



OFFICE OF THE  
PUBLIC ADVOCATE

# Advance Directives: The Legal Issues

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# Advance Directives: The Legal Issues

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## **1 Executive Summary:**

An advance directive is typically defined as a document which is created by a person while they are competent, that defines the medical treatment that the person wishes to refuse should they become incompetent in the defined circumstances. There are direct benefits in the active use of advance directives, namely, an effective advance directive will promote autonomy, it will remove the decision-making burden from the shoulders of family members or friends, and a treating doctor's decision to treat or not to treat is settled. However, it is found that an equally significant advantage of advance directives is to encourage discussion between patients and health care professionals and between patients and their families about important health care issues.

In determining the legal status of advance directives, a fundamental principle must be recognised. This is the principle of self-determination. This principle has been recognised in numerous cases in a variety of jurisdictions. Importantly, it follows from the recognition of this principle that a medical practitioner who administers medical treatment to a competent adult without their consent violates the right to self-determination and could be criminally or civilly liable. The most influential literature on the principle of self-determination comes from case law in the United States of America (USA) and the United Kingdom (UK). In connecting the case law to the discussion on advance directives, it is invariably the case that advance directives and the right to refuse treatment are logical extensions of the right to self-determination. However, in this context it must be noted that the exercise of the right to self-determination is not absolute. It will be subject to certain considerations. These could possibly include, for example, a person's level of understanding of their condition at the time of making the directive, and any other relevant circumstances surrounding the person's condition.

Another important concept at common law is the presumption of capacity. Essentially, this means that every person is presumed to be capable of consenting to or refusing treatment unless the contrary is proven. This concept plays a pivotal role in determining when an advance directive's operation will become an issue. Various tests are available at both an international and national level to determine a person's competency.

In determining the legal status of advance directives in Victoria, an examination of the relevant legislation was undertaken, namely, the *Medical Treatment Act 1988 (Vic) (MTA)*,

the *Guardianship and Administration Act 1986 (Vic)* (G & A Act) and the *Mental Health Act 1986 (Vic)* (MHA).

Under the MTA, a certain type of advance directive is available in the form of a Refusal of Treatment Certificate (RTC). It was found that the RTC was limited in its capacity as an advance directive as it could only be invoked for a current condition.

Under the MHA, the main issue around advance directives is their status when they are made by a person admitted as an involuntary patient. The legislation makes a distinction between psychiatric and non-psychiatric treatment in this context. Ultimately, if the patient requires psychiatric treatment and refuses to give consent to it, s12 (5) of the Act allows the consent of an authorised psychiatrist to override that of the patient, effectively renouncing the patient's right to self-determination.

To date, there is little case law in Victoria that directly addresses the question of advance directives and provides any support for their implementation. In *Qumsieh v Guardianship and Management Board & Pilgrim* (SC Vic, No. 5656 of 1998; High Court of Australia) (Q's Case), the Court of Appeal did not take the opportunity available to them to clarify the status of treatment refusals made by competent patients. The case failed to shed light on the uncertainty that surrounds the issue of advance directives in Australian common law.

Another Victorian case, *Gardner; re BWV* [2003] VSC 173 has a limited connection to advance directives in Victoria. The case may be authoritative to the extent that BWV's wishes were presented in evidence both before VCAT and the Supreme Court. However, this was in the context of the requirements of the MTA and therefore it is very difficult to establish any substantial probative value from this decision in relation to advance directives at common law.

Currently, the law regulating advance directives in Australia is a combination of legislation and case law. Some States in Australia have legislation dealing directly with this issue, namely, South Australia, Australian Capital Territory, Queensland and Northern Territory. New South Wales, Tasmania and Western Australia have no direct legislation available as to advance directives.

The decisions around advance directives on an international level, in general, uphold the protection of a patient's right to self-determination in regard to refusal of medical treatment. However, it is also important to note that certain elements are common to the cases where a Court has upheld the validity of an advance directive. In these cases, the Courts had consideration to such factors as the patient's comprehension of their illness and their prognosis. These factors are important to establish a successful outcome for the patient seeking to have their advance directive complied with.

Conversely, there are also a number of factors related to completing an advance directive, which can make them a difficult document for the Courts to uphold. Some of these factors include: possible advances in medical technology that were not evident at the time of making the directive; the requirement of a certain level of knowledge about the illness and the likely chances of recovery that may not generally be known or considered when an advance directive is made. These factors may ultimately effect the willingness of the Courts to enforce an advance directive. This would seem to be the position in Australia, yet there is no common law that is decisive in determining the status of advance directives in Australia.

In Victoria, it would seem to be that the common law regarding advance directives is that when a person is competent, their advance directive will be respected. However, once a person is defined as incompetent, their advance directive holds a much weaker position.

While advance directives have some limited legal status, the untested nature of them makes the more legally viable option the completion of a Refusal of Treatment Certificate (RTC) under the *Medical Treatment Act 1988* (Vic) in order to ensure patient self-determination.



## **2 Introduction:**

The promise of advance directives is that they may promote patient autonomy, facilitate decisions that will approximate patient preferences for care at the end of life, enable more human and ethical uses of medical technology, diminish the individual responsibility that surrogates may bear for decision-making and perhaps provide a more ethical approach to reducing health care costs ...<sup>1</sup>

An advance directive is typically defined as a document which is created by a person while they are competent, that defines the medical treatment that the person wishes to refuse should they become incompetent in the defined circumstances. An advance directive is sometimes labelled a 'living will' in which a person sets out their health care preferences before incapacity occurs.

There are benefits in the active use of advance directives. Firstly, an effective advance directive will promote autonomy by enabling competent individuals to determine the course of their lives and deaths. Secondly, advance directives can remove the decision-making burden from the shoulders of family members or friends who are often called upon to take responsibility for, or at least be involved in, decisions about life-sustaining treatment.<sup>2</sup> Similarly, a treating doctor's decision to treat or not to treat is settled, thus removing the burden of decision-making and unnecessary consultation with family members.<sup>3</sup> However, it is arguable that the most significant advantage of advance directives is that they "encourage discussion between patients and health care professionals and between patients and their families about important health care issues including death and dying."<sup>4</sup>

While it is not the primary focus of this paper, it is imperative to recognise that a more effective way of promoting and ensuring patient self-determination in a climate of rapid medical advances in medical technology is through the successful completion of a Refusal of Treatment Certificate (RTC) under the *Medical Treatment Act 1988* (Vic) (MTA). This a legally recognised advance directive. Additionally, a meaningful discussion between the

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<sup>1</sup> B Flynn; M Lowe; J McPhee; I Kerridge (1999) 'Advance Directives' in I Freckelton; K Petersen (eds) (1999) *Controversies in Health Law* The Federation Press, Sydney, p.303

<sup>2</sup> J Lynn (1991) 'Why I Don't Have a Living Will' 19 *Law Medicine and Health Care* 101

<sup>3</sup> J Downie [1992] 'Where There is a Will, There May Be a Better Way: Legislating for Advance Directives' 12 *Health Law in Canada* 73

patient, their family and the patient's treatment team about treatment options for the patient is another way of promoting patient self-determination. If the medical profession were to adopt these changes, there would be a significant shift away from the current medical practice of risk management that promotes futile treatment and towards a more informed position regarding the patient's treatment options.

For the purposes of this paper, the term 'advance directive' will be used in preference to 'living will'.

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<sup>4</sup>J Blackwood (1997) "I Would Rather Die with Two Feet than Live With One" – The Status and Legality of Advance Directives in Australia' 19 *University of Queensland Law Journal* 270, p.274

### **3 The Fundamental Status of the Principle of Self-Determination:**

Before the legal status of advance directives is discussed, it is important to recognise the principles that are protected by the effective pronouncement of an advance directive. The fundamental principle that is central to the making of an advance directive is the principle of self-determination.

The basic principle about self-determination was first enunciated by Cardozo J in *Schloendorff v Society of New York Hospital* when he said, “every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.”<sup>5</sup> Accordingly, it follows on from this statement that a medical practitioner who administers medical treatment to a competent adult without their consent violates the right to self-determination and could be criminally or civilly liable.

This reality was recognised by Lord Donaldson MR in *Re T (Adult: Refusal of Treatment)* when he stated, “the law requires that an adult patient who is mentally capable of exercising a choice must consent if medical treatment of him [or her] is to be lawful ... Treating him [or her] without his [or her] consent or despite a refusal of consent will constitute a civil wrong of trespass to the person and may constitute a crime.”<sup>6</sup> He added, “... a right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent.”<sup>7</sup> Straughton LJ in the same case agreed with Lord Donaldson MR as to the importance of the principle of self-determination, concluding that “an adult whose mental capacity is unimpaired has the right to decide for herself [or himself] whether she [or he] will or will not receive medical or surgical treatment, even in circumstances where she [or he] is likely, or even certain, to die in the absence of treatment.”<sup>8</sup> Butler-Sloss LJ also emphasised the importance of the principle, by stating that

the right to determine what shall be done with one’s own body is a fundamental right in our society. The concepts inherent in this

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<sup>5</sup> (1914) 105 NE 92 at 93

<sup>6</sup> [1992] 4 All ER 649 at 653

<sup>7</sup> *Ibid.*, at 113

<sup>8</sup> [1992] 4 All ER 649 at 478

right are the bedrock upon which the principles of self-determination and individual autonomy are based. Free individual choice in matters affecting this right should, in my opinion, be accorded very high priority.<sup>9</sup>

Because of the central importance of self-determination in advance directives, judges and academics alike have discussed the principle. Many have considered the autonomy that a competent person must enjoy in making decisions about what medical treatment they wish to refuse in a time of incompetency. Fay Rozovsky has discussed this point at length, concluding that “[however] disturbing a decision against treatment may be, the competent patient retains that prerogative. In the absence of any proof of mental incapacity that makes it impossible for a person to understand the nature and consequences of a refusal of care, his or her decision must stand.”<sup>10</sup>

The most influential literature on the principle of self-determination comes from case law in the United States of America (USA) and the United Kingdom (UK). As well as the *Schloendorf* and *Re T* cases that come from these jurisdictions, there is a wealth of judicial pronouncement on the centrality of the principle. In the UK, Lord Reid in *S v McC; W v W* emphasised that “...English law goes to great lengths to protect a person of full age and capacity from interference with his [or her] personal liberty.”<sup>11</sup>

Additionally, Lord Goff reaffirmed the principle in *Re F (Mental Patient: Sterilisation)* stating, “...[The] fundamental principle ... [is] now long established, that every person’s body is inviolate.”<sup>12</sup>

In *Re MB (Medical Treatment)*, Butler-Sloss LJ reaffirmed her earlier position on self-determination by emphasising that “[a] mentally competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death.”<sup>13</sup>

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<sup>9</sup> Ibid, p. 116-117

<sup>10</sup> F Rozovsky (1984) *Consent to Treatment: A Practical Guide* (2<sup>nd</sup> edn), p.20

<sup>11</sup> [1972] AC 25 at p.43

<sup>12</sup> [1990] 2 AC 1 at p.72

<sup>13</sup> [1997] 2 FLR 426 at 432

In addition to the case law in the UK that highlights the importance of the principle of self-determination, the case law in the USA<sup>14</sup> has also provided unshakeable support for the principle.

In *Re Melideo*,<sup>15</sup> the Court held that a woman's refusal of medical treatment on religious grounds was valid, and the State could not demonstrate a sufficiently compelling interest to override her refusal.

The Court in *Lane v Candura* also upheld the principle of self-determination, concluding that "the law protects [the patient's] right to make [his or] her decision to accept or reject treatment, whether that decision is wise or unwise."<sup>16</sup>

In *Bartling v Superior Court (Glendale Adventist Hospital)*,<sup>17</sup> it was held by the Court that if the right of the patient to self-determination as to his or her own medical treatment is to have any meaning at all, it must be paramount. This highlights the fundamental position of the right, in accordance with the judicial authority expressed in the UK.

In the important USA case of *Cruzan v Director, Missouri Department of Health*,<sup>18</sup> the US Supreme Court concluded that no right is held more sacred, or is more carefully guarded than the right of every individual to the possession and control of his or her own person. Again, the crucial importance of the right to self-determination shines through these judgments, highlighting the utmost importance that the right bestows.

As well as the recognition afforded to the principle of self-determination in the UK and the USA, the principle has also been recognised in other jurisdictions. In Australia, McHugh J in *Secretary, Department of Health and Community Services (NT) v JWB & SMB (Marion's Case)* expressed the principle as follows:

[The] common law accepts that a person has rights of control and self-determination in respect of his or her body which other persons must respect. Those rights can only be altered with the consent of the person concerned. Thus, the legal requirement of consent to bodily interference protects the autonomy and dignity of the individual and

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<sup>14</sup> See also *Vacco v Quill* (1997) 521 US 793 and *Washington v Glucksberg* (1997) 521 US 702

<sup>15</sup> (1976) 390 NYS 2d 523

<sup>16</sup> (1978) 376 NE 2d 1232 at 1236

<sup>17</sup> (1984) 209 Cal Rptr 220

<sup>18</sup> (1990) 110 S. Ct 2841

limits the power of others to interfere with that person's body.<sup>19</sup>

Case law in New Zealand also preserves the fundamental importance of the principle of self-determination. In *Smith v Auckland Hospital Board*, Greeson J confirmed that “an individual patient must, in my view, always retain the right to decline operative investigation or treatment however unreasonable or foolish this may appear in the eyes of his medical advisers.”<sup>20</sup>

Canadian case law also recognises the principle.<sup>21</sup>

In connecting the case law to the discussion on advance directives, it is invariably the case that advance directives and the right to refuse treatment are logical extensions of the right to self-determination. Lord Goff acknowledged this very point in *Airedale NHS Trust v Bland*, when he said,

the same principle [of self-determination] applies where the patient's refusal to give his consent has been expressed at an earlier date, before he [or she] became unconscious or otherwise incapable of communicating it; though in such circumstances especial care may be necessary to ensure that the prior refusal of consent is still properly to be regarded as applicable in the circumstances which have subsequently occurred.<sup>22</sup>

As is evidenced from the above case law, the right to self-determination is considered fundamental to a person's autonomy. In its application to advance directives, the right can be said to exist in a person's right to refuse medical treatment.

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<sup>19</sup> (1992) 175 CLR 218 at 309-10

<sup>20</sup> [1965] NZLR 191 at 219. Also see *Auckland Area and Health Board v Attorney-General* [1993] 1 NZLR 235

<sup>21</sup> See *Malette v Shulman* (1990) 67 DLR (4<sup>th</sup>) 321; *Fleming v Reid* (1991) 82 DLR (4<sup>th</sup>) 298, *Rodriguez v Attorney General of Canada* [1994] 2 LRC 136

<sup>22</sup> [1993] AC 789 at 894-5

## **4 Competency:**

From the outset, it is important to note that at common law, there exists a presumption of capacity. Essentially, this means that every person is presumed to be capable of consenting to or refusing treatment unless the contrary is proven. The presumption is succinctly stated by Butler-Sloss LJ in *Re MB (Medical Treatment)* when she said, “[every] person is presumed to have the capacity to consent to or refuse medical treatment unless and until that presumption is rebutted.”<sup>23</sup>

Lord Donaldson also formulated a version of the presumption in *Re T*, when he held that “every adult is presumed to have capacity but it is a presumption which can be rebutted.”<sup>24</sup>

In relation to advance directives, the contentious issue surrounding a person’s capacity is whether the patient can clearly understand the nature and purpose of the treatment when they made the decision to refuse it.<sup>25</sup> If they are deemed capable of understanding the nature and purpose of the treatment, they are considered to be ‘competent’. If they cannot understand, they are considered ‘incompetent’.

For the purposes of this paper, ‘competency’ and ‘capacity’ will be used interchangeably.

The issue of competency also plays a pivotal role in determining when an advance directive’s operation will become an issue. An advance directive is intended to operate when the person who made it has become incompetent. Therefore, the determination of whether a person is competent or incompetent is a most crucial requirement in the issue of when an advance directive will be considered to be operative for the person who made it. However, the determination of what is competent and what is not is not always clear-cut. As held in *Re Conroy*,<sup>26</sup> patients with limited mental capacity, who might be viewed as ‘generally incompetent’, may still be capable of making certain decisions – just as a ‘generally competent’ person may be incapable of making some choices. In this lies the difficulty: What is the benchmark for ascertaining who is competent and who is not? In order to answer this question, a review of the relevant case law will be most beneficial.

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<sup>23</sup> (Court of Appeal) [1997] 2 FLR 426 at p.436

<sup>24</sup> [1992] 4 All ER 649 at 470

<sup>25</sup> *In Re F (Sterilisation: Mental Patient)* [1989] 2 Fam 376

<sup>26</sup> (1985) 486 A 2d 1209

#### 4.1 International Tests Of Competency:

A leading case on the assessment of a patient's capacity to refuse treatment is the UK decision in *Re C (Adult: Refusal of Treatment)*.<sup>27</sup> Thorpe J defined capacity as a sufficient understanding of the "nature, purpose and effects of the proffered [treatment]."<sup>28</sup> As also determined by this case, the levels of understanding that need to be reached to satisfy this definition of capacity are threefold:

- (1) comprehension and retention of treatment information;
- (2) believing the information; and
- (3) weighing it amongst other factors to reach a decision.<sup>29</sup>

This test for capacity was subsequently endorsed in *Secretary of State for the Home Department v Robb*.<sup>30</sup>

Through their case law, the USA has used similar methods to determine a person's capacity. In *Re Schiller*, the test for capacity enunciated by the Court was: "Does the patient have sufficient mind to reasonably understand the condition, the nature and the effect of the proposed treatment, attendant risks in pursuing treatment, and not pursuing the treatment?"<sup>31</sup>

In a more recent case, a USA Court has outlined four requirements that should be met when determining a person's competency. The Court held that it must be determined whether the person:

- (1) has sufficient mind to reasonably understand the condition they have;
- (2) is capable of understanding the nature and effect of the treatment choices;
- (3) is aware of the consequences associated with those choices; and
- (4) is able to make an informed choice that is voluntary and not coerced.<sup>32</sup>

Canadian legislation has also confirmed the common law position on the tests to be used to determine capacity. The *Health Care Directive Act* 1992 in Manitoba has adopted the following definition: "A person has capacity to make health care decisions if he or she is

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<sup>27</sup> [1994] 1 WLR 290

<sup>28</sup> Ibid, at 295

<sup>29</sup> Ibid, at 292

<sup>30</sup> [1995] 1 All ER 677 at 681

<sup>31</sup> (1997) 372 A 2d 360 at 367

<sup>32</sup> *Re Martin* (1993) 504 NW 2d 917 at 924

able to understand the information that is relevant to making a decision and able to appreciate the reasonable and foreseeable consequences of a decision or lack of decision.”<sup>33</sup> Section 1 of the Act defines health care decisions as a “consent, refusal to consent or withdrawal of consent to treatment.” Also defined in s1 is treatment. It is defined as “anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health related purpose or includes a course of treatment.”

## **4.2 Australian Tests Of Competency:**

A Victorian lawyer and specialist in disability law, Alan Rassaby, has described five tests that have been used in assessing competence, based on American writing. These five tests are:

- (1) Can a person express a preference for or against a particular form of treatment?
- (2) Is the person making a reasonable, right or responsible decision?
- (3) Does the person give rational reasons for the decision?
- (4) Is the patient able to understand, even if the decision is not rational and the decision is unwise?
- (5) Has the patient actually understood all the major implications of a proposed course of treatment?<sup>34</sup>

Number 2 of Rassaby’s tests requires some comment. This test, in itself, is offensive to the right to self-determination. It changes the focus of the enquiry from the capacity of the decision-maker to the actual decision they made. Essentially, there is a relationship between decisions that people make and their capacity to make them. However, it is important to note that it is possible to be competent and yet to make a ‘bad’ decision. The test does not allow this distinction to be made, and consequently, it is flawed to that extent.

## **4.3 When Competency Is Tested:**

While a patient may be considered competent to make a decision regarding their right to refuse treatment, there are practical difficulties in obtaining a fully informed decision from a patient in their advance directive. Although a healthy patient may decide in advance that he or she does not wish to receive chemotherapy, be resuscitated etc, that decision may be altogether different if the patient is likely to return to good health after a period of suffering. Of course, where treatment is futile and will not benefit that patient in any way,

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<sup>33</sup> *Health Care Directive Act* 1992, s2. This is a Canadian Act.

<sup>34</sup> A Rassaby (1987) ‘Informed Consent to Medical Care by Persons with Diminished Capacity’ in Law Reform Commission of Victoria, *Symposia 1986: Informed Consent*, pp.77-79; citing L Roth,;A Meiser and C Lidz (1977) ‘Tests for Competency to Consent to Treatment’ *Am J Psychiatry* 134:3, pp.279-84

then their decision to refuse treatment will be considered to be informed to the extent that they will know they cannot be cured or helped by the treatment. Dr. David Tuxen, a Melbourne specialist in Intensive Care says that “whilst ... it is useful to know of a patient’s pre-illness decisions about advanced life support systems, ... decisions made by patients may be of limited value.”<sup>35</sup> This is because when faced with a situation in which the treatment might help or cure the patient, their decision regarding the treatment may well be different to their prior refusal.

The assessment of competency raises many practical questions in relation to health care decisions made by patients. Firstly, the assessment of competency is by no means clear. However, it would seem that the competency required depends on the consequences attached to the decision made by the patient. The more important the decision, the higher the level of competency that must be established.<sup>36</sup>

Additionally, there is a tension between determining whether the competency to be assessed is that of the patient or of the decision they have made. Often, if the decision made by a patient is not considered to be in their best medical interests, issues of competency may arise. This is because there is an inherent tension between “respecting people’s autonomy and in overriding their autonomy on the basis of beneficence.”<sup>37</sup> A doctor may feel that a patient’s decision is not to the patient’s benefit and therefore find it hard to respect people’s decisions that have a high likelihood of leading to poor outcomes.<sup>38</sup> This is where a question of competency will often arise. The doctor will question the patient’s capacity to make the decision. However, it could be argued that in this context, the competency of the patient is not being assessed; rather, it is the competency of the decision that is being questioned. In this context, Nancy King notes that “[a] ‘bad’ decision does not necessarily indicate decisional incapacity.”<sup>39</sup> Just because a doctor considers a decision to be unreasonable or irrational does not mean that the decision maker was incompetent to make the decision.

Cases in the USA have addressed the issue of patient competency, and when this competency will be perceived to be non-existent at the time of making the directive. If the

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<sup>35</sup> *Dying with Dignity*, (1993) a paper presented at the Intensive Bioethics Seminar held by the Monash University Centre for Human Bioethics, December 1993

<sup>36</sup> *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649

<sup>37</sup> P Darzins (2001) *Dementia Awareness for Lawyers – The Six Step Capacity Assessment Process* [www.cle.unsw.edu.au/dal/materials/darzins01summary.doc] (accessed 03.02.04), p.1

<sup>38</sup> *Ibid*

<sup>39</sup> N.M.P King (1996) *Making Sense of Advance Directives* Georgetown University Press, Washington, p.74

person is found to be incompetent when they made their advance directive, then that finding will effectively vitiate the directive.

In *Werth v Taylor*,<sup>40</sup> the advance directive in the case failed to appreciate the seriousness of the consequences that would ensue if the directive was followed. The Michigan Court of Appeal held that because the patient's prior refusals were made only in contemplation of routine procedures for pregnancy, they did not address the current situation faced by the patient, and therefore the advance directive was deemed ineffective.

In *the Matter of Alice Hughes*,<sup>41</sup> the Court said that, although a competent, adult patient is entitled to refuse life-sustaining treatment, the right operates only if the patient has a clear understanding of the illness and prognosis and the consequences of refusing the treatment. In this case, the patient's refusal to a blood transfusion had been made in anticipation that the hysterectomy she was undergoing was unlikely to be required (and indeed, the doctor had led her to believe that a transfusion would not be required). There was no discussion of what the patient would want if an emergency arose in which she would die without a transfusion. Her refusal therefore did not cover those circumstances and it was justifiable for a medical attorney to be appointed to consent to continuing transfusions. It is important to note in this case that the Court appointed a surrogate decision maker; the doctor did not simply substitute his decision for that of the patient.<sup>42</sup>

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<sup>40</sup> (1991) 475 NW (2d) 426

<sup>41</sup> (1992) 611 A 2d 1148 (NJ SC App Div)

<sup>42</sup> L Skene, (1998) *Law and Medical Practice – Rights, Duties, Claims and Preferences* Butterworths, Sydney

## **5 Advance Directives In Victoria:**

### **5.1 Medical Treatment Act 1988 (Vic):**

#### **5.1.1 Refusal of Treatment by a Competent Person:**

When undertaking an examination of the *Medical Treatment Act 1988 (Vic)* (MTA), it is useful to keep in contemplation the preamble to the Act. The preamble states that “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.”

Aim (d) is consistent with the right of the patient to self-determination and to having their wishes respected and acted upon. This aim is fulfilled through the making by a person of a Refusal of Treatment Certificate (RTC). The RTC (discussed below) allows a person to make a treatment decision in respect of a current condition. Once this RTC is legally effective, it cannot be ignored by any subsequently appointed guardian or anyone else, therefore ensuring that a person’s autonomy and self-determination are effectively preserved.

#### **5.1.2 The Medical Treatment Act 1988 (Vic) preserves the Common Law:**

In addition to the preamble to the Act, the purposes of the Act enshrined in s1 are also instructive. “The purposes of this Act are –

- (a) to clarify the law relating to the right of patients to refuse medical treatment;
- (b) to establish a procedure for clearly indicating a decision to refuse medical treatment;

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

The sections of the Act relating to the refusal of treatment by a patient or their agent or guardian in accordance with the provisions of the Act are clear and fulfil these aims. However under s4 (1), the Act does not affect any right of a person under any other law to refuse medical treatment. This provision preserved the common law regarding the right to refuse treatment, and a patient’s right to have their wishes respected. This provision means that the legislation is not the sole determinant in the issue on advance directives; people who are litigating in this area also have recourse to the common law. It is important to note that in the event of inconsistency between statute and the common law, the statute will always prevail. This is due to the parliamentary rule of supremacy, ensuring that parliament is the supreme lawmaker, prevailing over any ‘judge-made law’ (common law). However, there is no inconsistency between the common law and the MTA.

The common law position is affected by the person responsible provisions of the *Guardianship and Administration Act 1986* (Vic). These provide for a substitute decision maker to consent to medical and dental treatment where a patient is unable to do so. Thus an advance directive made at common law would have to be respected whilst the patient was competent, but once the patient lost capacity, the person responsible for their care could make decisions that go against the advance directive if the person responsible did not consider the advance directive to be in the best interests of the patient. [See further discussion below on the person responsible].

### **5.1.3 Guardian or agent’s right to refuse treatment on behalf of the patient:**

Another important provision of the MTA that is particularly pertinent when looked at in conjunction with the *Guardianship and Administration Act 1986* (Vic) is s5B. This section gives the right to make an advance directive to refuse medical treatment on behalf of a patient to their guardian or agent if certain preconditions are met. “If the registered medical practitioner and another person are each satisfied –

- (a) that the patient’s agent or guardian has been informed about the nature of the patient’s current condition to an extent that would be reasonably sufficient to enable the patient, if he or she were competent, to make a decision about whether or not to refuse medical treatment generally or of a particular kind for that condition [s5B (1)(a)]; and
- (b) that the agent or guardian understands that information [s5B (1)(b)] –

the agent or guardian, on behalf of the patient –

(c) may refuse medical treatment generally [s5B (1)(c)]; or

(d) may refuse medical treatment of a particular kind [s5B (1)(d)] – for that condition.”

Once the preconditions under s5B (1) are met, the Act provides additional safeguards that must also be met under s5B (2). “An agent or guardian may only refuse medical treatment on behalf of a patient if –

(a) the medical treatment would cause unreasonable distress to the patient [s5B (2)(a)]; or

(b) there are reasonable grounds for believing that the patient, if competent, and after giving serious consideration to his or her health and well being, would consider that the medical treatment is unwarranted [s5B (2)(b)].”

#### **5.1.4 Refusal of Treatment Certificate (RTC):**

Under the MTA, a certain type of advance directive is authorised. The Act provides a framework for the refusal of medical treatment for a current condition in the form of a Refusal of Treatment Certificate (RTC). A current condition is not defined in the Act but presumably refers to a condition that the person has at the time of completing the RTC. According to s5 (2) of the Act, the RTC must be in the form prescribed by the Act in Schedule 1. Again, in the form is not defined in the Act but presumably means in language consistent with that used in the Act.

It is also important to note s53 of the *Interpretation of Legislation Act* 1984 (Vic) in this context. This section states that where a form is prescribed by an Act or subordinate instrument for any purpose, any form in or to the like effect of the prescribed form shall, unless the contrary intention appears, be sufficient in law.

This means that a form that is similar in effect to a RTC in Schedule 1 of the MTA will have the same legal effect as the RTC prescribed by the Act. This then raises issues of what would be considered to be to the ‘like effect’ of a RTC. This could potentially cause problems for people who have attempted to create a RTC that they considered to be virtually the same as that prescribed by the Act, but the law may not conclude that it is so. Under the MTA, a RTC is the only legal advance directive available.

However, if a RTC does not comply with the provisions of the MTA, it may still have some relevance at common law, however limited this may be.

Section 5 of the Act provides for the witnessing of a RTC by a registered medical practitioner and another person. Additionally, under s5E, provision is made ensuring that copies of the RTC are given to the appropriate people mentioned under s5E (1)(a)-(c). Also, under this section, there are provisions for ensuring the advance directive is placed on the patient's record kept at the hospital or other relevant facility, specifically provided for in s5E (1)(a).

Section 6 is central to protecting the autonomy provided by the successful completion of a RTC. It provides: "A registered medical practitioner must not, knowing that a refusal of treatment certificate applies to a person, undertake or continue to undertake any medical treatment to which the certificate applies, being the treatment for the condition in relation to which the certificate was given." The penalty for such a breach is 5 penalty units. As the title of the section states, the offence is considered to be a 'medical trespass.'

### **5.1.5 Palliative Care:**

Another feature of the MTA is that its authority does not extend to palliative care, as acknowledged by s4 (2). This means that a person cannot refuse palliative care treatment under the provisions of the Act. Palliative care is defined in s3 as "the provision of reasonable medical procedures for the relief of pain, suffering and discomfort; or the reasonable provision of food and water." However, it is interesting to note that at common law, competent adults have a right to refuse any treatment.<sup>43</sup> Under common law, every adult person is presumed to have the mental capacity to consent to or refuse any medical intervention, including life-saving or life-sustaining treatment, unless and until that presumption is rebutted.<sup>44</sup> Accordingly, it would seem that at common law, a person has a right to refuse palliative care, even though under the MTA, they cannot.

A RTC will be legally valid, under the MTA, if a person of sound mind and over the age of 18 voluntarily completes it, after being informed about their current condition. Under s5, a

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<sup>43</sup> M Ashby; D Mendelson (2003) 'Natural Death in 2003: Are We Slipping Backwards?' *Journal of Law and Medicine* Vol 10

<sup>44</sup> *Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion's Case)* (1992) 175 CLR 218 per McHugh J. See also *Airedale NHS Trust v Bland* [1993] AC 789; *St. George's Health Care Trust v S* [1999] Fam 26; *R (Pretty) v DPP* [2001] UKHL 61; *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam)

registered medical practitioner and another person who attests to these matters must also sign it. The patient does not need to sign the document.

## **5.2 Guardianship and Administration Act 1986 (Vic):**

The *Guardianship and Administration Act 1986 (Vic)* (G & A Act) also has an impact on the effectiveness or otherwise of advance directives. The purpose of the Act is “to enable people with a disability to have a guardian or administrator appointed when they need a guardian or administrator,” as stated in s1. Disability is defined in s3, in relation to a person, “as intellectual impairment, mental disorder, brain injury, physical disability or dementia.”

### **5.2.1 Guardianship:**

Under s22, the Victorian Civil and Administrative Tribunal (VCAT) (the Tribunal) is empowered to make an order appointing a plenary guardian or a limited guardian in respect of a particular person, provided the criteria in s22 (1) are met. These are:

- (a) “that the person has a disability [s22 (1)(a)]; and
- (b) is unable, by reason of the disability, to make reasonable judgments in respect of all or any of the matters relating to her or his person or circumstances [s22 (1)(b)]; and
- (c) is in need of a guardian [s22 (1)(c)].”

Additionally, under s22 (2), the Tribunal must consider a number of factors when deciding if a person needs to have a guardian appointed. Section 22(3) makes it clear that the Tribunal cannot appoint such a guardian unless they are satisfied that the guardian will act in the best interests of the person whom they are representing.

### **5.2.2 Best Interests of the Patient:**

Section 28(1) of the G & A Act provides that the guardian must act in the best interests of the represented person. Section 28(2) provides a non-exhaustive checklist of situations in which the guardian is considered to be acting in the best interests of the represented person. The situation that is most pertinent to this discussion is s28 (2)(e). This subsection provides that “the guardian must act in consultation with the represented person, taking into account, as far as possible, the wishes of the represented person.”

In theory, this is where the person’s guardian could carry out the advance directive of a represented person. In practice, however, all the guardian is required to do at law is take it into account, with no obligation to strictly follow the wishes of the represented person.

Ascertaining the best interests of the patient is crucial. Suppose a person signed an advance directive in the accurate belief that no cure exists for their condition, but when they became incompetent, a cure for their condition had been discovered. Would this advance directive override a decision by a guardian or person responsible in the person's best interests? Here, there is an obvious tension between a patient's right to self-determination and someone acting in the patient's best interests. As *Re Melideo*<sup>45</sup> suggests, the right to self-determination is not absolute. Another USA case, *Re Conroy*<sup>46</sup> recognises that the State is said to have an interest in preserving all human life. "This public interest provides a justification for overriding the decision of terminally ill people to refuse treatment."<sup>47</sup> However, it must be acknowledged that the right to override a person's autonomy should only be exercised in extreme circumstances, such as the one given in the hypothetical example.

### **5.2.3 The Person Responsible:**

Under s36 of the G & A Act a, patient is defined as "a person with a disability who:

- (a) is of or over the age of 18 years [s36 (1)(a)]; and
- (b) is incapable of giving consent to the carrying out of a special procedure or medical or dental treatment, whether or not the person is a represented person [s36 (1)(b)]."

A person is incapable of giving consent "if the person –

- (a) is incapable of understanding the general nature and effect of the proposed procedure or treatment [s36 (2)(a)]; or
- (b) is incapable of indicating whether or not he or she consents or does not consent to the carrying out of the proposed procedure or treatment [s36 (2)(b)]."

If a person satisfies the criteria under s36 (1), then they are regarded as a patient and another person can make medical decisions on their behalf.

Under s37, a person that may make decisions on a patient's behalf is known as a person responsible. Person responsible is defined as the first person listed in s37 who is

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<sup>45</sup> (1976) 390 NYS 2d 523

<sup>46</sup> (1985) 486 A 2d 1209

<sup>47</sup> C Stewart [1999] 'Advanced Directives, the Right To Die and the Common Law: Recent Problems with Blood Transfusions' 23 *Melbourne University Law Review* 161, p.4

responsible for the patient, and who, in the circumstances, is reasonably available and willing and able to make a decision under Part 4A of the Act.

A list of people are given under s37 that may take on the role of the person responsible therefore effectively undertaking the role of making decisions for the patient in relation to medical treatment. The first of these is:

- (a) a person appointed by the patient under s5A of the MTA

A person appointed under this section of the MTA must be by way of an Enduring Power Of Attorney (Medical Treatment). If a patient has not made such an appointment by an Enduring Power of Attorney (Medical Treatment), the second person in the list provided in s37 of the G & A Act will then be the person responsible and so it goes until all the people in the list are tried.

If a person responsible cannot be found from the list provided in s37, an alternative process applies to the provision of medical or dental treatment under s42K. Under this section, a doctor must have made reasonable efforts to attempt to ascertain whether a person responsible exists for a particular patient. If, after such reasonable effort is made, the doctor cannot find a person responsible and, additionally, under s42K (1)(b), the doctor believes on reasonable grounds that the proposed treatment is in the best interests of the patient, then the doctor may, before commencing treatment, give notice to the Public Advocate expressing an intention to treat the patient under s42K (1)(c). Section 42K(2) specifies that the notice to the Public Advocate must include a list of information found in s42K (2)(a)-(d). These are:

- (a) “the nature of the patient’s condition [s42K (2)(a)];
- (b) the medical or dental treatment the registered practitioner proposes carrying out on the patient [s42K (2)(b)]; and
- (c) that the practitioner believes on reasonable grounds that the proposed treatment is in the best interests of the patient [s42K (2)(c)]; and
- (d) that despite reasonable efforts by the practitioner, the practitioner has been unable to ascertain whether there is a person responsible for the patient or, if there is a person responsible, the practitioner is unable to ascertain who that person is or to contact that person [s42K (2)(d).”

Therefore, if a person responsible cannot be found from the list in s37, the patient may still be subject to medical or dental treatment if the doctor attending them considers that the treatment is in the patient's best interests.

Under s38 (1) of the Act, a person responsible must take into account a number of factors in determining whether a medical procedure is in the best interests of the patient. The first of these is:

(a) "the wishes of the patient, so far as they can be ascertained."

Immediately, the problem becomes apparent. When a person responsible is selected, and the patient has previously made an advance directive at common law, such an advance directive only need be taken into account by the person responsible. Therefore, the person responsible may have regard to the advance directive, but may ultimately decide that their own decision regarding the patient will take precedence over the prior wishes of the patient. Of course, it may be possible for the person responsible to consider the patient's prior advance directive as paramount, and carry out the patient's wishes to the best of their ability. However, it is the case where the advance directive is totally overridden by the person responsible that is of the greatest concern to the patient's right to self-determination.

Currently, the law in Victoria under this Act would seem to mandate that a person responsible may override a patient's common law advance directive with their own decision as long as they still act within the patient's best interests, under s37. This interpretation would effectively deny an incompetent patient their autonomous right to decide what will happen to them, and therefore deny them the fundamental right to self-determination.

However, if a person has made a legally valid RTC under the MTA, this decision has to be respected by the person responsible because a doctor cannot act contrary to a RTC without committing an offence under that Act.<sup>48</sup>

### **5.3 Mental Health Act 1986 (Vic):**

The issue of advance directives also arises in a situation where the *Mental Health Act 1986 (Vic)* (MHA) comes into play. Under this Act, a person can be admitted into an approved mental health service as an involuntary patient. Under s3, involuntary patient is

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<sup>48</sup> Section 6 of the *Medical Treatment Act 1988 (Vic)*

defined as “a person admitted to an approved mental health service [under various parts] of the MHA.”

### **5.3.1 Involuntary Patients:**

Under s8 (1)(d), one of the criteria for the admission of an involuntary patient is that a person has refused or is unable to consent to the necessary treatment for the mental illness. This challenges the effectiveness of any advance directive refusing psychiatric treatment made by this person when they were considered competent because it reinforces the evidence that the person is mentally ill.

Advance directives will also be considered ineffective when the other criteria for the admission and detention of an involuntary patient can be established, under s8 (1)(a)-(e) of the MHA. These are:

- (a) “the person appears to be mentally ill; and
- (b) the person’s mental illness requires immediate treatment and that treatment can be obtained by admission to and detention in an approved mental health service; and
- (c) because of the person’s mental illness, the person should be admitted and detained for treatment as an involuntary patient for his or her health and safety (whether to prevent a deterioration in the person’s physical or mental condition or otherwise) or for the protection of members of the public; and
- (d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and
- (e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of that person’s freedom of decision and action.”

Mental illness is defined in s8 as “a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.” Treatment is defined under s3 to be “things done in the course of the exercise of professional skills to:

- (a) remedy the mental disorder; or
- (b) lessen its ill effects or the pain and suffering which it causes.”

To date, no cases have arisen in Victoria that have involved an involuntary patient having drawn up an advance directive while competent. This suggests that until such a case should arise for determination, the legislation would seem to indicate that if all the criteria

under s8 (1) of the MHA are satisfied, the patient becomes an involuntary patient regardless of any advance directives they may have made. If this is the case, such an interpretation would impact on the patient's right to self-determination.

The ultimate decision to admit a patient involuntarily lies with the medical practitioner who provides a recommendation about the person's mental well being, and whether they should be involuntarily admitted and detained in an approved mental health service. This is provided for in s9. Any directives made by this person would be effectively overridden, because if the criteria in s8 (1) are satisfied, the person can be admitted as an involuntary patient regardless of their acceptance or resistance to such a procedure.

As noted by Skene,

[many] of these cases raise profound ethical problems. If people like these are not treated because they will not or cannot consent, then they are being deprived of treatment that they need. On the other hand, their fundamental right not to be detained or treated without consent must be preserved as fully as possible.<sup>49</sup>

### **5.3.2 Non-Psychiatric Treatment:**

Although by definition an involuntary patient must be unwilling or unable to consent to the necessary treatment for his or her mental illness, it should not be automatically assumed that they cannot give consent to other, that is, non-psychiatric treatment. In practical terms, "a psychiatrist will need to assess whether a refusal by an involuntary patient to non-psychiatric treatment is reasonable in the circumstances or whether it reflects an inability to make a reasonable decision on whether to consent to treatment."<sup>50</sup> Note that in determining capacity to consent, it is the consent of the patient and not that of an agent under the MTA or a person responsible or guardian under the G & A Act that is relevant.<sup>51</sup>

Non-psychiatric treatment is defined in s83 (1) as:

- (a) "any surgical operation or procedure or series of related surgical operations or procedures; or
- (b) the administration of an anaesthetic for the purpose of medical investigation; or

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<sup>49</sup> L Skene (1998) *Law and Medical Practice – Rights, Duties, Claims and Defences* Butterworths, Sydney, p.87

<sup>50</sup> L Glanville (2000) *Consent & Refusal to Medical Treatment: Legal Framework – Summary*, p.5

<sup>51</sup> See s3A of the *Mental Health Act 1986* (Vic)

- (c) the administration of a course of treatment or course of medication requiring a prescription or other medical supervision – the primary purpose of which is not the treatment of any mental disorder or the effects of mental disorder but does not include a special procedure within the meaning of the [G & A Act].”

Section 53B sets out the elements required before an involuntary patient can give informed consent. This section provides a stringent test for securing the informed consent of the person. The consent will only be considered informed if the person gives written consent to the treatment after:

- (a) “the person has been given a clear explanation containing sufficient information to enable him or her to make a balanced judgment [s53B (1)(a)]; and
- (b) the person has been given an adequate description of benefits, discomforts and risks without exaggeration or concealment [s53B (1)(b)]; and
- (c) the person has been advised of any beneficial alternative treatments [s53B (1)(c)]; and
- (d) any relevant questions asked by the person have been answered and the answers have been understood by the person [s53B (1)(d)]; and
- (e) a full disclosure has been made of any financial relationship between the person seeking informed consent or the registered medical practitioner who proposes to perform the treatment, or both, and the service, hospital or clinic in which it is proposed to perform the treatment [s53B (1)(e)]; and
- (f) sub-sections (2) and (3) have been complied with [s53B (1)(f)].”

Sub-section 2 requires that a person be given the appropriate prescribed printed statement

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- (a) “advising the person as to his or her legal rights and other entitlements including –
  - (i) the right to obtain legal and medical advice (including a second psychiatric opinion) and to be represented before giving consent [s53B (2)(a)(i)]; and
  - (ii) the right to refuse or withdraw his or her consent and to discontinue all or any part of the treatment at any time [s53B (2)(a)(ii)]; and

(b) containing any other information relating to the treatment that the Department [of Human Services] considers relevant [s53B (2)(b)].”

Sub-section 3 requires that the patient must be given, in addition to the written statement, an oral explanation of the information contained in the statement and, if he or she appears not to have understood, or to be incapable of understanding the information contained in the statement, arrangements must be made to convey the information to the patient in the language, mode of communication or terms which he or she is mostly likely to understand.

Section 85 provides for a person who cannot give consent, and lists a number of people who can provide the consent on their behalf. Essentially, this means that if a person who is admitted as an involuntary patient has a current condition for which they have completed an RTC, that RTC will be respected in relation to their refusal for non-psychiatric medical treatment provided the refusal relates to that current condition under the MTA.

An advance directive that is not in the prescribed form under the MTA may still be respected because the patient remains competent to refuse treatment. Therefore, provided they are in a position to personally give the informed consent, they will be able to have an advance directive respected. However, once they lose competence, a substitute decision maker would be able to make a different decision about that treatment.

### **5.3.3 Psychiatric Treatment:**

Consent is also required in relation to certain specialised psychiatric treatment<sup>52</sup> to be performed on an involuntary patient. An advance directive made by a patient, for example, in relation to Electroconvulsive Therapy (ECT), will be respected in that a person needs to give informed consent to the ECT being performed. However, under s73 (4), “informed consent is not necessary if the nature of the mental disorder that a person has is such that the performance of the [ECT] is urgently needed.” This means that if the treatment is considered to be “urgently needed”, then the patient’s consent, or any advance directive, will be overlooked.

In relation to other psychiatric treatment, under s12 (5), “if an involuntary patient refuses to consent to necessary treatment or is incapable of consenting to treatment for his or her mental illness, consent in writing may be given by the authorised psychiatrist.” Therefore, the psychiatrist’s consent prevails over any advance directives of the patient.

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<sup>52</sup> Eg: psychosurgery and electroconvulsive therapy

The MHA is silent as to the effect a valid RTC refusing psychiatric treatment would have in relation to an involuntary patient who refuses to undergo psychiatric treatment.

Presumably, if a person cannot give informed consent, then their directive probably would not be honoured, especially if the treatment was considered to be 'urgent'. The MHA provides procedures to be followed in relation to a patient who is incapable of providing informed consent. However, these procedures are not designed to take the patient's advance directive or express wishes into account.

Another important issue is how common law advance directives are perceived when they attempt to refuse treatment that is of a psychiatric nature. While the Courts have generally allowed treatment refusals in regard to proposed medical interventions of physical illness, refusals made by competent people for psychiatric treatment are not given the same effect<sup>53</sup> as these people can become subject to being involuntarily detained under the MHA. This highlights the clear disparity between physical illness and mental illness, especially in the way they are viewed by society, and perhaps, the medical profession.

#### **5.3.4 How mental illness is viewed in other jurisdictions and the operation of advance directives:**

Jurisdictions such as Canada have recognised the operation of an advance directive in the face of mental illness. In *Fleming v Reid*,<sup>54</sup> two patients refused future courses of neuroleptic drugs during periods when they were competent. At later times when they were experiencing episodes of mental illness, a review board was legislatively empowered to override their competent anticipatory decisions. The Ontario Court of Appeal upheld the patient's anticipatory decisions and found that the legislation enacted by the review board offended the *Canadian Charter of Rights and Freedoms*. Although it is not clear on the facts of this case whether the two patients were involuntarily admitted, this case shows the broader Canadian approach to the acceptance of advance directives from mentally ill patients.<sup>55</sup>

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<sup>53</sup> R Dresser (1998) 'Commentary On: The Time Frame of Preferences, Dispositions and the validity of Advance Directives for the Mentally Ill' *Philosophy, Psychiatry and Psychology*

<sup>54</sup> (1991) 82 DLR (4<sup>th</sup>) 298

<sup>55</sup> Similar cases can also be found in the USA: *Osgood v District of Columbia* 567 F Supp 1026 (US Dist Ct, 1983); *Rockland Psychiatric Centre v Virginia G* 634 NYS 2d 648 (1995); *Rivers v Katz* 495 NE 2d 337 (NY, 1986); and *Re Boyd* 403 A 2d 744 (DC App Ct, 1979)

Some UK cases have also shown a willingness to accept directives from mentally ill people. In *Re C (Adult: Refusal of Treatment)*,<sup>56</sup> a man who suffered from mental illness was found to be capable of refusing treatment to amputate a gangrenous limb. Again, the facts do not indicate any admission as an involuntary patient however, the case is illustrative of a decision by a mentally ill patient who was competent, being given the same recognition as a 'competent' person's decision. The fact that the man was mentally ill was not determinative of his capacity to make the decision.

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<sup>56</sup> [1994] 1 WLR 290

## **6 Case Law on Advance Directives in Victoria:**

To date, there seems to be little case law in Victoria that directly addresses the question of advance directives and provides any support for their implementation. However, there are two cases that highlight the difficulty for the judiciary to uphold the refusal of living-saving treatment by a competent adult.<sup>57</sup>

### **6.1 *Qumsieh v Guardianship and Management Board and Pilgrim* ([1998] VSCA 45; High Court of Australia, No. M98 of 1998) (Q's Case)**

Being a Jehovah's Witness, a woman (Mrs. Q) had made a recent advance directive rejecting a blood transfusion. She had verbally indicated her wishes and had also written them on a consent form when she was admitted into hospital. However, Mrs. Q's advance directive did not comply with the requirements of the MTA, and therefore it was considered invalid. It is not known if it was considered in the light of s53B of the *Interpretation of Legislation Act 1984* (Vic). Mrs. Q experienced difficulties with haemorrhaging, and therefore was in need of a blood transfusion. Mrs. Q was heavily sedated and unable to communicate a reasoned decision as to the administering of the blood she needed.<sup>58</sup>

Mrs. Q's husband (Mr. Q) sought an order to have the Public Advocate appointed as a limited guardian for his wife (under s32 of the *Guardianship and Administration Board Act 1986* (Vic)) (as it then was). The Guardianship Board made an order appointing the Public Advocate as a temporary guardian and then made further orders delegating the temporary guardianship to Mr. Q. Mr. Q approved the blood transfusions his wife needed and they then were given to her. Once recovered, Mrs. Q sought a declaration that the order of the Guardianship Board was invalid. Beach J of the Supreme Court refused the application, stating that the order made was done so as to save Mrs. Q's life and no Court would contemplate exercising its discretion to grant a remedy in these circumstances.<sup>59</sup>

Mrs. Q then appealed to the Court of Appeal. One ground for such an appeal was a claim that the Guardianship Board had acted outside its jurisdiction, primarily because Mrs. Q had already exercised a competent and binding refusal of blood products. Winneke P (who gave the judgment for the Court) found that the Board did have the requisite jurisdiction as

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<sup>57</sup> M Wallace (2001) (3<sup>rd</sup> edn) *Health Care and the Law* LawBook Co, Sydney

<sup>58</sup> C Stewart [1999] 'Advanced Directives, the Right to Die and the Common Law: Recent Problems with Blood Transfusions' op cit

<sup>59</sup> M Wallace (2001) op cit

the refusal contained in the consent form only related to the administration of blood products during an anaesthetising procedure. “The existence of [the Guardianship Board’s] jurisdiction is not to be denied, in my opinion, because the protected person has previously made a decision that he or she did not want a blood transfusion in different circumstances.”<sup>60</sup> Winneke P also accepted that the Board was not authorising the transfusion, but merely empowering Mr. Q to make the decision.<sup>61</sup> Mrs. Q then applied for leave to appeal to the High Court of Australia, and this was subsequently refused.<sup>62</sup>

The decision in *Q’s Case* is disappointing in that the Court of Appeal did not take the substantial opportunity available to them to clarify the status of treatment refusals made by competent patients. The case failed to shed light on the uncertainty that surrounds the issue of advance directives in Australian common law. It has been recognised that there is a serious need for Australia to adopt a common law position on this issue,<sup>63</sup> and *Q’s Case* has failed to fulfil this need. As acknowledged by Cameron Stewart, “what is disappointing [about *Q’s Case*] is the manifest reluctance of the judges involved to discuss substantive issues of the right to refuse treatment ... [The] decision ... is also illustrative of how little we know about the Australian common law right to refuse treatment.”<sup>64</sup>

Another Victorian case considered the question of a person’s prior wishes in regard to medical treatment.

## **6.2 *Gardner; re BWV* [2003] VSC 173**

This case has a limited connection to advance directives in Victoria. Although the case did not directly involve an advance directive being made by the patient, the judgment of Morris J in the Supreme Court may be analysed for references to respecting a patient’s prior wishes, especially in regard to a person being in a terminal stages of their illness. The case concerned a woman, BWV, who suffered from a progressive and fatal form of dementia. BWV received fluid and nutrition via a percutaneous endoscopic gastrostomy (PEG), which kept her alive. “Reports indicate that the woman in question [had] no

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<sup>60</sup> *Q’s Case* [1998] VSCA 45 (Unreported, Winneke P, Brooking and Ormiston JJA, 17 September 1998) at 17

<sup>61</sup> *Ibid*, at 50

<sup>62</sup> *Qumsieh v Pilgrim* (M98/1998, 29 October 1999)

<sup>63</sup> C Stewart (2000) ‘Qumsieh’s Case, Civil Liability and the Right to Refuse Medical Treatment’ *Journal of Law and Medicine* Vol 8

<sup>64</sup> *Ibid*, p.56

prospect of recovery and that she would not have wanted to continue in the state she was in.”<sup>65</sup>

The main issue involved in this case was whether the PEG tube was considered to be ‘medical treatment’ or ‘palliative care’ in the context of the MTA. If it was considered to be medical treatment, the guardian on behalf of the patient, could refuse the treatment. On the other hand, if it was considered to be palliative care, the treatment could not be refused under the relevant provisions of the MTA.<sup>66</sup> In relation to advance directives, the judgments made in the VCAT decision<sup>67</sup> and by Morris J in the Supreme Court<sup>68</sup> contain statements that allude to the relevance of a patient’s prior wishes.

Both VCAT and the Supreme Court heard evidence of BWV’s prior wishes. BWV’s husband told VCAT that he could vividly remember a discussion he had previously had with his wife “in which it was agreed that if ever either of them reached a stage like her present one they should ‘do something about it’ and not make the other ‘linger on unnecessarily when life has no more meaning and [he or she] was not aware of things any more.”<sup>69</sup> VCAT was happy to accept the evidence given about BWV’s prior wishes, and believed it may have been sufficient to satisfy s5B (2)(b) of the MTA.

Morris J in the Supreme Court considered that BWV’s wishes would be an important consideration in assessing what was reasonable in the circumstances in regard to the artificial feeding received by BWV.<sup>70</sup>

BWV’s case may be authoritative to the extent that BWV’s wishes were presented in evidence both before VCAT and the Supreme Court. However, this was in the context of the requirements of the *Medical Treatment Act 1988* (Vic) and therefore it is very difficult to establish any substantial probative value from this decision in relation to advance directives at common law.

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<sup>65</sup> M Ashby, D Mendelson (2003) op cit, p.260

<sup>66</sup> D Mendelson, M Ashby (2004) ‘The Medical Provision of Hydration and Nutrition – Two Very Different Outcomes in Victoria and Florida’ 11 *Journal of Law and Medicine* 1 (forthcoming)

<sup>67</sup> BWV [2003] VCAT 121

<sup>68</sup> *Gardner; re BWV* [2003] VSC 173

<sup>69</sup> BWV [2003] VCAT 121

<sup>70</sup> *Gardner; re BWV* [2003] VSC 173

## **7 Current Legal Status of Advance Directives in Australia:**

Currently, the law regulating advance directives in Australia is a combination of legislation and case law – some jurisdictions have passed legislation relating to this issue while others have not.<sup>71</sup> In the next section, an examination of the current statute and case law for the Australian States will be undertaken, with the aim of determining how these States may have a persuasive influence on the position of advance directives in Victoria.

Additionally, an examination of international jurisdictions on this issue will be undertaken, again with the aim of discovering their persuasive value to prospective Australian cases. The analysis of these jurisdictions will be focused on the UK, Canada and the USA respectively.

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<sup>71</sup> B Flynn; M Lowe; J McPhee; Kerridge I (1999) 'Advance Directives' op cit

## **8 Advance Directives In The Australian States:**

### **8.1 South Australia:**

Currently, there is no case law in South Australia that discusses the issues relating to advance directives.

#### **8.1.1 *Consent to Medical Treatment and Palliative Care Act 1995 (SA)***

Under s7 of this Act, the advance directive available is an 'anticipatory grant' refusing consent to medical treatment. The anticipatory grant is only effective for patients in terminal stages of a terminal illness or in a persistent vegetative state, who are not competent to make treatment decisions, under s7 (1)(a) & (b).

Terminal illness is defined in s4 as "an illness or condition that is likely to result in death."

Terminal stage is also defined in s4 as "the phase of the illness reached when there is no real prospect of recovery or remission of symptoms."

Under s7 (1), the anticipatory grant will be legally valid if it is made by a patient of sound mind over the age of 18 years. The anticipatory grant must be in the prescribed form (that found in Schedule 2), signed by the patient and witnessed by one person, who need not be a medical practitioner.

### **8.2 Australian Capital Territory:**

Currently, there is no case law in the Australian Capital Territory that discusses the issues relating to advance directives. The Community Advocate was contacted, and she stated that she had no knowledge of any relevant case law in the State.

#### **8.2.1 *Medical Treatment Act 1994 (ACT)***

This Act is based on the Victorian MTA. The advance directive is a direction refusing treatment generally or treatment of a particular kind, as mandated by s6. Under s3, a direction is defined as "a direction made in accordance with Division I of Part II of the Act."

The treatment does not have to relate to a current condition, as currently mandated under the Victorian MTA. According to s6, the direction will be legally valid if made by patients of sound mind and over 18 years of age. It must also be in the prescribed form and witnessed by two people, neither of whom needs to be a medical practitioner, as required by s7.

Importantly, under s5 (2), the Act does not cover refusals of palliative care.

### **8.3 Queensland:**

Currently, there is no case law in Queensland that discusses the issues relating to advance directives. The Public Advocate in Queensland was contacted, and she did not have any knowledge of any relevant case law.

#### **8.3.1 Powers of Attorney Act 1998 (Qld)**

Under s35 (1), the directives authorised by this Act are advance health directives that are defined as “directions to withhold or withdraw life sustaining measures.” These cannot operate unless one of the following applies:

- (a) “the patient has a terminal illness or an incurable condition and is not expected to live more than a year, or is in a persistent vegetative state, or is permanently unconscious, or has a severe illness with no reasonable prospect of being able to live without the continued application of life sustaining measures [s36 (2)(a)]; or
- (b) if the direction concerns artificial hydration or nutrition, the life sustaining measure would be contrary to good medical practices [s36 (2)(b)]; or
- (c) the patient has no reasonable prospect of regaining capacity for health matters [s36(2)(c)].”

The advance health directives are legally valid if they are in the prescribed form, signed by the patient or another person at the patient’s direction, and witnessed by two people, one of whom must be a medical practitioner, as required by s44(2).

### **8.4 Northern Territory:**

Currently, there is no case law in the Northern Territory that discusses the issues relating to advance directives.

#### **8.4.1 Natural Death Act 1988 (NT)**

Under the Act, directives refusing treatment are only effective in the event of terminal illness. Terminal illness is defined in s3 as “such an illness, injury or degeneration of mental or physical faculties that death would, if extraordinary measures were not undertaken, be imminent; and from which there is no reasonable prospect of a temporary or permanent recovery, even if extraordinary measures were undertaken.” Extraordinary measures are also defined in s3 as “medical or surgical measures that prolong life, or are

intended to prolong life, by supplanting or maintaining the operation of bodily functions that are temporarily or permanently incapable of independent operation.”

According to s4(1), the directive will be legally valid if it is made by patients of sound mind who are over 18 years of age. The directive must be in the prescribed form, signed by the patient and witnessed by two people, who need not be medical practitioners. Under s4(2), the treating doctor cannot be a witness.

### **8.5 New South Wales, Tasmania & Western Australia:**

There is no direct legislation available as to advance directives in these States, but New South Wales and Tasmania have legislation providing for the appointment of surrogate decision-makers where a person is no longer competent to make their own decisions about their health care.

The legislation in New South Wales is the *Guardianship Act 1987* (NSW) and the legislation in Tasmania is the *Guardianship and Administration Act 1995* (Tas). Both of these Acts allow a person responsible or a guardian to consent to medical treatment on behalf of the patient.

Western Australia has no legislation in this area, either as to advance directives or the appointment of a person responsible or a guardian who can consent to medical treatment. It is assumed that the common law of England and Canada may apply in this jurisdiction.

## **9 Case Law In International Jurisdictions:**

### **9.1 United Kingdom:**

There are several cases in the UK that deal with the question of advance directives, and the right to refuse treatment. In *Re T (Adult: Refusal of Treatment)*,<sup>72</sup> the Court approved the Canadian case of *Malette v Shulman*.<sup>73</sup> Lord Donaldson confirmed that “if a patient, while competent and properly informed about the consequences of refusing or agreeing to treatment (in the circumstances of his or her present condition) had given a clear direction, then that direction is binding.”<sup>74</sup>

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<sup>72</sup> [1992] 4 All ER 649

<sup>73</sup> (1990) 67 DLR (4<sup>th</sup>) 321

<sup>74</sup> [1992] 4 All ER at 103

*Re C (Adult: Refusal of Treatment)*<sup>75</sup> continued to reinforce the significance of advance directives. Thorpe J stated that “it is also common ground that a refusal can take the form of a declaration of intention never to consent in the future or never to consent to some future circumstances.”<sup>76</sup>

The most recent case supporting the use of advance directives is *Ms B v An NHS Hospital Trust*.<sup>77</sup> In this case, Ms B was treated with a ventilator for recurring, persistent respiratory problems and had been dependent on the ventilator ever since she was put on it. She had expressed a wish not to be kept artificially alive by the use of the ventilator. During her long terminal illness, Ms B had made several requests to doctors tending to her to have the ventilator switched off. Those requests were met with refusals. Butler-Sloss P found that Ms B had the requisite capacity to make these decisions, and therefore the decisions should be respected. As noted by Butler-Sloss, “[Ms B’s] wishes were clear and well expressed. She had clearly done a considerable amount of investigation and was extremely informed about her condition.”<sup>78</sup> Butler-Sloss accepted that Ms B had the required capacity to make a decision about the ventilator being switched off, and stated, “one must allow for those as severely disabled as Ms. B, for some of whom life in that condition may be worse than death ... unless the gravity of the illness has affected the patient’s capacity, a seriously disabled patient has the same rights as the fit person to respect for personal autonomy.”<sup>79</sup>

## **9.2 Canada:**

The common law in Canada has also supported the use of advance directives, and this is evidenced by a number of cases that emphasize their importance.

In *Malette v Shulman*, Robins JA emphasized that “a doctor is not free to disregard a patient’s advance instructions any more than he would be free to disregard instructions given at the time of the emergency.”<sup>80</sup> This reinforces the strong position adopted by some Canadian Courts as to the issue of patient autonomy, and self-determination.

Robins JA in *Fleming v Reid* reaffirmed the position he adopted in *Malette v Shulman* and added,

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<sup>75</sup> [1994] 1 WLR 290

<sup>76</sup> *Ibid.*, at 294-5

<sup>77</sup> [2002] EWHC 429 (Fam)

<sup>78</sup> [2002] EWHC 429 (Fam) at 53

<sup>79</sup> [2002] EWHC 429 (Fam) at 94

<sup>80</sup> (1990) 67 DLR (4<sup>th</sup>) 321, at 330

a patient, in anticipation of circumstances wherein he or she may be unconscious or otherwise incapacitated and thus unable to contemporaneously express his or her wishes about a particular form of medical treatment, may specify in advance his or her refusal to consent to the proposed treatment. A doctor is not free to disregard advance instructions, even in an emergency.<sup>81</sup>

*Nancy B v Hôtel-Dieu de Québec*<sup>82</sup> was very similar in factual scenario to the English case of *Ms B*. It involved a competent woman with an incurable neurological disorder who sought an injunction to enforce her refusal of artificial ventilation, without which she was incapable of breathing independently. The Quebec Superior Court held that the plaintiff was entitled to the injunction sought, and ordered that the treating doctor be permitted to stop ventilation if and when the plaintiff so instructed. Dufour J found that the woman had a right to refuse treatment that was almost absolute, subject only to the corresponding right of others not to have their own health threatened.

### **9.3 United States of America:**

Lastly, the USA cases are also persuasive in their support of advance directives, and of a patient's right to refuse treatment and to have their autonomy respected. This is reinforced by the fact that advance directives have a statutory basis in all 50 American States.<sup>83</sup>

In *Cruzan v Director, Missouri Department of Health*,<sup>84</sup> the Court held that an advance directive could be an effective tool in ensuring that a patient's wishes that certain treatment not be given be respected.

Conversely, according to *Werth v Taylor*,<sup>85</sup> where a directive is based on a false premise or misunderstanding, or it fails to appreciate the seriousness of the consequences which would ensue, or it does not fully appreciate the range of alternatives that might be available, the directive may very well be insufficient and the refusal consequently ineffective.<sup>86</sup> The Michigan Court of Appeal held that because the patient's prior refusals had not been made when her life was hanging in the balance or when it appeared that

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<sup>81</sup> (1991) 82 DLR (4<sup>th</sup>) 298, at 310

<sup>82</sup> (1992) 86 DLR (4<sup>th</sup>) 385

<sup>83</sup> M.R. Tonelli (1996) 'Pulling the Plug on Living Wills – A Critical Analysis of Advance Directives' *Chest* 1996; 110

<sup>84</sup> (1990) 497 US 261

<sup>85</sup> (1991) 475 NW (2d) 426

<sup>86</sup> J Blackwood (1997) op cit

death might be a possibility if a transfusion were not given, her refusals were not contemporaneous or informed, and therefore, they were invalid.

#### **9.4 International Status of Advance Directives:**

As established in the international jurisdictions, advance directives have a considerable legal standing in the common and statutory law of the countries examined. However, it is also important to note that certain elements are common to the cases where a Court has upheld the validity of an advance directive.

As clearly emphasised in the English case of *Ms B v An NHS Hospital Trust*<sup>87</sup> and the Canadian case of *Nancy B v Hôtel-Dieu de Québec*<sup>88</sup>, the Courts had consideration to such factors as the patient's comprehension of their illness and their prognosis. Both of the women in these cases had a comprehensive knowledge of their illness and were both fully aware of the consequences of their refusal of treatment. The success of these cases highlights the importance of those factors to establish a successful outcome for the patient seeking to have their advance directive complied with.

Common law advance directives are practically difficult to apply to a person's illness.

There are also a number of factors related to completing an advance directive which can make them a difficult document for the Courts to uphold. Some of these factors include:

- possible advances in medical treatment that were not evident at the time of making a directive;
- the requirement of a certain level of knowledge about the illness and
- likely chances of recovery that are not generally known or considered when an advance directive is made.

These factors may ultimately effect the willingness of a Court to enforce an advance directive, as the case of *Werth v Taylor*<sup>89</sup> highlights. Because the advance directive in that case was sought to be enforced in substantially different circumstances to when it was made, the Court considered it to be ineffective.

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<sup>87</sup> [2002] EWHC 429

<sup>88</sup> (1992) 86 DLR (4th) 385

<sup>89</sup> (1991) 475 NW (2d) 426

Additionally, in the USA case of *In the Matter of Alice Hughes*,<sup>90</sup> the Court required the patient to have an unimpeded understanding of their illness and prognosis and the likely consequences of refusing the treatment.

These cases show that despite the fact that the Courts have been willing to accept the implementation of an advance directive, various factors have been considered to be important to an assessment of whether an advance directive will be upheld.

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<sup>90</sup> (1992) 611 A 2d 1148 (NJ SC App)

## **10 Conclusion:**

As has been shown, the decisions around advance directives in international jurisdictions have placed them in a prominent place in international common law. They are considered to be an important way of protecting a patient's autonomy and their right to self-determination in regard to refusal of medical treatment.

The UK and Canada have led the way in ensuring that advance directives will be acknowledged and adhered to in the majority of cases, provided certain factors, outlined below, are evident. However, the Australian position is much less clear. There is no common law that is decisive in determining the status of advance directives in Australia; therefore, all recourse must be made to international jurisdictions.

It is important to note that common law advance directives are practically difficult to implement. This is because the person making the advance directive might not have had access to the extensive knowledge they may have needed to make an informed decision, or they have not considered the speed with which medical treatment has advanced, and will continue to advance in relation to their illness. Additionally, they may not have considered the important issues surrounding the particular illness they are suffering. As has been highlighted, the Courts have considered factors like these to be important in their decision to uphold or override an advance directive. This is more clearly seen in the international jurisdictions.

In Victoria, it would seem that the law regarding advance directives is that when a person is competent, their advance directive may well be respected, subject to the issues previously discussed. However, once the person is defined as incompetent, their advance directive holds a much weaker position. The law only requires that guardians and agents take the advance directive 'into account' when they are ascertaining what treatment to refuse or consent to on behalf of the patient<sup>91</sup>, unless the directive is in the form of a legally recognised RTC under the MTA. Additionally, when a person responsible is appointed, they too only need to take the directives of the patient 'into account,'<sup>92</sup> unless it is a RTC under the MTA. This effectively renders a patient's common law advance directive of little significance, unless their guardian or person responsible decides that they will respect the patient's wishes as found in their advance directive. Indeed, given the

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<sup>91</sup> Section 28 of the *Guardianship and Administration Act 1986* (Vic)

<sup>92</sup> Section 37 of the *Guardianship and Administration Act 1986* (Vic)

inherent problems associated with completing an accurate, well-informed and up to date advance directive, it may not be in the interests of patient autonomy to require substitute decision makers such as agents to strictly adhere to it.

Advance directives have a status, however limited it may be, in the current Australian legal environment. However, given their current untested nature in an Australian Courtroom, the more legally viable option for a current condition is the completion of a RTC under the MTA. Through this, a patient can ensure that their wishes have a strong legal backing and cannot be overridden by a subsequent decision made by an agent or guardian once the patient becomes incompetent.

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### **11.5 Legislation:**

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*Guardianship Act* 1987 (NSW)

*Guardianship and Administration Act* 1986 (Vic)

*Guardianship and Administration Act* 1995 (Tas)

*Health Care Directive Act* 1992 (Canada)

*Medical Treatment Act* 1988 (Vic)

*Medical Treatment Act* 1994 (ACT)

*Mental Health Act* 1986 (Vic)

*Natural Death Act* 1988 (NT)

*Powers of Attorney Act* 1998 (Qld)

### **11.6 Office Resources:**

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