Model Policy Concerning the Care to Patients at Life’s End for Catholic Health Care Agencies

Increasingly, patients, families, health care providers, and agency ethics committees are faced with difficult decisions in terms of end-of-life care. The federal government enacted the Patient Self-Determination Act of 1990 to enable patients to execute advance directives and to designate surrogate decision makers in the event that they are unable to communicate their wishes concerning health care interventions. There are times when patients’ wishes are unknown, and competing opinions of patients’ best interests exist. Judicial intervention, as in the case of Terri Schiavo, increasingly is being sought as an “ethical resolver” of complex dilemmas, with a misperception that what is legal is thus ethical and morally licit. Legal mandates do not address the case-specific moral imperatives encountered in each end-of-life care situation. The Ethical and Religious Directives for Catholic Health Care Services provide the ethical framework for such decision making. Furthermore, specific guidance has been provided by the Congregation for the Doctrine of the Faith on questions concerning artificial nutrition and hydration, particularly as they pertain to those in a persistent vegetative state. The following model policy is offered as a prototype for Catholic health care agencies as they engage in the ministry of health care, founded on the innate dignity of each human being, regardless of the “quality of life” assigned by society. The model policy has been designed to allow local legal experts to incorporate legal standards specific to the locale of the Catholic health care agency. — M.T.H.

Model Policy

Purpose of Policy for Care at Life’s End

The purpose of this document is to explain how this health care Agency, sponsored by the Catholic Church, will respect the innate human dignity of each patient in the delivery of end-of-life care. It shall be the policy of this Agency to honor patients’ free and informed consent decisions consistent with the Ethical and Religious Directives for Catholic Health Care Services (ERDs), the teachings and governance of the local diocesan bishop, and the mission of this Agency’s sponsors. The ERDs are particular law, and hence are binding on any health care agency in the United States that is sponsored by the Catholic Church. The ERDs state that “Catholic health care services must adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel” (n. 5). Each employee of a Catholic health care agency must respect and uphold the religious mission of the Agency and adhere to these Directives (n. 9). The ERDs require compliance with federal and state laws which honor patient autonomy as long as the wishes of the patient (or the patient’s surrogate decision maker*) are not in conflict with Church teaching. These decisions may be expressed directly or through a patient’s surrogate decision maker or an advance directive executed in accordance with the Patient Self-Determination Act of 1990 and subsequent revisions. At any time during a patient’s admission or while enrolled in Agency care, the patient may execute or alter an advance directive at the patient’s request.

In the event that a patient is unable to express his or her health care wishes or is deemed not to be competent to make such decisions, decisions of a patient’s surrogate decision maker designated in accordance with State law and consistent with Catholic teaching will be honored. If at any time the wishes of the patient, directly expressed or expressed through an advance directive or a patient’s surrogate decision maker are inconsistent with the ERDs, an explanation will be provided by the Agency as to why these wishes cannot be honored (n. 24). In such circumstances, if agreement cannot be reached between this Agency and the decision maker, this Agency reserves the right to transfer the patient to an agency to which the decision maker has arranged transfer, consistent with local laws governing such transfers.

Statement of Law

State law provides for competent adults to have the right to control their health care decisions, including the decision to use or discontinue use of life-sustaining procedures, expressed directly or through other means, for example, an advance directive and designations of durable power of attorney, health care representative, legal guardian, or person with

*Words and phrases that appear in italics in the model policy are defined under “Definition of Terms.”
Catholic Position

This Agency will respect health care decisions that are freely made by a fully informed and competent patient or the patient’s surrogate decision maker, and will implement them if they are consistent with the ERDs (n. 26). In an emergency when consent cannot be obtained and there is no indication that the patient would refuse consent to the treatment, this Agency reserves the right to provide such treatment. Upon admission or at any time in advance of a health care decision, the competent patient may identify a representative, and an alternate, as the patient’s surrogate decision maker in the event that the patient loses the capacity to make health care decisions. The competent patient also, upon admission or at any time in advance of a health care decision, may make such decisions known through an advance directive. In the event that a patient’s surrogate decision maker has not been designated, those who are in a position to know best the patient’s wishes (usually family members and loved ones), as they pertain to the execution of the advance directive or even in the absence of such a directive, should participate in the health care decisions. These decisions should be faithful to Catholic moral principles and to the patient’s intentions and values, or if the intentions are unknown, to the patient’s best interests (n. 25). Free and informed consent requires that the decision maker receive all reasonable information about the essential nature of the proposed treatment and its benefits, risks, side effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all (n. 27). This Agency will disclose all pertinent information to the decision maker to achieve this end consistent with directive 28: “Each person or the person’s surrogate should have access to medical and moral information and counseling so as to be able to form his or her conscience. The free and informed health care decision of the person or the person’s surrogate is to be followed so long as it does not contradict Catholic principles.”

Furthermore, this Agency will respect patients’ rights and duties to maintain bodily and functional integrity. Functional integrity may be sacrificed only to maintain the health or life of the patient when there is no other morally permissible means available (n. 29). The well-being of the whole person will be considered in determining the appropriateness of therapeutic interventions. Those likely to cause harm or undesirable side effects will be justified only if there is a proportionate benefit to the patient (n. 33).

Definition of Terms

This policy is consistent with the Ethical and Religious Directives for Catholic Health Care Services, the missions of this Agency and its sponsors, the teaching and governance of the local diocesan bishop, and the laws of the local State. The terms contained in this policy are defined as follows:

Advance Directive: A written directive that indicates a competent patient’s decisions concerning do-not-resuscitate orders and procedures to prolong the process of dying, to be acted upon in the event that the patient is no longer competent to make or communicate such decisions.3

Attending Physician: A licensed physician or legally empowered and licensed physician-designated health care provider who holds privileges at this Agency, and who has the consent of the patient or the patient’s surrogate decision maker to order and direct the care of the patient while at this Agency.

Competent Patient: A patient who has reached the legal age of majority, has not been declared incompetent by a jurisdiction with legal authority to do so, and who has demonstrated to the patient’s attending physician the requisite cognitive and communicative ability to exercise the free and informed consent of proposed treatments, as expressed in the ERDs: “Free and informed consent requires that the person or the person’s surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all” (n. 27).

Decision Maker with Legal Authority for Making Health Care Decisions: The competent patient or, if the patient is not competent, the patient’s surrogate decision maker.

Do-Not-Resuscitate Order(s): Written orders by the attending physician that indicate a desire not to have administered specified levels of therapy or intervention which use mechanical or other artificial means to sustain, restore, or supplant a vital function necessary for life.

Ethics Committee: A committee appointed by the administrator of this Agency, consistent with the by-laws of the ethics committee and chaired by the director of pastoral care, in consultation with the diocesan bishop (n. 21). If the director is a priest or deacon, he must have the explicit approval or confirmation by the diocesan bishop (n. 21). Members of the committee will respect the diocesan bishop’s pastoral responsibility and the mandates of the ERDs, and will be familiar with Catholic medical ethics. At all times there shall be on the committee at least one physician who is not an attending physician for a specific case under consideration; one registered nurse; one health care consumer with no connection to a specific case under consideration; one member of the quality assurance/risk management office; a social worker; and an administrative liaison. The ethics committee shall provide ethical consultation on particular
ethical situations, offer educational opportunities related to bioethical decision making, and provide review of, and recommendations concerning, health care policies (n. 37).

Euthanasia: An action or omission that of itself or by intention causes death in order to alleviate suffering (n. 60).

Palliative Care: A comprehensive non-curative plan for prevention and relief of pain and other forms of physical, psycho-social, and spiritual suffering by means of early identification, assessment, and intervention.

Patient’s Surrogate Decision Maker: A person who has the legal authority to make health care decisions on behalf of a patient who is not competent, that is, the person holding designation as durable power of attorney, health care representative, or legal guardian, the patient’s immediate family, or a person who has established a caring relationship with the patient. Such a decision maker receives precedence consistent with the definition of person with legal priority for surrogate decision making.

Person with Legal Priority for Surrogate Decision Making: A patient’s surrogate decision maker with legal authority and priority over other patient associates to make health care decisions on behalf of the patient when the patient is no longer competent to make or express such decisions. State law determines in what order of priority the legally designated parties have legal decision-making authority, including who within the patient’s family has such authority.

Procedures to Prolong the Process of Dying: Any therapy or intervention which uses mechanical or other artificial means to sustain, restore, or supplant a vital function necessary for life when, by reasonable standards of medical judgment, it is anticipated that death is imminent, or when the benefit of the procedure to the patient is outweighed by the burden to the patient, or when the procedure’s risks or side effects are contraindicated for to the patient’s well-being. Palliative care or other therapies or interventions that provide comfort, hygiene, or pain control are not procedures that prolong the dying process and will not be withheld from any patient. Furthermore, unless death is imminent, the provision of nutrition and hydration, even by artificial means, is not a causative prolongation of the process of dying and will be administered as long as there remains a benefit to the patient that outweighs the burden, risks, or side effects of such administration to the patient (n. 58).

Proportionate Means: Those therapies or interventions 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 (nn. 56 and 57).

Vegetative State: A state of eyes-open unconsciousness with sleep–wake cycles but an apparent lack of awareness of self or others. There are no reproducible voluntary responses to external stimuli and no comprehension or expression of language. To be considered permanent, the duration must be at least greater than three months when the cause is nontraumatic (e.g., oxygen deprivation); otherwise, if traumatic, the duration must be greater than twelve months to be considered permanent. This diagnosis must be confirmed by two physicians trained in neurology or neurosurgery.

Statement of Policy

It is this Agency’s policy to respect patients’ expressed wishes, consistent with the ERDs. Decisions to administer or withhold any therapy or intervention are to be made by the competent patient or, if the patient is not competent, by the patient’s surrogate decision maker or pursuant to an advance directive. These decisions include those pertaining to a do-not-resuscitate order and to procedures to prolong the process of dying. Such decisions will be made in consultation with the patient’s attending physician, who will document and provide the written orders to implement such decisions.

The free and informed health care decision of the competent patient or the patient’s surrogate decision maker is to be followed so long as it does not contradict Catholic teaching. Catholic teaching dictates that while a patient may forgo extraordinary or disproportionate means of preserving life, each person has a moral obligation to use ordinary or proportionate means of preserving life (nn. 56 and 57). A foundational principle of this Agency’s policy is a presumption in favor of providing nutrition and hydration to all patients, including those who require medically assisted nutrition and hydration, as long as these are of sufficient benefit to outweigh the burdens involved to the patient (n. 58).

This Agency will only withhold procedures to prolong the process of dying which meet the standards defined by this Policy. Furthermore, if such procedures to prolong the process of dying are requested by the competent patient or the patient’s surrogate decision maker, the attending physician must document that the procedures are not detrimental to the patient’s well-being before such procedures will be administered. This Agency will continue to administer nutrition and hydration (whether by natural or artificial means) to all patients if such administration does not constitute procedures to prolong the process of dying, as defined above. Specifically, for patients in a vegetative state, including those for whom it is deemed permanent, this Agency will continue to administer nutrition and hydration (whether by natural or artificial means) as long as they can be assimilated by the patient’s body and are not “excessively burdensome for the patient or . . . [do not] cause significant physical discomfort, for example resulting from complications in the use of the means employed.”

This Agency will offer palliative care to all patients for whom death is imminent; or the benefit of a therapy or intervention to sustain, restore, or supplant a vital function necessary for life is outweighed by the burden to the patient; or the therapy or intervention’s risks or side effects are contraindicated for the patient’s well-being. This Agency will never condone or participate in euthanasia or assisted suicide in any way. Patients who directly or through an advance directive or the patient’s surrogate decision maker request euthanasia will receive loving care, psychological and spiritual support, and
appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death (n. 60). Patients will be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die. Medicines capable of alleviating or suppressing pain may be given to a dying patient, even if this therapy may indirectly shorten the patient’s life so long as the intent is not to hasten death. However, each patient has the right to prepare for his or her death while fully conscious. Every attempt will be made to alleviate pain without depriving the patient of consciousness without a compelling reason. Consistent with the Christian understanding of suffering, all patients will be provided with spiritual and psychological comfort measures in the face of such suffering (n. 61).

This Agency will offer to all patients, especially those more proximately in danger of death from illness, accident, advanced age, or similar conditions, appropriate opportunities to prepare for death, including the opportunity to receive spiritual support and the sacraments. This Agency will be responsive to patient’s wishes concerning pastoral care, regardless of the faith of the patient and, for Catholic patients, facilitate availability of priests for the administration of the sacraments of the Eucharist, including Viaticum, Penance, and Anointing of the Sick, consistent with ERDs nn. 15, 16, and 20. Patients and each patient’s surrogate decision maker will be provided with whatever information is necessary to help them understand the patient’s condition and have the opportunity to discuss it with family members and care providers. All appropriate medical information will be provided to these decision makers to enable them to address the morally legitimate choices available to them (n. 55).

If at any time the terms of this Policy are in conflict with the will of the patient or the patient’s surrogate decision maker, the matter will be referred to this Agency’s ethics committee. The ethics committee will make a recommendation to the administration of this Agency as to compliance with the request of the patient or the decision maker. However, in such circumstances, if agreement cannot be reached between this Agency and the decision maker, this Agency reserves the right to transfer the patient to a facility to which the patient or the decision maker has arranged transfer.

SIGNED: ____________________________
Name of administrator

DATED: ____________________________

5 The health care agency should include a legal definition pursuant to the law of the State of jurisdiction.
6 CDF, “Responses to Certain Questions, with Commentary,” 3.

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