

# Living a Catholic Life

## *Health Care Surrogates*

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“Living a Catholic Life” is a collaboration between dioceses, parishes, Knights of Columbus councils, grassroots organizations, and The National Catholic Bioethics Center to educate the laity on principles of the moral life and their application.

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Patients should make health care decisions in conformity with true moral norms. Catholics can be confident that they are doing this when they act in accord with the moral teaching of the Church. This essay discusses the moral responsibilities of adults who have been appointed to make health care decisions for patients who are not competent to do so for themselves.

Directive 25 of the *Ethical and Religious Directives for Catholic Health Care Services* by the United States Conference of Catholic Bishops specifically addresses the responsibilities of health care proxies:

Each person may identify in advance a representative to make health care decisions as his or her surrogate in the event that the person loses the capacity to make health care decisions. Decisions by the designated surrogate should be faithful to Catholic moral principles and to the person’s intentions and values or, if the person’s intentions are unknown, to the person’s best interests. In the event that an advance directive is not executed, those who are in a position to know best the patient’s wishes—usually family members and loved ones—should participate in the treatment decisions for the person who has lost the capacity to make health care decisions.

What precisely is the relationship between “Catholic moral principles,” “the person’s intentions and values,” and “the person’s best interests”? If there is any conflict among them, which must be preferred?

Health care decisions must be in conformity with Catholic moral principles. For example, Catholic moral teaching, as the *Ethical and Religious Directives* make plain, absolutely proscribes mercy killing or euthanasia (dir. 60). The Church also requires that patients receive interventions that are ordinary or proportionate. These measures “offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community” (dir. 56). Conversely, procedures designated as extraordinary or disproportionate may legitimately be refused or withdrawn (dir. 57).

It follows that, in a conflict between the patient’s “intentions and values” and the moral teachings of the Church, the surrogate has a moral responsibility to make the health care decision conform to the latter. Obviously, this conflict can and ought to be avoided. If asked to serve as another person’s surrogate, one ought to make it clear that he or she will refuse to honor any directive not compatible with Catholic teaching and try to

persuade the other person to accept the teaching of the Church and to do so precisely because it is true. Should the person persist in “intentions and values” contrary to Catholic teaching, then one is morally required to refuse to act as that person’s surrogate.

Similarly, a surrogate acts in the person’s “best interests” if and only if he chooses to provide ordinary or proportionate life-preserving procedures, does not withhold or withdraw measures unless they have been judged extraordinary or “disproportionate (although it is permissible to provide extraordinary measures if the patient desires), and steadfastly refuses to kill the patient either by acts of commission or omission.

Federal law requires that persons entering hospitals receive information on formulating advance directives stipulating the kind of health care they wish to receive if they become incompetent. There are three broad types of advance directives: (1) written instructions authorizing the provision, withholding, or withdrawing of life-sustaining procedures under specific conditions, (2) written appointment of a health care agent who will make health care decisions for one should one become incapacitated, and (3) oral directives indicating one’s wishes regarding treatment or the appointment of a health care agent.

Although it is possible to make a morally acceptable written advance directive, the instructions given in it frequently use vague language that can easily be misinterpreted. Then, too, it is exceedingly difficult and perhaps impossible to know in advance what decisions will be morally fitting in unforeseen circumstances or even what information is necessary to make such a decision. In addition, written directives are frequently modeled on the type of living will designed by advocates of euthanasia, who, exploiting the legitimate concern about excessive treatment, promote euthanasia by acts of omission.

Moreover, the civil law of many states offers several legally permissible models of advance directives that may authorize actions contrary to the value of human life. One may be tempted to use a directive of this kind merely because it is legal. Although it is foolish to claim that written advance directives ought not to be employed, it is very important to know the potential problems involved in preparing and interpreting them. If one chooses to prepare a written advance directive, one is morally obligated to seek advice from persons who can help prepare a document of this kind that is in conformity with Catholic teaching and free of ambiguous language.