

The VLRC Report on Guardianship and Catholic Teaching

The Victorian Law Reform Commission's Report on Guardianship contains many findings and recommendations about Advance Care Planning. This article considers the most significant of these from the perspective of the teaching of the Catholic Church.

Perhaps the simplest way of understanding this article is to think of it as a dialogue between what the Victorian Law Reform Commission's *Report on Guardianship* says about advance care planning and what Catholic teaching says about the same topic. In places, Catholic teaching questions some of the Commission's recommendations. In other places, the Commission's Report caused me at least to expand my understanding of what the Church teaches about advance care planning.

At this time, the people of Victoria including its Catholic community must engage with the Commission's Report. We must consider its recommendations, and work with our elected representatives to frame new laws which most effectively meet the needs of people with impaired decision-making capacity. I hope that this article contributes positively to this process.

This article contains two major sections. The first introduces the Commission's report. It notes some of its major recommendations about advance care planning. Here and there, I record either my agreement or my concerns about some of these recommendations.

In the light of the Commission's Report, the second major section of this article presents Catholic teaching about end-of-life decision-making and advance care planning. Here and there, I record places where the Commission's Report has caused me to expand my understanding of Catholic teaching. As we learn new insights about advance care planning, Catholic teaching itself will develop to reflect the best and most authentic of these insights.

I. THE VLRC REPORT

In May 2009, the Victorian Attorney-General directed the Victorian Law Reform Commission (VLRC) to review Victoria's *Guardianship and Administration Act 1986* and to offer recommendations on how the law might be changed so as to better respond to the needs of people with impaired decision-making capacity. Over a total period of two and a half years, the processes of review were

extensive. The Commission established two advisory committees to provide input from legal experts and from organisations which represent different groups of people with impaired decision-making capacity. It issued an Information Paper in January 2010, and received 60 submissions in response. Around the same time, it undertook broad community consultation. The Commission then issued a Consultation Paper in March 2011, this time receiving 86 submissions.¹ Around the same time, there was a second round of broad community consultation. The Commission also considered similar or related reviews both within Victoria and beyond.

The Victorian Law Reform Commission's *Final Report on Guardianship* was issued on 31 January 2012.² It is a massive document of almost seven hundred A4 pages. This article does not attempt a comprehensive summary of the Report. Instead, it simply focuses on a number of its most significant findings and recommendations about advance care planning:

IN THIS ISSUE

The VLRC Report on Guardianship and Catholic Teaching

- | | |
|--|------|
| I. THE VLRC REPORT | Pg 1 |
| II. CATHOLIC TEACHING | Pg 5 |
| A. Futile or Overly Burdensome Treatment | Pg 6 |
| B. Best Interests or Substituted Judgment? | Pg 8 |

by Kevin McGovern

Developments Since 1986

The VLRC noted two very important changes since the Victorian Guardianship law was first enacted twenty-six years ago in 1986. Firstly, those who use the provisions of the law have changed. The *Guardianship and Administration Act* was originally designed to serve the needs of people with intellectual disabilities, and indeed people with intellectual disabilities continue to be significant users of its provisions. Nowadays, however, the major users of its provisions are people with dementia, people with mental illness, and people with acquired brain injury. Further, with an ageing population, the major users of the provisions of this law over the next twenty years are most likely to be people with dementia. The Commission argues convincingly that the law should be changed to reflect this significant change in the people who use its provisions.

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Secondly, there has been a major change in community attitudes towards people with disabilities. Twenty-six years ago, the focus was on their protection from harm. Nowadays, the focus is on their participation. We seek to support people with disabilities to be active, participating members of society and also to participate as fully as possible in the decisions that affect their lives. This changed view is both reflected in and advanced by the United Nations' *Convention on the Rights of Persons with Disabilities*, which Australia ratified on 17 July 2008.³ Again, the VLRC argues convincingly that the law should be changed to reflect this significant change in community attitudes towards people with disabilities.

Assistance in Decision-Making

The current laws draw a sharp line between those with capacity to make their own decisions and those who lack this capacity. Under these current laws, those who lack capacity have their decisions made for them by another person. As the Commission notes, however, capacity is actually much more complex than this. For example, some people can still make many if not all decisions with only a small amount of assistance. The VLRC therefore proposes a greater variety of decision-making assistance so that those with some albeit limited capacity may still be involved in the decisions that affect their lives.⁴

The simplest form of assistance is informal as family and friends help in decision-making perhaps by reminding a person with impaired decision-making capacity what has always been his or her preferences.

The Commission also recommends **'supporters'** who are appointed either by the supported person or, with the agreement of the supported person, by the Victorian Civil and Administrative Tribunal (VCAT).⁵ These supporters

do not replace the supported person in decision-making, nor do the two of them make the decision together. Instead, they support the person to make his or her own decision. The person appointed as a supporter might be a trusted family member or friend, or in some cases they might be a trained volunteer. This concept of a supporter holds great promise to help those people who only need a small amount of assistance in order to make their own decisions.

For those who require a bit more decision-making assistance, the VLRC also recommends **'co-decision makers.'**⁶ Those who would benefit from a co-decision maker lack the capacity to make their own decisions by themselves. These appointments must therefore be made by VCAT, but the person with impaired decision-making capacity must also agree with the appointment. A person and his or her co-decision maker make decisions together. For those with significant impairment of their decision-making capacity, the concept of a co-decision maker holds promise of providing them with a greater degree of involvement in the decisions that affect their lives than is provided by the use of a substitute decision-maker.

I endorse these recommendations about supporters and co-decision makers. They seem to me to be particularly helpful strategies to assist people with dementia.

Finally, the greatest level of decision-making assistance is provided by the substitute decision-maker, who makes decisions on behalf of a person whose decision-making capacity is greatly impaired.

Substitute Decision Makers

The VLRC argues that Victoria's laws on substitute decision-making have become unnecessarily complex and inaccessible. There are currently six different types of substitute decision-making appointments under three different Acts.⁷ These current laws allow us to appoint substitute decision-makers for lifestyle (such as where and how we live), financial matters, and medical treatment. The Commission argues that these three categories are unnecessary. Instead, it proposes financial and personal matters as two categories, with personal matters including decisions about both lifestyle and medical treatment. This does seem like a good idea.

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The VLRC proposes five different types of substitute decision-maker. Its strong preference is for personal appointments chosen by the represented person. It recommends that we should be able to appoint an **'enduring personal guardian'** to represent us in personal matters and an **'enduring financial administrator'** to represent us in financial matters.⁸ The

Commission also accepts that some appointments do need to be made by the Victorian Civil and Administrative Tribunal. It therefore recommends that in certain circumstances VCAT should be able to appoint a **‘personal guardian’** to represent someone in personal matters and a **‘financial administrator’** to represent someone in financial matters. If no other substitute decision-maker has been appointed, the Commission also recommends the automatic (statutory) appointment of a **‘health decision maker’** who makes medical treatment decisions for a person who lacks capacity. It suggests a hierarchy of who should be appointed to this role, with the Public Advocate as the decision-maker of last resort if no one else is appropriate.

The current law requires substitute decision-makers to act in the “best interests” of the represented person.⁹ It also provides a number of guidelines on how to do this, one of which suggests “taking into account [the represented person’s] wishes as far as possible.”¹⁰

The VLRC expressed at least three concerns about the phrase ‘best interests.’ Firstly, it thought that what this concept really means is actually quite unclear. Secondly, it was concerned that this phrase might encourage substitute decision-makers to make decisions based on their own values, and thereby to impose their own values onto a represented person. And thirdly, the Commission was concerned that this phrase might encourage the paternalistic view that we substitute decision-makers know what is best for the persons we represent, and therefore that we should simply decide for them rather than seriously considering their wishes. For all these reasons, the VLRC recommends that the guiding principle for substitute decision-making should change from the “best interests” of the represented person to the “promotion of the personal and social wellbeing” of the represented person.¹¹

... the VLRC recommends that substituted judgments should be the “paramount guiding principle” in substitute decision-making....

In making this determination, the principle of substituted judgment directs the substitute decision-maker “to make the decision they believe the person they represent would have made themselves if they were able to do so.” In other words, it “asks the decision maker to ‘stand in the shoes’ of the represented person, and to seek to make that person’s decision.”¹² Significantly, the VLRC recommends that substituted judgments should be the “paramount guiding principle” in substitute decision-making.¹³ Of course, “it should not be the only consideration.”¹⁴ In some cases, we cannot apply this principle because for various reasons we really do not know what the represented person would want. In other cases, we should not apply this principle because its application would lead to the represented person suffering serious and unacceptable harm.¹⁵ For all that, however,

the Commission recommends that substituted judgment should be “the starting point and the paramount consideration for substitute decisions.”¹⁶ It adds that this recommendation is its “most significant reform proposal” and “the one that generated the most responses.”¹⁷ We will discuss this recommendation in more detail in the second part of this paper.

Instructional Directives

Logically, there are three ways through which someone may influence their future health care. One is by appointing a substitute decision maker. Another is by preparing a written statement. The third is by a combination of these two strategies: both appointing a substitute decision maker and at the same time preparing a written statement. In this case, the written statement may either bind or simply guide the substitute decision maker.

... if we are reasonably well, a sensible strategy for advance care planning is “combining an appointment of a trusted person with instructions that guide, rather than bind, decisions.” ...

Especially if we are reasonably well, it is almost impossible to predict what our health might be like in the future, or what sorts of health decisions may have to be made for us. The Commission observes that in these circumstances a sensible strategy for advance care planning is “combining an appointment of a trusted person as a substitute decision maker with instructions that guide, rather than bind, decisions.”¹⁸ In an official statement about advance care planning, the Australian Catholic bishops provide the self-same guidance.¹⁹

The health status of some people is much more complex. They may be frail and elderly. They may have chronic, degenerative, advanced or terminal conditions. They may also have had a lot of experience dealing with their condition and its treatment. And the trajectory of their disease may be predictable, at least to some extent. Especially in these circumstances, as the Commission notes, some people do want to make advance decisions, either refusing or consenting to specific treatments.²⁰

It must be admitted that there is some anxiety about binding advance directives within some parts of the Catholic Church. Catholic teaching holds that we are obliged to use the ordinary means of preserving life. There is therefore some anxiety that these ordinary means of preserving life might be refused through a binding advance directive.²¹

Despite this anxiety, we in the Catholic Church must recognise that there are some circumstances in which binding advance directives are appropriate and perhaps even necessary. Not For Resuscitation Orders are a form of advance directive, and Catholic teaching does not reject their use in appropriate circumstances. Advance

refusal of hospital admission, intubation, intensive care, dialysis, or (in some cases involving dementia) even the insertion of a feeding tube may also be appropriate in the specific circumstances of an individual patient.

Experience particularly in residential aged care facilities has revealed the limitations of relying exclusively on substitute decision makers. Crises often occur between midnight and dawn, and rightly or wrongly care staff often hesitate to phone and wake up substitute decision makers. Or they occur at other times when for various reasons substitute decision makers cannot be contacted. If the staff at the aged care facility are not sure what to do, they will call the ambulance, and an elderly, frail patient may cascade from the ambulance to the Emergency Department to Intensive Care. Finally, the family do arrive, and they observe sadly, “This is just what Mum was trying to prevent.”

In cases like these, a binding advance directive may well be the best strategy to spare a vulnerable patient from what will most probably be burdensome and futile treatment. We in the Catholic Church must recognise that there are circumstances in which a binding advance directive can be ethical and may even be necessary.²²

Current Victorian law provides a *Refusal of Treatment Certificate*. It may be used for advance refusal of treatment, but not for advance consent. The patient must be sufficiently informed about his or her condition and the consequences of refusing treatment so as to make reasonable decisions about the refusal of treatment. Treatment may be refused for a current condition only. However, palliative care may not be refused.²³

The VLCR proposes a new *Instructional Health Care Directive*. It should be designed in consultation with a wide range of stakeholders. It should be easy to understand and easy to use. It should permit both advance refusal and advance consent. It should apply to future as well as current conditions. It should permit statements which guide a substitute decision maker, along with binding instructions about health matters. It should not allow someone to demand treatment which is not being offered. It also should not permit someone to demand unlawful interventions such as euthanasia and assisted suicide.²⁴ All these proposals seem reasonable to me. Perhaps by oversight, the Commission has not stated explicitly that the new directive should not permit the refusal of palliative care.

As we have noted, the requirement under current Victorian law is that someone making an advance directive should receive information about their condition and the consequences of refusing treatment. The VLCR proposes that this should be encouraged, but that it “should not be mandatory.”²⁵ One of the witnesses to the current form must be a registered medical practitioner. However, the Commission also proposes that the authorised witness to the new form need not be a registered medical practitioner. Instead, it could be any person with legal authority to witness an affidavit – and therefore someone who could not be

expected to give medical advice. Given their proposal that a person making an advance directive need not seek such advice, the Commission argues that “there should not be a formal requirement that one of the witnesses is a registered medical practitioner.”²⁶

I am profoundly uneasy with both these proposals. Without adequate medical advice, someone might refuse treatment which could have saved their life. Or they may choose a path to death which is unnecessarily painful and distressing. (An example of this is an insulin-dependent diabetic who refuses insulin. They will almost certainly experience several days of quite distressing symptoms before they die.) Given that these are medical decisions, it seems reasonable to expect someone to consult with a medical practitioner as they complete an advance directive. And given that binding decisions may literally be matters of life and death, it does not seem overly onerous to require this. In advance care planning, our concern must be to empower people to make informed and reasonable choices about possible treatments or the refusal of treatment. I would be much more confident that this purpose will be achieved if we retain the requirements that those completing an advance directive must consult with a registered medical practitioner, and that this practitioner must witness that they are adequately informed.

... *Given that these are medical decisions, it seems reasonable to expect someone to consult with a medical practitioner as they complete an advance directive. ...*

Let me make one more point on this matter before moving on. The Commission has noted that the preferred advance care planning option for most people in good health is the appointment of a substitute decision-maker along with instructions which guide but do not bind future decisions. This reminds us that the *Instructional Health Care Directive* is not necessarily for everyone. As we think about this form, we should therefore not be attempting to design something that everyone can simply fill in at home. An advance directive is entirely appropriate in certain circumstances. Its completion can have very serious consequences. These are considerations which we should keep in mind as we think about the *Instructional Health Care Directive*.

Let us now turn to another topic. In its submission responding to the Commission’s Consultation Paper, the Catholic Archdiocese of Melbourne argued that “it is immoral to seek to bind someone else to acting in ways which they may find to be against their conscience. Advance directives are such that they risk violating the right to freedom of conscience, thought and belief.”²⁷

In its Final Report, the VLCR also acknowledges this concern. It “accepts that a lawful direction may be

inconsistent with a health professional’s conscience.” It therefore recommends that “new guardianship legislation should permit a health professional to refer a patient to another health professional if their personal views or beliefs prevent them from complying with lawful directions in a valid instructional health directive.”²⁸ This seems to me to be a reasonable balance between the rights of patients and the rights of health professionals.

There is one more issue which we should note under this heading. The Commission expresses support for “outcomes-based” advance directives – that is, advance directives which consider the “outcomes or goals” which a patient would consider to be either acceptable or not acceptable.²⁹ We will consider this recommendation in more detail in the second part of this paper.

Registration

The VLRC also recommends a system of on-line registration of all personal appointments³⁰ and advance directives. Those who have a legitimate need for this information (such as hospitals, medical practitioners, and a host of other organisations and individuals) should be licensed to access the register.

The Commission recommends that “it should be mandatory to register a personal appointment for it to be valid.”³¹ (They also propose a transitional period of 5 years during which existing appointments which are not registered remain valid.³²) When someone claims to represent another, organisations like hospitals and banks need to be able to check quickly that this authority is both valid and current. They also need to check if there are any limits on the representative’s authority. The Commission recommends compulsory registration of personal appointments to provide for these sorts of situations.

... if we are to take advance care planning seriously, a system of on-line registration accessible to those who need this information seems necessary. ...

On the other hand, the Commission recommends at least for now that the registration of instructional health directives and other advance directives should be encouraged but not compulsory. They make this recommendation as they do not believe that there are currently many disputes about advance directives. However, they comment that “it would be advisable to re-consider mandatory registration of instructional health directives if there were evidence of significant disputes about the existence or effect of these documents.”³³

These recommendations seem reasonable to me. Indeed, if we are to take advance care planning seriously, a system of on-line registration accessible to those who need this information seems even necessary.

Other Matters

The VLRC report also considers quite a number of other matters. These include the processes whereby authorisation could be given for the participation in research of persons with impaired decision-making capacity, the processes whereby restrictions on liberty could be authorised in residential care, and many other issues raised by disability and mental illness. All these matters are outside the scope of this article.

Having now presented some of Commission’s major recommendations about advance care planning, I turn now to Catholic teaching about end-of-life decision-making and advance care planning.

II. CATHOLIC TEACHING

In Australia, a competent adult has the legal right to refuse any form of medical treatment. By contrast, the Catholic approach to decisions about choosing or refusing treatment is based on a distinction between the ordinary and extraordinary means of preserving life. The Australian bishops expressed this Catholic standard well:

We have a moral responsibility to use those means of sustaining our lives that are effective, not overly burdensome and reasonably available. (Such means are referred to in the Catholic tradition as ‘ordinary’ or ‘proportionate.’)... [We] have a moral right to refuse any treatment that is futile, or that [we] judge to be overly burdensome or morally unacceptable (referred to in the Catholic tradition as ‘extraordinary’ or ‘disproportionate’).³⁴

These legal and ethical standards co-exist in sometimes creative tension. The Catholic ethical standard is the traditional morality of Western civilisation. Even today, it is still invoked in contemporary health care. If a patient is deliberating about a certain treatment, their health professional may remind them that they have a legal right to refuse this treatment. In some cases, he or she may also advise them that this particular treatment would be extraordinary means, and therefore that their right to refuse this treatment would also be recognised by traditional morality. Note too that the legal standard offers a broader choice than the Catholic ethical one. Under the legal standard, we may refuse ordinary means. Under the Catholic ethical standard, we should not. Are there many cases in Australia in which a patient uses their legal right to refuse what the ethical standard would regard as ordinary means? This is a matter of conjecture and debate. My own opinion is that such cases would be quite rare.

Catholics hold this standard because we have a profound sense of the connection between God and the deep mystery of human life. Just as people may say that a newborn baby is a miracle, Catholics believe that it is God along with our parents who gives each one of us the

Gift of life. At the same time, however, we also believe that our life still belongs ultimately to God, who created it. We are not absolute owners of our life. Instead, we are God's stewards, charged with the responsibility of using ordinary means to preserve God's gift. I should add that many people who do not have an explicit Christian faith also have a deep respect and even reverence for human life. The idea that we should use ordinary means to preserve human life makes sense to many people.

Catholic teaching about ordinary and extraordinary means is found in the following official statements:

- Pius XII's *The Prolongation of Life*
- the Congregation for the Doctrine of the Faith's *Declaration on Euthanasia (Jura et Bona)*, III & IV
- John Paul II's *The Gospel of Life (Evangelium Vitae)*, #65
- the Pontifical Council for Health Pastoral Care's *Charter for Health Care Workers*, #119-121
- *Catechism of the Catholic Church*, #2278-2279
- the *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*, II.1.12-16 & II.5.9-12
- the Australian bishops' *Guide for people considering their future health care and Guide for health care professionals implementing a future health care plan*

Drawing on these sources, what might we learn about distinguishing the ordinary and extraordinary means of preserving life? The *Declaration on Euthanasia* tells us that we can make this distinction "by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources."³⁵ John Paul adds that treatments are also extraordinary if they "impose an excessive burden on the patient and his family."³⁶ Much therefore must be considered to distinguish ordinary and extraordinary means. We should consider the risks and burdens of a proposed treatment, its availability and cost, and its probable results. We should also consider whether or not a patient has the physical and psychological resources to undergo this treatment. The *Catechism* states that these "decisions should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected."³⁷ Finally, the *Declaration on Euthanasia* notes that "when inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the

normal care due to the sick person in similar cases is not interrupted."³⁸

A. Futile or Overly Burdensome Treatment

In practical cases, we must never neglect any of the considerations which Catholic teaching identifies as relevant to distinguishing ordinary and extraordinary means. Even so, this distinction often focuses on whether or not a proposed treatment is either futile or overly burdensome. We should note that for a treatment to be extraordinary, only one of these two criteria must be satisfied. Treatment is extraordinary if it is futile without being overly burdensome. It is also extraordinary if it is overly burdensome without being futile. And of course it is extraordinary if it is *both* futile *and* overly burdensome.

Futility

The concept of futility is sometimes used by health professionals in a way that is problematic and concerning. Let me offer an example. A man is in intensive care after a serious car accident. While they probably could save his life, his health professionals believe that he will almost certainly never regain anything like normal consciousness. Almost certainly he will remain either in post-coma unresponsiveness (PCU) or in a minimally responsive state (MRS).³⁹ Because they do not regard this as a worthwhile outcome, the health professionals tell the family that further treatment would be futile and therefore that treatment will be stopped. The family concurs, for who would want futile treatment?

... The concept of futility is sometimes used by health professionals in a way that is problematic and concerning. ...

When the concept of futility is used in this way, it prevents informed decision-making. For informed decision-making, the family must be told the likely prognosis. It is their task, not that of the health professionals, to decide whether or not treatment with this likely outcome is futile for their loved one. Some families might come to the same conclusion as the health professionals did. Other families, however, might report that life itself was of great value to their loved one. Their loved one may even have said that he wanted his life to continue even if he did not experience normal consciousness. (This view accords with official Catholic teaching, and probably with the teaching of some other religions as well.) For this family – and for their loved one – treatment with this outcome is *not* futile.

'Therapeutic privilege' refers to the uncommon situation in which a health professional is legitimately excused from the normal obligation to inform the patient or their representatives fully. It may have some application in some mental health cases in which there are serious

concerns that the patient is not stable enough psychologically to handle all the facts. It is unreasonable, however, to invoke ‘therapeutic privilege’ in cases like the one above. The concept of futility should not be used to hide the facts from patients or their representatives, or to usurp the legitimate role of patients or their representatives in making decisions about treatment options. To do so is paternalistic and unethical.⁴⁰

... the Australian bishops rightly condemn “judgments about the ‘futility of a person’s life.’” ...

The concept of futility should also not be used to express and at the same time to conceal a judgment that some lives are not worth living. Once again, someone does this if they dismiss as futile any treatment which will probably leave a patient alive but in PCU because they regard such a life as not worth living. Others may view such a life quite differently. For example, Queensland Christian Brother Dan Courtney, who died recently, lived for more than 10 years in PCU. Long-term carer Sr Colleen O’Brien observed, “Some thought this period of Dan’s life was wasted. But no life is wasted – life is a gift. For the carers, walking into Dan’s room was really walking into the mystery of God. The great call was a call to faith and compassion, and the more they visited Dan, the more they grew in those areas. That was Dan’s gift to the carers...”⁴¹ From this perspective, the Australian bishops rightly condemn “judgments about the ‘futility of a person’s life.’”⁴²

The Australian bishops state that treatments are futile “if they provide no benefit to a particular patient.” They add that these benefits include “slowing down the progress of disease,” “sustaining the patient’s life,” and “relieving the patient’s distress or discomfort.”⁴³

Two nuances should be added to this position. Firstly, as we have noted above, treatment which offers only a short extension of life may cease to be obligatory as death becomes imminent. Secondly, some treatments have a very low chance of providing benefit (e.g. less than 3%). (Such treatments are sometimes called quantitatively futile.) Once again, if the probability of benefit is sufficiently low, I cannot see how these treatments could be regarded as morally obligatory. Someone may choose to try these treatments, but I cannot see how we could tell them on ethical grounds that they are obliged to do so.

Burdensome Treatment

Let us turn to overly burdensome treatments. Treatment is overly burdensome if it is physically too painful. After three cycles of chemotherapy, someone with cancer might make this judgment about a fourth cycle of chemo. Treatment may also be overly burdensome if it is psychologically too distressing. Someone who has always been greatly distressed by a naso-gastric tube might legitimately refuse NG tubes not on the grounds

that they are physically painful but on the grounds that they are for her too psychologically distressing. Treatment can be overly burdensome if it is socially too isolating. For example, a woman from a country town might refuse treatment which will require a long stay in a distant capital city because it will take her away from her extended family and all her friends. Treatment may be overly burdensome if it is financially too expensive, either for the patient or for society.⁴⁴ Treatment can also be overly burdensome if it is either morally or spiritually repugnant. For example, it is very important for some Indigenous people that they die in their traditional lands. They may therefore legitimately refuse treatment in a distant city because of the risk of dying away from country.⁴⁵ Treatment that will consume a great deal of the patient’s time and energy day after day may also be overly burdensome.

Future Burdens

There is one more way in which treatment can be overly burdensome. Let me make this point using an example. Some patients with motor neuron disease (MND) are assisted by non-invasive positive pressure ventilation (NIPPV). For some time, this treatment can greatly improve their quality of life. As their condition deteriorates, however, they begin to experience distressing symptoms such as swallowing difficulties (management of secretions), breathlessness, and agitation which cannot always be managed effectively. Further, it is reasonably certain that over time these symptoms and others will become more severe and less easy to manage.

There must be extensive discussions between the patient, their family and their health professionals. In some cases, it is reasonably certain that the patient will not survive for long without the ventilation. Even so, everyone may agree that, given what the future probably holds, the best course of action now is to withdraw NIPPV. This process must be managed carefully. The patient should be given medication perhaps including sedation to manage breathlessness and distress. Any family members who want to be there should be present. A health professional should monitor the patient. The patient may die quite quickly or perhaps will survive for a few hours or even a few days.

In this case, NIPPV is judged to be overly burdensome and then withdrawn partly because of the *current* burdens that the patient is experiencing. However, it is also judged overly burdensome because of well-founded concerns about the *future* burdens that the patient will almost certainly experience. It is sometimes said that the possible outcome of treatment is not a relevant consideration in the Catholic discernment of ordinary and extraordinary means. To the contrary, this case indicates that the outcome of treatment is sometimes a relevant and even necessary consideration in distinguishing the ordinary and extraordinary means of preserving life. In this regard, note that the *Declaration on Euthanasia* had identified “the result that can be expected” as a relevant consideration in this discernment.

There are probably a number of cases like this. Another example is an elderly, frail patient who develops pneumonia. With intensive care and extensive therapy, their life could probably be saved. This treatment is not attempted, however, for two reasons. The first is the burdens of the treatment itself. The second is the well-founded concern that after this life-saving treatment, the patient would be so debilitated that they could only continue to survive through ongoing, overly burdensome treatment. Once again, the probable outcome of treatment is a relevant consideration to the discernment of ordinary and extraordinary means.

... our limited but real appreciation of probable outcomes already influences many medical decisions, such as whether or not someone should have surgery. It would be surprising if this consideration was irrelevant to the discernment of ordinary and extraordinary means. ...

These reflections on the outcome of treatment may raise a number of concerns. The first is that we cannot know the future with absolute certainty. While this is true, however, our limited but real appreciation of probable outcomes already influences many medical decisions, such as whether or not someone should have surgery. It would be surprising if this consideration was irrelevant to the discernment of ordinary and extraordinary means. A second concern is that ahead of time we often overestimate future burdens and at the same time underestimate our ability to cope. As a result, we may refuse treatment and then die, whereas if we had gone ahead with treatment the future may well have been quite acceptable. (For example, most of us imagine that we would never cope with locked-in syndrome. However, a survey of 65 patients with chronic locked-in syndrome – the largest survey ever – found that only 28% were unhappy and only 7% wanted to end their lives.⁴⁶) This consideration is surely a reason to be cautious as we consider future burdens. However, it is not a reason to ignore future burdens as we discern ordinary and extraordinary means. Indeed, in some cases, our concerns about future burdens could be very well founded. A third and final concern is that some people will make foolish decisions in this regard. For example, I once heard of a lady who refused treatment and died, because after treatment she may have had to have moved into a nursing home, and this change of lifestyle seemed unbearable to her. However, all the other criteria for overly burdensome treatment may also be used foolishly. This potential for misuse does not mean that we should neglect any relevant criterion.

In the first part of this paper, we noted that the Victorian Law Reform Commission had expressed support for “outcomes-based” advance directives – that is, advance directives which consider the “outcomes or goals” which a patient would consider to be either acceptable or unacceptable.⁴⁷ Our discussion here demonstrates that

some consideration of outcome in advance care planning is not inconsistent with Catholic standards.

That being said, there needs to be careful thought about how outcomes might best be considered in advance care planning and particularly in advance directives. To contemplate possible futures which involve some measure of sickness, frailty and dependence can be upsetting and even frightening. Gripped by fear, people may make decisions which are really not in their best interests, such as refusing all treatment. Or again, people may fill in check boxes on a form without really considering the decisions that they are making. If good advance care planning facilitates informed decision-making, neither fear-based reactions nor the almost unthinking completion of forms is satisfactory. Both these processes are even more worrying if binding decisions are being made.

In my opinion, it would not be appropriate for a form to list various possible outcomes and then to ask a person either to indicate which outcomes they regard as acceptable or to specify what treatment they would or would not want in these various situations. To me, it is also inappropriate for a patient to authorise treatment only if the doctors expect a reasonable outcome. Given that there are so many different understandings of what constitutes a reasonable outcome, this directive is so vague as to be useless. Between the extremes of all possible treatment and no treatment at all, it is often useful to offer patients the alternative of a limited trial (perhaps for a few days) of perhaps limited treatment to see how well they do. If they do not make good progress in that time, treatment may then be withdrawn.

... there needs to be careful thought about how outcomes might best be considered in advance care planning and particularly in advance directives. ...

These reflections highlight the difficulties of designing a truly useful *Instructional Health Care Directive*.

B. Best Interests or Substituted Judgment?

If we are making medical decisions for another person who is no longer competent, should we be guided by the principle of best interests or the principle of substituted judgment? The former principle directs us to the *objective* standard of what is truly the best treatment decision. The latter principle directs us to the *subjective* standard of the decision that the represented person would have made if they had been able to do so. The question of which principle we should follow is not discussed in official Catholic teaching, which therefore gives us no explicit guidance on this matter.⁴⁸ Because Catholic bioethics places such stress on objective morality, we may at first feel more drawn to the best interests principle. In this

section, however, I argue that the principle of substituted judgment is not inconsistent with Catholic standards, and indeed that there are very good practical reasons why this principle should be supported by Catholic bioethics. I offer five points:

Interconnections

My first point is that while it is possible to separate objective and subjective standards conceptually and in the abstract, practically and in real-life cases the two standards are in fact quite closely related. Indeed, in the majority of real-life cases both the objective and subjective standard will lead to the self-same treatment decision. Let us note some of the interconnections between these two standards. On the one hand, it is not possible to apply the objective standard to an actual case without considering what are normally regarded as subjective matters. Is it in someone's best interests to have treatment which will probably save their life but which will almost certainly be reasonably burdensome? In the abstract, we cannot say. It is only after we consider subjective factors that we are able to say that this treatment is in the best interests of the young mother who wants to see her children grow, but not in the best interests of an elderly lady who is already very frail and sick. On the other hand, objective factors influence subjective decisions about treatment. Someone makes a subjective decision *in favour* of one treatment because this treatment is not too burdensome, but holds reasonable promise of cure. Or again, someone makes a subjective decision *against* another treatment because it holds much less promise of cure, but threatens much greater burdens. As I have said, because of these interconnections, in the majority of real-life cases both the best interests principle and the principle of substituted judgment lead to the self-same treatment decision. It is a mistake to overstate the difference between these two standards.

... I argue that the principle of substituted judgment is not inconsistent with Catholic standards, and indeed that there are very good practical reasons why this principle should be supported by Catholic bioethics. ...

Contemporary Problems with Best Interests

My second point is that nowadays attempts to identify objective best interests can be controversial, and may be problematic. Let a case from the Victorian Supreme Court *Gardner; re BWV [2003] VSC 173* serve as an example. Sixty-nine-year-old BWV was in post-coma unresponsiveness (PCU) and fed through a PEG feeding tube. Three medical witnesses argued that the ongoing provision of nutrition and hydration through the PEG was "futile, in the sense that it has no prospect whatever of

improving her condition." On the other hand, Archbishop Hart and Catholic Health Australia argued that this provision was not futile because it sustained her life. After several days of hearing, the Court in effect supported the first view.⁴⁹

This means that there is both a problematic concept of futility and a controversial legal precedent which inform any attempt in Australia to identify objective best interests in future cases like this. Catholic bioethics must be careful. Supporting the best interests principle may have the perverse consequence of disenfranchising those who want to follow Catholic teaching. As we have noted, Catholic teaching holds that in principle tube-feeding should be continued for those in PCU. Drawing on this concept of futility and this legal precedent, however, an attempt to identify objective best interests may well conclude that tube-feeding should be withdrawn.

As we have noted, current Victorian law provides something of a hybrid principle: best interests "taking into account [the represented person's] wishes."⁵⁰ Even this does not guarantee that tube-feeding will be continued in these sorts of cases, for those who support withdrawing nutrition and hydration in PCU cases could argue that even after taking into account the represented person's wishes, it still remains that case that objectively (by *their* standards) tube-feeding should be withdrawn.

The Sophistication of Substituted Judgment

I have just made the perhaps counter-intuitive point that the best interests principle might nowadays disenfranchise those whose views run counter to the current medico-ethical orthodoxy. My third point is also somewhat counter-intuitive. It is that the principle of substituted judgment might be the best way to ensure that views outside the current medic-ethical orthodoxy will still be heeded. This time, let us use the Maria Korp case as an example. In February 2005, Maria Korp was locked in the boot of her car for four days. Even after extensive treatment, in July she was in post-coma unresponsiveness (PCU) and fed through a PEG. Some months previously, Victoria's Public Advocate Julian Gardner had been asked to determine whether or not Mrs Korp's tube-feeding should be withdrawn. I once heard Gardner speak about this case.⁵¹ In effect, he sought to apply the principle of substituted judgment. He noted that Mrs Korp was a loyal Catholic who would want to follow her Church's teaching. He sought opinions from two Catholic bioethicists. Mrs Korp's clinicians advised that it had not been possible to stabilise her medical condition, and indeed by July that her condition had become terminal. Both Catholic bioethicists determined that according to the standards of the Catholic Church, it was now appropriate to stop tube feeding. Tube feeds were withdrawn on 26 July; Mrs Korp died on 5 August.⁵²

As I have noted, this determination took several months. Gardner noted that some health administrators complained that it was taking so long. For at least some

of them, this case was simple. Because Mrs Korp would almost certainly never regain anything like normal cognitive function, they applied this form of the best interests test to conclude that further treatment including PEG feeding was futile. They could not understand why Gardner was taking so long to reach this simple conclusion.

I submit that two conclusions may be drawn from this case. Firstly, it confirms an observation made by the Victorian Law Reform Commission. Substituted judgment is indeed “a relatively sophisticated approach to substitute decision making.” It is much more sophisticated than the best interests principle, especially in the way that this principle may be applied in Australia today. And secondly, as I have said, it is probably the best way to ensure that views which are outside the current medico-ethical orthodoxy will still be heeded. Far more than the best interests principle, the principle of substituted judgment “acknowledges the uniqueness of the represented person”⁵³ and reminds us to respect and heed their distinctive views.

Practical Considerations

My fourth point is that most substitute decision-makers tend to make substituted judgments.⁵⁴ Health professionals often encourage this approach. For example, as they sit with the family, they may point to an empty chair and ask, “If Mum were sitting here with us, what would she say?” The Victorian Public Advocate also encourages its guardians to make substituted judgments where appropriate.⁵⁵

... Substituted judgment is indeed “a relatively sophisticated approach to substitute decision making.”...

What is more, there are some practical advantages with substituted judgment. For one thing, many people find it easier to *speak* for another person (as in substituted judgment) instead of *deciding* for them (as in the best interests principle). I once had an experience which taught me this very powerfully. I had been asked to speak with a woman whose elderly mother was on a ventilator. It was clear that her mother was not going to recover, and she had been asked to authorise for the ventilator to be turned off. She had sat for some hours, and was obviously struggling with the decision, which is why I was asked to speak with her. I asked how it was going. She said that she was really struggling because if she said to turn off the ventilator, she was making a decision to end her mother’s life. I explained that she was not being asked to decide for her mother, but rather simply to speak for her. If her mother could speak, what would she say? “Oh, that’s easy,” she said, almost without thinking about it. “Mum wouldn’t want to be kept alive like this.” There was then a pause, as we both replayed her last sentence in our minds. “Is it as easy as that?” she asked. “Yes, it is,” I

explained. “You don’t have to decide for your mother. You only have to speak for her.” “Well, why didn’t someone tell me that!” she protested. “I’ve been sitting here sweating blood because no one told me what I was supposed to be doing!”

... most substitute decision-makers tend to make substituted judgments. ...

One obstacle to substitute decision-making may arise when the substitute decision-maker has some unresolved issues with the patient. Perhaps there is something they would like to discuss with them or resolve before the patient dies. Or if they feel some guilt towards the patient, they might insist on every possible treatment so as to calm their own guilt. While I cannot prove this, I believe that the principle of substituted judgment can help them to move beyond this. The best interests principle encourages them to weigh up many things, and somehow their own feelings and desires often get caught up in this. On the other hand, substituted judgment somehow gets them out of their own head and their own unresolved issues to look at this patient and this patient’s values and what this patient would want in these circumstances.

Obviously, good ethics is not determined by usual practice. Even so, good ethics should not ignore usual practice. We might suggest a different way if there were serious problems with the usual practice. In this case, however, I am not convinced that there are frequent, serious problems caused by the use of substituted judgment. I think it makes more sense in this case to recognise and affirm the usual practice, which seems to work well in the vast majority of cases.

Hard Cases Make Bad Law

My final point concerns some of the reasons which are put forward in favour of the best interests principle. Those who advocate for best interests usually suspect that there are many cases in which a vulnerable patient does not get the treatment that they really should get. They are particularly concerned about euthanasia by omission, which occurs when a patient is not given the ordinary means of sustaining life. Sometimes, they suspect unscrupulous health professionals. Other times, they suspect unscrupulous families, including those who want a family member to die quickly so they can inherit from them.

Those who advocate for the best interests principle often envisage court cases which seek a legal determination that a patient must be given certain treatments. One reason that these advocates support the best interests principle is that they believe this principle will be more compelling in these court cases than the principle of substituted judgment would be.

I cannot deny that abuses do happen, and that sometimes people do not receive the treatment that they should.

Even so, I suspect that such cases are much rarer than the advocates of the best interests principle believe. What is more, there is a legal saying that ‘hard cases make bad law.’ This means that if we try to frame laws to cover the difficult cases like these ones, we end up with a law which does not work well for the vast majority of cases in which there are no problems, and in which everyone - all the family and all the health professionals - agree on what is best to do.

I hope I have demonstrated that the principle of substituted judgement is not incompatible with Catholic standards, and indeed that there are very good practical reasons why this principle should be supported by Catholic bioethics. The Victorian Law Reform Commission recommendation that substituted judgment should be the “paramount guiding principle” in substitute decision-making is likely to be controversial in Catholic circles. I think that this recommendation is eminently reasonable.

Conclusion

From a Catholic perspective, there is much to support in the recommendations made by the Victorian Law Reform Commission about advance care planning. I have recorded my endorsement of supporters and co-decision makers, instructional health directives, and an on-line register. I recognise that some consideration of outcome is appropriate in advance care planning and in instructional health directives, though I believe that more thought is needed about how this can best be done. While it cannot be the only consideration, I support substituted judgment as the paramount guiding principle in substitute decision-making. On the other hand, I question the recommendation of removing the present requirement that people should consult with a registered medical practitioner as they complete an advance directive. I also question the recommendation of removing the present requirement that a registered medical practitioner should be one of the required witnesses for an advance directive.

As I have said, at this time the people of Victoria must engage with the Commission’s Report, consider its recommendations, and work with our elected representatives to craft new laws which most effectively meet the needs of people with impaired decision-making capacity. I hope that these reflections contribute positively to this process. I encourage everyone to take an interest and to contribute to community reflection on these important matters.

ENDNOTES

¹ This included a submission from the Catholic Archdiocese of Melbourne. For this, see Victorian Law Reform Commission (VLRC), http://www.lawreform.vic.gov.au/sites/default/files/Submission_CP_27_Catholic_Archdiocese_of_Melbourne_19-05-11.pdf

² VLRC, *Guardianship: Final Report 24* (Melbourne: Victorian Government Printer, 2012).

³ *Convention on the Rights of People with Disabilities*, United Nations, <http://www.un.org/disabilities/convention/conventionfull.shtml>

⁴ For a useful diagram which sets out the continuum of decision-making support, see VLRC, *Guardianship*, 55.

⁵ A significant impetus behind the concept of ‘supporter’ is the United Nations’ *Convention on the Rights of People with Disabilities*. Article 12.3 of this Convention calls us to provide people with disabilities with “the support they may require in exercising their legal capacity. The VLRC recommendation of this concept is also based on legislation in Alberta and in several other Canadian provinces. For more on this, see *Ibid.*, 126-130.

⁶ The VLRC recommendation of the concept of ‘co-decision maker’ is also based particularly on legislation in the Canadian province of Alberta. For more on this, see *Ibid.*, 152-154.

⁷ These are guardians, administrators, enduring attorneys (financial), enduring agents (medical treatment), enduring guardians, and persons responsible for medical treatment decisions, variously legislated for in the *Instruments Act 1958*, the *Guardianship and Administration Act 1986*, and the *Medical Treatment Act 1988*.

⁸ The Commission also recommends that we should be able to appoint “more than one, but no more than three” enduring personal guardians and enduring financial administrators. We may also assign different responsibilities to different people. For this, see VLRC, *Guardianship*, 194.

⁹ *Guardianship and Administration Act*, 28(1), 42H(2), 49(1), Victorian Legislation and Parliamentary Documents, [http://www.legislation.vic.gov.au/domino/Web_notes/LDMS/LTObject_Store/LTObjSt2.nsf/d1a8d8a9bed958efca257761600042ef5/cbe1d00615581929ca25776100214ab3/\\$FILE/86-58a063.pdf](http://www.legislation.vic.gov.au/domino/Web_notes/LDMS/LTObject_Store/LTObjSt2.nsf/d1a8d8a9bed958efca257761600042ef5/cbe1d00615581929ca25776100214ab3/$FILE/86-58a063.pdf)

¹⁰ *Guardianship and Administration Act*, 28(2)(e), 49(2)(b), cf 38(1)(a).

¹¹ VLRC, *Guardianship*, 92. The Public Advocate, among others, proposed this change.

¹² *Ibid.*, xviii, cf xxiv. ¹³ *Ibid.*, 393. ¹⁴ *Ibid.*, xxiv.

¹⁵ *Ibid.*, 393-395. ¹⁶ *Ibid.*, 396. ¹⁷ *Ibid.*, 383.

¹⁸ *Ibid.*, 220.

¹⁹ Catholic Health Australia (CHA) and the Australian Catholic Bishops Conference (ACBC), *A Guide for People Considering Their Future Health Care*, 3 & 4, CHA, <http://www.cha.org.au/images/resources/Future%20Health%20Care.pdf>

²⁰ VLRC, *Guardianship*, 223.

²¹ For example, Lisa Gasbarre Black expresses concern that binding advance directives “may implicitly allow patients to mandate nontreatment in a way that constitutes voluntary euthanasia.” For this, see Lisa Gasbarre Black, “The Danger of POLST Orders,” *Ethics & Medics* 35, no. 6 (June 2010): 1-2 at 2.

²² For helpful discussion of advance directives from a Catholic perspective, see John F. Tuohey, “POLST Orders Are Not Dangerous,” *Ethics & Medics* 35, no. 10 (October 2010): 3-4, and _____, “POLST Reflects Patient Wishes, Clinical Reality,” *Health Progress* March-April 2011, 60-64.

²³ *Medical Treatment Act 1988 (Vic)*, Victorian Legislation and Parliamentary Documents, [http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/LTObject_Store/LTObjSt3.nsf/DDE300B846EED9C7CA2577616000A3571/3244F901C1467F1ECA257761002773B4/\\$FILE/88-41a042.pdf](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/LTObject_Store/LTObjSt3.nsf/DDE300B846EED9C7CA2577616000A3571/3244F901C1467F1ECA257761002773B4/$FILE/88-41a042.pdf)

²⁴ VLRC, *Guardianship*, li, 222-224. ²⁵ *Ibid.*, 225.

²⁶ *Ibid.*, 225. On page 216, the Commission noted that current legislation in Western Australian “encourages a person to obtain advice before completing a directive but failure to obtain this advice does not invalidate the directive.”

²⁷ Catholic Archdiocese of Melbourne, *Submission to Victorian Law Reform Commission*.

²⁸ VLRC, *Guardianship*, li, 223. ²⁹ *Ibid.*, liv, 234.

³⁰ These personal appointments include supporters (for both personal and financial matters), co-decision makers, enduring personal guardians, enduring financial administrators, personal guardians and financial administrators appointed by the Victorian Civil and Administrative Tribunal (VCAT), and both personal and VCAT appointments under the existing legislation. For more on this, see *Ibid.*, 363-364.

³¹ *Ibid.*, 364. ³² *Ibid.*, 373. ³³ *Ibid.*, 365.

³⁴ CHA and ACBC, *Guide for People*, 5.2 & 5.3.

³⁵ Congregation for the Doctrine of the Faith, *Declaration on Euthanasia (Jura et Bona)*, IV, Holy See, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html

³⁶ John Paul II, *The Gospel of Life (Evangelium Vitae)*, #65, Holy See, http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html

³⁷ *Catechism of the Catholic Church*, 2nd ed., #2278, Holy See, http://www.vatican.va/archive/ENG0015/_INDEX.HTM

³⁸ *Declaration on Euthanasia*, IV. This teaching is also quoted in John Paul II's *Evangelium Vitae*, #65, and in the *Charter for Health Care Workers*, #120.

³⁹ Post-coma unresponsiveness was once called the vegetative state. For more on PCU and MRS, see National Health and Medical Research Council, *Ethical Guidelines for the Care of People in Post-Coma Unresponsiveness or a Minimally Responsive State*, NHMRC, http://nhmrc.gov.au/_files_nhmrc/publications/attachments/e81.pdf

⁴⁰ Drawing on these sorts of concerns, Dominic Wilkinson and his colleagues observe that "there are a number of well-described problems with the concept of futility." For this, see DJC Wilkinson, T Thiele, A Watkins, and L De Crespigny, "Fatally flawed? A review and ethical analysis of lethal congenital malformations," *British Journal of Obstetrics and Gynaecology* 119, no. 11 (October 2012): 1302-1308 at 1304.

⁴¹ Tim Scott CFC, "Beloved Br Dan Courtney leaves a lasting legacy," *The Catholic Leader* 12 August 2012.

⁴² Catholic Health Australia, *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*, II.1.14, CHA, <http://www.cha.org.au/images/resources/Code%20of%20ethics-full%20copy.pdf>

⁴³ CHA and ACBC, *Guide for People*, 5.4.

⁴⁴ The Australian bishops say that treatment is burdensome when it is "costly to obtain or provide." For this, see CHA and ACBC, *Guide for People*, 5.5.

⁴⁵ After I identified these 6 categories, I was pleased to see that Daniel Sulmasy also assesses burdens "physically, psychologically, socially, economically, morally and spiritually." For this, see Daniel P. Sulmasy, "The Last Word: The Catholic case for advance directives," *The Nathaniel Report* 35 (November 2011): 8-10 at 8.

⁴⁶ Michael Cook, "Locked in to euthanasia," MercatorNet, http://www.mercatornet.com/articles/view/locked_in_to_euthanasia

⁴⁷ VLRC, *Guardianship*, liv, 234.

⁴⁸ As we have already noted, the *Catechism* states in #2278 that the patient's "reasonable will and legitimate interests must always be respected." This reference to the patient's "legitimate interest" seems to support the best interests principle, whereas the reference to the patient's "reasonable will" seems to support the principle of substituted judgment.

⁴⁹ *Gardner; re BWV [2003] VSC 173*, Australasian Legal Information Institute, <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/vic/VSC/2003/173.html?stem=0&synonyms=0&query=gardner,%20re%20BWV>. I have written previously about some of the problems with this ruling in "Catholic Teaching about Tube Feeding," *Chisholm Health Ethics Bulletin* 16, no 2 (Summer 2010): 8-12 at 10.

⁵⁰ *Guardianship and Administration Act*, 28(2)(e), 49(2)(b), cf 38(1)(a).

⁵¹ This was at an Interfaith Symposium *On Death and Dying*, hosted by the Ecumenical and Interfaith Commission of the Catholic Archdiocese of Melbourne on 7-9 April 2010. Gardner spoke on Wednesday 7 April.

⁵² For more on this case, see "Ethicists support feed tube removal," *The Catholic Leader* 7 August 2005, 5; and *The Law Report: 9 August 2005 – The Death of Maria Korp*, ABC, <http://www.abc.net.au/cgi-bin/common/printfriendly.pl?http://www.abc.net.au/rn/talks/8.30/lawrpt/stories/s1431458.htm>

⁵³ VLRC, *Guardianship*, 393. ⁵⁴ *Ibid.*, 393. ⁵⁵ *Ibid.*, 393.

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