

## REFUSING ADVANCE REFUSALS: ADVANCE DIRECTIVES AND LIFE-SUSTAINING MEDICAL TREATMENT

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*[The law recognises the right of a competent adult to make an advance refusal of life-sustaining medical treatment. However, this right is not unqualified and there are circumstances in which a health professional or a court will be permitted to disregard an advance directive. Underpinning this qualified right is the tension between the principles of self-determination or autonomy, and sanctity of life. This article explores the excuses available in Australia to health professionals who do not wish to comply with an advance directive. It compares the common law with those jurisdictions that have enacted legislation, and evaluates and critiques the different excuses available.]*

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## I INTRODUCTION

There has not been an Australian case that has directly considered whether a competent adult has a right to refuse life-sustaining medical treatment. Nevertheless, there seems little doubt in the literature that this right would be recognised as forming part of Australia's common law should the issue ever be tested.<sup>1</sup> Certainly, such a right has been endorsed in other common law jurisdictions, including in the United States,<sup>2</sup> Canada,<sup>3</sup> New Zealand<sup>4</sup> and the United Kingdom.<sup>5</sup> These jurisdictions have also recognised that an adult may make a decision to refuse life-sustaining medical treatment in advance of the medical situation arising.<sup>6</sup> Again, the Australian courts have not yet directly considered whether the recognition of such directives forms part of the common law of this country but it is generally accepted that this is the case.<sup>7</sup>

Some Australian jurisdictions have put the matter beyond doubt by legislating to recognise the right of an adult to refuse treatment in advance. Legislation providing for advance directives has been enacted in the Australian Capital Territory,<sup>8</sup> the Northern Territory,<sup>9</sup> Queensland,<sup>10</sup> South Australia<sup>11</sup> and Victo-

<sup>1</sup> Cameron Stewart, 'Advanced Directives, the Right to Die and the Common Law: Recent Problems with Blood Transfusions' (1999) 23 *Melbourne University Law Review* 161, 173–8; John Blackwood, "I Would Rather Die with Two Feet than Live with One"; The Status and Legality of Advance Directives in Australia' (1997) 19 *University of Queensland Law Journal* 270, 278–81; Loane Skene, *Law and Medical Practice: Rights, Duties, Claims and Defences* (2<sup>nd</sup> ed, 2004) 296–7.

<sup>2</sup> *Cruzan v Director of Missouri Department of Health*, 497 US 261 (1990); *Vacco v Quill*, 521 US 793 (1997).

<sup>3</sup> *Nancy B v Hotel-Dieu de Quebec* (1992) 86 DLR (4<sup>th</sup>) 385; *Malette v Schulman* (1990) 67 DLR (4<sup>th</sup>) 321.

<sup>4</sup> *Re G* [1997] 2 NZLR 201; *Auckland Area Health Board v A-G (NZ)* [1993] 1 NZLR 235. See also *New Zealand Bill of Rights Act 1990* (NZ) s 11, although it refers only to refusing medical treatment in general terms.

<sup>5</sup> *Re B (Adult: Refusal of Medical Treatment)* [2002] 2 All ER 449 ('*Re B*'); *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819 ('*Re C*'); *Airedale NHS Trust v Bland* [1993] AC 789; *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 649 ('*Re T*'); *R (Burke) v General Medical Council* [2006] QB 273 ('*R (Burke) Appeal*').

<sup>6</sup> *HE v A Hospital NHS Trust* [2003] 2 Fam Law R 408; *Re C* [1994] 1 All ER 819; *Airedale NHS Trust v Bland* [1993] AC 789, 864 (Lord Goff), 892 (Lord Mustill); *Re T* [1992] 4 All ER 649, 653, 662–3 (Lord Donaldson MR), 665–6 (Butler-Sloss LJ), 669 (Staughton LJ); *Malette v Shulman* (1990) 67 DLR (4<sup>th</sup>) 321; *R (Burke) v General Medical Council* [2005] QB 424 ('*R (Burke)*') (although note that the Court of Appeal suggested caution in relying on aspects of Munby J's judgment in future cases: *R (Burke) Appeal* [2006] QB 273, 295 (Lord Phillips MR)).

<sup>7</sup> This accords with the view expressed in Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-Making by and for People with a Decision-Making Disability*, Report No 49 (1996) vol 1, 357. Further, although not expressly addressing the point, the Victorian Court of Appeal in *Qumsieh v Guardianship and Administration Board* [1998] VSCA 45 (Unreported, Winneke P, Brooking and Ormiston JJA, 17 September 1998) and the High Court in refusing special leave to appeal (*Qumsieh v Pilgrim* (2000) 21(4) Leg Rep SL 3d) seemed to accept that a common law advance directive would be binding. The missed opportunity to discuss the right to refuse life-sustaining medical treatment is discussed in Cameron Stewart, 'Qumsieh's Case, Civil Liability and the Right to Refuse Medical Treatment' (2000) 8 *Journal of Law and Medicine* 56.

<sup>8</sup> *Medical Treatment Act 1994* (ACT).

ria.<sup>12</sup> Although the statutes vary significantly in scope and operation, all allow an adult, in certain circumstances, to complete a directive refusing life-sustaining medical treatment at a future time when that adult no longer has capacity to make the decision. Other states are also considering legislative recognition of advance directives. In Western Australia, a current review of the law on medical treatment for the dying is giving consideration to whether the right to make an advance directive should be statutorily enshrined.<sup>13</sup> A Bill that would provide for advance directives has also been recently introduced into the Tasmanian Parliament.<sup>14</sup> In most jurisdictions where advance directives are recognised by statute, provision is also made for the common law to continue to operate, giving rise to a two-tier system.<sup>15</sup>

A failure to follow an advance directive, including one that refuses life-sustaining medical treatment, attracts legal consequences. Providing treatment without consent<sup>16</sup> brings with it the possibility of the health professional facing both criminal and civil liability.<sup>17</sup> Criminal charges of assault or battery<sup>18</sup> may be laid and the adult may also pursue a civil claim for trespass to the person.<sup>19</sup> Some jurisdictions with legislation on the issue also create a separate criminal offence.<sup>20</sup>

However, there are circumstances in which it is appropriate that an advance directive not be followed. Certainly the situation is more complex when a refusal

<sup>9</sup> *Natural Death Act 1988* (NT).

<sup>10</sup> *Powers of Attorney Act 1998* (Qld). The Queensland regime is discussed at some length in Ben White and Lindy Willmott, 'Rethinking Life-Sustaining Measures: Questions for Queensland' (Issues Paper, Queensland University of Technology, 2005) <[http://www.law.qut.edu.au/files/QUT\\_LifeSustainingIssuesPaper.pdf](http://www.law.qut.edu.au/files/QUT_LifeSustainingIssuesPaper.pdf)>.

<sup>11</sup> *Consent to Medical Treatment and Palliative Care Act 1995* (SA).

<sup>12</sup> *Medical Treatment Act 1988* (Vic).

<sup>13</sup> Attorney-General and Minister for Health, Western Australia, 'Medical Treatment for the Dying' (Discussion Paper, Department of Health, Western Australia, 2005).

<sup>14</sup> Directions for Medical Treatment Bill 2005 (Tas).

<sup>15</sup> *Medical Treatment Act 1994* (ACT) s 5; *Natural Death Act 1988* (NT) s 5; *Medical Treatment Act 1988* (Vic) s 4. The South Australian legislation is silent about the effect of the legislation on the common law, but in the absence of a provision to the contrary, common law rights would continue to apply: Cameron Stewart, 'The Australian Experience of Advance Directives and Possible Future Directions' (2005) 24 *Australasian Journal on Ageing* S25, S26. Due to a drafting error when enacting Queensland's guardianship regime (comprised of the *Powers of Attorney Act 1998* (Qld) and the *Guardianship and Administration Act 2000* (Qld)), the authors are of the view that the common law regime no longer applies in Queensland: see Ben White and Lindy Willmott, 'Will You Do as I Ask? Compliance with Instructions about Health Care in Queensland' (2004) 4 *Queensland University of Technology Law and Justice Journal* 77, 77–8, 83.

<sup>16</sup> It is beyond the scope of this article to consider when the provision of treatment without consent may be justified at law. However, in this regard, see generally Skene, above n 1, 83–170.

<sup>17</sup> *Secretary, Department of Health and Community Services v J W B* (1992) 175 CLR 218, 232 (Mason CJ, Dawson, Toohey and Gaudron JJ) ('*Marion's Case*').

<sup>18</sup> Note that in some jurisdictions, the crimes of assault and battery have been merged into a single offence. For example, in Queensland, the crime of assault as defined by *Criminal Code 1899* (Qld) s 245 includes what was battery at common law: *White v Connolly* [1927] St R Qd 75.

<sup>19</sup> It is beyond the scope of this article to consider in detail the civil actions that may be available, but it is noted that other civil claims may also be possible: see generally Skene, above n 1, 39–47. See also Stewart, 'Qumsieh's Case', above n 7, 59–67.

<sup>20</sup> See, eg, *Guardianship and Administration Act 2000* (Qld) s 79; *Medical Treatment Act 1988* (Vic) s 6.

of life-sustaining medical treatment is contained in an advance directive than when given at the time the decision needs to be made. In the latter case, there is scope for a health professional to discuss the issues with the adult and explore any doubts the health professional might have. If relying on an advance directive, there is no such opportunity and difficulties may arise in relation to issues such as what the adult intended their directive to cover or whether it should apply to the particular situation that has arisen.

This article explores the excuses upon which health professionals can rely at common law and under Australian legislation<sup>21</sup> to decline to follow valid advance directives that refuse life-sustaining medical treatment.<sup>22</sup> Part II explores a preliminary point on the issue of validity and what is required by common law and statute. Then, assuming that there is a valid advance directive in existence, Part III considers what excuses a health professional might be able to rely upon in relation to advance directives at common law. The common law has permitted nonadherence to such directives where the adult completing it would not have intended his or her refusal to apply to the circumstances that have actually arisen.<sup>23</sup> Although there is a single test, the different categories of case that might arise are considered separately. Part IV then examines the excuses available in relation to the various statutory provisions for advance directives.<sup>24</sup> Finally comparison is made with the common law and suggestions are advanced in relation to the appropriateness of different statutory excuses.

#### A Some Definitions

A final point should be made in relation to terminology. For the sake of clarity, a number of standard terms are adopted throughout this article, irrespective of those which may be used in a particular statutory regime, or at common law, for equivalent expressions. ‘Advance directive’ means instructions given by an adult about health care in advance of loss of capacity, intended to operate after loss of capacity.<sup>25</sup> ‘Life-sustaining medical treatment’ means treatment that sustains or

<sup>21</sup> For a recent comment on the current Australian experience regarding advance directives at common law and under statute, and their overall effectiveness in advance care planning, see Stewart, ‘The Australian Experience of Advance Directives’, above n 15, S28.

<sup>22</sup> It does not therefore address the issue of demands in advance for treatment that is futile. In this regard, see *R (Burke)* [2005] QB 424 which was overturned by the Court of Appeal in *R (Burke) Appeal* [2006] QB 273.

<sup>23</sup> Ian Kennedy and Andrew Grubb, *Medical Law* (3<sup>rd</sup> ed, 2000) 2037–8.

<sup>24</sup> This article does not consider in detail the proposed legislative regime for Tasmania as set out in the Directions for Medical Treatment Bill 2005 (Tas). This Bill was introduced into the Tasmanian Parliament in June 2005, but debate has been adjourned to allow for further consideration of the issues, including the impact of the Respecting Patient Choices programme: Tasmania, *Parliamentary Debates*, Legislative Council, 1 September 2005, 16–22 (Norma Jamieson). The Respecting Patient Choices programme promotes advance care planning and at the time of writing is being trialled in the Royal Hobart Hospital.

<sup>25</sup> *Re T* [1992] 4 All ER 649, 653 (Lord Donaldson MR) refers to an ‘anticipatory refusal’; *Medical Treatment Act 1994* (ACT) ss 3, 6 refer to a ‘direction’ to refuse medical treatment; *Natural Death Act 1988* (NT) s 4 refers to a ‘direction’ to refuse extraordinary measures; *Powers of Attorney Act 1998* (Qld) s 35 refers to an ‘advance health directive’; *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7 refers to an ‘anticipatory grant or refusal of consent to medical treatment’; *Medical Treatment Act 1988* (Vic) ss 3, 5 refer to a ‘refusal of treatment certificate’.

prolongs the operation of vital bodily functions that are incapable of independent operation.<sup>26</sup> In this article, this includes treatment such as assisted ventilation, cardiopulmonary resuscitation, and artificial hydration and nutrition. ‘Health professional’ means a person who provides medical treatment to an adult.<sup>27</sup> The term ‘excuse’ will be used generically to describe both provisions that permit a health professional not to follow an advance directive and those which actually prohibit reliance on such a document.<sup>28</sup> Finally, this article considers advance directives that can be made by an ‘adult’, that is a person who has reached 18 years.

## II ADVANCE DIRECTIVES — VALIDITY AT COMMON LAW AND UNDER STATUTE

The following provides an overview of when a common law advance directive and one made pursuant to statute will be regarded as valid. This is important to consider at the outset because a directive that is not valid is not binding and the later consideration of excuses for health professionals is premised on the existence of an advance directive that is otherwise binding. Limitations on the circumstances under which statutory advance directives refusing life-sustaining medical treatment can operate or be made are also briefly noted in this Part.

### A Common Law Advance Directives

For a common law advance directive to be valid, two requirements must be met.<sup>29</sup> First, the adult must have been competent at the time that the direction was given. This means that the adult had capacity to make the decision and was

<sup>26</sup> At common law, no standard terminology is used to refer to this type of treatment: see generally *Re T* [1992] 4 All ER 649; *Re B* [2002] 2 All ER 449; *HE v A Hospital NHS Trust* [2003] 2 Fam Law R 408. In the legislation, various terminology and definitions are used: *Powers of Attorney Act 1998* (Qld) sch 2 s 5A defines ‘life-sustaining measures’; *Medical Treatment Act 1988* (Vic) s 3 and *Medical Treatment Act 1994* (ACT) s 3 refer to ‘medical treatment’; *Natural Death Act 1988* (NT) s 3 refers to ‘extraordinary measures’; *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 4 refers to ‘life sustaining measures’.

<sup>27</sup> At common law, no standard terminology is used to refer to health professionals: see generally *Re T* [1992] 4 All ER 649; *Re B* [2002] 2 All ER 449; *HE v A Hospital NHS Trust* [2003] 2 Fam Law R 408. In the legislation, various terminology and definitions are used: *Powers of Attorney Act 1998* (Qld) sch 3 defines ‘health providers’; *Medical Treatment Act 1988* (Vic) s 3 refers to ‘registered medical practitioners’; *Medical Treatment Act 1994* (ACT) s 3 refers to a ‘health professional’; *Natural Death Act 1988* (NT) s 4 and *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 4 refer to ‘medical practitioners’.

<sup>28</sup> There are different approaches in different jurisdictions. For example, *Powers of Attorney Act 1998* (Qld) s 103 excuses a health professional from liability if he or she chooses, on reasonable grounds, not to follow an advance directive. By contrast, *Medical Treatment Act 1994* (ACT) s 12 prohibits a health professional from following a directive in certain circumstances.

<sup>29</sup> Some commentators suggest that there are four requirements for an anticipatory refusal of treatment to be valid: (1) that the patient be competent; (2) that there be no undue influence exerted on the patient when making the decision; (3) that the patient be sufficiently informed when making the decision; and (4) that the patient intend the refusal to apply to the situation that subsequently arose: see Kennedy and Grubb, above n 23, 2037. However, the authors of this article prefer the view that only the first two limbs relate to the validity of the directive and that the third and fourth categories are relevant to determining whether the directive will operate in the circumstances that have subsequently arisen. The third and fourth categories will be considered later: see below Part III.

able to communicate the decision in some way.<sup>30</sup> There have been many judicial pronouncements on what is meant by the term ‘capacity’ and the law is now regarded as settled.<sup>31</sup> Munby J recently summarised the test for capacity in the following way:

Essentially capacity is dependent upon having the ability, whether or not one chooses to use it, to function rationally: having the ability to understand, retain, believe and evaluate (ie, process) and weigh the information which is relevant to the subject matter.<sup>32</sup>

Adults are presumed to have the capacity to make a decision about medical treatment.<sup>33</sup> However, particular care must be taken in assessing the adult’s capacity where the direction relates to refusal of life-sustaining medical treatment. Because the consequences of such a direction are so grave, the adult’s competence must be correspondingly high.<sup>34</sup>

The second requirement for a valid advance directive at common law is that it must have been given free from undue influence.<sup>35</sup> In the well-known English case, *Re T*,<sup>36</sup> the Court of Appeal held that a woman who was 34 weeks pregnant and who refused a blood transfusion had been subject to the undue influence of her mother, a Jehovah’s Witness.<sup>37</sup> It was held that the doctors had therefore been justified in ignoring the woman’s refusal and administering the transfusion.

From a legal perspective, legitimate influence must be distinguished from undue influence. As pointed out by Staughton LJ in *Re T*, an adult’s decision regarding treatment is frequently ‘influenced’ by others,<sup>38</sup> such as the treating doctor, family and friends. However, the law regards influence as ‘undue’ only if there is ‘such a degree of external influence as to persuade the patient to depart

<sup>30</sup> *R (Burke)* [2005] QB 424, 440 (Munby J).

<sup>31</sup> See, eg, *Re C* [1994] 1 All ER 819; *Re MB (Medical Treatment)* [1997] 2 Fam Law R 426; *Re B* [2002] 2 All ER 449.

<sup>32</sup> *R (Burke)* [2005] QB 424, 440.

<sup>33</sup> *HE v A Hospital NHS Trust* [2003] 2 Fam Law R 408, 414–15, (Munby J); *Re C* [1994] 1 All ER 819, 824 (Thorpe J); *Airedale NHS Trust v Bland* [1993] AC 789, 864 (Lord Goff), 892 (Lord Mustill); *Re T* [1992] 4 All ER 649, 664 (Lord Donaldson MR).

<sup>34</sup> *Re B* [2002] 2 All ER 449, 472 (Butler-Sloss P); *Re T* [1992] 4 All ER 649, 661 (Lord Donaldson MR). For commentary about whether the high standard required of adults in this context is consistent with notions of autonomy, see Joanna Manning, ‘Autonomy and the Competent Patient’s Right to Refuse Life-Prolonging Medical Treatment — Again’ (2002) 10 *Journal of Law and Medicine* 239. See also Malcolm Parker, ‘Judging Capacity: Paternalism and the Risk-Related Standard’ (2004) 11 *Journal of Law and Medicine* 482, where he argues that there should be just the one standard for assessment of capacity, not a standard that alters with the gravity of the decision. He further argues that the latter ‘risk-related’ assessment of capacity is paternalistic in that it imports medical values into determination of capacity: at 489–90.

<sup>35</sup> Indeed, the same principle applies if the consent to, or refusal of, treatment was not made in advance of treatment.

<sup>36</sup> [1992] 4 All ER 649.

<sup>37</sup> *Ibid* 664 (Lord Donaldson MR), 668 (Butler-Sloss LJ). Although the patient had been raised by her mother as a Jehovah’s Witness and adhered to some of their beliefs, she was not herself a Jehovah’s Witness: at 654 (Lord Donaldson MR).

<sup>38</sup> *Ibid* 669.

from [his or] her own wishes'.<sup>39</sup> When this occurs, an advance directive made by the adult will not be valid.<sup>40</sup>

In contrast to the statutory regimes discussed below, there are no requirements at common law as to formalities, such as the need for the advance directive to be in writing or to be witnessed.<sup>41</sup> Of course, these matters will still be relevant to the question of whether it can be demonstrated that an advance directive has been made and the scope of that direction.<sup>42</sup>

### B *Statutory Advance Directives*

Legislation regulating directives about future health care has been enacted in the Australian Capital Territory,<sup>43</sup> the Northern Territory,<sup>44</sup> Queensland,<sup>45</sup> South Australia<sup>46</sup> and Victoria.<sup>47</sup> In most of these jurisdictions, the common law relating to advance directives continues to apply.<sup>48</sup> This allows a two-tier system to operate. An adult can choose to give an advance directive which, if valid at common law, will govern future treatment. Alternatively, the adult may choose to comply with the formal requirements of the relevant legislative regime so that his or her instructions will be regulated by statute. As will be seen from the following discussion, the statutory regimes differ from the common law by prescribing formal requirements with which the directive must comply. This raises the question of the enforceability of a directive that fails to comply with those formal requirements. As common law directives continue to be recognised in most of these jurisdictions, it is submitted that a directive that does not comply with the relevant formalities will still constitute a common law directive and so is likely to be binding on a health professional.

There are generally three conditions that must be met for an advance directive under the various statutory regimes to be valid. The first is that the adult must have the requisite competence; however the test for competence varies across jurisdictions. In the Australian Capital Territory, the Northern Territory, South Australia and Victoria, the adult must be of sound mind.<sup>49</sup>

<sup>39</sup> Ibid. See also NSW Department of Health, *Using Advance Care Directives: New South Wales* (2004) 9 <[http://www.health.nsw.gov.au/pubs/2004/pdf/adcare\\_directive.pdf](http://www.health.nsw.gov.au/pubs/2004/pdf/adcare_directive.pdf)>.

<sup>40</sup> The authors contend that the legal concept of 'undue influence' when used in the medical context differs from that used in the contract law context. In the latter, the contract that results from undue influence remains valid until it is set aside by the court. In the former context, the advance directive could never have been regarded as being valid. For support for this approach, see *Re T* [1992] 4 All ER 649, 669 (Staughton LJ). For an overview of undue influence and how it operates in the medical context, see Cameron Stewart and Andrew Lynch, 'Undue Influence, Consent and Medical Treatment' (2003) 96 *Journal of the Royal Society of Medicine* 598.

<sup>41</sup> *HE v A Hospital NHS Trust* [2003] 2 Fam Law R 408, 417 (Munby J).

<sup>42</sup> See, eg, Stewart, 'Advanced Directives', above n 1, 175–6.

<sup>43</sup> *Medical Treatment Act 1994* (ACT).

<sup>44</sup> *Natural Death Act 1988* (NT).

<sup>45</sup> *Powers of Attorney Act 1998* (Qld).

<sup>46</sup> *Consent to Medical Treatment and Palliative Care Act 1995* (SA).

<sup>47</sup> *Medical Treatment Act 1988* (Vic).

<sup>48</sup> See above n 15 and accompanying text.

<sup>49</sup> *Medical Treatment Act 1994* (ACT) s 6; *Natural Death Act 1988* (NT) s 4(1); *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7(1); *Medical Treatment Act 1988* (Vic) s 5(1)(d).

The position in Queensland is more complex. The *Powers of Attorney Act 1998* (Qld) defines the term ‘capacity’ in sch 3:

- capacity, for a person for a matter, means the person is capable of —
- (a) understanding the nature and effect of decisions about the matter; and
  - (b) freely and voluntarily making decisions about the matter; and
  - (c) communicating the decisions in some way.

Section 42 of the *Powers of Attorney Act 1998* (Qld) further details what an adult must be able to understand to complete an advance directive. In broad terms, the adult must be able to understand the nature and likely effects of each direction, and the various circumstances set out in the legislation determining when the direction will operate.<sup>50</sup> It is not entirely clear how this provision relates to the definition of ‘capacity’ in sch 3 but the authors suggest that it sets out a non-exhaustive list of matters that an adult must be able to understand to have the requisite ‘understanding’ within the sch 3 definition.<sup>51</sup>

The second condition that must generally be met for a statutory advance directive to be valid is that it must not have been made as a result of undue influence. Again, the statutes vary in their treatment of undue influence or similar behaviour. In Queensland, this sort of conduct is captured in the definition of ‘capacity’, as an adult is not regarded as having capacity unless he or she can ‘freely and voluntarily’ make a decision about a matter.<sup>52</sup> If undue influence was present when an advance directive was completed, the authors suggest that the adult would not have had the requisite capacity, and the advance directive would be void.

Other jurisdictions deal with undue influence in a way more analogous to the common law. In the Australian Capital Territory, a directive is void if it is obtained through the use of ‘violence, threats, intimidation or [if a person] otherwise hinders or interferes with [the adult] ... for the purpose of ... obtaining’ a directive.<sup>53</sup> This is broad enough to cover undue influence exerted on an adult. In Victoria, the witnesses who sign a refusal of treatment certificate attest to the fact that they are satisfied that the adult’s ‘decision is made voluntarily and without inducement or compulsion’.<sup>54</sup> Although the legislation does not provide that a certificate acquired in this way would be void, a health professional would not receive the protection of the legislation if he or she relied on such a certifi-

<sup>50</sup> *Powers of Attorney Act 1998* (Qld) s 42(1).

<sup>51</sup> An alternative interpretation is that s 42 is the only provision that is relevant for the purpose of ascertaining the capacity of an adult to complete an advance directive. However, this interpretation would result in the legislation containing two different tests for capacity, an outcome unlikely to have been intended by the legislature.

<sup>52</sup> *Powers of Attorney Act 1998* (Qld) sch 3. The term ‘freely and voluntarily’ is broad. It would include the situation where an adult completes an advance directive as a result of undue influence being exerted. It may also extend to the situation where an adult’s decision-making capacity is affected by a medical condition, for example, in the case of a psychotic mental illness, by delusional beliefs. It is beyond the scope of this article, however, to examine the meaning of this phrase.

<sup>53</sup> *Medical Treatment Act 1994* (ACT) s 19(1)(b).

<sup>54</sup> *Medical Treatment Act 1988* (Vic) s 5(1)(b). See also s 5F which provides for the imposition of a penalty upon a person who has a certain interest in property affected by the patient’s death and who procures the execution of a certificate by deception, fraud, misstatement or undue influence.

cate knowing that the adult had not signed voluntarily or knowing that there had been inducement or compulsion.<sup>55</sup>

Finally, South Australian and Northern Territory legislation is silent in relation to the validity of an advance directive obtained through undue influence. The South Australian legislation makes it an offence for a person to induce an adult to complete a medical power of attorney,<sup>56</sup> but not to complete a directive. Further, the legislation does not provide that a directive completed because of undue influence is void. The Northern Territory statute is also silent about a directive completed as a result of undue influence. The authors contend that in South Australia and the Northern Territory, common law principles would apply. An advance directive completed in such circumstances would be invalid and a health professional who is aware of the undue influence would not be able to follow the directive.

The third condition for validity of a statutory advance directive is that the relevant document is completed in accordance with the formal requirements of the legislation. All statutes impose certain formal requirements that must be satisfied.<sup>57</sup> In most cases, the adult is required to sign the document.<sup>58</sup> Witnessing requirements also exist in all jurisdictions. Generally the witness (or witnesses) must attest to the fact that the adult had the requisite capacity to make the directive.<sup>59</sup> However, in the Australian Capital Territory and the Northern Territory, the witnesses need only attest to the fact that the adult signed the document.<sup>60</sup> As mentioned earlier, in most Australian jurisdictions, common law advance directives will continue to be binding notwithstanding the introduction of a statutory regime. Therefore, an advance directive that does not comply with the formality requirements of the legislation will, in most jurisdictions, take effect as a common law advance directive.<sup>61</sup>

In Victoria, unlike the other states, there is also a fourth requirement that must be met before a valid statutory advance directive can be completed. The requirement is that the adult must be suffering from a 'current condition' before he or she can complete a directive refusing medical treatment generally or of a

<sup>55</sup> *Medical Treatment Act 1988* (Vic) s 9(1).

<sup>56</sup> *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 11(1).

<sup>57</sup> *Medical Treatment Act 1994* (ACT) ss 7, 8; *Natural Death Act 1988* (NT) s 4; *Powers of Attorney Act 1998* (Qld) s 44; *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7(2); *Medical Treatment Act 1988* (Vic) s 5.

<sup>58</sup> *Medical Treatment Act 1994* (ACT) s 7(b); *Natural Death Act 1988* (NT) s 4(1); *Natural Death Regulations 1989* (NT) reg 2, sch; *Powers of Attorney Act 1998* (Qld) s 44(3)(a)(i); *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7(2); *Consent to Medical Treatment and Palliative Care Regulations 2004* (SA) sch 1; *Medical Treatment Act 1988* (Vic) s 5(2), sch 1. To accommodate adults who are no longer physically able to sign the document, some statutes contain provisions to allow someone to sign on their behalf. For example, in the Australian Capital Territory, an adult can give an oral directive provided it is appropriately witnessed: *Medical Treatment Act 1994* (ACT) s 8. See also *Powers of Attorney Act 1998* (Qld) s 44(3).

<sup>59</sup> *Powers of Attorney Act 1998* (Qld) ss 44(4)(b), 44(5)(c); *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7(2); *Consent to Medical Treatment and Palliative Care Regulations 2004* (SA) sch 1; *Medical Treatment Act 1988* (Vic) s 5(1).

<sup>60</sup> *Medical Treatment Act 1994* (ACT) s 7(c)–(d), sch 1 form 1; *Natural Death Act 1988* (NT) s 4(2); *Natural Death Regulations 1989* (NT) reg 2, sch.

<sup>61</sup> This is probably not the position in Queensland. See above n 15 regarding the inapplicability of the common law.

specific kind for that condition.<sup>62</sup> This means that an adult can only give directives in relation to a particular condition or conditions from which the adult is suffering at the time of completion and so cannot give directions in relation to conditions that he or she may suffer from in the future. Such a requirement is not imposed by other statutory regimes.

However, all of the legislation, except for that in the Australian Capital Territory, contains conditions that affect when statutory advance directives refusing life-sustaining medical treatment can operate. This is not strictly an issue of validity because these advance directives can be validly made before these conditions are met; they are just not permitted to operate.<sup>63</sup> In broad terms, however, the legislation of the Northern Territory,<sup>64</sup> Queensland<sup>65</sup> and South Australia<sup>66</sup> only permits an advance directive refusing life-sustaining treatment to operate if the adult is sufficiently ill, for example, if he or she is in the terminal phase of a terminal illness.<sup>67</sup> Interestingly, the model proposed in the Tasmanian Bill is a hybrid, providing for both an advance directive for a current condition,<sup>68</sup> as well as a directive that will operate if an adult is at some stage in the future in the terminal phase of a terminal illness or in a persistent vegetative state.<sup>69</sup>

### III EXCUSES FOR NONCOMPLIANCE WITH COMMON LAW ADVANCE DIRECTIVES

Unlike the statutory jurisdictions which create formal excuses allowing health professionals not to follow advance directives in particular situations, the critical issue at common law is whether the refusal given in advance covers the situation that has arisen. If it does not, then the directive is not binding and need not be followed. The relatively sparse case law suggests that there are two elements to consider in determining whether an advance refusal will operate: first, whether the adult was provided with sufficient information to found a decision to refuse treatment and second, whether the adult intended his or her refusal to apply to the circumstances that have subsequently arisen.<sup>70</sup>

In relation to the first element, the provision of sufficient information, Lord Donaldson MR in *Re T* suggested that a direction in an advance directive either consenting to treatment or refusing it may not be valid if it was not an ‘informed’

<sup>62</sup> *Medical Treatment Act 1988* (Vic) s 5(1).

<sup>63</sup> Accordingly, it is beyond the scope of this article to articulate precisely what those restrictions are.

<sup>64</sup> *Natural Death Act 1988* (NT) s 4(1).

<sup>65</sup> *Powers of Attorney Act 1998* (Qld) s 36(2)(a). Additional restrictions on when a directive refusing life-sustaining medical treatment will operate also apply in Queensland: s 36(2)(b)–(c).

<sup>66</sup> *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7(3)(a)(i).

<sup>67</sup> This example is from the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7(3)(a)(i).

<sup>68</sup> *Directions for Medical Treatment Bill 2005* (Tas) s 4.

<sup>69</sup> *Directions for Medical Treatment Bill 2005* (Tas) s 5.

<sup>70</sup> *Re T* [1992] 4 All ER 649, 633 (Lord Donaldson MR); *HE v A Hospital NHS Trust* [2003] 2 Fam Law R 408, 419–20 (Munby J).

decision.<sup>71</sup> This dictum has been accepted by some academics as importing a requirement that an adult be sufficiently informed before an advance refusal of treatment will operate.<sup>72</sup>

However, the authors are of the view that the dictum of Lord Donaldson MR referred to above does not represent the common law. Lord Donaldson MR suggested that the requirement that an adult be informed in broad terms of the nature and effect of the treatment for consent to be valid also applies to a refusal of treatment. It follows from this that a failure to inform an adult in this way means that the refusal will not be effective. However, later in the same paragraph, Lord Donaldson MR narrowed his comments by saying that refusal of treatment may be vitiated if the adult was misinformed by a health professional or not given information that has been requested, expressly or impliedly, by the adult.<sup>73</sup> His Lordship falls short of imposing a blanket requirement that the health professional must provide information to the adult for a refusal to be valid in all cases. Further, when summarising his judgment, Lord Donaldson MR suggests that the only requirement for a refusal of treatment to be effective is that the adult be competent to make the decision.<sup>74</sup> His Lordship makes no reference to a requirement that the decision be based on sufficient information.

With respect to Lord Donaldson MR, a suggestion that a refusal can only be effective if the adult has first been given sufficient information must be incorrect. It is squarely in conflict with the fundamental proposition adopted and applied throughout the common law world 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>75</sup> If the right to refuse treatment for any or no reason at all is qualified by a requirement to be sufficiently informed, how does that sit with the principle of bodily integrity that underpins the right? The cases which endorse such a right do not qualify it by requiring the refusal to be based on sufficient information.

A health professional is entitled to disregard an advance directive based on the second element: that the adult did not intend for his or her refusal to apply in the relevant situation.<sup>76</sup> In *Re T*, the English Court of Appeal found that the adult's decision was vitiated due to her mother's undue influence, so it was not necessary to consider the issue of what she intended. Nevertheless, Lord Donaldson MR endorsed the statement of law that the refusal must be intended

<sup>71</sup> Lord Donaldson MR said that this does not mean that a patient needs to be fully informed of all of the possible risks associated with the treatment as that is the realm of the law of negligence: *Re T* [1992] 4 All ER 649, 663.

<sup>72</sup> See, eg, Kennedy and Grubb, above n 23, 2037; Sabine Michalowski, 'Advance Refusals of Life-Sustaining Medical Treatment: The Relativity of an Absolute Right' (2005) 68 *Modern Law Review* 958, 958.

<sup>73</sup> *Re T* [1992] 4 All ER 649, 663.

<sup>74</sup> *Ibid* 664.

<sup>75</sup> *Re MB (Medical Treatment)* [1997] 2 Fam Law R 426, 432 (Butler-Sloss LJ). See also *Re B* [2002] 2 All ER 449; *Re T* [1992] 4 All ER 649, 664 (Lord Donaldson MR), 665 (Butler-Sloss LJ), 668 (Staughton LJ); *Airedale NHS Trust v Bland* [1993] AC 789, 864 (Lord Goff), 891 (Lord Mustill); *Nancy B v Hotel-Dieu de Quebec* (1992) 86 DLR (4<sup>th</sup>) 385.

<sup>76</sup> Kennedy and Grubb, above n 23, 2037.

to apply in the particular situation,<sup>77</sup> as did the two other judges in this case, Butler-Sloss and Staughton LJ.<sup>78</sup>

The following considers the different situations in which it might be argued that an adult completed an advance directive but did not intend it to apply in the circumstances that subsequently arose, thus permitting a health professional to disregard it. We have endeavoured to articulate different categories of situation but note that there is some overlap between them, and indeed that there may be situations that fall outside of these categories in which an advance directive is not intended to apply.

#### A Change in Circumstances

Circumstances may change after an adult has executed an advance directive in such a way that the adult would not have intended the directive to apply to the changed circumstances. The law has recognised that, in such a case, a health professional should not be required to comply with the advance refusal of treatment. For the health professional to be excused, however, the change in circumstances must be ‘sufficiently relevant and significant to justify disregarding’ the advance directive.<sup>79</sup> It will not be sufficient to demonstrate simply that circumstances have changed; it is necessary for those changes to be such that the adult would no longer have intended the directive to apply.<sup>80</sup>

One way in which circumstances might change is in relation to an adult’s personal circumstances, such as a change in his or her values or beliefs.<sup>81</sup> This was alleged to have occurred in *HE v A Hospital NHS Trust*.<sup>82</sup> In that case, AE, a 24-year-old woman, had executed an advance directive refusing blood transfusions or other blood products. She had initially been a Muslim but was raised as a Jehovah’s Witness by her mother. AE’s father, HE, brought the matter before the court claiming that the directive no longer represented AE’s wishes. He claimed that AE had agreed to revert to Islam because she was marrying a man of that faith, and that she had implemented that decision by no longer attending Jehovah’s Witness meetings and services. In these circumstances, Munby J held that the directive

cannot have survived her deliberate, implemented, decision to abandon that faith and revert to being a Muslim. When the entire substratum has gone, when the very assumption on which the advance directive was based has been destroyed by subsequent events then ... the refusal ceases to be effective.<sup>83</sup>

Another change in circumstances sufficient to warrant not following an advance directive could arise in relation to the treatment options available in a

<sup>77</sup> *Re T* [1992] 4 All ER 649, 662–3.

<sup>78</sup> *Ibid* 668 (Butler-Sloss LJ), 669 (Staughton LJ).

<sup>79</sup> Michalowski, above n 72, 969–70.

<sup>80</sup> *Ibid*.

<sup>81</sup> *Ibid* 970–2.

<sup>82</sup> [2003] 2 Fam Law R 408.

<sup>83</sup> *Ibid* 422.

particular case.<sup>84</sup> Advances in medical science may mean that an adult suffering from what was previously a progressive, terminal and incurable illness could now be treated and cured. In such a situation, that change in circumstances may be sufficient justification for finding that the refusal of treatment is not intended to operate.<sup>85</sup>

### B *Uncertainty*

A health professional is justified in not following an advance directive if it is not expressed in clear terms, so its meaning is uncertain or ambiguous.<sup>86</sup> For example, a directive may refuse the provision of ‘heroic measures’, but not elaborate on what sort of medical treatment that might mean.<sup>87</sup> An uncertain direction was considered in the recent case of *W Healthcare NHS Trust v H*,<sup>88</sup> which dealt with advance statements made many years earlier by KH, a 59-year-old woman who was suffering from multiple sclerosis. KH had made statements about medical treatment that she did not want, including one statement refusing life support machines<sup>89</sup> and other statements refusing treatment if she could not continue with a ‘reasonable quality of life’.<sup>90</sup>

KH was being provided with artificial nutrition and hydration through a percutaneous endoscopic gastrostomy (‘PEG’) tube, which became dislodged. In considering whether the tube should be reinserted, the issue was whether she had given an advance directive refusing that form of treatment. None of KH’s statements had specifically addressed the issue of artificial nutrition and hydration. The court accepted that some of her statements may have been sufficient to refuse other medical treatment, for example, her desire not to be kept alive on ‘life support machines’.<sup>91</sup> However, the other remaining general statements refusing treatment based on quality of life considerations were insufficiently clear to amount to an advance directive and the court held that she had not refused the artificial nutrition and hydration.<sup>92</sup>

It is important to distinguish uncertainty as to the meaning of an advance directive from uncertainty in relation to matters of proof. Issues of proof can relate to a range of matters including, for example, doubt about whether the adult had sufficient capacity to complete the advance directive. Uncertainty in this latter sense is discussed further in Part VI of the article.

<sup>84</sup> Michalowski, above n 72, 969–70; see also *ibid* 419–20 (Munby J).

<sup>85</sup> Michalowski, above n 72, 969–70.

<sup>86</sup> *Ibid* 965–6; Stewart, ‘The Australian Experience of Advance Directives’, above n 15, S26.

<sup>87</sup> The use of this term and the vagueness of its meaning was considered by Ian Kerridge et al, ‘Advance Directives’ in Ian Freckelton and Kerry Petersen (eds), *Controversies in Health Law* (1999) 307.

<sup>88</sup> [2005] 1 WLR 834. Cf *Re AK (Medical Treatment: Consent)* [2001] 1 Fam Law R 129 where no issue of uncertainty arose, no doubt aided by the fact that the statements were given shortly before and in contemplation of the specific treatment that was being refused.

<sup>89</sup> *W Healthcare NHS Trust v H* [2005] 1 WLR 834, 836 (Brooke LJ).

<sup>90</sup> *Ibid* 839 (Brooke LJ).

<sup>91</sup> *Ibid*.

<sup>92</sup> *Ibid* 840 (Brooke LJ).

*C Incorrect Information or Assumptions*

A refusal contained in an advance directive that is based on incorrect information or an incorrect assumption may mean that an adult would not have intended that the refusal would apply in the circumstances that have arisen. This differs from the situation where circumstances change because the incorrect information or assumption was present when the refusal was first made.

An example arose in *Re T*,<sup>93</sup> where the adult's advance refusal of blood products was based on the erroneous assumption that non-blood products would be a satisfactory alternative should treatment be necessary at a later stage.<sup>94</sup> Although it was unnecessary to decide this issue since the English Court of Appeal had based its decision on other grounds, both Lord Donaldson MR and Butler-Sloss LJ indicated that a refusal based on an incorrect assumption would not be operative.<sup>95</sup>

*D No Decision Made*

This category involves situations where an advance directive has been made but is not intended to apply to a particular set of circumstances because it is found that the directive does not make a decision in relation to those circumstances. There is some overlap with earlier categories but it is distinguished from the situation where a directive was based on incorrect information or an incorrect assumption and where a change of circumstances arose. Those categories deal with instances where a decision has been made, but that decision should not be acted upon. The uncertainty category is also distinguished because, in that case, there is doubt about what decision has been made.

A commonly cited example of where an advance directive had been made but is construed as not involving a decision in relation to the circumstances that arose is the American case of *Werth v Taylor*.<sup>96</sup> In that case, the court held that a refusal of blood transfusions was not effective to cover the situation where blood became necessary to save a pregnant woman's life. This is despite the fact that documents refusing blood transfusions were signed two months prior to the woman's admission, and that the woman made verbal statements to the same effect at the time of the admission. The Michigan Court of Appeals found that because the directive was given at a time when the woman's life was not in danger, she was not regarded as having made a decision to refuse blood transfusions in the subsequent life-threatening situation that arose.<sup>97</sup>

<sup>93</sup> [1992] 4 All ER 649.

<sup>94</sup> Ibid 655 (Lord Donaldson MR).

<sup>95</sup> Ibid 663 (Lord Donaldson MR), 668 (Butler-Sloss LJ).

<sup>96</sup> 475 NW 2d 426 (Mich Ct App, 1991).

<sup>97</sup> Ibid 430 (Neef PJ).

#### IV EXCUSES FOR NONCOMPLIANCE WITH STATUTORY ADVANCE DIRECTIVES

As was the situation at common law, there are a number of excuses under statute upon which health professionals may rely in not following a valid advance directive. This Part of the article examines the excuses that are created by the various statutes that operate in Australia.

##### *A Change in Circumstances*

The situation where circumstances change after an advance directive is made, but before a medical situation arises, was considered earlier in the context of common law directives.<sup>98</sup> The changes in circumstance considered above included a change in the personal situation of the adult (for example in relation to religious faith) or a change due to advances in medical science. Another situation that might be regarded as falling within the ‘change of circumstances’ category is where an adult changes his or her mind about an advance directive that he or she has previously given, but does not actually revoke it. Because some statutes specifically address that situation, it is considered as a separate category of excuse in this Part.

Queensland legislation largely reflects the common law. Section 103(1) of the *Powers of Attorney Act 1998* (Qld) specifies that a health professional does not incur any liability for failing to follow a directive if he or she has

reasonable grounds to believe that ... circumstances, including advances in medical science, have changed to the extent that the terms of the direction are inappropriate.

This means that if, for example, an adult’s religious beliefs change (as in *HE v A Hospital NHS Trust*<sup>99</sup>) so that the adult would no longer consider him or herself bound by the directive, a health professional is excused from not following it.

The same result would follow if a directive was based on a particular state of medical science, but significant developments had been made by the time a decision was needed about the appropriate medical treatment. Indeed, the provision specifically refers to ‘advances in medical science’.<sup>100</sup> For example, an adult who is diagnosed with dementia may complete a directive that he or she does not want to receive life-sustaining medical treatment under any circumstances. This directive may have been made because there was no treatment for dementia and the adult did not want to experience a slow decline in mental capacity until death resulted. If there were an advance in medical science so that dementia could be treated and possibly reversed, this may be sufficient under the Queensland statute to excuse a health professional for not complying with the adult’s directive.

Other statutory jurisdictions do not contain a specific provision excusing noncompliance with an advance directive on the general ground of a change in

<sup>98</sup> See above Part III(A).

<sup>99</sup> [2003] 2 Fam Law R 408.

<sup>100</sup> *Powers of Attorney Act 1998* (Qld) s 103(1).

circumstances. Victoria has a limited provision that focuses on a change in circumstances relating to an adult's medical condition.<sup>101</sup> That provision provides that a directive will cease to apply 'if the medical condition of the person has changed to such an extent that the condition in relation to which the [advance directive] was given is no longer current.'<sup>102</sup> Although framed in terms of a limit on the operation of advance directives (rather than it ceasing to apply), provisions in the South Australian and Northern Territory legislation have a similar effect. As outlined in above Part II, an advance directive in those jurisdictions will only operate if the adult is suffering from a particular medical condition. If the adult's circumstances change so that he or she no longer suffers from that condition, the advance directive will no longer operate.<sup>103</sup> The situation is different in the Australian Capital Territory as its legislation does not contain a similar provision, nor otherwise deals with the situation where circumstances change.

#### B *Intention To Revoke Advance Directive*

Although it is clear that a health professional should not rely upon an advance directive that has been validly revoked, what of the situation where an adult may have changed his or her mind but has failed to actually revoke the directive? Statutes in the Australian Capital Territory, the Northern Territory and South Australia deal specifically with this kind of situation. A health professional must not comply with an advance directive if he or she believes that the adult intended to revoke that directive (the Northern Territory<sup>104</sup> and South Australia<sup>105</sup>) or if the health professional believes on reasonable grounds that the adult has changed his or her mind since making the direction (Australian Capital Territory<sup>106</sup>).

The legislation in Queensland does not contain an equivalent provision. However, the excuse relating to a change in circumstances discussed above may be broad enough to excuse a health professional from not following a directive if there is evidence that an adult intended to revoke the directive but had not yet done so.<sup>107</sup>

<sup>101</sup> *Medical Treatment Act 1988* (Vic) s 7(3).

<sup>102</sup> *Medical Treatment Act 1988* (Vic) s 7(3).

<sup>103</sup> Under legislation in South Australia and the Northern Territory, a health professional is not authorised to comply with an advance directive unless the adult is in the terminal phase of a terminal illness or in a persistent vegetative state (*Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 4(1)), or is suffering from a terminal illness (*Natural Death Act 1988* (NT) s 7(3)(a)(1)).

<sup>104</sup> *Natural Death Act 1988* (NT) s 4(3)(a).

<sup>105</sup> *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7(3)(b).

<sup>106</sup> *Medical Treatment Act 1994* (ACT) s 12(b).

<sup>107</sup> The Victorian Act does not specifically address the situation of an *intended* revocation. However, it does permit the cancellation of an advance directive with a minimum of formality requiring only that the adult 'clearly express' or 'indicate' to a health professional (or another person) their decision to cancel the certificate: *Medical Treatment Act 1988* (Vic) ss 7(1), 7(2).

*C Uncertainty*

The possibility of an advance directive being uncertain is considered specifically only in the Queensland legislation, where it excuses a health professional from complying with a directive if he or she has reasonable grounds to believe that the direction is uncertain.<sup>108</sup> However, before a health professional can be regarded as having reasonable grounds for reaching such a conclusion, he or she must have consulted any of the attorneys who have been appointed under the advance directive about the direction.<sup>109</sup>

*D Contrary to Good Medical Practice*

Queensland is also the only jurisdiction in which a health professional is excused from following a valid advance directive for reasons grounded in good medical practice. The Act defines ‘good medical practice’ in sch 2:

Good medical practice is good medical practice for the medical profession in Australia having regard to —

- (a) the recognised medical standards, practices and procedures of the medical profession in Australia; and
- (b) the recognised ethical standards of the medical profession in Australia.<sup>110</sup>

Notions of good medical practice are relevant to the binding nature of an advance directive under the legislative regime in Queensland. First, an advance directive to withhold or withdraw artificial nutrition and hydration cannot *operate* unless the commencement or continuation of that measure would be inconsistent with good medical practice.<sup>111</sup> This requirement does not apply to any of the other life-sustaining medical treatment such as artificial ventilation, cardiopulmonary resuscitation or the provision of antibiotics that are necessary to prolong an adult’s life. By way of comparison, compliance with good medical practice is not relevant to whether or not an advance directive will operate in any of the other statutory regimes.<sup>112</sup>

Second, even if the advance directive to withhold or withdraw life-sustaining medical treatment is one that can operate,<sup>113</sup> the Queensland legislation contains a provision that excuses a health professional who chooses not to follow it. Having much wider implications, a health professional does not incur any

<sup>108</sup> *Powers of Attorney Act 1998* (Qld) s 103(1).

<sup>109</sup> *Powers of Attorney Act 1998* (Qld) s 103(1). It is interesting to note that the legislation does not require a health professional to consult with an attorney for health matters who has been appointed by the adult under an enduring power of attorney, as opposed to an advance directive: s 103(3).

<sup>110</sup> *Powers of Attorney Act 1998* (Qld) sch 2 s 5B. See also *Guardianship and Administration Act 2000* (Qld) sch 2 s 5B.

<sup>111</sup> *Powers of Attorney Act 1998* (Qld) s 36(2)(b).

<sup>112</sup> In all of the jurisdictions (except the Australian Capital Territory), there are restrictions on when an advance directive to refuse life-sustaining medical treatment can operate: see above Part II(B). However, only in Queensland do these restrictions include compliance of the directive with good medical practice.

<sup>113</sup> That is, the advance directive complies with all of the requirements for validity, and is one that satisfies the restrictions in *Powers of Attorney Act 1998* (Qld) s 36 about when such a directive can operate.

liability for failing to follow a directive if he or she has ‘reasonable grounds to believe that a direction in an [advance directive] is ... inconsistent with good medical practice’.<sup>114</sup>

Professional standards of medical practice are also relevant to a statutory excuse under the South Australian legislation. Section 16 of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) exempts a health professional from liability for an act or omission done or made:

- (a) with the consent of the patient or the patient’s representative ... ; and
- (b) in good faith and without negligence; and
- (c) in accordance with proper professional standards of medical practice; and
- (d) in order to preserve or improve the quality of life.

Although two aspects of this excuse are grounded in compliance with proper professional standards of medical practice, the authors contend that a health professional who relied on a breach of these standards to justify not complying with an advance refusal of treatment would not be able to seek the protection of the excuse. Consent has not been obtained as required by s 16(a). Indeed, the adult has given an express refusal to treatment.<sup>115</sup>

The statutory regimes in the Australian Capital Territory, the Northern Territory and Victoria do not contain excuses for health professionals who do not comply with an advance directive on the basis of good medical practice.

#### V A COMPARATIVE ANALYSIS OF STATUTORY AND COMMON LAW EXCUSES

The right to self-determination or autonomy is a fundamental part of health law<sup>116</sup> and underpins the obligation on a health professional to obtain consent from a patient before providing medical treatment.<sup>117</sup> It is this right that permits a competent adult to make his or her own decisions about medical care and refuse to accept medical treatment.<sup>118</sup> This right has been recognised in the various Australian jurisdictions in relation to advance directives, both at common law and under statute, as the law allows adults, to a greater or lesser extent, to refuse treatment in advance.

<sup>114</sup> *Powers of Attorney Act 1998* (Qld) s 103(1).

<sup>115</sup> Cf Attorney-General and Minister for Health, Western Australia, above n 13, 36, which implies that health professionals would be excused in such circumstances.

<sup>116</sup> *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, 72–3 (Lord Goff) (*‘Re F’*); *Airedale NHS Trust v Bland* [1993] AC 789, 864 (Lord Goff); *Re T* [1992] 4 All ER 649, 652–3 (Lord Donaldson MR). See also discussion about the history of development of autonomy as a central idea in medical law in Derek Morgan and Kenneth Veitch, ‘Being Ms B: B, Autonomy and the Nature of Legal Regulation’ (2004) 26 *Sydney Law Review* 107.

<sup>117</sup> See, eg, *Re F* [1990] 2 AC 1, 73 (Lord Goff) where reference was made to each person’s body being inviolate; *Re T* [1992] 4 All ER 649, 664–5 (Butler-Sloss LJ) where the right to determine what happens with one’s body was recognised; *Re B* [2002] 2 All ER 449, 472 (Butler-Sloss P); *Marion’s Case* (1992) 175 CLR 218, 232–3 (Mason CJ, Dawson, Toohey and Gaudron JJ) where bodily inviolability was acknowledged, and it was noted that consent renders medical treatment lawful where it would otherwise be assault.

<sup>118</sup> *Re T* [1992] 4 All ER 649, 652–3 (Lord Donaldson MR).

The other major interest in this area, the state's interest in the protection of life, is also a fundamental principle of the law.<sup>119</sup> In cases of conflict, such as where an adult wishes to refuse life-sustaining medical treatment, the courts have consistently found that the right to self-determination is paramount and so will prevail over the sanctity of life.<sup>120</sup> However, given the gravity of the outcome, directives that refuse life-sustaining medical treatment are closely scrutinised by courts<sup>121</sup> and any doubt will be resolved in favour of the preservation of life.<sup>122</sup> The interest of the state in preserving life can also be seen in both common law and under statute in the excuses that are available to a health professional who does not follow an advance directive that refuses life-sustaining medical treatment.

This Part has two goals. First, to compare each of the excuses at common law and under the various statutes that are available to a health professional who does not follow an advance directive. Second, to examine each excuse in some detail and consider whether it is appropriate for the law to recognise an exception to the general rule that advance directives are binding and should be followed. Pivotal to this goal of assessing the appropriateness of an excuse is the tension between the right of the individual to self-determination or autonomy, and the interest of the state in protecting the sanctity of life. In short, advance directives are regarded as an expression of an individual's autonomy, whereas the excuses that permit noncompliance with a directive often reflect the state's interest in the sanctity of life. An examination of how this tension should be resolved will be considered below as part of determining whether an excuse is appropriate.

To facilitate a preliminary comparison, the authors have compiled a table outlining the excuses discussed to date and the extent to which each of them is available in the various jurisdictions.<sup>123</sup> One point that should be made is that this Table only includes those jurisdictions with an excuse that is specifically relevant. A health professional in a jurisdiction that does not contain such an excuse may still be protected, however, as another more general excuse may apply.

#### A Change in Circumstances

As explored in Part III(A) a change in an adult's personal circumstances may mean that the advance directive need not be followed. On the whole, a much narrower approach has been taken in the statutory jurisdictions than at common law in relation to the issue of a change of circumstances. Only the Queensland legislation expressly excuses a health professional for not following an advance

<sup>119</sup> Ibid 661 (Lord Donaldson MR); *Airedale NHS Trust v Bland* [1993] AC 789, 863 (Lord Goff), 889 (Lord Mustill).

<sup>120</sup> See, eg. *Airedale NHS Trust v Bland* [1993] AC 789, 864 (Lord Goff), 891 (Lord Mustill); *Re B* [2002] 2 All ER 449, 457 (Butler-Sloss P); *Re T* [1992] 4 All ER 649, 664 (Lord Donaldson MR), 665 (Butler-Sloss LJ), 668 (Staughton LJ).

<sup>121</sup> See, eg. *Re T* [1992] 4 All ER 649; *Re B* [2002] 2 All ER 449, 458–9 (Butler-Sloss P). See also Manning, above n 34, 240, referring to criticism of courts paying 'lip service to the right to refuse life-saving treatment' while behaving paternalistically.

<sup>122</sup> *Re T* [1992] 4 All ER 649, 661 (Lord Donaldson MR). Cf Michalowski, above n 72, 959–63.

<sup>123</sup> See below Part VIII.

directive if there is a change in the circumstances of the adult. The provision would obviously include a change in an adult's personal circumstances and it also specifically refers to a change in circumstances arising out of advances in medical science.<sup>124</sup> The Australian Capital Territory's legislation does not address the issue of change of circumstances. Provisions in the Northern Territory, South Australian and Victorian legislation do so only in a limited way, providing that an advance directive will cease to apply or will not operate if the medical condition of the adult has changed.<sup>125</sup>

It seems that the excuse in Queensland is broader than the common law as it refers to a health professional who has 'reasonable grounds to believe ... that circumstances ... have changed to the extent that the terms of the direction are inappropriate.'<sup>126</sup> At common law, the test that is applied is whether the change in circumstances is such that *the adult* would not have intended his or her refusal to apply to the circumstances that have arisen.<sup>127</sup> The wording of the Queensland provision, however, with its reference to a *health professional's belief* (on reasonable grounds) that the direction is *inappropriate* seems to shift the focus of the enquiry away from the adult and towards the health professional.

How such a provision might operate can be illustrated by the example of a 25-year-old woman who makes an advance directive refusing life-sustaining medical treatment. Subsequent to the completion of the directive, the woman has a child. The Queensland provision is wide enough to allow a health professional not to follow the advance directive on the basis that, since the adult now has the responsibility for a young child, it is no longer 'appropriate' to comply with the directive. The authors contend that the excuse as drafted in Queensland is too wide as it enables an unjustifiable departure from an adult's directive. The common law position is to be preferred as it strikes a more sensible balance between principles of autonomy and the sanctity of life.

#### B *Intention To Revoke Advance Directive*

If an advance directive has been revoked, it is clear that a health professional should not rely upon it. The situation is more complex if a health professional believes that the adult intended to revoke the advance directive, yet did not do so by the time a decision is needed to be made about treatment. As noted above, legislation in the Australian Capital Territory, the Northern Territory and South Australia specifically deal with this kind of situation.<sup>128</sup>

Queensland, Victoria and those jurisdictions governed by the common law do not have an excuse that specifically relates to such an intention. However, there is some overlap between this excuse and that relating to a change in circumstances discussed above, particularly where such a change relates to an adult's

<sup>124</sup> *Powers of Attorney Act 1998* (Qld) s 103(1).

<sup>125</sup> See the summation of the jurisdictional variations with respect to change in circumstances in Table 1: below Part VIII.

<sup>126</sup> *Powers of Attorney Act 1998* (Qld) s 103(1).

<sup>127</sup> Michalowski, above n 72, 970; see also Derek Morgan, 'Odysseus and the Binding Directive: Only a Cautionary Tale?' (1994) 14 *Legal Studies* 411, 411–32.

<sup>128</sup> See above nn 104–6 and accompanying text.

personal circumstances. Situations may arise where evidence of an intention to revoke an advance directive will also reveal a change in circumstances sufficient to warrant not following the directive. To further develop the case study used above, an adult may have made an advance directive before having children but, after becoming a parent, discussed with people that he or she has had a change of heart about the directions given. In such a case, a health professional would be entitled not to follow the directive and rely on the excuse of an intention to revoke a directive or on the excuse of a change in circumstances, depending on the jurisdiction in which the situation arose. This overlap of excuses is reflected by the fact that all Australian jurisdictions except for Victoria<sup>129</sup> have enshrined either one or the other in legislation.

Apart from the reservations already expressed in relation to the discretion given to health professionals by Queensland's change of circumstances excuse, the authors believe that the excuse of an intention to revoke the directive (or the application of the change in circumstances excuse in those situations) is appropriate. The excuse strikes a proper balance between the need to follow an adult's expressed directions while still ensuring that treatment is not withheld or withdrawn inappropriately. If an adult has indicated his or her intention to alter the advance directive but, at the relevant time, has yet to do so, the health professional should not comply with that directive and is excused for doing so.

### C *Uncertainty*

Uncertainty as to the meaning of a directive can arise when the language it uses is vague or imprecise.<sup>130</sup> One example discussed above is a directive that refuses the provision of 'heroic measures'.<sup>131</sup> Another example arose in the recent case of *W Healthcare NHS Trust v H*<sup>132</sup> which involved statements that referred to a 'reasonable quality of life'.<sup>133</sup> In Queensland and those jurisdictions governed by the common law, health professionals are excused for not following an advance directive when its meaning is uncertain. Again, a distinction is made here between uncertainty as to the *meaning* of an advance directive and uncertainty in relation to matters of *proof*. Uncertainty as to whether a change in circumstances is sufficient to disregard a directive, whether there was an intention to revoke it, or whether the adult had sufficient capacity to execute the

<sup>129</sup> Note though that the Victorian legislation contains a more limited excuse for a health professional not following an advance directive: *Medical Treatment Act 1988* (Vic) ss 7(1), 7(2).

<sup>130</sup> Kerridge et al, above n 87, 307, where they also refer to a large study conducted in the United States by J M Teno et al, which revealed that only 22 of 688 advance directives for terminally ill patients provided sufficient guidance to inform medical care: J M Teno et al, 'Do Advance Directives Provide Instructions that Direct Care' (1997) 45 *Journal of the American Geriatric Society* 508. See also Margaret Brown, 'The Law and Practice Associated with Advance Directives in Canada and Australia: Similarities, Differences and Debates' (2003) 11 *Journal of Law and Medicine* 59, 72 where she suggests that advance directives are difficult to 'write, interpret and implement' and that there is no perfect advance directive form which 'will cover all contingencies'. See further Paul Biegler et al, 'Determining the Validity of Advance Directives' (2000) 172 *Medical Journal of Australia* 545.

<sup>131</sup> See above n 87 and accompanying text.

<sup>132</sup> [2005] 1 WLR 834.

<sup>133</sup> *Ibid* 839 (Brooke LJ). See also the example discussed by Michalowski, above n 72, 966.

advance health directive, for example, falls into the latter category and is considered further in Part VI below.

The provision contained in the Queensland legislation excuses a health professional if he or she ‘has reasonable grounds to believe that a direction in an [advance directive] is uncertain’.<sup>134</sup> The legislation does not define ‘uncertainty’. However, the relevant section purports to provide further assistance in determining whether a directive is uncertain and states:

if an attorney is appointed under the [advance directive], the [health professional] has reasonable grounds to believe that a direction in the [advance directive] is uncertain only if, among other things, the [health professional] has consulted the attorney about the direction.<sup>135</sup>

This requirement to consult an attorney raises three issues. The first is that the provision suggests that an attorney may be able to clarify a directive so that it is no longer regarded as uncertain. In the case of a directive that refers to ‘heroic measures’, this may mean that if an attorney was capable of providing enough information to explain what the adult meant, the directive would no longer be uncertain. This begs the question as to how much clarification an attorney is able to provide. It is obviously a question of degree, but a touchstone to consider is whether the attorney is simply explaining or clarifying an adult’s decision or whether the attorney is making their own decision, albeit probably based on what he or she thinks the adult would have wanted. Certainly the more uncertain a directive is, the more likely it is that an attorney is making the decision themselves.

The second issue raised by the requirement to consult an attorney is that it is just that — a mere requirement to consult. This means that while a health professional must invite an attorney to clarify or explain the directive, there is no obligation to accept that clarification or explanation and to comply with the directive. For this reason, the requirement to consult is probably more effective in cases where those involved in the decision want to follow the advance directive than it is in cases of disagreement.

The third issue is that the requirement to consult an attorney is only imposed when an attorney is appointed under an advance directive, rather than under an enduring power of attorney. Perhaps the rationale for this is that it is likely that an attorney appointed under that document, rather than another enduring document, would be better able to clarify the intentions of the adult who made it.

Despite these issues, it is suggested that other statutory jurisdictions should enact an excuse that permits a health professional to disregard an uncertain advance directive. These documents often predict an uncertain future, so there is a real danger that a directive given now will later be ambiguous.<sup>136</sup> Having said this, there is less scope for uncertainty arising in Victoria where an advance directive can only be given in relation to a medical condition from which the

<sup>134</sup> *Powers of Attorney Act 1998* (Qld) s 103(1).

<sup>135</sup> *Powers of Attorney Act 1998* (Qld) s 103(3).

<sup>136</sup> Michalowski, above n 72, 965–6.

adult is currently suffering.<sup>137</sup> Given that the legislation further requires the adult to be informed about the nature of the condition to an extent that is sufficient to make a decision about the treatment that he or she wishes to refuse,<sup>138</sup> it is less likely that an advance directive made in Victoria would be uncertain. Nevertheless, that possibility still remains, as it does in the other statutory jurisdictions.

It may be that even without a specific excuse, an uncertain advance directive need not be followed in those statutory jurisdictions. An advance directive can only give directions if they are clear and capable of determining an adult's medical treatment. Simply, it may be that an uncertain advance directive is not capable of dictating what medical treatment an adult does or does not receive and so will not bind a health professional, even where there is no specific excuse. However, the inclusion of such a provision in legislation would add greater certainty and would enable the prescription of certain steps before a directive can be found to be uncertain.

The authors suggest that the Queensland approach might provide a useful model for the other statutory jurisdictions. A positive obligation should be imposed on a health professional to make enquiries from those close to the adult if the meaning of an advance directive is uncertain or ambiguous. If such consultation is capable of providing certainty, then the advance directive should be followed. If certainty is not achieved, the health professionals should not comply with the directive.<sup>139</sup> Such an approach represents an appropriate balance between autonomy — in that a directive is followed where possible — and the sanctity of life principle which is respected by not complying with an uncertain or ambiguous advance refusal of life-sustaining medical treatment.

#### D *Incorrect Information or Assumption*

At common law, an advance directive which is based on incorrect information or an incorrect assumption will not operate if the adult would not have intended that the refusal apply in the circumstances that have arisen.<sup>140</sup>

None of the statutes contain an equivalent provision regarding a directive being based on incorrect information or an incorrect assumption. However, in two of the statutory jurisdictions, there are requirements to provide information that will reduce the chance of an advance directive being based on flawed material. In Victoria, an advance directive can only be made in relation to a condition from which the adult is suffering,<sup>141</sup> and the adult must be informed

<sup>137</sup> *Medical Treatment Act 1988* (Vic) s 5(1)(a).

<sup>138</sup> *Medical Treatment Act 1988* (Vic) s 5(1)(c).

<sup>139</sup> It is interesting to consider the wording of *Powers of Attorney Act 1998* (Qld) s 103. If a health provider considers the direction to be uncertain (having consulted as directed by the provision), he or she is excused from following the direction. The legislation does not *prohibit* the health professional from so doing. Cf the approach in the Australian Capital Territory: *Medical Treatment Act 1994* (ACT) s 12(a).

<sup>140</sup> *Re T* [1992] 4 All ER 649. Although it was unnecessary to decide this issue on the facts, both Lord Donaldson MR and Butler-Sloss LJ endorsed this statement of law: at 663 (Lord Donaldson MR), 668 (Butler-Sloss LJ).

<sup>141</sup> *Medical Treatment Act 1988* (Vic) s 5(1)(a).

about the nature of the condition.<sup>142</sup> In the Australian Capital Territory, the legislation actually imposes an obligation on the health professional to advise the adult about his or her illness, alternative forms of treatment, the consequences of the treatment and the consequences of remaining untreated.<sup>143</sup> The other statutory jurisdictions do not impose a requirement to be informed of these matters.<sup>144</sup>

The Queensland legislation does not create an excuse or impose a requirement to specifically inform an adult completing an advance directive, but a health professional is entitled not to follow an advance directive if he or she has reasonable grounds to believe that a direction in it is inconsistent with good medical practice.<sup>145</sup> It would be inconsistent with good medical practice to rely on an advance refusal of treatment that would result in the death of an adult where that advance refusal was based on incorrect information or an incorrect assumption of sufficient importance.

The authors suggest that all statutory jurisdictions should have an excuse that permits noncompliance with an advance directive based on incorrect information or an incorrect assumption. However, such an excuse should require that the incorrect information or assumption be so significant that the adult would not have intended the directive to operate in the circumstances that in fact existed. Although the right to self-determination or autonomy should generally take priority, in circumstances where that decision is based on flawed material, it is appropriate for the principle of sanctity of life to prevail. If such an excuse is not enacted, a minimum requirement should be the imposition of a duty to provide information, as required in the Australian Capital Territory.

#### E *No Decision Made*

One situation where the common law has recognised that an advance directive is not intended to apply is where the directive does not make a decision in relation to the circumstances that have arisen. Often this will be a matter of interpretation by the courts as to what decision a directive has actually made.<sup>146</sup>

The statutory jurisdictions do not have a specific excuse that relates to the scope of a decision so the opportunity for a court to engage in an interpretive exercise is probably more limited. However, an argument advanced earlier in relation to uncertainty would also apply here.<sup>147</sup> An advance directive is only effective to guide decision-making if it actually makes a decision. A statutory

<sup>142</sup> *Medical Treatment Act 1988* (Vic) s 5(1)(c).

<sup>143</sup> *Medical Treatment Act 1994* (ACT) s 11(1).

<sup>144</sup> There is a requirement in the Queensland legislation for a doctor to certify that the adult completing the advance directive has sufficient capacity: *Powers of Attorney Act 1998* (Qld) s 44(6). However, there is no legal requirement for the doctor to discuss the directions being given. Notwithstanding the lack of legal requirement for the adult to discuss the advance directive with the doctor, the prescribed advance directive form advises the adult in a number of locations that such a discussion is highly desirable.

<sup>145</sup> *Powers of Attorney Act 1998* (Qld) s 103.

<sup>146</sup> The example discussed in above Part III(D) was the American case of *Werth v Taylor*, 475 NW 2d 426 (Mich Ct App, 1991).

<sup>147</sup> See above Part III(D).

directive that does not make the decision that arises in the circumstances will therefore not be binding.

The authors do not have reservations about the *existence* of this excuse, because a directive that has not made a decision about treatment should clearly not be followed. However, there are concerns about how advance directives may be *interpreted* to find that no decision has been made so that the directive need not be followed. These concerns relate to issues of proof and are discussed below.<sup>148</sup>

#### F *Contrary to Good Medical Practice*

Individuals have different views about what quality of life is acceptable to them and what medical treatment they are prepared to accept or endure. Advance directives allow an adult to give directions about withholding or withdrawing life-sustaining medical treatment in particular circumstances, thus allowing the adult to make a choice about when he or she wants to refuse treatment and be permitted to die. At common law, a health professional cannot refuse to follow an advance directive because it is contrary to conventional notions of what is in the medical best interests of the adult. If a valid advance directive applies to the relevant circumstances that have arisen, then it must be followed. This is also the law in all but one of the statutory jurisdictions.

The position in Queensland is different. The legislation creates a very broad excuse which permits a health professional not to follow an advance directive if he or she has 'reasonable grounds to believe that a direction in an [advance directive] is ... inconsistent with good medical practice.'<sup>149</sup> This is in stark contrast to all other jurisdictions where there is no ability to override an advance directive based on a medical assessment of the appropriateness of the decision.<sup>150</sup> The Queensland provision is interesting though because the excuse is one that permits a health professional some discretion. It does not prohibit following an advance directive that is inconsistent with good medical practice; it simply excuses from liability a health professional who chooses to ignore it.<sup>151</sup>

The significance of the excuse is clear when it is examined in light of the English decision of *Re B*.<sup>152</sup> In that case, a 41-year-old tetraplegic woman, Ms B, wished to refuse artificial ventilation. Her medical team disagreed and wanted her to try other treatment options. They refused to follow her direction. Butler-Sloss P found that the refusal to follow the directions of Ms B was unlawful and that treatment should be stopped.<sup>153</sup> Assume for the moment that Ms B had given those directions which were found to be binding, but subsequently lost capacity. At common law, those directions remain binding, despite contrary views as to what is medically appropriate. However, if Ms B had given those directions in a valid and operative advance directive executed in accordance with

<sup>148</sup> See below Part VI.

<sup>149</sup> *Powers of Attorney Act 1998* (Qld) s 103(1).

<sup>150</sup> Although most statutory jurisdictions do have limits on the conditions in which advance directives to refuse medical treatment can operate: see above Part II(B).

<sup>151</sup> *Powers of Attorney Act 1998* (Qld) s 103(2).

<sup>152</sup> [2002] 2 All ER 449.

<sup>153</sup> *Ibid* 450–1.

the legislation in Queensland,<sup>154</sup> a different result could occur. A health professional could lawfully refuse to follow those directions by relying on *Powers of Attorney Act 1998* (Qld) s 103.

An excuse based on good medical practice seriously weakens the essence of advance directives: the ability of an adult to choose the treatment that he or she wishes to refuse, even if others may disagree. It also undermines the primacy that the common law has given to the right to self-determination or autonomy. The practical effect of the excuse is that an adult cannot be confident that his or her advance directive will be followed if it is not considered good medical practice for treatment to be withheld or withdrawn. The authors are of the view that the excuse should be repealed and that, in this context, the common law position reflects a more appropriate balance between the right to self-determination or autonomy, and the sanctity of life.

#### VI JUDICIAL APPROACHES TO PROOF

This Part considers another factor which is influential in whether or not an adult's advance directive is followed: the degree of proof that is required by a court and/or a health professional in relation to determining the validity of the directive and whether it operates in a particular case. How sure does a court or health professional have to be before following an advance directive? How are issues of uncertainty resolved? Will a mere assertion that reasons exist for an advance directive not to be followed create sufficient doubt? These questions are answered by the interrelation of the right to self-determination or autonomy, and the principle of the sanctity of life. As already considered in this article, the law has consistently recognised that an adult's right to self-determination allows him or her to refuse life-sustaining medical treatment, and that the right prevails over any state interest in the preservation of life. Notwithstanding the paramountcy of the right to self-determination, however, directives that refuse life-sustaining medical treatment are closely scrutinised by courts. Any doubt about the validity of the directive or whether it was intended to apply to a particular situation is likely to be resolved in favour of the preservation of life.

There has been criticism of the way that the courts have approached this exercise. Sabine Michalowski claims that there is a strong bias in favour of the preservation of life that influences how decisions are made.<sup>155</sup> She suggests that enquiries as to questions of fact, such as whether an advance directive exists and whether it applies in the relevant circumstances, should be approached in a disinterested way. If there is doubt after such an enquiry, then the principle of sanctity of life requires that the directive not be followed. However, she argues that the bias in favour of life is influencing those findings of fact so that doubt is found more readily than should be the case.<sup>156</sup>

<sup>154</sup> That is, if the directive complied with the validity requirements and satisfied the requirements of *Powers of Attorney Act 1998* (Qld) s 36.

<sup>155</sup> Michalowski, above n 72.

<sup>156</sup> *Ibid.*

A similar point is made by Ian Kennedy and Andrew Grubb in commenting on the common law requirement that ‘the patient intend his or her refusal to apply to the circumstances which subsequently arise.’<sup>157</sup> They refer to it as a ‘Trojan Horse’ because of its ability to ‘undermine the law’s apparent commitment to the patient’s right of self-determination’.<sup>158</sup> Kennedy and Grubb suggest that the courts scrutinise advance directives so closely, particularly regarding whether the situation that arose was the one precisely contemplated by the adult, that it may be very difficult for an adult successfully to refuse treatment in advance.<sup>159</sup>

The authors of this article share those concerns. While it is accepted that in cases of doubt, the sanctity of life should prevail, caution is needed to ensure that a bias in favour of life does not in itself generate those doubts. For these reasons, it is suggested that a more robust approach, such as the one taken in *Malette v Shulman*,<sup>160</sup> should be preferred. In that case, the Ontario Court of Appeal held that the provision of a blood transfusion contrary to a woman’s advance refusal contained on a card in her purse was unlawful. The doctor argued that there was doubt that the card represented the woman’s views; for example, it was unknown whether she was still a Jehovah’s Witness, whether she still knew the card was in her purse or whether she had been sufficiently informed of the nature and effect of her decision.<sup>161</sup> The Court noted the possibility of these events but concluded that the doctor’s doubts as to these matters were ‘not rationally founded on the evidence before him.’<sup>162</sup> The authors endorse such an approach. The primacy of the sanctity of life in cases of uncertainty does not warrant accepting whatever doubts are asserted, without scrutiny. Suggestions of doubt or uncertainty should be tested, and only accepted if they are ‘rationally founded on the evidence’.

So far the discussion of issues of proof has focused on the common law jurisdictions, but similar questions arise in relation to advance directives completed under statutory regimes. In the Australian Capital Territory, a health professional may not act on an advance refusal unless he or she believes on reasonable grounds that the adult understood the information about the illness and treatment options and was able to assess it,<sup>163</sup> and that the direction complies with the legislation.<sup>164</sup> The Northern Territory legislation also excuses a health professional from complying with a directive if there is uncertainty about the adult’s capacity at the time of completing the directive.<sup>165</sup> Queensland’s legislation

<sup>157</sup> Kennedy and Grubb, above n 23, 2037.

<sup>158</sup> *Ibid.*

<sup>159</sup> *Ibid* 2037–8.

<sup>160</sup> (1990) 67 DLR (4<sup>th</sup>) 321.

<sup>161</sup> *Ibid* 331–2 (Robins JA).

<sup>162</sup> *Ibid* 326, 337 (Robins JA).

<sup>163</sup> *Medical Treatment Act 1994* (ACT) s 11(2).

<sup>164</sup> *Medical Treatment Act 1994* (ACT) s 12(a).

<sup>165</sup> It is the duty of the health professional to comply with the direction unless there is ‘reasonable ground to believe that’, among other things, the adult ‘was not, at the time of making the direction, capable of understanding the nature and consequences of the direction’: *Natural Death Act 1988* (NT) s 4(3)(b).

contains a specific excuse dealing with uncertainty but that only relates to uncertainty about a direction in an advance directive.<sup>166</sup>

Although issues of proof still arise under the statutory regimes, it is suggested that a court would be less likely to interfere with an advance refusal given under the statutory regimes than one made at common law. Although only speculation, this might be the case for three reasons. First, the courts may be more likely to interfere with a common law directive, as the right to refuse life-sustaining medical treatment at common law is one that was judicially created.<sup>167</sup> It may be that there would be more reluctance to read down a document authorised by statute.

Second, a court may feel that an advance directive given under a statutory regime is more reliable. As discussed above, there are varying requirements as to witnessing and other formalities which may mean that the completed document reflects a more considered approach.<sup>168</sup>

Third, determining whether a common law directive should be followed or not generally turns on whether the person intended his or her refusal to apply to the circumstances that have actually arisen.<sup>169</sup> The determination of such a question calls for the interpretation of an adult's wishes and so provides greater scope for interference. This can be contrasted with the more specific excuses under the statutory regimes which, with the exception of Queensland, create less room for interpretation. Having said that, it may be that in future the courts will take an active role in interpreting statutory advance directives, as they have with those at common law. Indeed, it may be that any differences may arise simply because the statutory regimes are relatively new and so have not been subject to the same judicial consideration as advance directives at common law.

## VII CONCLUSION

The presumption when dealing with a valid advance directive refusing life-sustaining medical treatment must be that such a directive is binding on health professionals. The right to self-determination or autonomy requires that the wishes of a competent adult be respected and that treatment not be given contrary to that directive. However, it is also appropriate for the law to recognise that there are circumstances in which a health professional should be excused from following an advance directive. The state's interest in the preservation of life reasonably requires that a directive be disregarded, for example, in cases where the directive was based on a misunderstanding of the existence of alternative treatments, or where circumstances have changed significantly since the directive was completed and the adult now has different views.

<sup>166</sup> *Powers of Attorney Act 1998* (Qld) s 103(1). See above nn 134–5 and accompanying text.

<sup>167</sup> See, eg, *Qumsieh v Guardianship and Administration Board* [1998] VSCA 45 (Unreported, Winneke P, Brooking and Ormiston JJA, 17 September 1998); special leave to appeal refused by the High Court in *Qumsieh v Pilgrim* (2000) 21(4) Leg Rep SL 3d.

<sup>168</sup> See above nn 57–60 and accompanying text. It is accepted that this is not always the case, and indeed a common law directive may be the product of a more considered decision. The point here is why judges might 'perceive' a statutory directive to be more reliable.

<sup>169</sup> See Kennedy and Grubb, above n 23, 2037–8.

The common law and the various statutory jurisdictions achieve this balancing exercise between the right to self-determination and the sanctity of life in different ways. The common law does not contain a set of specific excuses, relying instead on an enquiry as to whether the adult intended the directive to apply to the circumstances that ultimately arose. The statutory regimes, on the other hand, tend to require adherence to advance directives except where not doing so is specifically excused by the legislation. Despite the different approaches at common law and under statute, the law generally manages reasonably well the balance between respecting autonomy and ensuring that life-sustaining medical treatment is not withdrawn inappropriately.

There are, however, two glaring exceptions. The first is the excuse of good medical practice that is available under the Queensland legislation.<sup>170</sup> It is suggested that this part of the law be repealed as it is an inappropriate limit on the right to autonomy. One of the critical functions of advance directives is that they allow adults to make decisions with which treating health professionals (and others) may disagree. An excuse that permits noncompliance with a refusal of treatment based on notions of good medical practice defeats that function and should not be recognised.

The second glaring exception where the balance between the right to self-determination and the sanctity of life is inappropriately weighted arises in relation to issues of proof. Concerns have been raised that a bias in favour of the preservation of life has meant that courts have generally tried to construe an adult's advance directive very narrowly to prevent it from refusing treatment. Although judgments are couched in the language of legal doctrine, one wonders whether a particular judge's personal philosophy and belief system underpins a reluctance to recognise an adult's decision to refuse life-sustaining medical treatment. While it is appropriate for doubt about an advance refusal to be resolved in favour of preserving life, the authors urge courts to undertake that enquiry more objectively.

<sup>170</sup> *Powers of Attorney Act 1998* (Qld) s 103(1).



	New South Wales, Tasmania and Western Australia	Australian Capital Territory	Northern Territory	Queensland	South Australia	Victoria
	Common law	<i>Medical Treatment Act 1994 (ACT)</i>	<i>Natural Death Act 1988 (NT)</i>	<i>Powers of Attorney Act 1998 (Qld)</i>	<i>Consent to Medical Treatment and Palliative Care Act 1995 (SA)</i>	<i>Medical Treatment Act 1988 (Vic)</i>
<b>Intention to revoke advance directive</b>	Directive not intended to apply to the circumstances that have arisen.	Health professional shall not comply with a directive unless he or she believes on reasonable grounds that the adult has not in any way changed his or her decision since making the directive: s 12(b).	Health professional must comply with directive unless there are reasonable grounds to believe that the adult intended to revoke the directive: s 4(3)(a).	—	Not regarded as a refusal of medical treatment if there is reason to suppose that the adult intended to revoke the directive: s 7(3)(b).	—
<b>Uncertainty</b>	Directive not intended to apply to the circumstances that have arisen.	—	—	Excuse if health professional has reasonable grounds to believe that direction is uncertain: s 103. However, first they must have consulted any attorneys appointed under the directive: s 103(3).	—	—



