Advance Care Planning: A Catholic, Faith-Based Perspective

"If the most important thing in life is reconciliation with God, union with God, conformity with God, then any price is worth paying to attain that end, if necessary."

Peter Kreeft

Catholic Health Association of British Columbia

Acknowledgements....

The *Catholic Health Association of BC* would like to acknowledge, with gratitude, those who helped in the research, compilation and the review of the material in this document:

- The *CHABC* Ethics Committee, chaired by Father Patrick Tepoorten
- The BC and Yukon Bishops
- Dr. Howie Bright, family physician
- Monsignor Bernard Rossi, JCD

We are also grateful to Cari Hoffman from Fraser Health who has been of invaluable assistance to us in our Advance Care Planning work. We also thank those at *Providence Health Care* who offered their guidance and input.

We acknowledge, with appreciation, that we have adapted the wording for our advance care directive form from the one developed by the *National Catholic Bioethics Center* (Philadelphia).

Lastly, we express our sincere gratitude to the *Saint Mary's Health Foundation* which provided us with a generous grant that allowed us to produce and distribute this document.

Archdiocese of Vancouver
ARCHBISHOP'S OFFICE

A message from the Bishops of British Columbia and Yukon about planning for end-of-life care

September 1, 2011

To the faithful in British Columbia:

We recognize that life is a precious gift from God and that He alone has dominion over it. God has made us stewards of life and that requires that we use every reasonable means to protect and preserve it and forbids any action intended to end life.

The complexity of end-of-life care can be overwhelming for those who may need to make decisions on behalf of a loved one no longer able to make them for him or herself. An advance care directive can help families and health care providers make decisions informed by the individual's expressed intentions.

To attempt to detail what you want to happen in specific medical situations could result in complicated and even confusing instructions. The Catholic Health Association of BC has produced a document in the "Advance Care Planning: A Catholic, Faith-Based Perspective" resource which allows you to direct simply and clearly that you want your care and treatment to be carried out in accordance with the teachings of the Church.

Completing this directive indicates that you embrace the value of the human person, recognize the duty to preserve life, realize that medical resources are finite and understand that decisions must take into account the unique nature of each case.

On behalf of all of the Bishops of British Columbia and Yukon, I encourage you to complete an advance care directive and speak with your loved ones and physician about the care you wish to receive should the time come when you cannot speak for yourself.

Sincerely yours in Christ,

+ J. Michael Miller CSB

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" All of society, and in particular the sectors associated with medical science, are duty bound to express the solidarity of love and to safeguard and respect human life in every moment of its earthly development, especially when it is ill or in its terminal stages. In more concrete terms, this means ensuring that every person in need finds the necessary support through appropriate treatments and medical procedures – identified and administered using criteria of therapeutic proportionality – while bearing in mind the moral duty to administer on the part of doctors and to accept on the part of patients, those means for preserving life which, in a particular situation, may be considered as 'ordinary'."

Pope Benedict XVI

February 25, 2008

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Definitions:

Advance Care Directive - - A document containing written instructions expressed directly to your physician or other health care provider for the health care you wish to consent to or refuse in the event you are incapable when the care is needed. An advance care directive must state that the adult knows that a care provider may not provide to the adult any health care for which the adult refuses consult in the advance care directive and that a person may not be chosen to make decisions on behalf of the adult in respect of any health care for which the adult has given or refused consult in the advance care directive. The advance care directive must be signed by two witnesses or one witness who is a lawyer or a notary public.

Advance Care Plan - - A document that is intended to instruct or inform others concerning a person's needs, values and wishes, the identity of the proxy and/or the type of treatment a person desires should he or she lose his or her decision-making capacity or be unable to make his or her wishes known.

Anointing of the Sick - - A Sacrament administered to one in a seriously weakened state of health because of grave illness or the infirmity of old age. The Sacrament can bring the consolation of interior healing and a sense of God's loving presence. When a person is conscious and able, the anointing is normally preceded by the Sacrament of Confession and followed by Holy Communion.

Brain Death - - The irreversible arrest of all brain activity.

Cardiopulmonary Resuscitation (CPR) - - Basic CPR means trying to restart someone's heart by pressing on the chest or forcing air into the lungs. Advanced CPR involves medication and/or electric shock.

Cardiac Death - - A determination used in organ donation protocols that defines death after a planned termination of life support.

Double Effect - - A moral principle that provides guidance when a necessary act or omission will have two consequences, one of which is moral and intended, the other evil and inevitable, but not intended, even though foreseen.

Euthanasia - - This is the deliberate killing of a person by action or omission, with or without that person's consent, for supposedly compassionate reasons.

Extraordinary Care (also referred to as disproportionate care) - - See **Ordinary Care** (below). Where proportionality does not exist, the remedies are to be considered extraordinary.

Informed Consent - - This requires that an individual has the information and understanding necessary to make a reasonable decision in his or her own best interest and has the competence and freedom to make his or her own decision.

Moral Certainty - - This is the confidence that all of the conditions required for making an informed decision have been met beyond a reasonable doubt, with the elimination of all contrary probabilities.

Ordinary Care (also referred to as proportionate care) - - This refers to any treatment, operation or procedure that offers a reasonable hope of benefit without serious risk of death or excessive burden or excessive subjective repugnance or excessive pain or excessive expense.

Palliative Care- - An approach to care that embraces a combination of active and compassionate therapies intended to comfort individuals and their support communities who are facing the reality of impending death. It strives to meet physical, social and spiritual expectations and needs, while remaining sensitive to personal, cultural and religious values, beliefs and practices.

Persistent Vegetative State (PVS) - - This is the condition of patients with severe brain damage in whom coma has progressed to a state of wakefulness without detectable awareness.

Proxy (also referred to as a substitute decision maker) - - A person who is entitled to make a care and treatment decision for an incompetent person. This may or may not be a family member. Decisions made by a proxy should be based on the decision the person would have made for him or herself to the best of the proxy's knowledge. If this information is not known, the decision should be made in the person's best interest. (*In British Columbia, the legal way to appoint a proxy is through a Representation Agreement.*)

Spirituality - - The cultivation of the spiritual side of our humanity, especially as it involves and determines our personal relationship with God.

Viaticum - - The final reception of the Sacrament of the Eucharist in the face of death, as food for the journey towards eternity.

The Law in British Columbia and Yukon Regarding Advance Care Directives

In November of 2007, legislation was passed in Victoria that legalized written Advance Care Directives in British Columbia. This legislation was subsequently enacted on September 1, 2011. In Yukon, no specific legislation provides for making an advance care directive but legislation does allow for proxy directives. A Representation Agreement is the legal method in BC by which you can name someone to speak for you if you cannot speak for yourself.

With or without legislation in place, individuals have been putting their care and treatment intentions in writing and these documents have been recognized under common law. In fact, health care providers have expressed that such documents assist them in providing appropriate care and treatment to those who cannot speak for themselves. As well, families are grateful that they have these documents to guide them in making decisions for their loved ones.

In British Columbia's regional health authorities, work is currently underway to create standardized tools for individuals who wish to put their future care and treatment choices in writing. "*My Voice*", currently in use in some health authorities, is a valuable tool for this purpose, but it does not specifically address issues from a religious or spiritual perspective.

In other jurisdictions, advance care planning documents have been developed from a faith-based perspective, but since laws vary from province to province and from country to country, the ones from other parts of Canada or from the United States aren't totally compatible with BC requirements. In creating this document, the *Catholic Health Association of British Columbia* hopes to fill the need for people of faith in this province. It can be completed in conjunction with the tools and resources that are provided by our health authorities. We encourage you to use it as a complement to other available advance care planning documents.

We have also included the option in this document for individuals to plan for their funeral and burial, should they wish to do so.

Giving Voice to Your Wishes - -
planning in advance ....

If you are in need of health care treatments or procedures, you would normally discuss the related issues with your health care provider and come to a determination of how you would like to proceed.

But what if you could not speak for yourself?

What if you were unconscious because of an illness or accident? What if you had a type of dementia, like Alzheimer's or Pick's Disease, and were incapable of understanding your medical situation? What if it had been determined that you were brain dead after a traumatic head injury?

This document assumes that you would like to have a way to make your intentions known should you find yourself in any type of these situations. It also assumes that you wish to do so in keeping with the teachings of the Catholic Church.

Making your health care intentions known in advance does not necessarily mean that you have to complete a written document. You may want simply to discuss and make your wishes known to your family and loved ones or you may want simply to name an individual in your life whom you trust to make future decisions for you should a time come when you cannot make them for yourself. You can also do a combination of these, for example, put your intentions in writing **and** ask someone to speak for you if necessary.

If you choose a family member or someone else to make medical decisions on your behalf, that person must be at least 19 years of age and be willing and able to explain your wishes for your health care and end of life care. He or she should be responsible and willing to respect your convictions and religious beliefs.

Whatever your decision about planning your future medical care and treatments, the most important thing you can do is **communicate**. Talk to your family, other loved ones, your physician and your pastor about what your choices would be if you were faced with health care decisions.

Who Will Speak for Me?

In British Columbia, advance care planning not mandatory. However, advance care planning can be helpful to give guidance to those who may be asked to speak for you. This is the legal order in which individuals will be approached to make health care decisions for you:

1. A **representative** named by you in a Representation Agreement (see * below)

2. Your nearest relative (see * * below) in the following order - -

    - Your spouse, either by marriage or a marriage-like relationship
    - Your adult child (children equally ranked)
    - Your parent (parents equally ranked)
    - Your sibling (sisters and brothers equally ranked)
    - Your grandparent
    - Your grandchild
    - Anyone else related to you by birth or adoption
    - Your close friend
    - A person immediately related by marriage
    - Another person appointed by the Public Guardian and Trustee

* This is an agreement that allows you legally to appoint a person of your choice to be your health care decision maker. A Representation Agreement is a written document signed by two witnesses or one witness who is a lawyer or a notary public. To find out more about this document, you may wish to contact *Nidus* at 604-408-7414.

* * The relative consulted must be a capable adult (19 years of age or older), must have had contact with you within the previous 12 months, must not be in a dispute with you and must be willing to speak for you.

Making Decisions in Keeping with Your Catholic Faith

"Catholic health ministry sees care for the sick as a sacred ministry pursued in fidelity to the example and teachings of Jesus Christ. It is dedicated to the relief of suffering within the constraints of divine law. It gives primacy to man's spiritual destiny as well as his temporal well being. Contemporary culture for its part also seeks to relieve suffering and to improve the quality of human life. Its restraints, however, are imposed by human law and its end is primarily the quality of man's material life, without reference to divine law."

Edmund D. Pellegrino, MD
from Catholic Health Care Ministry and Contemporary Culture

There is sometimes a divide between the religious and the secular when it comes to the provision of health care and the decisions that are made by individuals about the care and treatment options available to them. Guided by our specific religious beliefs and moral values, we will sometimes make a different choice about attempting resuscitation, about dementia care or about organ donation than the choice that might be made by someone of a different faith or someone with no religious faith.

The principle of stewardship holds that human beings have a responsibility to care for the gift of their lives, their bodies and all of creation. This document is meant as a guide for those who wish to be good stewards of the gift of life that God has given us. When in doubt, we must always err on the side of life.

In order for us to give direction to those who may be making decisions about our care and treatment at a future date, we need to know what the Church teaches on these end-of-life issues.

It could be that the individual who will speak for you does not share your faith and convictions. Perhaps it will be your spouse who is not Catholic as your proxy. Perhaps it will be your adult child or a sibling who is no longer a practicing Catholic. Perhaps it will be a non-Catholic friend or your physician. If these individuals are not familiar with your faith and values, you will want to ensure that they have sufficient direction to follow.

At the same time, you will want to be cautious about the amount of detail you put into your written advance care plan. You do not know what the future holds for you or what your medical needs may be at a later date. You could not possibly anticipate each and every eventuality. Even if you have been diagnosed today with a specific condition or disease, circumstances could change. The care and treatment that you think you might want in the future may not be appropriate for your condition as time goes by and circumstances change.

We also have to keep in mind that when Catholics talk about ordinary or extraordinary means of care (proportionate or disproportionate means), these terms may not be understood or interpreted as you would want by those who are providing your care and treatment.

For these reasons we strongly encourage individuals to plan in advance, whether or not they decide to put their wishes in writing. We urge individuals to talk to family, loved ones, physicians and other care givers, as well as their pastors, about the care and treatment they would like to have if the time came when they could not speak for themselves. The greater the number of people who are aware of what your choices would be, the better the possibility that your wishes will be followed.

Good and open communication is paramount in this process. At the same time, it can be difficult to talk about some of these issues.

We encourage you to stay engaged with those with whom you need to discuss these issues and be attentive to those who might find it difficult to communicate. Keep talking to each other, even when it is difficult to do so.

Attempting Cardiopulmonary Resuscitation (CPR)

"*Many of the demands for therapy are based upon unrealistic expectations about what medicine can achieve .... After patients were educated about the realistic outcomes of cardiopulmonary resuscitation, those still wishing this intervention significantly declined in number.*"

C. Christopher Hook, MD
Medical Futility
Dignity and Dying: A Christian Appraisal

Public expectations of the success of Cardiopulmonary Resuscitation (CPR) are sometimes quite unrealistic. We watch medical shows on the television and perhaps think that this procedure is successful most of the time in bringing an individual back to life. In fact, a relatively low percentage of hospitalized patients for whom resuscitation is attempted will survive to discharge. It is an even lower percentage for an event that happens outside a hospital.

CPR does not work in all cases. If a person has few other serious medical conditions, it might be effective. However, if someone has cancer or a disease of the heart, lungs, kidney or brain, CPR will rarely bring him or her back to life because the disease has damaged the heart or other parts of the body.

For an individual who is elderly and frail, the procedure for giving CPR has the potential to cause serious and irreparable physical harm.

Not performing CPR does not mean an individual will be left to die. Everything will be done to help that person live as well as possible for as long as possible. It does not mean that no medical care is being provided.

It is morally and ethically permissible to forgo cardiopulmonary resuscitation if the circumstances are such that it would not be a benefit to the individual.

Artificial Nutrition and Hydration

This particular issue is sometimes one of the most complex and confusing to grasp.

We are taught by the Church about the application of proportionate and disproportionate means of care - - sometimes referred to as ordinary and extraordinary means, and sometimes as a weighing of the benefits versus the burdens of care.

Food and water are basic needs of every human person and are therefore part of the ordinary care that we should give to every patient, even if medical treatments have become extraordinary or disproportionate.

Food and water, even when given with medical assistance, should **always** be provided to an individual unless the burdens of delivering them clearly outweigh their benefits in a given case.

This statement from the Catechism of the Catholic Church clarifies this concept:

"*When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, as long as the normal care due the sick person is not interrupted.*" (n. 2278)

The presumption in favour of providing food and water, even by artificial means, also applies in the case of a patient in a persistent vegetative state (PVS). Individuals in a PVS "*are alive, they are not brain dead and they are not dying, unless there is some other terminal pathology present. They will not die from PVS in the immediate foreseeable future.*" (Thomas Pitre, from *Catholic Health Care in Tension with Contemporary Culture*)

In his March 2004 allocution on this issue, the late Pope John Paul II stated unequivocally: "*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*".

In that same allocution, the late Holy Father spoke about the inherent dignity of the human person remaining intact in patients in a PVS: *"Even our brothers and sisters who find themselves in the clinical condition of a 'vegetative state' retain their human dignity in all its fullness. The loving gaze of God the Father continues to fall upon them, acknowledging them as His sons and daughters, especially in need of help."*

We are morally obligated, as people of faith and stewards of the life we have been given, to accept food and water as ordinary care and to ensure that it is provided to those in a PVS. It would not be wrong to refuse or discontinue this care, however, if it was determined, for example, that the patient was dying and was unable to assimilate the food that is given.

Organ Donation

"To donate one's organs is an act of love that is morally licit, so long as it is free and spontaneous."

Pope Benedict XVI

The Catholic Church approves and promotes organ donation from those who have died, as well as from the living. Organ donation does not go against any Church teachings about the value and dignity of our bodies or the belief in the resurrection of the dead. Before he was elected Pope, Cardinal Ratzinger revealed to the Italian press that he was a registered organ donor.

In 1956, Pope Pius XII taught that organ donation is "*morally blameless and even noble*". Pope John Paul II confirmed this teaching, by saying that "*the gift of organ donation is a great act of love*".

The fears that some people have about organ donation and the transplantation of organs are real. The question of when a person is "brain dead" has indeed given rise to serious misgivings regarding the transplant of vital organs. The legislation and policies in British Columbia which govern the retrieval of organs are quite stringent. "Brain death" is not a coma or a quasi-vegetative state. Brain death is the actual irreversible cessation of all activity in the brain. The law provides that this be certified by two doctors, neither of whom is the attending physician to the organ recipient, nor connected to the *Transplant Society*. A series of tests is administered, including discontinuing the respirator for a period of time, to determine if the patient can breathe on his or her own.

While some have claimed that the heart cannot continue beating without the stimulus from the brain, this is disproved by the fact that the heart, in the presence of brain death, will continue to beat so long as it receives oxygen through a ventilator.

"*How can we know that the brain is dead? It's not enough to see the absence of brain waves on an EEG machine. The real criterion for brain death is the absence of reflex activity from the brain stem. This is the part of the brain between the cortex—the thinking part of the brain—and the spinal cord. The brain stem controls many automatic functions of the body, especially breathing. To prove brain death, you have to test several brain stem reflexes, and you have to do an apnea test. This means that you disconnect the patient from the ventilator and see if they start breathing on their own within a few minutes. Then you re-connect the ventilator and repeat the apnea test and the other brain stem reflexes after at least an hour to make sure they are all absent. There has never – never – been a patient who has come back from the dead when brain death is proven in this way*."

Howie Bright, MD
Chilliwack Family Physician
CHABC Ethics Committee member

Besides "*brain death*", another way of determining death prior to organ donation is referred to as "*donation after cardiac death*" (DCD). This is the removal of organs from an individual who is declared dead after the cessation of spontaneous heartbeat and respiration. This is different from the determination of brain death. Protocols have been developed in BC's hospitals to ensure that these procedures are carried out in a morally and ethically acceptable manner.

Organ donation saves lives. We are challenged to consider the Church's words and to respond to God's call to love and self-giving.

In order to donate your organs you must be registered with *BC Transplant*. This can be done by completing an organ donor registration form (available from the *Catholic Health Association of BC*) or online at **transplant.bc.ca**.

Forgoing or Withdrawing Treatment/ Medical Futility

"... although the Catholic tradition forcefully rejects euthanasia, it also would argue that no obligation exists, in regard to care for the terminally ill, to initiate or continue extraordinary medical treatments that would be ineffective in prolonging life or that would, despite their effectiveness, impose excessive burdens on the patient."

Joseph Cardinal Bernardin
Celebrating the Ministry of Healing

"...with the benefit of the best available medical counsel, patients can recognize that their death is at hand. They ethically forgo treatment in such situations not because they intend death – life to a significant degree cannot continue even with treatment – but because treatment will only add suffering to dying."

John F. Kilner, MDIV, PhD
Forgoing Treatment
from *Dignity and Dying: A Christian Appraisal*

Medical decision making can be very complex and we can be confused sometimes about what the right choice is. We are obliged to accept certain basic necessities of life (food, water, air), but when it comes to some of the more complex technologies that might be offered to us, the obligation is not always so clear.

An individual with a terminal medical diagnosis may be offered a long course of chemotherapy or the option to live permanently on a ventilator. These are not considered ordinary or

proportionate care. The Church tells us that decisions about such treatment options can be made based on an individual's subjective response. Some people may be willing to accept these treatments while others may find them an unacceptable burden.

For those who accept such treatments, there may come a time when they realize the treatments are not working. In such circumstances, it is perfectly acceptable to discontinue the treatments. When the facts indicate that the treatments are ineffective and not a benefit to the individual, it is morally and ethically acceptable to stop the treatments.

The Catechism of the Catholic Church (n. 2278) states: "*discontinuing medical procedures that are burdensome, dangerous, extraordinary or disproportionate to the expected outcome can be legitimate: it is the refusal of "overzealous" treatment. Here, one does not will to cause death; one's inability to impede it is merely accepted*".

While an individual has the autonomy to make his or her own decisions, it is never acceptable to ask for any kind of procedure or treatment that is immoral. It is never morally permissible to request a care giver to do anything that would cause or hasten death.

Certainly there is a moral obligation to care for oneself and to allow oneself to be cared for, but this duty must take account of concrete circumstances. It needs to be determined whether the means of treatment available are objectively proportionate to the prospects for improvement.

Pope John Paul II, from *Evangelium Vitae*

Certainly, the high road to truth and goodness is not a comfortable one. It challenges man. Nevertheless, retreat into self, however comfortable, does not redeem. The self withers away and becomes lost. But in ascending the heights of the good, man discovers more and more the beauty that lies in the arduousness of truth, which constitutes redemption for him.

Pope Benedict XVI, from *Conscience and Truth*

The Principle of Double Effect

"*The use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an end or a means, but only foreseen and tolerated as inevitable.*"

The Catechism of the Catholic Church (n. 2279)

Double effect is a basic principle in Catholic moral theology that helps guide decisions about performing actions that have two effects: one good and intended and the other bad and unintended. The principle holds that one may perform such actions if:

1. the action is good or neutral in itself;
2. one intends the good effect and not the bad;
3. the good and bad effects occur together so that the evil effect does not become a means to the good effect; and
4. there is a proportionately serious reason for allowing the unintended bad effect to occur.

An example of "*double effect*" would be giving drugs to relieve pain and suffering even if a foreseen but unintended effect is to shorten life, as explained in the quote above from the Catechism of the Catholic Church.

Palliative Care

"The physical, emotional and spiritual care that characterizes palliative care should be available to all who require it. It should be provided in the home as well as in institutional settings. Health care and social service providers, along with parish communities, are encouraged to be actively involved in securing palliative care for those persons and families in need of it.

The person receiving care should be given sufficient pain management to lessen pain and suffering, even if such pain management could shorten life, though not intentionally. The goal of such care is to alleviate pain and suffering while minimizing the potential side effects of medication. Persons receiving care have a right to be cared for by care providers who have sufficient expertise in pain and symptom management."

Health Ethics Guide
Catholic Health Association of Canada

The World Health Organization defines palliative care as an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten nor postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- enhances quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or

radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Palliative care can be provided anywhere and the best place to receive this care is the place that best suits an individual's needs. Wherever patients are living – at home, in a residential hospice, in hospital or in a personal care home – most programs can adapt to specific needs.

Suffering rarely occurs in isolation. It happens in community, and when our suffering lacks reflection the whole community suffers endlessly. Families, friends and associates are all affected if we fail to address our suffering to the right questions. Such questions should have the ability to lift us, and those in relationship with us, to a greater understanding of who we are. They must help us surrender to the mystery within which we live, and bring awareness of the sacred within our humanity.

Thomas D. Maddix and Ian C. Soles
from *Journey to Wholeness: Healing body, mind and soul*

Dementia Care

"A health care encounter remains a place of moral meaning for patients and their loved ones. Issues of trust, fidelity, pain, suffering and death remain at the heart of health care."

Dr. Nuala Kenny, OC
from *A Health Care Covenant*

The following information is excerpted with permission from an essay entitled "The Golden Rule in Dementia Care" by Arthur Enns, CEO at Menno Place in Abbotsford.

According to the latest estimates, about 300,000 Canadians (Blackwell, 2008) currently live with Alzheimer's Disease. In the US, it is predicted that about one in eight people will experience the onset of this mind-wasting disease in the coming generation. The odds are that most of us at some point will be dealing with the ethical issues surrounding dementia and seeking answers to questions like these:

- What is the appropriate scope of decision-making autonomy for persons with dementia?

- To what extent should caregivers and family take into account that person's prior beliefs, standards and values?

- In cases of advanced dementia (severe loss of cognitive abilities), are there legitimate objectives beyond contentment, health and safety?

- Should romantic relationships among residents with dementia be discouraged, tolerated or encouraged – and how would this issue be affected by an existing marriage relationship with a cognitively well spouse?

- How would we wish to be treated if we were affected by Alzheimer's Disease? What about the use of medications and/or physical restraints, for example?

We live in a country with an aging population. Along with aging comes the growing percentage of individuals who will develop some kind of cognitive impairment. While we are still able to do so, we should give some thought as to how we would like to be treated should we be one of those who will develop a condition that prevents us from being aware of our surroundings and our actions.

Many care facilities have developed policies that guide how they care for those who are not able to make good and/or appropriate decisions for themselves. These policies will generally be based on the common good of all residents who reside in the facility. These decisions will take into account privacy and safety issues. Long before the need arises, you and your family and loved ones may wish to discuss how you would like decisions to be made should a time come when you are not able to make them for yourself.

Pastoral Care

> *"According to medical research, faith in God is good for us and this is not exclusive to one denomination or theology. You can believe in God in a quiet, introspective way or declare your convictions out loud to the world and still reap the physiological rewards.*
>
> *For many reasons, religious activity and church going is also healthy. Religious groups encourage all kinds of health-affirming activities - - fellowship and socializing perhaps first among them - - but also prayer, volunteerism, familiar rituals and music. Prayer, in particular, appears to be therapeutic, the specifics of which science will continue to explore."*
>
> Dr. Herbert Benson
> Harvard Medical Researcher

"Health" is more than just physical well being. Social, spiritual and emotional aspects of an individual are integral components of health. An individual's faith sometimes becomes even more significant when he or she becomes sick and/or elderly. Whether that individual continues to live at home or whether he or she is admitted to a care facility, it is important that we are attentive to the care of the soul and ensure that holistic care is provided.

Research shows that spirituality affects mental health and well being; a healthy spirituality can strengthen the body's immune system. Growing spiritually is a life-long process. It permeates to the very core of our being, affecting the way we perceive God, ourselves, others and the world around us. Religious beliefs and practices are a part of spirituality and can be a source of strength and comfort during a time of illness or crisis.

We believe that what is good for the soul can also be good for the body. At the same time, "healing" can occur when "curing" is not possible. Being present to persons who are sick or dying can help them to resolve their anger, fear and anxiety and help to bring them to a place of peace and acceptance. Improving spiritual health may not cure illness, but it may help an individual to feel better, to

prevent certain illnesses and to cope with illness or death. Most of all, when we are spiritually healthy we are at peace with God, knowing that we are children of a merciful Father.

The privacy laws in British Columbia have been interpreted in some of our health authorities to mean that care facility personnel are not legally permitted to advise anyone that a specific individual has been admitted to a hospital or residential care facility. This includes the individual's faith community, including the pastor and other visitors from the parish who carry out pastoral visits and bring Holy Communion to the sick and dying.

Privacy laws are very important and must be adhered to in order to protect individuals from having their personal and medical information compromised. Nonetheless, we are not convinced that our privacy legislation was meant to cut off individuals from their faith communities at a time when they are most vulnerable and in need of spiritual and religious support.

Of particular concern is that, even if you are asked upon admission to a care facility if you wish to have your faith affiliation recorded as part of your medical records, this information is sometimes not passed on to those whom you may wish to have it. Individuals should not assume that, when they give this information upon admission, it is shared with those who should have it.

Unless family members call the pastor to request such a visit, an individual could be left without access to a visit from his or her pastor or to the Sacraments.

It sometimes happens that family members and friends do not understand the significance for their loved one to be able to go to Confession and receive Holy Communion.

Individuals may want to indicate, when they are doing their advance care planning, that they wish to have regular pastoral visits and access to the Sacraments, whether they are confined to their homes or admitted to a care facility.

Funeral and Burial Planning

"He will wipe away all tears from their eyes: there will be no more death and no more mourning or sadness or pain." *Rev. 21:4*

It is a sad reality that sometimes individuals who have been life-long, faithful, practicing Catholics are not afforded a Catholic funeral and burial when they die.

There are a number of reasons for this: one of them is that the adult children responsible for making these decisions are no longer practicing Catholics; they either don't know that this is the right thing to do or they don't know how to go about making the proper arrangements.

To further complicate matters, the individual may have moved from home to a care facility that is not in his or her parish, and the pastor and parish community lose track of that person.

This situation can be avoided if individuals ensure that they tell the people who are caring for them - - both family and care providers - - that their faith is an integral part of their being and that they want that fact to be respected, even in death. You can include in your advance care plan your wishes for a Catholic funeral and burial.

The complete guidelines and explanations are found in the booklet approved in 1999 for use in the dioceses of BC and Yukon, entitled *Guidelines for Funerals and Burials in the Catholic Church* and are available online at **rcav.org/Funerals/Guidelines**.

For those making decisions on behalf of a Catholic individual, following are just some of the things you need to know:

- It is important to notify caregivers, hospital staff and pastoral care visitors that the dying/deceased person is Catholic. Oftentimes, these individuals will know what procedures are to be followed and may be of assistance at this difficult time.

- It is highly recommended that contact be made with the parish of the deceased individual as soon as possible to inform the pastor of the death.

Funeral, cemetery or cremation arrangements should not be finalized until the family of the deceased has had an opportunity to discuss personally with the priest the various procedures and rites pertaining to a Catholic funeral and burial. The priest is there to offer guidance and support.

- In accordance with Catholic teaching, the funeral service for a Catholic consists of bringing the body of the deceased into the Church, the celebration there of Mass, followed by interment, preferably in the consecrated ground of a Catholic cemetery.

- While the Church accepts cremation, the body of the deceased is present in the Church at a Mass of Christian Burial. Cremation is to be delayed until after the Funeral Mass has taken place. Inform the pastor of the Church where the funeral is to be held if there is to be a cremation.

- Once the funeral home/director has been chosen, inform them that the deceased is Catholic. They have a copy of the official guidelines and regulations for a Catholic funeral and burial and will be able to assist you in making appropriate choices.

- A wake or prayer service may be offered in the Church, usually the afternoon or evening before the funeral.

- A eulogy is not part of the Funeral Mass. If there is to be one, it may take place at the conclusion of the wake or prayer service or at a gathering following the funeral and burial. It is important that the officiating priest be consulted for direction if a eulogy is desired. An alternative to a eulogy is a printed souvenir leaflet with biographical and other details of the individual's life and achievements, which serves as a more permanent keepsake.

You may also wish to give some thought as to the readings that you want to be incorporated into your funeral Mass and let your wishes be known to those who will make these decisions for you.

My Intentions for Health Care

For the benefit of those who will make decisions on my behalf should I become incapable, I hereby express my desire about some issues that others may face in providing my care. Most of what I state here is general in nature, since I cannot anticipate all the possible circumstances of a future illness. I know that a health care provider may not provide for me any health care for which I refuse consent in this Advance Care Plan, and I direct that those caring for me avoid doing anything that is contrary to the moral teaching of the Catholic Church. If I fall terminally ill, I ask that I be told of this so that I might prepare myself for death and I ask that efforts be made that I be attended by a Catholic priest and that I am afforded the opportunity to receive the Sacraments of Reconciliation and Anointing as well as Viaticum.

I know that a person might not be chosen to make decisions on my behalf with respect of any health care for which I have given or refused consent in this Advance Care Plan. Those making decisions on my behalf should be guided by the teachings of the Catholic Church contained in, but not limited to, the Health Ethics Guide (produced by the *Catholic Health Alliance of Canada* and approved by the Canadian Conference of Catholic Bishops), the document entitled *On Life-Sustaining Treatments and the Vegetative State* (Allocution of Pope John Paul II, March 20, 2004) and *Directive on Health Care* (an instruction on health care ethics issued May 11, 1993, by Vancouver Archbishop Adam Exner, OMI).

I want those making decisions on my behalf to avoid doing anything that intends and directly causes my death by deed or omission. Medical treatments may be forgone or withdrawn if they do not offer a reasonable hope of benefit while entailing excessive burdens or imposing excessive expense on my family or the community. There should be a presumption in favour of providing me with nutrition and hydration, assuming of course they are of benefit to me. In accord with the teachings of my Church, I have no moral objection to the use of medication or procedures necessary for my comfort even if they may indirectly shorten my life.

_____ initial

If, in the medical judgment of my attending physician, death is imminent, even in spite of the means which may be used to conserve my life, and if I have received the Sacraments of the Church, I direct that there be forgone or withdrawn treatment that will only maintain a precarious and burdensome prolongation of my life without reasonable hope of recovery, unless those responsible for my care judge at any time that there are special and significant reasons why I should continue to receive such care (such as those listed below).

Believing none of the following conflicts with the teachings of my Catholic faith, I hereby add the following special provisions and/or limitations to my future health care:

_____ I would like my tissue and organs to be used for research or transplantation after I am dead.

_____ I would like all reasonable steps to be taken to allow me to see my family.

_____ I would like all reasonable steps to be taken to allow me to be reconciled with someone from whom I may have become estranged.

Add your own special provisions, if you wish:

_____

_____

_____

_____ initial

Today's Date: _____

Name: _____

Address: _____

_____

Date of Birth: _____

Care Card Number: _____

Witnesses: 1. _____

2. _____

Note: These persons may not act as witnesses:

- One who provides personal care, health care or financial services to the adult for compensation, other than a lawyer or a member in good standing of the Society of Notaries Public of BC
- A spouse, child, parent, employee or agent of a person described in the point above
- A person who is not an adult
- A person who does not understand the type of communication used by the adult, unless the person receives interpretive assistance to understand that type of communication

Remember, you may change any part of this document at any time. It will be referred to only if you cannot speak for yourself. As long as you are capable, your health care providers will communicate and consult with you directly.

My Wishes for My Funeral and Burial

For the benefit of those who will make decisions on my behalf, these are the things that are important to me after I have died:

I wish to have a Catholic funeral Mass and burial.

Fill in any of the spaces below that are applicable to your situation.

I am a member of _____ Parish. Please contact the pastor there to arrange my funeral.

_____ I have already prearranged my funeral and burial.

I would like these readings to be included in my Funeral Mass:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Is there anything else you would like to add about your care and treatment choices and/or your wishes for a Catholic funeral and burial?

_____

_____

_____

_____

_____

Be sure to sign and date this document concerning your health care wishes and those for your funeral and burial.

Make copies of pages 29 to 33 of this booklet for members of your family, your physician, other health care providers and your pastor.

Initial _____

Date _____

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I believe that nothing can happen that will outweigh the supreme advantage of knowing Jesus Christ my Lord. For Him I have accepted the loss of everything... all I want is to know Christ and the power of His resurrection and to share His sufferings by reproducing the pattern of His death.

Phil 3:7-8, 10

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June 2016 (6)