MEDICAL TREATMENT FOR THE DYING

Discussion Paper

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ATTORNEY GENERAL

MINISTER FOR HEALTH; ELECTORAL AFFAIRS

FOR WESTERN AUSTRALIA

MEDICAL TREATMENT FOR THE DYING

The State Government has committed to reform the law relating to medical treatment for the dying. While the Government does not support euthanasia, terminally ill people deserve the right to die with dignity and have their wishes about medical treatment respected. Reform is necessary to give people certainty when dealing with end of life issues, enabling terminally ill people to govern their medical treatment and protecting medical professionals who adhere to their wishes.

This paper, *Medical Treatment for the Dying*, seeks to provide a description of the law and practice in other relevant jurisdictions and identifies a number of issues and options for reform. The purpose of the paper is to raise those issues for public debate and resolution. The Government is seeking to balance the interests of terminally ill people and medical professionals, as well as the broader public interest.

The Government is acutely aware that various organisations and members of the public have great insight in this area, and is very keen to receive public input about the issues raised. We ask that that input be provided by 29 July 2005, to be considered in determining a final position for Government.

I welcome the comments of all interested parties and look forward to working with these organisations and people in reforming this area of law.

Yours faithfully

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ATTORNEY GENERAL

23 May 2005

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PUBLIC SUBMISSIONS

Consultation

This Discussion Paper has been prepared, at the request of the Attorney General and Minister for Health Mr Jim McGinty MLA, by the State Solicitor's Office, Western Australia. A Government working group with representatives from the Department of Health, the Department of Justice (including the State Solicitor's Office), the Public Advocate and the Director of Public Prosecutions will oversee the consultation being conducted through this Discussion Paper. An advertisement will be placed in *The West Australian* and regional newspapers calling for submissions.

Your submissions will form part of the consultation process into issues and options for legislative reform concerning end of life decision making. The purpose of the consultation process is to provide information and seek your comment on the preferred position in Western Australia.

The consultation period will be approximately two months and will result in a framework for development of legislation. Further consultation may be undertaken in relation to the draft legislation when it has been prepared.

Further copies of this Discussion Paper can be obtained by contacting:

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The discussion paper is also available on the Department of Health's Internet site at www.health.wa.gov.au/publications and the Attorney General's Internet site at www.ministers.wa.gov.au/mcginty/

How to have your say

Written comments and submissions should be made to:

Legal and Legislative Services
Department of Health
PO Box 8172
PERTH BC WA 6849

Alternatively, comments and submissions may be emailed to: Legal.Services@health.wa.gov.au

The closing date for submissions is Friday 29 July 2005.

Please indicate whether the submission is being made as an individual or by an organisation. Your name, address, telephone number and/or email address should be included. Anonymous submissions will not be considered. Individuals or organisations who wish their comments to be treated confidentially should indicate this clearly (for example, by marking correspondence *private and confidential*). However, it should be noted that any submission may be subject to release under the *Freedom of Information Act 1992.*

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INTRODUCTION

This Discussion Paper has been prepared to assist appropriately focused community debate and input into the development of legislation which will facilitate, subject to appropriate safeguards and protections, advance health planning, and in particular end of life decision-making, and which will provide an acceptable level of certainty and protection for health professionals and others involved in this critical area of decision-making.

There clearly is a need to clarify and, as appropriate, modify the law in this area. Some reforms will generate debate only as to matters of detail. Other issues, especially those relating to decisions to withdraw or withhold life-sustaining measures, are complex and involve sensitive and difficult legal, medical and ethical considerations. As to these latter issues, it is to be emphasised that legislation to allow euthanasia is not being considered and will not be introduced. This paper assumes the sanctity of human life and deals only with the issues surrounding the discontinuance of life-prolonging treatment, not those relating to conduct intended to unnaturally end life.

According to the Australian Bureau of Statistics, more than 63,000 Western Australians (approximately 3% of the State's population) are estimated to be limited in their capacity to make reasoned decisions in their own best interests due to conditions such as dementia, mental illness, intellectual disability and acquired brain injury. The number of adults in Australia with decision-making disabilities is steadily increasing. For example, the number of Western Australians with severe to moderate dementia is currently estimated to be around 17,000 people. 70% of these have a dementia related to Alzheimer's Disease. With the continued ageing of the population, this figure of 17,000 is expected to double, representing 9-11% of the entire population of seniors, within the next 10 years. In relation to acquired brain injury, more than 7,000 Western Australians are admitted to hospital each year with a head injury and possible acquired brain injury. Most will make a full recovery, but it is estimated that about 600 people a year sustain permanent acquired brain injury and over half of these will require intensive and ongoing support. All of these people will require another person to make decisions on their behalf because, either temporarily or permanently, they will no longer be able to make decisions for themselves. The effect of the numbers is further compounded because medical technology is better able to prolong the lives of people who have a disability, or who sustain an acquired brain injury, that affects their cognitive function.

Currently most medical and other personal decisions are made informally and without legal authority through consultation with families. These informal arrangements often rely on the loose concept of next of kin which has no legal basis in the area of personal decision-making. For example, families are frequently asked to make medical decisions regarding such matters as the withdrawal of life support treatment and family decisions are usually respected by the treating health professionals.

From the patient's perspective, there is uncertainty whether his or her wishes will be carried out in the absence of a legislative framework. For the health professional,

informal expressions of a patient's wishes can be unclear in their content and uncertain in their consequences and the health professional may be unsure whether to rely on such wishes, particularly where they relate to the withdrawal or withholding of life-sustaining measures.

Western Australia has no legislation providing for advance health care planning. The *Guardianship and Administration Act 1990* provides a process for the formal appointment of a guardian with authority to consent to treatment or health care of a person, in the event of that person's incapacity. However, the Act does not specifically give authority for the withdrawal or withholding of treatment or health care. It also makes no provision for advance health care planning in the form of advance health directives and enduring powers of guardianship.

An advance health care directive (sometimes referred to as a "living will") is a mechanism for enabling a legally competent adult to indicate in advance the type of treatment he or she wants or does not want in the event of subsequent incapacity. It is most often used to refuse life-sustaining treatment in the event of a terminal illness or a state of persistent and permanent unconsciousness.

The ability to nominate a personal decision-maker in the form of an enduring power of guardianship also reflects the principle of personal autonomy in decision-making, allowing a person to choose his or her own substitute decision-maker rather than having an external State tribunal appoint a decision-maker on his or her behalf. Further, a person, by making an enduring power of guardianship, would be able to exert a greater measure of influence over the direction and decisions that may be made in the event that the person loses capacity.

This Discussion Paper is concerned not only with the rights of individuals to make decisions about their future health care but also with the protection of health professionals and substitute decision-makers from civil and criminal liability.

THE LAW IN WESTERN AUSTRALIA

ADVANCE HEALTH DIRECTIVES

Common Law Position

The right to self-determination is a fundamental principle that is part of the common law in many jurisdictions. In *Cruzan v Director, Missouri Department of Health* (1990) 110 S.Ct 2841, the United States Supreme Court stated that:

> "No right is held more sacred, or is more carefully guarded... than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."

The right not to consent to treatment as a part of the broader right to self-determination was described by Mr Justice Cardoza in *Schloendorf v Society of New York Hospital* (1914) 105 NE 92 at 93 in the following oft-quoted terms:

> "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."

The principle's application in Anglo-Australian jurisprudence is well illustrated by the United Kingdom decision in *Airedale N.H.S. Trust v Bland* [1993] AC 789 in which the House of Lords dealt with the withdrawal of life support from a patient in a persistent vegetative state. Lord Goff stated:

> "The principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so...To this extent, the principle of the sanctity of human life must yield to the principle of self-determination." (at 864)

The application of the principle is illustrated by the UK decision of *Re B* [2002] 2 All ER 449. In that case a 43 year old woman suffered from a neurological condition and was dependent on respiratory support. She had no prospect of recovery and had requested that the ventilator be turned off. She made an application to the High Court seeking a declaration as to her capacity and the legality of her treatment, and nominal damages. The Court granted declarations of competence and unlawfulness of past and continued ventilation, and awarded nominal damages. It observed that where capacity to consent or refuse treatment was not an issue, the wishes of the patient had to be respected by doctors regardless of the outcome, and clinical views as to the patient's best interests were therefore irrelevant. If the doctors were unable to comply with her wishes then it was their duty to find other doctors who would do so. Where a satisfactory conclusion could not be reached then an application should be made to the High Court.

In Australia the High Court recognised the right of a patient to self-determination in *Secretary, Department of Health and Community Services v JWB & SMB* ["*Marion's Case*"] (1992) 175 CLR 218.

It is now well established that it is an actionable tort at common law for a health professional to carry out medical treatment on a competent adult patient without the consent of the patient. If no consent (express or implied) is given, then in the absence of an authorising statute the health professional commits the civil wrong of trespass to the patient and may also commit the crime of assault.

There has as yet been no specific judicial consideration of the right to refuse treatment in advance in Australia. However, the issue has been considered by courts in Canada and the UK.

In *Malette v Shulman* (1990) 67 DLR (4th) 321 the Ontario Court of Appeal endorsed the principle that the right to refuse treatment at common law extends to making decisions to refuse treatment in anticipation of future events. The Court held that a medical practitioner could not give a blood transfusion to an unconscious patient after he became aware that the patient carried a card which identified her as a Jehovah's Witness. The card instructed that the patient was not to be treated with any blood products. Despite the card not being dated or witnessed, the Court held that to administer a blood transfusion contrary to the instructions on the card would constitute battery on the part of the doctor.

In the UK this area of law has developed significantly over the last decade and there are a number of decisions to the effect that a valid advance refusal has the same authority as a contemporaneous refusal at common law. In *Re T (adult: refusal of treatment)* [1992] 4 All ER 649 the Court of Appeal outlined the conditions for a legally valid anticipated refusal of a procedure as follows:

- the patient must be competent at the time of the declaration;
- the patient must be informed in broad terms about the nature and effects of the procedure;
- the patient must have anticipated and intended the refusal to apply to the circumstances that subsequently arise; and
- the patient must be free from undue influence when issuing the declaration.

In the House of Lords decision in *Airedale N.H.S. Trust v Bland*, Lord Goff applied the principle of self-determination earlier referred to, to advance directions:

> "The same principle applies where the patient's refusal to give his consent has been expressed at an earlier date, before he became unconscious or otherwise incapable of communicating it; though in such cases especial care may be necessary to ensure that the prior refusal of consent is still properly to be regarded as applicable in the circumstances which have subsequently occurred." (at 864)

It is likely that the High Court of Australia would follow the House of Lords decision in *Airedale N.H.S. Trust v Bland* and find that the common law in Australia supports the right of a competent person to give binding consents and refusals regarding the manner of his or her own future health care.

Statutory Position

There is no legislative scheme in Western Australia that provides for advance health directives to be made or for a refusal of treatment certificate to be completed by a competent adult.

SUBSTITUTE DECISION-MAKING

Parens patriae jurisdiction

Parens patriae jurisdiction (in essence, the State's guardianship of the vulnerable) is conferred on the Supreme Court by section 16(1)(d) of the *Supreme Court Act 1935* in the following terms:

> "... to appoint guardians and committees of the persons and estates of ... persons of unsound mind... and for that purpose to inquire into, hear, and determine by inspection of the person the subject of inquiry, or by examination on oath or otherwise of the party in whose custody or charge such person is, or of any other person or persons, or by such other ways and means by which the truth may be best discovered, and to act in all such cases as fully and amply to all intents and purposes as the said Lord Chancellor or the grantee from the Crown of the persons and estates of ... persons of unsound mind might lawfully have done at such date."

The availability of this jurisdiction has been recognised in a number of Australian cases, including *Carseldine v The Director of the Department of Children's Services* (1974) 133 CLR 345, *Marion's Case* and, most recently in Western Australia, *Minister for Health v AS* [2004] WASC 286.

Section 3A *Guardianship and Administration Act 1990* makes it clear that the provisions of that Act do not affect this inherent jurisdiction of the Supreme Court.

The Court in its inherent jurisdiction has the care of those who are not able to take care of themselves and must act in the best interests of the person who is the subject of the exercise of the Court's discretion.

Statutory Position

Part 5 of the *Guardianship and Administration Act 1990* makes provision for the State Administrative Tribunal to appoint a person, including the Public Advocate, to be a guardian for a person ("represented person") who has attained the age of 18 years; who is incapable of looking after his or her own health and safety, unable to make reasonable judgement in respect of matters relating to his or her person or is in need of oversight, care or control in the interests of his or her own health and safety or for the protection of others; and who is in need of a guardian.

A plenary guardian may consent to any treatment or health care of the represented person but a limited guardian must be given specific authority by the Tribunal to consent to such treatment or health care.

Section 3(1) of the Act defines "treatment" as "any medical, surgical, dental or related treatment or care that may lawfully be provided to a patient with a patient's consent or the consent of any person authorised by law to consent on behalf of the patient, but does not include the procedures referred to in Division 3 of Part 5". Division 3 relates to sterilization.

The definition of "treatment" does not include a specific reference to the withdrawing or withholding of treatment, including life-sustaining treatment. The Full Board of the Guardianship and Administration Board in *Re BTO* (Application GU 0192/2004, delivered on 14 October 2004) discussed the potential scope of the definition of "treatment" and stated:

> "In the context of the Act, and more particularly in the context of s119, we tend to the view that the concept of treatment adopted by the Act appears to include not only medical or surgical procedures designed actively to treat a person's illness or condition, but also the provision of care in the form of oversight of a person's condition and medical advice as to by what measures it may best be managed, the prescription of courses of medication and the like. Medical care, flowing from such oversight and medical advice, may also involve advice concerning the appropriateness of withdrawal of particular measures of treatment or care or the effect of not providing certain forms of treatment or care that may be available, including those by which a person is non-naturally hydrated or nourished, as well as the act of withdrawing such forms of medical treatment or care." (at paragraph 39)

There is no provision in the Act for a person, while competent, to appoint by means of an enduring power of guardianship a substitute decision-maker to make personal or life-style decisions in the event of the person's incapacity.

Part 6 of the Act makes provisions for the State Administrative Tribunal to appoint an administrator for a person of any age if that person is unable, by reason of a mental disability, to make reasonable judgements in respect of matters relating to all or any part of his or her estate and is in need of an administrator of his estate.

Part 9 of the Act provides that a person may also, while competent, appoint one or two attorneys pursuant to an enduring power of attorney to make decisions in respect of the estate of the person. An attorney may make decisions both prior to and during any incapacity of the donor.

Section 119 of the Act provides a further avenue for substitute decision-making. It establishes a mechanism whereby medical and dental practitioners may lawfully provide treatment to a patient who is incapable of consenting to the proposed treatment and in

respect of whom a guardian could have been appointed under the Act. It obviates the need for the appointment of a guardian unless there is no other person to consent.

Section 119 requires consent to be given to the provision of treatment by the person first in order of priority in the list of persons specified unless the patient is in need of urgent treatment, and, in the opinion of the practitioner, it is not practicable to obtain that consent.

LIABILITY OF HEALTH PROFESSIONALS

As is evident from the above discussion, no civil liability attaches to a health professional who complies with the refusal of a competent patient to consent to the provision of life-sustaining treatment. A person will be regarded as capable of consenting, and of refusing consent, to medical treatment if he or she is capable of understanding the nature and consequences of the treatment proposed. The issue in any particular case will be whether the person whose treatment is contemplated "possesses sufficient capacity and emotional maturity to understand the nature and consequences of the procedure to be performed" (*Marion's Case*, at 293). A practitioner or hospital who or which, perhaps reluctant to honour a life-threatening refusal of treatment (as in the case of *re B*), acts inconsistently with a competent patient's wishes, is at risk of a successful claim for damages in trespass or of an injunction or declaration (that the relevant treatment is unlawful) being granted.

Where a patient is not competent, then the health professional's obligations and hence potential civil liability will hinge on two factors. The first is whether there exist other circumstances, such as a health directive given while the patient was competent or the expression by a relative or guardian of the patient of their preferences in relation to future treatment, which are properly to be regarded as in law representing the current wishes of the patient, and so (provided that those wishes can lawfully be carried out) binding on those involved in the treatment of the patient. The second issue is the medical steps which, in the absence of the direct or indirect consent or otherwise of the patient, can lawfully be taken where those steps will or may have consequences for how long the patient will live. Implicit in both these issues is that the civil law obligations of health professionals (and indeed of anyone involved in the medical decision-making process) cannot be divorced from the backdrop of the criminal law. In particular, the Courts cannot in the civil context authorise, or regard as lawful, conduct which is prohibited by the *Criminal Code* or other legislation which attaches criminal penalties to defined conduct.

Legislatively declaring particular conduct to be criminally unlawful has of course a significance well beyond the consequences for civil liability. A breach of the *Criminal Code* may result (subject to the exercise of the prosecutorial discretion) in criminal charges which, if proved, will attract penal sanctions. It is unlawful for conduct which is itself unlawful to be facilitated or encouraged by third parties.

In a number of respects the current law, especially the criminal law, relating to the withdrawal or withholding of medical treatment for terminally ill patients is uncertain. As the Law Reform Commission of Western Australia observed in its Discussion Paper *Medical Treatment for the Dying* (Project No. 84, June 1988), at 12:

> "Doctors and patients may face substantial legal problems in relation to the provision of medical treatment of terminally ill people... In practical terms the real difficulties spring from provisions in the Criminal Code which impose duties on persons having the charge of others and provisions relating to unlawful killing. These problems arise because the legal duties have been developed to meet problems other than the bona fide treatment of patients suffering from terminal conditions, and the application of the Code provisions to such treatment is uncertain. This uncertainty arises because the provisions of the Criminal Code which might be relevant are of general application and there have been no reported cases in which their operation in the present area of concern has been specifically examined. The spectre of criminal liability raised by provisions of general application is undesirable where doctors are endeavouring to practise medicine with a humane concern for the terminally ill."

Some of these concerns have been addressed, and the law in some measure clarified, by a number of landmark Court decisions (most notably the *Bland* decision and the New Zealand case of *Auckland Area Health Board v Attorney General* (1993) 1 NZLR 235). Nevertheless, the legal position cannot be said to be certain.

To the sentiments expressed by the Law Reform Commission may be added the factual and legal uncertainties which can attach to advance health directives and the current legal uncertainty as to the entitlements of guardians to consent or decline consent on a patient's behalf to life-sustaining treatment. In the former case, the issues in any particular circumstances will be whether the directive was sufficiently clear and detailed to govern the provision or discontinuance of the particular treatment contemplated or being provided, and whether the expression of the patient's wishes ought in any event to be regarded as enshrining the patient's current wishes. The older the directive, the greater the likelihood, especially with medical advances, that it may not accurately reflect the patient's views and the greater the possibility that it may have been revoked. In the latter case, there is the uncertainty (addressed in *Re BTO*) which attaches to the term "treatment" in the *Guardianship and Administration Act 1990.*

The particular difficulty caused for health professionals and others by these uncertainties is that in determining civil liability, and indeed criminal liability where consent is an element of or a defence to an offence, the critical issue will be whether, as a matter of law and fact, the patient has or has not consented to the particular conduct - either directly or validly through a third party. In the criminal law it will at least be a defence, under section 24 of the *Criminal Code*, that the practitioner or other person honestly and reasonably believed that the patient had given or refused the relevant consent. In the civil context, however, absent statutory intervention (such as the protection given by section 114 of the *Guardianship and Administration Act 1990* to persons performing

functions under that Act or under an order of the State Administrative Tribunal for conduct not "done dishonestly, in bad faith or without reasonable cause"), there is no equivalent protection. The question will be solely whether consent was or was not given, ie it will be irrelevant whether the person the subject of a claim believed reasonably or in good faith that his or her conduct was compatible with the lawful wishes of the patient.

In Western Australia the lawfulness or otherwise, in criminal terms, of a decision not to provide life-prolonging treatment is determined by the provisions of the *Criminal Code*. The significant provisions for present purposes are sections 262, 265, 267, 268 and 273 of the Code, each as read with sections 277, 278, 279 and 280 (the sections rendering unlawful killing an offence and defining the ingredients of respectively wilful murder, murder and manslaughter). Section 288 of the Code, which proscribes encouraging or assisting a suicide, falls outside the scope of this Discussion paper.

Pursuant to section 268 it is "unlawful to kill any person unless such killing is authorized or justified or excused by law". It would appear that a relevant authorisation, justification or excuse must be found in the Code or in some other statute (*Ward v R* [1972] WAR 36). Ordinarily, the criminal law does not require one person to take positive steps to preserve the life or health of another unless there exists a legal duty to act. Relevantly, such a duty to act is imposed by the Code where one person has charge of another in such circumstances as create a duty to provide necessaries (section 262), where surgical or medical treatment is embarked upon (section 265) and where a person has undertaken to carry out actions a failure to perform which would be dangerous to life (section 267). Section 273 also attaches criminal liability to certain omissions in the treatment of the mentally disabled.

Section 262 provides:

> "It is the duty of every person having charge of another who is unable by reason of age, sickness, unsoundness of mind, detention, or any other cause, to withdraw himself from such charge, and who is unable to provide himself with the necessaries of life, whether the charge is undertaken under a contract, or is imposed by law, or arises by reason of any act, whether lawful or unlawful, of the person who has such charge, to provide for that other person the necessaries of life; and he is held to have caused any consequences which result to the life or health of the other person by reason of any omission to perform that duty."

The application of that section to modern means of prolonging life is by no means clear cut. Questions which arise are, firstly, whether and in what circumstances a health professional can properly be said to have "charge" of a patient within the meaning of that section and, secondly, whether "necessary" medical treatment encompasses all treatment which will or may extend life, no matter what the patient's circumstances and no matter how complicated and costly the technology. As to the former issue, there can be little doubt that a health professional can relevantly be regarded as in charge of a patient, but the matter becomes difficult where there is a treating team. As to the latter

issue, "the necessaries of life" would not be interpreted so as to require treatment whose objective was to preserve life at all costs, but would be construed so as to require a health professional to exercise a reasonable clinical judgment as to what medical treatment was in all the circumstances sensibly required. For example, a decision not to place a patient on a ventilator in circumstances where the patient would inevitably, if thereby kept alive, be in a vegetative state with no reasonable prospect of that condition being reversed, would be highly unlikely to be regarded as depriving the patient of a "necessary of life" within the meaning of section 273.

As was observed by Lord Goff in the House of Lords decision in *Airedale N.H.S. Trust v Bland* [1993] AC 789, a seminal case in which it was held to be lawful in England for doctors, in specified circumstances, to discontinue life-sustaining measures designed to keep alive a patient in a persistent vegetative state:

> "[I]t cannot be right that a doctor, who has under his care a patient suffering painfully from terminal cancer, should be under an absolute obligation to perform upon him major surgery to abate another condition which, if unabated, would or might shorten his life still further. The doctor who is caring for such a patient cannot, in my opinion, be under an absolute obligation to prolong his life by any means available to him, regardless of the quality of the patient's life. Common humanity requires otherwise, as do medical ethics and good medical practice accepted in this country and overseas." (at 867).

More directly relevant to the position in this State (in that the Court was dealing with the proper construction of section 151 of the *Crimes Act 1961* (NZ), a provision relevantly identical to section 262) is the conclusion of Thomas J in *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235 that a ventilatory-support system maintaining the breathing and heartbeat of a patient with an extreme and irreversible form of Guillain-Barre syndrome could not, on the facts of that case, be regarded as a "necessary of life" (at p.250) in the sense contemplated by section 151. The judge observed, at 250:

> "It is repugnant that a doctor who has in good faith and with complete medical propriety undertaken treatment which has failed should be held responsible to continue that treatment on the basis that it is, or continues to be, a necessary of life. Nor is it possible to say at one and the same time that a life-support machine is serving no other purpose than deferring certain death and, on the other hand, regard the provision of the machine as a necessary of life in the sense that the term is used in the section."

Similar considerations are relevant to section 267, which states:

> "When a person undertakes to do any act the omission to do which is or may be dangerous to human life or health, it is his duty to do that act; and he is held to have caused any consequences which result to the life or health of any person by reason of any omission to perform that duty."

Central to the application of this provision are the issues of what relevantly constitutes an undertaking and what circumstances, in the context of the technical availability of extreme medical measures capable of lengthening life, can be said to be "dangerous to human life or health". Again, the provision would not be construed so as to require a health practitioner to seek to extend life "by any means, regardless of the quality of the patient's life".

Section 265 ultimately requires consideration of the same matters but in the more familiar context of an evaluation of the reasonableness of the medical treatment provided. The section states:

> "It is the duty of every person who, except in a case of necessity, undertakes to administer surgical or medical treatment to any other person, or to do any other lawful act which is or may be dangerous to human life or health, to have reasonable skill and to use reasonable care in doing such act; and he is held to have caused any consequences which result to the life or health of any person by reason of any omission to observe or perform that duty."

It is to be emphasised that for the purposes of the section the test for whether material conduct is "reasonable" is not the civil one but rather whether "the negligence of the accused went beyond a mere matter of compensation between subjects and showed such disregard for the life and safety of others as to amount to a crime against the State and conduct deserving punishment" (*R v Bateman* (1925) 94 LJKB 791). As the High Court observed in *Callaghan v R* (1952) 87 CLR 115, at 124, "it would be wrong to suppose that it was intended by the Code to make the degree of negligence punishable as manslaughter as low as the standard of fault sufficient to give rise to civil liability". In other words, the test for the absence of reasonable skill and care is something close to recklessness.

The final provision of relevance is section 273. Under that section a person who by act or omission "hastens the death of another person who ... is labouring under some disorder or disease arising from another cause, is deemed to have killed that other person". The focus of that section is on ensuring that it is not a defence to a homicide that the victim would have died in any event from a cause unrelated to the accused's conduct (see *R v Martyr* [1962] Qd R 398, at 415), ie the provision is primarily concerned with causation. Nevertheless, the provision does deem the hastening of death to constitute a killing so that it has at least potential application to the act, say, of discontinuing life-sustaining treatment.

In the circumstance of a terminally ill patient kept alive by artificial means but with no brain function, the issues raised by section 273 would be, firstly, whether it could be said that there was the necessary intent for the purposes of section 268 to cause harm (bearing in mind that a shortened life span may be an incidental result of appropriate pain relieving treatment) and, secondly, whether in any event the relevant conduct truly hastened death or rather simply enabled nature to take its course. As to the latter issue, Lord Goff succinctly commented in *Airedale N.H.S. Trust v Bland*, at 868:

> "The question is not whether the doctor should take a course which will kill his patient, or even take a course which has the effect of accelerating his death. The question is whether the doctor should or should not continue to provide his patient with medical treatment or care which, if continued, will prolong his patient's life."

Thomas J in the *Auckland Area Health Board v Attorney-General* case similarly concluded, when interpreting section 164 of the *Crimes Act 1961* (NZ), a provision very similar to section 273, that "there is a significant difference between hastening the death of a living person who may nevertheless be terminally ill and discontinuing a life support system which is artificially prolonging the manifestations of "life" " (at 255). The latter scenario, provided it was in accordance with good medical practice, did not fall within section 164.

The legal position in the United Kingdom, enunciated in *Bland*, is that a decision to discontinue life prolonging treatment will be lawful if, according to the standards of a responsible body of medical opinion, such a course would be in the best interests of the patient. The legal position in Western Australia has not been tested, though there is no reason to believe, recognising that in the criminal context the question of criminal conduct will be resolved by interpretation of the relevant provisions of the *Criminal Code*, that it will in principle be different. The one significant distinction is that in this State the reasonableness from a medical perspective of the practitioner's conduct will fall to be determined by the Courts, not (as in the United Kingdom) by the practitioner's peers. In the United Kingdom, the acceptable standard for medical practice is that expressed in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, namely, that doctors are obliged to provide treatment to a standard which accords with the standards of a responsible body of medical opinion, skilled in the particular form of treatment. In Australia the *Bolam* principle was rejected by the High Court in *Rogers v Whitaker* (1992) 175 CLR 479. The Court held that medical evidence is relevant to, but not decisive of, the acceptable standard of care, the determination of that issue being within the exclusive province of the Courts. In the civil context, the law has been modified in Western Australia by the *Civil Liability Act 2002*. Section 5PB of that Act relevantly provides that a health professional's actions are not negligent if done in accordance with a practice, not itself irrational, that is widely accepted by the health professional's peers as competent professional practice. This is a similar formulation - although not identical - to the *Bolam* test. Section 5PB does not apply to "an unlawful intentional act that is done with an intention to cause personal injury to a person" (section 3A(1) Item 1).

Applying the provisions of the *Criminal Code* in a sensible manner to future circumstances which could not have been envisaged by the Code's draftsmen in 1913 is not a straightforward task and undoubtedly involves some straining of traditional concepts of causation and intent. Nevertheless, the legal position in this State in relation to the cessation of life support (assuming that the patient has not otherwise refused consent to the continuation of such support) would appear to be that a health professional will not be in breach of the *Criminal Code* if he or she acts in good faith in

the interests of the patient, and, in accordance with accepted medical standards and practice, withholds or withdraws artificial life support serving no therapeutic or medical benefit. In circumstances of doubt, an application should be made to the Supreme Court for a declaration as to the lawfulness or otherwise of the contemplated withholding or cessation.

PROPOSALS FOR REFORM IN WESTERN AUSTRALIA

REPORT OF THE LAW REFORM COMMISSION OF WESTERN AUSTRALIA

In February 1991 the Law Reform Commission of Western Australia reported on Project No. 84, *Medical Treatment for the Dying*. The recommendations made in the Report were based on the provisions of the Victorian *Medical Treatment Act 1988*.

In considering the relative merits of living wills and medical powers of attorney, the Commission concluded that the underlying medical treatment issues could be better addressed by an agent rather than by setting them out in advance in a living will. The Commission pointed out that a living will has the fundamental difficulty that it prescribes a form of medical treatment without knowing the precise circumstances which would exist when the directive is required to be used. Therefore it is likely to be either too specific, failing to cover all circumstances, or too general, causing interpretative problems. If it leaves too much discretion with another to interpret how it will apply then it differs little from the power of attorney approach.

The Commission made the following recommendations:

(a) Advance provision for terminal illness

- Persons should be able to appoint an agent by means of an enduring power of attorney to make decisions relating to their medical treatment, which takes effect only if the person giving the power becomes incompetent.
- Where no agent has been appointed by an enduring power of attorney, an appointed agent is unwilling or unavailable to act or the patient has never been competent to appoint an agent, a guardian appointed by the Supreme Court or the Guardianship and Administration Board should be able to make decisions to refuse treatment on an incompetent patient's behalf.
- Whether a decision to refuse treatment is made by the patient's agent or guardian, that decision should be made on the basis of whether or not the particular patient would have refused the treatment under the circumstances involved, that is, a "substituted judgement".
- Where the substituted judgement approach is inappropriate, the agent or guardian should make the decision on the basis of what would probably be conceived by a reasonable person in the patient's circumstances to be in the patient's best interests.

- So long as an agent or a guardian makes a decision in good faith in accordance with the prescribed criteria, the decision-maker should not be liable either civilly or criminally for that decision. The protection should extend to a case where the agent's or guardian's authority has been revoked so long as he or she does not have notice of the revocation.

(b) Refusal of treatment certificate

- To provide proof of the refusal of treatment, statutory provision should be made for the completion of a refusal of treatment certificate by a patient. The completion of a refusal of treatment certificate by the patient's agent or guardian should have the same effect.
- The refusal of treatment certificate should be confined to a current condition.
- The provision of palliative care should be subject to the same rules as those governing other medical treatment and the refusal of treatment certificate should be so drawn as to enable palliative care to be refused if the patient or the patient's agent or guardian so chooses.
- An offence of medical trespass should be created which applies to a health professional who, knowing that a refusal of treatment certificate applies to a person, undertakes, or continues to undertake, any medical treatment to which the certificate applies.
- A health professional who, in good faith and in reliance on the refusal of treatment certificate, does not give or continue any treatment specified in the certificate should not be liable in any civil or criminal proceedings or proceedings for professional misconduct for failing to give or continue that treatment.

(c) Protection for health professionals

Health professionals should not be civilly or criminally liable for administering drugs or other treatment for the purpose of controlling or eliminating pain and suffering, even if the drugs or other treatment incidentally shorten the patient's life, providing that consent of the patient or the patient's agent or guardian, is obtained and the administration of the drug or treatment is reasonable in all the circumstances.

MEDICAL CARE OF THE DYING BILL 1995

In 1995 the Hon Ian Taylor introduced the *Medical Care of the Dying Bill 1995*, a private member's Bill (which ultimately did not proceed), which sought to affirm and protect the rights of terminally ill persons to refuse unwanted medical treatment and protect medical practitioners and other health professionals from liability.

The Bill was modelled on the Victorian *Medical Treatment Act 1988* in that its provisions became operative upon the creation of a valid refusal of treatment certificate. The certificate allowed a person to make a decision to refuse medical treatment generally, or of a particular kind, for a current condition.

Palliative care was excluded from the definition of medical treatment in the Bill and was defined as including:

> "(a) the provision of reasonable medical procedures for the relief of pain, suffering and discomfort; or
>
> (b) the reasonable provision of food and water."

The Bill created a statutory offence of medical trespass which would be committed by a medical practitioner who carried out medical treatment to which a refusal of treatment certificate applied, knowing that the certificate applied.

The Bill also extended protection to medical practitioners from liability for misconduct as well as criminal or civil responsibility where the medical practitioners, in good faith, acted in accordance with instructions in a refusal to treat certificate. A further provision provided protection for a medical practitioner who administered drugs to a patient to control pain and suffering, where the administration of treatment also had the effect of shortening the patient's life expectancy.

THE LAW IN OTHER AUSTRALIAN JURISDICTIONS

APPROACHES TO REFORM THROUGHOUT AUSTRALIA

There is ample evidence from various jurisdictions in Australia that members of the general public would like a clear ability to record in advance their views as to the medical treatment they will receive should they lose capacity to give consent. They also want to be sure that those wishes are respected. In essence, the debate regarding advance health directives is concerned not with their appropriateness in principle but with whether the making of such directives should be the subject of legislation or of guidelines.

Legislation creating statutory forms of advance health directives has been enacted in South Australia, Victoria, Queensland, the Australian Capital Territory and the Northern Territory. However, the form of advance health directives authorised in the legislation varies between those jurisdictions.

Advance health directions are of course only one aspect of an appropriate scheme governing end of life decision-making. Consideration has also to be given to the appointment of substitute decision-makers and the protection of health professionals. Other jurisdictions' legislation relevant to all these areas is summarised in some detail below.

AUSTRALIAN CAPITAL TERRITORY

The material legislation in the Australian Capital Territory is the *Medical Treatment Act 1994* and the *Guardianship and Management of Property Act 1991*.

Medical Treatment Act 1994

The objectives of the *Medical Treatment Act 1994* are to protect the rights of patients to refuse unwanted medical treatment and to ensure that patients receive relief from pain and suffering to the maximum extent that is reasonable in the circumstances. The Act states that it does not apply to palliative care, or affect any person's rights or duties in relation to palliative care. Palliative care is defined as including the provision of reasonable medical and nursing procedures for the relief of pain, suffering and discomfort and the reasonable provision of food and water.

(a) Refusal of treatment

The Act enables a competent adult to make a direction to refuse medical treatment, either generally or of a particular kind.

A direction may be made in writing, orally or in any other way in which the person can communicate.

(b) Substitute decision-makers

The Act also allows a competent adult ("the grantor") to appoint an attorney who can consent to the withholding or withdrawal of treatment in the event that the grantor becomes incapacitated. The power cannot be exercised until a medical practitioner has declared the grantor to be incapacitated.

A number of conditions are imposed on the grantee's powers to request the withholding or withdrawal of medical treatment. The grantee must have consulted a medical practitioner about the nature of the grantor's illness, any alternative forms of treatment and the consequences of remaining untreated. The grantee must also believe on reasonable grounds that, if the grantor were capable of making a rational judgement and were to give serious consideration to his or her own health and wellbeing, the grantor would request the withholding or withdrawing of the medical treatment. The grantee may request the withholding or withdrawal of treatment based on an advance direction.

(c) Statutory protection for health professionals

The Act provides protection from liability for health professionals who withhold or withdraw medical treatment in good faith in reliance on a decision that he or she believes on reasonable grounds complies with the Act. Health professionals are also not liable for decisions about whether a direction or power of attorney was

revoked, and whether a person had the capacity to make a direction or power of attorney at the time of making it.

However, the Act also provides that a doctor shall not comply with a grantee's request to withhold or withdraw treatment unless satisfied that the power of attorney (that grants the power) complies with the Act. The doctor must also be satisfied that the grantee understands the information given by a medical practitioner about the illness, alternative treatments and consequences of remaining untreated, and has weighed the various options and, as a result, affirms the request.

Guardianship and Management of Property Act 1991

The *Guardianship and Management of Property Act 1991* provides for the Guardianship and Management of Property Tribunal to appoint a guardian for a person with impaired decision-making ability in relation to a matter relating to the person's health, welfare or property.

A guardian may be given the power to consent to a medical procedure or other treatment.

Protection is provided under the Act for medical practitioners who carry out treatment when they are not aware that the person giving consent is not competent to give it at the time.

NEW SOUTH WALES

In the early 1990s, as a result of concerns expressed in New South Wales regarding the legal consequences for health practitioners of withholding potentially life-saving treatment, the Minister for Health released a Discussion Paper seeking community comment on proposed legislation to protect medical practitioners. After a review of the submissions a decision was made not to introduce legislation to provide for advance health directives and instead to introduce guidelines for decision-making at the end of life. The Guidelines rely upon and complement the existing common law principles governing advance care directives.

Guidelines for decision-making

In 1993 the New South Wales Health Department released the *"Dying with Dignity: Interim Guidelines on Management"*. The guidelines have been revised and the "Guidelines for end of life care and decision-making" ("the Guidelines") were released in March 2005.

The Guidelines aim to assist health professionals by providing a process for reaching end of life decisions. That process seeks to promote communication between health professionals, patients and their families, compassionate and appropriate treatment decisions and fairness, and seeks to safeguard both patients and health professionals.

The Guidelines focus on achieving a consensus on decision-making and set out "guiding principles" to be followed in this process. The Guidelines suggest several methods of advance care planning:

- an advance care plan developed with healthcare professionals;
- discussing preferences with family in advance;
- formally appointing an enduring guardian;
- writing an advance care directive.

It is stressed that the critical element is discussion between the patient and those close to him or her while the patient still has decision-making capacity.

The Guidelines describe the conditions necessary for a valid advance care directive:

- it must be intended to apply to the circumstances that have arisen;
- it must be sufficiently clear and specific;
- there must not be any evidence to suggest that it does not reflect the patient's current intentions, or that it was made as a result of undue influence;
- it must be made by the patient him or herself, and should reflect his or her wishes, rather than the wishes of another person.

The Guidelines recommend that it is best practice, though not legally necessary, that an advance care directive should be:

- periodically reviewed by the patient;
- available at the time decisions need to be made;
- signed and witnessed;
- prepared with the involvement of a medical practitioner.

The Guidelines also include advice on decision-making in the end of life context, on the development of management plans and on methods of resolving disagreements, including the involvement of the Guardianship Tribunal or Supreme Court of New South Wales.

Guardianship Act 1987

In New South Wales provision is made in the *Guardianship Act 1987* for a person to appoint an enduring guardian to make decisions once he or she ceases to be competent. The functions of the enduring guardian include deciding the health care that the appointor is to receive and giving consent to the carrying out of medical or dental treatment.

The Guardianship Tribunal may also appoint a guardian to make decisions about medical or dental treatment.

In addition, the Act provides that a "person responsible" can consent to the carrying out of medical treatment and specifies a hierarchy of persons from whom the "person responsible" is to be ascertained. That hierarchy is, in descending order:

- a guardian, including an enduring guardian, if the guardianship order or instrument appointing the enduring guardian provides for the guardian or enduring guardian to give consent to the carrying out of medical or dental treatment;
- a spouse (where the relationship is close and continuing, and the spouse is not under guardianship);
- a carer;
- a close friend or relative of the person.

The powers of a "person responsible" to consent to medical or dental treatment are subject to Part 5 of the Act. The stated objects of that Part include ensuring that any medical treatment carried out is carried out for the purpose of promoting and maintaining the health and well-being of the person.

The Guardianship Tribunal may also give consent to the carrying out of medical treatment where it is satisfied that the treatment is the most appropriate form of treatment for promoting and maintaining the patient's health and well-being.

Part 5 does not address the issue of whether a "person responsible" or the Guardianship Tribunal can consent to the withholding or withdrawal of treatment, including life-sustaining measures.

NORTHERN TERRITORY

The scheme in the Northern Territory is governed by the *Natural Death Act 1988* and the *Adult Guardianship Act 1988*.

Natural Death Act 1988

The *Natural Death Act 1988* is described in the preamble as being an Act to provide for and give directions against artificial prolongation of the dying process.

(a) Power to make a direction

The Act allows a competent adult, who desires not to be subjected to extraordinary measures in the event of his or her suffering from a terminal illness, to make a direction in the prescribed form.

"Extraordinary measures" are medical or surgical measures that prolong life, or are intended to prolong life, by supplanting or maintaining the operation of bodily functions that are temporarily or permanently incapable of independent operation.

"Terminal illness" is defined as an illness, injury or degeneration of mental or physical faculties of such a nature that death would, if extraordinary measures were not undertaken, be imminent and from which there is no reasonable prospect of a temporary or permanent recovery, even if extraordinary measures were undertaken.

(b) Statutory protection for medical practitioners

The Act provides that a medical practitioner incurs no liability for a decision made in good faith and without negligence as to whether a patient:

- is or is not suffering from a terminal illness,
- revoked or intended to revoke a direction under the Act; or
- was or was not, at the time of making a direction under the Act, capable of understanding the nature and consequences of the direction.

Adult Guardianship Act 1999

The *Adult Guardianship Act 1999* provides that a guardian appointed by the Local Court under a full guardianship order or a conditional order can consent to any health care that is in the best interests of the represented person except in relation to "major medical procedures", which require the consent of the Court. "Major medical procedures" include those generally accepted by the medical profession as major.

QUEENSLAND

A report entitled *Assisted and Substituted Decisions: Decision-Making by and for People with a Decision-Making Disability* was published by the Queensland Law Reform Commission in 1996. The report considered, following an extensive review process, the appropriateness of all Queensland laws affecting people with decision-making disabilities. Recommendations made in the Report were largely adopted in the *Powers of Attorney Act 1998* and the *Guardianship and Administration Act 2000.*

Powers of Attorney Act 1998

(a) Advance health directives

Queensland has the most recently enacted and detailed advance health directive provisions.

The *Powers of Attorney Act 1998* provides that an adult may, by an advance health directive, give directions about future health care matters, elaborate upon those

directions, and appoint an attorney to make decisions about health care matters on behalf of the person if the directions prove inadequate. A directive only operates while the person has impaired capacity.

In an advance health directive a person may give a direction consenting to particular future health care or requiring, in specified circumstances, that a life-sustaining measure be withheld or withdrawn. A "life-sustaining measure" includes cardiopulmonary resuscitation, assisted ventilation, artificial nutrition and artificial hydration. Blood transfusions are excluded from the definition.

An advance health directive to withhold or withdraw a life-sustaining measure only comes into operation when the person has a terminal illness or condition that is incurable or irreversible, is in a persistent vegetative state, is permanently unconscious or has an illness or injury of such severity that there is no reasonable prospect that the person will recover to the extent that his or her life can be sustained without the continued application of life-sustaining measures. The person must also have no reasonable prospect of regaining capacity for decision-making in relation to health matters. A further safeguard applies in relation to a direction to withhold or withdraw artificial nutrition or artificial hydration. Such a direction has no operation unless the commencement or continuation of the measure would be inconsistent with good medical practice.

(b) Substitute decision-makers

The Act allows a competent adult to appoint an attorney under an enduring power of attorney to make decisions about financial or personal matters.

It also establishes a mechanism whereby a statutory health attorney may make any decision about a health matter for an adult who has impaired capacity.

The Act specifies, in listed order, a hierarchy of persons who may act as the statutory health attorney for an adult. A statutory health attorney is the first, in listed order, of the following people who is readily available and culturally appropriate to exercise power for the health matter:

- a spouse of the person if the relationship is close and continuing
- a person who is 18 years or more and who has the care of the adult and is not a paid carer for the adult
- a person who is 18 years or more and who is a close friend or relation of the adult and is not a paid carer of the adult.

If no-one in the list is readily available, the Adult Guardian is the adult's statutory health attorney for the health matter. The Adult Guardian is a statutory body established under the *Guardianship and Administration Act 2000* to protect the rights and interests of an adult who has impaired capacity.

(c) Statutory protection for health providers

The Act provides that a health provider is not affected by an adult's advance health directive to the extent that the health provider does not know that the adult made an advance health directive.

Furthermore, a health provider does not incur any liability either to the adult or to anyone else, if the health provider does not act in accordance with a direction in an advance health directive if he or she has reasonable grounds to believe that the direction is uncertain or inconsistent with good medical practice or that circumstances, including advances in medical science, have changed to the extent that the terms of the direction are inappropriate. If, however, an attorney is appointed under the advance health directive, the health provider has reasonable grounds to believe that a direction is uncertain only if, among other things, the health provider has consulted the attorney about the direction.

It should be noted that, in Queensland, section 282A *Criminal Code*, introduced in 2003 in accordance with the recommendations of the 1992 *Criminal Code Review Committee*, specifically excludes criminal responsibility for the provision of palliative care, even if an incidental effect of the provision of that care is to hasten the recipient's death, if:

(a) the palliative care is provided in good faith and with reasonable care and skill,

(b) the provision of the palliative care is in all the circumstances medically reasonable, and

(c) the care is provided by a doctor or was ordered in writing by a doctor.

"Palliative care" is defined as "care, whether by doing an act or making an omission, directed at maintaining or improving the comfort of a person who is, or would otherwise be, subject to pain and suffering".

Guardianship and Administration Act 2000

The *Guardianship and Administration Act 2000* provides that the Guardianship and Administration Tribunal may by order appoint a guardian to make decisions about the health care of an adult who has impaired capacity

Health care is defined to include the withholding or withdrawal of a life-sustaining measure for the adult if the commencement or continuation of the measure would be inconsistent with good medical practice.

A life-sustaining measure is health care intended to sustain or prolong life and that supplants or maintains the operation of vital bodily functions that are temporarily or permanently incapable of independent operation. It includes cardiopulmonary resuscitation, assisted ventilation, artificial nutrition and artificial hydration. A blood transfusion is not a life-sustaining measure.

Chapter 5 of the Act deals with decision-making in relation to health care not only by guardians appointed under the Act but also by attorneys under an enduring power of attorney and by statutory health attorneys.

Statutory protection for health providers

The Act relevantly provides that, to the extent that a health provider giving health care to an adult complies with a purported exercise of a power to make decisions about health by a person who represented to a health provider that the person had the right to exercise the power, the health provider is taken to have the adult's consent to the exercise of power. This protection does not apply if the health provider knew, or could reasonably be expected to have known, that the person did not have the right to exercise the power. Protection and relief from liability for individuals and health providers is provided by the *Powers of Attorney Act 1998* in a range of circumstances:

- where an attorney acts in accordance with the court's advice, directions or recommendations (unless he or she gave false or misleading information to the court);
- where an attorney is unaware that a power of attorney is invalid and purports to exercise the power;
- where a person other than the attorney acts in reliance on an advance health directive or an enduring power of attorney without knowing that it is invalid;
- where a health provider is unaware of an advance health directive;
- where a health provider believes on reasonable grounds that a direction in an advance health directive is uncertain or inconsistent with good medical practice or that circumstances have changed to the extent that the terms of the direction are inappropriate.

SOUTH AUSTRALIA

Consent to Medical Treatment and Palliative Care Act 1995

The *Consent to Medical Treatment and Palliative Care Act 1995* replaced the *Natural Death Act 1983* which was the first legislation in Australia to grant terminally ill adult patients of sound mind a statutory right to direct that extraordinary measures for prolonging life be discontinued.

(a) Anticipatory directions

The *Consent to Medical Treatment and Palliative Care Act 1995* enables a competent adult to give a direction about the medical treatment that the person wants, or does not want, if he or she is at some future time in the terminal phase of a terminal illness or in a persistent vegetative state and incapable of making decisions about medical treatment when the question of administering the treatment arises.

(b) Substitute decision-makers

The Act allows a competent adult, by a medical power of attorney, to appoint an agent with power to make decisions on his or her behalf about medical treatment in the event of incapacity.

"Medical treatment" is treatment or procedures carried out by a medical practitioner in the course of medical or surgical practice or by a dentist in the course of dental practice and includes the prescription or supply of drugs.

A medical power of attorney does not authorise the agent to refuse the natural provision or natural administration of food and water or the administration of drugs to relieve pain or distress. The agent also cannot refuse treatment that would allow the grantor to regain capacity unless the grantor is in the terminal phase of a terminal illness.

(c) Statutory protection for medical practitioners and others

The Act provides that a medical practitioner responsible for the treatment or care of a patient, or a person participating in the treatment or care of the patient under the medical practitioner's supervision, incurs no civil or criminal liability for an act or omission made:

- with the consent of the patient or the patient's representative, or without consent and in accordance with an authority conferred by this Act or any other Act;
- in good faith and without negligence;
- in accordance with proper professional standards of medical practice; and
- in order to preserve or improve the quality of life.

Furthermore, a medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness, or a person participating in the treatment or care of the patient under the medical practitioner's supervision, incurs no civil or criminal liability by administering medical treatment with the intention of relieving pain or distress;

- with the consent of the patient or his or her representative;
- in good faith and without negligence; and
- in accordance with professional standards of palliative care,

even though the incidental effect of the treatment is to hasten the death of the patient.

A medical practitioner is under no duty to use life-sustaining measures to treat the patient if the effect is merely to prolong life in a moribund state where there is no real prospect of recovery or the patient is in a permanent vegetative state. This protection is, however, subject to an express direction by the patient or the patient's representative to the contrary.

Guardianship and Administration Act 1993

The *Guardianship and Administration Act 1993* permits a competent adult to appoint a person as his or her enduring guardian to consent or refuse consent to the medical or dental treatment of the person, except where the person has a medical agent appointed who is available and willing to act in the matter. The Guardianship Board may also appoint a guardian who can consent to the medical treatment of a person.

Medical treatment is treatment or procedures administered or carried out by a medical practitioner or other health professional in the course of professional practice and includes the prescription or supply of drugs.

Where a person is incapable of giving effective consent and does not have a medical agent who is available and willing to make a decision as to the giving of medical or dental treatment, the appropriate authority to give consent is:

- a guardian, providing the guardian's powers have not been limited so as to exclude the giving of consent and he or she is available and willing to make a decision as to consent;
- in any other case a relative of the person or the Guardianship Board.

TASMANIA

Guardianship and Administration Act 1995

In Tasmania there is no legislative mechanism for a person to make an advance health directive.

The *Guardianship and Administration Act 1995* allows a competent adult to appoint an enduring guardian. The Guardianship and Administration Board may also appoint a

guardian. Such guardians may be given the power to consent to any health care that is in the best interests of a person and to refuse or withdraw consent to any such treatment.

Part 6 of the Act deals specifically with consent to medical and dental treatment. It relevantly provides that a "person responsible" can consent to medical treatment. The definition of medical treatment includes any medical or surgical procedure, operation or examination and any prophylactic, palliative or rehabilitative care normally carried out by, or under, the supervision of a medical practitioner.

A person responsible for an adult is, in order of priority, a guardian, spouse, unpaid carer and a close relative or friend of the person. A person who resides in a hospital, nursing home, group home, boarding house or hostel or any other similar facility at which he or she is cared for by some other person is not, by reason only of that fact, taken to be in the care of that other person and is taken to remain in the care of the person in whose care he or she was immediately before residing in the facility.

Where a consent to medical treatment has been given by a person who is not authorised to give that consent, the consent may be taken as valid if the person providing the treatment did not know that the person giving the consent was not authorised or reasonably believed that the person had authority.

VICTORIA

Medical Treatment Act 1988

The purposes of the *Medical Treatment Act 1988* are stated as being:

(a) to clarify the law relating to the right of patients to refuse medical treatment;

(b) to establish a procedure for clearly indicating a decision to refuse medical treatment;

(c) to enable an agent to make decisions about medical treatment on behalf of an incompetent person.

The Act does not apply to palliative care and does not affect any right, power or duty which a registered practitioner or any other person has in relation to palliative care.

(a) Refusal of treatment certificate

The *Medical Treatment Act 1988* provides that a competent adult can complete a "refusal of treatment certificate" to refuse medical treatment generally or of a particular kind for a current condition.

"Medical treatment" is defined as the carrying out of an operation or the administration of a drug or other like substance or any other medical procedure but excludes palliative care.

Palliative care includes the provision of reasonable medical procedures for the relief of pain, suffering and discomfort or the reasonable provision of food and water.

(b) Substitute decision-makers

The Act enables a competent person to appoint an agent under an enduring power of attorney (medical treatment) to make decisions about medical treatment when he or she becomes incompetent.

If the person is a represented person and an appropriate order has been made under the *Guardianship and Administration Act 1986* providing for decisions about medical treatment by the person's guardian, the guardian is authorised to make decisions in relation to medical treatment under the *Medical Treatment Act 1988.*

An agent or guardian may only refuse medical treatment on behalf of the patient if the treatment would cause unreasonable distress to the patient or if there are reasonable grounds for believing that the patient, if competent, and after giving serious consideration to his or her health and well-being, would consider that the treatment was unwarranted.

A medical practitioner who knows that a refusal of treatment certificate applies but undertakes or continues medical treatment commits the offence of medical trespass under the Act.

(c) Protection of medical practitioners and others

The Act provides that a registered medical practitioner and a person acting under the direction of a registered medical practitioner who, in good faith and in reliance on a refusal of treatment certificate, refuses to perform or continue medical treatment which he or she believes on reasonable grounds has been refused in accordance with this Act, is not guilty of misconduct or infamous misconduct in a professional respect, or guilty of an offence, or liable in any civil proceedings because of the failure to perform or continue that treatment.

Guardianship and Administration Act 1986

The *Guardianship and Administration Act 1986* allows a competent adult to appoint an enduring guardian and the Victorian Civil and Administrative Tribunal to appoint a guardian. Guardians may be given the power to consent to any health care that is in the best interests of the person.

Part 4A of the Act deals specifically with medical and other treatment. It relevantly provides that a "person responsible" can consent to medical treatment. The definition of medical treatment includes any medical or surgical procedure, operation or examination and any prophylactic, palliative or rehabilitative care normally carried out by, or under, the supervision of a medical practitioner.

A "person responsible" means the first person listed below who is responsible for the patient and who, in the circumstances, is reasonably available and willing and able to make a decision:

- an agent appointed under the *Medical Treatment Act 1988*;
- a person appointed by the Victorian Civil and Administrative Tribunal to make decisions about the treatment;
- a guardian with power to make decisions about the treatment;
- an enduring guardian with power to make decisions about the treatment;
- a person appointed in writing by the patient, before losing capacity, to make decisions about treatment which includes the proposed treatment;
- a spouse or domestic partner;
- the patient's primary carer;
- the person's nearest relative.

Protection of registered practitioners

A registered practitioner who, in good faith, carries out or supervises the carrying out of medical treatment in reliance on a consent or a purported consent given by another person, whom the practitioner believes on reasonable grounds was authorised to give consent, is not guilty of assault or battery, guilty of professional misconduct or liable in any civil proceedings for assault or battery.

THE LAW IN THE UNITED KINGDOM

In 1989, the Law Commission of England and Wales commenced a study into the law affecting decision-making, including decision-making relating to medical treatment, by those without capacity. In its *Report on Mental Incapacity* published in 1995 the Commission recommended the introduction of a single comprehensive piece of legislation to make provision for people who lack capacity.

In response, the United Kingdom government in December 1997 issued a consultation paper entitled *"Who Decides"* and, after consultation, in October 1999 issued a policy statement entitled *"Making Decisions"*. The policy statement set out the government's proposal to reform the law in order to improve and clarify the decision-making process

for those who are unable to make decisions for themselves, or who cannot communicate their decisions.

The draft *Mental Incapacity Bill* was presented to Parliament on 27 June 2003 and was subject to scrutiny by a Joint Committee which reported in 2003. The Department for Constitutional Affairs published a response in February 2004 and thereafter the *Mental Capacity Bill* was drafted. The renamed *Mental Capacity Act 2005* received the Royal Assent on 7 April 2005.

The Act governs a wide range of decisions made on behalf of adults, including medical treatment decisions, and establishes a new Court of Protection to oversee decisions made under the Act.

The Act is to be accompanied by a Code of Practice which will provide guidance as to the operation of the Act. A draft Code has been prepared but there is currently no final version.

ADVANCE DECISIONS TO REFUSE TREATMENT

The *Mental Capacity Act 2005* enables a person who has attained the age of 18 years and has capacity, to make advance decisions to refuse treatment. The Act seeks to codify and clarify the current common law, integrating it into the broader scheme of the Act.

There are no specific legal requirements or statutory forms. Advance decisions can be oral or in writing save that decisions about life-sustaining treatment must be in writing.

"Life-sustaining treatment" is defined as "treatment which in the view of a person providing health care for the person concerned is necessary to sustain life".

An advance decision must be valid and applicable to the treatment proposed.

An advance decision is not valid if the person:

- has withdrawn the decision at a time when he had capacity to do so;
- has, under a lasting power of attorney created after the advance decision was made, conferred authority on the donee to give or refuse consent to the treatment to which the advance decision relates;
- has done anything else clearly inconsistent with the advance decision remaining his fixed decision.

An advance decision is not applicable to the treatment in question if:

- that treatment is not the treatment specified in the advance decision;
- any circumstances specified in the advance decision are absent;

- there are reasonable grounds for believing that circumstances exist which the person did not anticipate at the time of the advance decision and which would have affected his decision had he anticipated them.

The effect of an advance decision is that a person does not incur liability for carrying out or continuing treatment unless, at the time, he is satisfied that an advance decision exists which is valid and applicable to the treatment. Conversely, a person does not incur liability for the consequences of withholding or withdrawing treatment if, at the time, he reasonably believes that an advance decision exists which is valid and applicable to the treatment.

The Court of Protection may make a declaration as to whether an advance decision exists, is valid or is applicable to a treatment. While a decision in relation to any relevant issue is sought from the Court, a person may provide life-sustaining treatment or do any act which he reasonably believes to be necessary to prevent a serious deterioration in the person's condition.

LASTING POWERS OF ATTORNEY

The *Mental Capacity Act 2005* enables a person ("the donor"), while he has capacity, to appoint an attorney ("the donee") under a lasting power of attorney to make decisions about his or her personal welfare, including health care, and property and affairs. A decision as to personal welfare can only be taken by a donee on the incapacity of the donor, is subject to any advance decision made to refuse treatment made after the lasting power of attorney was created and extends to giving or refusing consent to the carrying out of continuation of a treatment by a person providing health care for the donor. However, the donee may not give or refuse consent to the carrying out or continuation of life-sustaining treatment unless the instrument contains express provision to that effect.

A donee must act in the best interests of the donor. Section 4 of the Act lists a number of criteria which must be considered or taken into account by a substitute decision-maker. For example, the decision-maker must consider, so far as is reasonably ascertainable, the donor's past and present wishes and feelings and the beliefs and values which will be likely to influence his decision if he had capacity. The donee must also take into account, if it is practicable and appropriate to consult them, the views of anyone engaged in caring for the person or interested in his welfare. Where the determination as to the best interests relates to life-sustaining treatment, the donee must not be motivated by a desire to bring about the donor's death.

THE COURT OF PROTECTION AND DEPUTIES

The Court of Protection may make substitute decisions about the personal welfare, property and affairs of an incapacitated person or may appoint a person ("the deputy") to make decisions on the incapacitated person's behalf.

The Court of Protection has the power to give or refuse consent to the carrying out or continuation of a treatment by a person providing health care for the incapacitated person. However, a deputy may not refuse consent to the carrying out or continuation of life-sustaining treatment in relation to an incapacitated person.

The Court of Protection and a deputy must act in the person's best interests.

GENERAL AUTHORITY TO ACT

In the absence of a conflicting advance decision to refuse treatment or lasting power of attorney, general authority is given to anyone who does an act in connection with the care or treatment of a person who lacks capacity, to act in the best interests of that person.

The Act provides statutory protection against liability to the decision-maker if, before doing the act, he or she takes reasonable steps to establish that the person lacks capacity in relation to the matter in question and, when doing the act, reasonably believes that the person lacks capacity and that it will be in the person's best interests for the act to be done. The Act does not exclude a person's civil liability for loss or damage, or his criminal liability, resulting from his negligence in doing the act.

ISSUES AND OPTIONS FOR REFORM

ADVANCE HEALTH DIRECTIVES

Legislation is to be introduced to enable a person, who has attained 18 years of age and has capacity, to make an advance health directive about all future health care matters including the withholding or withdrawal of life-sustaining measures. An advance health directive will be operative only on a person's incapacity.

Formalities

Should common law advance health directives continue to be legally binding or should the statutory scheme apply to all advance health directives?

At common law a person can give a direction about his or her health care in a variety of forms, either orally or in writing. There are no specific requirements for the written form. For example, in *Malette v Shulman* a card carried by a Jehovah's Witness constituted a binding direction although it was neither dated or signed.

The current view is that the common law should not be preserved alongside the proposed statutory scheme for making an advance health directive. The scheme should be sufficiently flexible to promote personal autonomy in decision-making and to encourage future health care planning while at the same time be subject to additional safeguards to protect the rights of the person making the directive and health professionals acting upon the directive. These safeguards will be discussed in some detail below.

It is proposed that an advance health directive may be made in a written or oral form, with minimum formalities. The significant exception to this will be that a directive to withhold or withdraw life-sustaining measures must be specified in writing, signed by the person and witnessed.

What practical system could and should be introduced to increase the likelihood of health providers becoming aware that a patient has made an advance health directive?

It is not presently proposed that there be compulsory registration of written advance health directives as this would not sit comfortably with the preferred position to introduce a simple, flexible and accessible scheme. However, a case can be made for the establishment, subject to cost constraints and the very significant issue of meeting privacy concerns, of some mechanism or programme which would enhance the effectiveness of advance health directives by increasing the prospects of their existence becoming known to health providers.

Scope of Authority to Give a Direction in an Advance Health Directive

Should a person be able to give a direction in an advance health directive to withdraw or withhold life-sustaining measures? If so, should the definition of life-sustaining measures include artificial nutrition and artificial hydration?

A number of complex and controversial issues are involved in considering the scope of an advance health directive. In particular, one issue of significance is whether a person making such a document can direct that, in the event of his or her incapacity, life-sustaining measures be withheld or withdrawn at the end of life. Further, should life-sustaining measures refer to all health care given to sustain the operation of vital bodily functions that are permanently incapable of independent function, for example, cardiopulmonary resuscitation, assisted ventilation and the provision of artificial nutrition and artificial hydration?

Decisions to withhold or withdraw artificial nutrition and artificial hydration are difficult for patients, their families and health professionals and require careful consideration and discussion, for example, in the context of the withholding or withdrawing of a percutaneous endoscopic gastroenterostomy (PEG).

The Supreme Court of Victoria in *Gardner; Re BWV (2003) VSC 173* held that the provision of hydration and nutrition to the patient in question by a PEG feeding tube constituted "medical treatment" within the meaning of the *Medical Treatment 1988*.

Morris J stated that the use of a PEG for the administration of artificial nutrition and hydration was a medical procedure and could not be regarded as palliative care. Such a procedure was, in essence, a procedure to sustain life. He noted that this conclusion was consistent with the approach in other jurisdictions where artificial nutrition and artificial hydration had been considered in the context of the natural meaning of the term "medical treatment" and, in particular, he noted that his conclusion was consistent with the decision of the House of Lords in *Airedale N.H.S Trust v Bland.*

Should a person be able to give a direction in an advance health directive to refuse the provision of palliative care?

Palliative care has been defined in a variety of legislative provisions and guidelines to include the natural or reasonable administration of food and water and the administration of drugs and other measures to relieve pain, distress and discomfort.

The provision of palliative care has been excluded from the operation of the legislation providing for the making of advance health directives in a number of jurisdictions and it is the current preferred position that the legislation proposed for Western Australia should adopt the same approach.

Operation of Advance Health Directive

Should an advance health directive cover any situation in the future where a person may be incapable of making his or her decisions regarding health care or, alternatively, should the legislation restrict the operation of an advance health directive?

In a number of Australian jurisdictions which provide for statutory recognition of advance health directives the legislation restricts the operation of an advance health directive or refusal to treat certificate to particular circumstances. For example:

In South Australia, section 7 *Consent to Medical Treatment and Palliative Act 1995* provides that a person may only give a direction about medical treatment that he or she wants or does not want if the person is at some future time in the terminal phase of a terminal illness or in a persistent vegetative state.

In Victoria, pursuant to section 5 *Medical Treatment Act 1988*, a person may only give a direction in a refusal of treatment certificate in respect of a current condition.

In the Northern Territory, section 4 *Natural Death Act 1988* provides that a direction can only take effect in the case of terminal illness.

In Queensland, under section 36 *Powers of Attorney Act 1998*, a direction in an advance health directive to withhold or withdraw a life-sustaining measure cannot operate unless one of the following applies:

- the patient has a terminal illness or condition that is incurable or irreversible and is likely to die within a year, or
- the patient is in a persistent vegetative state, or
- the patient is permanently unconscious, or
- the patient has an illness or injury of such severity that there is no reasonable prospect that he or she will recover to the extent that his or her life can be sustained without the continued application of life-sustaining measures.

In February 2005 Dr Ben White and Associate Professor Lindy Willmott published an Issues Paper, *Rethinking Life-Sustaining Measures: Questions for Queensland,* which addresses the limits placed by section 36 *Powers of Attorney Act 1998* on the operation of advance health directives (at pages 30-34).

The authors state that the effect of these limits is that a person cannot use an advance health directive executed under the legislation to make all of their health decisions. They question whether these limitations are appropriate given that, at common law, there are no limits placed on the circumstances in which an advance direction about health care can operate.

Requirements for a Legally Valid Advance Health Directive

The following discussion applies to directions in an advance health directive in relation to all future health care matters including the withholding or withdrawing of life-sustaining measures.

At common law the conditions for a legally valid anticipated refusal of treatment were stated by the Court of Appeal in *Re T (adult: refusal of treatment)* [1992] 4 All ER 649 to be that a person:

- must be competent at the time of the decision;
- must be informed in broad terms about the nature and effects of the procedure;
- must have anticipated and intended the refusal to apply to the circumstances that subsequently arise; and
- must be free from undue influence when making the decision.

The legislation in Australia and the UK includes various of the following conditions which must be satisfied for an advance health directive to be valid:

- the person making the directive was competent at the time that it was made;
- the directive was made voluntarily and without inducement or compulsion;
- the directive was based on appropriate information and understanding of the choices and consequences;
- the directive was intended to apply to the circumstances that have arisen;
- there have been no changes in the wishes expressed and the directive has not been revoked;
- whether the person who made the directive is permanently or temporarily incapacitated;
- there are reasonable grounds for believing that new circumstances exist which did not exist at the time the person made the directive.

Which of the above criteria must be met for a legislated advance health directive to be valid?

If one of the criteria is to be that an advance health directive must be based on appropriate information and understanding of the choices and consequences, is it necessary for that information to be given by a health professional?

Good Medical Practice

Should a health professional be required to have regard to good medical practice before giving effect to a direction in an advance health directive?

Where, in particular, there is a direction in an advance health directive to withhold or withdraw life-sustaining measures, it is necessary to consider whether a health professional should have the right to refuse to carry out the direction if the direction is not consistent with good medical practice.

There are few examples where this safeguard is stipulated in legislation in other Australian jurisdictions.

In Queensland, section 36 *Powers of Attorney Act 1998* provides that a direction to withhold or withdraw artificial nutrition or hydration cannot operate unless the commencement or continuation of the measure would be inconsistent with good medical practice. Good medical practice" is defined in section 5B of Schedule 2 to mean:

> "good medical practice for the medical profession in Australia having regard to-
>
> (a) the recognised medical standards, practices and procedures of the medical profession in Australia; and
>
> (b) the recognised ethical standards of the medical profession in Australia."

In South Australia, section 16 *Consent to Medical Treatment Act 1995* provides that a medical practitioner incurs no civil or criminal liability for an act or omission made in accordance with proper professional standards of medical practice.

If the principle of "good medical practice" is to form part of the scheme for advance health directives, consideration will have to be given to whether is should be determined on ordinary evidentiary principles or by adoption of a test akin to that applied to civil claims in negligence by virtue of section 5PB *Civil Liability Act 1992* (WA).

ENDURING POWERS OF GUARDIANSHIP

There is no provision in the *Guardianship and Administration Act 1990* for a person, while competent, to appoint by means of an enduring power of guardianship a substitute decision-maker to make personal or life-style decisions in the event of the person's incapacity. The Act only enables a person, while competent, to appoint one or two attorneys pursuant to an enduring power of attorney to make decisions in respect of his or her financial affairs and estate both prior to and during any incapacity.

There has been extensive consultation over the past several years with key stakeholder groups in the community about legislative reform in the area of substitute decision-making. This consultation revealed significant community support and demand for the

enactment of legislation in Western Australia enabling a person to choose his or her own substitute decision-maker in relation to personal, life-style and medical decisions in the event that he or she loses capacity to make decisions in the future. The most pressing need appears to be in relation to medical treatment.

With the exception of Western Australia and the Northern Territory, all Australian jurisdictions have now enacted legislation authorising substitute decision-making in relation to health care through various forms of enduring powers of guardianship.

The current preferred position is that legislation should be introduced in Western Australia to enable a competent adult to appoint a substitute decision-maker by means of an enduring power of guardianship to make decisions on his or her behalf about personal, life-style and medical decisions. This reform will promote the principle of personal autonomy in decision-making and enable a person to exert a greater measure of influence over the direction and decisions that may be made in the event that he or she loses capacity.

It is proposed that an enduring power of guardianship will be in writing and must specify whether a person wishes the substitute decision-maker to have the authority to withhold or withdraw life-sustaining measures.

Scope of Enduring Power of Guardianship

Should a substitute decision-maker appointed under an enduring power of guardianship be given the authority to make decisions to withhold or withdraw life-sustaining measures?

Should the definition of life-sustaining measures include artificial nutrition and artificial hydration?

These issues are canvassed above in the discussion about advance health directives.

Should a substitute decision-maker appointed under an enduring power of guardianship be given authority to refuse the provision of palliative care?

These issues are canvassed above in the discussion about advance health directives.

The current preferred position is that a person appointed under an enduring power of guardianship should not be given authority to refuse the provision of palliative care.

The following statutory provisions are of relevance:

In Queensland, section 32 *Powers of Attorney Act 1998* allows a principal to make the exercise of a power by an attorney conditional and to complement the grant of the power with further information.

In South Australia:

- section 8 *Consent to Medical Treatment and Palliative Care Act 1995* provides that a medical power of attorney must be in the form prescribed by regulation or in a form to similar effect. The form prescribed in Schedule 1 of the *Consent to Medical Treatment and Palliative Care Regulations 2004* allows a person to require a medical agent to observe conditions and directions specified in the document in exercising, or in relation to the exercise of, the powers conferred by the medical power of attorney.
- section 25(5) *Guardianship and Administration Act 1993* allows a person to include conditions, limitations or exclusions in the instrument appointing an enduring guardian.

In Victoria:

- section 5A(2)(a) *Medical Treatment Act 1988* provides that an enduring power of attorney (medical treatment) must be in the form prescribed in Schedule 2. Clause 2 of the form only allows a person to appoint an agent or alternate agent to make decisions about medical treatment. There is no scope for a person to impose conditions or make directions.
- Form 1 in Schedule 4 of the *Guardianship and Administration Act 1986* allows a person to stipulate limitations he or she wishes to place on the enduring guardian's powers.

In New South Wales, section 6C *Guardianship Act 1987* provides that an instrument does not operate to appoint a person as an enduring guardian unless it is in or to the effect of the form prescribed by the regulations. The form prescribed in Form 1 *Guardianship Regulation 2000* allows a person to require an enduring guardian to exercise his or her functions subject to directions specified in the instrument.

In the ACT, Form 2 in Schedule 1 of the *Medical Treatment Act 1994* allows for a grantor to specify particular treatments that the grantee can request to be withheld or withdrawn.

In Tasmania, section 32(2)(a) *Guardianship and Administration Act 1995* provides that an instrument is not effective to appoint an enduring guardian unless it is in accordance with Form 1 in Schedule 3. This form allows an appointor to require a guardian to observe conditions specified in the instrument in exercising, or in relation to the exercise of, the powers conferred by the instrument.

In the UK, section 9(4)(b) *Mental Capacity Act 2005* provides that the authority conferred by a lasting power of attorney is subject to any conditions or restrictions specified in the instrument.

Restrictions on Exercise of Power by Substitute Decision-maker under Enduring Power of Guardianship

Unlike the enduring power of attorney, an enduring power of guardianship, like a direction in an advance health directive, will only be operative on the incapacity of the appointor.

Should the substitute decision-maker be required to have regard to the best interests of the appointor when making a decision about future health care?

The following factors are of relevance:

- consideration by the substitute decision-maker of the proposed treatment, the risks associated with the treatment, the consequences to the appointor if the treatment is not carried out and any alternative treatment;
- whether the treatment to be carried out is only to promote the health and well-being of the appointor;
- whether the appointor is permanently incapacitated;
- if it appears that the appointor is temporarily incapacitated, when it is likely that he or she will regain capacity;
- consultation with the appointor, taking into account, as far as possible, his or her past and present wishes and feelings;
- the beliefs and values that would be likely to influence the appointor's decision if he or she had capacity;
- consultation with family members and other concerned persons;
- any other factors.

Should a substitute decision-maker under an enduring power of guardianship be required to seek advice from or consult with a health professional before making a decision about the future health care of the appointor?

In the ACT, section 16 (1)(a) *Medical Treatment Act 1994* provides that a grantee of a power of attorney shall not request the withholding or withdrawing of medical treatment from the grantor unless the grantee has consulted a medical practitioner about the nature of the grantor's illness, any alternate forms of treatment that may be available to the grantor and the consequences to the grantor of remaining untreated.

In New South Wales, section 40 *Guardianship Act 1987* requires that a person seeking the consent of a "person responsible" for a patient, specify the particular condition of the patient that requires treatment, alternative courses of treatment, the general nature and effect of those courses of treatment and the nature and degree of the significant risks (if any) associated with each of those courses of treatment. A "person responsible" includes an enduring guardian.

In Queensland:

- clause 12 of Schedule 1 of the *Powers of Attorney Act 1998* states that, in deciding whether the exercise of a power is appropriate, an attorney must, to the greatest extent practicable, take the information given by the adult's health provider into account.
- section 76 *Guardianship and Administration Act 2000* provides that an attorney appointed under the *Powers of Attorney Act 1998* may request a health provider who is treating, or has treated, the adult to give information to the attorney unless the health provider has a reasonable excuse. The information is stated to include the nature of the adult's condition, alternative forms of health care and associated significant risks.

In South Australia, section 15 *Consent to Medical Treatment and Palliative Care Act 1995* provides that a medical practitioner has a duty to explain to an agent appointed under a medical power of attorney, so far as may be practicable and reasonable in the circumstances, the nature, consequences and risks of the proposed treatment, the likely consequences of not undertaking it and any alternative treatment or courses of action.

In Victoria, section 5B *Medical Treatment Act 1988* provides that if two people, one of whom is a registered medical practitioner, are satisfied that an agent under an enduring power of attorney (medical treatment) has been informed about and understands the nature of the patient's current condition to an extent that would be reasonably sufficient to enable the patient, if competent, to make a decision whether or not to refuse medical treatment generally or of a particular kind for that condition, then the agent may refuse the treatment.

Good Medical Practice

Should a health professional be required to have regard to good medical practice before giving effect to a decision of a substitute decision-maker under an enduring power of guardianship?

Where, in particular, authority is given in an enduring power of guardianship for a substitute decision-maker to make a decision to withhold or withdraw life-sustaining measures, it is necessary to consider whether a health professional should have the right to refuse to carry out the direction if the direction is not consistent with good medical practice.

This safeguard is stipulated in legislation in two Australian jurisdictions.

In Queensland, Section 66A *Guardianship and Administration Act 2000* provides that a consent to the withholding or withdrawal of a life-sustaining measure for an adult cannot operate unless the adult's health provider reasonably considers the commencement or

continuation of the measure for the adult would be inconsistent with good medical practice. "Good medical practice" is defined in section 5B of Schedule 2 of the Act to mean:

> "good medical practice for the medical profession in Australia having regard to-
>
> (a) the recognised medical standards, practices and procedures of the medical profession in Australia; and
>
> (b) the recognised ethical standards of the medical profession in Australia."

In South Australia, section 16 *Consent to Medical Treatment Act 1995* provides that a medical practitioner incurs no civil or criminal liability for an act or omission made in accordance with proper professional standards of medical practice.

GUARDIANSHIP ORDERS

Scope of Authority of Guardian

Should a guardian appointed under the Guardianship and Administration Act 1990 be given the authority to make decisions to withhold or withdraw life-sustaining measures?

Should the definition of life-sustaining measures include artificial nutrition and artificial hydration?

These issues are canvassed above in the discussion about advance health directives.

Should a guardian appointed under the Guardianship and Administration Act 1990 be given authority to refuse the provision of palliative care?

These issues are canvassed above in the discussion about advance health directives.

The current preferred position is that a guardian should not be given authority to refuse the provision of palliative care.

Restrictions on Exercise of Power by Guardian

Should a guardian be required to have regard to the best interests of the represented person when making a decision about future health care?

In Western Australia, section 51 *Guardianship and Administration Act 1990* provides that a guardian must act according to his opinion of the best interests of the represented person and gives examples of what is meant by "best interests". Of relevance to the present discussion is the reference to consultation with the represented person, taking

into account, as far as possible, the wishes of that person as expressed in whatever manner or as gathered from the person's previous actions.

A discussion of "best interests" appears above in the section entitled "Enduring Powers of Guardianship".

Should a guardian be required to seek advice from or consult with a health professional before making a decision to withhold or withdraw life-sustaining measures?

In Queensland, section 76 *Guardianship and Administration Act 2000* does not require a guardian to seek advice but does oblige a health provider who is treating, or has treated, the patient, absent reasonable excuse, to give requested health information to a guardian. The information provided is to include the nature of the adult's condition (which could include a condition requiring consideration of whether to withhold or withdraw life-sustaining measures), alternative forms of health care and associated significant risks.

The requirements of section 5B of Victoria's *Medical Treatment Act 1988* in relation to agents appointed under an enduring power of attorney (medical treatment) apply equally to guardians appointed under the *Guardianship and Administration Act 1986*.

Good Medical Practice

Should a health professional be required to have regard to good medical practice before giving effect to a decision of a guardian?

Where authority is given for a guardian to make a decision to withhold or withdraw life-sustaining measures, it is necessary to consider whether a health professional should have the right to refuse to carry out the direction if the direction is not consistent with good medical practice.

In Queensland, section 66A *Guardianship and Administration Act 2000* provides that a consent to the withholding or withdrawal of a life-sustaining for an adult cannot operate unless the adult's health provider reasonably considers the commencement or continuation of the measure for the adult would be inconsistent with good medical practice. "Good medical practice" is defined in section 5B of Schedule 2 of the Act to mean:

> "good medical practice for the medical profession in Australia having regard to-
>
> (a) the recognised medical standards, practices and procedures of the medical profession in Australia; and
>
> (b) the recognised ethical standards of the medical profession in Australia."

SECTION 119 GUARDIANSHIP AND ADMINISTRATION ACT 1990

Section 119 *Guardianship and Administration Act 1990* provides a mechanism whereby medical practitioners may lawfully provide treatment to a patient who is incapable of consenting to the proposed treatment and in respect of whom a guardian could have been appointed.

Section 119 requires consent to be given to the provision of treatment by the person first in order of priority in the following list of persons:

(a) a guardian of the person needing the treatment;

(b) the spouse or defacto partner of the person needing the treatment;

(c) the person who, on a regular basis, provides or arranges for domestic services and support for the person needing the treatment but does not receive remuneration for doing so;

(d) a person who is the nearest relative (other than the spouse or defacto partner) of the person needing the treatment and who maintains a close personal relationship with the person needing the treatment;

(e) any other person who maintains a close personal relationship with the person needing the treatment; or

(f) a person prescribed in the regulations.

No person has been prescribed under paragraph (f).

The term "nearest relative" is defined in section 3(1) of the Act to mean the first in order of priority of the following persons, who has attained the age of 18 years and is reasonably available at the relevant time -

(a) a spouse or defacto partner;

(b) a child;

(ba) a stepchild;

(c) a parent;

(ca) a foster parent;

(d) a brother or sister;

(e) a grandparent;

(f) an uncle or aunt;

(g) a nephew or niece.

A person is to be regarded as maintaining a close personal relationship with a person needing the treatment if the relationship is maintained through frequent personal contact and a personal interest in the welfare of the person needing the treatment.

Scope of Authority of a Person under Section 119

Should a person referred to in section 119 Guardianship and Administration Act 1990 be given the authority to make decisions to withhold or withdraw life-sustaining measures?

Should the definition of life-sustaining measures include artificial nutrition and artificial hydration?

These issues are canvassed above in the discussion about advance health directives.

Should a person referred to in section 119 Guardianship and Administration Act 1990 have the right to refuse the provision of palliative care?

These issues are canvassed above in the discussion about advance health directives.

The current preferred position is that a person referred to in section 119 should not be able to refuse palliative care, namely the natural provision or the natural administration of food and water or the administration of drugs to relieve or distress, for a represented person.

Restrictions on Exercise of Power by a Person under Section 119

Should a person referred to in section 119 Guardianship and Administration Act 1990 be required to seek advice from or consult with a health professional before making a decision to withhold or withdraw life-sustaining measures?

In Queensland, section 76 *Guardianship and Administration Act 2000* obliges a health provider to supply requested health information to a statutory health attorney in the same manner as requested information must be provided to a guardian.

Good Medical Practice

Should a health professional be required to have regard to good medical practice before giving effect to a decision of a person referred to in section 119 Guardianship and Administration Act 1990 ?

Where authority is given for a person referred to in section 119 to make a decision to withhold or withdraw life-sustaining measures, it is necessary to consider whether a health professional should have the right to refuse to carry out the direction if the direction is not consistent with good medical practice.

In Queensland, section 66A *Guardianship and Administration Act 2000* precludes the operation of a consent to the withholding or withdrawal of a life-sustaining measure for an adult unless the adult's health provider reasonably considers the commencement or

continuation of the measure for the adult would be inconsistent with good medical practice. "Good medical practice" is defined in section 5B of Schedule 2 of the Act to mean:

> "good medical practice for the medical profession in Australia having regard to-
>
> (a) the recognised medical standards, practices and procedures of the medical profession in Australia; and
>
> (b) the recognised ethical standards of the medical profession in Australia."

STATUTORY PROTECTION

Legislation is to be introduced which will appropriately protect decision-makers and those involved in end of life decisions by ensuring that, even in circumstances where an advance health directive or a direction by a substitute decision-maker may prove to be invalid or inapplicable, there will not be consequential civil (or criminal, though section 24 of the Criminal Code may give adequate protection in any event) liability if, in general terms, they have acted reasonably and in good faith on the assumption that the consent or substituted consent was valid. The precise form of that protection will depend upon the nature and detail of the ultimate legislation adopted for advance health directives and substitute decision-making.

Reasonable Conduct in Good Faith in the Consent Context

Should protection from civil and criminal liability in the consent context require that specified enquiries be carried out by a decision-maker or health professional before it can be said that the person has acted reasonably and in good faith?

The issue is whether a relevant protective provision or provisions should simply require that the person seeking the protection has acted in good faith and reasonably or whether these should be specified steps which must be taken to attract the protection.

The Application of the *Criminal Code*

In view of the current uncertainty as to the precise application of the provisions of the Criminal Code in the circumstance of a contemplated withholding or withdrawal of life-sustaining measures for an incompetent patient, should there be specific legislative amendment to achieve an increased measure of certainty?

The current preferred position is that specific legislative protection addressing these circumstances is desirable.

If legislative amendment is appropriate, what circumstances should that amendment address and what criteria should have to be met to gain protection?

One scheme to which consideration could be given is that in sections 16 and 17 of South Australia's *Consent to Medical Treatment and Palliative Care Act 1995.*

Under section 16, a medical practitioner incurs no civil or criminal liability for conduct in the course of treating a patient where the treatment was in accordance with the consent of the patient or a representative, was in good faith and without negligence, accorded with proper professional standards of medical practice, and occurred in order to preserve or improve the quality of life.

In circumstances where the patient was in the terminal phase of a terminal illness, then, pursuant to section 17(1), no civil or criminal liability attaches to treatment administered with consent and with the intention of relieving pain or distress, provided that the relevant conduct was in good faith and not negligent and in accordance with professional standards of palliative care. The protection applies even if the treatment incidentally hastens death.

Where a patient is in a moribund state with no real prospect of recovery or is in a permanent vegetative state, the effect of section 17(2) is that, subject to any contrary direction by the patient or an authorised representative of the patient, a medical practitioner does not fall under a duty to use life-sustaining measures which will merely prolong the patient's life in that state.

An alternative approach is that of the United Kingdom's *Mental Capacity Act 2005.* The essence of that approach (see particularly sections 4 and 5 of the Act) is that, subject to any contrary advance decision by the patient to refuse treatment, a health professional (and others involved in the decision-making process) will be protected in relation to non-negligent conduct which the practitioner (or decision-maker) reasonably believes is in the patient's best interests. Certain criteria governing compliance with the 'best interests' test and the steps which have to be followed to meet those criteria are spelled out in some detail.