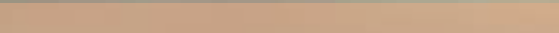


Now and at the Hour of Our Death

A Catholic Guide to
End-of-Life Decision-Making

by the Catholic Bishops of New York State





Introduction

Advances in medical technologies bring with them new means of curing disease and living longer, healthier lives than ever before. But they can also be the source of heightened patient anxiety about a needlessly prolonged, painful and expensive dying process. Medical advances bring with them new and complex questions with regard to medical treatments and moral decision-making.

Our Catholic faith offers both a long tradition of reflection and Church teaching to help guide us through these multifaceted issues. It is important not to let the struggle over such questions eclipse what should be transcendent and grace-filled moments in the dying process: attending to spiritual needs, healing broken relationships, and saying good-bye.

Difficult decisions about the use of medical technology at the end of life may be made easier if we take the time to express our wishes about end-of-life treatments before illness strikes. This guide is designed to explain the moral principles of Catholic teaching with regard to end-of-life decision-making and to outline the options that exist in New York State for advance care planning.

Church Teaching

The Church teaches us that each and every human life is an unrepeatable gift, created in the image and likeness of God. We are called to respect and protect human life because of its inherent dignity, sacredness and value. We understand that life is a sacred trust over which we have been given stewardship, but not ownership. Our life belongs to God, and we do not have absolute power over it. So while it is entrusted to us, we are called to care for it, preserve it and use it for the glory of God.

All those who are sick should rightfully expect, accept, and be provided appropriate food, water, pain control, bed rest, suitable room temperature, personal hygiene measures and comfort care. These are not medical treatments, but basic care-giving, the care that is owed to one human being by another. Truly to respect the dignity of the person, we must provide those who are sick with adequate pain relief, symptom management, compassion, acceptance, love, and physical, emotional and spiritual care.

The Church also teaches that the suffering of illness and dying is an opportunity for finding oneness with Christ. Suffering can be an instrument of redemption when we seek in faith to join our suffering to that of Jesus on the cross at Calvary.

For Catholics, death is a doorway to eternal life. In the face of illness, suffering, and death, our faith assures us that we are created for eternal life. "I look forward to the resurrection of the dead, and the life of the world to come. Amen."⁽¹⁾

These fundamental underpinnings of our faith, derived from Sacred Scripture and our Catholic tradition, guide our decisions about end-of-life treatment.

Life is a Gift to be Cherished, Never Rejected

"Human life is sacred and inviolable at every stage and in every situation; it is an indivisible good."⁽²⁾ Therefore, we must cherish and preserve all human lives as gifts from God. We may never deliberately and directly cause the death of an innocent person. To deliberately cause the death of an innocent person both contradicts human reason (natural law) and violates the Fifth Commandment, "you shall not kill," and our duty to "love one another."⁽³⁾

Euthanasia is "an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated."⁽⁴⁾ While some may view euthanasia as a way for a person with an incurable disease or disability to escape a difficult and painful life, such a view is a rejection of the precious gift of life and a rejection of God's plan. Those whose lives are diminished or weakened deserve special respect and preferential care.⁽⁵⁾

There may be a temptation to judge the quality of our own life and the lives of others and to use this “quality of life” standard to guide medical decisions. However, regardless of “quality” labels, the sacredness of all human life is always to be valued and protected.

Some who suffer with severe illness may be tempted to consider assisted suicide. Assisted suicide is the voluntary termination of one’s own life using physician-prescribed medications that will cause death. It is considered **active euthanasia** because it is the direct and intentional taking of life. It is gravely immoral both for the patient who is assisted and for the physician who assists. While assisted suicide is now legal in several states, it is illegal in New York State.⁽⁶⁾

Whatever the motives and means, euthanasia consists of putting an end to the lives of sick, despairing or dying persons, or persons with disabilities. Regardless of the civil laws, euthanasia always, without exception, constitutes a grave moral evil.⁽⁷⁾

Ordinary vs. Extraordinary Treatments

The immorality of directly intending and bringing about our own death or of assisting in the death of another by intentional action is evident enough. Decisions can become much more complex – and more difficult -- when we contemplate the removal or withholding of medical treatment such as a ventilator or dialysis. In an age of rapidly advancing life-sustaining treatment technologies, such decisions are not infrequent.

Out of deep respect for the gift of life, we must always accept, and others must provide, **ordinary medical means** of preserving life. Ordinary means are those that offer us a reasonable hope of benefit and would not entail excessive burden on us, our family or the community.⁽⁸⁾ Ordinary means of medical treatment are **morally obligatory**. Withholding ordinary care with the intention of causing death is considered **passive euthanasia** and is always gravely contrary to God’s will.

But Catholics are not morally bound to prolong the dying process by using every medical treatment available. Allowing natural death to occur is not the same as killing. Some treatments may be considered “**extraordinary**” (as opposed to ordinary) and are not morally obligatory because the burdens and consequences are out of proportion to the beneficial results anticipated for a particular patient. These are considered **morally optional** treatments.

For example, it would be permissible for a cancer patient to forego a particularly aggressive and expensive treatment if the patient judged the survival rate too low and the pain of the treatment too great a burden.

But what constitutes an “excessive burden?” Our Church suggests that when making a decision to accept or refuse a treatment, we should take into consideration the type of treatment recommended, how risky or complicated it is, its cost, side effects, how painful it will be, its availability, the likelihood of that treatment maintaining or enhancing the life of the patient, and the need to share limited medical resources.⁽⁹⁾ We should also consider the spiritual and emotional burdens on ourselves and our family.

One of the most important moral distinctions for end-of-life decision-making is between what is morally obligatory and what is morally optional. Even if death is thought imminent, ordinary care owed to a sick person cannot be legitimately interrupted.⁽¹⁰⁾ On the other hand, discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of “over-zealous” treatment.⁽¹¹⁾

Sometimes the very same medical intervention can be morally obligatory (ordinary) in one case, but morally optional (extraordinary) in another. For example, a relatively healthy person recovering from a bout with pneumonia may need to be on a ventilator for a few days to



restore him to his optimal condition. But for a patient in the final stages of lung cancer, being placed on the same ventilator may be painful, burdensome and only prolong the patient's dying process without any reasonable benefit. The particular burdens of any treatment will vary with each individual.

Weighing the burdens and benefits of particular medical treatments for each individual requires us to apply the virtue of prudence, using practical reason to discern the true good and choose the right path. Because such decisions are often sensitive and complex, Catholics may wish to seek guidance from a moral expert who regularly makes judgments on these matters, such as a priest, chaplain or ethicist.

The Special Case of Assisted Nutrition and Hydration

The important distinction between what is morally obligatory and morally optional extends even to food and water when it is medically assisted. In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally.⁽¹²⁾ This obligation extends to those with presumably irreversible conditions (such as "persistent vegetative state" or PVS) who are not imminently dying. This is so because even the most severely debilitated and helpless patient retains the full dignity of the human person and must receive ordinary and proportionate care such as food and water.

But as is the case at times with life-sustaining treatments, medically assisted nutrition and hydration, although constituting a form of ordinary care, may, under very specific circumstances, be deemed excessively burdensome and of little or no benefit to the patient. The most common case of this is when the patient enters into the dying process and the body can no longer properly assimilate food and water, even through a tube. When death is imminent (within days) or in rare instances when a gastric feeding tube may cause intractable side effects such as severe agitation, physical discomfort, aspiration into the lungs, or severe infection, any foreseeable benefits of maintaining the tube are likely outweighed in light of the attending burdens. In this case, other means of providing nutrition or if not feasible, at least hydration, even if minimally, must be carefully considered and employed if possible.

When medically assisted nutrition and hydration is withheld or withdrawn for licit reasons, death occurs as a result of the underlying disease, not through starvation or dehydration.

It is never permissible to remove a feeding tube, or any other form of life-sustaining treatment, based on a belief that the patient's life no longer holds value or with the intention to terminate the patient's life.

A Final Word on Church Teaching

In summary, medical interventions may be deemed ordinary (morally required) or extraordinary (morally optional) based on the weighing of benefits and burdens expected for each individual. This is not just a pragmatic decision of costs and benefits, but a moral decision that affects our spiritual health.

When we make decisions about these treatments either for ourselves or our loved ones, and we wish to make them in accord with our faith, we must take into account all factors – risks, benefits, alternatives, condition, prognosis, cost -- and consider all possible burdens on the patient, the family and the community. Determining if and when a particular treatment can morally be withheld or withdrawn should be done with all involved parties – patient, patient's surrogate (if the patient is incapacitated), family members, health care providers, and oftentimes a priest or ethicist trained in the Church's moral teachings.

The provision of food, water, cleanliness and warmth are elements of ordinary care that we owe to our brothers and sisters in Christ as we respond to the Gospel call to care for "the least among us." They are morally required for each patient.

Treatment decisions are moral decisions, and must be made with informed consent. Each of us has free will and the ability to reason and we must use these gifts as we make important medical decisions. As Christians, we have the moral obligation to make decisions which are good for us and are according to God's will.



Planning in Advance – Legal Options in New York State

There may come a time when our ability to reason, or even to communicate, is compromised and we will not be able to make our own medical decisions. We have the ability to plan in advance to ensure that our wishes about medical treatments and our religious beliefs are known and honored at that time. Advance directives are legal documents that take effect when a patient becomes incapacitated and incapable of making medical decisions.

Federal law requires all health care facilities to advise patients, upon admission, of their right to accept or refuse medical treatment and their right to issue advance directives.⁽¹³⁾ In New York State there are various forms such a directive can take. Each of them is discussed below. When considering an advance directive, it is important to study thoughtfully and prayerfully the principles of the Catholic faith and prepare the document in accord with Church teaching. While most advance directives may grant a surrogate the authority to make some or all health care decisions for us, the Church teaches that not all health care decisions are ours to make or to delegate to a surrogate.

It is impossible to cover all possible medical situations in an advance care directive. Therefore, it is important to ensure that there is room for interpretation when a particular medical situation occurs. For this reason, the Church recommends the health care proxy as the most morally appropriate advance care planning tool in New York State. It will allow an appointed surrogate to follow the patient's wishes in accord with Church teaching.

The Health Care Proxy

New York State law⁽¹⁴⁾ allows you to specify a particular individual, such as a family member or close friend, as your health care “agent,” empowered to make medical decisions on your behalf when you are no longer able to do so. Unless stated otherwise, a health care agent can make all decisions that you could make while competent, including decisions about life-sustaining treatments. Because you can choose an agent who will advocate for treatment that is in accord with your moral and religious beliefs, signing a health care proxy is a morally appropriate and desirable action to take.

When choosing someone to be your health care agent, it is important to choose someone known to be of good moral character, who knows you well, is familiar with your religious beliefs, has the ability to understand medical information, operates well under stressful conditions, and who will be sure that end-of-life decisions on your behalf are made in accord

with the Church’s moral teachings. Have a conversation with the person you wish to name as your agent about your preferences while you are healthy and competent. Be sure to have periodic conversations with that person as well, because your agent will be interpreting your wishes as medical circumstances change, and could be called upon to make decisions you may not have known would have to be made.

In addition to naming the person you choose as your surrogate decision-maker, your health care proxy can also include specific written instructions that your agent must follow. Therefore, you may wish to cite some official Catholic documents (such as the Catechism of the Catholic Church, the Declaration on Euthanasia, and the Ethical and Religious Directives for Catholic Health Care Services referenced within this booklet) so that your agent will be guided by the teachings of the Church. You may wish to specifically forbid any form of euthanasia. You may wish to state generally:

“Medical treatments may be withheld or withdrawn if they do not offer me a reasonable hope of benefit or if they are excessively burdensome to me, my family, or the community.”

Importantly, a health care agent does not have authority to make decisions about medically assisted nutrition and hydration unless you have given clear instructions about those particular measures. Therefore, if you want your health care agent to be empowered to make decisions about medically assisted nutrition and hydration for you, you should state as follows:

“My health care agent has full authority to make decisions about beginning, withholding and withdrawing medically assisted nutrition and hydration in accord with the teachings of the Catholic Church.”

A ready-to-use Health Care Proxy form from The National Catholic Bioethics Center, with some specifically Catholic language within, together with simple instructions, is included in this document.

The Living Will

Also recognized in New York State is the living will, wherein medical decision-making power is vested in a written legal document, rather than in an individual. A living will is limited and inflexible because it requires that you put in writing today, while you are healthy and capable, your wishes and preferences about medical conditions and treatments that are unforeseen or unknown in the future. Medical technology advances so quickly that it is practically impossible to know what will be available when illness or injury strikes. Moreover, changing treatment modalities may make a treatment that a patient once considered onerous, a life-saving intervention that could be denied because of its exclusion in a living will.

Although the living will is legally recognized in New York State, **from the Catholic perspective, the health care proxy is the much preferred advance directive.** A health care proxy does not require that you attempt to deal in advance with all the decisions that may have to be made.

Other Factors Governing Health Care Decision-Making in New York

Family Health Care Decisions Act (FHCDA)

For persons who have not appointed a health care agent or prepared any type of advance directive, New York State law now allows for surrogate consent to health care decisions, including life-sustaining treatment decisions, for patients who cannot make their own decisions. The “Family Health Care Decisions Act” (FHCDA) became effective in June 2010.⁽¹⁵⁾ Therefore, if you become incapacitated and you have not prepared an advance directive or appointed a health care agent, **the law will appoint a surrogate decision-maker for you.**

Do not assume that someone you trust will be empowered to make medical decisions for you if you become incapacitated. **Without someone you name to oversee your care or written instructions from you, your preferences, moral values and religious beliefs may not be adhered to as you near the end of life.**



The FHCDA establishes a protocol for hospitals to use that prioritizes the persons who can make decisions for you should you become incapacitated. The surrogate decision-makers who have legal authority to make medical decisions for you, ranked in priority order by the law, are:

- 1 Legal Guardian (for the mentally ill)
- 2 Spouse or Domestic Partner
- 3 Adult Son or Daughter
- 4 Parent
- 5 Adult Brother or Sister
- 6 Close Friend

If conflicts arise among any of the persons on the list regarding a health care decision, or if the attending physician objects to the surrogate's decision, the matter must be referred to a hospital ethics review committee.

Under the FHCDA, a surrogate must make health care decisions in accord with your wishes, including your moral and religious beliefs, provided that they are known. If your wishes are not known, the surrogate can use "substituted judgment," in other words, substitute his or her judgment for yours, keeping your best interests in mind.

In assessing your best interests, the law says the surrogate must consider:

- the dignity and uniqueness of every person;
- the possibility of preserving life;
- the restoration of the patient's health;
- the relief of the patient's suffering, and
- the patient's religious and moral beliefs.

The law allows a surrogate to withhold or withdraw life-sustaining treatment if:

- the treatment is an excessive burden and death is expected within six months; or
- the treatment is an excessive burden and the patient is permanently unconscious; or
- treatment would involve such pain, suffering or extraordinary burden that it would be deemed inhumane, and the patient has an irreversible or incurable condition.

The decision-making standards in the law are obviously complex. While the law does attempt to establish safeguards to protect vulnerable patients from inappropriate and dangerous decisions, it does not mirror authoritative Catholic teaching. For example, it does not define "excessive burden" nor does it make a presumption in favor of providing those who are permanently unconscious with nutrition and hydration, as Catholic teaching does. Therefore, **it is preferable for Catholics to appoint a health care agent under the health care proxy law** in order to guide their agent in adhering to their faith beliefs.

Do Not Resuscitate (DNR) Orders

A “Do Not Resuscitate” (DNR) Order, signed by a physician, is a medical order that will instruct medical personnel not to attempt cardiopulmonary resuscitation (CPR) if a patient’s heartbeat or breathing stops. CPR generally includes chest compressions, defibrillation, insertion of a tube to open the airway, or other resuscitation techniques. A DNR order is only about CPR and does not affect any other treatment.

In New York State, DNR orders are recognized both inside and outside of the hospital setting.⁽¹⁶⁾ Any adult can consent to a DNR order and if you are incapacitated, your health care agent can consent for you. In the absence of a health care proxy, a surrogate can be named for you to consent to a DNR order, based on the list of surrogate decision-makers outlined under FHCDA.

For Catholics, deciding about a DNR order again requires weighing burdens and benefits. For a frail elderly sick individual, or a terminally ill patient, signing a DNR order may be a morally appropriate thing to do if it is prudently judged that resuscitation would be of no significant benefit to the patient. Resuscitation techniques at times constitute extraordinary (and therefore morally optional) means of sustaining life, such as the case when reviving a patient would only allow him or her to continue in the dying process. On the other hand, for a patient who is not terminally ill, successful CPR can constitute a form of ordinary care which allows the person to resume their previous lifestyle.

Before deciding about a DNR order, you should speak with your doctor, priest or ethicist, family members and health care agent about the burdens and benefits of CPR in specific situations.

Medical Orders for Life-Sustaining Treatment (MOLST)

Another advance care planning tool recognized in New York State law is MOLST, or “Medical Orders for Life-Sustaining Treatment.”⁽¹⁷⁾ MOLST proposes broader application of the DNR concept in that it is a medical order extending beyond the decision to use or not use CPR to the use of other life-sustaining measures, such as the administration of antibiotics and medically assisted nutrition and hydration.

A MOLST form converts a person’s end-of-life treatment preferences into immediately actionable medical orders, signed by a physician. **This means that the form mandates compliance by all health care workers, including emergency responders.** A MOLST order supersedes any conflicting or pre-existing advance directives. And it is not conditioned on a patient losing capacity to make decisions; MOLST applies immediately upon signing.

MOLST orders are intended for persons who are near the end of their lives; indeed, MOLST was developed specifically for use by patients whose life expectancy is one year or less. And for this particular population, the form can be a useful and morally appropriate tool.

However, extreme caution is urged with regard to MOLST orders. The philosophy behind the MOLST is absolute patient autonomy, raising individual preferences about end-of-life care to the level of an enforceable legal right. As noted previously, no person has absolute autonomy over his or her life or health care decisions. It is always morally unacceptable to refuse ordinary treatments with the intention of hastening death of self or others.

MOLST can become a dangerous instrument when it is completed in advance of a fatal diagnosis. A person's theoretical decisions about what care they should or should not receive may be radically different than decisions made in the context of a real disease at the present moment. Even for those who are terminally ill, MOLST orders can easily and implicitly allow patients to mandate non-treatment in a way that constitutes euthanasia.

No person is required to consent to the execution of a MOLST. They should be used only with great care.

Conclusion

The best time to create an advance directive such as a health care proxy is now -- before you enter a hospital or nursing home or become seriously ill. That way you can consider all your options carefully and competently, through the lens of your faith. Take time to reflect on your beliefs and have conversations about those beliefs with your family members, loved ones and health care providers.

It is hoped that the guidance provided herein will be of assistance as you consider your own advance care planning or are charged with the responsibility of making medical decisions for a loved one.

Health Care Proxy

I, (Name) _____

residing at (Address) _____

(Date) _____, hereby create a Health Care Proxy and designate

Name

Address

Telephone

Address

to be my health care agent for making any and all health care decisions on my behalf should I ever become incompetent. If my agent is ever unable or unwilling to act as my agent, I hereby designate

Name

Address

Telephone

Address

to be my alternative health care agent.

Signature _____ Date _____

My health care agent has the authority to make any and all medical decisions on my behalf should I ever be unable to do so for myself. I have discussed my wishes with my agent (and with my alternate agent) who shall base all decisions on my previous instructions. If I have not expressed a wish with respect to some future medical decision, my agent shall act in a manner that he/she deems to be in my best interests in accord with what he/she knows of my beliefs.

My agent has the further authority to request and receive all information regarding my medical condition and, when necessary, to execute any documents necessary for release of such information. My agent may execute any document of consent or refusal to permit treatment in accord with my intentions. My agent may also admit me to a nursing home or other long-term care facility as he/she deems appropriate and to sign on my behalf any waiver or release from liability required by a physician or a hospital.

Please complete both sides of this form.

As a member of the Catholic Church, I believe in a God who is merciful and in Jesus Christ who is the Savior of the World. As the Giver of Life, God has sent us his only begotten Son as Redeemer so that in union with Him we might have eternal life. Through His death and Resurrection, Jesus has conquered sin so that death has lost its sting (I Cor. 15:55). I wish to follow the moral teachings of the Catholic Church and to receive all the obligatory care that my faith teaches me we have a duty to accept. However, I also know that death need not be resisted by any and every means and that I have the right to refuse medical treatment that is excessively burdensome or would only prolong my death and delay my being taken to God. I also know that I may morally receive medication to relieve pain even if it is foreseen that its use may have the unintended result of shortening my life.

Witness _____ Date _____

I affirm that the principal is at least eighteen years of age, of sound mind, and under no undue influence.

Witness _____ Date _____

I affirm that the principal is at least eighteen years of age, of sound mind, and under no undue influence.

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The National Catholic Bioethics Center
6399 Drexel Road, Philadelphia, PA 19151-2511

About the Health Care Proxy

1. The health care proxy is an important legal document. It gives the person you name as your health care agent the authority to make health care decisions for you, including decisions to provide, withhold or withdraw life-sustaining treatments, unless you state otherwise in the form.
2. Under New York State law, unless your agent has been given clear instructions regarding your wishes about medically assisted nutrition and hydration (nourishment and water provided by a feeding tube or intravenous line), he or she will not be permitted to make decisions about those measures for you.
3. You can use the sample health care proxy included in this booklet or you can draft your own, using this as a guideline.
4. The proxy does not expire, but you may update it or change it at any time simply by completing and dating a new one.
5. Even though you have signed a health care proxy, you have the right to make your own health care decisions as long as you are able to do so. Your agent will not have authority to make decisions for you until your doctor determines you are not able to make health care decisions for yourself.
6. You do not need an attorney to complete the proxy and it does not have to be notarized.
7. You do need two adult witnesses to your signature who must sign the document as well.
8. You should keep a copy of the document and give a copy to your doctor, your named health care agent and your alternate agent.



References

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2. *Evangelium Vitae*, The Gospel of Life, 1995, No. 87
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4. Vatican Declaration on Euthanasia, Congregation for the Doctrine of the Faith, 1980
5. Catechism of the Catholic Church (No. 2276)
6. Oregon, Washington, Montana (as of July, 2010); NYS Penal Law Section 125.15 (3)
7. Adapted from the Catechism of the Catholic Church (No. 2277)
8. Ethical and Religious Directives for Catholic Health Care Services, 5th edition, Part 5 (No. 56)
9. Adapted from the Vatican Declaration on Euthanasia, Congregation for the Doctrine of the Faith, 1980
10. Adapted from the Catechism of the Catholic Church (No. 2279)
11. Catechism of the Catholic Church (No. 2278)
12. Ethical and Religious Directives for Catholic Health Care Services, 5th edition, Part 5 (No. 58)
13. "Patient Self-Determination Act of 1990," 42 U.S.C. 1395 cc (a)
14. New York State Public Health Law, Article 29-C, 1990
15. New York State Public Health Law, Article 29-CC, 2010
16. New York State Public Health Law, Article 29-B; New York State Department of Health Memo, 92-32
17. New York State Department of Health Physician Order Form DOH-5003, approved January 17, 2006, updated June 2010

Additional Resources

1. The National Catholic Bioethics Center, a Catholic bioethics think tank staffed by ethicists. 215-877-2660; www.ncbcenter.org; e-mail: info@ncbcenter.org
2. United States Conference of Catholic Bishops, Pro-Life Secretariat, the official voice of the United States Bishops with links to Church documents and teachings. 202-371-3070; www.usccb.org/prolife/issues/euthanasia/index.shtml; e-mail: prolife@usccb.org

In-depth Reading

1. "Vatican Declaration on Euthanasia," Congregation for the Doctrine of the Faith, May 5, 1980; available at www.usccb.org/prolife/tdocs/euthanasia.shtml
2. Catechism of the Catholic Church, 2nd edition, United States Catholic Conference, 1997, available at www.vatican.va/archive/catechism/ccc_toc.htm
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New York State Catholic Conference
465 State Street
Albany, NY 12203-1004
518.434.6195 • Fax 518.434.9796
email: info@nyscatholic.org
www.nyscatholic.org