THE LAW REFORM COMMISSION
OF WESTERN AUSTRALIA

Project No 84

Medical Treatment for the Dying

DISCUSSION PAPER

JUNE 1988

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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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 doctors[1] 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

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

(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

(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 terminalrespTc S

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 another[8] 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.

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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

Chapter 2

EXISTING LAW

1. INTRODUCTION

2.1

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]

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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 necessaries 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 necessaries 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

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 necessaries 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 necessaries 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 health[11] or causes bodily harm.[12] One preliminary submission suggested that because of a fear that the duty to provide the necessaries of life might otherbh A98g H healtAuthoracie.

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."

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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*

(e) Unlawful killing

2.12 Even if a doctor is not under a duty to provide a patient with the necessaries of life or to fulfil acts undertaken, the treatment provided could be influenced because certain conduct

suicide[22]

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 caused[30] 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.

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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 Crottytment o975 0 TD /F2 9.75 Tf 0.0465 Tc 0.0122 Tw ([(9412) A6 CLR 603*

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

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

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

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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

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

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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.

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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 Australia[22] have made provision for enduring powers of attorney of general application.[23]

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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

acted in good faith in reliance on an enduring power of attorney would not be guilty of an offence.[25]

These costs could be substantial

will did not reflect the patient's preference it could be honoured. In one case[28] 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 case[29] 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 Quinlan[30] 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 cou

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.

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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 priority[34] 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

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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 guardian[41] 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

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 public[46] 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 weverionalduciswhe. Rathisved, parti ical treatcong

> 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 wishes[49] 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.

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 [redacted] generally applicable statutory definition of death has led to the following d[redacted]er jurisdictions both in civil and criminal law -

1. [redacted]o removed life-support systems from a brain dead patient have [redacted]eat of a charge of murder.[1]

2. [redacted]uiries have been held in cases in which doctors have removed life-[redacted]ems having concluded that the patient was brain-dead.[2]

3. [redacted] facing charges for murder have claimed that their actions did not [redacted] but that it was caused by the doctors who removed the

4. [redacted] for wrongful death has been instituted against doctors who [redacted]espirator from a brain dead patient. The jury accepted the concept [redacted]ath" and returned a verdict in favour of the doctors.[4]

5. [redacted]e refused to allow doctors to disconnect [redacted] their

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."

"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 patient[3] 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

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

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?7-21 ldraD -0. ans State?

(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 SUBMISSIONS[1]

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

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

Peters S M
Phillips B
Phillips H
Pleydell M
Pommerin J
Porter V
Praed V
Preshan D
Princess Margaret Hospital for Children
Pugh H W
Rance J A
Ratner M & S
Reed J H
Reimers A
Rentier A
Riegner E H
Right to Life Association
Riseley J & A
Robert M
Robinson F N & J
Robinson M E
Rogers A
Royal Australian Nursing Federation
Royal Perth Hospital
Russell S R
Sajtos E G & K
Sand G
Sanders J A
Sanderson A
Sanderson D F
Sayers K
Scarr R H
Schairer G U
Schwartz G R
Sclater R
Shannon J U
Shaw C
Sheridan P
Shields L
Simmons M
Simpson I

Appendix II

VICTORIAN MEDICAL TREATMENT BILL 1988

LEGISLATIVE COUNCIL

Read 1° 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 4341 Tw c1I-maxim 0 TD -0.0675/T5ev4

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

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:

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).

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5 0.5 ethnTD -0.068613.doon, cap8ion;

Appendix IV