



**THE LAW REFORM COMMISSION
OF WESTERN AUSTRALIA**

Project No 84

**Medical Treatment
for the Dying**

DISCUSSION PAPER

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

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PREFACE

The Commission has been asked to consider and report on the civil and criminal law relating to medical treatment for the dying.

The Commission has not formed a final view on the issues raised in this discussion paper and welcomes the comments of those interested in the topic. It would help the Commission if views were supported by reasons.

The Commission requests that comments be sent to it by 14 September 1988.

Unless advised to the contrary, the Commission will assume that comments received are not confidential and that commentators agree to the Commission quoting from or referring to their comments, in whole or part, and to the comments being attributed to them. The Commission emphasises, however, that any desire for confidentiality or anonymity will be respected.

The research material on which this paper is based can be studied at the Commission's office by anyone wishing to do so.

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ABBREVIATIONS

Bernat	J L Bernat, C M Culver and B Gert <i>Defining Death In Theory and Practice</i> The Hastings Center Report, February 1982, 5.
CLRC	Law Reform Commission of Canada Report No 20 <i>Euthanasia, Aiding Suicide and Cessation of Treatment</i> (1983).
Dickens	B M Dickens <i>The Right to Natural Death</i> (1981) 26 McGill LJ 847.
Dying with Dignity	(Vic) Social Development Committee <i>Inquiry Into Options for Dying with Dignity</i> (Second and Final Report 1987).
Murray Report	M J Murray QC Report on <i>The Criminal Code: A General Review</i> (1983).
President's Commission	(USA) President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research <i>Deciding to Forego Life-Sustaining Treatment</i> (1983).
Scott	R Scott <i>The Body As Property</i> (1981).
Skegg	P D G Skegg <i>Law, Ethics, and Medicine</i> (1984).
Williams	G L Williams <i>Textbook of Criminal Law</i> (2nd ed 1983).

Chapter 1

INTRODUCTION

1. TERMS OF REFERENCE

1.1 The Commission has been asked:

"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. PRELIMINARY SUBMISSIONS

1.2 To help identify the issues which arise under the terms of reference the Commission invited preliminary submissions from individuals and organisations by means of newspaper advertisements and letters. Approximately 250 individuals or organisations responded. Their names are listed in Appendix I. The Commission is grateful for these submissions which were taken into account in drafting this paper.

3. NATURE AND SCOPE OF THE PROBLEM

(a) Comments on the terms of reference

1.3 Since the *Criminal Code* was first enacted in 1902 there have been major advances in medical science. Even with diseases for which there is no long term cure, modern medicine can often substantially prolong life. 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 for a time though in considerable pain, stress or discomfort. In these situations it may seem inhumane to prolong the patient's life. 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, but people with close associations with the patient may consider that course to be in the patient's best interests.

1.4 These situations present legal difficulties because there is considerable doubt as to what doctors¹ may lawfully do. These doubts arise primarily from provisions in the *Criminal Code* which if interpreted strictly seem to put doctors and others engaged in care provision at risk of prosecution and conviction for an offence.

1.5 Though the Commission knows of no local cases in which doctors have been prosecuted for breaches of these provisions the mere fear of prosecution could have a number of profoundly undesirable consequences. It might subject doctors who wish to practise medicine with a humane concern for the terminally ill to uncertainty and worry about the legal consequences of their acts and this may inhibit them from providing the most appropriate care. A doctor might be reluctant to prescribe appropriate or sufficient medication for the relief of pain for fear of being accused of murder or some other offence if the patient's death would be hastened by it. The uncertainty involved also tends to produce variations in practice between hospitals and doctors as to the treatment of terminally ill patients. Uncertainty can also cause doctors to fail to comply with the law because they do not know what it requires or allows them to do.

1.6 The Commission's terms of reference require it to address these concerns. The emphasis is on "persons suffering conditions which are terminal or recovery from which is unlikely". The Commission understands these terms to mean a person suffering from a condition which it is believed will result in death in a short space of time, and of which it is highly unlikely, in practical terms, that the patient can be cured. The reference is therefore seen to extend to people with conditions, such as advanced stages of some forms of cancer, which are believed to be terminal even though there may be a remote possibility of spontaneous remission.

¹ Other health service providers face similar legal difficulties. Though this paper refers only to doctors the Commission has borne in mind other health care professionals such as nurses who act on the doctor's instructions in most instances but who will also be subject to legal liability.

1.7 The reference does not extend to those seriously ill, or handicapped, or impaired, babies (called "defective neonates"), who are suffering from a treatable condition which will kill them if it goes untreated.² These babies are not terminally ill within the meaning of the terms of reference. Their cases are currently being considered by the Commission in its project on Medical Treatment for Minors.³ There may, however, be babies born with conditions or illnesses which are terminal no matter what treatment is provided and they do come within the terms of reference. Since these babies cannot exercise any choice in the matter it is desirable that the Commission try to clarify the law about who may decide upon their treatment, and upon what principles, so that doctors and parents have a better idea about their responsibilities.

1.8 There are many diseases and conditions which will eventually cause death. In their early stages these cases are not within the Commission's concept of "terminal" though they would be in their later stages.⁴ Different issues arise when death may be many years off from when death is close. It is often not possible to predict the time of death with certainty in many cases. The Commission has not tried to define what "a short space of time" means in relation to terminal illness except that it is meant to indicate that those who are caring for the patient, and sometimes the patients themselves, have recognised that the process of dying, or waiting for death to happen, has begun.

1.9 The terms of reference also refer to "artificial prolongation of life". In some respects all medical and nursing treatment for a critically ill person results in an artificial prolongation of life. In this paper the Commission uses that phrase in a broad sense to include any medical, nursing or other treatment which is expected to extend the patient's life beyond the time when death would otherwise supervene "naturally". While this phrase often connotes the use of life-support equipment such as ventilators and other mechanical substitutes for organic functions, it may also apply to the administration of antibiotics or even the provision of food to a patient by artificial means. The Commission understands the term "artificial prolongation of life" to include a wide range of life-sustaining treatment.

² For example, Downs Syndrome babies sometimes suffer from a bowel blockage which if not operated upon will kill them. On the other hand surgery may provide them with a more or less normal lifespan for a person with this syndrome.

³ Project No 77.

⁴ For example Huntington's disease and Alzheimer's disease.

(b) Examples of cases which come within the terms of reference

1.10 Some typical examples of the kind of cases that come within the terms of reference, and the problems that can arise, are as follows -

- (a) A patient is in an irreversible coma having suffered massive brain injuries and is being kept alive only by a life-support system. Can the doctor incur any criminal liability for turning off the life-support system and allowing the patient to die? Would it make any difference if the patient had left specific instructions that the doctor should do so? If so, would it matter how recently the patient had given the instructions? If the patient has not given any instructions would (or should) the consent of the next of kin, spouse, de facto spouse or close relative relieve the doctor from criminal liability?
- (b) A patient is suffering from a terminal disease which is so painful or distressing that he or she wishes to stop treatment and be allowed to die. Can a doctor, with the consent of the patient, allow this to happen or is the doctor under an obligation to maintain the patient's life no matter how much pain, discomfort or indignity may ensue? If the doctor, at the request of the patient, withdraws treatment,⁵ can it be said that the doctor is helping the patient to commit suicide?⁶
- (c) A patient is suffering from a terminal disease which may lead to cardiac arrest. The patient has instructed the doctor that in such an event he or she does not wish to be revived. Can a doctor comply with the patient's wish not to be resuscitated? If the patient has given no instructions is the doctor obliged to attempt resuscitation even though he or she considers that in all the circumstances it is of no practical benefit to do so as the patient will die within a short time no matter what is done?

⁵ It is no longer a crime to commit suicide, but it is still a serious offence for another person to aid or counsel someone to commit suicide: para 2.14 below.

⁶ An example was reported recently when a patient in a Victorian hospital in the last stages of motor neurone disease was granted her request to have a ventilator withdrawn: *Hospital Switches off Dying Patient* The Australian 23.3.88 p 1. No charges at all were laid nor, apparently, contemplated.

- (d) A child is dying of a very painful disease and because of the pain refuses further treatment. In what circumstances will the child be capable of giving a doctor those instructions? Does this depend solely on whether the child is sufficiently "mature" to consent to his or her own medical treatment? If the child is not "mature" does the child have any right to be consulted about treatment? Can the parents or some other person authorise the discontinuance of life prolonging treatment and relieve the doctor of any obligation to provide that treatment?
- (e) An elderly, severely intellectually handicapped patient develops a malignant condition.⁷ The patient could be treated but the therapy will cause great pain and the doctors are of the view that the patient will die shortly in any event. The patient has no capacity to authorise or decline treatment and no ability to express a preference on the matter. Can the doctors lawfully decide not to treat and let the patient die?
- (f) A patient's agony from a terminal disease is manifest and distressing. The doctor knows that the only effective painkiller may hasten the patient's death. Would the doctor be criminally responsible for administering that drug to the patient to relieve the pain if the drug incidentally hastened the death of the patient? Would the patient's consent relieve the doctor of criminal responsibility?

(c) The practical issues

1.11 Treatment decisions about terminally ill patients do not take place in a calm and academic environment. Many take place under circumstances of great emotional stress for the patient and relatives. For doctors the situation is often complex and difficult for not only do they have a medical condition to manage but the decision about treatment may have to be made immediately. Sometimes the distress and conflict among the patient's relatives is a major concern both to the patient and the health service providers. It is often difficult to see clearly under such pressure whose interests have priority, and it is therefore desirable to develop a medico-legal framework in which correct decisions can be made which will take

⁷ See for example *Superintendent of Belchertown State School v Saikewicz* (1977) 370 NE 2d 417 where the patient had a mental age of two years and eight months: paras 3.23 and 3.24 below.

into account, firstly the interests of the patient, secondly the interests of close relatives or spouses and others who have a legitimate interest in the welfare of the patient, and finally the professional concerns of the treating doctors. It is also important that the method is simple enough to resolve issues quickly and with a minimum of distress.

(d) Capacity of a patient to make a rational decision

1.12 Another matter that has to be addressed is the patient's capacity to make a rational decision, whether this is to refuse new treatment, consent to the discontinuation of existing treatment, or to request some other treatment. The capacity to understand obviously varies from person to person. For dying patients much will depend on how much pain they are in, their age, and the effect upon them of the medication they are taking. At one end of the scale a person will fully understand all the implications of what is happening, while at the other a person may understand very little. A patient who is intellectually handicapped or severely psychiatrically disturbed may understand little or nothing. The same will be true where the patient is a very young child.

1.13 A dying patient's consent to medical treatment is a more subtle and difficult issue than for other patients. It might be thought that death would be preferable to a life involving great pain and distress for the patient, but balancing the benefits of death and further life under such conditions is a decision which ideally only the patient can make. It is not a simple decision. Many patients have changes of perspective during the course of their illness. Before the moment of death there is always the possibility that they are saying one thing but meaning another⁸ or that they could simply change their mind.⁹

1.14 Another problem is that some doctors do not always wish to inform patients fully of their prognosis because it may cause extreme distress. Without full knowledge it may not be possible for a patient to give a proper and informed consent to the proposed course of action.

⁸ Pleas by patients to be allowed to die often indicate that their pain and stress is not being adequately controlled rather than any real desire to die: *Dying with Dignity* 75.

⁹ This poses difficulties for the so-called "living will" or "enduring power of attorney" approaches referred to in paras 3.9 to 3.19 below which involve consent or directions which are usually given in an intellectual and abstract atmosphere divorced from an appreciation of the imminence of death. Though in a later part of this discussion paper the Commission suggests that the use of these sorts of documents might resolve some problems there is no way of knowing whether, and if so how many, people might use them, or whether having done so they might change their minds once they became unwell. There could be special difficulties for doctors and other health service providers who consider that a patient might wish to revoke that direction.

It seems inevitable that any reform must turn on the question of who may consent or authorise treatment so that the procedures and practice for obtaining authorisation from the patient are sufficiently discriminating to deal with real life situations and provide a clear result in which everyone can feel confident.

(e) General approach of the Commission

1.15 A competent patient who is terminally ill should have the right to decide whether to receive treatment or not. If the patient decides not to continue with treatment he or she should be able to determine the course which will make his or her last days as comfortable and as little traumatic as possible. Where a patient cannot give consent or directions because he or she is comatose, is medicated, is mentally incompetent through illness, injury, age or lack of maturity, or is in too much pain the law should provide a means to determine who may make decisions or give directions or consent on behalf of the patient and on what basis. In all cases there must be adequate safeguards to ensure that the proposed course of action is appropriate for the person concerned and not contrary to that person's wishes.

1.16 The Commission proposes ways in which the law might be reformed so that health service and care providers can avoid unacceptable risks of criminal and civil liability. The Commission also suggests some particular options such as a living will which some patients might choose to use for themselves and, where there are no options or they have not been taken up in time to be of use, proposes a clarification of the law in specific areas of concern. Whilst the law remains unclear at various points, the Commission believes that the study of particular cases may help to develop a general approach which might be acceptable to the community.

Chapter 2

EXISTING LAW

1. INTRODUCTION

2.1 As there may be some misconceptions about the duties individuals may owe to provide medical or life-supporting treatment to persons suffering from terminal conditions, this chapter contains a discussion of those duties. Doctors and patients may face substantial legal problems in relation to the provision of medical treatment for terminally ill people. In some instances it is not clear what the doctor and patient are permitted by criminal law to do notwithstanding that they agree with each other on what ought to be done from both an ethical and medical viewpoint. Generally as far as the civil law is concerned patients have control over their own treatment and cannot be treated without consent.

2.2 In practical terms the real difficulties spring from provisions in the *Criminal Code* which impose duties on persons having the charge of others and provisions relating to unlawful killing. These problems arise because the legal duties discussed below have been developed to meet problems other than the bona fide treatment of patients suffering from terminal conditions, and the application of the Code provisions to such treatment is uncertain. This uncertainty arises because the provisions of the *Criminal Code* which might be relevant are of general application and there have been no reported cases in which their operation in the present area of concern has been specifically examined. The spectre of criminal liability raised by provisions of general application is undesirable where doctors are endeavouring to practise medicine with a humane concern for the terminally ill. In succeeding chapters the Commission discusses the policy issues raised by this project and various reforms which could be adopted to remove these uncertainties.

2. CRIMINAL LAW

(a) Introduction

2.3 The criminal law imposes duties on individuals in various circumstances. Three of these duties; to provide the necessaries of life, to fulfil acts undertaken and to use reasonable care in administering surgical or medical treatment, are capable of applying to the treatment of persons suffering from terminal conditions. They are discussed below. As far as the Commission is aware there have been no prosecutions in this State arising out of breaches of these duties in respect of the treatment by doctors of persons suffering from terminal illness.

(b) Duty to provide the necessaries of life

2.4 It is the duty of every person having charge of another to provide him or her with the necessaries of life if he or she 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 him or herself with them.¹ For example, parents have a duty to provide the necessaries of life for their children.²

2.5 The application of this provision to the treatment of persons who are terminally ill raises a number of questions -

1. What is meant by the concept of necessaries of life? It certainly includes the basics of life such as food, water and shelter but does it go beyond this?
2. Does it extend to medical treatment? Although there is little authority on the point, it has been held that "medical aid" could under certain circumstances be one of the necessaries of life.³

¹ *Criminal Code* s 262. Similar issues arise with s 263 of the *Criminal 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.

² *R v MacDonald* [1904] StRQd 151.

³ *Ibid.* See also *R v Brooks* (1902) 5 CCC 372 where it was held that medical aid and remedies are necessaries of life.

3. Does the concept of the necessities of life involve the use of sophisticated medical procedures such as ventilation to provide oxygen or provision of a kidney dialysis machine?
4. Does the duty cease if death is "imminent"? It might be considered incongruous for the duty to continue to operate in this circumstance.
5. Does the concept of necessities of life involve the provision of only such treatment as is reasonably proper under the circumstances? This would involve the application of similar standards to those laid down elsewhere in the *Criminal Code*. For example, section 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.⁴
6. Is it sufficient compliance with the duty to provide the necessities of life merely to make those necessities available to a patient? There may be no duty to provide medical aid by intrusive means, for example intravenous feeding or ventilation, if the patient's consent to the intrusion could not be obtained. This result would be consistent with the provision in the *Criminal Code* which makes the touching of another person without consent an assault.⁵

2.6 Before the duty to provide the necessities of life can arise, a person must have charge of another. The charge may arise under contract, be imposed by law or arise by reason of an act,⁶ whether lawful or unlawful. Whether a person has charge of another is a question of fact, except where the law imposes a charge, for example in the case of a parent's duty to a

⁴ 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 necessities included "medical treatment and assistance when it was reasonable and proper that medical treatment and assistance should be provided".

⁵ *Criminal Code* s 222. On the other hand it may be held that the provision relating to assault is subject to the duty to provide the necessities of life so that an individual would not be criminally responsible for assault if he or she were complying with the duty.

⁶ For example, in *R v Stone* [1977] QB 354 it was held that a jury was entitled to conclude that the defendants had assumed the duty of caring for a relative where the relative had come to live in their house and they had made efforts to care for her.

child.⁷ It may be a temporary state of fact, for example where a child is being cared for by a grandparent or a permanent legal status or relationship.⁸

2.7 Where a patient is mentally competent but physically incapacitated, the question arises whether the term "unable to . . . withdraw" refers to the ability physically to withdraw from the charge or to competence to withdraw from the charge irrespective of physical ability to do so. If it has the latter meaning, a patient could withdraw from the charge and so terminate any duty of the doctor to provide the necessities of life merely by requesting that treatment be withdrawn or withheld.

2.8 If the duty were based on competence, it would be necessary to assess the competence of the patient, particularly where the patient was a minor, mentally ill or intellectually handicapped. In the case of minors, by analogy to the law relating to a child's capacity to give consent to medical treatment, the child might be able to request that treatment be withdrawn or withheld when the child is sufficiently mature.⁹ Mentally ill or intellectually handicapped persons are similarly placed; if the person had capacity to understand the consequences of a decision to withdraw or withhold treatment he or she would be competent to request that treatment be withdrawn or withheld. It is not clear whether a person may, in advance of becoming ill or incompetent, direct that the duty should not arise or, if it does arise, should terminate in certain circumstances, for example if the treatment provided had become therapeutically useless.

2.9 Where a doctor is under a duty to provide a patient with the necessities of life, the doctor is held to have caused any consequences which result to the life or health of the patient by reason of any omission to perform the duty.¹⁰ Where there is a breach of the duty and the patient dies as a result, the person who breached the duty could be charged with wilful murder, murder or manslaughter. It is also an offence if the omission merely endangers or is likely to endanger the life of the patient or injures or is likely permanently to injure the patient's health¹¹ or causes bodily harm.¹² One preliminary submission suggested that because of a fear that the duty to provide the necessities of life might otherwise be breached,

⁷ *R v MacDonald* [1904] StRQd 151.

⁸ *R v Phillips* (1971) 45 ALJR 467, 478 per Windeyer J.

⁹ See *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, referred to in para 2.26 below.

¹⁰ *Criminal Code* s 262.

¹¹ *Id* s 302.

¹² *Id* s 306.

some patients who have 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.¹³

(c) Duty to fulfil acts undertaken

2.10 Section 267 of the *Criminal Code* provides that when a person undertakes to do any act the omission to do which is or may be dangerous to human life or health, it is his or her duty to do that act. This could apply, for example, where a doctor has undertaken to provide medical treatment, such as ventilation, for a patient who later asked that it be removed so that he or she could die. Even though the patient was suffering from a terminal condition, the doctor may feel bound to continue the treatment if the omission to do so would be dangerous to the life or health of the patient.

(d) Duty to use reasonable care in administering surgical or medical treatment

2.11 It is the duty of every person who, except in a case of necessity, undertakes to administer surgical or medical treatment to any other person to use reasonable care. If the person fails to perform that duty, he or she is held to have caused any consequences which result to the life or health of the other.¹⁴ For example, if a person died as a result of a breach of the duty, the person who breached the duty might be liable to conviction for manslaughter. To establish criminal liability the facts must be such that the negligence of the accused showed such disregard for the life or safety of the patient as to amount to a crime against the State.¹⁵ In recent cases the degree of negligence required by the law to amount to manslaughter has been described as "recklessness". In *R v Stone*,¹⁶ for example, it was held that the defendant's state of mind should be capable of being described as reckless:

"Mere inadvertence is not enough. The defendant must be proved to have been indifferent to an obvious risk of injury to health, or actually to have foreseen the risk but to have determined nevertheless to run it."

¹³ For assault see *Criminal Code* ss 222 and 313.

¹⁴ Id s 265.

¹⁵ *R v Bateman* (1925) 19 Cr App R 8, and *Callaghan v R* (1952) 87 CLR 115.

¹⁶ [1977] QB 354, 363. This case was concerned with a breach of the duty to provide the necessaries of life.

(e) Unlawful killing

2.12 Even if a doctor is not under a duty to provide a patient with the necessities of life or to fulfil acts undertaken, the treatment provided could be influenced because certain conduct could render the doctor liable for unlawful killing. It is unlawful to kill any person unless such killing is authorised or justified or excused by law.¹⁷ Any person who unlawfully kills another is guilty of a crime which, according to the circumstances, may be wilful murder, murder, manslaughter or infanticide.¹⁸

2.13 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 him or her.¹⁹ If a doctor provided a patient with palliative care, such as morphine to relieve pain, and the doses of morphine hastened the patient's death, the doctor could in theory be deemed to have killed the patient. The doctor would, however, be criminally responsible for the death only if the elements of an offence such as wilful murder, murder or manslaughter were established. In the case of wilful murder, for example, it would be necessary to establish that the doctor intended to cause the patient's death.²⁰

(f) Aiding suicide

2.14 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".²¹ It would be aiding

¹⁷ *Criminal Code* s 268. The question arises whether an authority, justification or excuse must be found in the *Criminal Code* or a statute or whether one can be found in the common law. In *Ward v R* [1972] WAR 36, 42 the Court of Criminal Appeal accepted that the *Criminal Code* should be construed without any assumption that common law doctrines still apply except in so far as they are expressly adopted. This suggests that an authority, justification or excuse must be found in the *Criminal Code* or a statute. However, the case was not concerned with a factual situation in which a doctor faced a criminal charge notwithstanding that the treatment provided was reasonable having regard to the patient's condition at the time. In view of the major changes in the provision of medical treatment since the *Criminal Code* was enacted and that the justifications and excuses provided in the *Criminal Code* do not take into account these changes, in such a factual situation a court might hold that such conduct was justified or excused. One basis for doing so would be that the Code has not "covered the whole of the ground" in the area of justifications and excuses.

¹⁸ *Criminal Code* s 277. Infanticide is not relevant in the context of this discussion.

¹⁹ *Criminal Code* s 273. Further, s 261 of the *Criminal Code* provides that the responsibility of any person who caused the death of another is not affected by that other person consenting to the causing of his or her own death. This provision may need to be amended if, for example, provision were made for a person to make an advance written direction that treatment be withdrawn or withheld in certain circumstances: paras 3.9 to 3.13 below.

²⁰ *Criminal Code* s 278.

²¹ *Id* s 288.

suicide²² for a doctor to place poison by a patient's side with the intent that he or she should use it and the patient committed suicide by taking it.²³ It is unlikely that an offence is committed under this provision where a doctor merely withdraws or withholds medical treatment at the request of a patient and the patient dies. In this case it would be argued that the patient has not killed him or herself but merely "allowed the natural process of dying to take its course".²⁴

3. CIVIL LAW

(a) Introduction

2.15 The civil law also imposes obligations on doctors to provide medical or life supporting treatment to persons suffering from terminal conditions. These obligations arise in contract and tort.

(b) Contract

2.16 Where there is a contract between doctor and patient,²⁵ the doctor has a contractual duty to attend and treat the patient and to exercise reasonable skill and care in doing so. The patient must be informed of the treatment proposed and consent to it. The doctor would not be liable under the contractual duty if he or she agreed with the patient that certain treatment should be withdrawn or withheld even if that conduct resulted in the patient's death. Indeed in civil law²⁶ the act of touching another person is a trespass unless the person has consented to the touching or there is some other legal justification, such as necessity, or physical conduct which is accepted as ordinary conduct of everyday life.²⁷

²² Attempting to commit suicide is not a crime. The reason given for its decriminalisation in 1972 was that there was "general agreement that persons who attempt to take their own lives are in need of medical treatment and, therefore, should not be subject to court proceedings": Western Australian Parliamentary Debates (1972) Vol 193, 439.

²³ According to Williams 579: "Some doctors help their patients surreptitiously. A favoured means in the past was the 'Brompton mixture', consisting of morphia, codeine, alcohol and syrup. This was administered medically to relieve suffering; but when the doctor judged that the dying was unduly protracted he might leave a large bottle of the mixture by the bedside, warning the patient on no account to take all at once or he would surely die."

²⁴ This distinction has been made in cases in the USA: President's Commission 38.

²⁵ This will arise where a person consults a doctor at a surgery or is treated by the doctor in a private hospital. However, if a person is treated in a public hospital the contract is likely to be between the patient and the hospital, with the hospital undertaking to render services through its staff.

²⁶ Apart from being a wrong in civil law, assault is also a criminal offence: *Criminal Code* ss 222 and 313.

²⁷ See *Wilson v Pringle* [1987] QB 237, 252 in which this was said to be the basis for a casualty surgeon to perform an urgent operation on an unconscious patient who is brought into hospital.

2.17 If the doctor treated a patient in a manner which allowed the patient to die contrary to the patient's wishes a breach of the contractual duty would occur if the doctor's conduct involved a failure to exercise reasonable care. Damages could be recovered for any loss suffered as a result of the breach of the duty.²⁸ If the patient survived despite the doctor's conduct, the damages would depend on the harm suffered by the patient as a result of the breach of duty.

2.18 If the patient died as a result of the breach of the duty, "relatives"²⁹ of the patient would be able to recover damages for the loss they had suffered. These damages could be recovered where the patient's death was caused³⁰ by a "wrongful act, neglect or default, and the act, neglect or default is such as would (if death had not ensued) have entitled the party injured to maintain an action and recover damages in respect thereof."³¹ The reference to a default includes a breach of contract.³² The court may award such damages as it thinks fit, proportioned to the injury resulting from the death, to the "relatives", though they are only entitled to recover for loss of economic or material advantages.³³

(c) Tort

2.19 Whether or not there is a contractual relationship between a patient and a doctor,³⁴ the doctor has a duty to exercise reasonable skill and care in the treatment of the patient. If there were a breach of this duty, damages could be sought in the same way as for a breach of contract.³⁵ A failure to act by a doctor may be construed as an omission in the course of some larger activity and attract liability in the same way as a negligent act. What appears to be a mere omission is often, on further analysis, a case of a negligent act.

²⁸ The cause of action would survive the patient's death for the benefit of his or her estate: *Law Reform (Miscellaneous Provisions) Act 1941* s 4.

²⁹ *Fatal Accidents Act 1959* s 6 and Schedule 2.

³⁰ That is, there is a direct causal link between the wrong and the death and not that the death was reasonably foreseeable: *Haber v Walker* [1963] VR 339.

³¹ *Fatal Accidents Act 1959* s 4.

³² *Woolworths Ltd v Crotty* (1942) 66 CLR 603.

³³ *Fatal Accidents Act 1959* s 6(2). Where the deceased was an income earner the principal loss of economic advantage would be the loss of the deceased's net earnings. Ordinarily this would involve a calculation of the deceased's probable loss of earnings. Of course, in the case of a patient suffering from a terminal condition whose death was imminent, the loss of earnings would not be great.

³⁴ Where a patient is being treated by a member of the staff of a public hospital there may be no contractual relationship between the doctor and patient. In these cases the hospital will be vicariously liable for the breach of the tortious duty.

³⁵ Paras 2.16 and 2.17 above. The cause of action will also survive the patient's death for the benefit of his or her estate: *Law Reform (Miscellaneous Provisions) Act 1941* s 4.

2.20 A doctor is under a duty not to cause harm intentionally to a patient. This cause of action would apply to an act which hastened a patient's death and the doctor would be liable in the tort of battery. There is no battery however if the plaintiff has consented to the contact. Although the tort of battery is not applicable to intentional harm caused by an omission, a new tort could be developed by the courts to apply to an omission which set "in motion a force which directly or indirectly accomplishes the desired result."³⁶

(d) Professional misconduct

2.21 A doctor's treatment of a patient might be influenced by the fact that his or her conduct could lead to disciplinary action by the Medical Board. Such action could be taken on a number of grounds including "gross carelessness or incompetency" or "infamous or improper conduct in a professional respect."³⁷ The latter ground appears to involve conduct in relation to a doctor's profession which is "shameful" or "disgraceful".³⁸

4. INCOMPETENT PATIENTS

(a) Introduction

2.22 Where a patient is incompetent, the question arises whether any other person has authority to terminate the doctor's duties by requiring that treatment be withdrawn or withheld. The position in the case of minors³⁹ and of patients who are incompetent due to unconsciousness, mental illness or intellectual handicap is discussed below.

(b) An unconscious adult patient

2.23 Although it is sometimes assumed by those treating an unconscious adult patient that the patient's spouse or nearest relative may make decisions as to the patient's treatment, there

³⁶ J G Fleming *The Law of Torts* (7th ed 1987) 32. The basis for the development of such a tort is provided by *Wilkinson v Downton* [1897] 2 QB 57 where it was held that a person commits a tort if he or she wilfully does an act calculated to cause physical harm and physical harm results. Although the case was concerned with an act it could also be applied to an omission. See generally P R Handford *Wilkinson v Downton and Acts Calculated to Cause Physical Harm* (1985) 16 UWALRev 31.

³⁷ *Medical Act 1894* s 13(1).

³⁸ *Hoile v The Medical Board of South Australia* (1960) 104 CLR 157, 162.

³⁹ In this State a person is of full age and full capacity on attaining the age of 18 years: *Age of Majority Act 1972* s 5(1).

appears to be no legal basis for this view.⁴⁰ It is therefore questionable whether a spouse or near relative could, by consenting to the withholding or withdrawal of treatment, end any duty of the doctor in that regard.

2.24 Other possible decision-makers are the Public Trustee or guardians or committees appointed by the Supreme Court. The Public Trustee's powers in respect of infirm persons, that is, persons who are by reason of disease, illness, or physical or mental infirmity, incapable of managing their affairs,⁴¹ are limited to undertaking the care and management of their estates.⁴² The Supreme Court's power to appoint guardians and committees is confined to the "persons and estates of infants, lunatics and persons of unsound mind".⁴³

(c) **Mentally ill or intellectually handicapped persons**

2.25 If a mentally ill or intellectually handicapped person has the capacity to understand the consequences of the decision, he or she may request that particular treatment be withdrawn or withheld. If a person is a patient in an approved hospital, the director or superintendent of the hospital may give written consent to the performance of any surgical operation which is considered to be necessary or desirable for the safety or well-being of a patient.⁴⁴ If, however, a mentally disordered or intellectually handicapped person who was incapable of making a decision as to treatment was not a patient in an approved hospital, it would be necessary, in order to have a decision made as to the termination of treatment, either to have the person admitted to an approved hospital or to invoke the Supreme Court's *parens patriae* power.⁴⁵

⁴⁰ Skegg 73.

⁴¹ *Public Trustee Act 1941* s 2.

⁴² Id s 36C(1).

⁴³ *Supreme Court Act 1935* s 16(1)(d)(ii). This jurisdiction is based on a special delegation by the Crown of its prerogative rights, as *parens patriae*, to the Lord Chancellor: *Carseldine v The Director of the Department of Children's Services* (1974) 133 CLR 345, 350-351; *Re Eve* (1986) 31 DLR (4th) 1, 14-15. Without express authority it does not appear to be capable of extending to other persons.

⁴⁴ *Mental Health (Administration) Regulations 1965* reg 14.

⁴⁵ Para 2.24 above. Where the person is unable to give the necessary consent, it may also be possible to obtain a declaration from the Supreme Court that future action is not unlawful by reason of the absence of that consent. See *T v T* [1988] 2 WLR 189 where a declaration was made that a termination of a pregnancy and a sterilisation of an intellectually handicapped person were not in the circumstances unlawful acts by reason only of the absence of the person's consent.

(d) Minors

2.26 So far as minors are concerned, it would seem that a child could, in certain circumstances, give any consent that was necessary to terminate a duty so long as the child had sufficient understanding and intelligence to give the necessary consent. If the child did not have sufficient understanding and intelligence, it would be necessary to look to the child's parents or guardian. The question arises, however, whether the parents or guardian of the child could give consent. The law relating to the relationship between parents and children so far as giving consent to medical treatment is concerned was reviewed recently by the House of Lords in *Gillick v West Norfolk and Wisbech Area Health Authority*.⁴⁶ The discussion took place in the context of parental rights and authority over the child. It is therefore not expressly applicable to the question whether a parent or guardian can consent to the termination of a duty owed by a third person to a child under the criminal law. However, the views expressed in *Gillick* may provide guidance in determining whether or not a parent could give consent and, if so, the circumstances in which consent could be given. The House of Lords accepted that parents do not have absolute authority over minors. The majority were of the view that parental rights to control the child exist for the benefit of the child, and only while and to the extent they are necessary. One member of the majority, Lord Scarman, based his decision on the view that a parent has the right to consent to treatment for his or her child but that right:

". . . terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed."⁴⁷

As a corollary to the parent's right to consent to treatment for his or her child, it may be that the parent can consent to the termination of duties owed to the child by a third person. Another member of the House of Lords, Lord Fraser, imposed provisos on the parent's right to consent to treatment including a consideration of what is best for the welfare of the particular child.⁴⁸

⁴⁶ [1986] AC 112.

⁴⁷ Id 189.

⁴⁸ Id 173.

Chapter 3

OPTIONS FOR REFORM

1. INTRODUCTION

3.1 The major problem with the existing law is that doctors who comply with a patient's request to withdraw or withhold treatment may, in doing so, breach obligations imposed on them under the civil and criminal law and the *Medical Act 1894*. Where patients are incompetent to make decisions about their treatment it is not clear in most cases that any other person may make those decisions on their behalf. Further, there is no legal authority for individuals, in anticipation of being at some time incompetent to make decisions on their own behalf, to give advance written directions as to how they wish to be treated or to appoint an agent to make those decisions on their behalf.

3.2 A number of options for reform are discussed below. There are four general approaches -

- (1) The existing right of patients to control their own treatment could be specified in legislation so that those acting in accordance with their wishes would not commit an offence in so acting. This would address the concern of many of those who made preliminary submissions who feared that they would lose this right should they become terminally ill.
- (2) People could be given an opportunity to make advance written directions to the effect that they do not wish to receive certain treatment if they become terminally ill, or to appoint an agent by an enduring power of attorney to make decisions on their behalf should they become incompetent.
- (3) Where a person is incompetent, decisions as to treatment could, subject to certain qualifications and safeguards, be made by a proxy.

- (4) Doctors could be permitted to decide to withdraw or withhold treatment from a patient in certain circumstances.

Other possible reforms discussed in subsequent chapters deal with the definition of death and with palliative care.

2. CREATING A STATUTORY RIGHT TO REFUSE TREATMENT

3.3 Under the existing civil law a patient's consent to medical treatment is generally required. In some circumstances this might conflict with duties which are imposed on doctors by the criminal law. One way of reconciling this possible conflict would be to provide statutorily that a competent adult or a minor who has capacity to consent to medical treatment¹ has a right to refuse medical treatment unless that treatment is required under the public health laws.² Such legislation would also serve to bring the position to the attention of the public and health-care providers.³

3.4 A possible problem with this statutory right to refuse treatment would be that the patient's decision might not be a considered one. In some cases patients' ability to make a decision could be impaired by the pain or discomfort of their illness, disease or disability. The legislation would, however, serve to support the patient's autonomy. It should not be seen as interfering with a doctor's other responsibilities to a patient. A doctor would still be responsible for providing information to a patient about diagnosis, prognosis, the nature and consequences of possible methods of treatment, the consequences of non-treatment and the availability of palliative care. The doctor would also be responsible for discussing that information with the patient and any appropriate relatives, other health care-providers and social workers.⁴ If counselling failed to dissuade the patient from the course of action chosen and if that course of action offended against the doctor's moral, ethical or religious principles

¹ The question of consent to medical treatment by minors is being considered by the Commission as part of another project: *Medical Treatment for Minors* (Project No 77).

² For example there are provisions for the compulsory treatment of communicable tuberculosis (*Health Act 1911* s 294(1)) or venereal disease (id s 298).

³ The Victorian Social Development Committee found that the overwhelming proportion of those who made submissions to it were either unaware of the civil law position, or confused about what it meant, its purpose or the context in which it could be exercised: *Dying with Dignity* 99.

⁴ The doctor/patient relationship is a confidential one and a doctor would be in breach of that duty if a disclosure were made to a third party without the patient's consent. Any discussion with a person other than the patient would therefore require the consent (express or implied) of the patient: see generally Australian Law Reform Commission *Privacy* (Report No 22 1983) Vol 1 414-416.

or professional judgment, he or she could withdraw from the case and the patient could transfer to a doctor who would be prepared to accept and comply with the patient's decision.

3.5 In Victoria a Bill has been introduced which provides a statutory right to refuse treatment.⁵ The Bill permits any patient to complete a "refusal of treatment certificate" and provides that it is an offence for a medical practitioner, knowing that a refusal of medical treatment certificate applies to a person, to undertake or continue to undertake any medical treatment which the person has refused.⁶

3.6 One significant limitation in the Bill is that the refusal of treatment certificate may be completed 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".⁷ The certificate can therefore only be completed when the patient becomes ill. The Bill does not permit advance directions⁸ to be made.

3.7 To remove the possibility that a doctor who complied with a certificate could fail to discharge some criminal or civil duty, the Bill provides that a doctor⁹ who, in good faith and in reliance on a certificate, refuses to perform or continue the medical treatment which the person has refused is not -

- (a) guilty of misconduct or infamous misconduct in a professional respect;
- (b) guilty of an offence; or
- (c) liable in any civil proceedings -

because of the failure to perform or continue that treatment.¹⁰

⁵ Medical Treatment Bill 1988. The Bill as introduced into the Parliament is reproduced in Appendix II.

⁶ Id cl 6.

⁷ Id cl 5(1)(c).

⁸ These directions are discussed below: paras 3.9 to 3.13.

⁹ Or a person acting under the doctor's direction.

¹⁰ (Vic) Medical Treatment Bill 1988 cl 11(1).

3.8 The Victorian Bill is not confined to patients suffering from terminal conditions. Although the Commission's terms of reference are confined to such persons, if a statutory right to refuse treatment were introduced in this State it need not be confined to patients suffering from a terminal condition.

3. ADVANCE WRITTEN DIRECTIONS

3.9 A number of jurisdictions,¹¹ including South Australia,¹² have provided that individuals may make an advance written direction to the effect that they do not wish to receive certain treatment if they become terminally ill. In South Australia a person of sound mind above the age of 18 years who desires not to be subjected to extraordinary measures in the event of suffering from a terminal illness may make a direction in a prescribed form.¹³ This form provides, in part, that:

"I . . . am of sound mind and a person of or above the age of eighteen years AND in the event that I may suffer from a terminal illness within the meaning of the *Natural Death Act, 1983* AND having the desire not to be subjected to extraordinary measures, namely 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 DO HEREBY make the direction that I not be subjected to extraordinary measures."¹⁴

The direction must be witnessed by two persons.

3.10 Where a person who is suffering from a terminal illness has made such a direction and the medical practitioner responsible for his or her treatment has notice of the direction, the practitioner is under a duty to act in accordance with it unless there is reasonable ground to believe that the patient -

- (a) has revoked, or intended to revoke, the direction; or

¹¹ In the United States of America at least 38 States and the District of Columbia have such legislation: Society for the Right to Die, *Handbook of Living Will Laws* (1987) 5.

¹² The South Australian Act and Regulations are reproduced in Appendices III and IV respectively.

¹³ *Natural Death Act 1983* (SA) s 4(1).

¹⁴ Natural Death Regulations 1984 Schedule.

- (b) was not, at the time of giving the direction, capable of understanding the nature and consequences of the direction.¹⁵

3.11 The South Australian *Natural Death Act* defines a "terminal illness" as:

". . . 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."¹⁶

"Extraordinary measures" are:

". . . medical or surgical measures that prolong life, or are intended to prolong life, by supplanting or maintaining the operation of bodily functions that are temporarily or permanently incapable of independent operation."¹⁷

Section 6(1) of the South Australian *Natural Death Act*¹⁸ provides that:

"For the purposes of the law of this State, the non-application of extraordinary measures to, or the withdrawal of extraordinary measures from, a person suffering from a terminal illness does not constitute a cause of death."

3.12 The approach adopted in South Australia expressly recognises individual autonomy and gives people an opportunity to ensure that their lives come to a conclusion without being subjected to certain treatment. Many of those who made preliminary submissions to the Commission saw an advance written direction as one way of ensuring this, but other factors might also influence individuals to make such a direction. They may wish, for example, to avoid undue family suffering or to conserve the family's financial resources.

¹⁵ *Natural Death Act 1983 (SA)* s 4(3).

¹⁶ *Id* s 3. Recovery in relation to a terminal illness, "includes a remission of symptoms or effects of illness": *ibid.*

¹⁷ *Ibid.*

¹⁸ The purpose of this section is not clear. It could have been intended to protect those who comply with an advance written direction but it is not confined to them and could apply to the death of any person suffering from a terminal illness. Alternatively it could have been intended to preclude a submission by a defendant facing a charge for murder that his or her conduct did not cause the victim's death but that it was caused by the doctors who withheld or withdrew extraordinary measures from the victim.

3.13 Written directions have been criticised because they commit an individual in advance and in abstract terms to the rejection of certain treatment. At the time of making a direction a person cannot be expected to take into account all the factors, including personal circumstances, which may be relevant at some future time. Another criticism is that it could open the way to "psychological, social, family or other pressure upon sick or elderly persons to make declarations they would not spontaneously have made."¹⁹

4. ENDURING POWERS OF ATTORNEY

3.14 Another approach is the appointment of an agent to make decisions on behalf of a person who is incompetent. This approach, in effect, delegates to another person any right the patient has to make decisions as to his or her treatment. Such appointments are made by an enduring power of attorney. This could be adopted as an alternative to or as a supplement to the power to make an advance written direction.

3.15 A power of attorney is a document by which persons (the principal or donor) give another person (the agent, attorney or donee) authority to act on their behalf and in their name. The power may confer general or particular powers on the agent in respect of personal matters as well as property matters. It therefore could be used to appoint an agent to make decisions about the principal's medical treatment. Its use in this respect is limited because it becomes inoperative when the principal becomes incapacitated.²⁰

3.16 In the United States of America some states have expressly provided for the appointment of an agent to make decisions about medical treatment on a patient's behalf if the patient becomes incapacitated.²¹ Both Victoria and South Australia²² have made provision for enduring powers of attorney of general application.²³

¹⁹ Dickens 875.

²⁰ *Drew v Nunn* (1879) 4 QBD 661, 666; *In re Coleman; Ex parte Propsting* (1929) 24 Tas LR 77. There is an exception in the case of a power of attorney given for valuable consideration which is expressed to be irrevocable: *Property Law Act 1969* s 86.

²¹ Society For The Right To Die *Handbook of Living Will Laws* (1987) 9.

²² *Instruments Act 1958* (Vic) ss 114-118 (introduced 1981); *Powers of Attorney and Agency Act 1984* (SA). Powers of attorney relating to the refusal of treatment by the agent or guardian of an incompetent patient were dealt with expressly in ss 9 and 10 of the (Vic) Medical Treatment Bill 1988.

²³ In the United Kingdom provision has been made for the making of enduring powers of attorney in relation to all or a specified part of the property and affairs of the principal in the case of a principal who becomes mentally incapacitated: *Enduring Powers of Attorney Act 1985* (UK). New South Wales has

3.17 Powers of attorney have an advantage over directions of the sort provided in the South Australian *Natural Death Act* in that they allow individuals to give directions in a broad range of circumstances. The appointment of an agent offers the advantage that a decision will be made on the basis of the existing knowledge of a disease and its treatment, any instructions given in the power of attorney, any other information the agent has about the principal's wishes and the doctor's advice.²⁴ Possible difficulties are that the agent may have a conflict of interest or that he or she may not be available or willing to act at the relevant time.

3.18 One advantage of a power of attorney is that it allows the principal to give detailed directions as to the manner in which he or she should be treated. Enduring powers of attorney may authorise agents to -

- (1) provide or withhold consent to specific medical procedures (eg surgery, respiratory support, artificially administered feeding and water);
- (2) grant releases to medical personnel;
- (3) employ and discharge medical personnel;
- (4) have access to and disclose medical records and other personal information;
- (5) commence judicial proceedings relating to the principal's medical treatment decisions; and
- (6) expend or withhold funds necessary to carry out medical treatment.

One difficulty is that the power of attorney may not be expressed unambiguously. For this reason it is necessary to consider the circumstances under which an agent or doctors who

made provision for a similar power of attorney, called a "protected power of attorney": *Conveyancing Act 1919* (NSW) s 163F (introduced 1983).

²⁴ The certificate which would have been required to be completed by an agent pursuant to the Victorian Medical Treatment Bill 1988 as introduced into Parliament required the agent to certify that (Schedule 3): "I have been informed about the nature of the patient's current condition to an extent which 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. I now believe that [name of patient] would request that no medical treatment, or no medical treatment of the particular kind mentioned below, be administered to him/her."

acted in good faith in reliance on an enduring power of attorney would not be guilty of an offence.²⁵ Otherwise the introduction of enduring powers of attorney could lead to many applications to the Supreme Court for a declaration as to the effect of a power of attorney, with the cost and delay necessarily involved with such an application.²⁶

3.19 If provision were made for an enduring power of attorney it would be necessary to deal with a number of ancillary or procedural matters -

1. Provision would need to be made for the circumstances in which the power of attorney would become effective. This could be left to be specified in the power. The power might specify that it became operative, for example, when the principal became incompetent or if the principal was diagnosed as being "terminally ill" and incompetent to make decisions about his or her treatment.
2. The power of attorney would terminate on written revocation or destruction by the principal, on the principal's death or on the occurrence of any condition specified in the power. One issue is whether or not a donor who has become incompetent should be able to revoke a power of attorney. The President's Commission concluded that revocation in such a case was justifiable because:

"In the context of forgoing life-sustaining treatment, that result may be sensible, since it would generally seem wrong to cease such treatment based upon a proxy's orders when a patient, no matter how confused, asks that treatment be continued."²⁷
3. To prevent fraud, a central register of powers of attorney relating to medical treatment could be provided. These could be exercised only if they had been properly executed and registered. A requirement for registration would, of course, have its difficulties. If the power of attorney were not registered it would be invalid and the principal's intentions would be frustrated. There would also be certain costs in maintaining a registry which would have to be met by the Government or recouped from those registering powers of attorney.

²⁵ Civil liability would depend on whether there had been a breach of the duty to exercise reasonable care in the treatment of the patient: paras 2.16 and 2.19 above.

²⁶ Any person claiming to be interested under a written instrument may apply to the Supreme Court for the determination of any question of construction arising under the instrument, and for a declaration of the rights of the persons interested: *Rules of the Supreme Court 1971* Order 58 r 10.

²⁷ President's Commission 152.

These costs could be substantial as it would be necessary to provide access to the registry at all hours of the day and night to enable health care providers to check whether a patient had executed and registered a power of attorney. It would also be necessary to impose suitable safeguards to protect the principal's privacy.

4. Should enduring powers of attorney made in other jurisdictions be recognised and be given effect in the State? If so, should it be a requirement that they have been validly executed in the jurisdiction in which they were made or that they substantially comply with this State's requirements?

5. DECISION-MAKING BY A PROXY

(a) Introduction

3.20 Another possible reform would be to provide for decision-making by a proxy where patients are not competent to make decisions about their own treatment, for example, because the patient is unconscious, an immature minor, mentally disordered or intellectually handicapped. This could be used where a patient had not made or was not competent to make a written direction or an enduring power of attorney or as an alternative to providing for the making of such directions or powers of attorney. It allows a proxy to make a decision on the basis of what he or she believes the patient would have wanted had the patient been competent to make a decision. If this approach were adopted it would be necessary to provide the proxy decision-maker and those acting in accordance with his or her directions with immunity from liability in civil and criminal law. This could be done by providing that a proxy who acted in good faith and doctors and other health care providers who in good faith relied upon a proxy's decision to withdraw or withhold treatment from a patient would not be guilty of an offence.

3.21 In the case of adult patients and mature children, this approach would require the decision-maker to consider whether the patient had expressed a preference while conscious. Even if provision were not made for the making of a written direction or an enduring power of attorney, the patient may have completed a living will. In the absence of evidence that such a

will did not reflect the patient's preference it could be honoured. In one case²⁸ the Supreme Court of Florida ruled that if an incompetent person had executed a living will it would be "persuasive evidence" of the person's wishes and should be given "great weight" by anyone applying the "substituted judgment" test. The preference may even have been expressed orally. In another case²⁹ a member of a Roman Catholic order lapsed into a permanent vegetative state. His superior initiated proceedings to obtain judicial approval for the withdrawal of a respirator. It was held that such approval was justified where there was clear and convincing evidence that the patient wanted treatment terminated should he be irreversibly ill. In this case, the evidence existed because he had expressed such views publicly during the religious community's discussion of the case of Karen Quinlan³⁰ and had reiterated them prior to his own hospitalisation for surgery.

3.22 Where a patient had not expressly stated a wish in a living will or otherwise, the proxy could try to assess what the patient would want with respect to treatment. In making the decision the proxy could take into account views expressed by the patient about medical treatment, the patient's religious or moral beliefs and any decisions made by the patient about medical care while competent which might show a pattern of conduct. Of course, the probative value of such evidence may vary depending on the remoteness, consistency, and thoughtfulness of the prior statements or actions and the maturity of the person at the time of the statements or acts.

3.23 One shortcoming of this approach is that it involves making a hypothetical assessment from the perspective of the incompetent person, which is particularly pointed where the patient has not previously expressed a point of view, for example, a newborn infant or an intellectually handicapped person. An example of how difficult it is to make a judgment is provided by the case of *Superintendent of Belchertown State School v Saikewicz*.³¹ Saikewicz was 67 years old. He was profoundly mentally retarded with an IQ of ten and a mental age of approximately two years and eight months. He could not communicate verbally but used gestures and grunts to make his wishes known to other people. Leukaemia was diagnosed. If untreated he would live for perhaps several months without pain and death would probably come without discomfort. The alternative considered by the court was chemotherapy which

²⁸ *John F Kennedy Memorial Hospital Inc v Bludworth* (1984) 452 So2d 921.

²⁹ *In re Eichner* (1981) 420 NE2d 64.

³⁰ *In re Quinlan* (1976) 355 A2d 647.

³¹ (1977) 370 NE 2d 417.

would have a number of serious and painful side effects caused by the drugs used in the treatment.

3.24 The court tried to assess what decision Saikewicz would have made if he were competent. Because of Saikewicz's limited intelligence it was not possible to assess what the patient would want. This led the court to balance various factors which in effect involved an assessment of what was in Saikewicz's best interests.³² The court concluded that the evidence supported a determination that the patient, if competent, would have elected not to have chemotherapy.

(b) Possible proxy decision-makers

(i) Children

3.25 At present there is, of course, decision-making by proxies in the case of children who are not mature enough to consent to new or any medical treatment. In these cases the proxies are the child's parents or guardian. The Commission is provisionally of the view that there should be no change to this position.³³

(ii) Other incompetent persons

3.26 For unconscious, mentally disordered or intellectually handicapped persons, the following individuals or bodies could act as the proxy decision-maker -

- * the patient's nearest relative;
- * a guardian appointed by the Supreme Court or a board; or
- * a court.

³² Id 431-432.

³³ The law relating to the consent to treatment in the case of immature minors is being examined in the Commission's project on Medical Treatment for Minors (Project No 77).

* **The patient's nearest relative**

3.27 One approach is to provide for one of the patient's relatives to act as the proxy. This can be done by designating the first relative in a prescribed order of priority³⁴ who is reasonably available, willing and competent to act as the proxy decision-maker.³⁵ The President's Commission considered that it was appropriate to designate one of the patient's relatives as the proxy decision-maker because relatives are generally the most concerned about the good of the patient and will usually be the most knowledgeable about the patient's goals, preferences and values.³⁶ Of course, there may be reasons for it not being appropriate to appoint one of the relatives as a proxy decision-maker -

- (1) there may be a conflict between the interests of the patient and those of the relative;
- (2) the relative may not agree with the patient's values, preferences, wishes or specific earlier instructions;
- (3) the relative although close in relationship may not be the person who is closest to the patient in real life. For example, the patient may have lived in a de facto relationship for many years and regard the de facto spouse as the closest person to him or her. The close relatives may have been estranged.

* **Appointment of a guardian by a court or board**

3.28 The Supreme Court presently has power to appoint guardians or committees of the persons and estates of infants, lunatics and persons of unsound mind.³⁷ This power could be supplemented by expressly empowering the Court to appoint guardians and committees for other persons who are not competent to make decisions on their own behalf, in particular unconscious adults. This approach might be seen as being too formal and cumbersome and it might impose too great a burden on the operations of the Supreme Court. In particular it

³⁴ For example, the patient's spouse, any adult child of the patient according to age or the patient's parents. It would probably be desirable to exclude more distant relatives such as uncles, aunts, nephews, nieces or cousins.

³⁵ See *Life-Prolonging Procedures Act of Florida 1984* (Florida) s 7.

³⁶ President's Commission 128.

³⁷ Para 2.24 above.

would be too slow a procedure to be of any help to those who have suddenly become terminally ill and in respect of whom doctors and caregivers need a prompt decision to be made.

3.29 An alternative approach is to establish a Guardianship and Administration Board with responsibility for the appointment of guardians as has been done in a number of other jurisdictions in Australia.³⁸ In Victoria, for example, any person may apply to the Guardianship and Administration Board for an order appointing a plenary or a limited guardian in respect of any person with a disability who has attained the age of 18 years or to take effect upon that person attaining the age of 18 years.³⁹ Disability in relation to a person means intellectual impairment, mental illness, brain damage, physical disability or senility.⁴⁰ The Board may appoint a guardian⁴¹ if the person in respect of whom the application is made is -

- (a) a person with a disability,
- (b) unable by reason of the disability to make reasonable judgments in respect of all or any of the matters relating to his or her person or circumstances; and
- (c) in need of a guardian.⁴²

3.30 The powers of a plenary guardian are very wide and include power to consent to any health care that is in the best interests of the represented person, except as otherwise provided in Division 6 of the Act.⁴³ A limited guardian may be given all or any of the powers and duties in respect of the represented person that are conferred on a plenary guardian.⁴⁴

3.31 Division 6 includes a provision that a medical practitioner must not carry out any procedure which is a major medical procedure on a represented person unless the consent of

³⁸ *Guardianship and Administration Board Act 1986* (Vic); *Mental Health Act 1976* (SA) ss 20 and 26; *Mental Health Act 1963* (Tas) ss 8 and 22. It has been reported that the Government intends to establish a Guardianship and Administration Board: *Delay to Mental Health Reform* The West Australian 18.12.1987, p26.

³⁹ *Guardianship and Administration Board Act 1986* (Vic) s 19(1).

⁴⁰ Id s 3(1).

⁴¹ The Act also provides for the appointment of a Public Advocate. The Advocate may be appointed by the Board as a guardian: id s 16(1)(a).

⁴² Id s 22(1).

⁴³ Id s 24(2).

⁴⁴ Id s 25(1).

the guardian and the Board has been obtained.⁴⁵ The Board may issue guidelines specifying major medical procedures for this purpose.

* **Judicial decision-making**

3.32 Where a patient is incompetent to make a decision or incapable of expressing a choice about withholding or withdrawing treatment another possible decision-making model is the judicial model, the decision being made by a court. This has the advantage of providing a detached and impartial decision-making process. It is also public⁴⁶ subject to an express provision for the proceedings to be conducted in camera or for the publication of proceedings and decisions to be restricted. Though decisions could be based on a discretionary power, such powers are based on ascertainable principles or criteria and reasoned decisions are given which may be subject to further scrutiny in the courts.

3.33 Such a decision-making model does have difficulties. It would be cumbersome, unwieldy and expensive if it required a formal hearing and decision in every case involving an incompetent patient,⁴⁷ so much so that the existing judicial system might become overburdened. In some cases it could tend to promote confrontation between those interested in the decision. It could also be disruptive to the process of providing medical treatment to a patient and it would require health-care providers to spend time in court instead of in hospital attending to patients.

3.34 It may be worthwhile to bear these costs if patients are provided with additional protection. However, the experience in the United States of America suggests that the process of judicial review may become a mere formality:

"Judges may feel that they are unable to add much to the decisions already worked out among those most intimately involved, particularly in cases that are brought simply to obtain judicial sanction for a course of conduct on which all are agreed. Rather than examining questions that courts are accustomed to addressing, such as whether the particular surrogate should be disqualified because of a conflict of interest, the question typically addressed is whether the particular treatment chosen is the right one. Since an answer to this question would normally require substantial understanding of

⁴⁵ Id s 37(1).

⁴⁶ Though this might be seen as a disadvantage because of the distress which it might bring to the patient's family.

⁴⁷ Indeed in some of the leading cases in the USA arguments were heard and opinions written long after the patient had died.

the patient's evolving medical condition and options, which the courts lack, they may simply defer to the recommendation of the treating physicians."⁴⁸

3.35 Even if the judicial model were rejected the courts could play a role as a final review body where there was doubt as to the patient's wishes⁴⁹ or if it were doubtful that the decision-makers were acting lawfully. In such a role they would provide legal protection for incompetent persons.

6. DECISION-MAKING BY DOCTORS

3.36 Even if any of the proposals discussed above were introduced, there would be circumstances in which, as at present, doctors may be tempted to make decisions without the assistance of a direction by a patient, an attorney or a proxy decision-maker. In some cases a competent patient may be somnolent due to drugs and unable to engage in complex or intellectual discussion, be unwilling to face the issue, leaving it to the doctor to make the decision, or the doctor may wish to avoid causing the patient unnecessary stress by raising the issue. In other cases the patient may request that treatment be continued or provided which will be of no reasonable benefit to the patient. The doctor may feel pressured to continue treatment once begun, even if the treatment in question has become useless or unreasonable.

3.37 In these circumstances the doctor may need to make decisions which involve apparent breaches of one or more duties discussed in the previous chapter though he or she believes that the approach adopted is consistent with good medical practice and in the best interests of the patient. The doctor may decide, for example, to withdraw or withhold treatment which will neither cure nor ameliorate the patient's condition but merely prolong the patient's life for a short time. The community should perhaps recognise that a doctor may need to act to avoid prolonging the dying process in the circumstances mentioned in the previous paragraph without such a decision being made by a patient, the patient's attorney or a proxy decision-maker. A recommendation made by the Canadian Law Reform Commission would enable doctors, rather than one of these people, to make decisions. It recommended that nothing in various provisions of the Canadian *Criminal Code* should be interpreted as requiring a doctor "to continue to administer or undertake medical treatment, when such treatment has become therapeutically useless in the circumstances and is not in the best interests of the person for

⁴⁸ President's Commission 160.

⁴⁹ Para 3.20 above.

whom it is intended".⁵⁰ The word "therapeutically" was used to mean treatment which would cure or ameliorate the patient's condition. The "best interests" condition would require that therapeutically useless treatment be continued if it would be justified on grounds other than "treatment of the medical problem as such". The patient, though unwilling to face the issue of treatment, may for example wish more time to see a relative or put his or her affairs in order. A further condition which could be imposed would be to require that the decision was made in good faith, that is, that the doctor was not actuated by ill-will to the patient or by any improper motive.

7. HOSPITAL COMMITTEES

3.38 Some hospitals in Perth already have one or more committees which fulfil a wide range of functions. For example, the Repatriation General Hospital, Hollywood, has a Patient Care Management Committee which is available to meet with medical staff to discuss treatment in individual cases where clinical or social problems have arisen and an Ethics Committee which considers the broader ethical policies relating to patient care and medical treatment and recommends policies relating to the management of patients with advanced disease.

3.39 The Commission recognises that committees can perform valuable roles in this area as they do in some hospitals at present. They can act as a consultative committee providing guidance on broader ethical and social concerns including their application to particular cases. They can perform an educational role, providing advice and information on request to patients, guardians and the patient's nearest relatives. In furtherance of these ends they can provide a forum for discussion and community involvement in bioethical issues and the formulation of treatment guidelines and policies for the care of patients. They would need to be broadly based; for example the Ethics Committee of the Repatriation General Hospital, Hollywood, is comprised of doctors, hospital administrators, a minister of religion, a lawyer and community representatives. A diversity of members might help to ensure that the view of particular professional or social groups was not accepted uncritically.

3.40 These committees also have the capacity to participate in the decisions made with regard to the treatment of terminally-ill patients. While the Commission recognises that it

⁵⁰ CLRC 32.

may be argued that hospital committees should not be involved in the decision-making process in individual cases because the process may be cumbersome and interfere unduly with the doctor/patient relationship, it welcomes comment on what role (if any) they should have and whether those hospitals which do not have these committees should be encouraged to establish them.

Chapter 4

THE DEFINITION OF DEATH

1. INTRODUCTION

4.1 The definition of death is important in the context of the issues raised in this paper because 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 such as property rights (a corpse cannot have property or succeed to property) and the taking of organs for transplantation. This chapter discusses the existing law defining death and the desirability of providing a statutory definition of death.

2. EXISTING POSITION

4.2 There is no generally applicable statutory definition of death in Western Australia. Unless death occurs instantaneously through 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 heart and lung functions to be maintained by machines even though the whole of the brain including the brain stem has permanently ceased to function. Traditionally in practice it was accepted that death occurred where there was permanent cessation of respiration and circulation of the blood. These criteria no longer immediately equate with death because respiration and circulation of the blood can function through mechanical means despite loss of brain functions. It is now recognised that death occurs when there is cessation of brain function, including the brain stem. This definition of death is recognised statutorily in Western Australia in the limited area of operation of the *Human Tissue and Transplant Act 1982*. 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."

4.3 The absence of a generally applicable statutory definition of death has led to the following difficulties in other jurisdictions both in civil and criminal law -

1. Doctors who removed life-support systems from a brain dead patient have faced the threat of a charge of murder.¹
2. Coronial inquiries have been held in cases in which doctors have removed life-support systems having concluded that the patient was brain-dead.²
3. Defendants facing charges for murder have claimed that their actions did not cause the victim's death but that it was caused by the doctors who removed the victim's life support systems.³
4. A civil action for wrongful death has been instituted against doctors who removed a respirator from a brain dead patient. The jury accepted the concept of "brain death" and returned a verdict in favour of the doctors.⁴
5. Parents have refused to allow doctors to disconnect respirators from their children who were brain dead as a result of their abuse of the child because they could then be charged with murder.⁵

4.4 Though there is no statutory provision relating to brain death there is some suggestion in *R v Kinash*⁶ 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. In that case the defendant violently assaulted a woman about the head rendering her unconscious. She was sustained by a ventilator but despite two operations her condition deteriorated. Medical practitioners concluded that she had suffered permanent functional death of the brain stem and disconnected the ventilator. A short time later she suffered a cardiac arrest. It was held that the assault caused her death and that the use of the life support systems merely delayed the time at which respiration ceased and cardiac arrest occurred.

¹ Scott 150-151.

² Id 155.

³ Para 4.4 below and Scott 153-154 and 155-157.

⁴ Scott 151-152.

⁵ A R Holder *Legal Issues in Paediatrics and Adolescent Medicine* (2nd ed 1985) 118-119.

⁶ [1982] Qd R 648. For a similar view see *R v Malcherek* [1981] 1 WLR 690, 694.

3. PROVIDING A DEFINITION OF DEATH

4.5 To help doctors decide when death has occurred both in civil and criminal law, because death and the determination of it is also morally significant, the Commission suggests that a generally applicable definition of death should be introduced. In South Australia, for example, section 2 of the *Death (Definition) Act 1983*⁷ provides:⁸

"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."

4.6 Such a standard has, however, been criticised because "irreversible cessation of circulation of blood in the body of the person" is not a standard of death but a test which provides a means of determining whether death has occurred.⁹ According to this view:

"It would be sufficient to include only irreversible cessation of whole brain function and allow physicians to select validated and agreed-upon tests (prolonged absence of spontaneous cardiopulmonary function would be one) to measure irreversible cessation of whole brain function."¹⁰

The following standard was suggested based on the irreversible cessation of all functions of the brain but with a guide to the practising doctor which indicates that he or she may continue to declare death by cardiopulmonary tests in the majority of deaths uncomplicated by artificial cardiopulmonary support:

⁷ Almost identical provisions have been adopted 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). This definition of death is also contained in the National Health and Medical Research Council's Code of Practice for Transplantation of Cadaveric Organs 1982. Criteria on which the diagnosis of irreversible cessation of brain function is based have been endorsed by the Conjoint Conference between the Australian Medical Association and the Joint Advisory Committee of the Royal Australasian College of Physicians, Royal Australian College of Surgeons, Royal Australian College of Obstetricians and Gynaecologists and Royal Australian College of General Practitioners. The Victorian Social Development Committee concluded that the existing definition in Victoria provided an acceptable definition of death: *Dying With Dignity* 150.

⁸ A recent report on the *Criminal Code*, the Murray Report, contains a recommendation that a definition of death be included in the *Criminal Code* in the following similar terms:

"A person dies when there is irreversible cessation of all function of his brain or of circulation of blood in his body": Murray Report 169-170 and 562.

⁹ Bernat 8.

¹⁰ Ibid.

"An individual who has sustained irreversible cessation of all functions of the entire brain, including the brainstem, is dead.

- (a) In the absence of artificial means of cardiopulmonary support, death . . . may be determined by the prolonged absence of spontaneous circulatory and respiratory functions.
- (b) In the presence of artificial means of cardiopulmonary support, death . . . must be determined by tests of brain function.

In both situations, the determination of death must be made in accordance with accepted medical standards."¹¹

4.7 Some of those who made preliminary submissions to the Commission expressed concern that a statutory definition of death could become outdated. Their real concern seems to have been that the tests for determining whether death had occurred within the statutory definition would become outdated with advances in scientific knowledge. However, the Commission does not believe that this would be the result of the introduction of a statutory definition. While the statute would provide a definition of death it would still be the responsibility of the medical profession to determine the tests to be used, in accordance with accepted medical standards,¹² for determining whether death had occurred in accordance with the definition. The tests could be developed and changed from time to time with advances in medical knowledge.

¹¹ Ibid.

¹² See Scott 158-162 for a discussion of the process of development of medical criteria for enabling a positive diagnosis of brain death to be made.

Chapter 5

PALLIATIVE CARE

5.1 When a decision is made to withdraw or withhold life supporting treatment, palliative care can still be given to a patient to relieve pain and suffering and to make the patient as comfortable as possible. It may be necessary to provide doses of pain relieving drugs at levels which accelerate death. Under the existing law those who take actions which accelerate death in this way could be held criminally liable for their actions.¹ One preliminary submission suggested that in order to avoid a charge that death was caused by an excessive dose of drugs it is a practice to direct that drugs are not to be administered before the elapse of prescribed periods. These orders are followed even though the patient may be in extreme pain. The Commission understands that in other cases a drug such as morphine may be withheld from a patient in severe pain because it will probably suppress the patient's heart and lung functions and cause death.

5.2 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-killing medication with the intention of relieving pain and suffering, even though the medication may shorten life.² Once it is concluded that a patient's condition is terminal and a decision is made to withdraw or withhold life-prolonging treatment, the Commission welcomes comment on whether those responsible for the care of the patient³ should not be criminally liable if, in merely providing palliative care such as an analgesic, they hasten the patient's death, so long as that care is provided with the informed consent of the patient or any

¹ Para 2.13 above. See the English case of *R v Adams* (1957) unreported but see Dickens 868-870 and P Devlin *Easing the Passing: The Trial of Dr John Bodkin Adams* (1985). Dr Adams was charged with murder after a patient died of a morphine overdose. The defence was that the cause of death was the condition that the morphine was administered to relieve, and that the intention of administering the drug was to relieve pain and not to kill the patient. Although the trial judge directed the jury that the deliberate shortening of life amounted to murder he added that a doctor "is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten life". Adams was acquitted. For criticism of the judge's charge to the jury see Williams 385.

² Dying with Dignity 89 and 93-96.

³ Or those acting in accordance with their instructions, for example, the patient's spouse where the patient is being cared for at home.

other person responsible for making treatment decisions for the patient.⁴ A similar conclusion was reached by the Law Reform Commission of Canada in its report *Euthanasia, Aiding Suicide and Cessation of Treatment*. That Commission recommended that:

" . . . it be specified in the *Criminal Code* that a physician cannot be held criminally liable merely for undertaking or continuing the administration of appropriate palliative care in order to eliminate or reduce the suffering of an individual, only because of the effect that this action might have on the latter's life expectancy."⁵

The Commission said that the proposal:

" . . . simply expresses the idea that the physician's duty is to provide patients with appropriate palliative care when further therapeutic treatment would serve no purpose. For palliative purposes, the appropriate use of drugs, medication or other pain control treatment is legal and legitimate even if they may have the effect of shortening the patient's life expectancy."⁶

5.3 Such an express statutory provision could also be accompanied by a review of the provision of palliative care, particularly in hospitals, and the training of health-care providers in the provision of palliative care. The Commission notes that in Victoria the Social Development Committee found that many doctors:

" . . . both in general practice and at specialist level, pay insufficient attention to the need for palliative care for dying patients, and the need to shift treatment, where appropriate, from a curative to a palliative mode. Evidence indicates that in the training of health carers and the provision of resources, emphasis has been given to the curative role at the expense of palliative care. Such a curative role has often been continued beyond the point where it is appropriate. Insufficient resources are allocated to palliative care."⁷

The Commission agrees with the conclusion reached by the Victorian Committee that it is unacceptable that terminally ill patients should die in pain because there is insufficient attention to the need for palliative care.⁸ It would certainly be undesirable for a patient to be

⁴ The Law Reform Commission of Canada seems to have envisaged that such consent would be required. It stated (CLRC 22) that:

" . . . it is important to be assured of the patient's consent or the consent of those who are responsible for making decisions concerning that patient. Palliative care is subject, in fact, to all the rules governing medical treatment, including the requirements that it be reasonable and that consent must be sought and provided."

⁵ CLRC 23.

⁶ Id 35.

⁷ Dying with Dignity 222.

⁸ Ibid.

forced to commence a legal action against a doctor or hospital in order to receive suitable treatment as occurred in one case in the United States of America.⁹

⁹ *Bouvia* referred to by Society For The Right To Die, *Right-To-Die Court Decisions* CA-8.

Chapter 6

QUESTIONS AT ISSUE

6.1 The Commission welcomes comment (with reasons where appropriate) on any matter arising out of the terms of reference or this paper, and in particular on the following -

General

1. Is there any need to change the existing law?
2. Have any difficulties been encountered with the treatment of particular individuals either because of the existing law, or perceptions of the law, or because of practices with respect to dying patients, especially those who seek the withdrawal or withholding of medical treatment?

Creating a statutory right to refuse treatment

3. Should a statutory right to refuse medical treatment, unless that treatment is required under the public health laws, be provided in Western Australia?

Paragraphs 3.3 to 3.7

Advance written directions

4. Should provision be made for individuals to make an advance written direction to the effect that they do not wish to receive certain treatment?

Paragraphs 3.9 to 3.13

Enduring powers of attorney

5. Should provision be made for individuals to make enduring powers of attorney for the appointment of an agent to make decisions on their behalf when they are legally incapacitated?

Paragraphs 3.14 to 3.18

6. If provision were made for individuals to make enduring powers of attorney -
- (a) in what circumstances should a power become effective;
 - (b) in what circumstances should a power terminate;
 - (c) should a central register of powers relating to medical treatment be established;
 - (d) should enduring powers of attorney made in other jurisdictions be recognised and be given effect to in this State?

Paragraph 3.19

Decision-making by a proxy

7. Should provision be made for decisions to be made by a proxy decision-maker where a patient is not competent to make decisions about his or her own treatment?

Paragraphs 3.20 to 3.24

8. Should parents continue to be the proxy decision-maker for their children in all circumstances?

Paragraph 3.25

9. So far as other incompetent persons are concerned, should the proxy decision-maker be -

- (a) the patient's nearest relative;
- (b) a guardian appointed by the Supreme Court or a board; or
- (c) a court?

Paragraphs 3.27 to 3.35

Decision-making by doctors

10. Should a doctor be permitted to decide to withdraw or withhold life-prolonging procedures from a patient with a terminal condition and, if so, in what circumstances?

Paragraphs 3.36 and 3.37

Hospital committees

11. What role (if any) should be played by hospital committees in decisions about the treatment of terminally ill patients?

Paragraphs 3.38 and 3.40

Other reforms

12. Should any reform other than those referred to above be adopted?

The definition of death

13. Should a generally applicable definition of death be provided?

Paragraphs 4.2 to 4.5 and 4.7

14. If so, how should death be defined?

Paragraphs 4.5 and 4.6

Palliative care

15. Should it be provided that those who provide palliative care to a patient should not be criminally liable if, in merely providing palliative care, they hasten the patient's death so long as -
- (a) the patient's condition is terminal;
 - (b) a decision has been made to withdraw or withhold life-prolonging treatment; and
 - (c) the palliative care is provided with the informed consent of the patient or any other person responsible for making treatment decisions for the patient?

Paragraph 5.2

Appendix 1

PRELIMINARY SUBMISSIONS¹

Adams A F M	Church of Ancient Religion
Adams E	Claremont Baptist Church
Adams P J	Clifton G L
Amalgamated Metal Workers and Shipwrights Union of WA (Retired Members Association)	Cockbain S
Amoore E J	Cockrane S
Anderson D	Collins E
Appleyard P F	Colson P
Armadale Congregational Church (Inc)	Cope M
Australian Medical Association (WA Branch)	Coutts I
Beaver J G	Coyle S
Beck B E	Crosthwaite E
Bennett J	Cypher E & J I
Bernhardt J P	Date R O
Berry G F	Davidson P A
Biasin K	Davis M M
Bilton E M	Dawes S
Blampey D P	Deboer M J
Blundell E A	Delfs B
Board P W	Demasson B P
Botica C	Demasson V M
Bottrell D	Diggins J
Bougher S, Wheeler J & Wilson A	Diggins P
Brett M	Diggins R
Brims A	Diggins S
Bromilow E	Diggins S
Buddhist Society of WA	Diocesan Bioethics Committee of the Roman Catholic Archdiocese of Perth
Bunbidge P	Doye E D
Butler G	Doyle S
Butson O	Drummond F
Butterworth T	Dunne D
Cake F E	Edmett R
Canby M	Elliot H P
Cancer Foundation of Western Australia (Inc)	Emery G C
Cancer Support Association (Inc)	Eustice P
Carroll M	Evans B J
Casson M	Fearn P
Centrecare	Fisher P J
Chester A & B	Fitzpatrick B J
Chester M	Fletcher L
	Foothills School Students
	Ford-Adams J M
	Foreman E
	Formby D

Appendix I

Fox N	Kinsman J C
Frieze G	Kitching D A
Gaebler P	Kitto J P
Gale G	Klerk G de
Gaskin S	Klinger J
Geddes O	Knight P N
Gilks I	Koser H
Goodman K	Kowarski J
Goodwin J A and D P	Kowarski S
Gosnells SHS Students	Kraemer L
Graham B	Ladhamis E
Grant M R & M A	Lamb J H
Guinan S	Latham P
Hales A M	Law A & I
Hammett I	Law S
Hannah E	Ledger M
Hannah P	Ledger W R
Happe J	Leggoe E McB
Heard E	Loney S
Herbert M G	Lyon M N
Hill A	MacIntyre B M
Hille G	Manders W T
Holley N J	Margadant R
Holmes C R	Mariano N C
Hoover J	Martin M R
Horner A M	Maynard I J
Hospice Care Service	McCarthy E & others
Howe M J	McLean A & V
Howes A	Medicine, Faculty of, University of Western Australia
Hubbard K	Mentlein R
Hugall C B	Mingay N
Hughes C	Mitter A R
Humanist Society of WA (Inc)	Moir L
Hunt T B	Moore J
Hussey R	Musgrave L
Hutcheson K	Nelthorpe D
Hutchison I	Newmann G
Hutchison J	Nichols E
Jacobs S A	Nicholson I M
Jarvis H M	Nimmo V M
Jendry E	Nugent J B
Johnson H	O'Connell N M
Johnson S E I	Oliver P R
Johnson S M	Palmyra Neighbourhood Group
Karas E D	Paterson J
Kehl M	Patrick E M
Kennedy I V	Payne J
Kennedy J M	Pemberton J K
King A J	Peppernell S
King Edward Memorial Hospital for Women	Perrins I M

Peters S M	SLCG (Inc)
Phillips B	Slotema J
Phillips H	Smirk W E
Pleydell M	Smith I D & others
Pommerin J	Social Responsibilities Commission, Anglican Church, Diocese of Perth
Porter V	St Vincent's Bioethics Centre
Praed V	Stanton J
Preshan D	Stanton N
Princess Margaret Hospital for Children	Steele D
Pugh H W	Stronach R E
Rance J A	Talbot M
Ratner M & S	Taylor S
Reed J H	Tennant B G
Reimers A	Thielemann D
Rentier A	Thomas W E
Riegner E H	Thompson R
Right to Life Association	Thorpe I K
Riseley J & A	Toy N
Robert M	Triglone H
Robinson F N & J	Trout S
Robinson M E	Tunbridge J H
Rogers A	Turner M
Royal Australian Nursing Federation	Turpin M E
Royal Perth Hospital	Uniting Church In Australia
Russell S R	Uusna E
Sajtos E G & K	Vandervelde B & G
Sand G	Van Wees J F
Sanders J A	Vickers-Bush O E
Sanderson A	Wainwright M L
Sanderson D F	Wainwright N G
Sayers K	Wann L C & E
Scarr R H	Ward V
Schairer G U	West Australia Voluntary Euthanasia Society (WAVES)
Schwartz G R	White B
Sclater R	White D
Shannon J U	Williams M A
Shaw C	Winn P N
Sheridan P	Wolf W T
Shields L	Worsey F
Simmons M	Yates A
Simpson I	York K H
Singer P, Professor	
Sisson J	

¹A number of commentators requested anonymity and their names have not been included in this list

Appendix II

VICTORIAN MEDICAL TREATMENT BILL 1988

LEGISLATIVE COUNCIL

Read 1^o 23 March 1988

(Brought in by the Honourable J.H. Kennan)

(No 2)

A BILL

to create an offence of medical trespass, to make other provision concerning the refusal of medical treatment and for other purposes.

Medical Treatment Act 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 confirm a patient's right to appoint another person to make decisions about medical treatment if the patient becomes incompetent.

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" means a medical procedure for the purposes of relief of pain, suffering or discomfort, including the provision of food or water (or other medical care) which is not burdensome to the patient.

"Refusal of treatment certificate" means a certificate in the form of Schedule 1 or of Schedule 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.

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 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.

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 which the person has refused.

Penalty: 5 penalty units.

Cancellation, modification or cessation of certificate.

7. (1) A refusal of treatment certificate may be cancelled or modified-
- (a) in the case of a certificate in the form of Schedule 1, by the patient to whom the certificate applies; or

- (b) in the case of a certificate in the form of Schedule 3, by the agent or guardian who completed the certificate-

clearly expressing or indicating to a medical practitioner or another person a decision to cancel or modify 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 circumstances of the person have 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.

Agents and guardians.

9. (1) A person may provide for decisions about medical treatment to be made after he or she becomes incompetent by appointing another person as his or her agent.

(2) The appointment may be by way of-

- (a) an enduring power of attorney (medical treatment); or
- (b) a provision in an enduring power of attorney given under the *Instruments Act 1958* to the same effect as Schedule 2.

(3) An appropriate order may be made under the *Guardianship and Administration Board Act 1986* providing for decisions about medical treatment of a represented person to be made by the person's guardian.

(4) If the appointment takes the form of an enduring power of attorney (medical treatment) under sub-section (2)(a)-

- (a) it must be in the form of Schedule 2 and witnessed by two persons other than the agent to be appointed; and
- (b) it takes effect if and only if the person giving the power becomes incompetent.

(5) If a person gives a power of attorney in relation to medical treatment, the power revokes any earlier power given in relation to medical treatment.

(6) The person who makes an appointment under sub-section (2)(a) or (b) may revoke it in the manner provided in section 116 of the *Instruments Act 1958*.

(7) If a medical practitioner and another person are each satisfied that a person's agent or guardian has been informed about the nature of the person's current condition to an extent that would be reasonably sufficient to enable the person, 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 that the agent or guardian has appeared to understand that information, the agent or guardian may on behalf of that person-

- (a) refuse medical treatment generally; or
- (b) refuse medical treatment of a particular kind-

for that condition.

(8) 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.

(9) If an agent or guardian completes a refusal of treatment certificate and his or her appointment as agent or guardian is later revoked, that refusal of treatment certificate is also revoked.

Guardianship and Administration Board may revoke authority.

10. The Guardianship and Administration Board may revoke an enduring power of attorney (medical treatment) in the manner provided in section 118 of the *Instruments Act 1958*.

PART 3 - PROTECTION OF MEDICAL PRACTITIONERS

Protection of medical practitioners.

11. (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 the medical treatment which the person has refused 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 and section 6 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 or modified, is to be treated as having acted in good faith in reliance on a refusal of treatment certificate.

SCHEDULES

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 has attained the age of 18 years.

Dated:

Signed (Medical Practitioner)

Signed (Another person)

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)

* 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" means a medical procedure for the purposes of relief of pain, suffering or discomfort, including the provision of food or water (or other medical care) which is not burdensome to the patient.

SCHEDULE 2 Section 9(4)

ENDURING POWER OF ATTORNEY (MEDICAL TREATMENT)

THIS ENDURING POWER OF ATTORNEY is made on the _____ day of
19 __, by A.B. of _____ under section 9 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.

SIGNED SEALED AND DELIVERED by:

WITNESSED by:

(Signature of Witness)

(Signature of Witness)

(Name of Witness)

(Name of Witness)

(Address of Witness)

(Address of Witness)

SCHEDULE 3 Sections 3, 7(1), 9(8)

**REFUSAL OF TREATMENT CERTIFICATE:
AGENT OR GUARDIAN OF INCOMPETENT PERSON**

I [name] certify that I am empowered to act in relation to decisions about medical treatment of

[name of patient]

I have been *appointed* to act by-

- * an enduring power of attorney (medical treatment) issued under the *Medical Treatment Act 1988*.
- * a provision in an enduring power of attorney issued under the *Instruments Act 1958*.
- * 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 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. I now believe that [name of 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 (name of patient),
in relation to his/her current condition, I refuse-

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

Dated:

Signed (Agent/Guardian for
(Name of patient))

Verification

We certify that we are satisfied that
(name of agent or guardian) has been informed about the nature of the patient's current condition to an extent that would be reasonably sufficient, if the patient were competent, 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) for that condition and that the agent/guardian appeared to understand that information.

Signed (Medical Practitioner)

Signed (Another person)

* Delete whichever is not applicable

Appendix III

SOUTH AUSTRALIAN NATURAL DEATH ACT 1983

An Act to provide for, and give legal effect to, directions against artificial prolongation of the dying process.

[Assented to 22 December 1983]

BE IT ENACTED by the Governor of the State of South Australia, with the advice and consent of the Parliament thereof, as follows:

Short Title

1. This Act may be cited as the "*Natural Death Act, 1983*".

Commencement

2. This Act shall come into operation on a day to be fixed by proclamation.

Interpretation

3. In this Act -

"extraordinary measures" means 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:

"recovery", in relation to a terminal illness, includes a remission of symptoms or effects of the illness:

"terminal illness" means 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.

Power to make direction

4. (1) A person of sound mind, and of or above the age of eighteen years, who desires not to be subjected to extraordinary measures in the event of his suffering from a terminal illness, may make a direction in the prescribed form.

(2) The direction must be witnessed by two witnesses.

(3) Where a person who is suffering from a terminal illness has made a direction under this section and the medical practitioner responsible for his treatment has notice of that direction, it shall be the duty of that medical practitioner to act in accordance with the direction unless there is reasonable ground to believe -

(a) that the patient has revoked, or intended to revoke, the direction;

or

(b) that the patient was not, at the time of giving the direction, capable of understanding the nature and consequences of the direction.

(4) This section does not derogate from any duty of a medical practitioner to inform a patient who is conscious and capable of exercising a rational judgment of all the various forms of treatment that may be available in his particular case so that the patient may make an informed judgment as to whether a particular form of treatment should, or should not, be undertaken.

(5) The Governor may, by regulation, prescribe a form for the purposes of subsection (1).

Act not to affect other rights

5. (1) This Act does not affect the right of any person to refuse medical or surgical treatment.

(2) This Act (other than section 6) does not affect the legal consequences (if any) of -

(a) taking, or refraining from taking, therapeutic measures (not being extraordinary measures) in the case of a patient who is suffering from a terminal illness (whether or not he has made a direction under this Act);

or

(b) taking, or refraining from taking, extraordinary measures in the case of a patient who has not made a direction under this Act.

(3) A medical practitioner incurs no liability for a decision made by him in good faith and without negligence as to whether -

(a) a patient is, or is not, suffering from a terminal illness;

(b) a patient revoked, or intended to revoke, a direction under this Act;

or

- (c) a patient was, or was not, at the time of giving a direction under this Act, capable of understanding the nature and consequences of the direction.

Certain aspects of causation of death

6. (1) For the purposes of the law of this State, the non-application of extraordinary measures to, or the withdrawal of extraordinary measures from, a person suffering from a terminal illness does not constitute a cause of death.

(2) This section does not relieve a medical practitioner from the consequences of a negligent decision as to whether or not a patient is suffering from a terminal illness.

Saving clause

7. (1) Nothing in this Act prevents the artificial maintenance of the circulation or respiration of a dead person -

- (a) for the purpose of maintaining bodily organs in a condition suitable for transplantation;

or

- (b) where the dead person was a pregnant woman - for the purpose of preserving the life of the foetus.

(2) Nothing in this Act authorizes an act that causes or accelerates death as distinct from an act that permits the dying process to take its natural course.

Appendix IV

**REGULATIONS UNDER THE
NATURAL DEATH ACT, 1983 (SA)**

PURSUANT to the *Natural Death Act, 1983*, and all other powers, I, the Governor's Deputy, with the advice and consent of the Executive Council, make the following regulations.
C.L. Laucke, Governor's Deputy

Regulations under the Natural Death Act, 1983

1. These regulations may be cited as the 'Natural Death Regulations, 1984'.
2. For the purposes of section 4 of the *Natural Death Act, 1983* a direction shall be in the form of the Schedule to these regulations.
3. These regulations shall take effect on 30 September, 1984.

THE SCHEDULE

Notice of Direction Pursuant to *Natural Death Act, 1983*

TO: The Medical Practitioner responsible for my treatment at such time when I am suffering from a terminal illness*

I, declare
(Name of person making direction)

that I am of sound mind and a person of or above the age of eighteen years AND in the event that I may suffer from a terminal illness* within the meaning of the *Natural Death Act, 1983* AND having the desire not to be subjected to extraordinary measures, namely 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 DO HEREBY make the direction that I not be subjected to such extraordinary measures.

DATED.....19.....

SIGNATURE OF PERSON MAKING DIRECTION.....

WITNESSED in the presence of two witnesses:

(1)
(Name, address, occupation)

(2)
(Name, address, occupation)

*"Terminal illness" means 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.

And the Honourable the Minister of Health is to give the necessary directions accordingly.

D.J. Abbott, Clerk of the Council