Euthanasia - the Australian Law in an International Context

Part 1: Passive Voluntary Euthanasia

Research Paper
No. 3 1996–97
Parliamentary Research Service

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*Part 1: Passive Voluntary Euthanasia*

'when medical treatment is withdrawn or withheld from a patient, at the patient's request, in order to end the patient's life'

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9 September 1996

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Acknowledgments

This is to acknowledge the help given in producing this paper from Dr June Verrier, Mr Bob Bennett, Ms Jennifer Norberry, Mr Ian Ireland, Ms Bronwyn Young and Ms Catherine Lorimer (Department of the Parliamentary Library, Parliament House, Canberra); Ms Ann Somerville (British Medical Association, UK); Professor Sheila McLean and Ms Alison Britton (Institute of Law & Ethics in Medicine, Glasgow University, UK); Professor Andrew Grubb and Ms Sara Mason (Centre of Medical Law & Ethics, King's College London, University of London, UK); Public Information Office, House of Commons, London, UK; Dr Michael Irwin (Voluntary Euthanasia Society, UK); Ms Saskia Gaster, Amsterdam, The Netherlands.

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Major issues

In the early hours of 25 May 1995 the Northern Territory passed the Rights of the Terminally Ill Act 1995 (NT) - becoming the first jurisdiction in the world to permit a doctor to end the life of a terminally ill patient at their request.

The Act came into operation on 1 July 1996, but no-one has yet used it to end their life - although at least one person, Max Bell, has tried. Suffering from terminal stomach cancer, the 66-year old taxi driver left his home in Broken Hill to travel to Darwin to die. He returned home and has since died of natural causes after being unable to find, while in the Northern Territory, two of the three doctors required to examine him as stipulated under the Act. His last days were broadcast on national television.

So far, the law has survived an attempt in August 1996 in the Territory Parliament to repeal it and a legal challenge in the Northern Territory Supreme Court. Leave is being sought to challenge the Act in the High Court. In the Federal Parliament, a Private Member's Bill designed to override the Act is due to be introduced in September 1996.

The law has rekindled a very emotional debate on euthanasia which crosses party-political lines. Polls, including a Newspoll in The Australian in early July, suggest that a majority of Australians are in favour of euthanasia, as are the Doctors Reform Society and support groups for people suffering from HIV/AIDS. Those against include the Australian Medical Association, many Aboriginal groups, and the Churches.

The debate pits those who support an individual's right to a 'good death' at a time of their own choosing, against those who believe in the sanctity of human life, and who worry that any form of State-sanctioned killing will leave society's weakest even more vulnerable. It touches on the most fundamental philosophical questions of all - what is life, and are there some forms of life so truncated that they are not worth living. This, against the background of spiralling health costs, and the increasing ability of technology to prolong life.

This paper, the first in a series of four, puts the euthanasia debate in the wider national and international legal context. This first volume deals with passive voluntary euthanasia - the withdrawal or withholding of medical treatment at the patient's request in order to end the patient's life. The second part deals with active voluntary euthanasia - where a doctor actively take steps, at a patient's request, to end a patient's life. This volume also examines
the Northern Territory law. The final volumes will deal with situations where, without the patient's consent: medical treatment is withdrawn or withheld in order to end the patient's life; or health professionals actively take steps to end the patient's life.

In Australia, the common law already allows a competent adult to refuse medical treatment, even if the refusal will lead to death. The patient's refusal must be voluntary and informed. If these conditions are met, the patient's request must be respected. It is likely that this right extends to a pregnant woman, even if her refusal means that both she and her unborn child will die. At common law, a competent adult can also give a binding anticipatory refusal of medical treatment - including life-sustaining treatment.

In contrast, a child's right to refuse medical treatment is less clear. Recent English cases have found that a parent or guardian may override a child's refusal. This may not be the law in Australia. But in any case, it is clear that a court may override a child's refusal if it believes it is in the child's 'best interests' to do so, and would almost certainly take that course if the medical treatment was necessary to keep the child alive.

In 1976, the state of California in the United States was the first place in the world to enact 'living wills' legislation enabling a person to make a binding written directive about medical treatment including anticipatory refusal of treatment in certain circumstances. More than 40 other jurisdictions in the US have enacted similar legislation as have, in Australia, the Australian Capital Territory, the Northern Territory, South Australia and Victoria.

In Australia, South Australia, the ACT and Victoria, also allow a competent adult to execute an enduring power of attorney, allowing another specified adult to act as agent and make decisions about medical treatment should the principal become incompetent. These decisions extend to refusing or consenting to life-sustaining treatment.
Preface

Twenty-five years ago, two commentators on the medical, legal and ethical implications of euthanasia stated the following:

Euthanasia - a happy death - is every man's hope. Though we pray to be saved from sudden death, we certainly do not wish a lingering one: an easy death, in sleep perhaps, when we are already mentally and morally prepared for it - that is what most of us would ask for ourselves. When we are ill we expect our doctors to relieve us in our pain, and console us in our anxieties; in addition, a dying man expects his doctor to use his skill to make death when it comes as easy and painless as possible. In this we are seldom disappointed. If this, the literal meaning, were all that was meant by the use of the word euthanasia, there would be no one who could object to it on any grounds, nor would there be anyone who thought it necessary to pass an Act of Parliament to legalise it. It would simply be a word to describe every man's wish, and every doctor's endeavour at the approach of death.¹

There is no doubt that the word 'euthanasia' means different things to different people. It therefore is an imprecise and potentially confusing term. It literally refers to a 'good death', or a 'gentle and easy death'.² As such a death may occur in many ways, and the assistance of others to bring about such a death is lawful in some circumstances but not in others, 'euthanasia' is not a particularly helpful term for the purposes of legal or ethical analysis.

Another commentator notes:

I take euthanasia to have acquired at least the following meanings. It refers to actively bringing about the death of a patient, whether with or without the patient's consent, and to passively allowing a patient to die, with or without consent, when it would have been possible by continued treatment to keep the patient alive.³

For greater clarity, therefore, euthanasia can be divided into the following four categories:

- passive voluntary euthanasia
  - when medical treatment is withdrawn or withheld from a patient, at the patient's request, in order to end the patient's life
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• active voluntary euthanasia
  - when medical intervention takes place, at the patient's request, in order to end the patient's life

• passive involuntary euthanasia
  - when medical treatment is withdrawn or withheld from a patient, not at the request of the patient, in order to end the patient's life

• active involuntary euthanasia
  - when medical intervention takes place, not at the patient's request, in order to end the patient's life

This apparently neat and simple way of classifying different kinds of euthanasia can obscure important areas of overlap between the categories. It can also obscure important internal distinctions within the categories. This classification system nonetheless can be used to highlight important differences, legally and ethically, between different kinds of 'medical decisions concerning the end of life', and between different situations in which such behaviour occurs.

This paper therefore adopts these four categories. It discusses the Australian law relating to the first of these categories: passive voluntary euthanasia. Comparison is made, where appropriate, with the legal rules relating to passive voluntary euthanasia developed in other common law countries: England, Canada and the United States of America.

The law relating to the other categories of euthanasia - active voluntary euthanasia, passive involuntary euthanasia and active involuntary euthanasia - will be discussed in forthcoming papers.
Introduction

There is no Australian case law dealing specifically with passive voluntary euthanasia. Analysis of the common law position therefore is based upon application of the basic legal rules governing the doctor-patient relationship and the provision of medical treatment generally. Some assistance may be derived from case law from other common law jurisdictions which is likely to be of persuasive authority in Australia. In summary, the common law in Australia confers a right upon competent adult patients to refuse any kind of medical treatment. This extends to treatment necessary to keep the patient alive. The common law almost certainly does not confer the same right upon children.

The legal status of passive voluntary euthanasia in Australia is also affected by legislation. In four Australian States and Territories - South Australia, Victoria, the Northern Territory and the Australian Capital Territory - there are statutory mechanisms that give legal recognition to anticipatory refusals of medical treatment, including life-sustaining treatment, by competent adults. Children cannot use these statutory mechanisms. Other legislative provisions in South Australia seem to confer a right to refuse life-sustaining medical treatment on older children.

Competent Adults

The common law right to refuse unwanted medical treatment

At common law, a competent adult patient can refuse to consent to the initiation or continuance of medical treatment. A voluntary and sufficiently informed refusal of medical treatment by such a patient must be respected by a doctor.

An adult patient is presumed to be competent to decide whether to consent to or refuse proposed medical treatment. This presumption is only rebutted if it is shown that the patient lacks broad understanding of the nature and effect of the particular treatment proposed. The patient will have this understanding if he or she can do the following: comprehend and retain the necessary information about treatment; believe that information; and weigh the information, balancing risks and needs, to arrive at a choice.
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The patient's capacity is to be assessed at the time when the patient makes his or her decision about treatment. The more serious the decision facing the patient, the greater the level of understanding required by the law.

If a health care professional does not respect a valid refusal of medical treatment, she or he risks civil or criminal liability for trespass to the person. The most relevant category of trespass to the person in the medical context is the tort of battery. The tort of battery is committed by '... intentionally bringing about a harmful or offensive contact with the person of another ... The insult in being touched without consent has been traditionally regarded as sufficient, even though the interference is only trivial and not attended with actual physical harm.

By offering protection from the insult of interference with the person, the tort of battery seeks to uphold the fundamental common law principle that every person has a right to bodily integrity. That right was expressed by Blackstone in his Commentaries as follows:

[T]he law cannot draw the line between different degrees of violence, and therefore totally prohibits the first and lowest stage of it; every man's [sic] person being sacred, and no other having a right to meddle with it, in any [sic] the slightest manner.

The right to bodily integrity was famously articulated in the medical context in the early US case Schloendorff v. Society of New York Hospital: Every human being of adult years and sound mind has a right to determine what shall be done with his [sic] own body; and a surgeon who performs an operation without his patient's consent commits an assault.

The principle was affirmed recently by the High Court of Australia in Secretary, Department of Health v. JWB and SMB. The High Court stated that the requirement that a legally valid consent be obtained before medical treatment can be administered originates in 'the right in an individual to choose what occurs with respect to his or her own person' and thereby 'protects the autonomy and dignity of the individual'. In discussing this need for consent, the High Court also variously referred to 'the principle of personal inviolability', 'the right to personal security', 'the right to physical integrity [that] protects a person's self-estimate', and '[a person's] rights of control and self-determination in respect of his or her body' and 'a person's right of bodily integrity'.

The common law right extends to the refusal of life-sustaining medical treatment

The common law jealously protects a competent adult's right to refuse unwanted medical treatment. Thus courts in England, Canada and the United States of America have held that a competent adult patient's refusal to consent to medical treatment must be respected even if
the patient's death is likely or certain to result from that refusal. In a leading case decided in 1992, the English Court of Appeal stated the principle as follows:

Every adult has the right and capacity to decide whether to accept or to refuse medical treatment. This is so even if refusing treatment may risk permanent injury to health or even lead to premature death. It matters not whether the reasons for making the choice are rational, irrational, unknown or even non-existent. The patient's right to self-determination will outweigh the very strong public interest in upholding the concept that all human life is sacred and that it should be preserved if at all possible.23

A competent adult's right to refuse life-sustaining treatment subsequently was endorsed by the English House of Lords.24

In 1991, the Ontario Court of Appeal in Canada had expressed a competent adult's right to refuse life-sustaining medical treatment in the following terms:

The right of self-determination.. obviously encompasses the right to refuse medical treatment. A competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternate form of treatment, even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or the community... For [the freedom of individuals to make choices concerning their medical care] to be meaningful, people must have the right to make choices that accord with their own values regardless of how unwise or foolish those choices may appear to others.25

This principle was also affirmed by the Quebec Supreme Court in 1992.26

Courts in the United States of America have reached a similar result by relying on the individual's common law right to 'informed consent', which incorporates the right to refuse to consent to medical treatment. Many US courts have also held that a competent adult can refuse life-sustaining medical treatment on the basis of the individual's constitutional right to privacy.27

Despite stating that an individual's common law right to self-determination in this context is not absolute and must be weighed against competing state interests (an interest in the preservation of life; an interest in preventing suicide; an interest in preserving the integrity of the medical profession; and an interest in protecting innocent third parties),28 United States courts nonetheless have generally upheld refusals of life-sustaining medical treatment by competent adult patients.29 The application of constitutional law analysis by these courts, offering interpretations of both the Federal and State Constitutions, has generally led to the same conclusion. The United States Supreme Court, however, has not yet unequivocally confirmed that the Federal Constitution confers on an individual the right to refuse unwanted life-sustaining medical treatment.30
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Importantly, the English and North American courts have held that the common law right to refuse life-sustaining (or any other) medical treatment is not a right which is confined to patients who are terminally ill.31

These courts have also held that a refusal of life-sustaining medical treatment does not amount to an attempt to commit suicide.32 They have instead characterised such a refusal as merely a decision to allow the patient's illness or condition to take its 'natural' course. One important consequence of this is that a doctor who respects a patient's refusal of life-sustaining treatment will not be liable for assisting that patient's suicide.

None of these issues has been explored by an Australian court. It is likely, however, that the conclusions reached - if not the arguments and reasoning used to arrive at those conclusions - by an Australian court examining these issues would resemble those reached by the English and North American courts.

The common law recognises an anticipatory refusal of treatment

Recent English and Canadian case law also establishes that a competent adult can give a binding anticipatory refusal of medical treatment, including a refusal of life-sustaining medical treatment.33 This will be as effective as a contemporaneous refusal by a competent adult patient, provided the following three elements are satisfied:

• the patient was competent to refuse to consent to the treatment at the time of the prior refusal; and

• the patient anticipated and intended this decision to apply to the circumstances that ultimately prevailed; and

• the patient's decision was reached without undue influence.34

Medical treatment generally can be administered without consent if it is necessary to avert an imminent risk to a patient's life or health, and the patient lacks the capacity to give or refuse consent (for example, because the patient is unconscious).35 The common law recognition of anticipatory refusals of medical treatment by competent adults means, however, that a health care professional cannot administer emergency treatment if he or she is aware that the patient has expressed a valid anticipatory refusal of such treatment.36

This case law does not demand that an anticipatory refusal of medical treatment be in writing in order to be legally effective.37 Oral statements can suffice, but it could be difficult to adduce sufficient evidence to verify that a person had made statements that were sufficiently clear and clearly applicable to the situation that has eventuated.38 The existence of a written, signed and witnessed document therefore may serve as useful evidence that the patient made
an anticipatory refusal. The existence of such a document will not necessarily mean, however, that the patient's anticipatory refusal is legally valid. What is ultimately important is whether the patient's decision to refuse treatment satisfies the three conditions listed above, rather than the way in which that decision has been recorded.\textsuperscript{39}

The second of these conditions, namely that the patient anticipated and intended the decision to apply to the circumstances that ultimately prevailed, is the most likely of the three to invalidate an anticipatory refusal of treatment. Doctors and courts may be inclined to interpret both written and oral anticipatory refusals of treatment as restrictively as possible, particularly where the patient will die without the proposed treatment.\textsuperscript{40} The risk of this occurring may be minimised if the patient executes a document that:

- uses clear, succinct and non-technical language; and
- avoids detailed provisions about particular ailments or conditions or particular treatments or procedures, but instead refers to treatments with particular purposes.\textsuperscript{41}

Case law from the United States of America is broadly consistent with these common law principles articulated by the English and Canadian courts. Courts in the United States generally have held that an anticipatory refusal of medical treatment by a competent adult will authorise the withholding or withdrawal of that treatment in the event of the patient's incompetence, provided it is sufficiently clear that the patient contemplated the situation that eventuated.

The US courts have emphasised that a competent adult patient's common law right to consent to or refuse medical treatment, including life-sustaining medical treatment, survives the onset of incompetence.\textsuperscript{42} According to this principle, respect for an incompetent patient's right of self-determination demands that decisions about that person's medical treatment be made, where possible, by applying what is known as the 'subjective test'.\textsuperscript{43} Under this test, 'life-sustaining treatment may be withheld or withdrawn from an incompetent patient when it is clear that the patient would have refused the treatment under the circumstances involved'.\textsuperscript{44} It will be clear that the patient would have refused the proposed treatment if the patient, when competent, expressed his or her wishes in advance.\textsuperscript{45}

US courts generally have required 'clear and convincing evidence' of the patient's actual wishes before they will use this approach to authorise the withholding or withdrawal of life-sustaining medical treatment from an incompetent patient.\textsuperscript{46} Written directives are more likely to meet this evidentiary standard.\textsuperscript{47} A valid directive can also take the form of oral statements made to family members, friends or health care providers, the probative value of which will vary 'depending on the remoteness, consistency and thoughtfulness of the prior statements ... and the maturity of the person at the time of the statements.\textsuperscript{48}
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Most State legislatures in the United States of America have enacted legislation that gives legal effect to appropriately expressed anticipatory refusals of medical treatment by competent adults, in specified circumstances. The US cases exploring the law relating to anticipatory refusals of medical treatment therefore have mainly arisen in States where there is (or was) no such legislation, or in situations where the State legislation does not require or seem to permit the patient's prior wishes to be respected.

Again, the English and North American cases dealing with anticipatory refusals of medical treatment are not binding legal authority in Australia. An Australian court is likely, however, to consider the arguments and results in these cases if called upon to state the common law position in Australia.

Possible limitations on the common law right to refuse life-sustaining medical treatment

What is 'medical treatment'? The English and North American cases indicate that a competent adult's common law right to refuse life-sustaining medical treatment includes the right to refuse artificial ventilation and, more controversially, artificial hydration and nutrition.

There is more legal uncertainty in respect of refusals of the following, where public policy concerns may override the right of the individual patient to refuse unwanted care:

- pain relieving medication;
- direct oral administration of food and water;
- 'nursing care', i.e. care to maintain bodily cleanliness.

It is possible that the scope of a patient's right to refuse these kinds of 'treatment' may be broader if the refusal is contemporaneous rather than anticipatory.

Do pregnant women have the same right as other competent adults to refuse unwanted medical treatment?

It seems that a competent adult has a legal right at common law to refuse life-sustaining treatment even if she is pregnant and the foetus she is carrying will die as a result of her
refusal. There are no Australian cases addressing this question, but the report of a recent inquiry commissioned by the Australian Medical Association and other concerned professional groups concludes:

When a competent, properly advised pregnant woman has clearly communicated her decision to decline a particular form of treatment, there are no circumstances in which the law should seek to override this decision. The principle that her wishes should be respected should prevail, regardless of the degree of risk - either to herself or the fetus - which her decision entails. In some circumstances, this will mean that the woman will die in labour or that the fetus will not be born alive or will be born with a disability. The principle should also prevail, whether the recommended treatment is invasive or minor.

Accordingly, the report recommends that the States and Territories should consider enacting legislation to clarify the law, '[to] provide that it is unlawful for a doctor to perform a medical procedure on a mentally competent pregnant woman when she has expressly declined to give her consent to that procedure'.

Such a result would confirm that the Australian law on this issue is consistent with the substantial body of case law in England and Australia holding that: first, a foetus does not have any legal rights unless and until it is born alive; and secondly, a court will not intervene to protect a foetus by making it a ward of court or issuing an injunction to stop an abortion.

The North American case law affirms a pregnant woman's legal right to refuse medical treatment regardless of the consequences. In the United States of America, courts addressing this question initially tended to override the refusal by competent pregnant women of medical treatment recommended as necessary to save their lives. This trend was reversed by a landmark decision of the District of Columbia Court of Appeals in 1990, known as 'the Angela Carder case'. By a 7:1 majority that court strongly affirmed that a competent patient's right to bodily integrity, and her concomitant right to make decisions about her own medical treatment, is not diminished simply by virtue of being pregnant. The court stressed that a pregnant patient's wishes concerning treatment, including treatment needed to keep her alive, therefore must be respected in all except the 'extremely rare and truly exceptional' case. It left open the possibility that no circumstances could ever be sufficiently extraordinary or compelling to justify invasive medical treatment against a pregnant patient's wishes.

Canadian courts have also refused to intervene on behalf of the foetus to override refusals by pregnant patients to consent to recommended medical treatment.

The English case law displays internal incoherence. On one hand, there is the strong line of authority referred to above that refuses to confer legal personality on a foetus and refuses to protect the foetus from the behaviour of a pregnant woman that would damage or kill it. On
the other hand, there is a 1992 decision of the Family Division of the English High Court authorising performance of a caesarean section against the wishes of a pregnant woman, to save the life both 'of the patient and the unborn child'. Both the result and the legal reasoning in that case have been widely criticised. A different decision is likely to be reached if the English courts reexamine the issue.

The statutory right to refuse unwanted medical treatment in advance

Statutory recognition of advance directives and enduring powers of attorney - South Australia, the Northern Territory, Victoria and the Australian Capital Territory

Legislation in South Australia, Victoria, the Northern Territory and the Australian Capital Territory confirms, to varying extents, the legal validity of an adult patient's anticipatory refusal of medical treatment. The statutes do this by recognising two different mechanisms that can be used to express anticipatory refusals:

- 'advance directives', often referred to as 'living wills' (recognised by legislation in all four jurisdictions); and
- 'enduring powers of attorney' for the purposes of medical decision-making (recognised by legislation in South Australia, Victoria and the Australian Capital Territory only).

The advance directive provisions in these jurisdictions allow competent adults to execute formal written directives specifying their wishes concerning medical treatment. These directives are legally binding on health care professionals. The advance directive legislation in Victoria and the Australian Capital Territory recognises a patient's anticipatory refusal of treatment in a broad range of circumstances. The legislation in South Australia and the Northern Territory only recognises advance directives in relation to medical treatment during terminal illness and (in South Australia only) persistent vegetative state, but allows a patient to express anticipatory consent to specified treatment as well as recognising anticipatory refusals of treatment.

In South Australia, Victoria and the Australian Capital Territory there are also legislative provisions enabling a competent adult ('the principal') to execute an enduring power of attorney, under which the principal appoints another adult ('an agent') to make decisions about the principal's medical treatment in the event that the principal becomes incompetent. These decisions can include the decision to refuse or consent to most kinds of medical treatment, including life-sustaining medical treatment.
This enduring power of attorney legislation therefore provides another legal mechanism for giving effect to a person's anticipatory refusal of medical treatment. The legal recognition of such a refusal is more indirect in this context, as the actual decision about medical treatment is made by the agent rather than the principal. The enduring power of attorney mechanism, however, enables the principal to appoint as agent someone whom the principal knows and trusts to make decisions consistent with the wishes and values of the principal. In addition, the enduring power of attorney legislation does not empower the agent to make treatment decisions that conflict with any directions given by the principal when competent, provided those directions are contained in the enduring power of attorney itself or in a valid advance directive. The enduring power of attorney legislation therefore allows the previously expressed wishes of competent adults to continue to have some influence over the kind of treatment they receive, or do not receive, when they lose competence.

In Victoria, the Northern Territory and the Australian Capital Territory, the relevant legislation expressly states that it does not affect any right of a person under any other law to refuse medical treatment. This legislation therefore does not displace a competent adult's common law right to refuse unwanted medical treatment. Thus it does not diminish the common law right to give a binding contemporaneous refusal of unwanted medical treatment in general, and life-sustaining medical treatment in particular. Nor does the legislation displace a competent adult's common law right to give a binding anticipatory refusal of any kind of unwanted medical treatment, to the extent that such a right may exist in Australia.

**South Australia**

South Australia was the first Australian jurisdiction to enact advance directive legislation. The *Natural Death Act 1983 (SA)* provided that:

- a person who had attained the age of 18 years and who was of sound mind could make a direction refusing the application of 'extraordinary measures' in the event of a terminal illness.

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

- the direction was required to be written, in the form prescribed by the legislation, and witnessed by two adults.
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• medical practitioners were under a legal duty to act in accordance with the patient's direction.\footnote{79}

The *Natural Death Act* 1983 (SA) also specified that it did not authorise 'an act that causes or accelerates death as distinct from an act that permits the dying process to take its natural course.' \footnote{80} It made clear, however, that for this and other legal purposes the non-application or withdrawal of extraordinary measures from a terminally ill person did not constitute a cause of death. \footnote{81}

The *Natural Death Act* 1983 (SA) recently was repealed and replaced by the *Consent to Medical Treatment and Palliative Care Act* 1995 (SA), which was assented to on 27 April 1995 and came into effect on 30 November 1995. \footnote{82} The new legislation makes the following provision for advance directives:

• a person who has attained the age of 18 years and who is of sound mind can make a direction about the medical treatment that the person wants, or does not want, if he or she is in the future:
  
  – 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. \footnote{83}

• 'terminal illness' is defined as an illness or condition that is likely to result in death. The 'terminal phase' of such an illness is defined as 'the phase of the illness reached when there is no real prospect of recovery or remission of symptoms (on either a permanent or temporary basis).' \footnote{84}

• the direction must be written, in the form prescribed by the legislation, and witnessed by a justice of the peace, a proclaimed postmaster, a proclaimed bank manager, a proclaimed member of the police force, a commissioner for taking affidavits in the Supreme Court, a member of the clergy, or a registered pharmacist. \footnote{85}

• if the person who made the direction is in the terminal phase of a terminal illness or in a persistent vegetative state, and is incapable of making decisions about his or her medical treatment, the direction becomes operative - provided there is no reason to suppose that the person has revoked, or intended to revoke, the direction. When the direction becomes operative, the person is taken to have consented to medical treatment that is in accordance with his or her wishes as expressed in the direction. The person is taken to have refused medical treatment that is contrary to his or her wishes as expressed in the direction. \footnote{86}

• a medical practitioner or other health care professional who complies with such a direction is immune from civil and criminal liability in respect of that compliance; provided that person has also behaved: in good faith and without negligence; in
accordance with proper professional standards of medical practice; and in order to
preserve or improve the patient's quality of life.\textsuperscript{87}

The \textit{Consent to Medical Treatment and Palliative Care Act 1995} (SA) also introduces a new
regime for appointing agents to make health care decisions under enduring powers of
attorney. This replaces the old regime established under the \textit{Guardianship and
Administration Act 1993} (SA). The new legislation provides that:

- a person who has attained the age of 18 years and is of sound mind can execute a 'medical
power of attorney', appointing an agent 'with power to make decisions on his or her behalf
about medical treatment'.\textsuperscript{88}

- the medical power of attorney must be written in the form prescribed by Schedule 1 of the
legislation, or in a form to similar effect. It must be witnessed by a justice of the peace, a
proclaimed postmaster, a proclaimed bank manager, a proclaimed member of the police
force, a commissioner for taking affidavits in the Supreme Court, a member of the clergy,
or a registered pharmacist.\textsuperscript{89}

- the agent must be over 18 years of age.\textsuperscript{90} The agent can be someone who has an interest
under the principal's will or in the estate of the principal.\textsuperscript{91} The agent cannot be a person
who, in a professional or administrative capacity, is responsible for or involved in the
medical treatment of the principal.\textsuperscript{92}

- more than one agent may be appointed, but the medical power of attorney must indicate
the order of appointment and must not provide for joint exercise of decision-making
power by the agents.\textsuperscript{93}

- a medical power of attorney authorises the agent to make decisions about the medical
treatment of the principal, if the principal is incapable of making decisions on his or her
own behalf. Those decisions must be made in accordance with 'any lawful conditions and
directions contained in the power of attorney'.\textsuperscript{94}

- if the principal has also given an anticipatory direction (under the living will provisions of
this legislation), the agent must make decisions consistent with that direction.\textsuperscript{95}

- medical power of attorney does not authorise the agent to refuse: the 'natural' provision of
food and water; the administration of drugs to relieve pain or distress; or medical
treatment that would result in the principal regaining decision-making capacity, unless the
principal is in 'the terminal phase of a terminal illness'.\textsuperscript{96}

- a medical practitioner or other health care professional who complies with the instructions
of an agent is immune from civil and criminal liability in respect of that compliance;
provided that person has also behaved: in good faith and without negligence; in
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accordance with proper professional standards of medical practice; and in order to preserve or improve the patient's quality of life.97

The new legislation also clarifies the circumstances under which medical practitioners must respect the anticipatory refusal of emergency treatment - defined as treatment that is 'necessary to meet an imminent risk to life or health' - by a patient who is now incapable of consenting to the treatment. The relevant provisions include the following:

• a medical practitioner cannot administer emergency treatment to a patient aged 16 years or over if he or she is aware that the patient has refused to consent to the treatment.98 This reflects the common law position as stated in the English and Canadian case law in respect of adult patients (aged 18 years and over).

• if the patient has appointed an agent under a medical power of attorney, a medical practitioner cannot administer emergency treatment without the agent's consent, provided the medical practitioner is aware of the medical power of attorney and the agent is available to make the decision.99

Northern Territory

The Natural Death Act 1988 (NT) is based on the now-repealed Natural Death Act 1983 (SA). The wording of the Northern Territory legislation is virtually identical to that of the early South Australian Act, allowing competent adult patients to make a written direction refusing the application of 'extraordinary measures' in the event of a terminal illness.100

The Northern Territory does not have legislation providing for the appointment of an agent under an enduring power of attorney to make health care decisions.

Victoria

The advance directive provisions in Victoria are contained in the Medical Treatment Act 1988 (Vic). These provisions aim to give effect to two of the stated purposes of that legislation:

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

(b) to establish a procedure for clearly indicating a decision to refuse medical treatment.101
Under the *Medical Treatment Act 1988* (Vic):

- a 'refusal of treatment' certificate may be executed to express the decision of a patient to refuse medical treatment generally, or to refuse medical treatment of a particular kind.\(^{102}\)

- the patient must be of sound mind and have attained the age of 18 years.\(^{103}\)

- 'Medical treatment' is defined for these purposes as an operation, the administration of a drug or other like substance, or any other medical procedure. The definition of 'medical treatment' specifically excludes palliative care, which is in turn defined to include 'the provision of reasonable medical procedures for the relief of pain, suffering and discomfort' or 'the reasonable provision of food and water.'\(^{104}\)

- the patient's decision to refuse medical treatment may have been indicated in writing, orally, or in any other way in which the patient can communicate.\(^{105}\)

- the patient must be a person of sound mind who has attained the age of 18 years.\(^{106}\)

- the patient's refusal can only be a refusal of medical treatment 'for a current condition'.\(^{107}\)

- the refusal of treatment certificate must be in writing, in the form prescribed in Schedule 1 of the legislation.\(^{108}\)

- the refusal of treatment certificate must be witnessed by a medical practitioner and another person. Both must be satisfied that the patient's decision has been made voluntarily, and after the patient has received and understood sufficient information about the consequences of the refusal.\(^{109}\)

- if a medical practitioner knowingly treats, or continues to treat, a patient in contravention of a refusal of treatment certificate, the medical practitioner commits the statutory offence of medical trespass.\(^{110}\)

- a medical practitioner or other health care professional who refuses to perform or continue medical treatment is immune from civil liability, criminal liability and professional disciplinary action in respect of that refusal, provided that person has acted in good faith and in reliance on a refusal of treatment certificate.\(^{111}\)

- the patient can cancel the refusal of treatment certificate at any time by 'clearly expressing or indicating to a medical practitioner or another person a decision to cancel the certificate'. The patient can express or indicate this decision in writing, orally or in any other way in which the person can communicate.\(^{112}\)
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• a refusal of treatment certificate is automatically cancelled if the patient's medical condition has changed to such an extent that the condition in relation to which the certificate applied is no longer current.\textsuperscript{113}

The Medical Treatment Act 1988 (Vic) also contains enduring power of attorney provisions, inserted by amending legislation in 1990 and 1992.\textsuperscript{114} These provisions aim to give effect to the third purpose of this legislation:

\begin{itemize}
  \item (c) to enable an agent to make decisions about medical treatment on behalf of an incompetent person.\textsuperscript{115}
\end{itemize}

The enduring power of attorney provisions have the following effect:

• a person who is of sound mind can execute an 'enduring power of attorney (medical treatment)', appointing an agent to make decisions on his or her behalf about medical treatment.

• the appointment of the agent only takes effect if the principal becomes incompetent.\textsuperscript{116}

• the enduring power of attorney (medical treatment) must be written in the form prescribed by Schedule 2 of the legislation. It must be witnessed by two people, one of whom must be a justice of the peace.\textsuperscript{117}

• an 'alternate agent' may also be appointed in the manner specified in the legislation. The alternate agent only gains the original agent's power to make treatment decisions if that original agent dies, becomes incompetent, disappears or cannot be contacted.\textsuperscript{118}

• an enduring power of attorney (medical treatment) authorises the agent to refuse medical treatment on behalf of the incompetent patient. The agent may refuse medical treatment generally, or medical treatment of a particular kind. The agent is not empowered to refuse palliative care.\textsuperscript{119}

• the agent may only refuse medical treatment on behalf of the incompetent patient if the medical treatment would cause the patient unreasonable distress, or if there are reasonable grounds to believe that the patient would (if competent) consider the medical treatment to be unwarranted.\textsuperscript{120}

• if an agent refuses medical treatment on behalf of an incompetent patient, a refusal of treatment certificate must be completed.\textsuperscript{121}

• neither the execution of an enduring power of attorney (medical treatment), nor its coming into operation when the patient becomes incompetent, has the effect of cancelling a refusal of treatment certificate completed while the patient was competent.
Australian Capital Territory

In 1993 Mr Michael Moore MLA introduced a Private Member's Bill, the *Voluntary and Natural Death Bill* 1993, into the ACT Legislative Assembly. The Bill aimed to make active voluntary euthanasia lawful in specified circumstances. The Bill also contained provisions enabling a competent adult to make an advance direction about the withholding or withdrawal of medical treatment in the event that the person suffered a terminal illness. It also contained medical powers of attorney provisions. It was referred to a Select Committee on Euthanasia which concluded that it was 'politically inopportune' to proceed with the Bill in its current form, and that the Legislative Assembly should instead consider passing legislation relating to the withdrawal or withholding of medical treatment. The *Medical Treatment Act* 1994 (ACT) was passed as a result.

The *Medical Treatment Act* 1994 (ACT) is modelled on the *Medical Treatment Act* 1988 (Vic), but there are some differences between the two statutes.

The advance directive provisions of the ACT legislation provide that:

- a person may make a 'direction' to refuse medical treatment, or for the withdrawal of medical treatment generally, or medical treatment of a particular kind.
- the person must be of sound mind and have attained the age of 18 years.
- 'Medical treatment' is defined for these purposes as the carrying out of an operation, the administration of a drug, or the carrying out of any other medical procedure. The statutory right to refuse unwanted medical treatment conferred by this legislation does not apply, however, to palliative care. 'Palliative care' is defined to include 'the provision of reasonable medical procedures for the relief of pain, suffering and discomfort' or 'the reasonable provision of food and water.'
- the patient may make the direction in writing, orally, or in any other way in which he or she can communicate.
- a written direction is not valid unless it is made in accordance with the form set out in the Schedule to the legislation. The form must be signed by the person making the direction (or by someone else instructed to do so by that person, and in that person's presence). The signature must be witnessed by two other people.
- a direction that is not written is not valid unless it is witnessed by two health professionals present at the time the direction is made. One of these must be a medical practitioner.
- the patient's refusal can only be a refusal of medical treatment 'for a current condition'.
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- a person can revoke his or her direction to refuse or withdraw medical treatment at any time by 'clearly expressing to a health professional or other person a decision to revoke the direction. This may be done in writing, orally or in any other way in which the person can communicate'.

- a direction automatically ceases to have effect if the person's medical condition has changed to such an extent that the condition in relation to which the direction applied is no longer current.

- where the person who made the direction refusing medical treatment is still competent, a health care professional must take a number of steps before complying with a direction relating to that person's medical treatment. First, the health care professional must take all reasonable steps to ensure that the person has been informed about: the nature of the illness; any alternative forms of treatment that may be available; the consequences of those alternatives; and the consequences of remaining untreated. Secondly, the health professional must then believe that the person has understood this information, weighed the various options, and concluded that the direction still expresses his or her wishes concerning treatment.

- a patient has a right to receive relief from pain and suffering 'to the maximum extent that is reasonable in the circumstances'. In providing relief from pain and suffering, a health professional must 'pay due regard to the patient's account of his or her level of pain and suffering'.

- a health care professional who withholds or withdraws medical treatment from a person is immune from civil liability, criminal liability and professional disciplinary action in connection with the withholding or withdrawal, provided the health care professional has acted in reliance on a decision by the person that he or she believes on reasonable grounds complies with this legislation.

The Medical Treatment Act 1994 (ACT) also introduces a new regime for appointing agents to make health care decisions under enduring powers of attorney. This new regime enables the appointment of an agent who can authorise the withholding or withdrawal of medical treatment in the event that the principal becomes incompetent. The new enduring power of attorney provisions provide the following:

- a person who is of sound mind and who has attained the age of 18 years can confer on an agent the power to withhold or withdraw medical treatment on the principal's behalf.

- the agent is not entitled to exercise this power unless a medical practitioner declares that the principal is incapacitated.

- this power of attorney must be written in the form prescribed by Schedule 2 of the legislation. It must be signed by the principal (or by someone else instructed to do so by
the principal, and in the principal's presence). The signature must be witnessed by two persons. Neither witness can be the agent, nor a relative of the agent. 140

• if the principal has made a direction under the advance directive provisions of this legislation, and that direction is in force, the agent may request that medical treatment be withheld or withdrawn from the principal in accordance with that direction. 141

• if the principal has not made such a direction, the agent cannot request that medical treatment be withheld or withdrawn from the principal unless the agent satisfies two conditions. First, the agent must consult a medical practitioner about the nature of the principal's illness, about any alternative forms of treatment and the consequences for the principal of remaining untreated. Second, the agent must believe on reasonable grounds that the principal would request that medical treatment be withheld or withdrawn, if the principal had the capacity to make that decision himself or herself. 142

These new enduring power of attorney provisions in the *Medical Treatment Act 1994 (ACT)* supplement and modify the old regime established in 1989 under legislation amending the *Powers of Attorney Act 1956 (ACT)*. 143 Under that regime, a person has been able to execute an enduring power of attorney allowing the agent to consent to medical treatment on his or her behalf if the principal becomes incompetent. The principal has been able to confer this power by completing the medical consent section (Part C) of the standard power of attorney form. 144 The principal has been able to specify restrictions in the power of attorney on the agent's power to consent to medical treatment. 145

Enduring powers of attorney relating to medical treatment can still be created under the *Powers of Attorney Act 1956 (ACT)*. The new legislation provides, however, that an enduring power of attorney created under the old regime can now empower the agent to consent to the withholding or withdrawal of medical treatment. 146 If a person creates an enduring power of attorney under the old legislative regime, however, any direction or power of attorney that has been created under the *Consent to Medical Treatment Act 1994 (ACT)* is revoked automatically. 147 Conversely, if a person creates a direction or power of attorney under the *Consent to Medical Treatment Act 1994 (ACT)*, any enduring power of attorney that has been made under the earlier legislation is revoked automatically, to the extent that it applies to the withholding or withdrawal of medical treatment. 148
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Other Australian Jurisdictions

Tasmania

Tasmania does not have legislation recognising 'advance directives' or 'enduring powers of attorney' empowering an agent to make health care decisions.

Since 1985 the Tasmanian Greens have made a number of attempts to introduce legislation modelled on the *Medical Treatment Act 1988* (Vic). All these attempts have failed. Most recently, in 1992 the proposed legislation - the *Medical Treatment and Natural Death Bill 1992* (Tas) - was passed by the Lower House but subsequently rejected by the Upper House.149

Western Australia

Western Australia does not have legislation recognising 'advance directives' or 'enduring powers of attorney' empowering an agent to make health care decisions.

In 1991 the Western Australian Law Reform Commission recommended the introduction of legislation broadly modelled on the *Medical Treatment Act 1988* (Vic).150

In May 1995 the Hon. Ian Taylor MP introduced the *Medical Care of the Dying Bill 1995* (WA). The long title of this Private Member's Bill is 'An Act to affirm and protect the rights of terminally ill persons to refuse unwanted medical treatment, to protect medical practitioners and other health professionals and for related purposes'. The Bill had its second reading speech in the WA Legislative Assembly on 24 May 1995. The debate was adjourned. Mr Taylor has since resigned from Parliament. The Bill lapsed, but the Hon. Judyth Watson restored it to the Notice Paper. On 15 May 1996 it went to the Committee stage, and in early September was still there.

New South Wales

New South Wales does not have legislation recognising 'advance directives' or 'enduring powers of attorney' empowering an agent to make health care decisions.

New South Wales does have guidelines on the management of patients with terminal illnesses, which discuss advance directives as 'a means of indicating to the Attending Medical Officer the patient's wishes'.151 These guidelines have no legal force.
Queensland

Queensland does not have legislation recognising 'advance directives' or 'enduring powers of attorney' empowering an agent to make health care decisions.

Other Common Law Jurisdictions

United States of America

The state of California in the United States of America was the first place in the world to enact legislation to give legal effect to a patient's anticipatory decision to refuse medical treatment. That legislation was enacted in 1976.\textsuperscript{152} It was a living will statute that obliged health care professionals to respect a properly executed written directive refusing life-sustaining medical treatment. The only patients who could use this legislation were competent patients suffering from an incurable condition and for whom death was 'imminent' at the time the directive was signed.\textsuperscript{153}

Many other states followed the Californian lead and enacted similar legislation. Over 40 jurisdictions in the United States of America now have living will statutes.\textsuperscript{154} These statutes all allow competent adults to direct in advance that they do not wish to be kept alive by medical treatment in the latter stages of a terminal illness. Most also allow competent adults to direct that they do not wish to receive medical treatment if they become permanently and irreversibly unconscious.

The first legislation establishing a mechanism for appointing an agent to make health care decisions under an enduring power of attorney was also enacted in California, in 1983.\textsuperscript{155} Again, many other states enacted similar statutes. Currently over 30 states have this kind of enduring power of attorney legislation. Many states have legislation combining living will provisions and enduring power of attorney provisions.\textsuperscript{156} In addition, 20 states have legislation giving a patient's family members power to make decisions about the life-sustaining medical treatment of a patient when the patient becomes incompetent and has not made an advance directive.\textsuperscript{157}

In 1990 the US Congress passed the Federal \textit{Patient Self-Determination Act} 1990. This legislation came into force in December 1991. It requires all health care institutions receiving federal funding to inform all competent adult patients at the time of their admission, and regardless of the reasons for their admission, about their rights under state law to make an advance directive.\textsuperscript{158} The legislation also requires these institutions to record whether the patient has made an advance directive.
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United Kingdom

The United Kingdom does not have legislation recognising living wills. There is legislation enabling an agent to be appointed under an enduring power of attorney to make decisions if the principal becomes incompetent, but such an agent cannot make decisions about medical treatment.

There have been two significant attempts to introduce legislation to give advance directives legal force. Both attempts failed. In 1976 Baroness Wootton of Abinger introduced a Private Member's Bill into the House of Lords. The Incurable Patient's Bill sought 'to enlarge and declare the rights of patients to be delivered from incurable suffering'. It contained a clause designed to give legal effect to a limited kind of advance directive, requiring that 'a written request by a patient to have his life prolonged in the event of brain damage is to be regarded in that event as a current refusal' of such treatment. The Bill was defeated at its second reading in the House of Lords by 85 votes to 23.

The most recent attempt to introduce legislation to recognise advance directives was the introduction in 1993 of the Medical Treatment (Advance Directives) Bill into the House of Lords. This Private Member's Bill was introduced by Lord Allen of Abbeydale. The Bill had its first reading speech in the House of Lords on 16 March 1993 but has since lapsed.

In 1993, after the House of Lords handed down its decision in the important and controversial case Airedale NHS Trust v. Bland, a Select Committee was established to investigate the legal, ethical and social issues surrounding medical treatment decisions at the end of life. More specifically, the House of Lords Select Committee on Medical Ethics was required to consider:

- the ethical, legal and clinical implications of a person's right to withhold consent to life-prolonging treatment, and the position of persons who are no longer able to give or withhold consent;

- whether, and in what circumstances, actions that have as their intention or a likely consequence the shortening of another person's life may be justified on the grounds that they accord with that person's wishes or with that person's best interests; and

- in all the foregoing considerations to pay regard to the likely effects of changes in law or medical practice on society as a whole.

The Select Committee received written and oral evidence from a wide range of interested individuals and organisations. The report of the Select Committee was published in January 1994. In this report, the Select Committee 'strongly endorse[d] the right of the competent patient to refuse consent to any medical treatment, for whatever reason.' The Select Committee also commended the development of advance directives, but concluded that 'legislation for advance directives is unnecessary'. It considered that 'it could well be
impossible to give advance directives in general greater force without depriving patients of the benefit of the doctor's professional expertise and of new treatments and procedures which may have become available since the advance directive was signed. It recommended instead that the colleges and faculties of all the health-care professions should jointly develop a code of practice to guide their members, the informing premise of which should be that advance directives 'must be respected as an authoritative statement of the patient's wishes in respect of treatment'. The Select Committee additionally concluded that it did 'not favour the more widespread development of a system of proxy decision-making', which entailed an implicit rejection of any legislative change allowing competent patients to appoint agents under enduring powers of attorney to make health care decisions for the patient if he or she became incompetent.

The British Government issued a document responding to the recommendations of the House of Lords Select Committee on Medical Ethics in May 1994. The Government agreed with the Select Committee's support for the right of a competent patient to refuse to consent to any medical treatment. The Government also stated that it 'agrees generally' with the Select Committee's conclusions about the value of advance directives. It agreed that the development of a professional code on advance directives would be 'valuable'. It noted, however, that the Law Commissions of England/Wales and Scotland were considering the issue of advance directives and that any professional code would need to take account of any decisions made by the Government in response to the Law Commissions' recommendations.

In February 1995 the Law Commission (of England and Wales) issued its report on the law relating to the way decisions may be made on behalf of mentally incapacitated adults. In this report, the Law Commission recommended that legislation be introduced to:

- recognise a particular kind of advance directive (described as an 'advance refusal of treatment'); and
- enable the appointment of an agent under an enduring power of attorney (described as a 'continuing power of attorney') to make health care decisions in the event of the principal losing capacity to make those decisions.

The Law Commission included draft legislation to give effect to its recommendations, the Mental Incapacity Bill, as an appendix to this report.

The Law Commission recommended that the legislation should specify that a doctor does not have legal authority to administer medical treatment to a 'mentally incapacitated person' if the person concerned has made an 'advance refusal of treatment' that applies to the proposed treatment. The Law Commission recommended that an 'advance refusal of treatment' be defined for these purposes as 'a refusal by a person who has attained the age of 18 and has the necessary capacity of any medical, surgical or dental treatment or other
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procedure, being a refusal intended to have effect at any subsequent time when he may be without capacity to give or refuse his consent'. The Law Commission's other recommendations in relation to 'advance refusals of treatment' included:

- in the absence of any indication to the contrary, it should be presumed that an advance refusal was validly made if it is in writing, signed and witnessed.

- in the absence of any indication to the contrary, it shall be presumed that an advance refusal of treatment does not apply in circumstances where those having the care of the person who made it consider that the refusal (a) endangers that person's life or (b) if that person who is a woman who is pregnant, the life of the foetus.

- an advance refusal of treatment should not preclude the provision of 'basic care', namely care to maintain bodily cleanliness and to alleviate severe pain, as well as the provision of direct oral nutrition and hydration.

- an advance refusal should not preclude the taking of any action necessary to prevent the death of the maker, or a serious deterioration in his or her condition, pending a decision of the court on the validity or applicability of an advance refusal or on the question of whether it has been withdrawn or altered.

- No person should incur liability (1) for the consequences of withholding any treatment or procedure, if he or she has reasonable grounds for believing that an advance refusal of treatment applies; or (2) for carrying out any treatment or procedure to which an advance refusal applies, unless he or she knows or has reasonable grounds for believing that an advance refusal applies.

The Law Commission also recommended that a new form of power of attorney, to be called a 'continuing power of attorney', should be introduced. Only a person who had attained the age of 18 years would be able to create a continuing power of attorney. An agent appointed under a continuing power of attorney would have authority to make and implement decisions on behalf of the principal, which the principal is without capacity to make. These would include decisions about the health care of the principal. The agent's powers to make such decisions would be subject to certain specified restrictions.

In January 1996 the Parliamentary Secretary of the Lord Chancellor's Department made the following statement in Parliament:

The Government have considered the Law Commission report on mental incapacity very carefully and are grateful on this subject. The Government appreciate that this is an important and sensitive subject raising moral and ethical issues on which many people will have strong personal views.
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The Government have decided not to legislate on the basis of the Law Commission's proposals in their current form and have also concluded that it would be inappropriate to make any proposals to Parliament in the absence of full public consultation. The Government propose to issue a consultation paper on mental incapacity in due course.

Canada

In 1992, two Canadian Provinces - Ontario and Manitoba - enacted legislation giving legal effect to living wills and enabling the appointment of an agent under an enduring power of attorney to make health care decisions. Enduring power of attorney legislation in Nova Scotia and Quebec allows an agent to make health care decisions on behalf of the incompetent principal.

Following the 1993 decision of the Supreme Court of Canada in the Rodriguez case, in February 1994 a Special Committee of the Senate of Canada was set up to examine and report on the legal, social and ethical issues relating to euthanasia and assisted suicide. The report of this Special Committee - entitled Of Life and Death - was tabled on 6 June 1995. The report's recommendations include the following:

- that those provinces and territories that do not have advance directive legislation adopt such legislation.
- that the provinces and territories establish a protocol to recognise advance directives executed in other provinces and territories.
- that the Federal Ministry of Health, in cooperation with the provinces and territories, sponsor a national campaign designed to inform the public as to their rights with respect to the refusal of life-sustaining treatment.

Competent Children

The common law determines whether a child can make his or her own decisions about medical treatment everywhere in Australia except South Australia and New South Wales. In those two States, statutory positions modify the common law rules.

A competent child cannot refuse life-sustaining medical treatment at common law

In contrast to its approach to adult patients, the common law is generally less willing to recognise a child's right to make decisions about proposed medical treatment.
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At common law a child (a person under 18 years of age), unlike an adult, is not presumed to be competent to consent to medical treatment. A child will be competent to consent to a proposed treatment, however, if the child possesses sufficient understanding and intelligence to enable the child to understand fully what is proposed. In such circumstances a child has a common law right to consent to the proposed treatment.

It does not seem to be the case, however, that a child who is sufficiently mature to consent to proposed medical treatment (and thus has a legal right to do so) also has a concomitant right to refuse to consent to the same treatment. Recent English cases have stated that any refusal of medical treatment by a competent child can be overridden by the consent of the child's parent or guardian. This interpretation of the law has been widely criticised, and may not represent the common law position in Australia.

Even if it does not, it is clear in Australia that a court can use its inherent jurisdiction to override a child's refusal of medical treatment if it considers the refusal to be against the child's 'best interests'. In deciding whether to do so, a court would give some weight to the child's wishes. In situations where the refusal would not pose a serious risk to the child's life or physical or mental health, and where the child is older and more mature, a court would be more likely to uphold the child's refusal. In situations where the refusal relates to medical treatment necessary to keep the child alive or to avert an imminent and serious risk to the child's health, however, a court almost certainly would authorise treatment against the child's wishes.

A statutory right to refuse medical treatment?

In New South Wales, the Minors (Property and Contracts) Act 1970 (NSW) allows a sufficiently mature child aged 14 years or above to consent to medical treatment. The legislation makes it clear, however, that a competent child's refusal to consent to proposed medical treatment can be overridden by the consent of a parent or guardian if the child is under 16 years of age. In respect of competent children aged between 16 and 18 years, the legislation does not seem to affect the position at common law. The law in New South Wales therefore may respect such a child's refusal to consent to some or most kinds of medical treatment, but almost certainly does not do so if the treatment is necessary to keep the child alive.

The legal ability of a child to make decisions about medical treatment in South Australia is determined by the Consent to Medical Treatment and Palliative Care Act 1985 (SA). This new legislation repeals the Consent to Medical and Dental Procedures Act 1985 (SA), section 6 of which specified when a person aged under 18 years could consent to or refuse medical treatment.
One of the stated objects of the new *Consent to Medical Treatment and Palliative Care Act* 1985 (SA) is to make reforms to the law in South Australia 'to allow persons of or over the age of 16 years to decide freely for themselves on an informed basis whether or not to undergo medical treatment'.\(^{198}\) This legislation therefore redefines 'child' to mean a person under 16 years of age. It also provides that 'a person of over 16 years of age may make decisions about his or her own medical treatment as validly and effectively as an adult'.\(^{199}\)

This seems to mean that a doctor in South Australia must respect a refusal of medical treatment by a competent person aged 16 years or over, including the refusal of life-sustaining medical treatment. The legislation also specifically requires a doctor to respect an anticipatory refusal of life-sustaining medical treatment by a competent person aged 16 years or over, in emergency situations where the patient cannot consent to the proposed treatment.\(^{200}\)

The new South Australian legislation also provides that children aged under 16 years may only offer a legally valid consent to medical treatment if two doctors agree that the child is capable of understanding the nature, consequences and risks of the treatment, and that the treatment is in the best interest of the child's health and well-being. The refusal to consent to proposed medical treatment by a child of that age can be overridden by the consent of the child's parent or guardian.\(^{201}\)

**Endnotes**

5. This was the blanket term used by Dutch researchers conducting empirical investigations for the Remmelink Commission in 1990-1991. See P. Van der Maas, J. Van Delden and L. Pijnenborg, 'Euthanasia and Other Medical Decisions Concerning the End of Life - Volume 2' (1992) 22(2) *Health Policy* (Special Issue), p xv.
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8 Re T (Adult: Refusal of Treatment) [1992] 3 WLR 782.

9 Ibid.

10 Trespass to the person includes battery, assault, and false imprisonment.

11 Prosecution for the crime of battery is also possible, but very much less likely as criminal prosecutions, let alone successful criminal prosecutions, of doctors are extremely rare.


13 Blackstone's Commentaries (17th ed), 1830, vol. 3, p 120.

14 (1914) 105 NE 92 at 93 (Court of Appeals of New York) per Cardozo J.


16 Ibid at 233 per Mason CJ, Dawson, Toohey and Gaudron JJ.

17 Ibid at 309-120 per McHugh J.

18 Ibid at 234 per Mason CJ, Dawson, Toohey and Gaudron JJ.

19 Ibid at 266 per Brennan J.

20 Ibid at 268 per Brennan J.

21 Ibid at 309 per McHugh J.

22 Ibid at 311 per McHugh J.

23 Re T (Adult: Refusal of Treatment) [1992] 3 WLR 782 per Lord Donaldson MR. Statements to similar effect were made in this case by Butler-Sloss and Staughton LJ.

Some US courts recognising the right to refuse life-sustaining medical treatment have adopted only a common law analysis - e.g. In re Storar (1981) 420 NE 2d 64 (New York Court of Appeals), In re Conroy (1985) 486 A 2d 1209 (New Jersey Supreme Court); others only a constitutional law analysis - e.g. In re Quinlan (1976) 355 A 2d 647 (New Jersey Supreme Court); and others have combined both approaches - e.g. Superintendent of Belchertown State School v. Saikewicz (1977) 370 NE 2d 417 (Supreme Judicial Court of Massachusetts). For a summary of the approach in these and other relevant US cases, see Cruzan v. Director, Missouri Health Department (1990) 487 US 261 at 269-277.

Note that Australian courts have not articulated a 'state interests' doctrine of this kind.

e.g. Bouvia v. Superior Court (1986) 225 Cal Rptr 297 (California Court of Appeal); Bartling v. Superior Court (1984) 209 Cal Rptr 2020 (California Court of Appeal); In re Farrell (1987) 529 A 2d 404 (New Jersey Supreme Court); McKay v Bergstedt (1990) 801 P 2d 617 (Nevada Supreme Court); Thor v. Superior Court (1993) 855 P 2d 375 (California Supreme Court). In Re Conroy (1985) 486 A 2d 1209 at 1225, the New Jersey Supreme Court stated the following:

On balance, the right to self-determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death. Most of the cases that have held otherwise, unless they involved the interest in protecting innocent third parties, have concerned the patient's competency to make a rational and considered choice.

In an important case decided by the US Supreme Court in 1990 - Cruzan v. Director, Missouri Department of Health (1990) 497 US 261 - five of the nine Supreme Court Justices did affirm the existence of such a right or, more correctly, 'constitutionally protected liberty interest'. Only one of these judges, however, was part of the 5:4 majority on the rather different issue that the Supreme Court was deciding in this case. (That issue was whether a Missouri statute prescribing that life-sustaining treatment, including artificial feeding and hydration, could not be withdrawn from a legally incompetent patient without 'clear and convincing evidence' that this is what the patient would have wanted in the circumstances, contravened an individual's liberty interests under the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution. The Supreme Court held by a majority of 5:4 that this restriction did not violate the Due Process Clause.) The other four majority judges did not go this far. They affirmed the existence of a more limited liberty interest under the U.S. Constitution in refusing life-sustaining hydration and nutrition, and merely averted
to the existence of a constitutionally protected liberty interest in refusing any kind of unwanted medical treatment.


As to whether a health care professional is entitled to administer life-saving treatment against the wishes of a person who has attempted suicide, see: I. Kennedy and A. Grubb, Medical Law: Text With Materials (2nd ed), London, Butterworths, 1994, pp 336-7; In Re Kinney, unreported, Supreme Court of Victoria (Fullagar J), 23 December 1988.


34 See A. Grubb, supra note 7 at 367-370; I. Kennedy and A. Grubb, supra note 32 at pp 1325-1334.


36 This was the factual situation in the Canadian case Malette v. Shulman (1990) 67 DLR (4th) 321. A doctor was held liable in battery for administering blood transfusions to an unconscious adult patient in a potentially life-threatening situation. He had been aware that she was carrying a card stating that she was a Jehovah's Witness and that she therefore did not wish to receive blood products under any circumstances.

37 For example, see Re C (Adult: Refusal of Treatment) [1994] 1 WLR 290. See A. Morris, supra note 33 at 24.
In the USA people now often make tape recordings or video recordings of their wishes about future medical treatment: see Law Commission, *supra* note 7, para 5.29 n 67.

Law Commission, *supra* note 7, para 5.29.


Law Commission, *supra* note 7, para 5.22.

*In re Eichner* (1981) 420 NE 2d 64; *In re Conroy* (1985) 486 A 2d 1209 (New Jersey Supreme Court). Any constitutionally protected right or liberty interest, upon which a competent adult's right to refuse medical treatment may be grounded, may also survive the onset of incompetence: *In re Quinlan* (1976) 355 A 2d 647 (New Jersey Supreme Court); *Superintendent of Belchertown State School v. Saikewicz* (1977) 370 NE 2d 417 (Supreme Judicial Court of Massachusetts); *Cruzan v. Director, Missouri Health Department* (1990) 497 US 261 (US Supreme Court).

The test was laid down by the New Jersey Supreme Court in *In re Conroy* (1985) 486 A 2d 1209.


*Ibid.* That case also establishes that, if the 'subjective test' cannot be applied (because the patient did not make his or her wishes concerning future medical treatment sufficiently clear), life-sustaining medical treatment nonetheless can be withdrawn from an incompetent patient if either of two further tests are satisfied: the 'limited-objective' test or the 'pure-objective' test.

*Cruzan v. Director, Missouri Health Department* (1990) 497 US 261 at 284. Examples of such cases include *In re Eichner* (1981) 420 NE 2d 64 (New York Court of Appeals); *Saunders v. State* (1985) 492 NYS 2d 510 (New York Supreme Court); *In re Peter* (1987) A 2d 419 (New Jersey Supreme Court); *In re Westchester County Medical Center on Behalf of O'Connor* (1988) 531 NE 2d 607 (Court of Appeals of New York). Also note that the issue before the U.S. Supreme Court in *Cruzan* was the constitutional validity of Missouri's legislative requirement that an individual's wishes as to the withdrawal of life-sustaining treatment be proved by 'clear and convincing evidence' before they could be followed. Upholding the validity of such a requirement, the majority of the Supreme Court also upheld the lower court's conclusion that Nancy Cruzan's desire to have artificial hydration and nutrition withdrawn in the current circumstances (she was in a persistent vegetative state as the result of a car accident) has not been established to the standard of 'clear
and convincing evidence.' This evidentiary standard was not satisfied by statements she had made to her housemate about a year before her accident, at age 25, that she would not want to live should she face life as a 'vegetable'. Neither these statements, nor other statements she had made to a similar effect, averted to the withdrawal of medical treatment or the withdrawal of artificial hydration and nutrition.

See John F. Kennedy Memorial Hospital Inc v. Bludworth (1984) 452 So. 2d 921 (Florida Supreme Court); In re Conroy (1985) 486 A 2d 1209.

In re Conroy (1985) 486 A 2d 1209; c.f In re Quinlan (1976) 355 A 2d 647.

See below.


See generally Law Commission, supra note 7, para 5.34; A. Morris, supra note 33 at 17-18.


I. Kennedy and A. Grubb, supra note 32, p 1277.

Law Commission, supra note 7, para 5.34.

The Medical Protection Association of Australia, the Royal Australian College of Obstetricians and Gynaecologists, the National Association of Specialist Obstetricians and Gynaecologists, and the Australian College of Paediatrics.


Ibid pp 104-5.


Re F (In Utero) [1988] Fam 122.


e.g. Raleigh Fitkin - Paul Morgan Memorial Hospital v. Anderson (1964) 201 A ed 537 (New Jersey Sup Ct); Jefferson v. Griffin Spalding County Hospital Authority (1981) 274 SE 2d 457 (Georgia Sup Ct); In the Matter of the Application of Jamaica Hospital (1985) 491 NYS 2d 898 (New York Sup Ct); Crouse Irving Memorial Hospital Inc v. Paddock (1985) 485 NYS 2d 443 (New York Sup Ct). In these cases, the courts considered that the pregnant patient's right to bodily integrity was outweighed by the state's interest in the protection of third parties (in this case, foetuses).

In Re AC (1990) 573 A 2d 1235.

Ibid at 1237.

Ibid at 1237. See further I. Kennedy and A. Grubb, supra note 32, pp 350-358; J. Seymour, supra note 56, pp 77-79.


Re S (Adult: Refusal of Treatment) [1992] 4 All ER 671 per Sir Stephen Brown P.


Also note that clause 9(3) of the English Law Commission's Draft Mental Incapacity Bill (discussed further below) would enable a pregnant woman to express a binding anticipatory refusal of treatment, including treatment necessary to preserve her life or the life of the foetus. The Law Commission commented on this issue as follows:
We do not ... accept that a woman's right to determine the sorts of bodily interference which she will tolerate somehow evaporates as soon as she becomes pregnant. There can, on the other hand, be no objection to acknowledging that many women do in fact alter their views as to the interventions they find acceptable as a direct result of the fact that they are carrying a child. By analogy with cases where life might be needlessly shortened or lost, it appears that a refusal which did not mention the possibility that the life of a foetus might be endangered would be likely to be found not to apply in circumstances where a treatment intended to save the life of the foetus was proposed. Women of child-bearing age should therefore be aware that they should address their minds to this possibility if they wish to make advance refusals of treatment.

(Law Commission, supra note 7, para 5.25 and p 226. See also A. Morris, supra note 33 at 16-17.

Lord Allen of Abbeydale of the English House of Lords has criticised the phrase 'living will' as reflecting an American gift for 'phrases which defy intellectual analysis': Hansard (House of Lords), 9 May 1994, vol 554, col 1363.

The legislation in the ACT also allows competent adults to make appropriately witnessed oral directives. See discussion below.


The prescribed forms for appointing an agent to make medical decisions in both South Australia and the Australian Capital Territory provide that the principal may specify restrictions on the scope of the agent's power. The prescribed form in Victoria does not explicitly allow this.

The creation or activation of an enduring power of attorney does not have the effect of revoking a pre-existing direction made under the advance directive legislative provisions, except in some circumstances in the ACT (see discussion below).

Medical Treatment Act 1988 (Vic), section 4(1), Natural Death Act 1988 (NT), section 5(1), Medical Treatment Act 1994 (ACT), section 5(1). A similar provision was contained in the Natural Death Act 1983 (SA), but the new Consent to Medical Treatment and Palliative Care Act 1995 (SA) does not contain such a provision.

Section 4(1).

Section 3.
With the exception of section 14, which came into effect on 30 May 1996. Regulations made under the Act - the *Consent to Medical Treatment and Palliative Care Regulations* 1996 (SA) - also came into effect on 30 May 1996.
Section 3.
Section 5(3).
Section 5(1)(d).
Section 5(1)(a).
Section 5(2).
Sections 5(1)(b) and (c).
Section 6.
Section 9.
Sections 7(1) and (2).
Section 7(3).
The *Medical Treatment (Enduring Power of Attorney) Act* 1990 (Vic) and the *Medical Treatment (Agents) Act* 1992 (Vic), respectively.
Section 1.
Section 5A(2)(b).
Section 5A(2)(a).
Section 5A.
Section 5B(1).
Section 5B(2).
Section 5B(3).
Section 6.
Section 6.
Section 3.
Section 5(2).
Section 4.
Section 6.
Section 7.
Section 8.
Section 6.  
Section 9.  
Section 10.  
Section 11.  

This right is included to further the second of the two stated objectives of the Medical Treatment Act 1994 (ACT). These objectives are set out in section 4: 

• to protect the right of patients to refuse unwanted medical treatment; and 
• to ensure the right of patients to receive relief from pain and suffering to the maximum extent that is reasonable in the circumstances.

Section 23.  
Section 22.  
Section 13(1).  
Section 14.  
Section 13(2).  
Section 16(2).  
Section 16(1).  

Powers of Attorney Act 1956 (ACT), section 13, Sch Form 2 Part C.  
See further R. Creyke, supra note 6, pp 278-9.  
Sections 26 and 27.  
Section 18(3).  
Section 18(4).

NSW Health Department, Dying With Dignity - Interim Guidelines on Management, State Health Publication No (HPA) 93:33, 1 March 1993, para 5(e).  
The Natural Death Act 1976 (California); subsequently amended and currently California Health and Safety Code, sections 7185-7194.5.


The *Durable Power of Attorney Health Care Act* 1983 (California); currently *California Civil Code*, sections 2430 - 2445.


c.f. British Medical Association, *Code of Practice on Advance Statements About Medical Treatment*, London, BMJ, 1995 para 6.4, recommending against raising the issue of anticipatory decisions about medical treatment at the time of admission to hospital on the basis that this is an inherently stressful time for a patient.


*Incurable Patient's Bill* 1976 (UK), clause 3. Clause 1 of the Bill provided that an incurable patient is to be entitled to have pain and distress fully relieved by medical care, even if unconsciousness results. Clause 2 of the Bill provided that an incurable patient is to be entitled to take steps that may cause his own death i.e physician assisted suicide.

[1993] 2 WLR 316. In this case, the House of Lords authorised the withdrawal of artificial hydration and nutrition from Anthony Bland, a patient who had been in a persistent vegetative state since being injured in the Hillsborough disaster in 1989.


See *ibid*, pp 3-6.


*Ibid*, paras 263 and 296. The Select Committee preferred the term 'advance directive' to the term 'living will.' It defined 'advance directive' to mean 'a document
executed while a patient is competent, concerning his or her preferences about medical treatment in the event of becoming incompetent. The document may specify the types of treatment which the patient would or would not find acceptable in certain circumstances: para 27.

Ibid, paras 264 and 296.

Ibid, para 264.

Ibid, paras 265-7 and 297.

Ibis, paras 271 and 298.


Ibid, p 1.

Ibid, p 5.

Ibid, pp 5-6.


Ibid, paras 5.16 and 11.25; Mental Incapacity Bill, clause 9(1).

Ibid, paras 5.29-5.30 and 11.29; Mental Incapacity Bill, clause 9(5).

Ibid, paras 5.23-5.26; Mental Incapacity Bill, clause 9(3).

Ibid, paras 5.34 and 11.31; Mental Incapacity Bill, clauses 9(7)(a) and (8).

Ibid, paras 5.36 and 11.33; Mental Incapacity Bill, clause 9(7)(b).

Ibid, paras 5.27 and 11.28; Mental Incapacity Bill, clause 9(4).

Ibid, paras 7.20 and 11.62; Mental Incapacity Bill, clause 14(1).

Ibid, paras 7.1-7.6 and 11.51; Mental Incapacity Bill, clauses 12(1) and (2).

For more detail, see ibid, paras 11.51-11.83 and references contained therein.

Consent to Treatment Act 1992 (Ontario); Substitute Decisions Act 1992 (Ontario); Health Care Directives Act 1992 (Manitoba).

Medical Consent Act 1989 (Nova Scotia); Civil Code of Quebec, Arts 1701.1 and 1731.1-1731.11.


*Ibid;* see Summary of Recommendations, p x and Chapter VI: Advance Directives.

*Ibid;* see Summary of Recommendations, p x and Chapter V: Withholding and Withdrawal of Life-sustaining Treatment.

*Gillick v. West Norfolk and Wisbech Area Health Authority* [1986] AC 112 at 189 (English House of Lords). The *Gillick* test of competence was accepted as applying to adult patients by the English Court of Appeal in *Re T (Adult: Refusal of Treatment)* [1992] 3 WLR 782. The High Court of Australia has also affirmed that the *Gillick* test of competence also represents the position at common law in Australia: *Secretary, Department of Health and Community Services v. JWB and SMB* (1992) 175 CLR 318 at 237-8 per Mason CJ, Dawson, Toohey and Gaudron JJ; at 311 per McHugh J.

*Re R (A Minor)(Wardship: Consent to Treatment)* [1992] Fam. 11(English Court of Appeal); *Re W (A Minor)(Medical Treatment: Court’s Jurisdiction)* [1992] 3 WLR 758 (English Court of Appeal). Both cases interpret the *Gillick* case as being concerned only with a child’s capacity to consent, and deny the common law right of a *Gillick*-competent child to give a binding refusal.

See A. Grubb, *supra* note 7 at 373-375.

See *Department of Human Services and Health v. JWB and SMB* [1992] 175 CLR 218 at 238 n 75.

This was the interpretation of the law offered in *Re W (A Minor)(Medical Treatment: Court’s Jurisdiction)* [1992] 3 WLR 758 by Balcombe and Nolan LJJ. Compare the more paternalistic approach of Lord Donaldson MR in the same case.