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## Advanced Care Planning Programs and Catholic Healthcare.

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An 'advanced care planning' program which encourages the formulation and implementation of advance directives for healthcare is currently being implemented throughout several public hospitals in Australia.

This article looks at the ethical issues surrounding the use of advance directives and advanced care planning programs in light of Catholic moral teaching and the *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*.

### **In this Issue**

We publish an extended discussion of the strengths and weaknesses of 'advance care planning' programs when they are assessed against the standards of the health found in the *Code of Ethical Standards for Catholic Health & Aged Care Facilities in Australia*. It is written by Dr. Brigid Vout, a medical practitioner who directs the Life Office in the Catholic Archdiocese of Sydney.

We wish all our readers and subscribers a very happy Christmas and a peaceful New Year.

Enclosed with this issue is a renewal of subscription form for 2005.

It concludes that, in its current form, advanced care planning fails to reflect the fullness of Catholic moral teaching and healthcare practice. It is recommended that advanced care planning of this type not be introduced into Catholic healthcare facilities and programs.

### **What are advance directives for healthcare?**

When, as a result of illness or injury, patients no longer have the capacity to participate in their personal medical decision making, their previously expressed wishes or *advance directives* may help to guide their care. Advance directives are a stipulation, made by a competent person about medical treatment he or she should or should not receive in the event of becoming incompetent (i.e. unable to make rational decisions), or unable to communicate treatment choices. In their most formal sense, advance directives include written instructions in the form of a document known as a 'living will' or

statutory 'refusal of treatment certificates', or the appointment of someone with a 'durable power of attorney for healthcare' to make healthcare decisions on behalf of the patient in the event that the patient becomes incompetent. Advance directives are largely concerned with the non-provision of life-saving or life-sustaining medical treatment; although an advance directive could purport to request treatment, it could not place a health professional under a duty to provide it when it was clearly futile or likely to cause harm.<sup>1</sup>

In the United States the right to refuse life-sustaining or life-saving treatment has a constitutional and common law foundation. In Australia and the United Kingdom, the law is grounded in the tort of battery, understood as "...a species of trespass to the person, which protects a competent adult's right to be free from non-consensual contacts, including medical interventions, unless these interventions are authorized by statute or justified by law."<sup>2</sup> Importantly, this is primarily based upon the legal interest in self-determination, expressed as the liberty to refuse treatment, and not a presumed 'right to die'.

Within Australia, Victoria, South Australia, Queensland, the Northern Territory and the Australian Capital Territory all have legislation which enforces the right of competent adults to refuse medical treatment, (through the signing of statutory refusal of treatment certificates) and Victorian, South Australian and ACT legislation allows for the appointment of a medical power of attorney.<sup>3</sup> Depending on the legislation, these directives become operative when a patient becomes incompetent in the context of a current condition, a terminal illness, post-coma unresponsiveness or any serious condition. In New South Wales and Tasmania, guardianship acts allow competent patients to appoint guardians to make medical decisions on their behalf in the event that they become incompetent. In Western Australia advance directives would be governed by common law.<sup>4</sup>

While Australian common law includes recognition of the right of a patient to self-determination, there has not been a major

Australian judicial statement of the anticipatory power to refuse treatment. However, given the weight of cases in overseas common law jurisdictions<sup>5</sup>, such a right is likely to be upheld in an Australian court and treatment against a patient's wishes, as expressed in a valid advanced directive, may constitute battery.<sup>6</sup> The criteria by which the validity of an advanced directive would be assessed remain somewhat less clear.<sup>7</sup> Case law from other jurisdictions suggests that the factors which would need to be considered would include: the competence of the decision-maker; the true scope and basis for the decision; and undue influence from others.<sup>8</sup>

### What form might an advanced care planning program take?

Austin Health, Melbourne, has recently become the first Australian hospital to implement an 'advanced care planning program' which encourages patients to plan their end of life care. Entitled "*Respecting Patient Choices*" (RPC), this program has been initially funded by the Australian National Institute of Clinical Studies to the extent of \$100 000, and piloted within the Austin's cardiology, oncology, aged care, vascular, renal and thoracic surgery departments. In its annual report for 2003, Austin Health has announced that it has been successful in securing \$1.33M from the Federal Government and a further \$318, 481 from the Department of Human Services to build on knowledge gained from the RPC pilot.<sup>9</sup> It is planned that, once established, the program will be introduced across the Medical Centre and to other healthcare facilities in the region.

Austin Health's program uses trained nursing and allied health staff, as well as carefully selected volunteers to facilitate patient understanding of advance care planning. This involves 'counselling' patients and assisting them to form advanced directives for healthcare. These are expressed through the completion of a 'Patient Advance Request' (PAR) form, and nomination of a person with enduring power of attorney for healthcare. The PAR is placed at the front of

patient's medical record in a green sleeve, so that it is readily available for health professionals to use as a guide to medical decision making for the patient. It is planned that this will be reviewed with the patient on each subsequent hospital admission. The program also includes educational and promotional materials that are placed in hospital clinics and doctors' offices. The RPC Project officer says that a major thrust of the program is to increase community awareness about advance care planning through community education among groups such as Rotary and other clubs, nursing home staff and residents, general practitioners, religious organizations, ambulance staff and police.<sup>10</sup>

RPC Project Officer, Meagan-Jane Lee, reported in the Austin Health, Report to the Community (2003) that 1000 patients have been approached, 85% of whom expressed an interest in engaging in discussion about their end-of-life treatment. Within 6 months of the program's implementation, 75% of patients had completed an advanced care plan, a Not For Resuscitation (NFR) form, or document recording the appointment of someone with enduring power of attorney for healthcare. She reports that:

*We've had discussions with more than a thousand patients, many of whom have chosen to document their wishes, which has led to a reduction in Intensive Care Unit admissions, a reduction in prolonged treatment and an increase in the number of patients who are able to die at home; all a reflection of patient choices?*

The program has been based upon an advanced directive program from La Crosse, Wisconsin, entitled "Respecting Choices". A study of this program has been published in the *Archives of Internal Medicine*, (1998), 158:383-390. It showed that the availability of advance requests and the appointment of people with medical power of attorney increased from 4% to 96% of patients over 2 years in the La Crosse community hospital. The patients' wishes, as stated in the advance request form, were followed in 98% of deaths, where deceased patients with an advance request form were 7 fold less likely to die in hospital and 4 fold more likely to be admitted to a long-term care facility or hospice prior to

death. The Wisconsin program is now being employed in other states in the USA, and has been recognized as 'best practice' by the [US] National Coalition on Health Care and the Institute for Healthcare Improvement.<sup>11</sup>

### **What place, if any, should similar programs have within the Australian Catholic healthcare system?**

Catholic Health Australia's *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*, 2001, proposes to set "... the standards in which ethical health care practices can be pursued," with the goals of "... respect for the dignity of the person and the promotion of the common good." The *Code* applies across all Catholic health, aged and community care services.<sup>12</sup>

Those sections of the *Code* which deal most directly with the place of advance directives in healthcare, and the conditions under which medical treatment can be legitimately withheld or withdrawn, are found in Part II, 1.1-1.19 and 5.9 - 5.19. At this point it is useful to draw attention to two particularly relevant sections of the *Code*.

The first clearly recognises a patient's moral right to refuse medical treatment *under specified circumstances*, while the second focuses more upon the practical clinical and legal provisions for securing this right in the event that a person becomes unable to do so.

#### *Refusal of treatment*

*1.16 Patients have the moral right to refuse any treatment which they judge to be futile, overly burdensome or morally unacceptable, and such refusals must be respected. In addition, healthcare practitioners may not override any refusal of treatment by a competent patient who is not mentally disturbed, clinically depressed or suicidal, irrespective of whether or not they agree with the patient's refusal (see also 5.4). There is, however, an obligation to prevent suicide when this is possible.*

## Medical power of attorney

1.18 Patients should be encouraged to talk with family, doctors and other relevant people about their hopes for, and fears of, treatment, and to communicate to them their wishes about treatment should a situation arise in which they are unable to make their wishes known. Patients and residents in care should be informed of their right to appoint someone to make decisions on their behalf should a situation arise in which they were unable to do so themselves (see also 1.6 and 1.7).

Given the complexity of medical decision making, as well as developments in law and medical practice, it is necessary further to specify the normative implications of these sections of the *Code*, before specifically considering whether or not advanced care planning programs such as *RPC* have a legitimate place in Catholic healthcare.

## Presuppositions

Before turning to specific questions about the place of advance care planning programs in Catholic health, aged and community services, it pays to recall the basic principles which are presupposed in the *Code's* statements on withholding and withdrawing medical treatment.

Under what circumstances should medical treatment or care be withheld or withdrawn from patients?

From the outset, any consideration about withholding or withdrawing treatment must be based in a clear understanding of the value and meaning of human life. While it is true that medicine always focuses on the care of a particular patient, with his or her personal physical, psychological, social and moral resources, alongside these subjective considerations there will be certain objective truths about the life of every patient, at every stage and in every state of life. Foremost amongst these truths is: because every human person<sup>13</sup> has dignity<sup>14</sup>, every person is worthy

of equal care and respect, and his or her life is inviolable. The direct and voluntary killing of an innocent human person is always gravely immoral.<sup>15</sup>

Therefore, the withdrawal or withholding of life-saving or life-sustaining treatment and care, with the direct intention of ending a person's life, is a gravely immoral action or omission, irrespective of any good motive. If the death of the patient is intended by the caregivers or by the patient himself, such acts or omissions will be morally equivalent to euthanasia<sup>16</sup> or suicide.<sup>17</sup>

Within the life of every human person, however, there are limits to the extent to which life and health should be actively pursued. While life and health are clearly important human goods, they are not the only goods which are constituent of a flourishing human life. If the pursuit of these goods can only be achieved at the expense of other human goods, a person can refuse medical treatment even though an earlier death may be foreseen, without adopting by choice the proposal to kill oneself. From this perspective, 'living well' means pursuing and protecting health, and being able to accept death when it becomes inevitable.

Within the Catholic moral tradition, and in traditional medical ethics, this has been expressed in terms of the distinction between 'ordinary' and 'extraordinary', or 'proportionate' or 'disproportionate' means of healthcare. Irrespective of the terms chosen, as the Congregation for the Doctrine of the Faith has written:

*In any case, it will be possible to make a correct judgment as to the means 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.*<sup>18</sup>

Essentially, then, a judgment about whether or not a treatment is 'extraordinary' or 'disproportionate' is based upon a consideration of whether a treatment is *futile or overly burdensome*. A person is obliged to take ordinary means, but not to take extraordinary means to care for his health.

This has most recently been reiterated by John Paul II in *Evangelium Vitae* where he makes the point that "...to forgo extraordinary or disproportionate means is not the equivalent of suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death."<sup>19</sup>

The concept of futility has traditionally guided clinicians' decisions to withhold or withdraw treatment.<sup>20</sup> Generally speaking, an action is said to be futile if it is unable to bring about its required end. When the good of health and life can no longer be achieved by a particular treatment, that treatment should be withdrawn or withheld. Futility, then, is largely an objective consideration about the effectiveness of a given treatment for a particular patient, based upon measurable clinical data about prognosis and therapeutics.<sup>21</sup>

Burdensomeness refers to the physical, emotional, fiscal or social costs imposed on the patient by a particular treatment.<sup>22</sup> Grisez and Boyle have specified some of the discernible features in and of the treatment that can impose undue burdens on the patients, and on others. These include: the treatment's risks; side-effects; the degree to which the application of medical care would interfere with the pursuit of other goals and fulfilment of responsibilities; the belief that the treatment itself violates some important principle; psychological repugnance of the treatment; or the likelihood that the treatment would make severe demands upon others.<sup>23</sup>

While more or less extensive lists could be compiled, one thing is very clear. Neither futility nor burdensomeness can be equated with a particular diagnosis, clinical condition or category of patient. They are both concepts which pertain to the treatment, and never the life, of the patient. The life of a person always retains its intrinsic value. So-called 'quality of life' judgements should never be the basis of deciding whether or not a person is 'worthy' of medical treatment.

At the same time, however, judgments about burdensomeness are necessarily made in the context of the life of a particular patient. The burden of treatment can depend "...on a patient's overall condition and its potential for improvement, his resources and

sensibility; as these vary from patient to patient so may and should the assessment of burden."<sup>24</sup>

Various opinions have been held within mainstream Catholic medical ethics about the circumstances under which fluids and nutrition, particularly when these are administered by artificial means such as a naso-gastric or gastrostomy tubes, can be legitimately withheld or withdrawn from patients.

Pope John Paul II has recently spoken of the obligation to provide nutrition and hydration to patients who are in a state of post-coma unresponsiveness.<sup>25 26</sup> The Pope stated that the provision of nutrition and hydration, even when provided by artificial means, should be viewed as a natural form of care and not as a medical procedure or treatment. The provision of nutrition and hydration, furthermore, should be considered, in principle, to be *ordinary and proportionate* and, as such, morally obligatory, as long as it gives nourishment and/or relief from suffering. Indeed, to cease providing nutrition and hydration where this is neither futile, nor unduly burdensome, with a view to shortening a patient's life, would be euthanasia by omission.

Following from this statement, the Australian Catholic Bishops Conference has issued a Briefing Note on the Obligation to Provide Nutrition and Hydration<sup>27</sup> which states that:

*In itself, the provision of food and water (by whatever means) is the ordinary way of sustaining a patient's life and a minimal part of the care we owe to others. Accordingly there is always a presumption that nutrition and hydration be provided to a patient, unless this would be futile or unduly burdensome.*

The briefing note also points out that although the immediate context for the Pope's remarks was a conference on the Vegetative State, the Pope's statement is of wide relevance to healthcare professionals caring for patients with conditions such as advanced dementia, severe stroke, advanced metastases or advanced neurogenic disease.

This and other important statements<sup>28</sup> are consistent with Catholic Health Australia's position in regard to the provision of nutrition and hydration as stated in the *Code*.

*Continuing to care for a patient is a fundamental way of respecting and remaining in solidarity with that person. When treatments are withheld or withdrawn because they are therapeutically futile or overly-burdensome, other forms of care such as appropriate feeding, hydration and treatment of infection, comfort care and hygiene should be continued. Nutrition and hydration should always be provided to patients unless they cannot be assimilated by a person's body, they do not sustain life, or their only mode of delivery imposes grave burdens on the patient or others. Such burdens to others do not normally arise in developed countries such as Australia. (5.11) See also 1.12-1.12*

Making general reference to advance directives about 'ordinary care', the Catholic Bishops Conference of England and Wales and the Linacre Centre for Healthcare Ethics have also stated that:

*In some cases, even a well-informed, non-suicidal advance refusal should, in our view, be overridden, though this would certainly be the exception. In particular, an advance refusal of pain relief, hygienic care or feeding - whether orally or by tube - should not bind absolutely. Patients should be given a minimum level of care, both for their own sake and for the sake of protecting an ethic of care on the part of doctors and nurses. It needs to be stressed that incapacitated people have objective health interests, which doctors and nurses should be permitted to promote to a certain basic standard. No advance directive, and no attorney or deputy, should have the power to refuse such basic interventions in the patient's interest.<sup>29</sup>*

## **Who decides when treatment ought to be withdrawn or withheld?**

Health is a personal good - an aspect of personal wellbeing and flourishing. As a general principle, therefore, each person's health is primarily his or her own responsibility. Each person should be permitted to make decisions about his or her own health, (provided that he or she is competent to exercise personal choice).<sup>30</sup> Since it is one of several basic human goods or values, an individual may choose to instantiate or realize the good of health more or less intensively, depending upon other commitments and responsibilities. While this ought never involve the intentional neglect of, or attack upon health, it may involve placing the pursuit of other goods before health interventions (for example, by declining treatment so as to minimize time in hospital and maximize time at home with family). These are clearly personal, not medical, decisions; medical personnel may help by providing necessary information and sometimes advice, but they cannot make these decisions for patients. This would be unacceptable paternalism.

Generally considered, therefore, doctors and other healthcare workers must always respect the choice of a competent patient to refuse treatment which is judged to be futile, overly burdensome or morally unacceptable. (See 1.16 of the *Code*.) The law also recognizes a patient's right of self-determination and that medical treatment is unlawful unless done with the patient's consent (excepting emergencies or when the patient is incompetent and the treatment is reasonable and clearly in the patient's best interests). Therefore if a competent patient definitely refuses an immediate treatment, even if the foreseeable result of the choice - but not the intended result - is the death of the patient, the doctor cannot force the patient to undertake the treatment. However morally irresponsible the doctor finds this choice, it involves no unlawful intent (such as suicidal intent) and ought to be respected.<sup>31</sup>

Many people would also take the position that even if such a choice is clearly tantamount to suicide, a doctor can never impose a treatment, however 'useful' or 'burden-free', against the will of a competent patient. Doctors are generally not obliged to override competent patients' suicidal refusals of treatment. While they cannot directly assist a patient in committing suicide, it is recognized that because competent patients will often be well-placed to make it difficult to override their suicidal refusals of treatment or care, it is unreasonable to impose upon doctors the additional obligation to override such refusals.<sup>32</sup> Doctors and other healthcare workers may, however, legitimately choose to discharge these patients from their care, rather than materially cooperate in the patient's decision not to participate in an otherwise morally indicated treatment. While the *Code* appears to imply that suicidal refusals ought to be overridden, (See 1.16), the precise meaning of the phrase, "...where this is possible", may be in keeping with this position. The meaning of this phrase, is however, somewhat ambiguous.

It is debatable, however, how far in advance such refusals can be meaningfully made and followed and whether or not there is a stronger case for overriding suicidal advance directives made by a now incompetent patient. Gormally claims that: "Since it is not in the interests of the incompetent patient to respect his suicidal advance refusal of treatment made while competent, the doctor should override it where he is in a position (legally) to do so."<sup>33</sup> The Linacre Centre's euthanasia submission explains that:

*When persons have exercisable capacities for self-determination then respect for their self-determination is integral to respect for their good as person: for it is in and through choice that they have the possibility of shaping their characters for good (or ill). But when persons do not yet, or no longer, possess presently exercisable capacities for self-determination, self-determination cannot be an essential ingredient, so to speak, in what one respects in respecting their good. Any exercise of self-determination which seeks to determine what should (or should not) happen to*

*one, if and when one comes to be incompetent, should be respected only to the extent that doing so is consistent with respecting the good of the now incompetent patient.*<sup>34</sup>

Otherwise, it appears reasonable that if a doctor judges that the considered choice of a once competent, but now incompetent, patient has not been superseded by the passage of time, later indications of patient wishes or changes in treatment, clearly stated and relevant advance directives expressed by a Living Will, or by someone with Medical Power of Attorney, should be respected.

### Practical problems.

Formal advance directives are an important part of advanced care planning. General debate about their place in healthcare today is rarely about *if* advanced directives should be used, rather it is about *how* they should be used. Reservations which have been expressed about the practicalities of their implementation include:<sup>35</sup>

- The role and value of a medical power of attorney is questioned by studies that have consistently demonstrated a substantial lack of accuracy in proxy determinations of patient preferences for healthcare.

- The possibility that individuals may change their minds about healthcare directives as their health changes and decisions become real rather than hypothetical, and that this will be difficult to formalize in updated advance directives.

- The possibility that advanced directives may be completed without informed deliberation or adequate communication, and that individuals will make choices against treatments on the basis of false beliefs or misunderstanding of the complex issues of disease and treatment.

- The validity of advanced directives which arise from discussions in an inpatient setting where patients may be acutely ill or anxious and, therefore, not fully 'competent'.

- The use of terminology which is vague, e.g. 'not for resuscitation', and difficult to interpret.

Concern that advance directives may actually diminish, rather than facilitate, interaction between healthcare professionals and patients and their families.

The British Geriatrics Society has also pointed out that advanced refusals which are obeyed during a period of temporary incapacity may have the effect of the patient surviving in a much more disabled state than would otherwise have been the case.<sup>36</sup>

Essentially, these reservations reflect the common sense understanding that advanced refusals are more likely to be ill-informed or inapplicable to the current clinical situation of the patient than contemporaneous refusals of treatment. The very fact that all advance directive legislation provides that, while competent, makers of declarations may readily revoke them, acknowledges that for a variety of reasons one may come to recognize original directives as mistaken.<sup>37</sup> It is not possible to predict all the circumstances that may be faced in the future and proposed treatments are most meaningful and best explained in light of a patient's current medical condition. Hence, in one legal judgment dealing with an advance refusal of treatment, *Re: AK*, it was explicitly said by Mr Justice Hughes that 'Care must be taken to investigate how long ago the expression of wishes was made.'<sup>38</sup>

## Ethical problems.

**Suicidally motivated advance directives.** Concern has been raised throughout the world about the compelling force of existing or evolving case and statute law, which requires doctors to respect advance directives about refusal of treatment, which are suicidally motivated.<sup>39</sup> While doctors may legitimately follow an advance refusal which is recent, well-informed and not suicidally motivated, this must be distinguished from other situations where a refusal of treatment is clearly made with the aim of ending life. Those who are, or have been, suicidal need to be treated in their objective interests, not to have their lives ended out of 'respect' for their wish for this to be done. If patients, living as they do in a society which devalues

the lives of disabled people, act on the basis that such a life would be worthless and should be curtailed, this is not an intention which it is in their interests, or society's interests, to respect.<sup>40</sup>

The unilateral emphasis upon patient autonomy which often lies at the centre of advocacy of advance directives is not compatible with the fullness of Catholic moral teaching about respect for all human goods and the persons in whom they are meant to flourish. Respect for patient autonomy, previously expressed in the form of an advance directive, must be considered in the wider context of respect for the fundamental dignity of the patient. The question "what would he have wanted?" must be posed within the context of the broader question, "what is best for him now?"<sup>41</sup>

There are those who say that to override the antecedent suicidal will of the now incompetent patient is to fail to respect the dignity of that patient. But the claim mistakenly demands respect for a past statement of choice rather than the actual living human being... autonomy as a capacity is to be valued precisely in so far as its exercise makes for well-being and flourishing of the human beings who possess it.<sup>42</sup>

By a Christian understanding, and one which is shared with people of different faiths or no faith, no one has a moral right to suicide. Legally, too, although decriminalized, suicide remains unlawful behaviour. This is clearly shown by the fact that assistance in suicide is still a crime which carries a substantial penalty.<sup>43</sup> Doctors ought not be obliged to assist a patient in committing suicide.

**Advanced directives and standards of care.** Reflecting upon how an incompetent person can seem to become almost a 'stranger' to us, Gilbert Meilander has expressed concern that the uneasiness consequent upon this may prompt us to do less than we ought to sustain such a person's life. To this end, he argues that it is:

*'... essential that we structure the medical decision-making in this situation in such a way that conversation is forced among the doctor, the medical caregivers, the*



*patient's family, and perhaps still others, such as pastor, priest or rabbi. Advanced directives, designed to eliminate the need for such extended conversation – lest it should burden loved ones – are from this perspective, somewhat problematic. They may not force us to deal with our own ambivalence in "taking care of" a loved one who is now a burdensome stranger'.<sup>44</sup>*

Making particular reference to advance care planning which combines written directives with the appointment of a medical power of attorney, Meilander writes that such a move, although it

*...may be seen as an attempt to avoid burdening the loved one who must make such decisions – may not, in any case, accomplish our aim. What it commits us to is an endless, futile search to determine what a now-incompetent person would wish. Still more important, it is one last-ditch attempt to bypass the interdependence of human life, by which we simply do and should constitute a burden to those who love us.<sup>45</sup>*

He suggests that advance directives which are made with the intention of relieving loved ones from the 'burden' of medical decision making for others may in fact deny them valuable opportunities to develop and express care and concern, values which as a community, we ought to seek to foster in each other. By this account, although advance care planning may be promoted and undertaken as a benevolent act which is intended to spare others from decision making, it may become an act which promotes autonomy at the expense of solidarity within families and communities.

Positive features of programs like 'Respecting Patient Choices'. There are several foreseeable positive features of advanced care planning.

Advanced care planning encourages patients to accept greater responsibility for their health. This is consistent with the ethos of the Code, (see 1.2).

Advanced care planning provides patients with guaranteed opportunities for dialogue with healthcare professionals. Unfortunately, such dialogue can often be overlooked in a health system which can be difficult to navigate and where time and resources are often in short supply.

Encouraging patients to consider end of life issues in a systematic way can lead to personal clarification of values and responsibilities, and communication, not just with medical professionals, but also with family and friends. In a culture that increasingly avoids consideration of illness and mortality, this can encourage the preparation for, and acceptance of illness, disability and death, in morally appropriate ways.

Advance care planning may provide guidance for medical professionals in difficult cases, particularly when time or circumstances have not allowed the development of a good therapeutic relationship in which the healthcare professional has had the opportunity to learn of the patient's personal resources and values.

On some occasions too, advance care planning could help to inject common sense into clinical situations where health professionals are acting in an unreasonably vitalistic manner. Hence, Luke Gormally rightly recognizes that:

*There may well be a case for setting down, in the form of a declaration which one intends to be advisory in character, a statement of the kinds of things one anticipates one may find burdensome to oneself or a statement of one's desire not to have treatment which one anticipates will be excessively burdensome to others. The case for doing so may be strong if one anticipates that those who have to act for one will be largely ignorant of one's sensitivities and outlook, or if one thinks that relatives may need written testimony of one's desires in order to relieve them of potential embarrassments in saying what one has desired.<sup>46</sup>*

It appears that declarations of the above character could legitimately and usefully be taken into account in Catholic hospitals when doctors and others are deciding whether or

not to proceed with a particular course of treatment which is likely to have significantly burdensome consequences for incompetent patients.<sup>47</sup>

Accordingly, the *Code* at 1.18, encourages patients to talk with family, doctors and other relevant people about their hopes for and fears of treatment, and to communicate to them their wishes about treatment should a situation arise in which they are unable to make their wishes known. The *Code* does not, however, make specific reference to the use of written advance *directives*: in stating that patients and residents in care should be informed of their right to appoint someone to make decisions on their behalf should a situation arise in which they were unable to do so themselves, it appears to recommend the appointment of a person with an enduring power of medical attorney over written directives.

#### Features of advanced care planning programs which should be of concern to Catholic health, aged and community services.

**Uninformed refusals.** An advance care program like *RPC* shares many of the practical problems outlined earlier.

In general, problems with informed 'consent' (or refusal) will always arise due to advanced decision making where there is: potential for new discoveries and treatments; uncertain diagnoses; lack of information and understanding by patients; explicit or implicit influence of others; and the impossibility of consistently reliable predictions about how individuals would regard forms of treatment at some future stage and state of health.

The *RPC* program does allow for Patient Advanced Request documents to be changed or revoked at any time, by telling one's agent that his or her power of attorney (medical treatment) is withdrawn and by destroying all copies of the Patient Advance Request document.<sup>48</sup>

Yet this safeguard could not be relied upon to overcome all the instances where an advanced care plan is likely to be 'out of date'. Remembering, let alone being able to implement, the steps necessary for revocation

of advanced directives, is likely to be overlooked by an individual who is becoming unwell.

Furthermore, the minimal place accorded to doctors in the process of advance care planning utilized by *RPC* is likely to increase the formulation of advanced directives which are not consistent with the real clinical situation of the patient, or at least, a reasonable assessment of the likely clinical situation, including potential benefits and burdens of treatment.

**Refusal of treatment with suicidal intent - effects on patients.** Widespread advocacy of advance directive planning, in the absence of a shared understanding of the moral considerations which ought to inform decisions to withhold or withdraw treatment (i.e. consideration of the burdensomeness or futility of the *treatment*), may be an occasion for scandal. As the Linacre Centre have recently pointed out, the likelihood of a suicidal motivation being expressed in an advanced directive is far from remote, in view of the widespread belief that life in some conditions - for example, permanent unconsciousness, or advanced Alzheimer's - is 'not worth living'.<sup>49</sup>

Accordingly, the *RPC Advanced Care Planning Information Booklet* encourages individuals to:

*Think about what is important to you first and then let your family know what quality of life you value... Be specific about your values and wishes, for example some people say things like "Don't keep me alive if I am disabled." If you feel that way, explain what you mean by "disabled". Does this mean if you can't talk, can't dress or feed yourself or whether you need assistance to go to the toilet? (p. 8)*

Speaking to patients, the *RPC* program Information Booklet also says that Advance Care Planning "...enables you to clarify your values and wishes and enables your family, doctors and nurses the opportunity to respect those wishes ... Their knowledge about your values will help them to make the right decisions about your medical treatment." (p.3) Here, however, no consideration is given to the substantive moral content of patient values

and wishes. Furthermore, as it currently stands, the *Victorian Medical Treatment Act*, and similar legislation throughout Australia makes no attempt to try to ensure that those making or giving effect to refusal of treatment certificates understand the moral significance of omissions undertaken with the intention of ending life.<sup>50</sup> Finnis argues that:

*In these and many other ways, the advance directive legislation seems likely to have the 'educative' effect of undermining public consciousness of the significance of intention in the context of suicide, homicide and, on the other hand, of upright and reasonable refusal of burdensome or futile treatment.*<sup>51</sup>

As has been pointed out, Catholic morality, and traditional medical ethics, does recognise circumstances where advance directives might be usefully made, without suicidal intent. However, as society's appreciation of the role of intention in moral decision making is increasingly undermined by advocates of euthanasia, and even our courts, prudence would at least demand that advance directive programs within the Catholic Health System would incorporate comprehensive moral guidance which is consistent with Catholic teaching.

**Refusal of treatment with suicidal intent - effects on healthcare workers.** The *RPC* information booklet states that a Patient Advance Request Document is only used once a patient becomes incompetent to "...guide the decision making of your doctor, your agent and family." It points out, however, that "...if these wishes are applied during a current illness, they are legally binding." (p.10)

One danger, therefore, inherent in any program which encourages enforceable advance directives, is that doctors and other health care providers will inevitably be presented with enforceable *suicidal* advance refusals of treatment.<sup>52</sup> This is of even greater relevance in light of the recent decision of the Supreme Court of Victoria in *Gardner; re BWV* that the provision of artificial nutrition and hydration via a percutaneous endoscopic gastrostomy (PEG) constitutes 'medical

treatment' under the *Medical Treatment Act 1988* (Vic.). Under the Act, individuals can now lawfully refuse artificial nutrition and hydration in the same way that they can refuse any medical treatment for a current condition. This is carried out by the execution of a refusal of medical treatment certificate by the patient or by a person legally appointed to have medical power of attorney (if the patient is incompetent), and healthcare workers are legally obliged to comply with this irrespective of whether or not this represents a deliberate choice to end one's own life, or the life of another.

The *Code* clearly states that healthcare practitioners have an obligation to prevent suicide where this is possible. (1.16) Therefore, the use of a program like *RPC* in a Catholic healthcare facility is likely to increase the incidence of clinical situations where practitioners are seemingly locked in to non-negotiable situations where there is a clear conflict between 'legal obligations' and moral obligations. In such a situation, a health professional may decide that he or she has no option other than discharging the patient from his or her care, or even the healthcare facility. Clearly, this is an eventuality which would cause considerable anguish to all involved, and which should, if at all possible, be avoided and not perpetuated by the promotion of morally indiscriminate advanced care planning.

Gormally alerts us to the potential for legally enforceable advance directives to have a profoundly demoralizing effect upon doctors and nurses who are obliged to act in ways which are contrary to what they regard as the best interests of their patients. The State, he reminds us, has an interest in maintaining conditions supportive of the proper practice of the professions of medicine and nursing.<sup>53</sup> So too, one might add, does Catholic healthcare.

**Encouragement of negative attitudes towards ill, disabled and elderly people.** A foreseeable side-effect of programs like *RPC* is the further promotion of the idea that life in some conditions is not worth living. Advance care planning may thereby serve

further to devalue life lived in the midst of illness, disability or old age and affect societal attitudes towards ill, disabled and elderly people.

**Potential to advance the cause of pro-euthanasia lobby groups.** Advanced refusal of treatment is strongly encouraged by advocates of voluntary euthanasia who make no distinction between morally acceptable and morally unacceptable choices to withdraw or withhold treatment. Indeed, many advocates of voluntary euthanasia see the widespread acceptance of 'passive euthanasia' as the necessary forerunner to turning the tide of community opinion about the legitimacy of active voluntary euthanasia. This is particularly likely if refusal of treatment directives require that patients die in a slow and distressing way, such as through starvation, seemingly creating a 'need' for active euthanasia as an 'humane' act which brings relief in the face of an individual's inevitable death.<sup>54</sup>

**Negative effects upon doctor - patient relationships.** It is reasonably foreseeable that advanced directive planning could have a detrimental effect upon the relationship between patients and their doctors and other healthcare providers.

The increasing interest in advance directives is likely to be related, in part, to the way in which the medical profession is currently perceived, rightly or wrongly, by the community. In the face of the increasing technicalization and specialisation of medicine, healthcare is often perceived or experienced as impersonal - as something which happens to a patient, rather than something in which a patient participates. There has been, Gormally proposes, a "...breakdown of trust between patients and doctors, and the consequent desire of patients to have tools to control the behaviour of doctors."<sup>55</sup>

It is, however, difficult to see how the encouragement of decision making which is removed from the doctor-patient relationship will help to overcome this experience of healthcare. If anything, fostering a culture where there is over-reliance on advance directives may discourage doctors from engaging in necessary communication with their patients, and from seeking to determine

what is in their best interests now. As the Linacre Centre suggests:

*A culture of absolutely binding advance directives could have the effect of reducing trust in doctors to give appropriate care. It could encourage doctors to rely on advance directives as an easy and legally safe option, rather than making an effort to communicate with patients, and to promote their best interests when communication is not possible.<sup>56</sup>*

Admittedly, the RPC Information booklet says that patients need to talk to their doctor about their treatment wishes: "... make sure that your advance care plan is clear and complete and that your decisions are supported by your doctor." (p. 9.) Generally, however, most of the discussion and the actual formulation of the advanced care plan is undertaken, *not with the patient's treating doctor, but with an "RPC consultant"*.

**Possibly of patient coercion.** Non-directive counselling on complex issues is difficult to achieve. In this light, it is important to acknowledge that while advanced care planning programs purport to be aimed at encouraging patient autonomy in decision making, they are likely to be increasingly motivated by the recognized potential for significant cost-saving in end of life care. As Mendleson points out, the provisions of the United States Patient Self Determination Act 1993 stipulate that every patient being admitted to a health program who receives Medicaid or Medicare funds has to receive the mandatory "opportunity" to sign a living will.<sup>57</sup>

More likely, however, is the possibility that well meaning but misplaced notions of compassion<sup>58</sup> will influence the advice given by 'advanced care consultants' to patients who are perceived to have 'low quality of life'. These patients may be discouraged from medical treatment which they might otherwise have legitimately chosen, on the basis that someone else - who does not know them - feels that they would not want to go through with treatment that might prolong their life. A counsellor's personal aversions to various forms of treatment - such as tube

feeding – or her own attitudes to disability, dependency and other forms of suffering, may unduly influence patients' decisions about healthcare.

### Legal problems

The precise place of advance directives in Australian law is still somewhat obscure<sup>59</sup> and it would be imprudent to proceed with programs which directly promote advanced care planning until this is clarified.

### Recommendations

In light of the above arguments, there appears to be a good case for judging advanced care planning programs like *RPC* as unsuitable for use in Catholic healthcare.

In their current form, these programs promote decision making about healthcare in a way which is insufficiently informed by the fullness of Catholic moral teaching pertaining to this area. They are also fraught with practical difficulties, which could have a potentially detrimental effect upon the relationship of trust and beneficence between healthcare workers and their patients.

This is not to say, however, that these programs ought to be rejected in their entirety. They do have some positive aims and features which may usefully challenge Catholic healthcare workers and facilities to re-examine current attitudes and practices in relation to helping patients assume primary responsibility for their health, particularly in relation to end of life care.

There may in fact be an important place for alternative educational forums within the community and healthcare facilities, but ones which would promote a Christian or more traditional medical understanding of the attitude we ought to adopt towards medical treatment and our own life, health and inevitable death. The potential may even exist for a modified form of advanced care planning where the *treating* health professionals, who are able to provide appropriate information about treatment options in the context of a patient's current and likely future medical condition, encourage patients to consider some form of

medical *declaration* or to appoint someone with an appropriate medical power of attorney. This would certainly call for greater attention to be paid to the education and formation of health professionals in healthcare ethics if it were to proceed in morally acceptable ways.

It would seem, however, that essential to the success and legitimacy of any program such as this are more overarching efforts within Catholic healthcare to foster a 'culture of life' which would help health professionals and patients to understand and accept the 'middle way' between vitalism and a too-ready disregard for life and health.

As a final consideration, perhaps Catholic healthcare workers would do better to focus their attention on the importance of helping patients to make good healthcare choices within the context of therapeutic relationships which do not presume to be less than satisfactory and a 'threat to patient autonomy', but which seek to respect all human goods and the persons in whom they are meant to flourish. Here nothing can replace the virtues of honesty, fidelity, charity and prudence at work in a personalized medical relationship, where information sharing prepares the ground for the doctor, family and friends to act in the best interests of patients when they are unable to make their own treatment decisions.

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## Footnotes

1 Hornett, Stuart, "Advance Directives," in *Euthanasia Examined: ethical, clinical and legal perspectives*, John Keown (Ed.) Cambridge: Cambridge University Press, 1995, pp.297-314, at 298 and 304.

2 Mendelson, Danuta, "End of Life – Legal Framework," in *Controversies in Health Law*, Ian Freckelton and Kerry Petersen (Eds.), p. 60. Here, authorized interventions, would include non-voluntary treatment under the legal doctrine of necessity, or involuntary treatment under various mental health acts.

3 Mitchell, K., Kerridge, I. & Lovat, J. *Bioethics and Clinical Ethics for Health Care Professionals, 2nd Ed.* Katoomba: Social Science Press, 1996, p. 180.

4 See Mendelson's article for a comprehensive outline of the law pertaining to this area in Australia, p. 59-67.

5 Hornett, pp.301-2 on anticipatory refusals.

6 Biegler, P, Stewart, C., Savulescu, J. and Skene, L., "Determining the validity of advance directives," *Medical Journal of Australia*, 2000; 172: 545-548. Retrieved from the Internet: [www.mja.com.au/public/issues/172\\_11\\_050600/biegler/biegler.html](http://www.mja.com.au/public/issues/172_11_050600/biegler/biegler.html)

7 Stewart, Cameron. "Advanced Directives, the Right to Die and the Common Law: Recent Problems with Blood Transfusions", *Melbourne University Law Review* 6; (1999) 23.

8 Biegler, et al, p. 3.

9 *Austin Health, Report to the Community*, 2003, downloaded from the Internet.

10 *Australian Resource Centre for Hospital Innovations. Respecting Patient Choices – Use of Advance Care Plans*. Retrieved from the Internet at [www.archi.net.au/document/index.php?id/114topic\\_id/217](http://www.archi.net.au/document/index.php?id/114topic_id/217)

11 Reported in *Newsletter of Australian and New Zealand Society of Palliative Medicine Inc.* July 2002, retrieved from the Internet at [www.anzspm.org.au/newsletter/02jul/respecting-patient-choices.html](http://www.anzspm.org.au/newsletter/02jul/respecting-patient-choices.html)

12 *Catholic Health Australia, Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*. Catholic Health Australia Inc: Canberra, 2001.

13 Here, and throughout this paper, the term 'person' will be used in its proper sense to refer to any living human being.

14 Dignity is a descriptive term which expresses the intrinsic and inestimable value of every human person. The dignity of the person is manifested in the fact that human beings are the kind of creatures who are able, amongst other things, to think and choose. However, properly understood, dignity does not depend upon the active expression of these characteristics. Dignity is never lost; the life of a human person never loses its value. This understanding of the human person is the foundation of tradition ethics, civil and international law and healthcare.

15 John Paul II, *Evangelium Vitae: Encyclical Letter on The Value and Inviolability of Human Life*. Homebush: St Pauls, 1995, n.57.

16 *Evangelium Vitae* defines euthanasia as "...an act or omission which of itself and by intention causes death, with the purpose of eliminating all suffering," n. 65.

17 Since the judgments in *Airedale N.H.S Trust v Bland* [1993] the place of intention in law, has been radically undermined, and consequently, an artificial legal distinction has been made between acts and omissions which result in the intended death of a person. See Finnis, John, "Bland: Crossing the Rubicon?" 109 *Law Quarterly Review* [1993] 329-37. However, as John Finnis points out elsewhere: "... even if the common law, under siege from consequentialist ethics and euthanasia sentiment, were to surrender its principle, the moral significance of intention will remain unimpaired. Every analysis which bypasses intention, replacing it with questions about causation and/or foreseeability and/or inevitability and/or 'positive action', shows itself to have abandoned the fundamentals of ethics. The same must be said of every legal or moral analysis which is content to proclaim rights specified without reference to intention, e.g. 'to refuse treatment', 'to decline life-sustaining measures', and so forth."

Ref: Finnis, John. "Living Will Legislation," in *Euthanasia, Clinical Practice and the Law*, Luke Gormally (ed.), London: The Linacre Centre, 1994, p.169.

18 *Congregation for the Doctrine of the Faith, Declaration on Euthanasia*, May 5, 1980. Retrieved from the Internet at [www.vatican.va](http://www.vatican.va)

19 EV, n. 65, goes on to recall Church teaching as it is outlined in the *Declaration on Euthanasia*: "Euthanasia must be distinguished from the decision to forego so-called 'aggressive medical treatment', in other words, medical procedures which no longer correspond to the real situation of the patient, whether because they are by now disproportionate to any expected results or because they impose excessive burden on the patient and his family. In such situations where death is clearly imminent and inevitable, one can in conscience 'refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the ordinary care due to the sick person is not interrupted.'"

20 Hippocrates wrote in *The Art*: "First I will define what I conceive medicine to be. In general terms, it is to do away with the sufferings of the sick, to lessen the violence of these diseases, and to refuse to treat those who are overmastered by their disease, realising that in such cases medicine is powerless. Hippocrates, "The Art", in *Hippocrates II. The Loeb Classic Library*. Cambridge, Massachusetts: Harvard University Press, 1992. Cited by Christopher Hook, "Medical Futility", in *Dignity and Dying: A Christian Appraisal*, Ed Kilner, J.F. et al., Grand Rapids Michigan: W.B. Eerdmans Publishing Co, 1996, p.86.

21 Pellegrino, Edmund. "Decision at the end of life: the use and abuse of the concept of futility," in *The Dignity of the Dying Person, Proceedings of the 5th Assembly of the Pontifical Academy for Life, Feb 1999*, edited by Juan de Dios Vial Correa and Elio Sgreccia. Vatican City: Libreria Editrice Vaticana, p.225-6.

22 *ibid*, p.228.

23 Grisez, Germain and Boyle, Joseph. *Life and Death with Liberty and Justice: A Contribution to the Euthanasia Debate*. Indiana: University of Notre Dame Press, 1979, p.268-9.

24 *Linacre Centre Working Party. Euthanasia, and Clinical Practice: trends, principles and alternatives. The Report of a Working Party*. London: The Linacre Centre, 1982, p. 47.

25 This has commonly been referred to as a 'persistent vegetative state'. The *Australian National Health and Research Council* has recently proposed, however, that patients in such a clinical state be described as 'post coma unresponsive.'

26 "Address of John Paul II to the Participants in the International Congress of 'Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas,'" March 20, 2004. Retrieved from the Internet at [www.vatican.va](http://www.vatican.va).

27 *Australian Catholic Bishops Conference Committee for Doctrine and Morals, "Briefing Note on the Obligation to Provide Nutrition and Hydration," 3rd September 2004*. Retrieved from the Internet at [www.acbc.catholic.org.au/bc/docmoral/index.asp](http://www.acbc.catholic.org.au/bc/docmoral/index.asp)

28 "The administration of food and liquids, even artificially, is part of the normal treatment always due patients when this is not burdensome for them; their undue suspension could amount to euthanasia in a proper sense." *Pontifical Council for Pastoral Assistance to Health Care Workers. Charter for Health Care Workers*. Vatican City: Vatican Press, 1995, n. 120.

See also *United States Conference of Catholic Bishops, Ethical and Religious Directives for Catholic Health Care Services, Fourth Edition, June 2001*, Retrieved from the Internet at [www.nccbuscc.org/bishops/directives.htm](http://www.nccbuscc.org/bishops/directives.htm)

29 *Catholic Bishops' Conference of England and Wales and the Linacre Centre for Healthcare Ethics, Response to the Draft Mental Incapacity Bill, September 2003*. Retrieved from the Internet, [www.linacre.org/JoinsubmissionLatest.html](http://www.linacre.org/JoinsubmissionLatest.html)

30 *Linacre Centre for Healthcare Ethics, "Response to Lord Chancellor's Department Making Decisions leaflets (April 2002 consultation)*, p. 1. Retrieved from the Internet, [www.linacre.org/makdec.html](http://www.linacre.org/makdec.html) and Luke Gormally (Ed.), *Euthanasia, Clinical Practice and the Law*, London: The Linacre Centre, 1994, pp.135-137. Section 1.2 of the Code also states that: "The primary responsibility for safe guarding and maintaining one's health so far as that is reasonable belongs to each person in his or her own right. It follows that each person is primarily responsible for making decisions concerning his or her own health (and that of any incompetent person for whom he or she is responsible). Since people sometimes need to seek help and advice in order to make reasonable healthcare decisions, this responsibility may at times be best exercised in consultation with others."

31 Finnis, *Living Will*, p. 169

32 Gormally, Luke. *Legislating for Advance Refusals of Treatment: What is at issue?* Retrieved from the Internet at [www.linacre.org/legislating\\_for\\_advance\\_refusals.htm](http://www.linacre.org/legislating_for_advance_refusals.htm)

33 *ibid*

34 *Linacre Centre for Health Care Ethics, Euthanasia And The Law: The Case Against Legalization. Submission to the Select Committee of the House of Lords on Medical Ethics*, June 1993. Published in *Euthanasia, Clinical Practice and the Law*. Luke Gormally (Ed) p. 146-147

35 Based on summary by Mitchell, pp.180-183, which also cites relevant studies.

36 *British Geriatrics Society, Legally Binding Living Wills or Advance Directives. Cited in Linacre Centre Submission, "Making decisions..."*, p. 4

37 *Linacre Centre, "Euthanasia And The Law: The Case Against Legalization,"...Published in Euthanasia, Clinical Practice and the Law*. Luke Gormally (Ed) p. 145.

38 *Linacre Centre, "Response to Making Decisions..."* p.3, citing [2001] 1FLR 134E-G

39 Commenting recently on the United Kingdom's *Draft Mental Incapacity Bill*, a joint submission by the *Catholic Bishops' Conference of England and Wales and the Linacre Centre for Healthcare Ethics* warned against the failure to: "... distinguish between choices on the part of doctors, patients or proxies with the aim of causing death and choices with the aim of avoiding the burden of certain interventions. Rather, in emphasizing the need to respect the patient's past 'wishes and feelings' -- whatever (it appears) they may be -- the Bill would apparently require doctors to respect advance refusals which are suicidally motivated; i.e., where the patient's aim was to end a life predicted to be not worth living."

*Catholic Bishops' Conference of England and Wales and the Linacre Centre for Healthcare Ethics, Response to the Draft Mental Incapacity Bill, September 2003*. Retrieved from the Internet, [www.linacre.org/JoinsubmissionLatest.html](http://www.linacre.org/JoinsubmissionLatest.html)

40 *ibid*. Note too, that when, commenting on whether advance refusals of treatment should be binding in United Kingdom law, Luke Gormally

writes that: "There may be circumstances in which it is reasonable to withhold or withdraw certain forms of treatment. But if the reason for doing so is an advance refusal of treatment in which a patient has made it clear that life-preserving treatment or tube-feeding would be unacceptable in certain circumstances because he judges his life would not be worth living in those circumstances, then it is evident that the reason for withholding or withdrawing is to put an end to the patient's life. The patient's objective is made the doctor's objective by the advance directive." Gormally, Luke. *Legislating for Advance Refusals of Treatment: What is at issue?* Retrieved from the Internet at [www.linacre.org/legislating\\_for\\_advance\\_refusals.htm](http://www.linacre.org/legislating_for_advance_refusals.htm)

41 Some people have even identified logical problems in the very notion of advance directives as an expression of individual autonomy: "There are indeed rights protecting one's fundamental interests and well-being (life, privacy, reputation, bodily integrity etc.) which can be vindicated and, in that sense, exercised on one's behalf while one is incompetent. But a right which is a right to form one's own intentions and make and execute one's own choices, simply cannot be executed by the choices of another. ... the refusal to carry out a now-incompetent person's unrevoked advanced directive that he be killed if permanently incompetent frustrates his earlier intention but does not and cannot violate his autonomy; he no longer has any autonomy to be exercised, though he retains his ineliminable human dignity, and the rights and interests which should be respected in virtue of that dignity."

Ref, *Euthanasia, Clinical Practice and the Law*, p. 146.; See also, John Finnis, "Living will legislation," p. 172.

42 Gormally, "Legislating for advance refusals.", p.3-4.

43 *ibid*; Note too, as Mendelson points out, all Australian jurisdictions have statutory provisions which create a serious offence of aiding and abetting suicide. Hence, "... a medical practitioner who, when faced with both a refusal of treatment certificate and a suicide note, withdraws life-saving treatment may subsequently be deemed to have thus assisted the patient to complete his or her suicide. It is also possible that a doctor who has complied with a depressed patient's wish not to be treated for a condition, which they both know, unless treated, will result in the patient's death, may come within the definition of aiding and abetting suicide under s 6B(2) of the Crimes Act 1958 (Vic)." Mendelson, "End of Life...", p. 65.

44 Gilbert Meilander, "I want to burden my loved ones," *First Things*, October 1991, pp. 12-14.

45 *ibid*.

46 Gormally, "Legislating for Advance Refusals of Treatment...", p. 5.

47 See Linacre Centre for Health Care Ethics, *Euthanasia And The Law: The Case Against Legalization. Submission to the Select Committee of the House of Lords on Medical Ethics*, June 1993. Published in *Euthanasia, Clinical Practice and the Law*: Luke Gormally (Ed) p. 147. This could even apply in relation to the question of advanced directives about the refusal of tube-feeding. The report states that: "... it should also be recognized that an advance directive stipulating that in certain circumstances one would not want tube feeding, need not be suicidal.

Persons making such directives may have in mind that even tube feeding and nursing care, while not burdensome to them, could prove financially very burdensome to others. They might truly wish that the resources be used to meet other needs. This reason for rejecting care is, then, not a false valuation of what their life might be at some future time. Rather it is a desire not to take up resources which they think disproportionate, to the detriment of others. ... one would not be acting in a way contrary to a person's dignity if one honoured a directive which was prompted by what is generally agreed to be an admirable desire and involved an acceptance of death rather than the choice of death as a means or an end." pp. 147-8

48 *Respecting Patients Choices, Information Booklet*, p. 10. The booklet recommends that the original document is kept with important personal documents, and that a copy is provided for the agent, an alternative agent (if nominated), one's family and doctor, in addition to the copy which is kept in the patient's medical record.

49 Linacre Centre for Healthcare Ethics, "Response to Lord Chancellor's Department Making Decisions leaflets (April 2002 consultation)", p. 2. Retrieved from the Internet, [www.linacre.org/makdec.html](http://www.linacre.org/makdec.html)

50 Finnis, "Living Wills," p. 170. Here also, Finnis writes that some Catholics' support for the Victorian Medical Treatment Acts of 1988 and 1989 were based on the understanding that this legislation was consistent with Catholic principles. However, he writes, that in doing so "... they confused legislation with a treatise on Catholic morality. Propositions which, in the context of a Catholic treatise, would have an acceptable meaning, reference and force take on a quite different sense when divorced from that context, as legislation in a pluralist community is, of course, divorced." p. 170.

51 *ibid*, p. 171.

52 Gormally, "Legislating for Advance Refusals," p.5.

53 *ibid*.

54 For example, see the article by euthanasia advocate, Rodney Syme, in the *Herald Sun (Melbourne)*, May 30 2003, commenting on the decision of the Victorian Supreme Court in *Gardner; re BWV*.

55 Gormally, "Legislating for Advance Refusals...", p.6.

56 Linacre Centre, "Response to Making Decisions...", p. 4.

57 Mendelson, "End of Life...", p. footnote 9, p. 71.

58 See *Evangelium Vitae*, n 66.

59 Mendelson, Danuta, "End of Life - Legal Framework," in *Controversies in Health Law*, Ian Freckelton and Kerry Petersen (Eds.) and Biegler, P, Stewart, C., Savulescu, J. and Skene, L., "Determining the validity of advance directives," *Medical Journal of Australia*, 2000; 172: 545-548. Retrieved from the Internet: [www.mja.com.au/public/issues/172\\_11\\_050600/biegler/biegler.html](http://www.mja.com.au/public/issues/172_11_050600/biegler/biegler.html)

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