INTRODUCTION:
CATHOLIC DECLARATION FOR HEALTH CARE DECISION MAKING

The **Catholic Declaration for Health Care Decision Making** that follows 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 pastoral letter by the bishops serving Maryland, *Comfort and Consolation*, and in light of Maryland law, the Maryland Health Care Decisions Act.

How to use this document:

- Read the Declaration carefully.
- Pray about and talk with others about your wishes - with your health care agent, family, physician, parish priest.
- Fill out the Declaration.
- Sign in the presence of two witnesses who are not your health care agent (and one of whom is not a blood relative and will not benefit from your death) OR sign in front of a notary.
- Give copies to your doctor, health care agent, and family members. Copies are just as valid as the original.
- Keep one accessible (e.g., in the kitchen, on the fridge) in case paramedics need it or you take a trip to the hospital.

Note: You can revoke an old directive by executing a new advance directive, destroying or writing "void" on the old form, or saying you revoke it either in writing or orally to a health care practitioner.

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)

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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: _____

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(s)

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.

State of Maryland

County of _____ (or City of Baltimore), to wit:

On this _____ day of _____, 20_____, before me the undersigned officer, personally appeared

_____ (name of person who makes acknowledgement), known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledged that he/she executed the same for the purpose therein contained.

In witness whereof, I hereunto set my hand and official seal.

Sworn and subscribed to me this _____ day of _____, 20_____

[Notary Seal]

_____

Signature of Notary Public

_____

Printed name of Notary Public

_____

My commission expires on