out of fear that euthanasia and assisted suicide may be legalized, some Catholic commentators have raised questions about the ethics of advance directives for medical decisions. They have almost made it seem as if such documents are intrinsically tied to the “culture of death” and ought to be avoided by faithful Catholics. This is a mistaken view.

An advance directive is a document, like a living will or durable power of attorney for health care, by which a person provides guidance for others who may be called upon to make medical decisions on behalf of the issuer of the directive if he or she is unable to do so.

Like any good thing, advance directives are susceptible to abuse, but they are not intrinsically connected with euthanasia. Although not a panacea, they can be very useful.
Advance directives should be viewed by Catholic Christians as tools to help families and physicians make good decisions about patients who cannot speak for themselves at the end of life. They fit squarely within the Catholic tradition of forgoing extraordinary means of care, a tradition that springs from four natural law principles that can be held independent of any faith commitments.

The first principle is the dignity of the human person. Each individual, by virtue of being human, has an intrinsic value Catholics call dignity. This is the fundamental principle of all interpersonal morality. Medicine reaches out to the sick first and foremost because each person has an intrinsic dignity.

The second principle is the duty to preserve life. This duty, while not absolute, is based on natural instincts, gratitude for the gift of life and duties to fulfill responsibilities toward others.

The third principle is the fact of finitude. Human beings are finite. People get sick; they die. Medicine is a finite craft, and all patients ultimately die. Individual and collective resources are also finite.

The fourth principle is the diversity of the human. Individuals are different from each other in all sorts of ways. Decisions must take into account the uniqueness of each case.

Extraordinary Meanings
Suicide and euthanasia are considered immoral because they violate the dignity of the person and undermine the duty to preserve life, which can never be made consistent with a direct intention to eliminate life. Western moral thinking, however, has always recognized the fact of finitude. The duty to preserve life, therefore, is limited. Hippocrates does not counsel physicians to keep treating patients to the bitter end. Rather, he urges physicians not to treat those who are “overmastered” by disease, recognizing that “in such cases medicine is powerless.” Today, it is recognized that even with the most sophisticated technology, doctors cannot keep patients alive forever.

It is from these principles, simultaneously affirming the dignity of the human person and human finitude, that the moral tradition of forgoing extraordinary means of care arose. To say that an intervention is extraordinary signifies that its use is optional—that one need not use it. One should not be confused by the use of the words ordinary and extraordinary in everyday speech. Extraordinary is used here as a technical term meaning non-obligatory, and ordinary is used to mean obligatory.

By tradition, an intervention is deemed extraordinary if it is futile, that is, if it will not work (will not cure the patient, reverse the condition or appreciably forestall an imminent death) or if the burdens imposed by the intervention—physically, psychologically, socially, economically, morally and spiritually—outweigh the benefits. By tradition, one does not focus on the intervention itself, a priori, divorced from a case. The adjectives ordinary and extraordinary modify one’s duty to use an intervention; they do not modify machines or treatments. That means one can never say, “This treatment is always ordinary,” or “That treatment is always extraordinary.”

In keeping with the principle of diversity, these judgments always depend upon the circumstances. So, for example, one can never say, “Ventilators are extraordinary and antibiotics are ordinary.” Surgery for a ruptured appendix, for instance, might require a ventilator. Other things being equal, the duty to use a ventilator would be

ordinary in such circumstances. But in the case of pneumonia in a patient with untreatable metastatic or widespread cancer, a ventilator might not appreciably forestall an imminent death. Even if not strictly futile, the burdens could certainly be judged to outweigh the benefits and so the duty to use the very same machine, a ventilator, would be extraordinary in such circumstances. Even antibiotics could be considered an extraordinary means in such a case. Since antibiotics would preserve the patient's life perhaps a few hours or days, in this case even the burden of being stuck with a needle could be judged to outweigh the benefits. In such circumstances, the duty to use antibiotics would be morally optional. No intervention can be judged ordinary or extraordinary apart from the circumstances.

The Patient’s Perspective
The Catholic tradition of forgoing extraordinary means of care has always examined these cases from the perspective of the patient, asking only whether it would be reasonable, in the patient’s circumstances and in the patient’s judgment, to forgo the intervention. The perspective is not that of the physician or the family in light of their duties toward the patient, but is instead that of the patient who has a duty to preserve his or her own life. The patient traditionally has been given wide latitude in deciding what is extraordinary, within the bounds of reason and the judgment of the community. The limits are broadly drawn, not because of any notion of unrestrained autonomy, but because of the fact of diversity. People do, in fact, differ. They have different pain
ing its many benefits is the responsibility for deciding when not to use it. Otherwise people will become prisoners of technology.

The third reason is the great weight that falls upon loved ones. Studies have shown that making these decisions is exceedingly stressful for families—equivalent to the stress of having survived a house fire or other calamity. These stud-

Glossary
Advance directive: a document, like a living will or durable power of attorney for health care, that enables a person to provide guidance for others who may need to make medical decisions on that person's behalf in the event that the author of the directive loses the capacity to make decisions.

Living will: a listing of the patient's preferences for or against specific treatments at the end of life, which goes into effect if one is terminally ill and lacking in decision-making capacity.

Durable power of attorney (health care proxy): a document that names a person (and usually also an alternate) to whom physicians should turn for medical decisions in the event that the patient is unable to make decisions.

Extraordinary means: a technical term in ethics that means non-obligatory; the use of extraordinary means is optional.

Ordinary means: a technical term in ethics that means obligatory.

Relieving the Burden
Advance directives help put the focus back where it should be—where families, friends, pastors, physicians and the law all should have their focus—squarely on the patient. In the 21st century, advance directives have become useful instruments for carrying out traditional morality. This is primarily because so many people now die after they have already lost their decision-making capacity. Because of medical successes against cancer and heart disease, more people will live long enough to succumb to Alzheimer's disease, for example. People who used to be dead within hours from septic shock can now survive in intensive care units. But this success comes at a price. While some will survive, most will still die after having spent weeks on life support, unable to speak for themselves. Studies have shown that as much as 86 percent of the time, judgments to forgo cardiopulmonary resuscitation are made when the patient cannot participate in the decision. There is almost a moral imperative for people, realizing that they very well might die in a state of mental incapacity and aware that each is the best judge of his or her own limits, to execute advance directives in order to assist those who will make decisions for them.

The second reason to reconsider the value of advance directives is the power of medical technology. An advance directive is not an arcane abstraction. With so many possible treatments, studies now demonstrate that approximately 90 percent of hospitalized patients die after a decision to forgo a procedure that could have been tried. One of the burdens of contemporary medical technology accompany-
family wounds; and the consequence is, as a default, the continuation of life-sustaining treatment. That decision might not be what the patient would have wanted. It might not be what the physician thinks is in the patient’s best interests. It might not be what most of the family thinks is right. But without some way to resolve the dispute short of recourse to the courts (always a bad idea), the treatment continues because the alternative is irreversible. Advance directives can provide a simple way of settling such disputes.

**Preference for a Proxy**

How do these instruments work in practice? There are two basic types of advance directives—the living will and the durable power of attorney for health care (or health care proxy). Briefly, a living will lists the patient’s preferences for or against certain treatments at the end of life and goes into effect if one is terminally ill and lacking in decision-making capacity. The health care proxy names a person (and generally an alternate) to whom the physicians should turn for medical decisions in the event that the patient is unable to make them. Some documents combine elements of both. Forms can be obtained from physicians’ offices, state government Web sites, hospitals and lawyers. Lawyers are not necessary, however. All one needs, typically, is for two persons to sign an attestation that the person making the directive was in a rational state of mind at the time the document was executed.

Advance directives are not a panacea for the complexity of end-of-life decisions. People often hesitate to fill them out, and most Americans die without them. Living wills can be too vague or too specific, and these documents, which are written texts, are as such subject to interpretation. Most patients would opt to give their loved ones substantial authority to interpret their documents and even to over-ride their preferences, because they trust their families to act out of love. Thus the health care proxy form is the overwhelming preference of ethicists and clinicians. It is much easier for them to talk to a person who knows the patient and has been selected by the patient than it is to try to interpret a piece of paper. Catholics who are wary that their documents could be abused and their religious beliefs ignored would be best served by designating a health care proxy as they prepare their advance directives. But even this important role has its limits: Patients frequently fail to discuss their wishes with the person they appoint as proxy, and studies have shown that proxies are often inaccurate in predicting patient wishes.

Some faithful Catholics might worry that recent changes in church teaching regarding the use of feeding tubes for persons suffering from devastating neurological conditions, like the persistent vegetative state, will require them to alter their existing advance directives or to avoid using advance directives altogether. Recent church teaching, however, emphatically has not altered the centuries-old Catholic tradition of forgoing extraordinary means of care. Feeding tubes can still be considered extraordinary (i.e., optional) for patients who are dying of progressive underlying conditions like cancer or advanced dementia or if the use of the tube is associated with great burdens or costs. To try to specify in a living will all the nuances of Catholic teaching about feeding tubes would do more harm than good by creating a complicated and confusing text that others would later have to interpret. This is just another reason for preferring a health care proxy. Then one needs only to instruct one’s proxy to decide on one’s behalf in accord with church teaching.

Despite their limitations, advance directives provide an important means to accomplish the goals of the tradition of forgoing extraordinary means. Advance directives foster decision-making by those who know and love the incapacitated patient that is focused on the authentic values and real interests of the dying patient. Such decisions would constitute good care, recognizing both the dignity and the finitude of the human person, affirming the value of life but conscious that our ultimate destiny is eternal, not temporal.