THE LAW REFORM COMMISSION
OF WESTERN AUSTRALIA

Project No 84

Medical Treatment for the Dying

REPORT

FEBRUARY 1991

The Law Reform Commission of Western Australia was established by the *Law Reform Commission Act 1972*.

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To **HON J M BERINSON QC MLC**
ATTORNEY GENERAL

In accordance with the provisions of section 11(3)(b) of the *Law Reform Commission Act 1972*, I am pleased to present the Commission's report on Medical Treatment for the Dying.

J A THOMSON, Chairman

12 February 1991

Contents

Abbreviations

CLRC	Law Reform Commission of Canada *Euthanasia, Aiding Suicide and Cessation of Treatment* (Report No 20 1983).
Discussion Paper	The Law Reform Commission of Western Australia *Medical Treatment for the Dying* (Project No 84, 1988).
Dying with Dignity	(Vic) Social Development Committee *Inquiry Into Options for Dying with Dignity* (Second and Final Report 1987).
President's Commission	(USA) President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research *Deciding to Forego Life-Sustaining Treatment* (1983).
Skegg	P D G Skegg *Law, Ethics, and Medicine* (1984).
The Living Will	*The Living Will*: A Working Party Report published by Age Concern Institute of Gerontology and the Centre of Medical Law and Ethics, King's College, London, under the chairmanship of Professor Ian Kennedy.

Chapter 1

INTRODUCTION

1. TERMS OF REFERENCE

> *"To review the criminal and civil law so far as it relates to the obligations to provide medical or life supporting treatment to persons suffering conditions which are terminal or recovery from which is unlikely, and, in particular, to consider whether medical practitioners or others should be permitted or required to act upon directions by such persons against artificial prolongation of life."*

2. BACKGROUND TO THE TERMS OF REFERENCE

1.1 As a result of developments in recent decades,[1] modern medicine can often substantially prolong life, even with diseases for which there is no long term cure. Many illnesses and conditions, however, eventually reach a point of hopelessness, in the sense that there is neither any prospect of the patient being cured nor any prospect of a further period of life of reasonable quality. Yet with the use of life support systems a patient may still live on for a time, though perhaps in considerable pain, stress or discomfort.

1.2 The patient, if able to make a rational decision, may ask that treatment aimed at the prolongation of life should cease in favour of palliative care designed to ensure that he or she suffers the minimum of pain and distress before dying. Alternatively a patient may not be able to make such a request (for example if he or she is unconscious or enfeebled by illness or medication), yet people with close associations with the patient may consider a change from therapeutic treatment to palliative care to be in the patient's best interests. However it is not clear that another person has legal authority to make that decision on the patient's behalf.

1.3 In addition to these problems such situations may present legal difficulties because of the general application of provisions in the Criminal Code that impose duties on doctors and others to provide the necessaries of life and to do acts which, if omitted, may be dangerous to human life or health.[2] These provisions may seem to put doctors and other health care

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1 Such as the use of emergency resuscitation, respirators, dialysis, artificial hydration and nutrition, and other methods of intensive care and advanced life support

2 ss 262 and 267: see paras 1.11-1.12 below.

professionals at risk of prosecution and conviction for an offence if they withdraw or withhold life support systems.

1.4 The legal problems involved in the treatment of the terminally ill, as outlined above, are part of a wide-ranging debate about the care of the dying. The interests of all concerned must be given proper consideration. This means, first and foremost, patients themselves and their loved ones. It is also necessary to view the problem from the perspective of the health professionals who seek to give dying patients the most appropriate care, those who have the responsibility of making decisions about the provision of resources for the care of the terminally ill,[3] and the community at large, which bears much of the financial burden.

1.5 In other countries, notably the United States of America, and in other Australian jurisdictions, such problems have prompted the setting up of inquiries to review the civil and criminal laws governing the provision of life supporting treatment to terminally ill patients. As a result, legislation has been enacted which, in various ways, clarifies the obligations of doctors and provides specific legal mechanisms whereby people can exercise some control over the treatment they receive.[4]

1.6 Arising out of these developments, the Attorney General asked the Commission to consider whether the law in Western Australia required clarification or amendment. The Commission's terms of reference are confined to the provision of medical or life supporting treatment to persons who are terminally ill and are concerned with the question whether doctors should be permitted or required to act on directions by such persons that their life not be artificially prolonged by medical treatment. The reference does not cover euthanasia, in the sense of the application of a procedure or treatment with the deliberate intent to terminate life.

3. DISCUSSION PAPER AND REPORT

1.7 With the aim of seeking public comment on the issues involved, the Commission published a Discussion Paper on the reference in 1988. The names of the people and organisations who responded are listed in Appendix I. The Commission thanks them for the

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3 For example, as to the nature and amount of equipment available in a hospital's intensive care unit.

4 See, for example, the legislation in Victoria discussed in Chs 2 and 3. The legislation is set out in Appendix II.

time and trouble they took. Their comments helped the Commission by clarifying the practical issues involved. Others did much to enable the Commission to gain a deeper appreciation of the emotional and social context in which patients, doctors, family and friends are placed in making decisions relating to terminal illness.[5]

1.8 In the light of these comments and of its discussions and research the Commission now submits this report. This chapter sets out the relevant Western Australian law, indicating where the Commission believes uncertainties exist. It then outlines the attempts made elsewhere to deal with some of these uncertainties and the general principles which it considers should guide changes to the law in this State. The following chapters set out the Commission's recommendations in detail.

4. PROBLEMS WITH THE EXISTING LAW

(a) Competent patients

1.9 Patients have a number of important legal rights as respects medical treatment. They have a right not to be treated without their consent and, as a corollary, a right to be provided with information to enable them to make informed decisions about whether or not to undergo any specific treatment or indeed any treatment at all. If they do choose to undertake treatment they have a right to be treated with reasonable care and skill.[6]

1.10 The right not to be treated without consent is an aspect of a person's right to self-determination, an important aspect of individual liberty.[7] The right was recently restated by the House of Lords in *Re F* in the following terms:

> "At common law a doctor cannot lawfully operate on adult patients of sound mind, or give them any other treatment involving the application of physical force however small ("other treatment"), without their consent. If a doctor were to operate on such

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5 To further increase its understanding of the range of problems involved the Commission also held discussions with a wide range of people with a particular interest in the issues concerned, including staff of the Hospice Care Service and the Cottage Hospice, Dr C R Goucke of Sir Charles Gairdner Hospital, Ms Helga Kuhse of the Centre for Human Bioethics, Monash University, Mr Nicholas Tonti-Filippini, then Director of St Vincent's Hospital Bioethics Centre in Melbourne, Mrs Jean Davies, President of the World Federation of Right to Die Societies and Professor Ian Kennedy of King's College, London.

6 J K Mason and R A McCall Smith *Law and Medical Ethics* (2nd ed 1987) Chs 9 and 10.

7 I Kennedy *Treat Me Right* (1988) 320. For a discussion of this right see D Lanham *The Right to Choose to Die with Dignity* (1990) 14 Crim LJ 401.

> patients, or give them other treatment, without their consent, he would commit the actionable tort of trespass to the person."[8]

This principle applies to persons suffering from a terminal condition as much as it applies to other patients.

1.11 Certain sections of the Criminal Code, which impose duties on individuals, including doctors, in various circumstances may seem to conflict with this principle. Two of these duties, the duty to provide the necessaries of life and the duty to do acts the omission to do which may be dangerous to human life or health, are capable of applying to the provision of medical treatment.[9] The first requires every person having charge of another to provide him or her with the necessaries of life if that person is unable by reason of age, sickness, unsoundness of mind, detention or any other cause to withdraw from such charge and is unable to provide himself or herself with such necessaries.[10] Necessaries can include medical treatment.[11] The second requires a person who undertakes to do any act which, if not carried out, is or may be dangerous to human life or health, to do that act.[12]

1.12 Some doctors have expressed the fear that they remain bound by these duties notwithstanding the patient's withdrawal of consent to treatment.[13] In the Commission's view this misunderstands the legal position. Where a patient who is able to do so (that is, a

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8 [1990] 2 AC 1, 55, per Lord Brandon. Similar statements were made by other members of the House of Lords.

9 Another duty provision applying to medical treatment is s 265, which provides that a person who undertakes to administer surgical or medical treatment must have reasonable skill and use reasonable care. This however could not conflict with a patient's right not to be treated without consent.

10 Criminal Code s 262. Similar issues arise with s 263 of the Code which imposes a duty on the head of a family to provide the necessaries of life for any child under 16 years in his or her charge.

11 It has been held that "medical aid" could under certain circumstances be one of the necessaries of life: *R v MacDonald* [1904] St R Qd 151; *R v Brooks* (1902) 5 CCC 372. But this does not mean that all forms of medical treatment would be so regarded: modern forms of life-supporting treatment such as those listed in fn 1 above may not be regarded as necessaries in certain circumstances.

12 Criminal Code s 267.

13 One commentator suggested that because of a fear that the duty to provide the necessaries of life might otherwise be breached, some patients who refused to take food have been fed by an oesophageal tube or intravenous drip, even though this treatment might have involved a technical assault on the patients. A submission from the Department of General Practice, Medical School, University of Western Australia stated that:

> "There have been difficulties with particular individuals because of the existing law. This has happened where members of the nursing staff or a minority of relatives have felt that further surgical or medical procedures should be attempted in order to prolong life when it has been the contrary wish of the patient who has clearly indicated to the doctor that these measures should not be undertaken. The clinician in charge of the case has felt under considerable pressure with the implied threat of one of the nursing staff or relatives going to law if he did not concede to their wishes. In the event members of the Faculty had not found themselves attacked under the law, but have felt themselves under threat."

competent patient) asks that treatment be withdrawn or withheld the effect is to terminate both of these duties.[14] Indeed so far from merely terminating a duty to *continue* treatment, the assault provisions of the Code would impose a duty on the doctor to *cease* treatment.[15]

1.13 Another source of fear for some doctors is the section of the Criminal Code which provides that it is a crime to aid "another in killing himself" or to procure "another to kill himself" or to counsel "another to kill himself and thereby induce him to do so".[16] In the Commission's view this fear is also misplaced. It would be aiding suicide for a doctor to place poison by a patient's side with the intent that he or she should use it, if the patient committed suicide by taking it. But the situation is different where a doctor merely discontinues medical treatment because of the patient's withdrawal of consent, even though the patient dies as a result. In this case it would appear that the patient has not killed himself but merely "allowed the natural process of dying to take its course".[17]

1.14 Thus there is no legal reason why doctors should not comply with a patient's decision to refuse treatment. In any case the Commission's recommendations below in relation to a refusal of treatment certificate will avoid any legal uncertainty in those cases where the patient has completed the certificate.

(b) Incompetent patients

1.15 Different problems arise where terminally ill patients are not competent to make a

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14 A similar approach was adopted in *People v Robbins* (1981) 443 NYS2d 1016, a decision of the New York Court of Appeal. In this case the court accepted that a husband had a legal duty to summon care or to administer insulin to his wife when she became incapacitated, but there would be no breach of that duty if the wife, while capable of doing so, had made a rational decision to forgo medical assistance: "Since that was her right, and since treatment could not be rendered because of her refusal, the state could not impose criminal sanctions on her husband for respecting her wishes": L H Glantz *Withholding and Withdrawing Treatment: The Role of the Criminal Law* (1988) 15 Law, Medicine and Health Care 231, 239.

15 "A person who strikes, touches, or moves, or otherwise applies force of any kind" to another person without his or her consent commits an offence unless it is authorised or justified or excused by law: Criminal Code ss 222 and 223. It would be difficult to argue that a doctor who continues to administer treatment involving touching (ie assaulting) a competent patient without consent is doing an act which was "authorised or justified or excused by law". There may be certain statutory provisions which would specifically authorise force on competent patients, but that is not the issue here. See generally D Lanham *The Right to Choose to Die with Dignity* (1990) 14 Crim LJ 401.

16 Criminal Code s 288.

17 This distinction has been made in cases in the USA: President's Commission 38. See also D Lanham *The Right to Choose to Die with Dignity* (1990) 14 Crim LJ 401, 410-415.

decision about medical treatment on their own behalf.[18] Under the present Western Australian law there is no means by which people can give legally binding directions as to withdrawing or withholding treatment should they become incompetent, though as a matter of principle if the patient has expressed clear wishes before becoming incompetent those wishes should be respected.[19] Nor is it legally possible for a person to appoint someone to make treatment decisions on his or her behalf. Doctors commonly consult the spouse or near relatives of an incompetent patient, and it is sometimes assumed that such persons may make decisions to withdraw or withhold treatment, and in doing so terminate the duties referred to above.[20] However, there appears to be no legal basis for this view.[21] The only persons who may make treatment decisions on behalf of another are the parents or guardian of a minor[22] and a guardian appointed by a court to look after an adult person's affairs.[23]

1.16 In cases in which a doctor is bound by one of the duty provisions referred to above, and there is no one who can make decisions on behalf of the patient (and no evidence of the patient's wishes), the precise extent of the duties would be very important. This situation could occur, for example, when a patient, having committed himself or herself to the doctor's care while competent, lapses into unconsciousness during the course of the illness. It could be argued that -

* The duty provisions are to be read in the context of the Criminal Code as a whole, where a reference to medical treatment is typically expressed in terms

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18 An obvious example is someone who is unconscious due to concussion. Making decisions as to competence in other cases, such as a mentally disordered or intellectually handicapped person, may be more difficult: para 2.4 below.

19 There is no case or statute authority in support of this proposition, but it is affirmed by Skegg 116 and *The Living Will* 35. The latter work discusses the United States decision of *In re Conroy* (1985) 486 A2d 1209, in which the court took the view that if known, the patient's wishes would be determinative.

20 Para 1.11.

21 Skegg 73; *The Living Will* 31. See also *In re Kinney* (unreported) Supreme Court of Victoria, 23 December 1988, No M2/1989 which suggests that relatives have no right to instruct a doctor as to the treatment of a patient, though in this case a guardian had been appointed for the patient and was responsible for making those decisions.

22 A parent or a guardian can make treatment decisions on behalf of a minor except where the minor has sufficient understanding and intelligence to comprehend the implications of the decision: *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.

23 Under the existing law it is necessary to apply to the Supreme Court for the appointment of a guardian: *Supreme Court Act 1935* s 16(1)(d)(ii). When the *Guardianship and Administration Act 1990* comes into force it will be possible to make applications to the Guardianship and Administration Board for the appointment of a guardian. This Act gives the guardian the right and responsibility to make decisions concerning the daily care and control of the person: *Guardianship and Administration Act 1990* s 45.
s 259 of the Criminal Code (for details see the following footnote) in effect gives a doctor power to treat an incompetent patient in certain cases without consent. However, that context concerns treatment whereas the issue in this report in non treatment.

of a doctor using "reasonable skill and care."[24] A decision to withdraw or withhold certain treatment may be a reasonable decision. This approach was adopted in a Californian case where it was held that a doctor had no duty to continue treatment once it was proved to be ineffective or of no reasonable benefit to the patient.[25]

* If death is "imminent" then these duties terminate. It seems incongruous for the doctor to be bound to continue treatment when it would be useless to do so. As respects the duty to provide the necessaries of life, intrusive medical treatment may not be "necessary" for a person who is days or weeks away from death whatever treatment is provided.

1.17 The scope of medical liability is further complicated by the distinction between an act and an omission. This is an important distinction because under the Criminal Code, though a person is not responsible for a death caused by an omission unless a specific duty to act - such as those dealt with above - is imposed by law,[26] a person could, depending on the circumstances, be criminally liable[27] for a death caused by an act even though not liable by virtue of the duty provisions.

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24 For example, s 259 provides that a person is not criminally responsible for performing, in good faith and with reasonable care and skill, a surgical operation upon any person for his or her benefit having regard to the patient's state and to all the circumstances of the case. s 265 provides that, except in the case of necessity, a person who undertakes to administer surgical or medical treatment, or to do any other lawful act which is or may be dangerous to human life or health, must have reasonable skill and use reasonable care. See also s 275 of the Criminal Code which provides that if a person does grievous bodily harm to another as a result of which that person dies he or she is deemed to have killed that person, though the immediate cause of death was the treatment, so long as the treatment was "reasonably proper" and was applied in "good faith", and *R v Lewis* (1903) 7 CCC 261, 266 where it was said that necessaries included "medical treatment and assistance when it was reasonable and proper that medical treatment and assistance should be provided".

25 See *Barber v Superior Court of the State of California* (1983) 195 Cal Rptr 484, 491. In this case two doctors were charged with murder having agreed to the requests of the patient's family to discontinue the patient's life support equipment and intravenous tubes. It was held that a doctor had no duty to continue treatment once it proved ineffective or of no reasonable benefit to the patient.

26 That is, it is only an omission to observe or perform a duty that is to be regarded as giving rise to criminal responsibility: *Evgeniou v R* (1964) 37 ALJR 508.

27 Depending on the circumstances, the person could be liable for wilful murder, murder or manslaughter. To establish wilful murder, it is necessary to show that a person unlawfully killed another intending to cause the death: Criminal Code s 278. A person who unlawfully kills another with another intention, such as an intention to cause grievous bodily harm, is guilty of murder: s 279. A person who unlawfully kills another under such circumstances as not to constitute wilful murder or murder is guilty of manslaughter: s 280.

1.18 It is not always easy to determine whether an event is an act or an omission.[28] But even if an admitted "act" was involved it does not follow that the actor would be held criminally responsible for the death caused thereby. A court might rule that the act was not for legal purposes a cause of death because any acceleration of death would be so trifling that it would be disregarded.[29] In other cases if, for example, "the doctor terminated artificial ventilation in circumstances in which the court accepted that it was proper to do so, the doctor's conduct would not be regarded as a cause of death."[30]

1.19 It is to be emphasised that the problems discussed in this section of the Report do not arise in the case of competent patients. The duty of a doctor to continue treatment is terminated by a competent patient's withdrawal of consent. That withdrawal absolves the doctor from criminal and civil liability even though termination of the treatment involved a positive act.

5. REFORMS ELSEWHERE

1.20 The problems outlined above have been addressed in two broad ways in other jurisdictions in Australia and elsewhere.

* *Advance written directions*

  In South Australia, the Northern Territory and many United States jurisdictions, "living will" legislation has been enacted which allows people to make advance written directions to the effect that they do not wish to receive certain treatment if they become terminally ill.

* *Enduring powers of attorney*

  In Victoria and in a number of United States jurisdictions legislation allows people to execute an enduring power of attorney, that is to appoint an agent to make treatment decisions on their behalf should they become incapable of making decisions for themselves.[31]

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28 For example, is the discontinuance of a drip feed by withdrawing the tube an act, and failure to replace an emptied bag an omission? See J C Smith and B Hogan *Criminal Law* (6th ed 1988) 51.

29 Skegg 165-166.

30 Skegg 166. Skegg acknowledged that this approach can be criticised: id 167-169.31

31 The Victorian legislation provides for the completion of a refusal of treatment certificate by the agent. A doctor who in good faith complies with the certificate is not liable in any civil or criminal proceedings or proceedings for professional misconduct: see paras 3.2-3.6, 3.11 below.

1.21 In Australia, therefore, South Australia and Victoria have adopted different ways of dealing with the problem under examination. The South Australian law is contained in the *Natural Death Act 1983*.[32] The Victorian provisions are the result of the *Inquiry into Options for Dying with Dignity* conducted by the Social Development Committee of the Victorian Parliament in 1987. The *Medical Treatment Act 1988*, which established a procedure by which patients could signify their refusal of medical treatment, and an amendment to that Act in 1990 which gave patients power to execute an enduring power of attorney, resulted from the recommendations of the Inquiry.[33]

6. THE COMMISSION'S APPROACH

(a) General

1.22 The Commission considers that, although doctor's fears of prosecution are more apparent than real, a strong case can be made out for the enactment of legislation in Western Australia to clarify the rights of patients. In the absence of such legislation some doctors who wish to practise medicine with a humane concern for the terminally ill may be subjected to uncertainty and worry about the legal consequences of their acts and this may inhibit them from providing the most appropriate care. The uncertainty involved tends to produce variations in practice between hospitals and doctors as to the treatment of terminally ill patients. It can also cause doctors to fail to comply with the law because they do not know what it requires or allows them to do.

1.23 The Commission therefore recommends the enactment of legislation along the lines summarised below. Its approach closely follows that now found in the Victorian *Medical Treatment Act 1988*.[34] Some of the Commission's recommendations, like the Victorian provisions on which they are based, are capable of applying to all kinds of patients, and not just to those who are terminally ill. The recommendations are intended to enhance a patient's control over his or her medical treatment and to that extent should be capable of applying generally.

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32 Discussion Paper paras 3.9-3.13. The legislation in the Northern Territory, the *Natural Death Act 1988*, is modelled on the South Australian legislation.

33 Reforms involving enduring powers of attorney were considered in detail in the Discussion Paper: paras 3.14-3.19.

34 The Act is reproduced in Appendix II.

1.24 The Commission has kept in mind what it regards as a basic principle: that persons have a right to self determination. This includes the right to choose whether or not to be treated, or to continue to be treated, and the right to determine the course of future treatment if their mental or physical condition makes them unable to exercise their right of choice at the time.

(b) Competent patients

1.25 In the Commission's view, the existing law already gives proper recognition to the principle that a person has the right not to be treated without consent. But people may be concerned that doctors will not respect their wishes. To provide a means by which patients' decisions about medical treatment may be clearly laid down, and to ensure that they are respected, the Commission recommends that adult patients should be able to complete a refusal of treatment certificate. This would specify that the patient did not wish to receive life-supporting treatment. Doctors who act in accordance with the certificate would be immune from civil and criminal liability.[35]

(c) Incompetent patients

1.26 Persons who are terminally ill but incapable of making treatment decisions present a different problem. Some people may wish to make advance provision for this possibility. In the Commission's view, this is better done by appointing an agent to make treatment decisions when the time comes, rather than by setting out advance directions in a "living will".[36]

1.27 The Commission accordingly recommends that adults should be able to appoint an agent by an enduring power of attorney. An agent, in this sense, is a person, such as a relative or close friend, appointed by another to make decisions on his or her behalf. The power of attorney is the document by which an agent is appointed. It is called an enduring power of attorney because, unlike a normal power of attorney, it continues to have effect even though the person making the appointment becomes incompetent. The agent would be required to make decisions in the light of what the agent believed the patient would have wanted, so far as this is known. Where no agent has been appointed or the agent so appointed is unable or

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35 And from liability for breach of professional misconduct.

36 For a more detailed discussion of this issue, see paras 2.5-2.12 below.

unavailable to act those decisions should be made by a guardian appointed by a court. The agent or guardian would complete a refusal of treatment certificate on their behalf.

(d) Order of discussion

1.28 The most important of these recommendations is that dealing with the appointment of an agent or guardian to make treatment decisions on behalf of an incompetent patient. This is dealt with in Chapter 2. Refusal of treatment certificates, which may be completed by a competent patient or the agent or guardian of an incompetent patient, are dealt with in Chapter 3. Chapter 4 deals with pain control and Chapter 5 with the definition of death.

(e) Minors

1.29 The Commission makes no recommendations as regards the making of enduring powers of attorney by minors,[37] or the execution of a refusal of treatment certificate by minors or by their parents or guardians on their behalf. These issues will be dealt with by the Commission in its report on medical treatment for minors.[38] Minors present special legal difficulties because the question of who may consent to medical treatment depends on the age and maturity of the child, the nature of the treatment and other factors. The question of decision-making in respect of severely impaired or defective newly borns will also be dealt with in that project.

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37 A person ceases to be a minor on attaining the age of 18 years: *Age of Majority Act 1972* s 5(1). The making of an enduring power of attorney by a minor raises a different issue from that of an adult appointing a minor as an agent. As to the latter issue see para 2.16 below.

38 The Commission published a discussion paper on this Project, *Medical Treatment for Minors* (Project No 77), in 1988.

Chapter 2

ADVANCE PROVISION FOR TERMINAL ILLNESS

1. INTRODUCTION

2.1 The Commission received many submissions suggesting that the law needed to be clarified so that people could make provision for the treatment they wished to receive if they became terminally ill and were then incompetent, that is, unable to make those decisions for themselves. As foreshadowed in Chapter 1, the Commission has concluded that such wishes should be accommodated within an appropriate legislative framework.

2.2 In addition to providing a framework for self-determination, which for some patients would be reassuring, such a scheme could -

(1) alleviate the fear of suffering unbearable pain in terminal malignant disease;

(2) promote discussion between patients and doctors, thereby creating increased professional awareness of anxieties relating to advanced terminal illness;

(3) discourage over-intrusive medical care;

(4) assist health professionals to deal with the ethical dilemmas involved in treating the terminally ill;

(5) reduce the level of distress suffered by a patient's relatives.[1]

2.3 As indicated in Chapter 1, two different legislative approaches have been adopted in various jurisdictions elsewhere. One allows persons to stipulate directly the treatment they wish withheld or withdrawn should they become terminally ill - the so-called "living will".

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1 *The Living Will* 46-47.

The other allows people to execute an "enduring power of attorney",[2] appointing an agent to make treatment decisions on their behalf should they become unable to do so. These two approaches are considered in turn below.

2.4 In paragraph 2.1 above the Commission has referred to the concept of incompetence. This is a legal term and refers to the legal inability of a person to make certain binding decisions.[3] In the field of medical treatment a person's mental state may be such that his or her decision may have no legal effect in the sense that the doctor would not be required to act upon the patient's expressed wishes. In other words, the person lacks capacity to understand and appreciate the nature and consequences of a decision to refuse treatment. In some cases incompetence to make decisions about the refusal of treatment will be obvious, for example, where a person is unconscious. However, a person who is mentally ill or intellectually handicapped, for example, may be competent as regards some treatment decisions but incompetent as regards others. Thus a doctor should be satisfied in each case of the capacity of a patient to make that particular treatment decision.

2. LIVING WILLS

2.5 At first sight the living will approach appears to have much to commend it. It enables persons while competent to stipulate the circumstances in which they wish treatment to be withheld should they be unable to give those directions at the time. But for that very reason it has the fundamental difficulty that it proscribes a form of medical treatment without knowing the precise circumstances which would exist when the will is required to be activated. A direction to withhold life sustaining treatment, made when a person is healthy, cannot normally be expected to take into account all the factors which would usually inform a decision made at the time of the illness or injury. It is only then that a person can be expected to have a full appreciation of the consequences of a such a profound decision.

2.6 The living will concept has other difficulties. Should the triggering event be incompetence alone, or incompetence with the addition of a particular condition or disability, or incompetence with the addition of terminal illness? Incompetence alone may require the living will to be implemented in circumstances which many would regard as inappropriate,

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2 See para 1.27 above.

3 For example, in a commercial context a person because of his or her mental state may be incompetent to enter into a contract. The contract would be void, that is, of no legal effect.

for example, a moderate degree of dementia without other disability.[4] Incompetence plus specified conditions may lead to problems because of the impossibility of itemising every relevant clinical circumstance, and the uncertainty in interpreting those which are specified. Incompetence plus terminal illness does not capture all the circumstances in which many people would wish a living will to become operative. It may also cause problems of interpretation as to the meaning of "terminal illness".

2.7 There could also be problems in determining what the doctor is to do (or not do) once the triggering event has been identified. A will could contain detailed and specific instructions, but this carries the danger that some circumstance or combination of circumstances would be unprovided for. On the other hand a will expressed in general terms would almost certainly bring with it substantial interpretative problems. To overcome this, a will could be drawn so as to leave wide discretions to the doctor, but this may present the doctor with dilemmas which he or she may find ethically unacceptable, and in any case would be little different from investing the doctor with a power of attorney.[5] The benefit of a will as an advance written directive would be lost.

2.8 In general terms, therefore, the living will concept has the major objection that a will is likely to be -

(a) too specific, thereby failing to cover all circumstances;

(b) too general, thereby causing interpretative problems; or

(c) too discretionary, thereby differing little from the power of attorney approach.

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4 Many would object to a living will which became operative if the patient suffered a mild and/or fluctuating degree of dementia. If he or she developed a condition requiring antibiotics it would seem inappropriate to follow the terms of the will and not treat for that condition.

5 As to which, see paras 2.13-2.20 below.

2.9 There are also practical difficulties. One is that of bringing the will to the notice of the attending doctor, who may not be the patient's usual doctor.[6] Another concerns revocation or amendment. This of course should be possible, but the consequence of doing so may be that there may be no means of ascertaining whether a purported living will is still valid.

2.10 An Australian precedent for living will legislation can be found in South Australia. Under that State's *Natural Death Act 1983* a person of sound mind of or above the age of 18 years who desires not to be subjected to life-prolonging treatment[7] in the event of suffering from a terminal illness[8] may make a direction in a prescribed form to that effect. The direction must be witnessed by two persons. Where the doctor responsible for the patient's treatment has notice of the direction, the doctor is under a duty to act in accordance with it unless there is reasonable ground to believe that the patient has revoked or intended to revoke it or was not, at the time of giving the direction, capable of understanding its nature and consequences.[9]

2.11 The South Australian Parliament appears to have attempted to avoid some of the difficulties referred to above by confining its operation to a very narrow range of circumstances.[10] However, this is at the cost of denying the patient any flexibility as to the contents of the will. Only one standard form is prescribed; a person making a living will is unable to stipulate withdrawal of treatment in any conditions other than those laid down, nor can he or she specify the precise form or forms of treatment to be withdrawn, or the circumstances in which it was to be withdrawn. The legislation appears to do little more than

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6 A central registration system of living wills would be expensive to maintain. A person could himself or herself notify all major hospitals in the Perth metropolitan area but this also would place on the hospital the burden of maintaining the necessary records.

7 The term used in the Act is "extraordinary measures", which are 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": s 3.

8 A "terminal illness" is:
". . . any illness, injury or degeneration of mental or physical faculties -
(a) such that death would, if extraordinary measures were not undertaken, be imminent; and
(b) from which there is no reasonable prospect of a temporary or permanent recovery, even if extraordinary measures were undertaken": s 3.
"Recovery" in relation to a terminal illness, "includes a remission of symptoms or effects of the illness."

9 S 4(3).

10 Nevertheless some difficulties remain -
* The definition of "terminal illness" is such that much is left to the judgment of the doctor: in particular under (b), which introduces the criteria of "reasonableness" and "recovery".
* The definition of "extraordinary measures" does not always enable ready identification of treatment that is or is not acceptable. For example, does feeding by a tube through the nose into the stomach constitute an extraordinary measure?

reflect what is probably acceptable medical practice in any case and to that extent may only be of symbolic importance.[11]

2.12 On balance, therefore, the Commission does not recommend the introduction of legislation to provide for living wills.

3. APPOINTING AN AGENT BY AN ENDURING POWER OF ATTORNEY

(a) Introduction

2.13 The other approach - appointing an agent by an enduring power of attorney - has been adopted in a number of jurisdictions including Victoria, where the *Medical Treatment Act 1988* was amended in 1990[12] to make provision for such appointments. This approach has the advantage that the agent can step into the shoes of the patient and make decisions on the basis of the existing knowledge of a disease and its treatment, the doctor's advice, any indication given in the power of attorney of how the patient wished to be treated and any other information about the patient's wishes available to the agent. A person selected by the patient, such as a spouse or close relative or friend, is likely to be aware of and appreciate the patient's wishes. If there is disagreement over treatment among the patient's relatives or friends the doctor can rely on the fact that the agent's decision is as determinative as the patient's would have been had he or she been competent.

2.14 Accordingly, the Commission considers that the most satisfactory way of ensuring that persons are able to exercise some control over treatment decisions, should they be unable to do so when the time comes, is to enact legislation enabling them to appoint an agent by an enduring power of attorney to make those decisions on their behalf.[13] As in Victoria, the power of attorney should take effect only if the person giving the power becomes incompetent.[14]

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11 A Select Committee of the South Australian House of Assembly was set up late last year to review the position in South Australia, including "the extent to which both the health services and the present law provide adequate options for dying with dignity".

12 By the *Medical Treatment (Enduring Power of Attorney) Act 1990*.

13 That is, subject to the recommendations made below, a legislative provision along the lines of s 5A of the *Victorian Medical Treatment Act 1988* should be adopted.

14 *Medical Treatment Act 1988* (Vic) s 5A(2)(b).

(b) Who can execute a power of attorney

2.15 A person should not be able to execute an enduring power of attorney unless -

(a) he or she is an adult;

(b) he or she understands the nature and effect of the power, and that the agent is going to be able to refuse treatment on his or her behalf.[15]

The Commission has already explained its reason for limiting this legislation to adults.[16] The second condition does no more than state a requirement of the general law.

(c) Who can be an agent

2.16 There should be no limitation on whom the patient can appoint as agent. A patient will ordinarily, no doubt, appoint a friend or relation.[17] Under the general law a minor may act as an agent providing the minor has sufficient understanding to consent to the agency or do the act required[18], and there should be no prohibition on the appointment of a person under providing that this requirement is satisfied. There may be situations in which a person may wish to appoint as agent his or her spouse who is under the age of 18, or his or her child who has not yet reached the age of majority but in whom the person has confidence.[19]

(d) Formalities

2.17 Certain formalities would be required in appointing an agent, because at the time the power comes into effect the patient will not be in a position to affirm the contents of the

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15 The prescribed form for enduring power of attorney in Victoria, set out in Schedule 2 of the *Medical Treatment Act 1988* (reproduced in Appendix II), provides that the attesting witnesses each believe that the maker of the power "is of sound mind and understands the import of this document".

16 See para 1.29 above. Under the existing law it is not clear whether a minor can execute a valid power of attorney: see *Bowstead on Agency* (15th ed 1985) 30-31 and C W O'Hare *Agency, Infancy and Incapacity* (1970) 3 Tas ULR 312, 314-321.

17 When the Public Guardian is appointed under s 91 of the *Guardianship and Administration Act 1990* that person could be appointed as a person's agent. In Victoria, the Public Advocate, who has similar responsibilities to the Public Guardian, has been appointed as an agent under an enduring power of attorney in some cases. The principals are interviewed by the Public Advocate so that the Advocate understands the circumstances in which they would wish to have treatment refused on their behalf.

18 *Bowstead on Agency* (15th ed 1985) 33.

19 There should be no bar to appointing as agent a person who benefits under a will of the patient. In most cases a person leaves his or her property to a near relative and therefore persons who are likely to be appointed an agent under an enduring power of attorney may well benefit under the patient's will. The matter should be left to the patient to decide.

document. In this respect, the enduring power of attorney is very similar to a will. The formal requirements for making a will not only provide a safeguard against forgery, fraud or undue influence but also impress upon the testator the serious nature of the document. The Commission accordingly recommends that -

(1) The document should be signed by the patient.[20] However, where the patient is physically unable to sign it, another person (other than the proposed agent) should be able to sign it on the patient's behalf, so long as it is signed in the patient's presence and by his or her direction.

(2) The document should acknowledge that the patient has read and understands a simple statement as to the effect of the power.

(3) The agent should also sign the document to indicate his or her willingness to act as agent.

(4) The signing of the document by the patient and the agent should be witnessed by two persons, one of whom should be authorised to witness a statutory declaration, and neither of whom should be the agent.

(e) Revocation

2.18 To avoid any doubt, the legislation should specifically provide that the power of attorney should be revocable at the will of the patient at any time before the patient becomes incompetent.

2.19 The President's Commission discussed the question whether the patient should be entitled to revoke the power after he or she becomes incompetent.[21] It took the view that an incompetent patient should be able to revoke the power in so far as life-sustaining treatment is concerned, on the ground that "it would generally seem wrong to cease such treatment based

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20 As with a will, whether by written name, initials or mark: I J Hardingham, M A Neave and H A J Ford *Wills and Intestacy in Australia and New Zealand* (1989 2nd ed) 33.

21 President's Commission 152.

on [an attorney's] orders, when a patient, no matter how confused, asks that treatment be continued." This Commission agrees and recommends that provision be made accordingly.[22]

(f) Successive agents

2.20 Cases will arise in which an agent is appointed under an enduring power of attorney a considerable time before there is a need to make decisions about treatment. The appointed agent may then be unwilling or unavailable to act. To help overcome this problem the legislation should enable the patient to appoint successive agents in the enduring power of attorney, the appointment of the second agent being conditional upon the appointment of the first agent coming to an end because the latter is unwilling to act, dead or incapable (for example, due to mental illness) or because all reasonable efforts to find him or her have been unsuccessful.[23] The problem can of course be minimised by the patient, while competent, ensuring that the power is kept up to date.

4. APPOINTMENT OF A GUARDIAN BY A COURT

2.21 The enactment of enduring powers of attorney legislation will not provide a solution for all cases.[24] Not all patients who become incompetent will have appointed an agent; an appointed agent may be unwilling or unavailable to act;[25] and there are persons, such as the intellectually disabled, who may never have been capable of exercising the power of appointment.[26]

2.22 In such cases an interested person could apply to the Supreme Court for the appointment of a guardian.[27] Once the *Guardianship and Administration Act 1990* comes into

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22 The reason for the limitation to life-sustaining treatment is that revocation in other circumstances could disrupt a course of treatment authorised by the attorney: ibid.

23 See item 9 of the Statutory Form Durable Power of Attorney for Health Care provided in California: California Civil Code s 2500.

24 As stated in para 1.15 above, under the existing law, spouses or other relatives have no power to make decisions on the patient's behalf.

25 See para 2.20 above.

26 Persons suffering from an intellectual disability are not, by reason of that fact alone, precluded from making a decision about their own treatment. Their capacity depends upon whether they can understand and come to a decision upon what is involved.

27 The Supreme Court has power to appoint a guardian for someone who is "of unsound mind" and this power may be wide enough to include those who are not mentally ill but merely unconscious or incapable: *Supreme Court Act 1935* s 16(1)(d)(ii). It was once considered to be wide enough to extend to all persons who were incapable of managing their own affairs whether or not properly deemed of unsound mind: *Story's Equity Jurisdiction* ed by W E Grigsby (1884) 947. The existence of this jurisdiction was affirmed in Re Eve (1986) 31 DLR(4th) 1.

force the Guardianship and Administration Board to be established under that Act will have power to appoint a guardian.[28] The guardian so appointed could then make decisions as to treatment on the patient's behalf.[29]

5. BASIS FOR DECISION-MAKING BY AN AGENT OR GUARDIAN

2.23 The Commission recommends that the decision (whether by an agent or a guardian) should be made on the basis of whether or not the patient would have refused the treatment under the circumstances involved, so far as this can be established. That is, a "substituted judgment" should be made.[30] This approach is consistent with promoting patient autonomy. Evidence of the patient's wishes could be provided by any indication given in the enduring power of attorney (if there is one) or by any other statement the patient made before becoming incompetent.[31]

2.24 The substituted judgment approach will not always be appropriate. The patient may never have indicated a preference, for example because the situation was never contemplated, or because the patient has never been capable of forming a preference. The Commission recommends that in such cases the agent or guardian should make a decision on the basis of

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28 Under the Act, a person can be declared to be in need of a guardian if he or she has attained the age of 18 years, is in need of a guardian and is incapable of looking after his or her own health and safety, unable to make reasonable judgments 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: *Guardianship and Administration Act 1990* s 43(1).
Where there is no relative or friend who can be appointed as the guardian, the Public Guardian could be so appointed. This is the approach being adopted in Victoria by the Guardianship and Administration Board. The Board is encouraging the continuation of the practice of decision-making involving the patient's relatives and doctors. Appointment of a guardian, whether an individual or the Public Advocate, is seen as a fall back position if a consensus cannot be reached or if there is unease with a decision.

29 Apart from two exceptions which are not here relevant, a guardian appointed under the *Guardianship and Administration Act 1990* is expressly authorised to consent to any treatment or health care of the represented person: s 45(2).

30 A similar approach has been adopted in Victoria where s 5B(2)(b) of the *Medical Treatment Act 1988* provides that an agent or guardian may only refuse treatment on behalf of a patient 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 medical treatment is unwarranted."

This approach is also common in the USA: S M Richard *Someone Make Up My Mind: The Troubling Right to Die Issues Presented by Incompetent Patients with No Prior Expression of a Treatment Preference* (1989) 64 Notre Dame LR 394, 403. It has also been recommended by the Report of a Working Party in England: *The Living Will* 70.

31 For example, in a "living will" of the kind distributed by the West Australian Voluntary Euthanasia Society.

what would probably be conceived by a reasonable person in the patient's circumstances to be in the patient's best interests.[32]

2.25 The best interests approach allows for a consideration of all of the particular circumstances of the case which may reasonably affect the decision whether or not to refuse particular treatment for a terminally ill patient, including personal privacy and dignity. Other factors might include whether the treatment is useless; the degree of physical pain resulting from the medical condition, treatment and termination of treatment; the life expectancy and prognosis with or without treatment; the various treatment options; and the risks, side effects and benefits of each of those options. At some stage the agent or guardian might conclude that it is in the patient's best interests to discontinue intensive care and life support treatment because the efforts at treatment are ineffective, and instead opt for general nursing care to make the patient comfortable, including pain relief and hydration and nutrition.[33] All such decisions would of course be made against the background of appropriate medical and other advice.

6. REVIEW OF DECISIONS

2.26 To provide legal protection for incompetent persons it should be possible for a decision (or proposed decision) concerning treatment made by an agent or guardian to be reviewed. The existence of a review procedure would also provide a means for a doctor, hospital administrator or any person who has a special interest in the welfare and interests of the patient to obtain a declaration as to the course of action that should be followed if, for example, there is disagreement between an agent or guardian and a doctor or a relative of the patient.

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32 President's Commission 136. Similar approaches have been adopted by courts in the USA: S M Richard *Someone Make Up My Mind: The Troubling Right to Die Issues Presented by Incompetent Patients with No Prior Expression of a Treatment Preference* (1989) 64 Notre Dame LR 394, 407-413, and recommended (in the case of a person who has never been competent) in the Report of a Working Party in England: *The Living Will* 70.
The Victorian Social Development Committee at 195 of its report, *Dying with Dignity*, emphasised ". . . that decision-making structures or procedures must relate essentially to the `best interests' of the individual concerned whether neonates, child or adult. Such a principle must be the basis of decisions by proxies, and not other related concerns such as the burden on parents, family, the health care team or society." A narrower approach was, however, adopted in s 5B(2)(a) of the *Medical Treatment Act 1988* (Vic) which provides that an agent or guardian may only refuse treatment on behalf of a patient if the medical treatment would cause unreasonable distress to the patient.

33 In this context it is important to understand that many terminally ill patients are not aware of thirst or hunger and a decision to refuse to provide hydration and nutrition by aggressive means may be consistent with promoting the patient's comfort.

2.27 The Commission therefore recommends that any person who can establish to the satisfaction of the review body that he or she has a special interest in the welfare and interests of the patient should be able to apply to that body for a review of the decision on the basis that the decision was not in accordance with the wishes of the patient or, as the case may be, was not in the patient's best interests.[34] The most appropriate body to carry out such a review would be the Guardianship and Administration Board, when established, or the Supreme Court.

7. PROTECTION OF AGENT OR GUARDIAN

2.28 Agents or guardians would bear a heavy responsibility. It is important that they should not be unduly inhibited by fear of legal liability. The Commission therefore recommends that if an agent or a guardian makes a decision in good faith[35] in accordance with the prescribed criteria, the agent or guardian should not be liable civilly or criminally for that decision.[36] 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.

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34 Para 2.24 above. In Victoria s 5C(3) of the *Medical Treatment Act 1988* provides that the Guardianship and Administration Board may suspend an enduring power of attorney if it is satisfied that refusal of medical treatment is not in the best interests of the patient.

35 According to *Webster's Third New International Dictionary* "good faith" is "a state of mind indicating honesty and lawfulness of purpose: . . . belief that one's conduct is not unconscionable." *Black's Law Dictionary* (5th ed 1979) states that "good faith" is:

> ". . . an intangible and abstract quality with no technical meaning or statutory definition, and it encompasses, among other things, an honest belief, the absence of malice and the absence of design to defraud or to seek an unconscionable advantage, and an individual's personal good faith is a concept of his own mind and inner spirit and, therefore, may not conclusively be determined by his protestations alone."

36 As to protection of doctors see para 3.11 below.

Chapter 3

REFUSAL OF TREATMENT CERTIFICATE

1. INTRODUCTION

3.1 Under the existing law persons who are terminally ill, like all other patients, can make decisions concerning medical treatment, including refusing such treatment. Under recommendations made in the previous chapter, an agent appointed under an enduring power of attorney, or a guardian, will have lawful authority to make decisions on behalf of incompetent patients. However, doctors may face the difficulty of establishing that a cessation or withdrawal of treatment was in response to the request of the patient, where competent, or of the agent or guardian of an incompetent patient.

2. REFUSAL OF TREATMENT CERTIFICATE

3.2 To meet this difficulty, the Victorian *Medical Treatment Act 1988* provides that proof of refusal of treatment may be obtained by the completion of a "refusal of treatment certificate" by the patient, or by the agent or guardian, as the case may be.[1] The Commission considers that similar legislation should be enacted in Western Australia.

3.3 It must be emphasised that the refusal of treatment certificate is intended merely as one possible means of evidencing the fact that the patient, or the agent or guardian, has withdrawn consent. It is not intended to be the only way in which withdrawal of consent could be achieved.[2]

3.4 The Commission therefore recommends that, in the case of a competent patient, if a doctor and another person are satisfied that the patient -

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1 ss 5 and 5B. There is a similar provision in Delaware in the United States of America: *Society for the Right to Die Handbook of Living Will Laws 1981-1984*, 43-44.

2 The *Medical Treatment Act 1988* (Vic) s 8 provides that in the absence of evidence to the contrary the certificate constitutes proof that the patient has refused medical treatment, but that this does not affect other methods of proving a decision to refuse medical treatment.

* has expressed or indicated a decision to refuse medical treatment generally or of a particular kind for a current condition;[3]

* took the decision voluntarily and without inducement or compulsion; and

* was of sound mind,

the doctor and the other person should be able to witness a refusal of treatment certificate[4] in a prescribed form.[5] It should be possible for the patient to express or indicate a decision in writing, orally or in any other way in which he or she can communicate.[6]

3.5 In the case of an incompetent patient, where the patient's agent or guardian has decided to withdraw treatment on the patient's behalf, it should again be possible for a doctor and another person to witness a refusal of treatment certificate[7] in a prescribed form.[8]

3.6 In the case of a competent patient, it should be possible to make a certificate only where "the patient has been informed about the nature of his or her condition to an extent which is reasonably sufficient to enable the patient to make a decision about whether or not to refuse medical treatment generally or of a particular kind (as the case requires) for that condition and that the patient has appeared to understand that information".[9] In the case of an incompetent patient, there should be a similar requirement that the agent or guardian had been given the necessary information and understood it.[10]

3. CURRENT CONDITION

3.7 In Victoria, the refusal of treatment certificate may only be made in respect of a "current condition". The Commission agrees with this limitation. The certificate does not

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3 On "current condition", see para 3.7 below. Details of the current condition at the time the certificate is issued should be recorded on the certificate.

4 Cf *Medical Treatment Act 1988* (Vic) s 5(1).

5 Schedule 1 of the *Medical Treatment Act 1988* (Vic) (reproduced in Appendix II) sets out the form used in Victoria.

6 Cf id s 5(3).

7 Cf id s 5B.

8 Schedule 3 of the *Medical Treatment Act 1988* (Vic) (reproduced in Appendix II) sets out the form used in Victoria.

9 Cf *Medical Treatment Act 1988* (Vic) s 5(1)(c).

10 Cf id s 5B(1).

provide a means by which a patient, or the patient's agent or guardian, can refuse treatment for some other condition that may develop at a future time,[11] that is, a living will.[12]

4. PALLIATIVE CARE

3.8 The Victorian legislation provides that the refusal of treatment certificate may be given in respect of "medical treatment" which is defined to exclude "palliative care". "Palliative care" is defined[13] to include the provision of reasonable medical procedures for the relief of pain, suffering and discomfort or the reasonable provision of food and water.[14] The purpose of these provisions is to ensure that a refusal of treatment certificate would not prevent a doctor from providing treatment designed to reduce pain, suffering and discomfort,[15] from fear that by doing so he or she committed an offence.[16]

3.9 However a patient who is able to make decisions about his or her treatment could refuse palliative care under the common law right not to be treated without consent.[17] It may not be unreasonable to refuse such care, for certain types of palliative care could be intrusive and the patient may not wish to endure them.[18] In the Commission's view, the provision of palliative care should accordingly 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.

5. ENFORCING THE DUTY

3.10 The question arises whether, as in Victoria, there should be an offence of "medical trespass" which would be committed by a doctor who, knowing that a refusal of treatment certificate applies to a person, undertakes, or continues to undertake, any medical treatment to

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11 See id s 7(3).

12 See paras 2.5-2.12 above.

13 *Medical Treatment Act 1988*(Vic) s 3.

14 The definition has been criticised by K S M Clark *The Medical Treatment Act 1988: Safeguarding Patient Rights or Risking Patient Welfare?* (1989) 63 Law Institute Journal 473, 477: "Various doctors have commented on the difficulty of ascertaining if any particular form of treatment is in fact curative rather than palliative, and whether in fact treatment that 'cures' a condition may ultimately be `palliative' as well."

15 Victorian *Parliamentary Debates* (Legislative Council) 23 March 1988 p 334.

16 That is, the offence of medical trespass: see para 3.10 below.

17 Para 1.10 above. D Lanham *The Right to Choose to Die with Dignity* (1990) 14 Crim LJ 401, 429-430.

18 In some cases placement of a nasogastric tube to provide food and water may be quite painful. Intravenous methods are also intrusive and may lead to complications such as thrombosis, haemorrhage and infection.

which the certificate applies.[19] The Commission considers that a doctor would be committing the offence of assault and also the tort of trespass.[20] However, the Commission considers that, as in Victoria, there should be an offence which enforces the duty laid down in the legislation. It therefore recommends the creation of an offence of medical trespass. The offence should be a simple offence with a penalty of a fine.[21]

6. PROTECTION OF DOCTORS

3.11 It is important that doctors who, in good faith, refrain from treating patients in reliance on a refusal of treatment certificate should be able to do so without any fear of legal liability. Under the Victorian legislation the refusal of treatment certificate protects doctors who act in accordance with it. The legislation provides that a doctor who does not give or continue any treatment specified in a refusal of treatment certificate completed by a patient, agent or guardian should not be liable in any civil or criminal proceedings or proceedings for professional misconduct for failing to give or continue that treatment if he or she acts in good faith[22] and in reliance on the certificate.[23] A similar provision should be enacted in Western Australia. This would remove any doubt as to the doctor's criminal responsibility under the existing law.[24]

7. CANCELLATION OF CERTIFICATE

3.12 In the paragraphs above the Commission has recommended that the law make provision for a certificate evidencing a refusal of treatment. Clearly, there should be legislative provision for a case where the patient, or the agent or guardian, wishes to cancel a certificate. Accordingly the Commission recommends that, following Victoria,[25] legislation should provide for such cancellation to be indicated in the same manner as the execution of the original certificate.[26]

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19 *Medical Treatment Act 1988* (Vic) s 6.

20 See paras 1.10-1.12 above.

21 The maximum penalty under s 6 of the *Medical Treatment Act 1988* (Vic) is 5 penalty units (currently $500 under s 96 of the *Penalties and Sentences Act 1985*).

22 See footnote no. 35 in Ch 2.

23 *Medical Treatment Act 1988* (Vic) s 9.

24 See paras 1.11-1.18 above.

25 *Medical Treatment Act 1988* (Vic) s 7.

26 That is, by the person who gave the certificate clearly expressing or indicating a decision to cancel the certificate in writing, orally or in any other way in which the person can communicate.

Chapter 4

PAIN CONTROL

1. THE EXISTING POSITION

4.1 One area of concern with the treatment of terminally ill patients is that pain control care[1] given to a patient to relieve pain and suffering and to make the patient as comfortable as possible may involve prescribing doses of pain relieving drugs at levels which accelerate death. The Commission has been informed that the problem is not as great as it once[2] was due to increasing knowledge of the use of various pain control drugs but that nevertheless difficulties remain.

4.2 It is uncertain whether those who take an action that accelerates death in this way commit a criminal offence. The Criminal Code[3] provides that, where a person is labouring under some disorder or disease, any other person who does any act or makes any omission which hastens the death of that person is deemed to have killed that person.[4] If a doctor provides a patient with doses of a drug such as morphine, and those doses hasten the patient's death,[5] the doctor could be deemed to have killed the patient. But to ascribe criminal responsibility to the doctor for the death it would also be necessary to establish that the killing was "unlawful". However, it is far from clear that courts would so regard it.[6]

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1 In the Discussion Paper the Commission used the term "palliative care". A number of commentators criticised the use of this term because it involves more than pain control which was the real concern of the legal issues raised in the Paper. The Commission accepts this criticism and therefore uses the term pain control to refer to the aspect of palliative care considered in this Chapter.

2 At least amongst doctors in specialist facilities in the state, such as the Cottage Hospice. Modern medicine has drugs and methods (including cutting part of the spinal cord) that are capable of eliminating or reducing suffering to an acceptable level in the majority of cases.

3 s 273.

4 Also s 270 of the Criminal Code provides that any person who causes the death of another, directly or indirectly, by any means whatever, is deemed to have killed that other person.

5 One matter that makes prosecution difficult is the need to establish that the drugs used caused the patient's death. There may be some other cause such as the patient's illness or other drugs used for pain relief. See the case of Dr Lodwig who was charged with murder after administering potassium chloride and lignocaine to a patient who suffered terrible pain from a tumour that could not be controlled by injections of heroin. A verdict of not guilty was entered when the prosecution offered no evidence against Dr Lodwig because of information that indicated that the patient's death could have been caused by the heroin or his tumour: D Brahams *The Reluctant Survivor* (1990) 140 NLJ 586.

6 Para 1.18 above.

2. DISCUSSION

4.3 Uncertainty about the scope of the existing law has had the effect of making some doctors reluctant to manage pain control appropriately in dying patients. The then Director of Medical Services with the Hospice Care Service[7] said that he had "made frequent observations of totally inadequate doses of analgesics being given for pain control".[8]

4.4 Treatment to reduce or eliminate pain, even if it may shorten a patient's life expectancy, is obviously humane for terminally ill patients. It is also sensible and appropriate, particularly when further therapeutic treatment would serve no purpose. The inquiry by the Victorian Social Development Committee into options for dying with dignity found that there was common ground among the major religious and philosophical traditions of the community that it was morally acceptable to administer pain-control medication with the intention of relieving pain and suffering even though the medication may shorten life.[9] This finding was confirmed in this State by comments received by the Commission on the Discussion Paper.

3. RECOMMENDATIONS

4.5 As the existing law is capable of leading to inhumane treatment of terminally ill patients, the Commission considers that it ought to be amended. It recommends that, subject to the conditions in the following paragraph, doctors 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.[10]

4.6 A decision to administer drugs or other treatment for the purpose of controlling or eliminating pain and suffering may of course require the drawing of a fine distinction involving as it does a distinction between the goals doctors seek to achieve or the means they use, on the one hand, and the unintended but foreseeable consequences of their actions on the other. Nevertheless, doctors should not be held to be civilly or criminally liable if their real

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7 Dr Reid.

8 He added that in other cases general practitioners had refused to write prescriptions for morphine and requested Hospice doctors to do this instead, apparently to avoid the risk of "complications" being involved with narcotics.

9 *Dying with Dignity* 89 and 93-96.

10 Similar approaches have been proposed by Law Reform Commission of Canada: CLRC 23 and the Australian College of Paediatrics Report of the Working Party on *The Management of Children with Major Handicaps* (1983).

purpose in administering the drug or treatment to a patient is to eliminate or to relieve the patient's pain or suffering even though it is known to be likely to shorten the life expectancy of the patient. Such a decision involves two important elements. First, the doctor must act with the consent of the patient or the patient's agent or guardian if the patient is not competent. Secondly, the doctor should act in a professionally skilful manner: he or she should act in good faith with reasonable care and skill and the administration of the drug or treatment should be reasonable having regard to the patient's state at the time and to all the circumstances of the case.

Chapter 5

THE DEFINITION OF DEATH

1. INTRODUCTION

5.1 The Commission considered the definition of death in the context of medical treatment for the dying because if a patient is already "dead", there is no need to make decisions about medical care: a doctor cannot be held to be responsible either in civil or criminal law for withdrawing or withholding treatment if life is already extinct. A definition of death is also important in other contexts. Legally, the time of death is relevant to property rights (a dead person cannot own or succeed to property), the dissolution of marriage,[1] insurance,[2] taxation, tortious and contractual claims[3] and the taking of organs for transplantation. This chapter discusses the existing law relating to the definition of death and makes a recommendation for a definition of death.

2. THE EXISTING POSITION

5.2 There is no generally applicable definition of death in Western Australia, though the *Human Tissue and Transplant Act 1982* recognises that death occurs when there is cessation of brain function, including the brain stem. Section 24(2) of this Act provides that where:

> ". . . the respiration and the circulation of the blood of a person are being maintained by artificial means, tissue shall not be removed from the body of the person . . . unless 2 medical practitioners . . . have declared that irreversible cessation of all function of the brain of the person has occurred."

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1 See the case of *Joe v Joe* (1985) 3 NZFLR 675 referred to by P R H Webb Brain Death and Dissolution of Marriage [1986] NZLJ 78 in which it was held that a women in an irreversible coma was not dead and that her husband was not entitled to remarry.

2 In one case, for example, the time of death was important because a payment to the beneficiary under a life insurance policy was predicated on the assured person dying within 90 days of the accident that caused the death: M J Rotnem *Redefining the Moment of Death: Implications on Sustaining Life* 47 Sask LR 287, 290.

3 For example, a defendant in a claim for damages for personal injuries could argue that a plaintiff who had sustained irreversible cessation of brain function was no longer a living person, and hence not entitled to damages on the basis that he or she was still alive.

In Queensland, where there also is no generally applicable definition of death,[4] there is some suggestion in *R v Kinash*[5] that since the medical profession accepts that death occurs when there is permanent functional death of the brain stem no court will question the fact.

5.3 As pointed out in the Discussion Paper,[6] the absence of a generally applicable statutory definition of death has led to difficulties in other jurisdictions, ranging from civil actions for wrongful death to charges of murder following the removal of a respirator from a patient believed to be brain dead.[7]

3. DISCUSSION

5.4 Unless death occurs instantaneously as a result of some traumatic event, it usually involves a process in which various organs fail and eventually cease to function, successively and at different times. Establishing when that process is complete and that the condition of death is irreversible is complicated by the fact that it is possible for the functions of various body organs to be maintained by machines even though the whole of the brain including the brain stem has permanently ceased to function.[8] Death was once thought to have occurred where there was permanent cessation of respiration and circulation of the blood. These criteria are no longer appropriate because respiration and circulation of the blood can be mechanically maintained despite the loss of brain functions. As the case and statute law referred to in paragraph 5.2 above show, it is presently recognised that death occurs, particularly where circulation and respiration are being artificially maintained, when there is cessation of brain function, including the brain stem.

5.5 Responses to the Discussion Paper suggest that there is widespread community support for a statutory definition of death. This reflects the view that the concept of death,

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4 s 45 of the *Transplantation and Anatomy Act 1979* (Qld) applies in similar circumstances to the *Human Tissue and Transplant Act 1982*.

5 [1982] Qd R 648. For a similar view see *R v Malcherek* [1981] 1 WLR 690, 694.

6 Para 4.3.

7 See R G Smith *Refining the Definition of Death for Australian Legislation* (1983-1984) 14 MULR 199, 213.

8 Functionally, the brain stem has two specific levels: the cerebrum (also known as the cortex) and the brain stem. The cerebrum directs consciousness, awareness, memory, emotion and anticipation. The brain stem contains two vital centres of particular importance: the respiratory centre that regulates the rate and depth of breathing and the cardiac centre that regulates the heart rate. As breathing is dependant on the brain stem there can never again be spontaneous respiration if the stem is dead. However, heart action is not dependent on the brain because it has its own intrinsic rhythm. If respiration is maintained artificially, though the brain stem is dead, it is possible for the heart to continue to beat.

and the determination of it, is a legally[9] and morally significant issue which should be clarified if at all possible. Legislation would provide a norm, within which the medical profession could continue to develop standards and tests for the determination of death, and thus ensure uniformity of practice and provide a basis for avoiding the sort of legal and social problems which have arisen elsewhere.

5.6 In South Australia, a generally applicable definition of death is provided by section 2 of the *Death (Definition) Act 1983*,[10] which provides:

> "For the purposes of the law of this State, a person has died when there has occurred-
>
> (a) irreversible cessation of all function of the brain of the person; or
>
> (b) irreversible cessation of circulation of blood in the body of the person."[11]

5.7 The reference to circulation of blood in the South Australian legislation acknowledges the traditional approach to the definition of death and has been criticised because irreversible cessation of circulation of blood in the body of the person is merely a test which provides one means of determining whether death has occurred.[12] These time-honoured criteria are indicative of death only when they persist long enough for the brain to die. According to this view, death should be defined in terms of cessation of whole brain function, leaving the medical profession to establish the criteria, including prolonged absence of spontaneous cardiopulmonary function,[13] on which the diagnosis of irreversible cessation of brain function should be based.

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9 As indicated in para 5.1 above, a definition of death is important in various legal areas.

10 Almost identical generally applicable definitions have been provided in Victoria (*Human Tissue Act 1982* s 41), Tasmania (*Human Tissue Act 1985* s 27A), New South Wales (*Human Tissue Act 1983* s 33), the Australian Capital Territory (*Transplantation and Anatomy Ordinance 1978* s 45) and the Northern Territory (*Human Tissue Transplant Act 1979* s 23). A similar definition has been provided in Queensland except that it applies only for the purposes of the *Transplantation and Anatomy Act 1979* (s 45).

11 In this State, a similar definition of death was recommended in the report *The Criminal Code: A General Review* (1983) at 169-170 and 562.

12 J L Bernat, C M Culver & B Gert *Defining Death in Theory and Practice The Hastings Centre Report* (1982) 5, 8. See also the discussion of the concept of brain stem death by C Pallis *Brain Stem Death - The Evolution of a Concept* (1987) 55 Medico-Legal Journal 84.

13 Cardiopulmonary tests may be adequate in the majority of cases but brain-based tests will be required in the other cases.

5.8 Professor Singer and Dr Kuhse suggested in a submission to the Commission that loss of personhood should be based on "total and irreversible loss of consciousness". This would occur where there had been irreversible cessation of neocortical functions of a person, that is death of that part of the brain which controls the higher brain functions such as thought, rather than cessation of all brain functions. Persons with this condition may have a normally functioning brain stem despite severe damage to, or complete loss of, their neocortex. They may be permanently comatose but be capable of maintaining spontaneous respiration and heartbeat.

5.9 The philosophical basis for a definition based on consciousness[14] is not likely to receive wide community acceptance at present and "consciousness" does not appear to be susceptible to medical diagnosis.[15] Many people would not be prepared to accept as dead a person whose cortex is irreversibly destroyed, but who still has spontaneous cardiac and respiratory functions.

4. RECOMMENDATION

5.10 The Commission recommends that death should be defined in the following manner:[16]

For the purposes of the law of Western Australia, a person has died when there has occurred irreversible cessation of all function of the brain of the person, including the brain stem.

Comments on the Discussion Paper suggest that there is widespread acceptance in our community that death of the brain is a surer indication of biological finality than absence of spontaneous cardiopulmonary function.[17]

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14 See Skegg 210-223.

15 Skegg says (at 222) that there is less agreement about the identification of this state than there now is about the identification of brain death.

16 A similar definition has been recommended by the Law Reform Commission of Manitoba (*A Statutory Definition of Death* (1974) 24), the Law Reform Commission of Canada *(Criteria for the Determination of Death* (Report No 15, 1981) 24-25) and the Law Reform Commission of Saskatchewan (*Proposals for a Definition of Death Act* (1980) 15).

17 Although no other Australian jurisdiction has adopted a definition based solely on irreversible cessation of all function of the brain such a definition had, in 1981, been adopted in a number of States in the United States of America: California, Connecticut, Georgia, Illinois, Montana, Nevada, North Carolina, Oklahoma, Tennessee, West Virginia and Wyoming (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research *Defining Death* (1981) 120-134). Since then California, Georgia, Montana and Tennessee have adopted the *Uniform Determination of Death Act* which contains a definition similar to that in South Australia: Society for the Right to Die *Handbook of Living Will Laws* 1981-1984 30.

5.11 The Commission stresses that while its proposed definition should be provided by statute, it would still be the responsibility of the medical profession to determine the criteria, tests and procedures to be used for determining whether death had occurred in accordance with the definition.[18]

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[18] For such clinical criteria see T E Oh *Intensive Care Manual* (2nd ed 1985) 193-194. A discussion of the process of development of medical criteria enabling a positive diagnosis of brain death to be made is contained in R Scott *The Body as Property* (1981) 158-162 and Skegg 190-195. For a discussion of the clinical criteria for the determination of death see Dr E Byrne *The Medical Determination of Death Proceedings of the 1984* Conference on Bioethics, St Vincent's Bioethics Centre.
In some cases special care is required. There is, for example, a special difficulty in establishing the viability or death of newly born infants. The Commission has been told that in some such cases it may not be possible to assess the infant's brain function at all even if it has been born "anencephalic". Such an infant may lack a substantial portion of the skull and most of the brain tissue normally found in infants yet have the appearance of life - spontaneous respiration and cardiac function, for example, and a partially functioning brain stem, but is likely to have no other brain function at all. When any infant has just been born no assessment could have been made of the functioning of any of their bodily organs and, we were told, it is sometimes impossible to assess brain activity or the function of any organ for some period of time.

Chapter 6

SUMMARY OF RECOMMENDATIONS

INTRODUCTION

6.1 The recommendations in chapters 2, 3 and 4 are made in relation to persons suffering conditions which are terminal or recovery from which is unlikely. The recommendations, however, like the Victorian provisions on which they are based, are capable of applying to all kinds of patients, and not just those who are terminally ill.

ADVANCE PROVISION FOR TERMINAL ILLNESS

Appointing an agent by an enduring power of attorney

1. Persons should be able to appoint an agent by means of an enduring power of attorney to make decisions relating to their medical treatment. The power of attorney should take effect only if the person giving the power becomes incompetent.

Paragraphs 1.27, 2.13-2.14

Appointment of a guardian by a court

2. Where no agent has been appointed by an enduring power of attorney, the agent so appointed 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.

Paragraphs 2.21-2.22

Basis for decision-making by an agent or guardian

3. 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 judgment" should be made.

Paragraph 2.23

4. Where the substituted judgment 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.

Paragraphs 2.24-2.25

Review of decisions

5. Any person who can establish to the satisfaction of a duly appointed review body that he or she has a special interest in the welfare and interests of a patient should be able to apply to that body for a review of a decision made by an agent or guardian on the basis that the decision or proposed decision was not in accordance with the wishes of the patient or, as the case may be, was not in the patient's best interests.

Paragraph 2.27

Protection of agent or guardian

6. 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.

Paragraph 2.28

ANCILLARY MATTERS RELATING TO ENDURING POWERS OF ATTORNEY

Who can execute an enduring power of attorney

7. A person should not be able to execute an enduring power of attorney unless he or she is an adult, and understands the nature and effect of the power and that the agent is going to be able to refuse treatment on his or her behalf.

Paragraph 2.15

Who can be an agent

8. There should be no limitation on whom the patient can appoint as agent.

Paragraph 2.16

Formalities of execution of an enduring power of attorney

9. (1) The document should be signed (whether by written name, initials or mark) by the patient. However, where the patient is physically unable to sign it, another person (other than the proposed agent) should be able to sign it on the patient's behalf, so long as it is signed in the patient's presence and by his or her direction.

(2) The document should acknowledge that the patient has read and understands a simple statement as to the effect of the power.

(3) The agent should also sign the document to indicate his or her willingness to act as agent.

(4) The signing of the document by the patient and the agent should be witnessed by two persons, one of whom should be authorised to witness a statutory declaration, and neither of whom should be the agent.

Paragraph 2.17

Revocation of an enduring power of attorney

10. The power of attorney should be revocable at the will of the patient, before or after he or she becomes incompetent.

Paragraphs 2.18-2.19

Successive agents

11. The maker of an enduring power of attorney should be able to appoint successive agents in the power, the appointment of the second agent being conditional upon the

appointment of the first agent coming to an end because the latter is unwilling to act, dead or incapable (for example, due to mental illness) or because all reasonable efforts to find him or her have been unsuccessful.

Paragraph 2.20

REFUSAL OF TREATMENT CERTIFICATE

General

12. 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.

Paragraphs 1.25, 1.27, 3.4-3.6

13. The refusal of treatment certificate should be confined to a current condition.

Paragraph 3.7

Palliative care

14. 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.

Paragraph 3.9

Enforcing the duty

15. To enforce the duty laid down in the legislation a specific offence of medical trespass should be created. It should be a simple offence with a penalty of a fine.

Paragraph 3.10

Protection of doctors

16. A doctor who, in good faith and in reliance on the 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.

Paragraph 3.11

Cancellation of certificate

17. The legislation should provide for the cancellation of the certificate to be indicated in the same manner as the execution of the original certificate.

Paragraph 3.12

PAIN CONTROL

18. Doctors 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, if the patient is not competent, is obtained and the administration of the drug or treatment is reasonable in all the circumstances.

Paragraph 4.5

THE DEFINITION OF DEATH

19. The following definition of death should be provided:

For the purposes of the law of Western Australia, a person has died when there has occurred irreversible cessation of all function of the brain of the person, including the brain stem.

Paragraph 5.10

J A THOMSON, *Chairman*

R L LE MIERE

C W OGILVIE

12 FEBRUARY 1991

Appendix I

LIST OF THOSE WHO COMMENTED ON THE DISCUSSION PAPER[1]

1. Armstrong Dr B K (then Commissioner of Health)
2. Australian Association of Social Workers
3. Australian Association of Surgeons
4. Australian Medical Association (Western Australian Branch)
5. Baptist Churches of Western Australia
6. Baskford Mr and Mrs S
7. Beumer Dr G
8. Blampey D
9. Blundell E
10. Bromilow E
11. Casson M
12. Catholic Doctors' Association
13. Colson P
14. Cope M
15. Cottage Hospice, The
16. Country Women's Association of Western Australia (Inc)
17. Curtin School of Nursing
18. Cypher J P
19. Davidson N
20. Davis C
21. de Klerk G
22. Delfs B
23. Department of General Practice (University of Western Australia)
24. Diocesan Bioethics Committee of the Archdiocese of Perth (Catholic)
25. Doye E D
26. Fitzpatrick B J
27. Golightly W
28. L J Goody Bioethics Centre

[1] The name of a commentator who requested anonymity has not been included in this list.

29. Heenan D C, Chief Judge of the District Court of Western Australia
30. Hodge A J
31. Holmes Dr C R
32. Hospice Care Service
33. Hugall C B
34. Humanist Society of WA (Inc)
35. Hussey R
36. Jackson Dr J M
37. Johnson E
38. Keenan R
39. Kilpatrick B M & N F
40. King Edward Memorial Hospital for Women (Nursing Advisory Committee)
41. Koser M A
42. Lensell J
43. Mentlein R
44. Nolan A
45. Nursing Homes and Hostels Committee, Catholic Health Care Association
46. Perrins I M
47. Phillips M
48. Princess Margaret Hospital for Children
49. Private Hospitals Committee, Catholic Health Care Association
50. Purcell Dr D M
51. Reed J H
52. Right to Life Association (Western Australia)
53. Riseley J & A
54. Roberts M
55. Royal Australian Nursing Federation (Western Australian Branch)
56. Salvation Army, The
57. Sclater R
58. Selk G
59. Singer P and Kuhse H, Centre for Human Bioethics, Monash University
60. Sir Charles Gairdner Hospital
61. Sivewright C W, Wallis A G & Bryden D ("The Brethren")
62. Smith E P

63. Social Responsibilities Commission (Anglican Diocese of Perth)
64. Social Welfare Section (Health Department)
65. Stallard W
66. Thompson D
67. Thompson P L M
68. Uniting Church in Australia, Sub-Committee of WA Synod
69. West Australian Voluntary Euthanasia Society (Inc)
70. Williams Dr P
71. Yates A

Appendix II

VICTORIAN MEDICAL TREATMENT ACT 1988

No 41 of 1988

MEDICAL TREATMENT ACT 1988

[Assented to 24 May 1988]

Preamble.

The Parliament recognises that it is desirable -

(a) to give protection to the patient's right to refuse unwanted medical treatment;

(b) to give protection to medical practitioners who act in good faith in accordance with a patient's express wishes;

(c) to recognise the difficult circumstances that face medical practitioners in advising patients and providing guidance in relation to treatment options;

(d) to state clearly the way in which a patient can signify his or her wishes in regard to medical care;

(e) to encourage community and professional understanding of the changing focus of treatment from cure to pain relief for terminally-ill patients;

(f) to ensure that dying patients receive maximum relief from pain and suffering.

The Parliament of Victoria therefore enacts as follows:

PART 1 - PRELIMINARY

Purpose.

1. The purposes of this Act are -

(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.

Commencement.

2. This Act comes into operation on a day to be proclaimed.

Definitions.

3. In this Act -

"Medical practitioner" means a legally qualified medical practitioner.

"Medical treatment" means the carrying out of -

(a) an operation; or

(b) the administration of a drug or other like substance; or

(c) any other medical procedure -

but does not include palliative care.

"Palliative care" includes -

(a) the provision of reasonable medical procedures for the relief of pain, suffering and discomfort; or

(b) the reasonable provision of food and water.

"Refusal of treatment certificate" means a certificate in the form of Schedule 1 or 3 and, if that certificate is modified, includes that certificate as modified and in force for the time being.

Other legal rights not affected.

4. (1) This Act does not affect any right of a person under any other law to refuse medical treatment.

(2) This Act does not apply to palliative care and does not affect any right, power or duty which a medical practitioner or any other person has in relation to palliative care.

(3) This Act does not -

(a) affect the operation of section 6B (2) or 463B of the *Crimes Act 1958*; or

(b) limit the operation of any other law.

(4) A refusal of medical treatment under this Act does not limit any duty of a medical practitioner or other person -

(a) to advise and inform the patient or the patient's agent or guardian; or

(b) to provide medical treatment, other than medical treatment that has been refused.

PART 2 - REFUSAL OF TREATMENT

Refusal of treatment certificate.

5. (1) If a medical practitioner and another person are each satisfied -

(a) that a patient has clearly expressed or indicated a decision -

(i) to refuse medical treatment generally; or

(ii) to refuse medical treatment of a particular kind-

for a current condition; and

(b) that the patient's decision is made voluntarily and without inducement or compulsion; and

(c) that the patient has been informed about the nature of his or her condition to an extent which is reasonably sufficient to enable the patient to make a decision about whether or not to refuse medical treatment generally or of a particular kind (as the case requires) for that condition and that the patient has appeared to understand that information; and

(d) that the patient is of sound mind and has attained the age of 18 years-

the medical practitioner and the other person may together witness a refusal of treatment certificate.

(2) A refusal of treatment certificate must be in the form of Schedule 1.

(3) For the purposes of sub-section (1) (a), the patient may clearly express or indicate a decision in writing, orally or in any other way in which the person can communicate.

Agents and guardians.

5A. (1) A decision about medical treatment of a person may be made in accordance with this Act -

(a) if the person has appointed an agent in accordance with this section, by that agent; or

(b) if the person is a represented person and an appropriate order has been made under the *Guardianship and Administration Board Act 1986* providing for decisions about medical treatment, the person's guardian.

(2) An appointment of an agent -

(a) shall be by way of an enduring power of attorney (medical treatment) in the form of Schedule 2 and must be witnessed by two persons, one of whom shall be a person authorised by law to take and receive statutory declarations and neither of whom shall be the agent to be appointed; and

(b) takes effect if and only if the person giving the power becomes incompetent.

(3) If a person gives an enduring power of attorney (medical treatment), any earlier power of attorney (medical treatment) given by the person is revoked.

(4) Despite any rule of law to the contrary, an enduring power of attorney (medical treatment) is not revoked -

(a) by the subsequent incapacity of the donor of the power; or

(b) upon the donor of the power becoming -

(i) a protected person within the meaning of the *Public Trustee Act 1958*; or

(ii) a represented person within the meaning of the *Guardianship and Administration Board Act 1986*-

but is revoked in any other way in which a general power of attorney is revoked.

Refusal of treatment certificate by agent or guardian.

5B. (1) If a medical practitioner and another person are each satisfied -

(a) that the patient's agent or guardian has been informed about the nature of the patient's current condition to an extent that would be reasonably sufficient to enable the patient, if he or she were competent, to make a decision about whether or not to refuse medical treatment generally or of a particular kind for that condition; and

(b) that the agent or guardian understands that information -

the agent or guardian, on behalf of the patient -

(c) may refuse medical treatment generally; or

(d) may refuse medical treatment of a particular kind-

for that condition.

(2) An agent or guardian may only refuse medical treatment on behalf of a patient if -

(a) the medical treatment would cause unreasonable distress to the patient; or

(b) 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 medical treatment is unwarranted.

(3) Where a refusal is made by an agent or a guardian, a refusal of treatment certificate must be completed in the form of Schedule 3.

Guardianship and Administration Board may suspend or revoke authority.

5C. (1) The Guardianship and Administration Board may suspend or revoke an enduring power of attorney (medical treatment) on an application under this section.

(2) An application may be made by -

(a) the Public Advocate; or

(b) a person who, in the opinion of the Board, has a special interest in the affairs of the donor of the power; or

(c) the agent appointed under the power.

(3) If the Board is satisfied that refusal of medical treatment, either generally or of a particular kind, at a particular time or in particular circumstances is not in the best interests of the donor, the Board may suspend the power for a specified period.

(4) If the Board is satisfied that it is not in the best interests of the donor of a power for the power to continue, or for the power to continue to be exercisable by the agent, the Board may revoke the power.

(5) Where -

(a) the donor of a power is a patient in a public hospital, denominational hospital, private hospital or nursing home; and

(b) the Board revokes or suspends the power -

the Board must give written notice of the revocation or suspension to the chief executive officer (by whatever name called) of the hospital or home and the chief executive officer must ensure that a copy of the notice is placed with the patient's record kept by the hospital or home.

Revocation or suspension of refusal of treatment certificate.

5D. (1) If -

(a) an enduring power of attorney (medical treatment) is revoked; or

(b) the order appointing a guardian under the *Guardianship and Administration Board Act* 1986 is revoked -

any refusal of treatment certificate completed by the agent or guardian is also revoked.

(2) If the Guardianship and Administration Board suspends an enduring power of attorney (medical treatment), any refusal of treatment certificate completed by the agent before the suspension ceases to have effect during the period of the suspension.

Copies of refusal of treatment certificate.

5E. (1) The Board of a public hospital or denominational hospital and the proprietor of a private hospital or nursing home must take reasonable steps to ensure that a copy of any refusal of treatment certificate applying to a person who is a patient in the hospital or home and of any notification of the cancellation of such a certificate -

(a) is placed with the patient's record kept by the hospital or home; and

(b) is given to the chief executive officer (by whatever name called) of the hospital or home;

(c) is given to the Guardianship and Administration Board within 7 days after the certificate is completed.

(2) A medical practitioner who signs the verification in a refusal of treatment certificate for a person who is not a patient in a public hospital, denominational hospital, private hospital or nursing home must take reasonable steps to ensure that a copy of the refusal of treatment certificate is given to the Guardianship and Administration Board within 7 days after it is made.

Penalty for obtaining certificate by fraud etc.

5F. (1) A person who -

(a) is a beneficiary under the will of another person; or

(b) has an interest under any instrument under which another person is the donor, settlor or grantor; or

(c) would be entitled to an interest in the estate of another person on the death intestate of that person -

and who, by any deception, fraud, mis-statement or undue influence, procures or obtains, whether directly or indirectly, the execution by that other person of a certificate under this Act, forfeits any interest under the will, instrument or intestacy, as the case requires.

(2) This section is in addition to any other penalty in respect of the deception, fraud, mis-statement or undue influence under any other Act or law.

Offence of medical trespass.

6. A medical practitioner must not, knowing that a refusal of treatment certificate applies to a person, undertake or continue to undertake any medical treatment to which the certificate applies, being treatment for the condition in relation to which the certificate was given.

Penalty: 5 penalty units.

Cancellation, modification or cessation of certificate.

7. (1) A refusal of treatment certificate may be cancelled by the person who gave the certificate clearly expressing or indicating to a medical practitioner or another person a decision to cancel the certificate.

(2) For the purposes of sub-section (1), a person may clearly express or indicate a decision in writing, orally or in any other way in which the person can communicate.

(3) A refusal of treatment certificate ceases to apply to a person if the medical condition of the person has changed to such an extent that the condition in relation to which the certificate was given is no longer current.

Effect of certificate or notice issued under this Part.

8. (1) This section applies to a refusal of treatment certificate and to a written notice of a cancellation of a refusal of treatment certificate.

(2) In any civil or criminal proceeding, production of either of the instruments mentioned in sub-section (1) is -

(a) evidence; and

(b) in the absence of evidence to the contrary, proof-

that the patient has refused medical treatment or has cancelled a refusal of treatment certificate.

(3) This section does not affect other methods of proving a decision to refuse medical treatment.

PART 3 - PROTECTION OF MEDICAL PRACTITIONERS

Protection of medical practitioners.

9. (1) A medical practitioner or a person acting under the direction of a 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 -

(a) guilty of misconduct or infamous misconduct in a professional respect; or

(b) guilty of an offence; or

(c) liable in any civil proceedings-

because of the failure to perform or continue that treatment.

(2) For the purposes of this section a person who acts in good faith in reliance on a refusal of a treatment certificate but who is not aware that the certificate has been cancelled, is to be treated as having acted in good faith in reliance on a refusal of treatment certificate.

_____

SCHEDULE 1 Sections 3, 5(2)

REFUSAL OF TREATMENT CERTIFICATE: COMPETENT PERSON

We certify that we are satisfied-

(a) that . . . . . (name of patient) has clearly expressed or indicated a decision, in relation to a current condition, to refuse-

* medical treatment generally;
or
* medical treatment, being . . . . . .
(specify particular kind of medical treatment);

(b) that the patient's decision is made voluntarily and without inducement or compulsion;

(c) that the patient has been informed about the nature of his/her current condition to an extent which is reasonably sufficient to enable him/her to make a decision about whether or not to refuse medical treatment generally or of a particular kind (as the case requires) and that he/she has appeared to understand that information; and

(d) that the patient is of sound mind and has attained the age of 18 years.

Dated:

Signed . .. .(Medical Practitioner)

Signed. . . . . (Another person)

Patient's current condition

The patient's current condition is .....(describe condition)

Dated:

Signed: . . . .
(To be signed by the same medical practitioner)

Verification to be completed by patient, if physically able to do so.

In relation to my current condition, I refuse-

***** medical treatment generally
or
***** medical treatment, being. . . . . .
(specify particular kind of medical treatment).

I give the following instructions as to palliative care:

Dated:

Signed . . . .(Patient)

NOTICE OF CANCELLATION *(for completion where patient cancels the certificate under section 7 of the Medical Treatment Act 1988)*

Dated:

Signed: (Patient)

OR

The patient clearly expressed or indicated a decision to cancel this certificate on (Date).

Signed.....
(Person witnessing patient's decision)

*** Delete whichever is not applicable**

NOTE: "Medical treatment" means the carrying out of-

(a) an operation: or

(b) the administration of a drug or other like substance: or

(c) any other medical procedure-
but does not include palliative care.

"Palliative care" includes -
(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 refusal of palliative care is not covered by the *Medical Treatment Act 1988*.

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SCHEDULE 2
Section 5A (2)

ENDURING POWER OF ATTORNEY (MEDICAL TREATMENT)

THIS ENDURING POWER OF ATTORNEY is given on the day of 19 , by A.B. of under section 5A of the *Medical Treatment Act 1988*.

1. I APPOINT C.D. of to be my agent.

2. I AUTHORISE my agent to make decisions about medical treatment on my behalf.

3. I REVOKE all other enduring powers of attorney (medical treatment) previously given by me.

SIGNED SEALED AND DELIVERED by:

We.....(names of witnesses) each believe that A.B. in making this Enduring Power of Attorney (Medical Treatment) is of sound mind and understands the import of this document.

WITNESSED by:

(Signature of witness) (Signature of witness)

(Name of Witness) (Name of Witness)

(Address of Witness) (Address of Witness)

NOTE: Section 5A (2) (a) requires at least one of the witnesses to this instrument to be a person authorised by law to take and receive statutory declarations.

SCHEDULE 3 Sections 3, 5B

REFUSAL OF TREATMENT CERTIFICATE
AGENT OR GUARDIAN OF INCOMPETENT PERSON

I .....[name]
.....[address]
certify that I am empowered to act in relation to decisions about medical treatment of.....[name of patient] ("the patient").

I have been appointed to act by -

* an enduring power of attorney (medical treatment) issued under the *Medical Treatment Act 1988*.

* an order of the Guardianship and Administration Board under the *Guardianship and Administration Board Act 1986*.

I certify that-

(a) the patient has attained the age of 18 years;

(b) I have been informed about and understand the nature of the patient's current condition to an extent that would be reasonably sufficient to enable the patient, if he/she were competent, to make a decision about whether or not to refuse medical treatment generally or of a particular kind for that condition. I believe that the patient would request that no medical treatment, or no medical treatment of the particular kind mentioned below, be administered to him/her.

On behalf of the patient, in relation to his/her current condition, I refuse-

* medical treatment generally.

*medical treatment, being ……
.....
(specify particular kind of medical treatment).

Dated:

Signed . . . . . .

(Agent/Guardian for . . . . . .
[Name of patient])

***Delete whichever is not applicable**