

**A CATHOLIC  
ADVANCE DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES**

**THIS IS AN IMPORTANT LEGAL DOCUMENT KNOWN AS AN ADVANCE DIRECTIVE. ITS PURPOSE IS TO COMMUNICATE YOUR WISHES REGARDING LIFE-SUSTAINING TREATMENT IN THE EVENT YOU SUFFER A TERMINAL OR IRREVERSIBLE CONDITION AND YOU ARE UNABLE FOR WHATEVER REASON TO COMMUNICATE YOUR WISHES AT THE TIME. IT ONLY APPLIES WHEN YOUR ATTENDING PHYSICIAN HAS CERTIFIED IN WRITING THAT YOU ARE IN A TERMINAL OR IRREVERSIBLE CONDITION.**

This Catholic Advance Directive has been prepared in light of the teaching of the Catholic Church, and in conformity with the Texas Advance Directives Act. Specifically, the "General Directives," near the beginning of the legal document, summarize key Catholic principles applicable to individuals who are terminally ill or who are suffering from an irreversible condition and cannot make important decisions for themselves. As a practicing Catholic, you should consider these General Directives to be fundamental to your care. Beyond these fundamental principles, practicing Catholics may differ on how long to continue life-sustaining treatment when they are in a terminal or irreversible condition. Thus, this document permits you to make choices about if and when you would like life-sustaining treatments to end.

You are encouraged to discuss your values and wishes with your family or chosen agent (i.e., the person you have chosen to make health care decisions for you). You also are encouraged to discuss this matter with your physician and spiritual director. Your priest, physician, health care provider, and hospital may provide you with various resources to assist you in completing your Advance Directive. Brief definitions from the Texas Advance Directives Act are listed at the end of this Advance Directive and may help you understand this form.

In order to adopt this Advance Directive, do the following:

1. In the sections marked "*My Preference if I am in a Terminal Condition*" and "*My Preference if I am in an Irreversible Condition*," put your initials beside the treatment choice that best reflects your personal preferences.
2. *In the presence of a notary public OR two adult witnesses* (no more than one of whom should be a family member, your agent, an heir, or one of your health care providers), sign the document. If you travel frequently to other states, it is advisable that you sign the document in the presence of both a notary public and two adult witnesses, in order to help make this document enforceable in other states.
3. Make multiple copies of your Advance Directive to give to your doctors, health care providers, family members and your agent. Make sure your agent has access to the original. This will make it easier for all involved in your end-of-life care to know your wishes in advance and to have ready access to your Advance Directive should you be unable to provide it yourself because of your medical condition.
4. It is recommended that you periodically review this document. By periodic review, you can best assure that the directive reflects your preferences.

It is important to understand that, under Texas law, if you do not have an Advance Directive, there is no presumption that you want life-sustaining treatment to be administered or continued. Moreover, any physician or health professional who has no knowledge that you have an Advance Directive is not civilly or criminally liable for failing to act in accordance with your Advance Directive.

You should know that no physician, health care facility, health care provider, insurer, or health care service plan may require you to execute or issue an Advance Directive as a condition for receiving health care services or obtaining health insurance. All health care institutions in Texas are required to maintain written policies regarding the implementation of Advance Directives; you should ask for a copy of these policies, and read them, when you are admitted.

You also should know that, under Texas Law, your Advance Directive is not effective in the event you are pregnant at the time life-sustaining treatment decisions are required to be made. Life-sustaining treatment must be continued during the duration of your pregnancy.

## DIRECTIVE

I, \_\_\_\_\_, belong to the Catholic Church and desire to follow the moral teachings of my Church by receiving all the care that my Church teaches one has a duty to accept. But I also know that the Church teaches that I may refuse medical treatment that is excessively burdensome or would merely delay my death needlessly. I therefore direct that the following instructions be carried out if my attending physician has, in writing, diagnosed me with a terminal or irreversible condition and if I am not able to communicate at that time:

### General Directives:

1. I direct that those making decisions on my behalf be guided by the moral teachings of the Catholic Church. I direct them to consult my priest, my bishop, and/or the National Catholic Bioethics Center to help them in their decision-making, if necessary.
2. I direct that those making decisions on my behalf consider only the quality and effectiveness of the proposed treatment and not make any judgment about my quality of life.
3. Food (nutrition) or water (hydration) may not be withheld or withdrawn from me for the purpose of, or with the intent of, hastening my death. Food or water may only be withheld or withdrawn from me when my agent, after consulting with my attending physician, determines that (1) my body can no longer absorb food or water, (2) providing food or water likely will cause life-threatening complications, or (3) providing food or water will cause me significant physical pain. By this statement, I expressly reject any statutory language that "life-sustaining treatment" includes "artificial nutrition and hydration."
4. No drug or lethal injection may be given to me for the purpose of, or with the intent of, hastening my death.
5. Palliative care, as defined below, shall be provided to me until I die.
6. I wish all reasonable effort be made to contact a Catholic priest so that I may receive the sacraments and prepare for my death, if imminent.
7. Nothing in this Advance Directive shall be construed to authorize my attending physician to sign an Out-Of-Hospital Do Not Resuscitate Order.

### My Preference if I am in a Terminal Condition:

If, in the judgment of my attending physician, I am suffering with a terminal condition and if my agent, after consultation with my attending physician, determines that life-sustaining treatment does not offer a reasonable hope of prolonging my life or the provision of such treatment entails an excessive burden to me, then:

\_\_\_\_\_ I request that all life-sustaining treatments be discontinued and my attending physician allow me to die as gently as possible, but only in conformity with my General Directives set forth above; OR

\_\_\_\_\_ I request that I be kept alive in this terminal condition using available life-sustaining treatment.

**My Preference if I am in an Irreversible Condition:**

If, in the judgment of my attending physician, I am suffering with an irreversible condition and if my agent, after consultation with my attending physician, determines that life-sustaining treatment does not offer a reasonable hope of prolonging my life or the provision of such treatment entails an excessive burden to me, then:

\_\_\_\_\_ I request that all life-sustaining treatments be discontinued and my attending physician allow me to die as gently as possible, but only in conformity with my General Directives set forth above ; OR

\_\_\_\_\_ I request that I be kept alive in this irreversible condition using available life-sustaining treatment.

**Impact of Hospice Care**

After signing this Advance Directive, if my agent or I elect hospice care, I understand and agree that only those treatments needed to keep me comfortable would be provided and I would not be given available life-sustaining treatments, unless such treatments would likely be effective in remedying a condition I may have or develop. Nevertheless, all of my General Directives set forth above shall remain in full force and effect.

**Definition of Palliative Care**

"Palliative care" means "A comprehensive non-curative plan for prevention and relief of pain and other forms of physical, psychosocial, and spiritual suffering by means of early identification, assessment, and intervention."

**Pregnancy**

I understand that, under Texas law, life-sustaining treatment may not be withdrawn or withheld during my pregnancy.

**Revocation**

This Advance Directive will remain in effect until I revoke it. I understand that I may revoke this Advance Directive orally or in writing, but that the revocation will not be effective until my attending physician has been told of the revocation and has recorded the revocation in my medical file.

**My Agent**

If I do not have a Medical Power of Attorney, and I am unable to make my wishes known, I designate the following person(s) to make treatment decisions with my physician compatible with my personal values.

*Primary Agent:*

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Include City, County and State)

Telephone: \_\_\_\_\_  
(Include Primary Phone or All Phone Numbers)

Alternate Agent (If the Primary Agent Cannot be Reached)

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Include City, County and State)

Telephone: \_\_\_\_\_  
(Include Primary Phone or All Phone Numbers)

(If a Medical Power of Attorney has been executed, then an agent already been named and you should not list additional names in this document).

If the above persons are not available, or if I have not designated a spokesperson, I understand that a spokesperson will be chosen for me following standards specified in the laws of Texas.

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I sign my name to this Advance Directive on the \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Residence Address: \_\_\_\_\_  
(Include City, County and State)

STATE OF TEXAS )  
 )  
COUNTY OF \_\_\_\_\_ )

Before me, the undersigned authority personally appeared \_\_\_\_\_, the Declarant, proved to me through \_\_\_\_\_ (description of identity card or other document) to be the individual whose name is subscribed to the foregoing instrument and acknowledged to me that it was executed for the purposes and consideration therein expressed.

Given under my hand and seal of office this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_.

(Personalized Seal)

\_\_\_\_\_  
Notary Public

*(In Texas, two witnesses are required on a Medical Power of Attorney only if the Principal's signature is not notarized. Further, Texas law does not require the signatures of the two witnesses to be notarized. The notary seal is included below only as a precaution, not as a legal necessity in Texas, in order to help make this document enforceable in states outside of Texas).*

**STATEMENT OF FIRST WITNESS:**

I am not a person designated to make a treatment decision for the Declarant. I am not related to the Declarant by blood or marriage. I am not entitled to any portion of the Declarant's estate on the Declarant's death. I have no claim against any portion of the Declarant's estate on the Declarant's death. I am not the attending physician of the Declarant or an employee of the attending physician. Furthermore, if I am an employee of a health care facility in which the Declarant is a patient, I am not involved in providing direct patient care to the Declarant and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_  
(Include City, County and State)

**SIGNATURE OF SECOND WITNESS:**

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_  
(Include City, County and State)

STATE OF TEXAS )  
 )  
COUNTY OF \_\_\_\_\_ )

Before me, the undersigned authority, personally appeared \_\_\_\_\_ and \_\_\_\_\_ as witnesses, proved to me through \_\_\_\_\_ (*description of identity card or other document*) to be the individuals whose names are subscribed to the foregoing instrument and acknowledged to me that they executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_.

(Personalized Seal)

\_\_\_\_\_  
Notary Public

## DEFINITIONS

For your use in understanding this form, here are definitions of some key terms, as defined by Texas statute. Please note that the statutory definitions are not always consistent with Catholic moral teaching. For example, the definition of “life-sustaining treatment” under Texas law conflicts with Catholic teaching because the Church considers food and water, even “artificial nutrition and hydration,” as ordinary care, not a “life-sustaining treatment.” This is why your Catholic Advance Directive specifically states that food or water may not be withheld or withdrawn from you for the purpose of hastening your death. Other provisions in this Catholic Advance Directive are intended to protect against a non-Catholic interpretation of these statutory terms.

**"Artificial nutrition and hydration"** means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).

**"Irreversible condition"** means a condition, injury, or illness:

(1) that may be treated, but is never cured or eliminated;

(2) that leaves a person unable to care for or make decisions for the person's own self;  
and

(3) that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.

**"Life-sustaining treatment"** means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support such as mechanical breathing machines, kidney dialysis treatment, and artificial hydration and nutrition. The term does not include the administration of pain management medication, the performance of a medical procedure necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.

**"Terminal condition"** means an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care. A patient who has been admitted to a program under which the person receives hospice services provided by a home and community support services agency licensed under Chapter 142 is presumed to have a terminal condition for purposes of this Chapter.

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