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_

Witness \_\_\_\_\_

as my health care agent to make health care decisions for me should I be diagnosed as comatose, incompetent, or otherwise mentally or physically incapable of communication. My agent must not be an owner, operator, or employee of a health care facility from which I am receiving health care, or an immediate relative of such facility's owner, operator, or employee. My agent is to make decisions for me only for the duration of my incompetency. I have carefully discussed my preferences for medical treatment with the above-named agent and I direct my agent to choose on my behalf the appropriate course of treatment or non-treatment that is consistent with the preceding "Instructions for My Health Care." I charge my agent and all those attending me neither to approve nor commit any action or omission which by intent will cause my death. In all decisions regarding my health care, I instruct my agent to act in accordance with Catholic teaching. Notwithstanding the foregoing or any other provision in this document, I do not intend that any person other than my agent have the right to intervene in decisions about my health care, including initiating or joining in any court proceeding.

If the person named as my agent is not available or is unable to act as my health care agent, I appoint the following person(s) to act on my behalf.

**Alternate Agent 1**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home: \_\_\_\_\_

Cell: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_

Witness \_\_\_\_\_

**Alternate Agent 2**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home: \_\_\_\_\_

Cell: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_

Witness \_\_\_\_\_

**Note:** *Your appointed health care agent(s) may not serve as a witness to your declaration. One witness may not be someone who will benefit from your death.*

## Authorization and Consent Under HIPAA

This advance directive is my direct authorization and consent under the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, and its regulations. I waive all rights to privacy under all federal and state laws and designate my agent as my personal representative under HIPAA, for the purpose of requesting, receiving, using, disclosing, amending, or otherwise having access to my personal, individually identifiable health information. I authorize any health care provider to release to my agent or to any person designated by my agent, all medical records of whatever nature, mental health records, billing statements, radiological films, pathology material, photographs, videos, and other information about me. This advance directive also authorizes any health care provider to speak to and disclose orally, to my agent and any person designated by my agent, any information about my diagnosis, care, treatment, prognosis, and opinions about me. It is my express intention that, to the greatest extent permitted by law, the authorization and consent provided herein will be effective for so long as this advance directive is effective.

## Optional Notarization

(Notarization is not required by Maryland, but is recommended for those who travel to other states. It may be prudent, after you have filled out the *Declaration* but before you sign it and have it witnessed by two persons, to make a number of copies for several hospitals or health care facilities. Then sign each of them as an original and have each witnessed in front of a notary.)

Sworn and subscribed to me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

My term expires: \_\_\_\_\_ (Notary)







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Whether death comes unexpectedly or at the end of a long and full life, it is important for us to consider not only the spiritual dimension of death, but to think in a very practical way about how we would want the circumstances of our death to reflect our deepest beliefs.

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