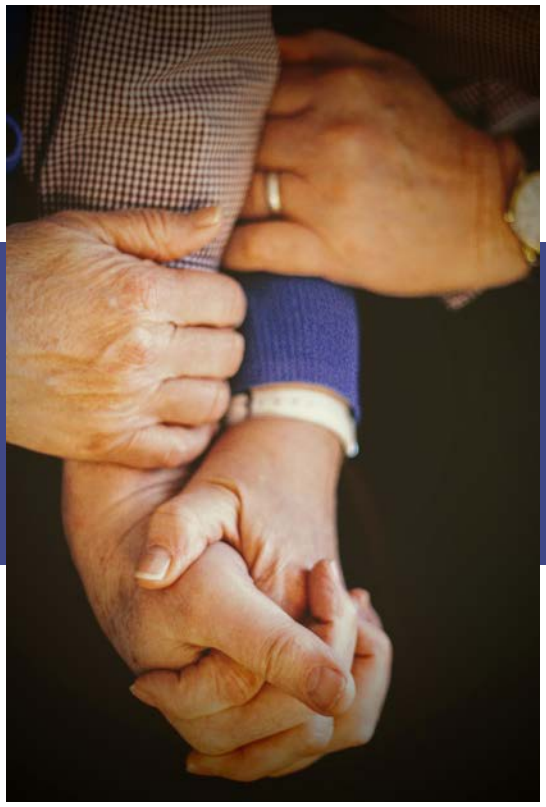
Three Beliefs

A Guide for New Hampshire Catholics on End-of-Life Decisions



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OFFICE OF THE BISHOP
DIOCESE OF MANCHESTER

April 2022

Dear Brothers and Sisters:

This guide which you now hold: *Three Beliefs: A Guide for New Hampshire Catholics on End-of-Life Decisions*, has been very carefully researched, edited and written with the utmost attention to authentic Catholic teaching in order to present to our Catholic people and, in fact, to all people who find themselves at this crossroads and unable to respond to the question, "What should I do?" or "What is too much?" or for the most intimate of all questions, "What does God expect of me in my particular circumstances?"

Sometimes we will have to make decisions for others, and this is probably the most heart-wrenching. Sometimes we find ourselves wondering what we would do or what we want others to do for us when the time comes. This may not be as emotionally charged as being responsible for someone else, but it is of no less magnitude and importance. As our life must end in this world, the Lord Himself, "just judge as He is," as St. Paul says, entrusts His grace to us throughout our life to prepare us well for our earthly death and our soul's going forth to Him.

Part of responding to God's grace in this life is the care we give to our body, our soul and our mind. Our body may be able to respond to care, but eventually its strength and resilience gives way. Our soul, created in the image and likeness of God, gives dignity and responsiveness to the body, and is by its nature always seeking union with its Divine Creator. At death the soul leaves the body and, as it were, makes its way toward God, seeking, perhaps even more eagerly, that blessed union. As long as it has the capacity, our mind wonders and can absorb an understanding response of faith, hope and love as a prelude to the soul's going forth.

None of us can say from experience what that perfect transition from life to Life will be, and so we search the Sacred Scriptures (the Bible) and we turn to the wisdom of those faithful Christian men and women whose experiences with life in the face of death have left us the reliable teaching and application of words of the Bible to this most holy experience of preparation.

Here, then, is the fruit of our prayer, research, editing, writing and presentation of the Church's teaching. We hope that you will find it enlightening. We pray that it will help you, as a guide would, to find the right path and be able to attend to the signs along the way.

Faithfully yours in Christ,

+Peter A. Libasci

Most Reverend Peter A. Libasci
Bishop of Manchester

"There are, in the end, three things that last: Faith, Hope and Love; and the greatest of these is Love" *(1Corinthians 13:13)*

Introduction

How much medical treatment or care is enough? · Is it ever right to stop medical treatment or care if that means the patient will die? · Who can make decisions for me if I am not able to make them for myself?

As Catholics trying to answer these questions, we are fortunate that we can turn to our Catholic faith tradition, which is the fruit of more than two thousand years of experience and prayerful reflection. Difficult questions must not be allowed to overshadow moments in our dying process that should be filled with grace and hope.

Thus, we have developed this Guide to help New Hampshire Catholics make their own wise decisions about end-of-life health care. We hope this booklet will help you think about the instructions that you want to give the people who will be responsible for your health care if there ever comes a time when you cannot make your own health care decisions. Difficult decisions about care at the end of life will be easier to make if we take the time to express our wishes while we can.

Part One:

What the Catholic Church Teaches About End-Of-Life Decisions

Three basic Catholic beliefs are the foundation for how we think about end-of-life decisions.

1 **Each one of us has been created in the image and likeness of God.** This gives each human being a priceless dignity, value, and purpose in life. It is why we are called to respect and protect human life and to care for the gift of life that has been entrusted to us, for the glory of God.

None of us lives for oneself, and no one dies for oneself. For if we live, we live for the Lord, and if we die, we die for the Lord; so then, whether we live or die, we are the Lord's. For this is why Christ died and came to life, that he might be Lord of both the dead and the living. (St. Paul's Letter to the Romans, 14:7-9)

2 **Caring for this gift of life means that we should avoid the opposite extremes of the deliberate hastening of death on the one hand, and the overzealous use of treatment or care to artificially extend life and prolong the dying process on the other.**

So we are always courageous, although we know that while we are at home in the body we are away from the Lord, for we walk by faith, not by sight. Yet we are courageous, and we would rather leave the body and go home to the Lord. Therefore, we aspire to please Him whether we are at home or away. (St. Paul's 2nd Letter to the Corinthians, 5:6-9)

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

Now I rejoice in my sufferings for your sake, and in my flesh I am filling up what is lacking in the afflictions of Christ on behalf of His body, the Church. (St. Paul's Letter to the Colossians, 1:24)

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

How Much Medical Treatment or Care is Enough?

Is it ever acceptable to withhold or stop medical treatment, even if that means the person will die? This is one of the most common questions that people face when they are making end-of-life decisions. The Church's teaching on this question revolves around the difference between two ways of thinking about life-sustaining treatment and care: **"ordinary medical means"** (sometimes referred to as "proportionate means") and **"extraordinary medical means"** (sometimes referred to "disproportionate means"). (Although these terms may appear technical, "means" is just another word for the way that something is done.)

Ordinary (or proportionate) means are forms of treatment or care that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community. From a Catholic perspective, this includes various forms of care that may be judged ordinary for a particular patient even when death is near. **Out of deep respect for the gift of life, others must provide us with, and we must always accept, ordinary means of preserving life.**

Extraordinary (or disproportionate) means are forms of treatment or care that in the patient's judgment do not offer a reasonable hope of benefit or that entail an excessive burden or impose excessive expense on the family or the community. **Catholics are not morally bound to use "extraordinary means" of medical care and are not bound to prolong the dying process by using every medical treatment available.** Allowing natural death to occur is not the same as killing a patient.

There is no list that classifies some treatments as ordinary and others as extraordinary. The decision about how to classify any form of care depends on the unique conditions and circumstances of that particular patient at that particular point in time. There are various factors to consider when making that decision.

In deciding whether to think of a treatment or form of care as ordinary or extraordinary means, there are general factors to consider.

A treatment might be considered as an ordinary means of care (and thus be morally required) if it:

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

A treatment might be considered an extraordinary means of care (and thus be morally optional) if it:

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

Example: *A person who is expected to make a good recovery from major surgery and is on a ventilator may need to continue to be on the ventilator for a few days in order to be restored to full health. In consideration of these and other circumstances of the patient's condition, the ventilator may be judged to be ordinary and therefore morally required. That same ventilator treatment can be seen in a very different light, however, when it is being used for a patient in the final stages of lung cancer, where the treatment may have no reasonable hope of benefit or is excessively burdensome and where it will simply prolong the patient's process of dying. In such a circumstance, the ventilator may be judged to be extraordinary care and the patient morally might decide to decline that treatment.*

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

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

These questions are as important as any that we will ever come across in our lives, and they will rarely be easy to answer. Weighing the burdens and benefits of a particular medical treatment or form of care requires each person to be prudent and thoughtful in order to choose the right path. This decision affects our spiritual health as well as our physical health. Thus, Catholics may wish to seek guidance from a person with knowledge of Catholic teaching on these types of matters, such as a pastor or hospital chaplain.

Is it Ever Permissible to Stop Giving a Person Food and Water?

Is it morally required that food and water in the form of medically assisted nutrition and hydration ("MANH") through a feeding tube be used in all circumstances when a person cannot swallow?

Food and water are two of the most basic forms of care that we can provide to anyone, especially someone who is sick. Thus, in principle there is an obligation to use MANH. As with other forms

of health care, though, this general obligation needs to be assessed in relation to the particular circumstances of each patient. If MANH has a reasonable hope of benefit for a person and will not pose an excessive burden, then MANH is an ordinary means of treatment and is morally required. But if MANH is excessively burdensome or has no reasonable hope of benefit, then it may be considered to be an extraordinary means of care and thus not be morally required.

What are the circumstances under which medically assisted nutrition and hydration may be considered excessively burdensome or have no reasonable hope of benefit? The most common example of this is when the patient enters into the dying process and the body can no longer properly assimilate food and water, even if given through a tube. When death is only days away, or when a feeding tube may cause unavoidable side effects such as severe agitation, physical discomfort, aspiration into the lungs, severe infection, or another excessive burden, any foreseeable benefits of maintaining the tube likely will be outweighed by the burdens imposed by the tube.

Sometimes it is suggested that MANH should be removed from a person who is deemed to be permanently unconscious in order to bring about that person's death. But the mere fact that a person has been deemed to be permanently unconscious cannot by itself be a reason to withdraw or withhold MANH. If MANH has a reasonable hope of sustaining the patient and does not pose an excessive burden, then MANH is morally required because even the most severely debilitated patients never lose their full dignity as human beings and are entitled to receive ordinary means of care. MANH may not be withheld from a person who is deemed to be permanently unconscious unless MANH is an extraordinary means of care.

Note that when MANH is withheld or withdrawn because it has become an extraordinary means of care, **death occurs as a result of the underlying illness, not as a result of starvation or dehydration.** In the Catholic view, it is never morally permissible to withhold or remove a feeding tube (or any other form of life-sustaining treatment or care) with the intention of ending the patient's life. And it is never morally permissible to stop or withhold any form of care or treatment based on a belief that the patient's life no longer holds value.

Assisted Suicide

Assisted suicide (or "euthanasia") is a grave evil. It is always morally wrong. **In the Catholic view, there is never a situation where it is right to either assist in someone else's suicide or to arrange for it on one's own behalf.**

Contrary to what its supporters claim, assisted suicide is not designed to end the suffering; it is designed to end the patient. God has called us to defend life and stand up for those who are weak or in need, not to cause the death of an innocent person deliberately and directly through what Pope Francis has called the "false compassion" of assisted suicide.

In the face of suffering or advancing years or discussions about quality of life, the Christian demonstrates true compassion by helping one to see how much he or she matters to those who are standing strong with them and for them, reaffirming the truth that they matter, and inspiring and supporting the self-confidence that is bolstered by hope and faith.

A small number of states have passed laws legalizing assisted suicide. But that does not make assisted suicide *morally* right, even in those states. Assisted suicide laws normalize suicide, and they send

the dangerous message that the state approves of suicide in certain cases – a message that obviously undermines efforts to prevent suicide, especially among at-risk groups like young people, first responders, and veterans with traumatic brain injury. In the end, assisted suicide laws inevitably victimize the most vulnerable of our sisters and brothers – the poor, the elderly, and individuals with disabilities.

There is a better approach – what Pope John Paul II called "the way of love and true mercy." This is a readiness to surround patients with love, support, and companionship, and to provide the assistance needed to ease physical, emotional, and spiritual suffering. As Pope Francis said in his 2017 *Message to Participants in the Regional Meeting of the World Medical Association:* "The categorical imperative is to never abandon the sick."

Hospice and Palliative Care

One way of carrying out that "way of love and true mercy" is palliative care, including what is known as hospice care. Palliative care is a philosophy of care that prevents and relieves suffering and attends to the emotional as well as spiritual needs of patients. "Palliative care, which is proving most important in our culture... opposes what makes death most terrifying and unwelcome—pain and loneliness." Pope Francis, *Message to Participants in the Regional Meeting of World Medical Association,* November 7, 2017. It is something that should be made available for all patients with any serious illness, but for those diagnosed with a terminal illness, effective palliative care is especially important because it allows patients to devote their attention to the unfinished business of their lives and to arrive at a sense of peace with God, with loved ones, and with themselves.

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

Further Resources

The following resources may provide additional helpful information.

Please visit catholicnh.org/threebeliefs for these documents and additional resources.

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

Part Two:

Planning in Advance: Legal Options in New Hampshire

The Durable Power of Attorney for Health Care in New Hampshire

Some of us may reach the point where we are unable to make medical decisions for ourselves. But we do have the ability to plan in advance to ensure that our religious beliefs and our wishes about medical treatments or care are known and honored by the people who will be responsible for our care. New Hampshire law allows these wishes to be put into documents called **"advance directives."** The section of the New Hampshire statutes that creates the rules for these advance directives is RSA 137-J, which can be found online at catholicnh.org/threebeliefs.

Advance directives are legal documents that do not take effect until a person becomes incapacitated and incapable of making his or her own health care decisions. There are two types of advance directives. One is called a **"living will."** In a living will, a person gives specific instructions for care when the individual is not capable of making health care decisions. **We recommend that Catholics NOT use living wills**, because a living will is inflexible and does not allow the opportunity to reflect later advances in medicine or the changing circumstances that may arise in connection with an illness that may appear many years in the future. Health care professionals also may have problems interpreting a living will if the living will is not clearly written.

The other type of advance directive is called a **"durable power of attorney for health care"** (or DPAHC). **This is the form of advance directive we recommend**, because the DPAHC is a more flexible and useful way to ensure that someone will direct your health care in accordance with your wishes. With a DPAHC, a person (called the "Principal") gives someone else the authority to act on his or her behalf when the Principal is not capable of making those decisions (the person who receives the authority is called the "Health Agent"). The document can also include specific instructions about the kind of care the Principal wants or does not want, including if and when life-sustaining treatment or care should be provided.

Choosing a Health Care Agent

The person you choose as your Health Care Agent under a DPAHC will have the power to make health care decisions on your behalf when you are no longer able to do so. This Health Care Agent can make all decisions that you would be able to make if you were competent to do so, including decisions about withholding or withdrawing life-sustaining treatment or care. It is important, then, that you choose as your Agent a person who will advocate for the sort of health care that is consistent with your moral and religious beliefs. Your Agent should be someone who knows you well, cares deeply about you, is familiar with your religious beliefs, can understand medical information, operates well under stressful conditions, and who will be sure that end-of-life decisions made on your behalf are made in accordance with the Church's teachings. You should have periodic conversations with your Agent about your preferences while you are healthy and competent, because the Agent will be interpreting your wishes as medical circumstances change and the Agent could be called upon to make decisions that you may not have predicted.

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

The DPAHC form we have included in this Guide is consistent with Catholic teaching on end-of-life issues and with New Hampshire laws concerning advance directives. We have used the draft advance directive template that is found in the New Hampshire statute (RSA 137-J) and included instructions that are reflective of Catholic teachings. **Note that the form we have prepared intentionally omits the Living Will option that is contained in RSA 137-J because of the problems with Living Wills as discussed above.**

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

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

Surrogate Decision-Makers

If you become incapacitated and you do not have a valid advance directive or a court-ordered guardian, New Hampshire law allows health care providers to look to certain people (called "surrogate decision-makers") who can make health care decisions for you.

The law creates a ranking of people who may be named as a surrogate:

- The patient's spouse, civil union partner, or common law spouse unless there is a divorce proceeding, separation agreement, or restraining order limiting that person's relationship with the patient;
- Any adult son or daughter of the patient;
- Either parent of the patient;
- Any adult brother or sister of the patient;
- Any adult grandchild of the patient;
- Any adult aunt, uncle, niece, or nephew of the patient;
- A close friend of the patient;
- The Agent with financial power of attorney or an appointed conservator; and
- The guardian of the patient's estate.

A surrogate must make health care decisions in accordance with your best interests and wishes, including your religious and moral beliefs, provided that these wishes are known. If they are not known, the surrogate can act in accordance with his or her assessment of your best interests and in accordance with accepted medical practice.

You should not think of the surrogacy law as a useful alternative to an advance directive, however. **The best way to ensure that your preferences, moral values, and religious beliefs will be followed as you near the end of life is to name as Health Care Agent someone you are confident will be able to oversee your care in accordance with written instructions from you under a Durable Power of Attorney for Health Care.**

Do Not Resuscitate (DNR) Orders

A "do not resuscitate" (DNR) order is a medical order that instructs medical personnel not to attempt CPR if a patient's heartbeat or breathing stops or is about to stop.

CPR should be thought of in the same way as any other type of life-sustaining treatment. If it is judged that CPR will not have any reasonable hope of benefit or that it will be an excessive burden, then a DNR order is morally justified. For example, for a frail, elderly, sick individual or for a terminally ill patient, signing a DNR order may be a morally appropriate thing to do if it is prudently judged that CPR will not have any reasonable hope of benefit or will be an excessive burden. In contrast, for a patient who is not terminally ill, successful CPR may constitute a form of ordinary care which allows an individual to resume his or her previous lifestyle.

POLST

A POLST (Provider Order for Life-Sustaining Treatment) is a form that converts a person's end-of-life treatment preferences into immediately actionable medical orders signed by a physician or advanced practice registered nurse (APRN). A POLST extends beyond the decision to use or not use CPR and also might address other life-sustaining measures such as the administration of antibiotics and medically assisted nutrition and hydration. POLSTs are intended for persons who are near the end of their lives; indeed, they were developed specifically for use by patients whose life expectancy is one year or less (the Catholic Church recommends life expectancy of less than 6 months). For these patients, the form can be a useful and morally appropriate tool to use.

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

Part Three:

Frequently Asked Questions

- **What is meant by "ordinary means" of care?**

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

- **What is meant by "extraordinary means" of care?**

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

- **If I signed an advance directive prior to 2007 when the New Hampshire Advance Directive law took effect, or at any time after 2007 when the Advance Directive law was amended, do I need to execute a new advance directive?**

  No. If your advance directive was valid when it was executed, you do not need to complete a new advance directive form (RSA 137-J:16).

- **If I executed an advance directive in another state using a form different from the one used in New Hampshire, is that advance directive valid in New Hampshire?**

  If your advance directive is valid in the state where it was executed, it is considered valid in New Hampshire. Note, though, that no directive executed in another state can provide for anything that is illegal under New Hampshire law. (RSA 137-J:17).

- **What happens if I do not have an advance directive in place and I become incapacitated and cannot make my own medical decisions?**

  Your health care practitioner will try to determine if there is a relative or friend available who can serve as your health care surrogate and who can make health care decisions for you. The order by priority of those who may be chosen as a surrogate is found above on p. 12. You should not rely on the surrogacy law, however. Preparing a durable power of attorney for health care in advance is the best way to ensure that the health care decisions that are made *for* you are the same ones that would be made *by* you.

- **Are "do not resuscitate" (DNR) orders acceptable for Catholics?**

  Like all decisions about medical treatment or care, determining whether to execute a DNR order requires weighing whether CPR has a reasonable hope of benefit or will pose an excessive burden on the patient.

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

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

- **What does the Church say about organ donation?**

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

- **Who can I name as my Health Care Agent?**

  Your Health Care Agent can be an adult family member or any other adult person you wish, except that it cannot be your attending practitioner or a person that works directly for the practitioner, and it also

cannot be a nonrelative of yours who is an employee of your health care provider or residential care provider. You should consider appointing an alternate, who would serve as your Health Care Agent if the person that you designate is not available. You may also decide to appoint two or more Health Care Agents. However, if you designate more than one Health Care Agent, you should state whether the Agents are to act jointly or whether one Agent has the authority to make the decisions and the other is simply an alternate selection. Before you prepare your DPAHC, be sure to ask the people you are considering as Health Care Agents whether they would be willing to accept the appointments.

- **When does an advance directive take effect?**

  The advance directive does not take effect until a determination has been made by your attending health care practitioner that you lack the capacity to make health care decisions. At that point, it is the responsibility of your Health Care Agent to make a good faith effort to act in accordance with what your desires would be. The Agent will be able to draw on information such as the instructions you put in the advance directive, your advance conversations with the Agent, and your known religious and moral beliefs. If you regain your capacity to make health care decisions, the Agent's authority is terminated.

- **Can I change or revoke an advance directive once I have signed it?**

  Yes. Once you have signed an advance directive (whether a living will or durable power of attorney for health care), you can change or revoke it by various methods. The best way is to issue a new advance directive and note in the new one that the old one is revoked. If all you want to do is revoke the directive without issuing a new one, you can do that in writing, orally, or by destroying the old one (RSA 137-J:15).

- **From a Catholic perspective, is there any difference between withdrawing a form of care and not starting that care in the first place?**

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

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

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

- **The NH advance directive law passed in 2021 allows for Agents and surrogates to agree to the use of experimental treatments under certain circumstances. What does the Church say about experimental treatments?**

  The 2021 version of the advance directive law allows your Agent or surrogate to agree to the use of treatment that is considered experimental if you say in your advance directive that they can do that. If your advance directive does not say anything about experimental treatments, then your Agent or surrogate can agree to such treatments only under certain circumstances as laid out in RSA 137-J:5, IV-a. If you want to prohibit your Agent or surrogate from agreeing to the use of experimental treatments entirely, then you should add that instruction into the advance directive you sign (note that this is not addressed in the form advance directive attached to this *Three Beliefs* booklet, so you will need to insert that added instruction if you want to prohibit any experimental treatments).

  The Church considers experimental treatments to be permissible as long as the patient or the patient's Agent/surrogate first has given free and informed consent and the treatment does not violate Catholic moral teaching. In the case of nontherapeutic experimentation, the surrogate can give this consent only if the experiment entails no significant risk to the person's well-being. The greater the patient's incompetency and vulnerability, the greater the reasons must be to perform any medical experimentation, especially if it is nontherapeutic in nature.

- **After my advance directive goes into effect, what happens if I object to a treatment that I said should be done when I signed my advance directive?**

  An advance directive only takes effect when you become incapable of making your own health care decisions. Thus, something you say after an advance directive is in effect is not a reliable statement of your actual wishes – these are laid out in the advance directive which you executed when you *did* have the capacity to make health care decisions. The law says that in this type of circumstance the health care providers should go ahead with the treatment in accord with what the advance directive says, not what you say after you no longer have the capacity to make your own health care decisions. While you have the right to change this presumption by stating so in your advance directive, we recommend that you **not** do that because leaving it alone is the best way to ensure that your real wishes will be carried out.

- **I am interested in making plans for my Funeral Mass and in learning more about Catholic teaching on burial and cremation. Where can I get more information?**

  Visit catholicnh.org/funeral-rites for resources from the Diocese of Manchester on Catholic funeral rites as well as Church teaching on burial and cremation.

Part Four:

Donation of Organs

After death has been declared by either cardiopulmonary or by neurological criteria for death of the whole brain (including the brain stem), the donation of organs (for transplantation, medical education, or medical research consistent with Catholic teaching) is a charitable act and is entirely consistent with our obligation to be good stewards of the life that has been entrusted to us.

If you are interested in donating your organs, you may check one or both boxes below:

- ☐ I want my organs to be donated after I have been declared dead, either after my heart and lungs have irreversibly stopped functioning, or after my entire brain (including the brain stem) has irreversibly ceased to function determined by appropriate neurological criteria.
- ☐ If I have sustained an irreversible traumatic brain injury and all life-sustaining treatment and care is judged to be ethically disproportionate apart from my decision to donate organs, then:

  Medical preparations of my body may be made in anticipation of collecting my organs after I have been certainly declared dead by cardiopulmonary criteria, but no such preparations may be undertaken that will hasten my death.

Part Five:

A Durable Power of Attorney for Health Care for New Hampshire Catholics

The form that follows is drafted in accordance with the relevant provisions of the New Hampshire advance directive law (RSA 137-J) and is consistent with Catholic teaching. Please note that the form contains the text of the applicable New Hampshire law, and the language in bold has been added to assist those interested in executing an advance directive consistent with Catholic teaching. The form may be executed without making any changes other than to fill in the appropriate blanks. However, **it is essential that you review this entire document carefully and that you feel free to make any changes that you wish to make.** It is important that the final product be an accurate reflection of your wishes.

NEW HAMPSHIRE ADVANCE DIRECTIVE

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Name (Principal's Name): _____

DOB: _____

Address: _____

I. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

The durable power of attorney for health care form names your Agent(s) and, if you wish, sets limits on what your Agent can decide.

I choose the following person(s) as Agent(s) if I have lost capacity to make health care decisions (cannot make health care decisions for myself).

(If you choose more than one person, they will become your Agent in the order written, unless you indicate otherwise.)

A. Choosing Your Agent:

Agent: I appoint _____, of _____, and whose phone number is _____ to be my Agent to make health care decisions for me.

Alternate Agent: If the person above is not able, willing, or available, I appoint _____, of _____, and whose phone number is _____ to be my alternate Agent.

If no one listed above can make decisions for you, a surrogate will be assigned in the order written in law (spouse, adult child, parent, sibling, etc.), and will have the same powers as an Agent. If there is no surrogate, a court appointed guardian may be assigned.

B. Limiting Your Agent's Authority or Providing Additional Instructions

When you can no longer make your own health care decisions, your Agent will be able to make decisions for you. Please review the Disclosure Statement that is attached to this advance directive for examples of how you may want to advise your Agent. You may write in limits or additional instructions below or attach additional pages.

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

- **I want to receive all forms of treatment and care that have a reasonable hope of benefit for me AND which will not cause an excessive burden.**
- **I do not want any care or treatment that does not have a reasonable hope of benefit or constitutes an excessive burden.**
- **My Health Care Agent's judgment on these matters and any other matters addressed in this document should be made in light of** *Three Beliefs: A Guide for New Hampshire Catholics on End-of-Life Decisions***;** *the Catechism of the Catholic Church***;** *The Vatican Declaration on Euthanasia;* **and** *Ethical and Religious Directives for Catholic Health Care Services***, and as these documents may be revised.**
- **Even if my Health Care Agent judges that a particular form of treatment or care should be withheld or withdrawn, I still want to receive any other form of care or treatment already in use that does have a reasonable hope of benefit AND will not be an excessive burden.**
- **Even if all other forms of treatment or care are withheld or withdrawn, I still want all appropriate palliative care, including hospice care where appropriate.**
- **I want all appropriate pain medication to control pain even if, in the course of directly treating my pain, the medication indirectly hastens my death.**
- **If I am deemed to be permanently unconscious, I want medically administered nutrition and hydration until such time as my Health Care Agent judges that they no longer provide a reasonable hope of benefit or are excessively burdensome.**
- **I authorize my Health Care Agent to direct that a Do Not Resuscitate Order be put into effect if CPR will either have no reasonable hope of benefit or will be an excessive burden.**
- **I would like a visit from a priest, so that I may receive the Sacraments of the Church and so that my spiritual needs and those of my family can be addressed.**

10. I have intentionally declined to complete the Living Will section of the RSA 137-J New Hampshire Advance Directive form.

_____

_____

I have attached additional pages titled "Additional wishes for my Durable Power of Attorney for Health Care" to express my wishes.

II. LIVING WILL [This Living Will section is being intentionally omitted. My instructions to my Agent as set forth above under Section I ("Durable Power of Attorney for Health Care") fully express my wishes, and I want these wishes to govern decisions made by any Agent, surrogate, or health care provider.]

III. SIGNATURE

I have received, reviewed, and understood the disclosure statement, and I have completed the durable power of attorney for health care and/or living will consistent with my wishes. I have attached __ pages to better express my wishes.

Signed this ___ day of _____, 20___

Principal's Signature: _____

(If you are physically unable to sign, this advance directive may be signed by someone else writing your name in your physical presence at your direction.)

THIS ADVANCE DIRECTIVE MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC OR A JUSTICE OF THE PEACE.

We declare that the Principal appears to be of sound mind and free from duress at the time this advance directive is signed and that the Principal affirms that the Principal is aware of the nature of the directive and is signing it freely and voluntarily.

Witness: _____ Address (city/state): _____

Witness: _____ Address (city/state): _____

STATE OF NEW HAMPSHIRE

COUNTY OF _____

The foregoing advance directive was acknowledged before me this ___ day of _____, 20___, by _____ (the "Principal").

_____

Notary Public/Justice of the Peace

My commission expires:

DISCLOSURE STATEMENT FROM THE STATE OF NEW HAMPSHIRE

INFORMATION CONCERNING THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

AN ADVANCE DIRECTIVE IS A LEGAL DOCUMENT. YOU SHOULD KNOW THESE FACTS BEFORE SIGNING IT.

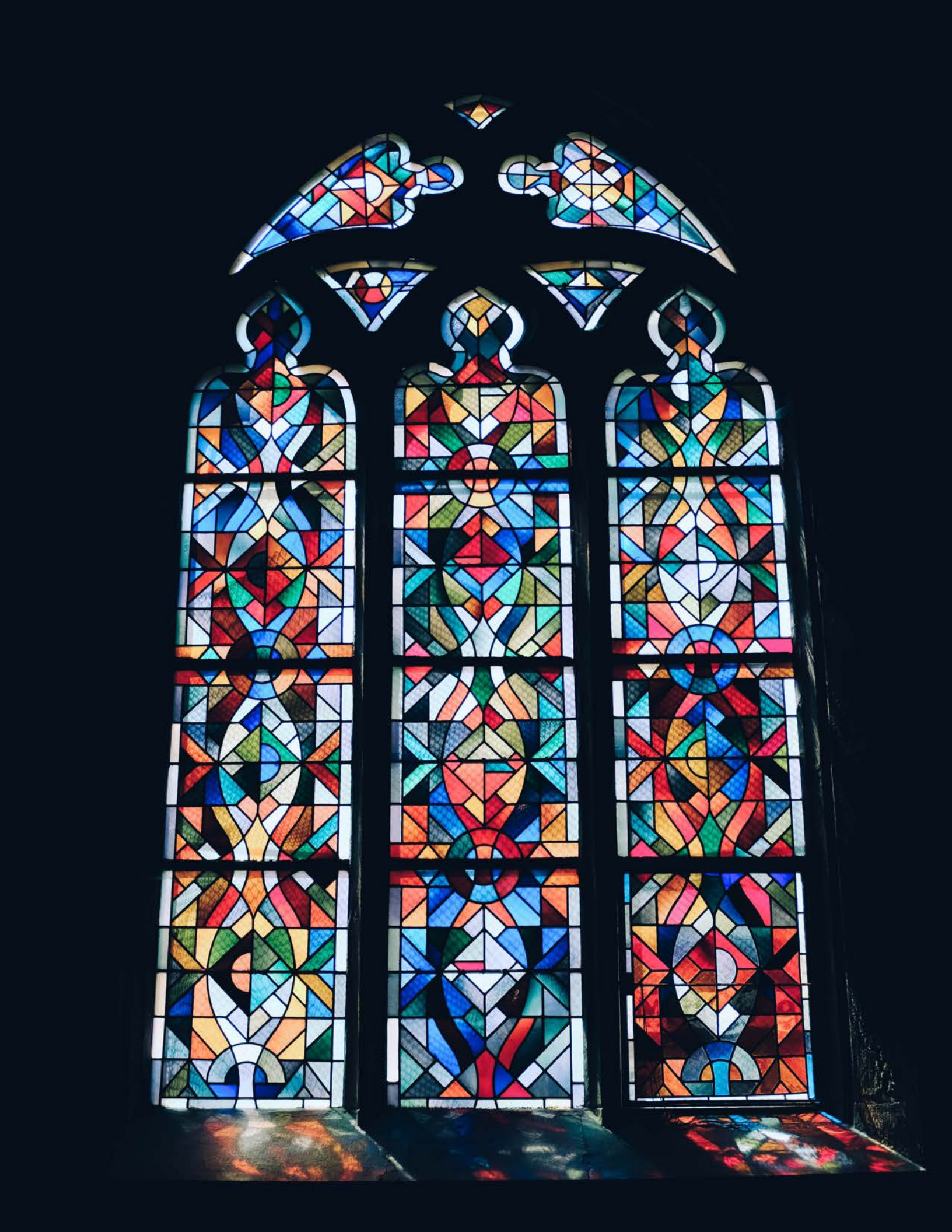
- This form allows you to choose who you want to make decisions about your health care when you cannot make decisions for yourself. This person is called your "Agent". You should consider choosing an alternate in case your Agent is unable to act.
- Agents must be 18 years old or older. They should be someone you know and trust. They cannot be anyone who is caring for you in a health care or residential care setting.
- This form is an "advance directive" that defines a way to make medical decisions in the future, when you are not able to make decisions for yourself. It is not a medical order [e.g., it is not in and of itself a DNR (do not resuscitate order or (POLST)].
- You will always make your own decisions until your medical practitioner examines you and certifies that you can no longer understand or make a decision for yourself. At that point, your "Agent" becomes the person who can make decisions for you. If you get better, you will make your own health care decisions again.
- With few exceptions(*), when you are unable to make your own medical decisions, your agent will make them for you, unless you limit your Agent's authority in Part I.B. of the durable power of attorney form. Your Agent can agree to start or stop medical treatment, including near the end of your life. Some people do not want to allow their agent to make some decisions. Examples of what you might write in include: "I do NOT want my Agent . . .
    - to ask for or agree to stop life-sustaining treatment [such as breathing machines, medically-administered nutrition and/or hydration (tube feeding), kidney dialysis, other mechanical devices, blood transfusions, and certain drugs]."
    - to ask for or to agree to a Do Not Resuscitate Order (DNR order)."
    - to agree to treatment even if I object to it in the moment, after I have lost the ability to make health care decisions for myself."
- The law allows your Agent to put you in a clinical trial (medical study) or to agree to new or experimental treatment that is meant to benefit you if you have a disease or condition that is immediately life-threatening or if untreated, may cause a serious disability or impairment (for example, new treatment for a pandemic infection that is not yet proven).

You may change this by writing in the durable power of attorney for health care form:

- *"I want my Agent to be able to agree to medical studies or experimental treatment in any situation."* **or**
- *"I don't want to participate in medical studies or experimental treatment even if the treatment may help me or I will likely die without it."*

- **Your Agent must try to make the best decisions for you, based on what you have said or written in the past. Tell your Agent that you have appointed them as your healthcare decision maker. Talk to your Agent about your wishes.**
- **In the "living will" section of the form, you can write down wishes, values, or goals as guidance for your Agent, surrogate, and/or medical practitioners in making decisions about your medical treatment.**
- **You do not need a lawyer to complete this form, but feel free to talk to a lawyer if you have questions about it.**
- **You must sign this form in the physical presence of 2 witnesses or a notary or justice of the peace for it to be valid. The witnesses cannot be your Agent, spouse, heir, or anyone named in your will, trust or who may otherwise receive your property at your death, or your attending medical practitioner or anyone who works directly under them. Only one witness can be employed by your health or residential care provider.**
- **Give copies of the completed form to your Agent, your medical providers, and your lawyer.**

* **Exceptions:** **Your Agent may not stop you from eating or drinking as you want. They also cannot agree to voluntary admission to a state institution; voluntary sterilization; withholding life-sustaining treatment if you are pregnant, unless it will severely harm you; or psychosurgery.**



Three Beliefs

Wallet Cards

Cut out card, fold and laminate for safe keeping

NOTICE TO HEALTH CARE PROVIDER

I have a Durable Power of Attorney for Health Care

The original signed document is located at:

_____

_____

_____

My Health Care Agent:

Name _____

Address _____

City, State, Zip _____

Phone _____

ADVANCED DIRECTIVE CARD

Name _____

Address _____

City _____

State, Zip _____

Phone _____

Signature _____

Cut out card, fold and laminate for safe keeping

NOTICE TO HEALTH CARE PROVIDER

I have a Durable Power of Attorney for Health Care

The original signed document is located at:

_____

_____

_____

My Health Care Agent:

Name _____

Address _____

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Phone _____

ADVANCED DIRECTIVE CARD

Name _____

Address _____

City _____

State, Zip _____

Phone _____

Signature _____

Diocese of Manchester | 153 Ash Street, Manchester, NH 03104 | 603.669.3100 | www.catholicnh.org/threebeliefs