Advance Directives for Health Care:

A Catholic Perspective

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ADVANCE DIRECTIVES FOR HEALTH CARE:
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Explanation

The Catholic Bishops of New Jersey have prepared the following Advance Directives for Health Care. The naming of a health care representative (proxy) and instruction directive are combined into one form. The New Jersey Advance Directives for Health Care Act went into effect on January 7, 1992. This act allows adults to complete an advance directive. You can choose either a health care representative (proxy) or give directions about your health choices and wishes, or both. It is not a law that you must have an advance directive. You cannot be refused admission to a health care facility because you do not have an advance directive.

Before completing an advance directive, it is important to think about the following:

- You should talk about your choices with your entire family. Your family may include your spouse, adult children, parents, brothers, and sisters.
- You should talk to your doctor about your health care choices.
- Your health care representative (proxy) should know you and your wishes about medical treatment. Your health care representative has the legal right to make health care decisions based on your advance directive when you cannot make decisions.
- You do not need a lawyer to complete an advance directive. You may talk to one if you wish.
- You need to review your advance directive from time to time to make sure that your wishes are still the same.
- You can decide to change your advance directive at any time.
- If you want to cancel your advance directive, put it in writing or talk to your health care representative, doctor or family.
- You have a right to make decisions about your medical treatment.
- Medical care will not be withheld just because you become unable to make your own treatment decisions.

This document is approved by the Catholic Bishops of New Jersey.

Steps for Completing Your Advance Directive

Part One:

- **Choose a person whom you trust to act as your health care representative (proxy).**
- **Direct your health care representative (proxy) to make your health care choices in accordance with your health care instructions or wishes when you cannot make these choices for yourself.**

Part Two:

- **Give directions about your health care choices and wishes to those who will be responsible for your care.**
- **Tell your health care representative (proxy), family member or friend to bring a copy of this form to the hospital when you are admitted.**

Part Three:

- **Sign the advance directive form in the presence of two witnesses 18 years of age or older.**
- **Have those two witnesses sign and date the form (but not your health care representative, alternate health care representative, or doctor) .**
- **Give copies of the advance directive to your health care representative (proxy), your doctor, and appropriate family members or friends.**
- **Keep the original copy of this form for yourself.**
- **Bring a copy of this form to the hospital when seeking medical treatment.**

Combined Advance Directive for Health Care
(Combined Proxy and Instruction Directive)

STATEMENT OF BELIEF

Catholics believe that life is a gift of a loving God. Life is a holy gift for which we are responsible, but do not own. We believe that assisted death and suicide destroy human life and are never allowed.

As an adult, I have the right to make decisions about my health care. As a Catholic, I may never choose my own death as an end or a means. There may come a time when I am unable to express my own health care decisions. By writing an advance directive, I give instructions and wishes for my future health care decisions. This advance directive for health care shall take effect when I am not able to express my health care decisions, as determined by my attending doctor. I direct that those responsible for my care make health care decisions according to my stated wishes. I direct that this advance directive be included in my permanent medical record.

Part One: Naming My Health Care Representative

A) I have chosen the following person to be my Health Care Representative.

Name _____

Address _____

City _____ State _____ Zip _____

Telephone Number _____

He or she will be my health care representative to make my health care decisions when I am not able to speak for myself. If my wishes are not clear or events take place that I have not talked about, I ask that my health care representative make the decisions based upon what he or she knows of my wishes.

I have talked with my health care representative about this responsibility. He or she has willingly agreed to accept this role.

B) I have chosen the following person(s) as my Alternate Health Care Representative, if the person I have chosen above is not able, not willing, or not available to act as my health care representative:

1. Name _____

   Address_____City_____State_____

   ZIP_____Telephone Number_____

OR

2. Name_____

   Address_____City_____State_____

   ZIP_____Telephone Number_____

He or she will be my health care representative to make my health care decisions when I am not able to speak for myself. If my wishes are not clear or events take place that I have not talked about, I ask that my health care representative make the decisions based upon what he or she knows of my wishes.

I have talked with my health care representative about this responsibility. He or she has willingly agreed to accept this role.

Part Two: Treatment Choice Instructions

In Part Two, you are asked to give directions about your future health care. This will mean making important and difficult choices. You need to think about and write down different situations when different types of medical treatments, including life-sustaining actions, should be given or should not be given. Before finishing this part, you should talk this over with your health care representative, doctor, priest, deacon, spouse, family members or those who may be responsible for your care. It is suggested that from time to time you look over these instructions with these same people to make sure that your wishes are still the same.

<u>Please take time to look over all of Part Two before completing the form.</u>

GENERAL INSTRUCTIONS: I direct the people who are responsible for my care to carry out the following:

- **Initial one of the following statements -- either A or B.**

_____**A.** I direct that all medically indicated treatments and food and water (through tubes if necessary) be given to maintain my life, no matter what my physical or mental condition. **(Skip B & C)**

OR

_____**B.** If a serious health condition occurs and my primary doctor and at least one other doctor who has personally examined me, decide that the irreversible process of dying has begun and death is very near, I direct **not** to have treatments that would only prolong my dying. If these treatments have been started, they should be stopped. I also want to be given all necessary medical care appropriate to stop pain and to make me comfortable. **(Go to C)**

C. If I have been diagnosed as being in a permanent coma or in a persistent vegetative state after being examined by my primary doctor and at least one other doctor who is qualified to make this decision, **choose either 1 or 2.**

_____1**.** I direct that **extraordinary*** medical care, as understood in the teachings of the Catholic Church**,** including food and water (through tubes if needed) shall be used no matter what my physical or mental health.

OR

_____**2.** I direct that **extraordinary*** medical care, as understood in the teachings of the Catholic Church, shall **not** be used. I direct that food and water (through tubes if needed) be continued unless or until the benefits of this food and water are clearly outweighed by a definite danger or burden, or are useless.

* **Extraordinary** medical care is understood as those medicines, treatments or operations which may be very expensive, may cause excessive pain or other extreme difficulties or which may offer no reasonable hope of benefit.

Examples of extraordinary measures that I would want are as follows:

_____

_____

_____

_____

D. If I am **pregnant** and I am diagnosed as being in a permanent coma, in a persistent vegetative state or that the process of dying has begun and death is near, I direct that all medically indicated measures and food and water (through tubes if necessary) be given to maintain my life, regardless of my physical or mental condition, if this could maintain the life of my unborn child until birth.

E. The State of New Jersey recognizes the irreversible cessation of all functions of the entire brain, including the brain stem (also known as whole brain death), as a legal standard for the declaration of death. Generally, physicians will follow this standard. However, if you cannot accept this standard because of your personal religious beliefs, you may request that it not be applied in determining your death by initialing the following statement:

_____ To declare my death on the basis of the irreversible cessation of all functions of the entire brain, including the brain stem, would violate my personal religious beliefs. I therefore direct that my death be declared solely on the basis of the traditional criteria of irreversible cessation of cardiopulmonary (heartbeat and breathing) function.

F. Please initial one:

_____ Upon my death, I am willing to donate any parts of my body that may be beneficial to others.

_____ Upon my death, I am not willing to donate any parts of my body that may be beneficial to others.

Part Three: Signature, Witnesses and Copies

A. Signature: By writing this advance directive, I ask that my wishes as stated be put into effect by those people indicated to make health care decisions for me when I can no longer make them for myself. I have talked about the terms of this agreement with my health care representative. He or she has willingly agreed to accept the responsibility for making decisions for me according to this advance directive. I understand the purpose and effect of this document. I am signing it willfully, voluntarily, and after careful consideration.

Signed today on (month, day, year) _____

Signature _____

Name (print name) _____

Address _____ City _____ State _____

B. Witnesses: I state that the person who signed this document above did so in my presence, and appears to be of sound mind and free of duress or undue influence to complete this advance directive. I am 18 years of age or older and am not designated by this or any other document as this person's health care representative.

1. Witness signature_____ Date_____

Print witness name_____

Address_____ City_____ State_____

2. Witness signature_____ Date _____

Print witness name_____

Address_____ City_____ State_____

C. COPIES: A copy of this advance directive has been given to the following people. **(It is important to provide your doctor, your health care representative, and appropriate family members or friends with a copy of this document. You keep the original.)**

1. Name _____

Address_____ City_____ State_____

Telephone number_____

2. Name _____

Address_____ City_____ State_____

Telephone number_____

A COPY OF THIS DIRECTIVE SHOULD BE GIVEN TO YOUR HEALTH CARE REPRESENTATIVE, YOUR DOCTOR, AND APPROPRIATE FAMILY MEMBERS OR FRIENDS.